PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent Investigations

Investigation into the death of a man at HMP Frankland in January 2012

Report by the Prisons and Probation Ombudsman for England and Wales

January 2013

This is the report of the investigation into the apparently self inflicted death of the man, in January 2012, at HMP Frankland. I offer my condolences to his family and friends.

The investigation was carried out by one of my investigators. A clinical review was conducted by a clinical reviewer. Staff at Frankland cooperated fully with the investigation.

The man was sentenced to life imprisonment on 15 January 2009, with a minimum period to serve of over 31 years. He had a long history of alcohol and substance misuse and suicidal feelings before coming into prison. The man never seemed to have come to terms with his conviction and sentence, and found it difficult to see a future for himself, a sentiment he repeated on a number of occasions. During a routine roll check on the morning of his death he was found hanging in his cell.

The investigation found that the man was given a good level of care. He was identified as at risk of suicide and prison officers and healthcare staff spent time counselling him and reviewing his progress. I am satisfied that staff at Frankland did what they could to help keep the man safe, and encouraged him to find ways to adapt to prison life and his long sentence.

The investigation did not find any deficiencies in the man's care, and nothing could have been done to save him once he was found. However, there were some frailties in the post-incident emergency procedures at Frankland which need some attention.

This final version of the report reflects both the man's family and the National Offender Management Service (NOMS) response at the consultation stage.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman **January 2013**

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SUMMARY

1. At the time of his death, the man was serving a life sentence at HMP Frankland following his conviction for murder. He was initially remanded to HMP Liverpool before his conviction in January 2009, and then transferred to Frankland. This was not his first time in prison custody.

2. Soon after the man's arrival at Liverpool in March 2008, he reported feeling suicidal and was placed on an ACCT[1] (Assessment, Care in Custody, and Teamwork). His ACCT monitoring gradually reduced as his mood was considered to have improved, although the man told staff that he was likely to kill himself after he was sentenced and would not tell prison staff if he intended to do so.

3. On 15 January 2009 the man was sentenced to life imprisonment with a minimum period to serve of 31 Years and 178 days until he could be considered for release. He transferred to Frankland in February 2009. He was still regarded as a risk of suicide and self-harm and subject to ACCT monitoring. The man appeared to settle into the prison regime and as a result of his improved mood his ACCT was closed in April 2009.

4. In October 2009, he was again identified as at risk of suicide and placed on an ACCT. Staff noted that he had continuing difficulties coming to terms with his long prison sentence and he was referred to the Community Psychiatric Nurse (CPN). He was subsequently prescribed medication to treat depression and the ACCT was closed in November.

5. The man's frustration at being in prison was a constant feature of his time at Frankland, and his contact with the CPN continued. He was prescribed further medication to assist with his feelings of panic and anxiety. This appeared to have a positive effect on him and his mood and behaviour improved. He was however again subject to ACCT monitoring from February 2010 to March 2010 because of his risk of suicide and self harm.

6. ACCT procedures were again opened for the man in October 2011. As his mood swings continued to fluctuate, his level of risk and monitoring under the ACCT did so too. On one occasion, staff noted that he had self harmed by making lacerations and talked openly to staff about taking his own life. He was supported by staff in healthcare and on the wing, and again his mood improved, and the frequency of his ACCT observations gradually lowered. By the end of November 2011, his ACCT observations had been reduced.

7. During December, the man had five ACCT reviews plus two mental health reviews with the CPN. The general view of staff was that the man's mood had improved and he had no thoughts of self harm. His interaction with staff was good and, by 19 December, his ACCT observations had reduced to one staff interaction with him each shift. The man's ACCT was eventually closed on 29

[1] ACCT is the Prison Service policy and process to manage prisoners considered to be at risk of self harm or suicide.

December because those involved considered he had consistently demonstrated positive behaviours and attitude.

8. Over the Christmas and New Year period, the man spoke to a number of family members on the telephone. He gave no indication to them that he intended to harm himself. During the day of the man's death, staff had no concerns about the man's wellbeing. He was last seen alive at around 8.00pm. When his cell was unlocked around 5.45am the next morning, he was found hanging from shoe laces tied to a table leg which had been wedged high up in the corner of the room. Resuscitation was not attempted as rigor mortis had already set in. Paramedics arrived and at 6.04am formally confirmed his death.

9. Although at that stage nothing could have been done to save the man, the investigation found some deficiencies in the emergency procedures and three recommendations are made to address them.

THE INVESTIGATION PROCESS

10. The investigator visited HMP Frankland on 10 January 2012 and met the Deputy Governor, a member of the Prison Officer's Association (POA) and the prison's family liaison officer. A member of the Independent Monitoring Board (IMB) was not available, although the investigator left his contact details.

11. The investigator issued notices in advance of his visit inviting staff and prisoners to contact him with any information relevant to the investigation. There was no response to the notices. He obtained copies of the man's prison and medical records. He interviewed a number of prison staff. The Governor was given written feedback on the progress of the investigation on April 2012.

12. A clinical reviewer was commissioned to review the clinical care the man received at Frankland.

13. Her Majesty's Coroner for Durham and South Darlington district was informed of the investigation and will be sent a copy of this report to assist his enquiries.

14. One of the Ombudsman's family liaison officers contacted the man's mother. She explained the purpose of the investigation and invited her to raise any questions or concerns. The Ombudsman's family liaison officer and the investigator later met the man's mother and other members of his family with their legal representative at the family home. His family raised the following concerns:

    - His family asked about ACCT monitoring, who monitored him and how well they knew him. They asked who assessed him in regards to his location. They asked why the man had been allowed to have a razor blade when he was on an ACCT.

    - His family asked about staffing levels over the Christmas and New Year period and whether this had any effect on the final ACCT being closed.

    - The man's mother visited her son on Christmas Eve, but she said the visit was initially delayed, and there had been some confusion about whether he had a visit or not, which might have affected him especially at that time of year.

    - The man's family were not told of his death until 11.45 am by staff from HMP Altcourse, and believe they should have been informed sooner

15. The family received a copy of the draft report as part of the consultation period and raised issues that have been covered within the report. However they wished to note their concern that the ACCT process lacked communication and a multidisciplinary approach. They also believed that the man's ACCT document should not have been closed on 29 December, just before New Years' eve when he was most at risk. The man's mother also said that she had telephoned the prison sometime in 2010/2011 and informed them that the

man had told her he wanted to kill himself. She relayed her concern to the person she spoke to who told her that they would assess and monitor him. The family's legal representative also raised some issues which have been addressed in a separate letter to them.

16. There have been fourteen deaths at Frankland since January 2010. The man's death was one of two apparently self-inflicted deaths, and there are no direct similarities.

HMP FRANKLAND

17. Frankland is one of eight high security prisons in England and Wales, and can hold up to 844 men. It holds convicted category A and B adult male prisoners, and some high risk remand prisoners. The man was a category B prisoner (those who do not require the maximum security but for whom escape must be made very difficult). All prisoners have single cells.

18. Until April 2011, healthcare services at Frankland were provided by County Durham Primary Care Trust. Since then Care UK, provides healthcare services at Frankland and a number of prisons in the area. There is 24 hour inpatient care.

Her Majesty's Inspectorate of Prisons

19. HM Inspectorate of Prisons conducted an unannounced full follow up inspection in November 2010. The Chief Inspector reported that:

> "Support for prisoners at risk of suicide and self-harm was reasonably good. … Assessment, care in custody and teamwork (ACCT) documents for prisoners identified as at risk of suicide and self-harm were mostly completed to a reasonable standard and there were some very good examples of care, particularly on Westgate unit. Initial assessments were generally good but there was little continuity of case manager at reviews and only limited health care input. Some care maps needed more specific targets. Most daily entries in ACCT documents were observational but others showed good positive interaction."

20. Inspectors noted that a recommendation from the previous inspection in 2008 about the need for more specific and measurable targets in ACCT care plans had not been achieved. They commented that targets were rarely specific or related to issues identified at ACCT reviews, and were not regularly updated. Prisoners were responsible themselves for most goals rather than specific members of staff being identified to help.

Independent Monitoring Board (IMB)

21. Each prison has an Independent Monitoring Board of unpaid volunteers from the local community who monitor all aspects of prison life to ensure that proper standards of care and decency are maintained. The most recent IMB annual report for Frankland (2010-2011) identified that, as far as reasonably practical, the prison continued to provide a safe and secure environment and prisoners continued to be treated decently and respectfully. The report also noted that:

> "Feedback from the Safer Custody and Listener group meetings suggests that while the risk of self harm at Frankland may be relatively high the risk of suicide is low…"

Roll checks

22. The roll check is the physical count of the number of prisoners on each wing in a prison. Roll checks occur on a number of specified occasions during the day and night, and staff sign that the roll is correct. Staff carry out a physical head count to ensure that the prisoner is in his cell and the cell door is locked. If they cannot see the prisoner, staff must satisfy themselves the person is in the cell.

Suicide and self harm monitoring

23. The Assessment, Care in Custody and Teamwork (ACCT) system is the Prison Service process for supporting and monitoring prisoners thought to be at risk of harming themselves. An ACCT plan can be opened by anyone working in the prison if they have any concerns that a prisoner might have tried, or, in the future, might try to harm himself.

24. The purpose of ACCT is to try to determine the level of risk posed, the steps that might be taken to reduce this and the extent to which staff need to monitor and supervise the prisoner. Levels of supervision (where staff must check the prisoner) and interactions (where staff must have a conversation with the prisoner) are flexible and can be set according to the perceived risk of harm. If staff believe the risk of harm to be very high, the prisoner may be constantly supervised, with a member of staff positioned outside their cell at all times. Where the perceived risk is lower (low or raised), the level of supervision may be several times an hour or day. As part of the process, a CAREMAP (plan of care, support and intervention) is put in place and there should be regular multi-disciplinary review meetings. Wherever possible, the prisoner at risk is included in review meetings.

KEY EVENTS

Events before the man's arrival at HMP Frankland

25. The man was born in Liverpool. He had a number of criminal convictions for various offences.

26. On 16 July 2008, the man was remanded to HMP Liverpool. His reception healthscreen noted that he had been in prison in 2007 at Liverpool and HMP Risley. He said he felt suicidal and could not face serving a life sentence. He was also suffering from alcohol withdrawal and was immediately referred to the prison doctor.

27. In response to the man's suicidal thoughts, an ACCT document was opened. The man said he could not trust himself and thought about taking his life by hanging. The doctor described his behaviour as impulsive and he was prescribed chlordiazepoxide (a type of medicine called a benzodiazepine used for its sedative and anxiety-relieving and muscle-relaxing effects to counteract withdrawal symptoms from alcoholism) and he was referred to the mental health team.

28. The man told the mental health nurse that he had experienced constant suicidal thoughts for a number of years and believed there was nothing anyone could do to help him. He said he had no immediate plans to kill himself, but reiterated that he would be dead before he was sentenced. He also stated that he was constantly hearing voices, but was reluctant to discuss this further with staff. A mental health nurse spoke to wing staff about the man's risk of suicide, and asked that he should be monitored closely while he was going through his alcohol detoxification treatment.

29. The man appeared to have responded well to the treatment for his alcohol withdrawal. He continued to be monitored under the ACCT system and also had regular contact with mental health nurses. He said that his risk of suicide had decreased and he was looking forward to visits from his girlfriend. On one occasion, he described experiencing auditory hallucinations which he said came from "inside his head". However, mental health staff felt his concentration and level of eye contact was good and consistent. Despite this, he maintained that he would, more than likely, attempt suicide just before being sentenced. He requested continued support from the mental health team but said he would not tell prison staff when he intended to take his life.

30. On 15 January 2009, he was found guilty of his offence. Four days later, he was sentenced to life imprisonment with a minimum period to serve of 31 years and 178 days. This meant that the earliest possible date he could be released was 16 July 2040. The man maintained that he was innocent of the crime.

The man's arrival at HMP Frankland

31. The man transferred to HMP Frankland on Monday 2 February 2009. His ACCT document was still open. He went through the routine reception process and was located on D wing as an enhanced IEP[2] prisoner. The day after arrival he had a reception healthcare screen. The nurse noted that the man said he had no current thoughts of harming himself, although he had a history of doing so, and had tried to hang himself in 2000 as well as previously contemplating jumping out of a building. The man requested to be referred to the doctor. He was not listed as using any medication at that time.

32. On 5 February 2009, he was seen by a nurse for a secondary health screen, during which he became tearful. He was admitted to the healthcare centre and his ACCT monitoring was increased to two observations every hour. The man said he had no thoughts of harming himself and hoped the ACCT would be closed soon. He also said he did not want any support from the mental health team and that he received a lot of support from his family. During his induction into the prison, he said he wanted to get a prison job.

33. In March, he appeared to settle into prison regime, but was still preoccupied about his long sentence. Staff therefore set a goal on his ACCT CAREMAP for him to come to terms with his length of sentence which could be helped by keeping his time occupied. He got a job in the Woodmill assembly shop. His ACCT observations were soon reduced to one conversation each staff shift and his risk was considered low. As a result of his improved mood and apparent lack of thoughts of self harm, the ACCT document was closed on 3 April. The man moved to B wing about a week later.

34. From March through to September, staff noted regular observations about the man in his wing history sheet. He was described as settled on the wing, continued to work and generally caused staff no problems.

35. On 3 June 2009, nurses made a risk assessment to decide whether the man could be allowed to keep his medication 'in-possession'.[3] Nurses noted that he had previously been managed on an ACCT, but was not now. It was decided that he was low risk, so the decision was made that in-possession medication was appropriate.

36. On 11 September, the man saw the doctor as he was experiencing heartburn. He was prescribed omeprazole, medication commonly used for treating acid-induced inflammation and ulcers of the stomach. On 23 September 2009, he said he was experiencing palpitations at night although he said he was not stressed, or worried about anything. He was seen two weeks later by a prison doctor who considered that "in all probability he was having the odd ectopic (a premature heartbeat) but would need to see GP re: onward referral if

[2] IEPS, Incentives and Earned Privileges Scheme is an incentive to reward good behaviour in prisons. There are three levels - Basic, Standard and Enhanced. Incentives include access to in-cell television, more private cash to spend, wearing own clothes, more time out of cell and community visits.

[3] Prisoners can be issued with several weeks supply of medication at a time to keep in a lockable cabinet in their cell and take as prescribed.

concerned". The man was seen on 8 October 2009, and prescribed propranolol (a medication known as a beta-blocker and prescribed for anxiety and feelings of panic). The doctor carried out an ECG[4] test, and noted the result was normal.

37. The man saw the doctor again on the morning of 5 November 2009. He told the doctor that he had a lot of family problems and that he felt frustrated and wanted to die. He said he had stopped eating although was still drinking, and had not slept properly. He denied having any thoughts of actively harming himself, but said he wanted to die from starvation. He claimed to have also stopped taking his medication (propranolol) because he wanted to die and continued to refuse any mental health input. The doctor told the man to speak to staff if he felt worse or felt like self-harming. The man's history of self-harm was noted and despite the man's reluctance to speak to the mental health team, the doctor spoke to them as well as submitting a mental health referral. The mental health team subsequently made a referral for the man to see a psychiatrist.

38. Following his return to the wing, the man made a telephone call. Staff thought that he appeared to have received bad news as he asked to be "put behind his door" afterwards. He would not talk to or acknowledge staff through his cell door when they tried to interact with him. As staff were concerned about his state of mind they opened an ACCT. Initially, observations were set at four each hour.

39. The man was more forthcoming at the ACCT assessment interview which was carried out the next day. He said his low mood was a result of relationship problems and he would deal with matters himself and wanted no "interference". He had no current thoughts of self harm although acknowledged this might change in the future. He wanted to see how he settled into prison life and described himself as only having a small future with few people to rely on. The man said he was now happy to engage with the mental health team. He acknowledged that he had learning difficulties, something he had not done before. The man was described as having poor and limited vocabulary, partly it was thought, because he had left school when he was 15, and also because his education had been disrupted by his previous non attendance, exacerbated by his propensity for alcohol.

40. A central part of all ACCT procedures is the CAREMAP which details the prisoner's problems and the ways in which they might be addressed. One of these was the difficulty the man was having coming to terms with his life sentence and long tariff. The target set to address this was for him to seek assistance from the mental health team's community psychiatric nurse (CPN) to develop coping strategies. A referral to a CPN was arranged. In order to address his learning difficulties, the man was to attend education to be assessed, which he did on 30 November.

[4] an ECG is an electrocardiogram which is a test that measures the electrical activity of the heart to test for any heart problems or if a medicine is adversely affecting the heart because of its side effects for example.

41. On 10 November 2009, the man was seen by the CPN. The man told the nurse that he had felt depressed for many years. The CPN carried out a comprehensive assessment, although the man was initially not very forthcoming. The CPN noted that he had a limited vocabulary, but he was able to make his needs known. He presented with a sad expression and appeared very negative about his life in general. The CPN wrote:

> "I established that the man has been depressed for a number of years, is probably moderately depressed at present and has had recent thoughts of self- harm. From his account he is under stress as he was recently given a long sentence (32 years) and insists he is not a murderer. Girlfriend has now split with him and he sees no future apart from appeal via his co-defendant."

42. The CPN recommended the man start a trial of fluoxetine 20mg (a medicine used to treat depression) and for him to be reviewed regularly to assess its efficacy. The first review was scheduled for two weeks. The man was seen later that day by the prison doctor who prescribed fluoxetine, but because of his identified risk of self-harm this was initially to be dispensed daily.

43. The ACCT was closed 13 November. The man said he felt much better than when the ACCT was first opened. His positive attitude was also reiterated at the post closure review meeting conducted on 23 November. Through the support provided, he said he had learnt new coping strategies, felt better and more positive. He still received ongoing support from the mental health team and his family, and his job helped occupy his time.

44. On 7 December 2009, the man was seen by the mental health nurse. Some improvement in the man's mood was noted since taking fluoxetine. The CPN said that he seemed alert and noted there was a reduced frequency and severity of the man's suicidal thoughts. He was not so withdrawn from other people and was able to introduce positive thoughts into his thinking. The prison doctor noted the medical record saying that the CPN was now happy for the man's to receive weekly supplies of his medication.

45. The man attended a sentence planning meeting on 9 December 2009. The aim of the meeting was to discuss how the prison could help the man serve his sentence. The meeting discussed programmes and courses he could and should participate in, along with associated targets and plans. At this meeting, he was described as totally disinterested. He was negative and said he was never going to be released. Staff reminded the man that, to remain as an enhanced prisoner, he would have to partake in the sentence planning process, which he eventually agreed to do. Targets were set for him to make use of his time in custody by attending education, gaining further qualifications and improving his basic skills. He was already in contact with the CARATs team (counsellors) with the aim of addressing his alcohol and drug misuse.

46. On 5 January 2010, the man was seen by the CPN, who commented:

> "The man agrees that his mood has improved and seems to cope with prison stress better. He is worried about palpitations[5]…. Finds that they occur for no reason as he lays in his bed on an evening. When describing these he seems to be monitoring / raised alertness. Advised the man not to 'monitor' palpitations, previous ECG seems normal but he should consider reduce/stop smoking and diet/exercise to reduce weight."

47. On 24 February 2010, the man saw the prison nurse and doctor after taking an overdose of his prescribed medication. The man said that he had taken more than 50 tablets (he said that he was sure he had taken 27 propranolol tablets but was not sure how many fluoxetine 20mg and omeprazole 20mg tablets he had taken). He said he felt dizzy and was sweating but would not say why he had taken the overdose. The ACCT process was immediately reactivated and he was taken by emergency ambulance to hospital.

48. The man was discharged from the hospital later that night as his condition did not get worse and no treatment was required. He was offered a place in the healthcare unit for the night so staff could observe him further, but wanted to return to the wing. Following an assessment, he was no longer allowed to keep his own medication in his possession. His ACCT observations were set at one an hour but reduced gradually till the ACCT document was closed on 17 March. By this time, the goal set by staff in his ACCT CAREMAP of keeping him occupied had been achieved. The man was now working full time in the spray workshop from 2 March and staff considered that his risk had sufficiently reduced.

49. On 20 May 2010, the man was seen by the CPN. He said he was frustrated and they discussed his recurring feelings of panic and agreed for the man to start propanolol and be reviewed in four weeks time. This was later referred to the prison doctor to authorise the prescription.

50. When the CPN saw the man on 17 June 2010 he noted that he "…appears brighter and reactive at present, says he feels much calmer on propanolol and able to cope". By contrast a month later on 23 July, he told the CPN that he had been "putting on a front, telling people that he is alright when underneath he remains frustrated and angry / often panicky…". The CPN asked the doctor to increase his propanolol to 60mg once daily and noted that he was to be reviewed in four weeks' time.

51. At the review on 25 August, the CPN wrote in the clinical record that:

> "The man continues to benefit from propanolol in managing his anger / social anxiety. …No obvious mental health needs at this time, reports good anxiety management strategies and is compliant with meds. The man appears relaxed, confident and amenable at present…"

[5] A palpitation is an abnormality of the heartbeat.

52. Over the next 15 months, the man seemed to have coped better with prison life and he had no substantive contact with the mental health team. He saw some healthcare staff for minor physical ailments.

53. Between December 2010 and January 2011, a number of prison staff from different departments submitted contributions for the man's sentence planning review meeting, which was scheduled for January 2011. His personal officer A noted that, since the last review, the man had no adjudications and had a good working relationship with staff. The education department noted that the man was working in a workshop and also currently undertaking an art course and DJ music course. His teachers commented that the man had good attendance, punctuality and behaviour. The CARATs team noted that they had done some work with the man relating to drugs and alcohol.

54. The man attended his sentence planning meeting on 27 January 2011 as planned. The wing senior officer and the man's offender supervisor were present. It was noted that the man had not met his sentence plan target to improve his basic skills in education. The man said he did not want to listen to his offender supervisor and was not interested in education. He refused to complete the sentence plan meeting and left angrily. Because the man had refused to comply with the sentence planning process, a decision was taken to downgrade him to standard IEP status. In later discussion with his personal officer the man said he was frustrated that numeracy and literacy targets should be included in his sentence plan, but agreed that he would apply for an education assessment.

55. On 12 February, the man's personal officer A reported that the man had a better week. The man had long and open discussions with members of the sentence planning board, and his enhanced IEP status was reinstated at the end of February. This meant he remained on A wing, which was for enhanced status prisoners.

56. In March, the prison assembly workshop informed the man that due to a shortage of available work, he was not required. He put in an application for a change of job which was supported by his personal officer as he felt the man needed to keep motivated. From May through to June, the man's personal officer only had positive comments to record about the man, who he generally described as "positive" and "quite happy".

57. However, from mid-June to July, staff reported that the man's mood went up and down "like a roller coaster". He made a number of telephone calls to his family and girlfriend often ending in him shouting and returning to his cell. He was described as very agitated but declined staff support, who managed to glean that his girlfriend appeared to have met someone else. Staff noted that the man's home life appeared to have settled down by mid-July and his behaviour after his telephone calls to his family was calmer.

58. On 28 July, following a security investigation the man was moved to C wing (cell C3-24) because of conflict with another prisoner. He was given a new personal officer. Personal officer B made numerous entries in the man's record

between July and September. He commented that the man had settled on the wing since his move, mixed well with the other prisoners and caused no problems on the wing. The man largely chose not to speak with staff and, when he did, it was because he needed something. He attended the gym and worked regularly. Contact with his family also appeared good. However, personal officer B described the man's demeanour as sometimes looking as though he had the "world on his shoulders, looks unhappy/surly". He had spoken to the man occasionally about playing his music too loud, but generally he seemed okay on the wing. The man continued to attend his DJ workshop and was enthusiastic about the lessons.

59. On 3 October, the man's new personal officer wrote:

> *"Still acting surly towards staff, does not communicate well. Associating with some of the bad elements on the unit, wanders across the whole unit. Attends his work with no problems. Regularly contacts his family on the phone, often coming off in a bad temper as it seems he gets wound up with these calls. "*

60. During the serving of the evening meal on 5 October (around 6.15pm), staff noticed marks on the man's neck consistent with what they believed were ligature marks. The man said he had fallen and that his "head was all over the place" and only one thing would sort his problem out. When asked what this was, he refused to answer. He also failed to respond to staff when asked if he had any intention to kill himself. ACCT procedures were opened, with four observations an hour. He was reminded of the support available including access to Listeners[6]. An ACCT CAREMAP was also opened. Amongst the solutions on the CAREMAP was a requirement for staff to communicate with the man to help him express his feelings, and for him to acknowledge he had learning difficulties.

61. Shortly after, the man was taken to the Listener suite so he could speak to a Listener. He said his head was "banging". On his return, staff noted he seemed a lot happier. He said he was okay and had no intention of "doing anything silly".

62. The next day, the man refused to participate in an ACCT assessment and review. He said he had nothing to say and that the marks on his neck had just appeared. Initially, his mood was calm and he showed no signs of distress so staff reduced his observations to two an hour. As the day progressed, the man continued not to interact with staff or prisoners and he refused to eat. Concerned about this, staff raised his observations to four times an hour as his risk was considered to have increased from low to raised. His CAREMAP was updated to inform staff that he should be encouraged to attend work.

63. Staff attempted to engage with the man at his ACCT review on the morning of 7 October. He said he did not want to live and admitted that he had tried to hang

[6] Listeners are prisoners trained by the Samaritans to provide a confidential service for other prisoners. They do not offer counselling but offer support, particularly for prisoners at risk of self-harm.

himself and gave staff the ligature and implements he had used. He said that speaking to the Listeners had helped. He also spoke more to staff which was encouraging. As the man seemed more forthcoming, his ACCT observations were reduced to twice an hour and his risk level reduced to low. He was referred again to see the CPN.

64. The CPN assessed the man on the afternoon of 13 October. The man appeared sad and spoke openly about his current suicidal thoughts, something he said he considered even before coming into prison. The man said he did not care what his family thought, he was very negative and refused to accept any reasons to stay alive or that he had a future. He could not see how he could serve such a long sentence, and was bored with prison. However, he said he was willing to accept support from the mental health team.

65. Later that evening (13 October), a member of the prison mental health in-reach team attended the man's ACCT review (at approx 5.45pm). Her note included the following comment:

> "The man attended his ACCT review and appeared to be angry. He refused to discuss his plan to kill himself stating "that defeats the object". He states that he does not want to see the mental health team. After discussing his family and how they would grieve if anything happened to him he was observed to get upset but also angry…he asked to leave the room….His observations have been increased to 4 x hourly due to his risk of attempting suicide and not being willing to discuss his plans…". (His risk level again increased to raised)

66. Over the next two days, positive entries were noted in the man's wing history sheet. He was observed as "a bit more settled" and said he felt better. He apologised to staff for his recent behaviour and mood. He was also working regularly. On 16 October, he requested that his ACCT observations during the night should be reviewed as he was being woken up four times an hour because of the checks. Following discussions with landing staff, who noted that he appeared genuine and was in much "better spirits", the man's ACCT observations were later reduced to twice an hour. It was recorded that the man's interaction with staff was much better and the reduction would help him sleep better.

67. When the CPN, saw the man on 17 October, he said he "appeared sullen and uncooperative" and was not willing to discuss his recent suicidal thoughts. His ACCT observations remained at two an hour.

68. The next morning, 18 October, at morning unlock, the man told staff that this would be the last time he intended to come out of his cell and that, from now on, he would remain "banged up at all times". When asked what he meant, he simply said he would not be coming out of his cell ever again. The wing senior officer was informed as was the CPN, who saw him again. He noted:

> "…I spoke to him through the glass panel at his cell door. He told me initially that he did not want to talk and not to bother opening the door.

> He said he just wants to go to the block (segregation), away from the wing to be left alone. I made it clear that going to the segregation was not an option and he then produced a ligature (a strip of bedding made into a loop around 18" diameter) and said well if you leave me here he would use the ligature. Again advised that this was not option though would consider a move to healthcare and he said that he would go there…"

69. The CPN s informed the wing staff that the man had produced a ligature. He was immediately made subject to constant supervision[7] and the duty governor was informed. The duty governor spoke to the man through his cell door for about 45 minutes as he told staff not to open his door. The duty governor eventually persuaded him to come out of his cell. The duty governor, CPN and the man spoke in private in the SO's office where the CPN reminded him of the support the mental healthcare team could provide, including reviewing his medication and a possible referral to a psychiatrist. The man responded positively to these discussions and agreed to accept the support offered. He also agreed not to do anything "stupid". He appeared less agitated and returned to his cell. An ACCT review was conducted around midday and it was agreed that his observations would be five per hour, to be reduced to four if he settled overnight.

70. That afternoon the man attended work, but was sent back early because of concerns about his mood. The man said he wanted to end his life. The duty governor and the CPN were informed and the man was moved to the healthcare centre and constant supervision was restarted.

71. The man's personal officer B spoke to the member of staff conducting the constant supervision on the morning of 19 October. The man was said to be interacting well and, although his mood was considered good, he was still finding it hard to come to terms with his sentence. An ACCT review was carried out with mental healthcare input later that day. It was noted that his mood had improved a little he said he would not self harm and he wanted to return to the wing. It was decided that he should remain on constant supervision for at least one more night.

72. On 20 October, the man saw a visiting psychiatrist. He was reluctant to engage fully, but answered most of the psychiatrist's questions. He refused to have any family input into his situation, although he said he knew they cared. He was prescribed 20mg paraxetine to be taken daily (used to treat depression, anxiety disorders, obsessive compulsive disorder and panic attacks).

73. At his ACCT review the next day (Friday 21 October), the man said that he had started to feel that life was precious and asked staff to trust him. He denied that he felt suicidal. He seemed calmer with none of the anger or agitation he had shown earlier that week. He was reminded of the support of the Samaritans and Listeners. He interacted well with the constant supervision officer, and ate and slept well. It was agreed the man should be given the chance to return to

[7] Constant supervision is used in response to an immediate and life threatening risk of suicide or self harm. It is carried out on a one to one basis.

his wing from the healthcare centre. His observation level was reduced to five time per hour.

74. On Monday 24 October, the CPN reviewed the man's weekend ACCT records. He noted that his mood had improved over the weekend along with his sleeping pattern, appetite and interactions with others. The man also appeared to be able to talk about the future with more enthusiasm. Later at the ACCT review, staff agreed that the man's mood had improved and any suicidal thoughts he had were fleeting. It was agreed to reduce his ACCT observations to four an hour and, if his presentation continued for the next 24 hours, observations would be then reduced to three times an hour for the rest of the week.

75. The next day, 25 October, the man returned to work. He was said to work well and his mood was upbeat. However, at about 6.00pm that evening healthcare were contacted as he had said he intended to kill himself. He was seen by the in-reach mental health nurse and talked about being stuck in prison for 30 years. He said he had told his mother this and provided her telephone number. The nurse contacted the man's mother who said her son "could not take it anymore". The man was placed back on constant supervision. He refused all support and did not want to go to the healthcare centre. His cell door was therefore left open to aid observation and contact. He was reviewed the following day, but refused to engage, and said he did not want to leave his cell. He was persuaded to move to the healthcare centre and constant supervision continued.

76. On 27 October, the man attended his ACCT review. The CPN was also present. The man said he was 'alright' although he still had suicidal thoughts. He had had a settled night, slept well and was eating. It was agreed the man would remain in healthcare with six observations an hour. He would be able to return to his wing during the day for association, but spend the nights in the healthcare centre.

77. The next day, the man attended his ACCT review again and seemed more positive. The CPN noted that he was eating and sleeping well and talking to staff. He also complied with his medication. The man's improved mood continued over the coming days. He spent time on the wing mixing with other prisoners, attended work and slept in the healthcare centre at night. His ACCT reviews noted his mood was brighter and he had not expressed any suicidal ideas nor was his behaviour cause for concern.

78. On 4 November, the man's attended his ACCT review. Staff noted that he was initially quite negative. He accepted that he had been more settled during the week and had not expressed any suicidal intentions. He said he often thought about dying each day, although he denied having any plans to act upon them. The man said he was ready to return to the wing. The ACCT panel, which included the CPN, agreed that although his suicide risk was high, they would work towards resettling him back on the wing.

79. The man attended ACCT reviews on 7 and 11 November. Both reported that he appeared brighter, settled, was eating and sleeping well and associating

with other prisoners. The ACCT panel decided that the man could return to the wing. His risk level was considered low and his observations were to be reduced to three times an hour, followed by twice an hour on 11 November. The prison doctor also reviewed the man's medication and he was prescribed venlafaxine 75mg (a medication prescribed for the treatment of depression, depression with associated symptoms of anxiety), not in-possession.

80. Staff reported no concerns once the man settled back onto the wing. He continued to say that he had no thoughts of self-harm. On 14 November, his ACCT observations were reduced to once every hour. His personal officer B, reported that the man had settled back well on the wing, but staff were reminded of the need to be vigilant.

81. Shortly before midnight on 14 November, the man made lacerations to his left arm. Healthcare were informed and immediately attended to dress his wound. Staff retrieved a razor blade from his cell. The man said he had done it because he was 'bored'. An ACCT review was carried out, his risk level raised and his observations were increased to twice hourly. (Safety razors are issued to prisoners for their personal use. They can be removed if staff are particularly concerned they may be used for harm, but the Prison Service guidance is that they should not be removed from at-risk prisoners as a matter of course.)

82. On the morning of 23 November, the man handed in a piece of torn bed sheet to the wing office. He told staff he had tried to hang himself during the night. He was reviewed by the CPN and took part in an ACCT review where he said he was struggling with thoughts of ending his life. He was agitated but refused to say what he was planning to do to end his life. Staff observed that he had marks on his neck and the man said he would continue to try to hang himself if no-one was looking. He had also apparently tried banging his head on the wall and said he was not able to sleep (although he had appeared asleep when observed by staff). The man was placed on constant supervision and admitted to healthcare. His mother was contacted and she agreed to participate in a teleconference ACCT review scheduled for the following day (although there was no mention the next day if this occurred).

83. The next day, 24 November, at his mental health review, the man was initially agitated when he was asked to attend the ACCT review. He eventually agreed to attend the review and conceded that his mood was a little better than the previous day, but could not assure staff that he was not thinking of suicide. It was decided to continue constant supervision and review again the following day. There was no medical reason for him to stay in the healthcare centre and he was later discharged back to the wing, but observed in a cell using the prison's CCTV system.

84. At his ACCT review on 25 November, the man was unable to explain his thoughts about suicide. He was a little agitated and, although he gave his word that he would not make any more attempts to self-harm, the review team agreed that he could not be trusted. He had had a settled night on the wing, associated with other prisoners and had not voiced any threats of self-harm.

The review panel agreed to continue constant supervision but, if there were any further concerns, he would be taken immediately to healthcare.

85. On 28 November, following his ACCT review, the man's observations were reduced to four an hour. The ACCT record indicated that he had been reasonably settled over the weekend, had a normal routine, some social interaction, and was eating and sleeping normally. He had not voiced any thoughts of suicide or caused any concern. He had had a good talk with his mother over the weekend and felt calmer and settled. The man was encouraged to keep talking to staff regarding how he felt

86. As he was not able to attend the ACCT review on 1 December, the CPN, contributed by telephone before the meeting. Staff had told him that they had noticed red marks on the man's neck, possibly from a ligature. The CPN therefore believed the man's observation levels should remain at four times an hour. . When the man attended his ACCT review staff described his mood as "pleasant & open" when communicating. Wing staff had few concerns about him and he had made no attempts to harm himself. Staff believed his risk level to be low. The man said he had no thoughts of harming himself and it was agreed to reduce his observations to three an hour with staff to make four written entries per day following interactions with him.

87. On 8 December, the man attended his ACCT review. The CPN was present. It was noted that the man appeared a little brighter, had had a settled week, was sleeping okay, was associating with others and staff had not reported any concerns. His observations levels were reduced to twice an hour.

88. The man attended his mental health review with the CPN on 14 December. Again he seemed brighter and more communicative. He spoke enthusiastically about his job in the workshop and agreed that keeping occupied, associating with other prisoners and communicating his feelings, helped to manage what he described as 'bad thoughts'. He denied that suicide was on his mind all the time. The CPN discussed increasing his venlafaxine in the hope that his mood would further improve, but considered that the man's risk of suicide appeared to be slowly reducing.

89. The next ACCT review was the following day. The man was positive, talkative, and confident. No concerns had been identified during the previous week and the man had engaged with staff, was sociable and was sleeping well. When asked about feeling suicidal he denied having any 'bad thoughts'. Observations were reduced to one every hour with a plan to review after the weekend and to reduce further if he continued to make progress. His risk level remained as low.

90. On 19 December, at his ACCT review, staff commented again on his "bright mood" and positive interactions. He reported no thoughts of self harm. The man said he felt positive about the future. His ACCT record notes that he seemed to be settled on the wing, had been associating with other prisoners, had no current problems sleeping and had maintained positive links with his family. When praised by staff for his progress over the last few weeks, the man smiled and showed some humour. The ACCT review panel agreed to reduce

his hourly observations to written entries only, one a shift. The man's risk level had been considered low for nearly three weeks at this stage. The CPN said he had spoken to the prison psychiatrist and it was suggested that the man's dose of venlafaxine could be increased. The man was to be reviewed a fortnight later.

91. The man's Personal Officer B spoke to the man on Christmas Eve. He described him as happy around other prisoners, but noted that with staff his demeanour was as if he had the "world on his shoulders". He still attended work regularly and kept in contact with his mother. The man had a visit from his mother that day. There was some confusion as to whether the visit was to take place, but it did and his mother reported no concerns about him. Over the Christmas period, staffing levels remained much as for any other period of the year and staff noted no concerns about the man. He was reported to have continued to show an improved "positive frame of mind".

92. On 29 December the man attended an ACCT review. The CPN was there as well as two other members of staff. The man was described as settled and did not express any thoughts of suicide or self-harm. The review noted that he had "consistently demonstrated positive behaviour and attitude since his last review and for a significant period preceding that". The ACCT record concurred with this and noted good interactions with others, good sleeping pattern, and no concerns expressed from staff. The ACCT review panel agreed that the ACCT would be closed, although the man was still to continue to receive support in the form of ongoing individual sessions with the CPN.

93. Later that afternoon CPN conducted a mental health review. The man told the CPN that he was taking each day as it came and he continued to receive support from his family and from staff. He hoped to comply with his sentence planning requirements next year, but said he could not promise he would. The man felt that he had benefited from taking anti-depressants and the CPN was hopeful that the recent increase in his dosage would help him make further improvements. The man said he could not envisage his long-term future but that he had never been able to. He expressed appreciation for the support he was getting. His mood was settled and he said that he had no thoughts of suicide or self-harm. His next mental health review was arranged for two weeks later, the same day as his ACCT post closure review on 12 January 2012.

Events on 4 – 5 January 2012

94. Officer A was on duty from 6.45pm on the evening of 4 January 2012. He was assisted on the wing by Operational Support Grade (OSG). Although the officer did not know the man well, he knew what he looked like. His first task when he arrived on C wing was to conduct a roll check. The officer said he was certain that he had no concerns about the man when he checked. As the man was not

on an ACCT, he did not need to be checked again until the morning roll check. The officer confirmed that the man did not ring his cell bell during the night.

95. The following morning the man died, Officer A began the wing roll check at about 5.45am. The OSG was in C wing main office at this time. When the officer opened the man's cell door observation flap, he saw the man's face right up against the observation panel. He appeared to be hanging. The officer broke his sealed key pouch[8], took his cut down[9] tool out from its holster and used his radio to request help. The radio message received by the staff in the communication room was logged at 5.47am noting "Oscar 1 to Charlie wing immediately". The officer also shouted for assistance to the OSG. The officer told the investigator that although he was aware of the emergency codes[10] used at Frankland, he did not use one as he wanted to get into the cell to assist the man as quickly as he could.

96. Officer A unlocked the cell, but as the man was a large and heavy man he had to push the door with some force to get in. The man had used shoe laces to hang himself, tied to a table leg which had been wedged high up in the corner of the room by the door. The officer cut the laces and, although he had no current first aid training, he checked the man for any signs of life, but found no pulse. The officer told the investigator that the man's skin was cold to the touch and his body had started to stiffen.

97. The OSG arrived at the man's cell just as Officer A was coming out. He said that the officer told him that the man's body was directly behind the door and so OSG could not get into the cell. The officer said that the man's body was "stone cold" and therefore resuscitation would be futile. The officer then told the OSG to complete the roll check of the wing. The OSG confirmed to the investigator that he did not enter the man's cell. The Oscar 2 night manager (second in charge of prison), SO A then arrived.

98. Knowing he was closer to the wing than the Oscar 1 night manager (officer in charge of the prison) when the radio message was broadcast, SO A immediately responded. He said it took him about 30 seconds to get to the man's cell. Officer A was waiting on the landing and appeared visibly shaken. He directed the SO to the man's cell. The SO slightly pushed the door open and looked in, at first not seeing the man until he looked behind the door. The Oscar 1 night manager, SO B and the night nurse then arrived.

99. SO B was in the healthcare centre with the nurse when she heard the message for assistance and asked the nurse to go with her to C wing. Although the radio call did not describe the type of incident, the nurse said she got the impression the call was urgent. However, she did not take the emergency equipment bag with her to C wing. They arrived on the wing in less than two minutes.

[8] During night state, officer grade staff carry a sealed key pack which can be broken to gain entry to cell in emergencies.

[9] Cut down tools are knives that are specifically designed for safely cutting ligatures and are carried by all officers and healthcare staff who are in contact with prisoners.

[10] Emergency codes are used to summon staff to deal with a particular situation. A Code Red indicates a blood related injury and a Code Black is used to indicate a life threatening incident or if a prisoner is unconscious.

100. Nurse A also had to push open the cell door so that she could enter as the man's body was still behind it. Once inside, she found the man in what she described as a "kneeling position". He was not breathing, had no pulse and "was freezing cold". The nurse said that CPR would not be effective. The nurse told the investigator that she had worked at Frankland for just over a year and this was the first time she had attended an incident like this. She left the cell to inform SO B of the man's condition, leaving him in the same position she had found him. An ambulance was recorded as being called at 5.55am. The nurse returned to the healthcare centre to update the man's medical records and did not return to the wing.

101. Not wanting to leave the man in the position he was in behind the door, SO A and Officer A laid him flat on the cell floor. From his recollection and corroborated by the officer, the shoe laces, although loose were still around the man's neck. They were removed at this point. The paramedics arrived at 6.04am and at 6.08 confirmed the man's death.

102. A note was found in the man's cell. He wrote that his life in prison was a misery and "now I can 'R.I.P'".

After the man's death

103. The prison's death in custody contingency plan was activated by the duty governor. The police, coroner and the governor in charge were informed of the man's death. A hot debrief[11] was held by the governor at around 7.00am with the all staff, except the nurse, that had attended the man's cell. The nurse said she was not aware of the hot debrief meeting and was not invited to attend. The staff care team were deployed to ensure counselling was offered to staff and prisoners and included the use of the chaplain and Listeners. Staff began to collate the man's prison records and appointed the prison's family liaison officer (FLO).

Contact with the man's family

104. The man's mother was listed as his next of kin and lived in Liverpool, over 160 miles away. To try to ensure that the man's family were informed quickly, the prison's family liaison officer contacted HMP Liverpool to see whether anyone was available to break the news to the man's family, but they were unable to action this. HMP Altcourse (also in Liverpool) was then contacted and the deputy family liaison officer agreed to make the visit. He made security enquiries with the local police and then, along with a prison chaplain, he went to the man's mother's home. They arrived at 11.25am. The man's sister answered the door and said that her mother was not in, but she would contact

[11] A 'hot debrief' takes place immediately after a serious incident allowing staff to receive immediate support.

her by telephone. The man's sister contacted her mother and told her that there were two prison staff who needed to speak to her personally. The man's mother said she would return immediately. The deputy family liaison officer and the chaplain waited in the car as they believed it would be more appropriate to tell the man's mother first the news about her son.

105. The man's mother arrived at 11.45am and the deputy family liaison and the chaplain were invited back into the house. They explained that they were from HMP Altcourse and had made the visit to the man's family on behalf of HMP Frankland, to ensure that his family were told personally of the man's death, as quickly as possible. They said that Frankland would be in touch with further details. The deputy family liaison officer and the chaplain left the family home at 12.15pm and contacted Frankland at 1.00pm to let them know his family had been informed.

106. The FLO for Frankland contacted the man's mother at 1.30pm. the man's mother requested that all discussion and information about her son be directed through her sister. The FLO for Frankland contacted the man's mother's sister and explained the circumstances of the man's death. Over the forthcoming days, the FLO for Frankland spoke with the man's family almost daily updating them on the post mortem and funeral arrangements. The funeral was arranged for Friday 20 January 2012 and the prison provided financial assistance towards the funeral cost. She also made arrangement to ensure that the man's personal property was returned to his family.

Post-mortem report

107. The pathologist's summary and conclusions are as follows:

> *'…The man died as a result of pressure on the neck due to hanging. The ligature mark around the neck was entirely consistent with hanging and in particular rose to a point of suspension towards the back of the neck… There were no other neck injuries and no other injuries to suggest that the man had been assaulted.*

108. The forensic toxicology report did not find anything suggestive of an overdose of medication.

The man's telephone calls

109. The man kept in regular contact with his family by the telephone while in prison. He made a number of calls to his mother between 23 December 2011 and 3 January 2012. The last of these calls was made at 5.06pm on Tuesday 3 January. The investigator examined transcripts of the calls. Although the man said he was bored and fed up, there was no indication that he intended to take his life. His mood seemed generally stable with lots of discussion about the festive season in his last telephone call, which was to his mother.

ISSUES

110. The clinical review was conducted by the clinical reviewer and is annexed to this report. It includes one recommendation, about the delivery of healthcare in Frankland. The most pertinent issues about the man's death raised in the clinical review and from the investigator's investigation are discussed below.

111. In his report, the clinical reviewer states that:

112. "If one was to compare this standard of care and risk management to that which the man might have received had he been in the community and not in prison, then this would have been very favourable and at least of an equivalent standard of care."

113. He writes in the clinical review that he considers that the mental healthcare assessments, interventions, monitoring and reviews were of an extremely high standard and quality.

In-possession medication

114. The clinical reviewer found that the process of prescribing and administrating the man's medication, whether given in-possession or not, was managed appropriately and properly monitored and reviewed.

The man's risk of suicide and how it was managed

115. The man's propensity for suicide and his risk of self harm had been a recurrent feature of his life both in the community and in custody. He was clearly a troubled and unhappy person who found it very difficult to come to terms with the very long minimum term he was expected to serve as part of his life sentence. This was not something the prison could change and it was very difficult for the prison to motivate the man beyond attempting to keep him purposefully occupied and to address his educational deficits.

116. The man was frequently regarded as at risk of suicide and self-harm and was managed for long periods through ACCT procedures. The ACCT procedures were generally well managed and the CAREPLAN, continuous record and review records were mostly well completed, with a clear aim of attempting to reduce his risk of suicide by identifying when and why he was in crisis and setting goals to help reduce his risk.

117. What is apparent and consistent throughout the man's time in prison was that he could not see a long term future for himself. Staff identified and understood this and tried to improve his outlook through support for his social, mental and physical well being. It was established that the man had some learning difficulties. Staff believed that if his educational baseline was improved, this would also improve his communication skills. The ACCT reviews continually assessed and reviewed the level of risk the man posed to himself and the level of supervision that was needed. Staff worked together collaboratively to help

reduce his risk and there was some good joint working by the CPN who liaised well with wing staff and others to ensure the man's care was appropriate. His mother was also involved in the ACCT process.

118. Before the last ACCT was closed on 29 December, staff believed they had established a good understanding of the man. From the ACCT documentation, and interviews with staff, it was apparent that staff had consistent and worthwhile interaction with him. Their decision to close the ACCT was based upon their accumulated knowledge and judgment of a man, who through monitoring and support, seemed to have reduced his risk level. They assessed his mood as a lot more settled and were pleased with his positive progress to the extent that they felt the support and observations he had once required from ACCT monitoring were no longer needed.

119. Staff told the investigator that they continued to keep a watchful eye on the man and his support from the mental health nurse was still ongoing. There is no evidence that the man waited for the ACCT document to be closed before he took his life. Before it was closed, his observations had been reduced significantly to one written entry per shift and during that time he had made no attempt to self-harm although he had lots of unwatched time when he could have chosen to harm himself.

120. Our only concern about the closing of the ACCT is whether sufficient consideration was given to the significance of the time of year. The man had expressed suicidal thoughts throughout his time in prison, had made previous attempts to self-harm and constantly said he had no hope for the future. Although he had demonstrated a period of stability, it might have been a precaution to continue ACCT observations until after the New Year period was over – a time when many people's thoughts inevitably turn to the future, sometimes not positively. Other than this observation, the investigation found that staff used the ACCT process appropriately, and the interventions provided throughout the man's periods of crisis, had a positive effect on him. While it is worth staff taking into account whether to close ACCTs at significant periods of the year, ultimately it is very difficult to prevent someone who is determined to do so, from taking their own life. We are satisfied that the closure of the ACCT was a reasonable decision for the staff at the time based on their own knowledge and observations of the man.

Emergency response

121. There is clear evidence to suggest that when the man was found, the onset of rigor mortis had already begun and so any attempt to resuscitate him would have been futile. Such a procedure is undignified for the deceased and unduly distressing for staff, who have to attempt resuscitation when there are clearly no signs of life. The response by staff was in line with the guidance given by the National Offender Management Service.

122. However it is incumbent for lessons to be learnt in any death in custody and this investigation found some areas of concern. The shoe laces tied around the man's neck were not immediately removed nor was he placed flat on the cell

floor while staff assessed him for any signs of life. Laying a person on a flat surface is considered by healthcare practitioners as the optimal positioning if emergency aid / CPR is to be attempted. While CPR was not appropriate in the man's case, in other emergencies it could be important and help save a life.

123. The officer who discovered the man did not indicate the nature or seriousness of the emergency when he raised the alarm. This would normally be done by use of one of the two emergency codes used at Frankland, a Code Red or Code Black. The codes assist staff by preparing them for what to expect when they respond to an emergency and also ensure that healthcare staff are aware of the type of medical emergency equipment required. In this case, the responding healthcare nurse arrived at the man's cell quickly but without the emergency medical bag. Again, while in the circumstances the emergency bag was not needed, in another incident it could have been vital.

124. Prison Service Order 2710 Follow Up To Deaths In Custody, section 2, paragraph 2.2 (in force at the time of The man's death) states:

> *"…The first person on scene must summon help and request local emergency clinical assistance. If establishments use codes to alert clinical staff to the type of emergency and type of first aid equipment that will be needed, local contingency plans must explain clearly the code definitions…"'*

125. The investigator found that the first responding officer and nurse both appeared to try to act in The man's best interests. Although it was too late to save the man, a more professional response would have been to lay him flat on the floor, and remove the ligature from around his neck. We make the following recommendations about these issues.

The Governor and the Head of Healthcare should ensure that all frontline staff are adequately trained to ensure that they are able to take appropriate action on discovery of an unresponsive prisoner or an apparent death.

The Governor should ensure that all staff use the appropriate local emergency codes on discovery of a serious incident.

Staff support

126. As part of the death in custody contingency plan, a hot debrief was conducted. Nurse A was unaware of this and was not invited to attend by the governor who conducted the meeting. As a result she was not offered support from the prison care and support team, who were present at the hot debrief meeting.

127. In line with PSI 08/2010 Post Incident Care a 'Hot Debrief' must be held immediately after the all deaths in custody. A senior member of staff must act as the debriefer and a member of the care team must attend. All staff directly involved in the incident, including healthcare staff, should be invited. We therefore make the following recommendation.

The Governor should ensure that all staff directly involved in a serious incident, including healthcare staff, are invited to attend a hot debrief meeting.

Family contact

128. The man's mother lived some distance from the prison and it would have taken some time for someone from Frankland to deliver the news about the man's death personally. The prison therefore decided to ask for help from a prison near his mother's home. They initially requested help from HMP Liverpool, then HMP Altcourse, to deliver the news. We consider this was done in line with Prison Service guidance. Altcourse staff were fully briefed on the circumstances surrounded the man's death and immediately fed back to Frankland once they had delivered the news to the man's next of kin. The FLO at Frankland then made contact with the man's family within 30 minutes of the being informed of his death. Thereafter, regular contact was made by the FLO with the man's family to ensure they had all the necessary information about his death and to make the funeral arrangements.

CONCLUSION

129. The man was serving a life sentence with a very long minimum period to serve before he could be considered for release. He found it very difficult to come to terms with serving such a long sentence and to see a future for himself in prison. He had threatened to take his own life from the outset of his imprisonment, even before he was sentenced.

130. This investigation has shown that staff offered him support throughout his time in custody and there were times he showed an improvement in his general wellbeing. ACCT procedures and mental health interventions were used frequently to help him, and at times seemed to have had some positive effects on his mood.

131. We are satisfied that the staff at Frankland did what they could to prevent the man from taking his life when he appeared most at risk. At the time of his death the considered opinion of those who knew him was that he did not appear to at high risk of self-harm, and it would have been difficult to foresee his intentions.

RECOMMENDATIONS

1. The Governor and the Head of Healthcare should ensure that all frontline staff are adequately trained to ensure that they are able to take appropriate action on discovery of an unresponsive prisoner or an apparent death.

   The National Offender Management Service accepted this recommendation, writing

   "All healthcare professionals are trained in Basic Life Support and Defibrillation. This training is mandatory once a year. All nursing staff are adequately trained in Basic Life Support; however, as a healthcare professional, they will have the skills to determine whether the commencement of CPR will be deemed necessary and make a judgment whether or not the patient is clinically dead. Policy and protocol should be adhered to at all times and healthcare professional have signed to say that they understand the contents.

   Basic Life Support and Defibrillation training will increase from October 2012, when training is planned for the First Aid Trained discipline staff to be trained as tutors. First Aid training remains a priority at Frankland."

2. The Governor should ensure that all staff use the appropriate local emergency codes on discovery of a serious incident.

   The National Offender Management Service accepted this recommendation, writing

   "A Governor's notice will be issued reminding staff of the appropriate local emergency codes used on discovery of a serious incident."

3. The Governor should ensure that all staff directly involved in a serious incident, including healthcare staff, are invited to attend a hot debrief meeting.

   The National Offender Management Service accepted this recommendation, writing

   "A hot debrief takes place as part of procedure following every death in custody at Frankland. Greater care is now taken to ensure that all staff directly involved in the incident are included in the briefing."