Investigation into the circumstances surrounding the death of a man at HMP Gartree in October 2007

Report by the Prisons and Probation Ombudsman for England and Wales

June 2009

This is the report of an investigation into the circumstances surrounding the death of a man in 2007 at HMP Gartree. The man was found dead in his cell during the morning roll check. He died as a result of a self inflicted cut to his throat. The man had spent six months at Gartree. He had threatened to take his life on a number of occasions during his time in custody.

The loss of any family member is distressing, but especially so whilst they are in prison (and, in the man's case, in prison for the first time). I offer my sincere condolences to the man's family and friends. I must also apologise for the delay in issuing this report. I much regret the further distress caused as a consequence.

The investigation was undertaken by two of my investigators. I would like to thank the then Governor of Gartree and her staff for their co-operation. I am particularly indebted to the prison's Liaison Officer for ensuring that documentation and additional information were made available to my investigators and for facilitating the visits that were made to Gartree.

A Consultant Psychiatrist from Leicestershire Partnership NHS Trust carried out a clinical review into the care and treatment the man received whilst at Gartree. The clinical reviewer was assisted by a senior nurse. I would like to thank them both for the clinical review and attach it as an annex to this report.

I am sad to report that the Night Orderly Officer (NOO) involved in the emergency response when the man was found has himself since died. To respect his anonymity, I refer to him by the role he performed that night and not by his name.

The man was serving a life sentence that he found difficult to accept. He was under the supervision of Gartree's visiting psychiatrists soon after he arrived. He was then placed in the care of the prison's own mental health team. The man refused food and threatened to kill himself or others. He also threatened to harm himself, although the actual incidence of self harm was infrequent. He was placed on suicide and self harm monitoring and support procedures (ACCT - Assessment, Care in Custody and Teamwork), and remained in the healthcare centre under constant or a raised level of observation for several months.

Six weeks before his death, the man's ACCT document was closed.

This is the eighth death in custody at Gartree that I have investigated over the last four years, and the third apparently self inflicted death. One of my earlier investigations found that the level of support given to a man with comparable difficulties to those of this man was high. However, my report spoke of gaps in information sharing between wing staff and healthcare staff, and suggested that local emergency responses should be reviewed to ensure that staff were better equipped to attend life threatening situations. In this investigation, I found that Gartree had taken on board two of the lessons from my previous report.

I have considered the circumstances of the man's death against the difficult balance that prisons have to strike when caring for vulnerable prisoners. I have been impressed by the way that staff at Gartree attempted to ensure the man's safety and the safety of others, whilst providing a care plan that would return him to mainstream prison life. My investigation also uncovered examples of joined up working between healthcare and operational staff within the context of safer custody.

However, two main issues dominate the findings of this report. They centre around the management of the closure of the man's ACCT in August 2007 and the decision not to open one in September. I make five recommendations. Four recommendations relate to ACCT procedures for case reviews, closing ACCTs, family involvement and the follow up closure interview. My final recommendation relates to the issuing of razors to emotionally vulnerable prisoners.

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Prisons and Probation Ombudsman **June 2009**

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SUMMARY

The man was remanded in custody in September 2005, charged with murder. He spent around a week at HMP Leeds before being transferred to HMP Doncaster. He remained at Doncaster until his trial at Leeds Crown Court. He was convicted and sentenced to life imprisonment in June 2006, and returned to Doncaster as a convicted prisoner until his transfer to HMP Gartree in April 2007.

When the man arrived at Gartree, he was located onto B wing (the induction wing). During his First Night in Custody interview, he told a member of staff that he had previously been on a self harm monitoring and support form (ACCT). Unfortunately, the document had not accompanied him. In April 2007, the man was found with a television cord around his neck and an ACCT was opened. He was seen by a doctor who prescribed diazepam (a benzodiazepine used for its sedative and anxiety-relieving effects) and zopiclone (a sleeping tablet).

Between late April and early May, the man was managed on the wing. At his case reviews, his risk was assessed and then increased from low to a medium or raised level. On 7 May, the man's case review was attended by one of the prison's mental health nurses. The nurse decided that his risk had heightened and moved him to the healthcare centre for constant observation and assessment. From 8 to 12 May, the man was placed on intermittent observations of one per hour and case reviews every other day. By 14 May, his observations were reduced again to one every two hours. His compliance with taking medication was variable.

The man's behaviour was characterised by a number of traits. He paced up and down his cell for long periods of time, and fluctuated from being well presented and keeping a clean cell to not looking after himself at all. He also displayed a mood that was described as 'hyped' and ate on an irregular basis. His mental health on any given day was irregular, and he often described intrusive thoughts or thoughts that seemed bizarre.

Throughout his time in custody, the man maintained that he had the condition called temporal lobe epilepsy which was the cause of both his challenging behaviour and the seizures he had experienced in the community and in prison. He was referred to a neurologist, but was not diagnosed with the condition. In addition, two psychiatrists who visited the man at Gartree independently concurred that he was not suffering with any treatable mental illness. They diagnosed personality disorder, which the man resisted. He made some attempts at self harm: he made ligatures, bladed weapons and stockpiled his medication.

The man made some progress in August 2007 and steps were taken to reduce his observations and officer supervision. He also had a trial period of reintegration on a main residential wing, but this was not successful. The man returned to the healthcare centre for a second time and was placed on constant watch again.

The man continued to struggle with his diagnosis. He began to show signs of wanting to move into the main prison with a view to securing a place in the therapeutic community and progress with his sentence. At his case reviews, staff reached a consensus that they would begin the process of reintegrating him onto B wing for a second time. After discussing the plan with the man, and making him aware of what he would need to achieve in order to become eligible for both, he moved back to normal location on or around 25 August.

The man's ACCT was closed, in agreement with all staff who attended his case review, on 30 August. He spent the next six weeks on B wing and began the process of induction. His behaviour was changeable. Some days he would be upbeat, but on others he was unkempt and said strange things. However, his focus was that he believed he was suffering from epilepsy and he attended several appointments with nurses and doctors during this time. The follow up ACCT closure interview appears not to have taken place.

The man was locked up just after 7.30pm, the day before his death in October. He was discovered by the night operational support grade at approximately 5.40am the following morning. The man had cut his throat and was pronounced dead at 6.31am.

I conclude that in the main the man received a high level of care whilst at HMP Gartree. Healthcare staff acted appropriately in assessing and treating him for food refusal and his mental health needs. However, I have concerns regarding how quickly his ACCT was closed following a period of constant watch. I also raise issues regarding proper consideration of recent events in case reviews, and ensuring post closure reviews take place. I also ask the Governor to explore the question of restricting the access of more emotionally vulnerable prisoners to razors.

THE INVESTIGATION PROCESS

1. I appointed two of my colleagues to lead the investigation on my behalf. One of my investigators opened the investigation at Gartree in October 2007 when she met the then Governor. On her initial visit, my investigator was given a tour of Gartree, including the cell where the man died. She met members of the local committee of the Prison Officers' Association (POA) and the Independent Monitoring Board (IMB).

2. Notices were issued to both prisoners and staff, inviting anyone who might have information relating to the man to make themselves known to the inquiry. As a result, three prisoners came forward and were subsequently interviewed by my investigators. The man's prison and medical records were made available to my investigator. She returned with my second investigator to conduct interviews in December 2007 and January 2008.

3. My investigator also made contact with a detective sergeant who conducted the investigation for the police. The detective sergeant agreed to share the police witness statements.

4. My investigator was unable to interview two members of staff due to the fact they no longer worked in the prison.

5. Following the man's death, the Night Orderly Officer (NOO) who found the man was signed off from work as he was unwell. This meant my investigator was unable to interview him, although the police shared his police witness statement. Sadly, the NOO has since died. I have therefore chosen to protect his anonymity out of respect when referring to the role he played during the night of the man's death.

6. My investigator asked Leicestershire County and Rutland Primary Care Trust (PCT) to conduct a review into the clinical care afforded to the man. Given the man's mental health issues, the PCT commissioned a Consultant Psychiatrist from Leicestershire Partnership NHS Trust, to conduct the review. I am grateful to the PCT for providing someone with the relevant expertise.

7. The clinical review contributed in part to the delay of his report, as it was not received until May 2008. However, the remainder of the delay has been due to staff changes within my office. I recognise the man's family have been waiting a considerable time for this report. I also realise that, although my investigator fed her findings to the deputy governor at the time of investigating, the Prison Service and Coroner would have benefited from receiving the report earlier. I sincerely apologise for these delays.

8. One of my Family Liaison Officers contacted the man's mother shortly after the investigation was opened. My Family Liaison Officer

explained her role and that of my office and provided information about the investigation process. The Family Liaison Officer then spoke to her on two occasions in November 2007. During the conversations, the man's mother raised a number of concerns in relation to her son's care and treatment at Gartree and asked for more information about certain events. The man's mother's main concerns are summarised as follows:

- Why did the man have a razor in his possession?
- Was he "on watch" at Gartree and what did this entail?
- What medication was he receiving?
- What other medical treatment was he receiving?
- What is the nature of the letter found in his room addressed to (a named individual)?
- What are the facts about the method he chose to take his life?

9. In answer to the penultimate point, it is my understanding that the police took possession of the letter. The police told my investigator they did not believe the letter was a 'suicide note'. However, the contents are unknown to my investigator. I address the other issues in the appropriate sections of the report and hope that the man's family find them helpful.

HMP GARTREE

10. HMP Gartree opened in 1966, originally as a category C prison. Within a year, it was converted to a top security dispersal prison and maintained this function for approximately 25 years. In the early 1990s, Gartree was re-categorised to a B category training prison for adult male life sentenced, and now indeterminate sentenced, prisoners. Typically, it holds prisoners in the early stages of their sentence for up to five years. Gartree has a certified normal accommodation of 399 and an operational capacity of 404.

11. The prison's purpose is to help prisoners come to terms with their sentences, to assess their individual needs and to provide specific interventions, such as offending behaviour programmes, until such time that they can move through the prison system towards eventual release.

12. Gartree has four residential wings (A to D), a therapeutic community unit, a healthcare unit and a supervision and assessment unit. Due to the nature of the prisoners, Gartree has a fairly static population and receives and transfers on average around nine prisoners per month.

13. Her Majesty's Chief Inspector of Prisons carried out a full unannounced inspection at Gartree in 2001 and an announced inspection in 2005. The more recent report, published in August 2005, compared both sets of findings and concluded that Gartree had 'drifted' away from its essential functions. The prison had lost its focus on providing both a positive and risk reducing sentence plan for individual prisoners during their first few years of prison life.

14. In her summary, the Chief Inspector of Prisons commented more positively on areas such as the therapeutic community, the drugs intervention work, and offending behaviour programme delivery at Gartree. She also found that the staff/prisoner relations were good and were demonstrative of a sound foundation on which to rebuild the key functions of the prison. Of the residential units, the Chief Inspector of Prisons said that wings A to D were clean, light and warm in the main.

15. B wing was opened as a designated induction wing in July 2006. All new prisoners go to B wing and remain there until they have completed their sentence planning boards, held around three months after their arrival, in accordance with national procedures. It is important to note that the Chief Inspector of Prison's' inspection took place before B wing was made into an induction wing.

Life sentence prisoners

16. When I took over responsibility for deaths in custody investigations in 2004, the number of life sentenced prisoners stood at 5,594. Since then, there has been a near 25 per cent increase in the 'lifer'

population. At the time of writing, the lifer population is 6,919 (6,511 adult men, 207 adult women, 201 juveniles and young offenders.) Gartree is on course to hold more life sentence adult men than any other establishment in England and Wales. Since the Chief Inspector's inspection in 2005, the population has risen from 402 to 576 (as at June 2008). This is not the projected increase of 700 that the Independent Monitoring Board envisaged in their most recent annual report at Gartree (2006/07), but it is still a significant increase which places an additional weight on Gartree.

Mental Healthcare

17. In 2001, funding became available for Mental Health In Reach Teams (MHIRT) in prisons. The thinking behind this development was that provision would mirror the services available in the community. The National Standards Framework for mental health was applied to ensure both primary and, as far as possible, secondary provision became available to prisoners.

18. The MHIRT clients in prison largely mirror the caseloads of community MHIRTs. Of a sample interviewed in 2007 for the Chief Inspector's thematic review of the care and support of prisoners with mental health needs, 74 per cent suffered from depression, schizophrenia and psychosis. Of the total number sampled (66 prisoners), 76 per cent had previous mental health contact in the community and 77 per cent were on medication. At the time of the thematic review, 80 per cent of prisoners had nurse-led MHIRTs with access to other mental health professionals including psychiatrists, clinical psychologists, and counsellors.

19. The thematic review's overall conclusion was positive, in that the last ten years had seen a marked improvement in both the quality of care and the extent of care available. However, the review highlighted two areas of concern: a significant number of gaps in service which led to unmet needs, and a demand for provision from the prison population that continued to outweighing supply. Commenting on provision at Gartree in 2005, the Chief Inspector of Prisons said that care was delivered by two teams (MHIRT and Gartree's own prison mental health team), and was well supported by doctors and the visiting psychiatrists.

Assessment, Care in Custody and Teamwork (ACCT)

20. There is a strong link between prisoners with mental health problems and self harm. In general, Gartree has relatively low levels of self harm. In 2006/07, the prison opened 110 ACCTs.

21. Open ACCT documents are kept on the wings and travel with an individual prisoner wherever he goes. When ACCT documents are closed, the deputy governor carries out a quality check of the document. The Chief Inspector of Prisons commented in 2005 that

reviews of prisoners ‘at risk’ were satisfactory and some reviews were of a high standard. In their annual report from 2006/07, the Independent Monitoring Board echoed these findings and said that Gartree’s ACCT document completion had improved. However, the IMB reported that there was room for improvement and a need for staff to receive annual refresher courses. This training would make further improvement to individual care maps and staff completion of the ‘trigger’ boxes in the document.

Healthcare Centre

22. Gartree delivers both primary and secondary healthcare services, akin to a doctor’s surgery and an inpatient facility. The healthcare centre is over 40 years old, and somewhat tired in appearance. The IMB commented in 2006/07 that refurbishment plans were currently under discussion at senior and area management level. Despite appearances, the IMB report said that the healthcare centre delivered an ‘excellent service’.

23. When new prisoners arrive, they are seen by a member of the healthcare team in reception and a needs assessment is then carried out in the healthcare centre. The healthcare centre has a good skills mix and employs a number of registered mental nurses, general nurses, one counsellor and a visiting psychiatrist who carries out, on average, one session every two weeks.

24. The inpatient facility consists of 14 beds, one of which is reserved for continual observation and is fitted with Closed Circuit Television (CCTV) and is a gated cell. (This is where the man spent much of his time.) The IMB commented that numerous prisoners located in the inpatient wing should be accommodated in more appropriate accommodation, such as secure hospitals, where the necessary treatment could be provided.

KEY EVENTS

25. When the man was transferred from Doncaster to Gartree in April 2007, he was assessed by healthcare staff. During his assessment, the man said that he had not been eating because he thought that staff had poisoned his food. He was then located on B wing, the induction wing, and was interviewed by an officer as part of the first night in custody procedures. According to first senior officer who recalled the man's arrival on the wing, staff became aware that the man had previously been placed on an ACCT at Doncaster. It was closed before he transferred, but the documentation did not travel with him. The first senior officer requested the man's closed ACCT from Doncaster. Healthcare staff referred the man to the mental health in reach team.

26. Approximately two weeks later, the man saw a registered mental health nurse (RMN) and said that he was suffering from seizures brought on by temporal lobe epilepsy. In his medical record, the nurse made a note which said that the man would be referred to a neurologist. Two days later, an unsigned entry in his medical record said that the man did not have temporal lobe epilepsy. During consultation, the man's mother told my investigator, that the man had received a diagnosis of epilepsy in the community. Indeed, the man was maintained on medication to prevent seizures.

27. In April, the man admitted to having intrusive suicidal thoughts and said that he felt agitated. He was found with a cord from a television around his neck, and was prescribed diazepam and zoplicone by the prison doctor. The man was never allowed to have his medication in possession, and a nurse would dispense each dose to him individually. An ACCT was opened the same day, and the immediate action plan said that the man would remain on B wing, with two observations per hour, and have access to Listeners and the Samaritans by telephone. At the review, the man said that he did not want the document opened, and that there was nothing wrong other than his illness. He said that he did not feel that the staff could do anything to help. I have found that his caremap was of a good standard.

The man's ACCT reviews in May 2007

28. At his case review in May, the man denied thoughts of suicide or self harm but was concerned about his previous mental health problems returning. He explained that the last time he was ill, he had self harmed by cutting his wrist and severing an artery. The man said that his medication was helping. The man's ACCT was to remain open and his allocated RMN was invited to the next case review.

29. The next day, the man told staff that he regularly heard voices which told him that staff were going to harm him by poisoning him. The mental health team leader at the time suspected that the man was

suffered from psychosis and wrote on his Cell Sharing Risk Assessment that the man was too vulnerable to share a cell.

30. A few days later (7 May), the RMN went to the man's case review and noticed that he had deteriorated. The man said that he was not eating, and felt that by eating he 'got hyped up'. He also said that he was suffering from rapid intrusive thoughts telling him to kill himself. These thoughts were regular and intense, and the man believed that he should be dead and said that he wanted to die. He also said that he would cut an artery, and had tried this before. The man made several references to God and that he had received messages through the television and radio. During his review, it was noticed that the man would not make eye contact and was rambling. The man told the RMN that he had been sleeping. However, staff on B wing had reported that he was deteriorating rapidly.

The man's stay in the healthcare centre

31. The following day, the man was admitted to the healthcare centre for assessment. He was placed on constant watch in a cell with a gated door to allow for observation. His history of psychiatric problems and a diagnosis of personality disorder were recorded. As the man was not eating, healthcare staff began food refusal procedures (this involves monitoring what a prisoner is eating, drinking and how frequently they are using the toilet, as well as regular clinical tests to measure the impact on the body). At his case review, the man's observations were reduced from constant to intermittent and the man said that he felt more paranoid on constant watch.

32. At his next review on 9 May, the man said that he felt 'hyped up'. By not eating, he thought it would help to calm him. Despite being advised of the effects of not eating, the man said he would not eat until he felt better. Throughout his review, the man made poor eye contact and looked unkempt. He also refused to take his medication, saying it was like poison the same as his food. The mental health team leader eventually persuaded the man to take olanzapine, an antipsychotic drug every night.

33. The following day, the man continued to agree to take his medication, but said that he was not sure that the drugs were as strong as those he had been prescribed whilst in the community. The man said that it would take a lot of drugs and alcohol to calm him down. He remained on a minimum of four intermittent observations per hour.

34. The man said that he no longer felt 'hyped up' at his review on 11 May. However, he did explain that his impulsiveness made him unpredictable. The man continued to present as someone who was agitated, and paced up and down his cell. His eating and drinking habits were also discussed (The man was seen to have a cup of tea and one slice of toast). He had lost weight. The same day, the man

was due to see the visiting psychiatrist but the appointment was cancelled as the psychiatrist could not attend. The man was monitored by staff for the rest of the day and it was observed that his eating continued to be a problem.

35. At his review on 12 May, staff noticed an improvement in the man. The observations were reduced to once hourly, and reviews were extended from every day to once every two days. The man told staff that he did not feel suicidal and described his mood as 'elated'. He had also had a shower and a shave. The man's review notes said, 'to the man this means he feels well'.

36. During a review of the man's ACCT on 14 May, he appeared anxious and did not keep eye contact well. The man said that he was feeling much better and described himself as elated and not suicidal. However, the man was barely eating and was concerned that if he ate his thoughts would become bizarre. He was encouraged to clean his cell which he agreed to do. The man's observations were then further reduced to once every two hours. Healthcare staff kept a record of his weight and it was noted that he was taking fluids.

37. The man was reviewed again on 16 May. At the review, the man said that he did not want to harm himself but failed to recognise what harm he was doing by not eating. He continued to pace up and down his cell, and did not want to occupy his time doing anything else. Explicit in his ACCT was a note to say that the man needed to be urgently reviewed by the visiting psychiatrist. During a routine cell check, a large quantity of medication was found hidden in a sock in the man's cell. The tablets were his prescription medication.

38. A visiting Forensic Psychiatrist saw the man on 17 May. The man told the visiting Forensic Psychiatrist that he did not have a choice about coming to Gartree. He denied having any problems on B wing and said that he knew people in the prison who had also been transferred from Doncaster. The man confirmed that he had stopped taking his medication. His reason was that he did not trust them any more. When asked about his eating habits, the man reiterated that food made him feel 'hyped up'. The man told the visiting Forensic Psychiatrist that he was unhappy that epilepsy was not diagnosed, as he blamed the condition for his problems. The man said that, following the dismissal of epilepsy, he was at a loss to explain his behaviour. The visiting Forensic Psychiatrist asked the man about his self harming, and specifically about 20 April (when the man was found with a cord around his neck). The man denied an attempt to harm himself, and said that staff were making it up. He also explained that using drugs and not eating were his way of controlling his feelings outside of prison. Having absorbed the man's comments, the visiting Forensic Psychiatrist did not think that he was psychotic. Instead, the visiting Forensic Psychiatrist thought that the man was desperate to medicate his problems rather than try and deal with them himself. Medication was, therefore, clearly

important to him. The visiting Forensic Psychiatrist suggested that the man had a personality disorder with paranoid, histrionic and dissocial features.

39. At his next ACCT review on 18 May, the man said that he felt quite 'hyped' but had improved over the last few days. He was moved to another cell in the healthcare centre (HCC), and was noticeably more relaxed. For the next few days, the man's food refusal was intermittently monitored. His weight was recorded as 66kgs, and the clinical reviewer has recorded that ketones were present in his urine. (Ketones are an indication of the risk of diabetes or kidney and liver problems, often due to poor diet.)

40. By 21 May, the man was placed on constant watch again. The night before, he had experienced obsessive thoughts, particularly about hunger strikes. The man told the RMN at the review that he believed that it would take him 70 to 100 days to die on hunger strike. He said he was sending out visiting orders to his family to say goodbye to them. The man said he was fed up of feeling ill and having mental health problems, and had no intention of finishing his sentence. The RMN in his medical record that the man was behaving bizarrely and laughing at inappropriate moments. The nurse also said that the man seemed agitated and depressed. The man agreed to try antidepressant medication but would not eat.

41. At his next ACCT review the following day, those present discussed why the man was placed back on constant watch. Another prisoner in the healthcare centre told staff that the man had said he was going to kill himself. The review noted that constant watch was to continue due to the risk of the man harming himself, but not specifically due to self starvation. Later that day, the head of healthcare discussed the man's food refusal with the deputy governor. Both agreed to discuss the issue with other prisons, to enhance their knowledge about how to manage someone on food refusal.

42. On 23 May, the man did eat some toast and took his diazepam. He said that he had slept better, but he was also seen pacing his cell again. In his ACCT review, it was noted that he had spent some time speaking with another prisoner, which seemed to have a positive effect. The man was encouraged to spend more time with other prisoners, but whilst his ACCT remained open (pending doctor assessments) he remained a high risk. His medical record held a letter dated 10 May from a consultant neurologist. The consultant neurologist explained that s/he had received a letter from the man in which he complained that he experienced seizures. The consultant neurologist asked for eye witness confirmation, and said that if the seizures appeared to be 'complex partial seizures', it might be appropriate to prescribe oxcarbazepine, an anticonvulsion and mood stabilising drug.

43. The next day, the man spoke to his mother on the telephone. At his ACCT review, he asked for constant watch to be removed. Staff explained that his level of observation could not be reduced at that moment because of his presentation.

44. The man was seen again on 25 May by a prison doctor. During the session, the man said that he was still not eating, although the prison doctor noted that a member of staff had observed the man eating a sandwich the previous day. The man was not taking olanzapine, again because he did not trust it, but was taking diazepam. The man repeated that he was fed up with being ill. He told the prison doctor that he did not want to kill himself, and accepted that long term starvation would lead to a painful death. The man denied hearing voices, but said he did not watch television as it talked about his life. When asked for further examples, the man just smiled. He was unkempt in appearance and made little eye contact during the session. The prison doctor noted that the man was not experiencing delusions and there was no evidence of cognitive or perceptual abnormality. Although the man believed he had temporal lobe epilepsy, the prison doctor agreed with the visiting Forensic Psychiatrist that his behaviour was not attributed epilepsy. He also felt that the man had not been entirely honest when discussing his feelings and perceptions.

45. At the man's ACCT reviews on 25 and 26 May, he maintained that he had only eaten cheese on toast in the last four weeks and would continue on a minimal diet until he felt alright. The man said that he was prepared to die if it took that long, and that he had had enough. He then became a little aggressive. This review decided that his constant watch observations should remain unchanged.

46. Over the next few days, the man's mood and habits did not change. At his ACCT reviews it was said that he had been observed pacing in his cell and on the exercise yard. He had eaten some sweets, offered by the first Principal Officer whilst she carried out a constant watch, but maintained that he would not eat proper food. At his review on 29 May, the man said that his brother was due to visit him at the weekend. He remained on constant watch, and his review documented that this level of observation would continue until his state of mind improved.

47. The man resisted the idea that, in refusing food, he was likely to cause serious or fatal damage to his health. On 31 May, his case manager questioned the use of constant watch for the man's food refusal. He also questioned whether the man presented as someone who was at an acute risk of suicide. However, the man remained in the healthcare centre on constant watch.

The man's ACCT reviews up to 21 June 2007

48. For the first few days in June, the man displayed a heightened level of agitation. At his ACCT reviews, he maintained that he would not eat,

and reiterated that he did not like what the staff were putting in his food. He also said that he wanted a transfer to HMP Wakefield. On 1 June, The man made a telephone call to his mother and left an abusive message. (At consultation stage, the man's mother said this call was made after a long exchange between prison staff and the man about not receiving a visit. The man's mother said that this was not typical of the man and he apologised afterwards.) The next day, his weight loss was noticed again but he remained adamant that he would not eat. Another discussion about the appropriateness of keeping the man on constant watch took place and a meeting was arranged to discuss the issue further. The man's behaviour during a review on 3 June was aggressive, and he told the RMN that he felt threatened by prison staff and would kill in self defence. The man added that he felt frustrated that the psychiatrists had not listened to him, and after he killed someone it would be too late. Despite these thoughts, the man agreed to eat again. His level of risk remained high.

49. On 4 June, the man seemed more communicative and a full inter-departmental review was arranged. Following his ACCT review, his level of risk was reduced. Staff observed that he had eaten a considerable amount of food, and had also had a shower, shave and hair cut. The next day, the man's brother and brother in law came to the prison for a family visit.

50. The RMN saw the man on 6 June at his request. He told her that he felt out of control and was having more serious thoughts of killing someone. The man also said that he was hearing voices telling him to kill. He warned that he did not want to kill someone and therefore might kill himself. He remained on constant watch. It was noted that he was not taking his olanzapine.

51. Later that day, a case review was carried out with the full multi-disciplinary team. This included the head of healthcare, the duty governor, the security PO (Principal Officer), a B wing SO (Senior Officer), The man's B wing personal officer and his mental health worker, the RMN. The man only stayed briefly, and left saying that he wanted no further part in the review. In his absence, it was agreed that the man's personal officer on the B wing (as well as an ACCT assessor), would reassess him. The multi-disciplinary team concluded that the daily reviews up to date differed with regard to the man's intention to die. His level of risk remained the same.

52. For the next week, the man continued to have daily ACCT reviews where he frequently asked to come off of constant watch. This was not granted. On 7 June, the man participated more in his review than he had the day before. He said that he felt isolated and more agitated in the healthcare centre than on B wing and would prefer to go to the segregation unit. The man said that being in the healthcare centre was preventing him from killing himself. He told staff at the review that he did not self harm, rather he would make attempts on his life. When the

man was asked if he wanted to die, he said “don’t care”, and that he was “… fed up of being ill”. When asked if he had a plan, the man replied “don’t know”, but then said that he would hang or cut himself.

53. The man said that he slept okay, did not suffer from panic attacks, but that he did sometimes hear one voice that made him anxious and worried. This was not an everyday occurrence, but he had heard a voice in the past few days. The man said that the voice spoke and mumbled but he would not say what the voice actually told him. The man expressed a wish to see a psychiatrist, but added that the psychiatrists he had seen did not believe him or take him seriously, and lied to him. The man then denied ever threatening anyone else, and said that others threatened him, either to force him to eat or to take away his medication.

54. The man spoke about his lack of trust for staff and prisoners in Gartree but did say that he communicated with some of them. He mentioned the pacing in his cell, and said that this made him feel better and that he only felt safe when in his cell. He disclosed that he did not like to go on the exercise yard.

55. The family visit that took place on 5 June was also mentioned. The man described his feelings after the visit as more anxious. He said that his brother had noticed a change in him and that his mother was worried about him. The man told staff that he was not writing to his family but was receiving letters from them.

56. In terms of his medication, he thought that his prescription only gave him limited help. With regard to his eating habits, the man still believed that he would not die of starvation. He said that he felt ‘hyped’, but he could not elaborate further on what this meant other than to say that eating made him feel more suicidal. The man told staff that he did not care if he was on constant watch or not, as he would feel threatened either way. He mentioned that at Doncaster the protocols of handling his food refusal had been very strict. However, the man said that he did not care whether Gartree adopted a strict position or not. Commenting on the multi-disciplinary review from the day before, he said that there were too many people, and that he would attend reviews in future as long as there were a small number of people there.

57. Between 8 and 10 June, the man went to his case reviews. He spoke about feeling very well and safe when locked up. His medication was increased. Although he was not eating to begin with, this had improved by his review on 9 June. In response to his request to come off constant watch, the man was told that staff would need to see continued positive steps over the course of the weekend, and would consider his level of observations again. On 10 June, staff agreed to develop an action plan for the man to encourage these positive changes. He did not turn up for his review the following day but did speak to the second nurse. The man said that he would not harm

anyone, was not hearing voices and was convinced that he would be transferred to another prison.

58. On 12 June, The man's behaviour was still said to be up and down. He continued to talk about prisoners and staff being 'shipped out', but on a positive note he had an appetite and seemed more upbeat to staff. He went outside for two periods of exercise under constant watch, and had something to eat. The man did not attend his ACCT review that day.

59. A hand made weapon with a blade was found under his pillow during a routine search the following day. His risk was raised to high. At the review meeting on 14 June, the team agreed that little progress had been made towards reducing the man's level of observations from the maximum. The team also agreed that the man should be interviewed by a psychiatrist about the weapon in his cell.

60. During the night, the man seemed preoccupied with transferring out of the prison. He was observed packing his bags and spoke about a move to another establishment. Between 13 and 15 June, he made several ligatures. A cell search on 15 June found a ligature under his pillow and drawings of other ligatures. Staff also found a small bag containing a crushed white substance.

61. Later that day, during an assessment with a psychologist, the man explained that he intended to use the weapons on himself. The man then told the psychologist that he was going to be 'shipped out', and that all the prisons in the area were going to be emptied. The man said that this was why he wanted to use the weapon on himself. At his ACCT review, the man talked about the discovery of his ligature and the drawings of nooses. He talked openly about the subject, and said that he no longer felt safe where he was, that he was not comfortable with being searched, and did not want to be on constant watch. The man then said that he did not feel that his behaviour was in his control. Staff agreed that the man should remain on constant watch, and that his bedding should be checked daily to determine whether a further search would be necessary.

62. The next day (16 June), the man was found making a ligature from a bed sheet. At lunchtime, his bedding was removed and staff replaced it with anti-tear sheets. He was also seen bending a TV aerial into the sheet. Staff removed his TV aerial along with other items. The man responded aggressively and did not attend his ACCT review that day.

63. On 17 June, the man did attend his review and said that he was having a better day. The RMN told him that he would have to have a few good days before any of his items could be returned to his cell. The man said that he would not make ligatures, but later said that suicide would happen at some time. Following the review, the man remained on constant observation.

64. The man's description of how he felt over the next two days was contrasting. At his ACCT review on 18 June, he said that he felt happier and was having another good day. He described his mental health from the previous week as very confused and delusional. The man maintained that he often had suicidal thoughts but had not had any that day. However, on 19 June the man mentioned that he again heard voices which told him how to make a ligature. He also admitted that he would have cut his arm with the intention of killing himself, not just to harm himself. Following a lengthy discussion over how best to manage the man, he remained on constant observation.

21 June – 6 July

65. For the next few weeks, the man began to show gradual and consistent improvement. He also expressed an interest in working towards a place in the therapeutic community at Gartree. The man was told that in order to secure a place, he would have to come off his current medication. His eating became more regular, his cell condition and personal appearance improved, and his level of observation was reduced so that he was constantly observed for only part of the day.

66. During his period of improvement, the man was given a radio and treated it well. On 21 June, at his case review, it was agreed that the man would be unlocked more often for free movement. The following day he remained in positive mood, and his appearance and eating had improved. However, when asked about thoughts of hurting himself or others, he said he did not want to talk about it as he 'did not want to get himself into trouble'.

67. On 24 June, the man said that he wanted to see someone about coming off his medication. The information was passed to the RMN in order for an appointment to be made. The man continued to improve and comply with his medication. On 25 June, his time out of cell was increased to two hours in the morning and two hours in the afternoon. He asked if he would be able to go back into his cell if he wanted to and this was agreed. The man's observations remained constant.

68. The next day was another good day for the man and it was reported that he had responded well to more time out of cell. However, he became slightly preoccupied with thinking he was going to be 'shipped out'. His thoughts continued despite reassurances from staff. More positively, the man did think that the olanzapine he had recently restarted was helping his mood and was also increasing his appetite.

69. At his ACCT review on 28 June, staff agreed that he was continuing to progress and was at a lower risk of self harm. The man said that he did not feel suicidal and attributed this to his medication. Staff at the review decided to remove the officer from outside his cell during unlock periods. However, an officer was to remain during patrol states (these are periods when all prisoners are locked in their cells and there are

limited staff on duty – specifically at lunch, teatime and overnight). The new arrangement was monitored over the next few days to assess whether the man could come off constant watch. His risk was reduced to low.

70. The man would not enter into discussion at his next review on 30 June. This meant that no assessment could be made. In this light, a decision was made to increase the man's risk to 'raised' and for constant observations to resume. He was more talkative the following day, but by 2 July appeared cautious about being totally open on reviews. The man seemed worried that anything he disclosed could be misinterpreted or highlighted as a security issue. He continued with his medication, and said that he still wanted a referral to discontinue his prescription.

71. On 3 July, the man's ACCT review went ahead without him as he refused to attend. Staff discussed how he was, and again mentioned the prospect of changing his observations so that at lunchtime and tea time the officer would withdraw and observe the man from a greater distance or by camera. It was agreed that at night a patrol officer would sit outside the cell. It was decided that steps should be taken for the man to familiarise himself with B wing to build towards his eventual return. The wing observation book was updated and recorded that the man remained on ACCT. The book also had an entry which said that the man should not be given a razor 'in-possession'. In practice, wing staff told my investigator that this meant the man could use a razor but he had to return it to a wing officer once he had finished with it.

72. The following day (4 July 2007), the man's observations were reduced and he was only on constant watch from 5.30pm through the night. During the day, an officer was deployed from the wing staff to observe the man from a distance four times an hour. This was in order to give healthcare staff additional support during the day. The man did not attend his review. At his next review the day afterwards, the man reiterated that he wanted to see the visiting psychiatrist when he next attended Gartree. The man's new observations remained unchanged.

73. On 5 July, The man gave a letter to a member of staff that contained threats to harm himself and others. The man spoke to a member of staff, the third nurse, about the notes he had been making which were aggressive and threatening in nature. The man reiterated to the nurse that he had been diagnosed with schizophrenia in the community and had been treated in hospital, but that his diagnosis had changed to that of personality disorder at a later date. The man asked to see the visiting Forensic Psychiatrist, and explained that his mental health history had not been properly explored. This information was not duplicated in the man's ACCT document.

74. The next day (6 July), appeared to mark the end of the man's improvement. Although he attended his review and was positive in his

response, contrastingly, the first officer made a note of concern in the man's ongoing record. The officer's entry said that he had entered the cell after noticing paper over the camera. The officer asked the man to remove it and saw that it was paper with the words "knife is king" [sic] written on it. Whilst the staff in healthcare discussed this, the second officer saw the man go into his cell, reach down behind his bed, and put his hand down his toilet bowl. Around 15 minutes later, he was seen taking something out of a plastic bag given to him by another prisoner and placing it in his toilet bowl.

75. At 5.22pm, the man was seen placing a length of sheeting around his neck. The third officer entered the cell and removed the sheeting. Around 40 minutes later, the man began to pace up and down in his cell and then punched the cell door before he got into bed. Shortly afterwards, the man put a small amount of toothpaste on the camera. This was removed. The man asked for his cell door to be shut, but he did the same thing again and kicked the door before returning to his bed.

7 July – 3 August

76. A discussion about the man's behaviour over the previous 24 hours took place at his ACCT review and staff broadly agreed that the observations should remain in place for the time being. The man was described as having had "a couple of spats" since his last review but staff concurred that they appeared due to frustration rather than any intent to harm himself or anyone else. There was no recorded reference to the fact that the man had been found with a sheet around his neck the day before.

77. For the next three days, the man attended all his ACCT reviews. At his review on 8 July, he appeared in a reasonable mood but remained frustrated by working towards his eligibility for a move to the therapeutic community. The RMN explained that the way forward was to get himself off the constant observations in order for an assessment to commence. The nurse asked the man to realise that the onus was on him for things to proceed, which he appeared to grasp. In the ongoing record, an officer recorded a conversation regarding the man's index offence. During the conversation, the man said that he thought he acted in self defence. He also said that he had been hearing voices for years, and often could not watch television as he heard voices coming from it.

78. On 9 July, the man chose to stay behind his door. At his ACCT review, The RMN reiterated the trust issue, and said that the man's observations could not be scaled down until everyone was satisfied with the arrangement. It was noted that the man appeared to be more receptive to reason. The review outcome was to wait for the man's psychiatric assessment. Pending the assessment, a multi-disciplinary team would formulate a safe management plan.

79. Two days later, the man was assessed by the visiting Forensic Psychiatrist. The man's ACCT review recorded that the psychiatrist continued to diagnose him with a personality disorder rather than schizophrenia, but that he might experience psychotic episodes. The man did seem to accept that he did not suffer from temporal lobe epilepsy, but struggled with his current diagnosis. The psychiatrist also noted that the man was beginning to come to terms with being at Gartree, and was eating and drinking. The man continued to express an interest in going to the therapeutic community and was receptive to counselling. The visiting Forensic Psychiatrist reviewed the man's medication, and said that he should continue with olanzapine, diazepam and mirtazapine (an antidepressant). However, the visiting Forensic Psychiatrist stressed that, once the man was back on B wing, his medication should be tailed off after four to six months.

80. At his ACCT review on 12 July, the man was described as verging on angry and complained that no staff had put forward ideas to help him find a solution to his problems. The man was reassured that his requests regarding counselling and the therapeutic community were being explored. However, staff stressed that this might not happen until he had demonstrated a period of stability and was not on constant watch.

81. The next day, the man refused to attend his review as he did not like the PO who was present. Instead, the man wrote a note that he was finding it hard to come to terms with the fact that he had killed somebody. He also said that he had experienced warnings about his mental health, and did not do enough about it. The same day, during a search of the man's cell officers found another handmade bladed weapon under his pillow. They alerted security to the find and an entry was made in the man's medical record. No duplicate entry was made in his ACCT.

82. The man did attend his next review, and reflected on his appointment with the visiting Forensic Psychiatrist, saying that it had 'gone okay'. However, the man then explained that he felt 'hyped up' and was not going to eat. In his ongoing record, the man spoke about football and about his offence, and that he was sorry about what had happened.

83. On 15 July, the man said that he was having a good day, but was not sleeping as well. He put this down to stopping taking his sleeping tablets. He expressed an interest in reducing his level of observations, and those present at his review discussed how the man could occupy his time better. The man declined all suggestions but did agree to think about them. In his ongoing record, he told an officer that he thought he had an alien in his stomach, and that this was why he did not eat much.

84. The following day, another prisoner told staff that the man had a sharpened aerial in his possession and intended to use it on staff. At

the review, and in the man's absence, staff discussed his level of observations with the duty governor. They agreed that his observations should remain the same, and that the man should remain in his cell due to the potential risk he posed to staff. In his ongoing record, an officer recorded that the man had been rubbing his stomach and told the officer that he had felt the alien years before. The man spoke about it further, and said that it did not cause him pain but that he knew it was always there.

85. At around 9.30am on 17 July, the man asked for a razor so that he could have a shave. The razor was issued by one of the officers, and it was explained to him that he would have to return it when he had finished. About five minutes later, the man handed the razor back. The officer checked it before disposing of it. The man then had a wash and began to pace his cell. A multi-disciplinary review took place at 10.45am and was chaired by the deputy governor. The man did not attend. His care plan was revised and his observations were reduced from constant to intermittent observations during the day (four hourly). However, staff still agreed that the man would remain on constant watch overnight. He was also to remain behind the gated door to his cell overnight due to security issues.

86. For the next few days, the man attended his ACCT reviews and staff introduced the idea of a possible location to B wing. He had a lengthy conversation with the third officer and spoke of thoughts of hanging himself on the bolt of the viewing flap. The man also told the officer that he had made a knife out of an aerial, which was for him to use to stab the alien in his stomach. The man mentioned thoughts of stabbing himself on two or three occasions, and said that he would probably have these thoughts even if he was located on another wing.

87. On 18 July, the man's personal officer from B wing, spoke to him about returning to the wing. In his ongoing record, the man's personal officer on the B wing said that the man seemed positive about his potential re-location. The officer explained to the man that he would be his personal officer if and when he moved to B wing. Following the man's review on 19 July, staff agreed to remove his constant watch overnight. The man agreed to work with both healthcare staff and B wing staff to expedite a move to B wing in the next few days, but he remained on intermittent observations which would be carried out not less than half hourly.

88. The man was seemingly stable and, apart from covering his cell camera with paper, there were no apparent changes in his actions for two days. The man spent time sleeping and was polite and reasonable with the staff who interacted with him. He was observed pacing his cell again, and staff scheduled a review for 23 July.

89. On the day of his next review, a Principal Officer took over as the man's case manager whilst work continued to reintegrate him to the main

prison population. The man continued to display a positive attitude towards moving to B wing, although he did say that he had thoughts of self harm and had planned to recommence food refusal. His appearance had improved, having had a shave that morning. As agreed, the man returned the razor after he had finished with it. That afternoon, the Principal Officer noticed that he had not refused food and was eating well. The Principal Officer chatted to him about his proposed move from the healthcare centre and a possible further move to the therapeutic community in future. The same day, the Principal Officer took the man over to B wing for a visit. Again, they discussed his reintegration.

90. On 25 July, following a security review of his recent behaviour, it was agreed that the man's cell could remain unlocked. During the evening of 26 July and the early hours of 27 July, the man was found making a noose. He was later discovered with a ligature around his neck. Staff intervened to help the man and no first aid was needed. This led to a review with the mental health team leader (Head of the mental health team) the following morning. At the review, the man appeared to be open about his past and said that he continued to have similar thoughts to those he had previously described. He discussed his history of psychiatric problems. He cited examples of preaching on the streets, and receiving messages from the television and radio. He also told the mental health team leader that he had once told his mother that he thought he had an alien growing inside him. He did not eat to avoid feeding the alien. The man said that he did not want to get sick like that again, and that he had suffered enough in the last ten years. He maintained that he would try to kill himself.

91. The mental health team leader returned later in the day to speak more with the man. The man said that he thought it was a "good time to commit suicide". He repeated his fears of becoming ill again, and said that he was unhappy at the diagnosis of personality disorder. The man did not feel that his diagnosis explained why he received messages from the television, and told the mental health team leader that he had been in psychiatric hospitals twice, in France and Manchester, when he was 21 and 26 years old respectively. The man denied any unusual experiences, but then spoke again of aliens. When the mental health team leader asked for clarification, the man became upset and said he could not bear to have those thoughts again. He added that it was best if he killed himself before it happened. After a lot of persuasion, the man agreed not to. However, when asked to speak to staff if he felt like harming himself, the man refused and said, "No, I am going to do it if I feel like it without speaking to someone."

92. In the man's medical record, the mental health team leader wrote that it was difficult to assess him as his symptoms changed and he made regular threats. The man remained guarded and seemed to stop short of being completely open. However, the man was able to think

appropriately and did not come across as someone who was very unwell. The mental health team leader wrote:

> "… it does not appear to me that he genuinely wants to kill himself. It appears he wants people to believe him and he wants to tell them and feel [it's] an attempt to prove something to other people, I consider him as a high risk in ending his life by mistake or pure desperation to prove something."

93. Five days later, at the man's ACCT review, the move to B wing was planned in more detail. The RMN agreed to see him at least weekly on the wing. His medication was to be collected at tea time and monitored to ensure he did collect and take it. The man told staff at the review that he was happy to make his way to the medications hatch on the wing to collect his medication. The plan also detailed that wing staff would contact the prison mental health team if they had any concerns about the man's behaviour on the residential unit. His next review was scheduled for 2 August, on B wing.

The man's relocation to B Wing

94. The man's wing history and ACCT documentation do not record when he was relocated back to B wing. However, a letter from Principal Officer Whitmore, addressed to staff and governors on 24 July, confirmed that the man was scheduled to move to the wing on Monday 30 July. It is assumed that the man did indeed move to the residential unit that day.

95. According to his ACCT review on 2 August, the man settled onto B wing well and mixed with other prisoners. He also collected his own meals, and attended exercise, which was something he often found difficult to do in the healthcare centre. The first senior officer, the man's two personal officers (The man's personal officer on the B wing and the fifth officer), and the RMN were at his review. They agreed that the fifth officer would contact the education department to enquire about classes for the man. His observations were reduced to one hourly when in his cell. His ACCT also stipulated that officers would engage the man in three conversations during the core day and two during the night. All conversations were to be recorded. First senior officer entered 21 August as the date of his next review. The man was supported as planned.

96. On 7 August, the RMN visited the man on the wing after wing staff raised concerns about his unkempt state and poor personal hygiene. The man claimed he had not eaten for several days and again maintained that the food was contaminated. The RMN confirmed with the wing staff that he was collecting his meals.

97. In addition to concerns about his personal appearance, the man had also packed his belongings. He told staff that the whole of

Leicestershire was contaminated and had been evacuated to the north. He also said that all staff were 'doppelgangers' and that the real staff had left. When asked, the man denied any thoughts of self harm or suicide, but the RMN noted that he seemed in a state of excitement. The RMN checked that he had been attending the treatment room to collect his medication every day, which he had. She also arranged for the man to have his urine tested for ketones because of his food refusal, and advised wing staff to initiate food refusal procedures.

98. The man's original review date was brought forward to 8 August because of a death by natural causes at Gartree that morning. The man appeared in good spirits at the review, and said that he had settled back into B wing. He disclosed that he knew some of the other prisoners on his landing and had been spending time with them. He also stated that he had eaten his lunch that day. Those present at the review said that the man did not appear distressed by the day's events.

99. On 9 August, the mental health team leader and the RMN saw the man on the wing and agreed that he appeared more stable and was well cared for. The man told them that he had thought everyone was going to be evacuated but did not know why. He said that he was confused and could not remember things, but confirmed that he was taking his medication. The mental health team leader noted in the man's medical record that he had experienced episodes of unusual thoughts, but that there was no major cause for concern. The mental health team leader concluded that the RMN should regularly monitor the man, although he did not specify how frequently this should be.

100. The following day, the man's personal officer on the B wing noted in the wing observation book that the man had expressed an interest in going to the segregation unit. The man told the officer that he would "do something special" to stay in segregation for a long time. The man's personal officer on the B wing also wrote that the man had said he would kill someone in order to be transferred out.

101. The RMN met the man again on 13 August, and noted that he continued to experience unusual thought patterns. He told the RMN that he thought he was in a direct blood line to Jesus and that Rasputin was his father. The man still believed that a major evacuation plan was in progress, and that he would be going to the segregation unit. When the RMN assured him that this would not happen, the man repeated the threat he had made to the man's personal officer on the B wing, that he would "do something special" to get there. The man told the nurse that he believed he would be safe in segregation.

102. The man's cell was filthy. He was unkempt and maintained poor eye contact. The RMN noted that the man said he was taking his medication when it was dispensed and was now eating again. The man told her that he had no plans to harm himself at that time and did not feel depressed. After her visit, the nurse told staff to be aware of

the man. She also made an appointment for him to see the psychiatrist on 15 August. There were no changes to the level of observations documented in the man's ACCT.

103. Later that day, wing staff searched the man's cell and found a quantity of tablets (approximately 15 tablets of olanzapine and two mirtazapine). Healthcare staff thought that the tablets resembled his prescribed medication. The observations continued as before.

104. The man's appointment with the visiting psychiatrist on 15 August was cancelled. His medical record noted that another appointment would need to be scheduled as soon as possible.

105. At the man's next ACCT review on 21 August, he told the staff that he felt suicidal and had a plan for how he would kill himself by hanging. The man believed that he had nothing to focus on as there was no chance of getting a place in the therapeutic community. The man said that he did not know why he felt so down. However, he did mention that it was close to the anniversary of his offence. In the light of his comments, all staff agreed that he should be put back on constant watch overnight and reviewed the next day. He was returned to the healthcare centre.

The man's stay in the healthcare centre 22 – 25 August

106. At his first review since his return to healthcare, the man said that there were too many people present so he refused to attend. In his absence, staff discussed his past and present behaviour and agreed that he should be reassessed. They would explore when the anniversary date of his offence was, and agreed that it could be linked to the decline in his mental health. The man remained on constant watch that night, and was reviewed again the next day. At this review, he appeared keen to return to B wing and said that he had no thoughts of self harm and no desire to die. It was agreed that the third nurse would be consulted about a referral for to a medium secure psychiatric unit that has a personality disorder clinic. The man's observations were reduced as the risk to himself and others was judged to be less than before. He was to be monitored twice an hour in the healthcare centre.

107. At his ACCT review on 24 August, the man reiterated that he wanted to go back to the wing, and to see a doctor to discuss a previously diagnosed condition of epilepsy. Staff present at the review noted that the man was refusing his medication despite encouragement from the healthcare team. However, as he had no current thought of self harm or suicide, it was agreed that he should move back to B wing and a review conducted in two days time. It was also agreed that an appointment would be made to facilitate the man's wishes.

108. It would appear that the man went back to B wing on or around 25 August and attended his next ACCT review the following day. Present

at the review were two senior officers. The man appeared to settle back onto B wing, and was positive about his application for a place at the medium secure unit with a personality disorder clinic. According to the man's case review record, he seemed to accept that this may not be "a short term fix". In the longer term, the man said that he still hoped to go to the therapeutic community. He had also sent a Visiting Order to his sister. His next case review was scheduled for 30 August.

109. A doctor saw the man and he told the doctor that he had been experiencing seizures and that he had temporal lobe epilepsy. The man said that the condition had been diagnosed 12 years previously at a Royal Infirmary. The man told the doctor that he used to take tegretol (a medication to treat epilepsy), and that this was changed to lamotrigine (another epilepsy medication to stabilise electrical activity in the brain) when he was at HMP Doncaster. His prescription was changed again to keppra (levetiracetam, a similar drug to lamotrigine), after he developed a rash. The man told the doctor that keppra did not help him and caused him to have blackouts. He added that the blackouts led him to stop taking the drug about a year earlier, but he wanted to commence the medication again. A doctor made an urgent referral via fax to the neurologist epilepsy clinic at outside hospital.

110. The same day, the man was also seen by the third nurse, and a mental health review was conducted. Again, the nurse got the impression that the man appeared to be coping on the wing, but noted that he sometimes needed to be reminded about his personal hygiene. The third nurse also said that the man was "… still expressing some suspicion but easily distracted from these thoughts today". The third nurse and the man completed a questionnaire from the medium secure unit with a personality disorder clinic together.

111. On 30 August, another doctor noted in the man's medical record that he met the criteria for the medium secure unit with a personality disorder clinic, and had completed the application. The same day, at the man's ACCT review, he told staff that he was looking forward to starting classes in the education department. He looked on his application to the medium secure unit with a personality disorder clinic as a step forward. The staff at his review explained that wing officers would always be available if he needed to speak to anyone. The man's ACCT was then closed for the first time since 20 April. First senior officer, his case manager, scheduled a post ACCT interview with the man for 8 September.

The man's behaviour following closure of his ACCT

112. On 3 September, the man complained of seizures and was seen in triage (where patients are assessed by nurses to prioritise their clinical needs). Whilst there, the man asked about his appointment with the neurologist epilepsy clinic, and a note was made in his clinical record to reflect that he had made enquiries. The following day, a B wing officer

telephoned healthcare to say that the man had reported another seizure, but would not go to the healthcare centre. According to the officer, the man presented as orientated and not confused. The man's personal officer on the B wing also noted in the man's wing history that he did not attend education. It is not clear whether a nurse went to see him on the wing that day. What is certain is that the man had an appointment with the triage nurse for 5 September but did not attend.

113. On 8 September, the man was scheduled to see a senior officer for a post closure ACCT interview. There is no documentary evidence to suggest that this took place.

114. Around one week later, the man had another triage appointment. Again, this was made in relation to his fits. A nurse made an entry in his medical record which said that the man had been referred out (to the neurological clinic). The man was advised to keep a diary of his fits. He was also referred to see the prison doctor and attended an appointment the next day. The doctor commenced the man on tegretol (200mg), and made a note that the man would be reviewed in three to four weeks time.

115. A B wing officer noted in the wing observation book that staff should keep an eye on the man as the anniversary of his index offence was approaching.

116. Approximately one week later, the man self referred to the Counselling Assessment Referral Advice and Throughcare service (CARATs – a drugs and alcohol education and support service), and was seen by a CARATs worker. His referral arose as part of his lifer sentence plan, agreed by the sentence planning board. Having answered a series of questions about his level of drug use in both the community and while in custody, the man was then asked about his history and current thoughts of self harm. The man told the CARATs worker that he had suicidal thoughts every day. On hearing this, the CARATs worker reminded him that disclosure of certain confidential information, like suicidal thoughts, would have to be passed on. The CARATs worker acted on the information and spoke to B wing officers and the healthcare team. Following consultation with her colleagues, the CARATs worker decided not to open an ACCT document and the man returned to his cell.

1 – 12 October

117. The man did not come to the attention of the healthcare centre again until 1 October. At some point that day, the fourth nurse, who was on hotel 2 duty (the code indicating responsibility for responding to emergencies), saw the man, presumably in his cell. Her entry in the man's medical record said that he presented with dizziness, nausea and was unsteady on his feet. The fourth nurse's entry said "c/o side effects of Tegretol". According to her entry, the man asked about

lowering the dose but was advised not to. An appointment was made for him to see a prison doctor.

118. The man saw a doctor the following day. The doctor recorded that the man's last episode of fitting was five days earlier, and that there was no sign of him suffering from a shortness of breath. The man was advised that he might have had a suspect vasovagal episode, which is the most common form of fainting. He was told to continue his medication and was advised that his dosage may need to increase if he continued to experience fits.

119. On 3 October, the RMN saw the man for another mental health consultation. The man told her that he was fit and well. He denied having any thought of self harm or suicide. The man reaffirmed that his problems in the past were due to temporal lobe epilepsy and not mental health issues. He also said that the epilepsy was a causal factor in his index offence. The RMN assessed that the man showed no evidence of mental health problems at that time, and was coping well on B wing. The nurse added that the man was still to be monitored.

120. Two days later, the man asked to see the RMN and echoed his previous concerns about the visiting forensic psychiatrist's diagnosis of personality disorder. The man stressed that he could not easily accept that his behaviour was caused by his personality, and asked for a more definitive diagnosis of a treatable mental illness. The RMN's summary of her interaction with the man, which she duplicated in B wing's observation book, said the following:

> "Has asked how much he has to do to get sectioned out of Gartree. Says he knows he is going to get ill in the future and is becoming delusional. During interview could find no evidence of gross mental illness. Told him I am happy to refer him to the visiting forensic psychiatrist again, but as he is currently being investigated for temporal lobe epilepsy we should see what the outcome of that is."

121. On 8 October, an entry in the wing observation book said that one of the officers had been approached by a prisoner who was concerned about the man. The concern came as a result of the man pacing his cell again, and speaking about air strikes. The officer who made the entry said that he would speak to the man and alert the healthcare team. The officer left a message for the RMN and spoke to the man about his personal hygiene, collecting his meals, and his worry about air strikes. In response, the man said that he had kept his cell clean, did not need any food at the moment and kept to his cell because of the air strikes. The RMN spoke to the wing staff later that day and said that, although she could not see the man that day, staff should contact her if he deteriorated.

122. Wing staff became increasingly concerned about the man the next day and repeatedly asked for a member of the healthcare team to see him.

As the RMN was on annual leave that day, the fourth nurse attended and made a note of her visit in the man's medical record. The note said that the man had not taken care of his personal hygiene and had not been collecting his meals. The man displayed signs of agitation but the fourth nurse did not think that his body language was too convincing. The nurse advised wing staff that the man's behaviour was likely to preclude him from admission to the therapeutic community, which was something that the man had been keen to do. The fourth nurse confirmed that the RMN would see the man "in the next few days".

123. The RMN did see the man, at his request, on her return. She made an entry in his medical record summarising her interaction with him on 11 October. The man had repeated that he did not accept his diagnosis and said that his mental health problems were not investigated at his trial. The man told the nurse that he was being treated unfairly, and was living in a delusional world. The RMN said that there was no evidence of gross thought disorder, that the man maintained good eye contact, and presented her with a normal rate and content of speech, and a normal body posture. The man also denied any thoughts about harming himself. B wing staff also reported that the man had been mixing with other prisoners and collecting his meals.

124. A prisoner on B wing said that over the time the man had been on the wing he had been open about wanting to die, and his moods were changeable. He said that the man did not often make the effort to approach people, but if they spoke to him he would chat. The man was not the cleanest of people and the prisoner had witnessed staff encourage him to clean his cell. This prisoner said he felt able to approach staff when he was concerned about the man. Staff always responded by speaking with the man or calling healthcare. In the week prior to the man's death, the prisoner described him as showing "mixed signals".

125. The third officer saw the man on 12 October by chance on the wing. She was planning to meet him to talk about his OASys report (a sentence planning document). She felt the man seemed much better than she remembered when he first came to B wing in April.

From the evening before the man died

126. I am not able to say with any accuracy how the man presented to staff before he was locked in his cell at around 7.30pm. On the evening before the man's death. An Operational Support Grade (OSG) was on B wing night duty. She remembered seeing the man when she was conducting a roll check at about 9.00pm. (A roll check is when staff must make an audio or visual check that a prisoner is in their cell.) She said that she saw the man pacing in his cell at the time. He did not speak to her. The next time the OSG saw him was at approximately 5.40am on the day of the man's death. The OSG began to carry out the morning roll check of all the prisoners on the wing. She

approached the man's cell and opened the flap. The OSG turned on the light and saw that the man was lying on the floor. She called for emergency assistance on her radio.

127. The Night Orderly Officer (the NOO is the person in charge of the prison at night) responded to the emergency call at around 5.43pm. The NOO was on C wing at the time and asked the second officer, another C wing officer, to accompany him. All three members of staff went to the man's cell and the NOO opened the cell door. He saw the man lying on the floor with his legs straight out in front of him and his arms bent, with a large amount of blood in the cell. The NOO told the OSG that he believed that the man was already dead. He left the cell, relocked it, and did not let the other staff go inside.

128. A third nurse also responded to the emergency radio call for assistance. As the only nurse on duty, the third nurse told my investigator that he grabbed the green and red emergency bags from the healthcare centre (containing oxygen and medical supplies for blood injuries) and made his way to the main prison. On the way there, the third nurse was met by the NOO who told him that the man was dead. The third nurse told my investigator:

> "He [the NOO] said to me, can't remember the exact words but something to the effect of, there's nothing you can do, he's already dead, he's cut his throat".

129. Both the second officer and the OSG were outside the man's cell when the third nurse arrived. The cell was locked and so the third nurse did not go in. However, he looked through the observation panel in the cell door and saw the man lying on the floor with his eyes open and his fists clenched. The third nurse also noticed that there was a large amount of blood on both the bed and the floor. The man was not moving and, according to the nurse, there were no signs of life and it looked as if rigor mortis had begun. It appeared to all staff that the man had cut his own throat.

130. The third nurse said:

> "I knew I had the option to say to the officer, can you let me go into the cell to check and he had already indicated to me that he was dead and he was a senior officer running the prison that night and it was a crime scene so I didn't insist on going into the cell … I heard quite clearly the night orderly officer saying to me, he's already dead, now he's not qualified to make that assessment, that's a medical assessment and neither am I. However, when I got to the scene what I saw confirmed to me that there wasn't anything I could do."

131. An ambulance was called and paramedics arrived at the man's cell at approximately 6.25am. The paramedics recorded that there had been

a large amount of blood loss and rigor mortis (the stiffening of the body after death) was present. Whilst some definitions can vary depending on the size of the person and the temperature of the room, it is generally accepted that rigor mortis takes around two hours to develop. The paramedics pronounced the man dead at 6.31am.

Events following the man's death

132. As the man's family live some distance from the prison, Gartree contacted the prison closest to the family to ask them to break the news of his death. Two chaplains visited the man's family and explained what had happened and provided contact details for Gartree.

133. The man's family were grateful for the assistance they received from the prison, although they felt they were given misleading information about how he had actually died.

134. Gartree offered to contribute to the man's funeral expenses. However, they initially deducted the money which was in the man's prison account, mistakenly believing that they were compelled to do so by financial regulations. My investigator contacted the Safer Custody and Offender Policy Group in Prison Service HQ and they confirmed that this was not the case, nor was it in the spirit of the relevant Prison Service Order. In a report into the investigation of another death at Gartree, I have commented on this matter. As a result Gartree has now amended its family liaison policy to avoid a repetition.

135. In accordance with Gartree's local contingency plans following a death in custody, the relevant agencies were contacted and a Coroner's seal was placed on the man's cell to preserve evidence. A hot de-brief took place, but the third nurse did not attend.

136. Other prisoners from the wing were told the news of the man's death at about 8.00am as they were unlocked. Both staff and prisoners were offered support. A memorial service was held, attended by staff and prisoners.

137. The man's family told my family liaison officer that he had a friend in another prison to whom he wrote. My investigator made attempts to contact the prisoner, including writing to him, but received no response.

ISSUES

138. I am pleased that the clinical reviewer extended the scope of his enquiry to include the time that the man spent at both HMP Leeds and HMP Doncaster, in addition to Gartree. This has enabled the clinical reviewer to tell the man's story, as it relates to his contact with prison healthcare teams, in full. Having reviewed all the relevant documentation made available to him, the clinical reviewer's review focuses specifically on the appropriateness of the man's diagnosis, the level of the man's compliance as a patient and the continuity of care he received. I deal with the issues raised by the clinical review below.

139. My own investigation has concentrated on the management of the man's risk of harm to himself and others and Gartree's use of the ACCT process. I have also focussed on the emergency response procedures used, and the issues raised by the man's family.

140. This was the man's first time in prison and he faced a long sentence. When he arrived at Doncaster, he maintained that he suffered from a form of epilepsy and had regular seizures or 'blackouts'. Prior to his arrival at Gartree, he was referred to a forensic psychiatrist, and was regularly assessed by consultant psychiatrists. Throughout his time at both Doncaster and Gartree, the man was closely monitored using the ACCT process. His final ACCT document was closed approximately six weeks before he died.

141. Despite the man's insistence that he suffered from temporal lobe epilepsy, he was diagnosed with a personality disorder. The man was seen by a neurological specialist at Gartree, but his apparent self-diagnosis of epilepsy was ruled out. Unhappy with this development, the man requested an appointment with one of the doctors at Gartree and asked for another referral. The man was waiting for a second appointment with the neurological clinic when he died. At consultation stage, the man's mother pointed out that the man had received a diagnosis of temporal lobe epilepsy at a Royal Infirmary when he lived in the community. Indeed, the man was still receiving medication for the treatment of epilepsy. However, doctors questioned whether his behaviour could be attributed to epilepsy, and decided it his behaviour was due to personality disorder. It should be said, that given the man's apparent previous diagnosis of epilepsy, and subsequent medication, his insistence and confusion over the diagnosis is understandable, and likely to have caused him some anxiety.

142. A personality disorder is not classed as a mental illness. Rather it is a deeply ingrained way of behaving in certain social or stressful situations that differs from what is considered to be the norm. Of course, people with mental health problems can be dual diagnosed with a personality disorder, and episodes of self-harm, anxiety and depression are all symptomatic of the disorder.

143. HM Chief Inspector of Prisons found in her recent thematic review that Mental Health In Reach Teams (MHIRTs) predominantly treat prisoners with severe and continuing mental illnesses. Prisoners like the man do not normally come under the remit of a MHIRT. The man was initially referred to the MHIRT at Gartree, and was also seen by visiting psychiatrists on several occasions. The psychiatrists concurred that it was more likely that the man had a personality disorder with possible psychotic episodes. It is clear from the man's story that he found this difficult to accept and regularly questioned their diagnoses.

144. In short, the man presented as someone who threatened to harm himself or others regularly. However, he rarely converted his threats into action. This is particularly significant given the length of time he was under close supervision. I do not underestimate the difficulty of caring for a prisoner as vulnerable and, on occasions, as challenging as the man. Indeed, despite the man's discontentment with his diagnosis, and his reluctance to accept his sentence, I judge that he was managed appropriately by the prison's mental health team. That said, there are always lessons to be learnt. I discuss them below.

The man's time at Doncaster and his transfer to Gartree

145. Prior to his transfer to Gartree, there is some evidence that the man had attempted to self harm at Doncaster. In March 2006, whilst still a remand prisoner, the man was apparently found with a red mark around his neck and may have had a seizure. He was referred to a psychiatrist and a neurologist for further examination in respect of mental illness and temporal lobe epilepsy. He was also prescribed olanzapine.

146. The man was then admitted to the healthcare centre and placed on an ACCT. This was closed shortly before he was transferred to Gartree. It was not until he was interviewed as part of Gartree's first night in custody procedures that one of the B wing officers learnt of his previous risk. The first senior officer told my investigator:

> "I had to chase Doncaster up to get it and when it arrived he hadn't – it hadn't been closed that long and he'd been more or less on constant supervision all the time he'd been at Doncaster."

147. However, during the consultation process, the Director of HMP Doncaster, said that in fact, the man's LSP1G form was faxed to Gartree on 27 March 2007. This stated that he was on an open ACCT and was located in healthcare a week before his transfer. It also gives details of him telling a nurse that he had suicidal intentions. He further said that the ACCT document was sent with the man's core record when he transferred to Gartree.

148. Prisoners transfer between establishments on a frequent basis for a number of reasons. The man transferred to begin his life sentence proper at Gartree. It is difficult to understand what happened to the

information regarding the man at reception. I am pleased to report that whatever the reason for the delay in viewing the man's ACCT history, it had no bearing on how Gartree's staff managed him during his first few weeks.

The man's mental health

149. When the man was diagnosed with a personality disorder, he was cared for by Gartree's own mental health team. His RMN became his main link to both internal and external mental health services. The man was referred to the visiting forensic psychiatrist on several occasions, and latterly to another psychiatrist for assessment. The man did not receive the diagnosis that he wanted. Both specialists agreed separately that he did not have a severe mental illness and so he was not placed under the provision of the external MHIRT.

150. From the moment the man was identified with a personality disorder, he was cared for by the RMN. In her interview with my investigator, the nurse described the man as a "troubled man" with complicated mental health needs, who wanted further mental health referrals after his diagnosis. The RMN recalled that the man wanted to transfer to a psychiatric unit, and frequently steered discussions with her back to the problem with his diagnosis.

151. Eventually, the man agreed to apply for psychological treatment at the medium secure unit with a personality disorder clinic. He had begun the application process in the weeks leading up to his death, and this was seen as progress. Similarly, the man expressed an interest in reducing his medication in order to become eligible for a place on Gartree's therapeutic community.

152. Prisoners with personality disorders are monitored at Gartree before further psychiatric referrals are made. The RMN explained to my investigator that the visiting forensic psychiatrist did not rule out a referral for psychiatric care for the man, but wanted to see how well he could settle into his sentence first.

153. The man struggled to come to terms with his crime. He maintained that his index offence and subsequent threats to self harm and take his own life were caused by a physical condition (epilepsy) and mental illness, but not his personality. He frequently said that he struggled to accept he was capable of murder. When the diagnosis of epilepsy and mental illness was discounted, the man found it difficult to accept. His attitude towards his medication fluctuated, and he would switch from perceiving it as a help or a hindrance to his mental well being. The man also stockpiled drugs on occasion. This was largely regarded as avoidance of taking his medication, rather than indicating an intention to save it for an overdose.

154. The clinical reviewer focusses on the appropriateness of the man's diagnosis and subsequent mental health needs. In his clinical review, the clinical reviewer concludes that his diagnosis was consistent with "a dissocial, histrionic, paranoid personality". Referring to past psychiatric assessments, the clinical reviewer notes that the man was suspected by psychiatrists of fabricating a mental illness in order to transfer out of the mainstream prison system. The clinical reviewer confirms that thought disorders, such as schizophrenia, are difficult to simulate, and there was no evidence to support the man's claims that he was mentally ill. In addition, the clinical reviewer's analysis of the man's mental health history highlights inconsistencies in the accounts he gave to individual specialists at different prisons. At first, the man denied that he suffered from a mental illness. Whilst at Doncaster, the man told one psychiatrist that he had been prescribed olanzapine, and found this effective in reducing his disorientation and feelings of confusion. In contrast, the RMN recorded the man's consistent belief that his problems were due to temporal lobe epilepsy and not mental illness. Olanzapine was prescribed, but the man did not always take his medication.

155. The clinical reviewer says that, from the evidence he saw, the man's physical and mental health needs were recognised and dealt with sufficiently well. Gartree's staff provided the man with an appropriate level of care, and began the process of referrals to both the medium secure unit with a personality disorder clinic, and their own therapeutic community. The clinical reviewer considers these to be fitting referrals, given the man's diagnosis. The clinical review includes no recommendations.

The management of the man's refusal of food

156. It is clear from speaking to staff, and from consulting the documentation made available to my investigator, that the man did not always refuse food. On several occasions he told staff that he no longer wanted to eat, but was observed when on constant or raised levels of observation to be eating reasonably well. That said, the man did refuse food in the healthcare centre, and when back on B wing he did not always collect his meals. When he was subject to an ACCT, the man's food refusal was monitored and he was weighed in accordance with the food refusal procedures. When his ACCT was closed, and the man was relocated to B wing, it is less clear what, if any, procedures were followed.

157. When interviewed, the fourth officer told my investigators that before the man's death there was no formal process for documenting prisoners who did not collect their meals. The fourth officer clarified that he was aware that, after three days of non-collection of meals, prisoners were expected to be monitored by the food refusal procedures. However, when asked how an officer would know that three days had passed given that there would be no record, the fourth officer agreed that it was unclear. Of course, the non-collection of

meals does not necessarily mean that a prisoner is not eating, as they may buy food from the prison shop. The fourth officer confirmed that since the man's death there is a more recognised place in wing documents for recording irregular meal collection. In the light of this development, I make no formal recommendation. That said, I urge the Governor to remind staff of the importance of recording all prisoners who fail to collect their meals, as this is often an indication of underlying causes for concern.

The management of the man's risk to himself and others

158. It is apparent that the man consistently threatened to self harm, to kill himself, and more latterly to kill others. However, it is also clear that the man's threats did not lead to frequent episodes of self harm or harm to anyone else. The man was found with makeshift weapons in his cell on more than one occasion, but he did not use them. His threats to staff, although frequent, never materialised. More generally, staff did not give my investigator the impression that they found the man threatening. The RMN had the most meaningful contact with the man, whilst he was subject to close ACCT supervision. In her interview with my investigator, the nurse said that she did feel at risk from the man "a couple of times" but had a good relationship with him in the four months that he spent in the healthcare centre. Similarly, when the man was moved to B wing, the man's personal officer on the wing could not recall witnessing any violent behaviour from him.

159. The man's threats to kill himself were taken seriously. He was placed under constant or an intermittent level of supervision for much of his time at Gartree, and was assessed either daily or every other day. The man's risk remained high or raised, and his 'triggers' were identified although they were not documented appropriately in his ACCT document. When he felt "hyped up", refused to eat, or refused to attend to his personal hygiene and the hygiene of his cell, it is evident that staff understood the signs and discussed them at length in case reviews.

160. I do not underestimate the scale of resource necessitated by the decision to keep the man closely monitored. This was especially so for healthcare staff who were also responsible for another 13 inpatients and many outpatients. I am pleased to see that wing staff were deployed for the constant observations and interacted well with the man. I am also pleased that wing staff were included in the plans to reintegrate the man to B wing on both occasions. The man's supervised visit back to B wing served as a good familiarisation exercise, and helped to facilitate his move back to the main prison.

161. The care the man received whilst on an open ACCT was of a good standard overall. It is rare I have come across such a level of detailed care planning involving a multi-disciplinary team. As I have already said, the actual incidence of self harm was rare. Staff did not seem

overly threatened by the man's behaviour and managed him well. However, there were occasions when notes in the ongoing record, clinical record or the ACCT did not correlate well with the notes in the care plan. (For example, the finding of a ligature was not recorded in the case review notes.) These occasions were few amongst a high number of entries, but they are important. I therefore recommend:

The Governor should remind staff to refer to the ongoing record when conducting case reviews. When there has been an incident to cause concern, they must be made explicit in the case review and a record made of planned action.

The closure of the man's ACCT on 30 August

162. I remain concerned over the apparent speed in which the man went from constant watch to no observations when his ACCT was closed.

163. As I have already mentioned, the man was on an ACCT for just over four months and was on constant watch for most of the time. His level of observations did reduce when it was agreed at case reviews that he presented less of a risk and had a period of stability. However, his observations were increased again when his behaviour and thoughts took a downward turn. In the days leading up to the closure of the ACCT, the man became more positive in mood and was more receptive towards working with staff on his application for the medium secure unit with a personality disorder clinic. He also agreed to return to B wing and work towards gaining a place in the therapeutic community. Given the man's previous denial of the diagnosis, it is not surprising that staff saw it as a positive step, and indeed so it would seem did the man himself.

164. The man moved back to B wing successfully to begin with. When his ACCT was closed a few days later, he was no longer subject to any observations. At his final case review, the first senior officer, the fifth officer and the third nurse agreed that his risk of harm to himself or others was low. The man was also present at the review and was told that there would be ongoing support for him should he need it. His post closure interview was scheduled for 8 September with the first senior officer.

165. The first senior officer described the progress the man made in his interview with my investigator:

> "We felt that being isolated in healthcare wasn't helping him and that he needed to sort of perhaps get back into a normal routine and interact again. So we worked quite closely to get him back onto the wing and the last time I saw the man, he was actually quite clean, quite tidy, he was actually participating in the education class, I think he'd done some of the induction programme."

166. I was surprised by the timing of the ACCT closure. The man's behaviour was frequently changeable and his time on B wing was far from wholly positive. Within a week of his return to B wing, staff raised concerns about his personal hygiene and claims that he was not eating. The man explained strange thoughts that staff were 'doppelgangers' and there were to be air strikes. He seemed more positive over the next couple of days, but then on 10 August he implied threats to harm others which resulted in a security information report being submitted. The RMN noted the man's unusual thoughts again on 13 August. Two days later a quantity of drugs, believed to be his prescribed medication, were found in his cell. The man returned to the healthcare centre on constant watch on 21 August after saying he planned to kill himself.

167. The man returned to B wing and had an ACCT review on 26 August and appeared upbeat. It was at the next review that the ACCT was closed. The first senior officer, the fifth officer and the third nurse attended the review. All were experienced in such procedures and had varying degrees of knowledge of the man. Concern was expressed that, whilst on a high level of observation, it restricted normality for the man. However, the ACCT can be used to support prisoners in a positive and unobtrusive manner. It ensures that staff are aware of the risks a prisoner may pose, and make efforts to engage with them. (It should be said that the man's personal officer on the B wing made considerable efforts to speak with the man every day, even once the ACCT was closed.)

168. In my view, it would have been more appropriate for there to have been a greater weaning off period. This is especially pertinent given that the man had been subject to such a high level of observations. For the majority of the man's time on ACCT, he was managed well, and efforts were made to gradually introduce change. His observations were gently decreased or increased according to his vulnerability at a given time, and the presence of an officer or officers to carry out constant watches was also tailored to accommodate his progress or any relapse that staff felt he had. At no point in the man's ACCT history were there sudden changes that did not appear to reflect the circumstances, save for the closure of the document itself.

169. Closing an ACCT is always a matter of judgement. On this occasion, three staff members, and the man himself, agreed that this was the correct course of action. A great deal of good work was conducted with the man whilst he was on the ACCT, and the reintegration to B wing was well planned. However, I am concerned that the ACCT was closed only a week after he was being observed constantly (for a period of three days). The man's behaviour was far from consistent both before and after the ACCT was closed.

The Governor should remind staff to examine patterns of behaviour when considering closure of an ACCT document. When a prisoner has been subject to the procedures for a long period of

time, sustained and prolonged improvement accompanied by a gradual reduction in observation and interactions should occur before the ACCT is closed.

170. It would also appear that no post closure interview took place. The first senior officer explained that, after the closure of an ACCT, post closure interviews were scheduled in the wing diary. Unfortunately, the man's interview was not carried out by the senior officer because it coincided with her period of sick leave. In the absence of the first senior officer, it does not appear that the man's interview was carried out by another member of staff. Neither the man's ACCT documentation nor his wing history contain evidence of a review.

171. Follow up interviews are an important part of the post ACCT process and allow staff to further monitor how a prisoner is responding to prison life without intensive support. On examination of other ACCT documents, the apparent failure to follow up in this case seems to have been an isolated incident. However:

I urge the Governor to remind wing staff of the importance of post closure interviews, and to ensure that cover is arranged when case managers cannot conduct interviews.

172. After the man's ACCT was closed, he began to display behaviour that worried officers. The man's personal officer on B wing told my investigator that the man had periods of being unkempt and he paced up and down his cell on the wing. As concern about the man's presentation grew, the man's personal officer contacted healthcare and both the fourth nurse and the RMN went to see the man at different times. The man's personal officer said he was confident about contacting healthcare, and his actions demonstrate that the man received ongoing support, and that the relationship between discipline and healthcare staff was positive.

The man's level of risk on 25 September

173. When the man self referred for a CARATs assessment, he told the CARATs worker, that he had suicidal thoughts on a daily basis. The CARATs worker approached healthcare staff but was advised not to open an ACCT in the light of the progress the man had made. During her interview with my investigator, the CARATs worker said:

> "But then when we came onto the section about suicide and self harm, he then did say that yes, he does have suicidal thoughts on a daily basis, that he had self harmed and if he was going to commit suicide he wouldn't tell anybody and I did remind him about the disclaimer that's on the confidentiality statement, that if somebody is at risk of suicide or self harm, that I have to act on that information, I can't keep that to myself. And he said he understood that, he'd been on ACCT documents, he was now off it, he was

> doing much better, and he didn't want to go back on one. I did say to him that I've got to document this elsewhere other than the CARATs file and I think my colleague talked to him as well a little bit about it and then we did go and speak to the wing staff and then went down to healthcare to speak to them to see whether we felt that it was appropriate to raise an ACCT document at that time."

174. The CARATs worker' response to learning that the man had suicidal ideas demonstrates the judgements that staff have to make when considering whether to open an ACCT. Knowing the outcome for the man, it is easy to say with the benefit of hindsight that he should have been placed on some level of observation, and that case reviews should have re-commenced. This may be especially true given that the man told the CARATs worker that he had daily suicidal thoughts just three weeks before he died, and that he would not tell staff.

175. However, the CARATs worker consulted widely about opening an ACCT and documented this in the appropriate records. She too shared information widely and had a good knowledge of the ACCT process. She took her lead from the healthcare staff who managed the man's first four months at Gartree.

176. The CARATs worker did tell my investigator that she did not think that there was a consensus over her decision. She said:

> "I think he [the second senior officer] was happy that I'd documented it, as to whether he thought I was right in my decision, no I don't think he did think I was right."

177. When interviewed, the second senior officer could not remember the discussion he had with the CARATs worker as vividly as she did. The second senior officer told my investigator:

> "… an ACCT document isn't just opened up by wing staff, it can be opened by anybody, if they're concerned enough, they should open the ACCT document."

178. The CARATs worker spoke confidently about opening an ACCT, and confirmed that she had done so previously. I have found no evidence to suggest that the staff who interacted with the man were not sure of the process. That said, I am not convinced that all staff approach the process and perceive the purpose of the ACCT process in the same way. The first senior officer told my investigator:

> "… if in doubt, [I] open a document because once the assessment's been done, we can also close the document off after the first 24 hours. Me personally, I would always open a document and then do the assessment and then, if need be, close it off."

179. I am not critical of the CARATs worker' decision, taken in conjunction with colleagues who knew the man better, not to open an ACCT. In any event, no one can know whether opening another ACCT would have made a difference to the outcome for the man. Staff firmly believed that the progress he had made was greater than the risk he posed at that time. There was legitimate concern that the man might be negatively affected by being the subject of an ACCT at a time when he was looking to the future. That said, and as the first senior officer pointed out at interview, an open ACCT is a safeguard that can be removed once an assessment is made that a prisoner's risk is low. The ACCT process should not be viewed as something that prisoners could become dependent upon, but as a supportive process which is tailor made to care for individual needs to reduce risk of harm.

Issuing the man with razor blades

180. The third nurse spoke to my investigator about issuing the man with a razor while he was still on an ACCT and in the healthcare centre. The nurse said during interview that he had regular conversations with the man when he was based in the healthcare centre, and supervised the man when he had a shave. The third nurse confirmed that he told the man that he could use a razor, but that he would be supervised while he used it and would have to return it after use. The third nurse recalled that the man understood this and did as he was asked.

181. When the man visited B wing as part of his reintegration plan, an entry in the wing observation book said that he was not permitted to use a razor, presumably for safer custody reasons. My investigator explored the issue of razor blade use in an interview with the fourth officer, a B wing officer. The fourth officer was asked how difficult it was to ensure that prisoners like the man did not have easy access to razor blades. The fourth officer agreed that it was "very difficult". He described the process of issuing disposable razor blades and said that he had personally pressed for a sharps bin on B wing to dispose of used blades. The fourth officer explained that this had helped to remove razors from more communal parts of the wing, where in the past prisoners had discarded them. That said, the officer was keen to point out that this had not guaranteed that prisoners who should not have razors did not have access. The fourth officer said that prisoners could easily buy razors from the canteen list. The officer was familiar with 'supervised shaves' as the man had in the healthcare centre, but said that this did not tend to happen on B wing.

182. With regard to issuing the man with a razor, the fourth officer said:

> "No, I'm sure I can remember issuing him with razors and I can remember always when I issued him I've always said, in sort of like a jokey way like, you know, make sure you are going to shave your chin with it and not do something else and he always said, yeah you know and went off and you know, that's it, he goes up the stairs and

that's it, that's as far as it went. Fortunately that was your bit of the job done."

183. During the consultation stage of the draft report, a statement from the paramedic said that he saw a broken plastic disposable razor. Part of this was by the television in the man's cell, and part of it was on the floor next to the man. It is not for me to assume that it was a razor blade issued by a member of the wing staff. However, my investigators questioned the value of using the wing observation book to request that the man be denied access to razors when there was no process for ensuring that the request was implemented. None of the members of staff interviewed said that refusing access to razor blades could effectively be policed at Gartree.

I recommend that the Governor considers whether Gartree can reliably prevent prisoners accessing potentially harmful objects

The emergency response on 14 October

184. When the OSG discovered the man on the floor of his cell, she raised the alarm and waited for assistance to arrive. The NOO and the second officer made their way from C wing but only the NOO went in. The third nurse responded to his radio at around the same time and arrived on the wing a few minutes later. He brought two emergency medical bags and a defibrillator but none of the equipment was used. On the way to B wing, the third nurse met the NOO who told him that the man was dead and that there was nothing he could do. The third nurse told my investigator that when he got to the man's cell, he prepared to go in to check for vital signs of life. The cell was sealed. The third nurse said that he could see through the observation panel that the man was motionless. He had no eye movement, his chest did not rise and fall, and an element of rigor mortis might have set in. The third nurse could see that the man had cut his throat and commented on the amount of blood in the cell. When my investigator visited Gartree in the days following the man's death, she was able to view the cell and witnessed the volume of blood that the man had lost.

185. It is the third nurse's recollection that there was nothing he or his colleagues could do to save the man. Reflecting on his response to the man's emergency, the third nurse told my investigator that he had experienced a number of self inflicted deaths and attempts to take life, and would always try to resuscitate. In relation to the man's story, the third nurse said that he knew that he could have requested entry to the man's cell and would have been confident making the request. He thought that the man was dead and that nothing could have been done to save his life.

186. It is of course not for an orderly officer to decide whether a prisoner has died. Indeed, this is a decision that has only recently been given to the Ambulance Service. That said, it is clear that the philosophy behind the

NOO’s decision to prevent staff from entering the cell was to protect them from the scene. The NOO effectively pronounced the man dead, and treated his cell as a crime scene without attempting to resuscitate him. I do not level any criticism at the NOO or his staff for not entering the man’s cell.

Family involvement in suicide prevention

187. Prison Service Order (PSO) 2700, Suicide and self harm, requires the following mandatory actions:

> "3.4 Follow-up actions, and care for prisoners who have self-harmed
>
> 3.4.3 After consultation with the prisoner, the nominated next of kin must be notified, unless:
> There is a clinical reason not to, or;
>
> If aged 18 and over, the prisoner does not consent, or;
>
> The prisoner's support plan indicates otherwise (e.g. in the case of a prisoner who repetitively self-harms).
>
> Where appropriate, after serious incidents of self-harm consideration should be given to allowing the prisoner themselves the opportunity to notify the next of kin by a phone call and/or an extra exceptional visit."

188. I acknowledge that prisoners are adults and can make a decision whether to contact their family. Some may have unhappy family relationships or no family to support them, or may not wish to upset them. However, the man was clear that he had family support. At consultation stage, the man's mother emphasised this point, saying that she visited the man five times, and he was visited by other friends and family. At no point were concerns raised with them. The Prison Service, as a whole, seems not to involve families in suicide prevention and support as much as it could. In some cases, like the man's, family support could complement the locally available support.

The Governor should remind staff that consideration should be given to contacting families in line with PSO 2700 when a prisoner commits serious self harm. Staff should also encourage those on ACCTs to speak with their supportive family members where appropriate. This should be included in the local suicide prevention policy

189. During consultation, the man's family told my investigator that after the man's death, his artwork was praised to the family by his tutors, who asked if they could keep some items. They found it odd that more was not made of his artistic ability in an effort to use his time more constructively. I have sympathy with this view, and would urge the Governor to remind staff of the importance of harnessing a vulnerable individual's skills and interests to make best use of their time and keep their mind occupied.

CONCLUSION

190. When the man arrived at Gartree, staff inherited a man who found it difficult to come to terms with his life sentence and the reason it had been imposed. He also did not accept that he had a personality disorder and believed his problems resulted from mental illness and epilepsy. In April 2007, he was placed on an ACCT for his own safety and the safety of others, and was moved to the healthcare centre. The man presented with a range of behaviours and thought processes that became familiar to healthcare staff. However, his repeated threats to harm himself and others, as discussed at what were often daily case reviews, rarely became actions.

191. The man's wish to make weapons was appropriately reported. His first reintegration to B wing was short lived and he was sent back to healthcare. His second attempt to join the main prison population appeared more successful. Staff believed that the man was looking to the future and becoming more receptive to moving on to therapy and offending behaviour programmes.

192. The man's journey through his first few months at Gartree was unorthodox in that his induction was halted until his ACCT closed, when he could demonstrate that he no longer wished to harm himself or others. From mid July onwards, the staff who closely monitored the man, and those who did not, all agreed that he should move back to B wing and begin his sentence proper. I remain unconvinced over the way in which the man's ACCT was closed in late August, and I am concerned that the closure was too abrupt.

193. By early September 2007, the man began to display (albeit sporadically) similar behavioural patterns to those that healthcare staff had become familiar with in the months after his arrival at the prison. He presented with abnormal thoughts, looked unkempt and began to pace his cell. In deciding whether to open another ACCT, staff had to balance the 'triggers' associated with the man, against the progress he seemed to make in engaging with his induction and long term sentence plan, most notably his application for a place on the therapeutic community and at the medium secure unit with a personality disorder clinic.

194. In analysing whether the man should have been made the subject of safer custody procedures three weeks before he died, I have the benefit of hindsight. Staff at Gartree did not. Instead, they made a collective decision not to reopen the ACCT. Following his death, and when interviewed, a number of staff had differing opinions as to the circumstances in which an ACCT should be opened. My investigation has therefore highlighted that there is no consensus as to whether, in disclosing that he felt suicidal most days, the man should have been placed on an ACCT. HM Coroner may wish to explore further the

closure of the man's ACCT, and the circumstances surrounding the decision not to open a second one.

195. When the man was subject to the ACCT procedures, it was stated that he should not have access to blades. There is no evidence as to what that was to mean or how it was to operate, and indeed when he would be allowed access to razors again.

196. Upon finding the man lying on his call floor covered with blood, the NOO took a brave decision to say he believed the man to be dead, and not allow other staff to see him. This is not a decision that I can endorse, but I understand why it was made and make no criticism.

RECOMMENDATIONS

To the Governor at HMP Gartree:

1. The Governor should remind staff to refer to the ongoing record when conducting case reviews. When there has been an incident to cause concern, they must be made explicit in the case review and a record made of planned action.

   The Prison Service this recommendation and said:

   "The comment that there was a high level of detailed Care Planning within the ACCT document involving a multi disciplinary team is acknowledged. However, on the occasions when the notes did not correlate would suggest that there may be an issue with individual entries that require further staff training. It is recognised that further training in ACCT foundation, ACCT Case Management and ACCT Assessor must be built into the prison Training Plan as a mandatory requirement. This should also be noted as an objective within all staff's SPDR's. This action point fits in with the Suicide and self harm audit requirement to identify this training on all staff SPDRs."

2. The Governor should remind staff to examine patterns of behaviour when considering closure of an ACCT document. When a prisoner has been subject to the procedures for a long period of time, sustained and prolonged improvement accompanied by a gradual reduction in observation and interactions should occur before the ACCT is closed.

   The Prison Service accepted this recommendation and said:

   "As identified, the closure of any ACCT document is always a matter of risk assessment. As stated above, this is a training need identified with a whole prison approach required."

3. I urge the Governor to remind wing staff of the importance of post closure interviews, and to ensure that cover is arranged when case managers cannot conduct interviews.

   The Prison Service accepted this recommendation and said:

   "As identified, follow up reviews are an important part of the ACCT process. All staff, during all levels of ACCT training will be made aware of the importance of Post Closure reviews, chaired by the ACCT Case Manager and involving a multi disciplinary team. Case manager training and regular team meetings to support the need for post closure reviews."

4. I recommend that the Governor considers whether Gartree can reliably prevent prisoners accessing potentially harmful objects

The Prison Service partially accepted this recommendation and said:

"The issuing of objects that may be deemed as potentially harmful is a difficult area to police, particularly on the residential wings, for example, a prisoner may access a razor blade from another source if he is deemed high risk. Within the Segregation Unit and the Health Care Unit, there are electric razors now available for prisoners deemed at risk of self harm through cutting. Risk assessment required on each individual may consider any prisoner High Risk of Cutting to be located in Segregation or Healthcare for better supervision."

5. The Governor should remind staff that consideration should be given to contacting families in line with PSO 2700 when a prisoner commits serious self harm. Staff should also encourage those on ACCTs to speak with their supportive family members where appropriate. This should be included in the local suicide prevention policy

   The Prison Service responded to this recommendation:

   "As identified, PSO 2700 advocates the consideration of prisoners who self harm contacting their families, and the man was encouraged to keep in touch with his family – he was offered a visit to be facilitated whilst in the Health Care Centre and had open access to the telephone during hours of unlock. To be raised during the case managers team meetings"