PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent investigations

A Report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

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

Our Vision

‘*To be a leading, independent investigatory body,*
a model to others, that makes a significant contribution
to safer, fairer custody and offender supervision’

This is the report of an investigation into the death of a man, in January 2012, at HMP Frankland. He was 55 years old. I offer my condolences to the man's family and friends.

The investigation was led by one of my investigators. Two clinical reviewers conducted a review of the man's clinical care in prison. HMP Holme House and HMP Frankland cooperated fully with this investigation. I apologise for the delay in issuing this report.

This is a sad and unusual story. The man had spent almost all of the previous five years in prison, mostly at Holme House. He moved to Frankland a month before his death. The man's behaviour in prison was extremely challenging and required staff to demonstrate commendable professionalism and considerable daily effort merely to try to keep him and his cell clean. Several psychiatrists and doctors considered that he was not mentally ill but was feigning his symptoms. However, because of his strange behaviour, he had significant input from both physical and mental health staff. At Holme House, he lived for several years as an inpatient in the healthcare centre. Afterwards he was managed in the segregation units at Holme House and then at Frankland.

The cause of the man's death was unclear and appears to have been the result of him blocking his airway by swallowing some cardboard. As he had a propensity to eat a range of materials, eating cardboard was not unusual behaviour for him and there is no indication that this was a deliberate act of self-harm.

The clinical review found that the man's clinical care was at least commensurate with that he would have received in the community and I am satisfied that staff at both prisons did as much as they could to manage him humanely. Without a diagnosis of mental illness it is hard to see what else could have been done for him and I do not believe that the prison could reasonably have foreseen or prevented his death.

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 **May 2013**

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SUMMARY

1. The man had a history of alcoholism and mental health problems from his early twenties. On 4 December 2007, he was convicted of arson with intent to endanger life and sentenced to three years imprisonment. Apart from two short periods when he was released on licence in June 2009 and August - October 2010, he remained at HMP Holme House until December 2011.

2. During his second period on licence in 2010, the man set a fire in his room in the hostel where he was living and was charged with arson. On 9 December 2011, he was sentenced to an indeterminate sentence for public protection with a minimum period to serve of three years before he could be considered for release.

3. The man's behaviour in prison was abnormal and challenging. He frequently flooded his cell and covered it in urine and faeces. Staff reported him eating paper plates and other non-edible objects. He often shouted, banged on his cell door and talked incoherently, but also had periods when he was lucid and capable of conversation. He was seen by a number of doctors and psychiatrists who thought that he was feigning his symptoms. He was not diagnosed as being mentally ill but his behaviour meant that he received support from mental health staff as well as general nurses and officers.

4. On 21 December 2011, the man transferred to HMP Frankland. Staff were concerned about him when he arrived and he was taken to the segregation unit until he could be assessed by the mental health team. An ACCT document was opened under Prison Service suicide and self-harm prevention procedures. The man continued the same difficult behaviour as at Holme House. Efforts were made to keep him and his cell clean and to take him to mix with others in the healthcare inpatient unit, but without success.

5. On a day in January, the man was found dead in his cell at morning roll count. Prison staff entered the cell promptly and a nurse attended. None of the staff attempted resuscitation because it was clear he had been dead for some time.

6. A clinical review of his healthcare in prison found that the man had received good care from all staff groups at both prisons and that his care was at least equivalent to that he would have received in the community.

7. A post-mortem examination was unable to find any obvious cause of death. The pathologist found a piece of cardboard from the top of a juice carton in the man's windpipe that at a certain angle might have stopped him breathing. In the absence of any other cause, the pathologist gave this as the likely cause of death.

THE INVESTIGATION PROCESS

8. We were notified of the man's death on 20 January 2012. The investigator issued notices about the investigation to staff and prisoners at HMP Frankland inviting anyone with information to contact her. No response was received. She also issued notices at Holme House and a number of staff and one prisoner asked to be interviewed. Another investigator visited Frankland on 23 January and spoke informally to segregation unit officers and arranged to obtain relevant documents from the man's prison record.

9. NHS County Durham and Darlington North East Offender Health Commissioning Unit commissioned a clinical reviewer to carry out a review of the man's clinical care at HMP Frankland. The clinical reviewer passed responsibility for the review to a colleague in late March 2012. The investigator and clinical reviewer agreed that the review should include the man's clinical care at Holme House. They interviewed nine members of staff and one prisoner at Holme House and Frankland on 16 and 17 May 2012. The clinical reviewer's report was received in June 2012. The clinical reviewer who first had conduct of this case undertook further interviews with members of the mental health team at Holme House in September 2012 and a final report was received on 27 September.

10. A post-mortem examination on 21 January 2012 did not find any obvious cause of death. The investigator received the man's final post-mortem and toxicology report on 3 October 2012. The pathologist concluded that it was likely that the man had died because of a blockage of his airway by a foreign body - a piece of cardboard.

11. One of our family liaison officers spoke to the man's brother on 9 March 2012 to explain the investigation process and ask if there were issues he wished the investigation to cover. He spoke about his brother having both physical and mental health problems. He asked what assessments the prison had carried out for both during his time in prison, what medication he received, and that the investigation consider the appropriateness of his physical and mental healthcare. He said that his brother was mentally unfit to stand trial and that his actions in setting the fire and locking himself in the room were not the actions of someone who was mentally sound. His brother considered that his behaviour in prison was uncharacteristic as he would not send his family any visiting orders and locked himself away. We contacted the man's family at draft report stage but unfortunately we got no reply from the telephone number and address we used before. We contacted the Coroner but they had the same contact details as we did.

12. We are sorry for the delay in publishing this report. We decided it would be prudent to suspend our investigation until the results of the final post-mortem and toxicology reports were available to ensure we covered the appropriate issues. These were not received until October 2012.

HMP FRANKLAND

13. HMP Frankland is the largest high security prison in England and Wales. It holds over 800 adult male prisoners serving sentences of over four years and a small number of the highest security category prisoners on remand. Four of the wings hold up to 108 vulnerable prisoners each and the Westgate Unit accommodates a maximum of 80 prisoners with dangerous or severe personality disorders. Healthcare is commissioned by NHS County Durham and contracted to Care UK. Mental health services are sub-contracted to Tees, Esk and Wear Valley National Health Service Foundation Trust.

14. The segregation unit has 28 cells and two further cells for very violent prisoners. All prisoners are reviewed at a monthly meeting chaired by the segregation unit manager. Prisoners assessed as especially difficult to manage are discussed at a monthly meeting chaired by the Director of High Security (the person in the National Offender Management Service with overall responsibility for all high security prisons). Part of the segregation unit is a designated 'progression unit' which prepares prisoners who have spent a long time in segregation for a return to a standard wing.

HM Inspectorate of Prisons (HMIP)

15. Her Majesty's Inspectorate of Prisons' (HMIP) last published inspection report of Frankland is of an unannounced full follow-up inspection in November 2010. The report of a more recent inspection in December 2012 has yet to be published. In 2010 HMIP found significant improvement since the previous inspection in 2008. The segregation unit was clean and appropriately furnished and the regime was basically decent with prisoners allowed to shower and exercise daily. HMIP found staff there had good knowledge of the prisoners and a senior manager was based there. Segregation reviews were multi-disciplinary and there was a clear emphasis on progressing prisoners back to residential wings.

16. Assessment, care in custody and teamwork (ACCT) documents (ACCT is the Prison Service system to manage and support prisoners at risk of suicide or self-harm) were completed to a reasonable standard. Assessments were prompt and were completed by a mix of staff from different disciplines including healthcare and psychology. HMIP found that reviews were not always well coordinated and care plans did not always reflect identified issues or who was responsible for resolving them. The entries on the on-going record were variable but HMIP found evidence of some good engagement and interaction between the prisoners and staff.

Independent Monitoring Board

17. Every prison has an Independent Monitoring Board (IMB) made up of unpaid volunteers from the local community who monitor standards to help ensure that prisoners are treated fairly and humanely. The 2012 IMB annual report noted more timely mental health assessments and a general improvement in the delivery of mental health services in Frankland. However, the IMB were

concerned that the segregation unit was still the default "place of safety" for those with acute mental health needs. The IMB also identified a need for increased input from a clinical psychologist in the day-to-day delivery of mental health services to prisoners.

18. The IMB raised concerns at the number of prisoners with mental health issues or on ACCT documents held in the segregation unit. They believed that non-dangerous prisoners in this category would be better placed in the in-patients unit in healthcare. The IMB recognised the good work with these prisoners done by segregation unit staff but was concerned that they were not trained to cope with mental health problems. Aside from those concerns they believed that the regime was good and that staff prisoner relations were very good. Some mental health awareness training had been provided to segregation unit staff towards the end of the reporting period.

Previous Deaths

19. This office has investigated 46 deaths at Frankland since 2004. Five of these occurred after this man's. The circumstances of his death are unusual and there are no direct similarities between the circumstances of other deaths at Frankland.

HMP&YOI HOLME HOUSE

20. Holme House is a local prison near Stockton on Tees. It holds up to 1212 prisoners with a mixture of young adult offenders and adult males on remand or sentenced.

HM Inspectorate of Prisons

21. HMIP last inspected Holme House in a full unannounced inspection in July 2010. The inspection team found the segregation unit was clean and well managed. Staff there had a good knowledge of the prisoners. There were no reintegration or management plans and activities on the unit were limited. Transfers from the segregation unit were rare. Primary and secondary mental health care was good. There was no mental health awareness training for uniformed staff and HMIP recommended this should happen.

Independent Monitoring Board

22. In their 2011 annual report, the IMB raised five matters of particular concern. One was the lack of provision for prisoners exhibiting bizarre and extreme behaviour who had been assessed as not mentally ill. The IMB was concerned that these prisoners ended up on the segregation unit (known in Holme House as the Care and Separation Unit or CASU) and that this was inappropriate. The investigator spoke to a member of the IMB who confirmed that the following excerpt from the report referred to the man:

> "A prisoner with severe behavioural problems was located on the unit for some weeks. This necessitated the allocation of two cells, as

industrial cleaners had to be brought in each day to clean one of the cells while the prisoner was moved to the other. The prisoner had been assessed as not having mental health problems, but his bizarre and disruptive behaviour meant he was very difficult to manage and the other prisoners were disturbed by the noise, particularly at night. The Board recognises that there is probably, within a standard prison, no ideal location for a prisoner like this but huge demands were put on staff that had little training to deal with such extreme behaviour. The staff did their best to ensure the comfort and safety of this prisoner, he was treated with great kindness and tolerance. However, the Board questions whether CASU was an appropriate location, given that its primary purposes are separation for punishment or own protection, not for containment."

KEY EVENTS

23. The man had a history of alcoholism and mental health problems from his early twenties. On 4 December 2007, he was convicted of arson with intent to endanger life and sentenced to three years imprisonment. He went to HMP Holme House the same day.

24. From the time he arrived at Holme House, the man appeared confused, disorientated and agitated. He was managed as an in-patient in the healthcare centre, was very thin and appeared dishevelled and dirty despite showering regularly and being given clean clothes. His cell was also very dirty. He spread food on the floor, and frequently flooded it and blocked his toilet with faeces and paper plates. He was described as spending large parts of each day and night screaming or shouting, although he had some periods when he appeared lucid.

25. A consultant forensic psychiatrist saw the man on 14 January 2008 and recorded that he appeared unsteady and dishevelled and made lots of grandiose and bizarre statements. He knew where he lived and that he was charged with arson and remembered the names of psychiatrists who had previously assessed him. He said the man's statements were not typical of psychotic illness and that he became angry when challenged that his symptoms were not genuine.

26. The consultant forensic psychiatrist contacted a psychiatrist who had treated the man in a medium secure hospital before he arrived in prison. The psychiatrist thought that the man had genuine psychotic episodes when drinking alcohol but feigned psychosis at other times. The consultant forensic psychiatrist attempted to see the man again on 21 January but he refused to talk to him. He reiterated that he had not seen any evidence of genuine psychosis in the man.

27. The man's difficult behaviour continued. On one occasion, staff saw him eating milk cartons. He had long periods of shouting, screaming and banging objects in his cell or kicking his door. He was sometimes rational but was mostly incoherent and often abusive. The consultant forensic psychiatrist saw the man again on 3 March. He complained that he was not getting enough food and was losing weight but denied eating paper and flooring, which he had been observed doing. He said he should not be in prison but in hospital. The consultant forensic psychiatrist concluded that there was no evidence of mental illness and felt that he was pretending to have symptoms.

28. The man remained in the inpatient unit. On 3 June, a prison GP prescribed a 5mg dose of the anti-psychotic haloperidol. The reasons for this are not clear from the record. On 12 June, a further prison GP reviewed this prescription after the man was noticed to be very drowsy. The GP continued haloperidol but told staff to give the dose at night. From this point until April 2009, the man was very settled. He worked as a cleaner and interacted well with staff and peers. His personal hygiene was good and he cleaned his own cell and attended the gym.

29. On 8 April 2009, the man asked a prison GP if he could be taken off haloperidol and be put on depixol, an anti-psychotic given by depot injection every four weeks. He said he was due for conditional release in early June and it would be easier for him to take depixol in the community. The doctor agreed.

30. On 27 April 2009, a prison GP reviewed the man on behalf of the consultant forensic psychiatrist. He noted that the man had no recent symptoms of schizophrenia. The man agreed with him that a previous diagnosis of schizophrenia (which appears to have been historical, possibly made as far back as his twenties) had been controversial and he himself had doubts about it. The doctor suggested a trial period without any anti-psychotic medication. The man agreed to come off depixol for a trial period before his release.

31. The man was released on licence from Holme House on 3 June but was recalled to prison on 26 June after hostel staff were concerned about his behaviour. He was allocated to a standard wing but returned to the healthcare centre as an in-patient on 5 July after staff saw him eating his own faeces and dipping his food in his toilet. He began to behave disruptively again. On 10 July, three prisoners reported that he had said he would pretend to be mad to stay in the healthcare centre. A doctor saw him, and although he was not convinced that he had symptoms of genuine psychosis, he did not rule it out. He prescribed a smaller oral dose of depixol and the man's behaviour improved. On 27 July, the doctor made it clear in the man's medical record that depixol was not for psychosis but to help other symptoms such as involuntary muscle spasms.

32. On 5 August, the man was discharged from the mental health team caseload. He began to behave strangely again on 10 August and a doctor began him on mirtazapine, an anti-depressant. The consultant forensic psychiatrist reviewed him on 6 October and found no evidence of mental disorder, although the man asked for his medication to be increased. His behaviour was reasonably settled from October 2009 to January 2010 and he moved to a standard residential wing. The consultant forensic psychiatrist saw him again on 1 February 2010, when he behaved and spoke normally. He said he had not had a parole hearing yet and asked the consultant forensic psychiatrist to help him. The consultant forensic psychiatrist agreed to speak to the offender management department about this.

33. Later that month, wing staff were concerned about the man's behaviour. The mental health team said that he had not been diagnosed with a mental illness and was no longer on their caseload but they referred him to the consultant forensic psychiatrist who saw him again on 22 February. The consultant forensic psychiatrist said he presented with a variety of physical and mental health problems and asked to be admitted to the healthcare centre and be given benzodiazepines. When this was declined, the man said he had no mental health problems, but had problems breathing. The consultant forensic psychiatrist said he would write to the man's probation officer about his concerns about his release.

34. On 18 August 2010, the Parole Board decided to release the man on licence again. In their written decision, the panel said they had concerns about the apparently rapid deterioration in his mental health and his bizarre behaviour. They noted reports that he might be fabricating this behaviour and that there was no diagnosis of mental illness or neurological problems. The panel concluded that it would better serve public protection if the man was released with supervision. He was released to a hostel on 23 August.

35. On 29 October, the man set a fire in his room in the hostel. He was recalled to Holme House on 1 November. He was referred to the mental health team and found to be anxious and depressed but lucid. He was allocated to a standard wing. On 15 November, he was reported to be not eating and behaving strangely. He was described as unkempt, and was shouting, banging and being verbally aggressive. He was admitted to the healthcare centre for observation and referred to the mental health team. The consultant forensic psychiatrist tried to see him on 18 and 25 November but the man refused to talk.

36. A doctor saw the man on 30 November and concluded that his behaviour was put on for her benefit and that he showed no signs of psychosis. She decided not to prescribe him anti-psychotic medication but he remained an in-patient. He was agitated and incoherent and his hygiene was poor. He often smeared his cell in faeces and urine, ate and drank poorly and was often naked. The consultant forensic psychiatrist saw him on 13 December and again thought that he was not mentally ill. Some staff reported that he was able to interact appropriately with them and sometimes he was described as calm and coherent.

37. Between January and May 2011, the man's behaviour continued to fluctuate. Periods of shouting, screaming, verbal abuse, flooding his cell and living in unsanitary conditions were interspersed with occasions when he was lucid, polite and clean. Some entries suggested that his behaviour improved when he wanted tobacco or extra food. In March, he attended an adjudication (a prison disciplinary hearing) for abusive or threatening behaviour to an officer. He was lucid and asked to return to a standard residential wing. Healthcare staff confirmed there was no medical need for him to remain in the inpatient unit, although he continued to live there.

38. On 30 March 2011, the man told a nurse that he did not want to be re-prescribed anti-psychotic medication as there was nothing wrong with him. On 27 April, he was officially 'discharged' as a healthcare patient but remained in the inpatient unit because there was no suitable place for him elsewhere. His behaviour remained extremely disruptive to other patients, which he attributed to spending so much time in his cell. He made several requests to return to a residential wing during this period.

39. On 16 June, a meeting was held between two operational managers and the head of healthcare to discuss his return to a wing. They decided to re-integrate him on houseblock 1 and wrote a plan detailing how wing officers

and healthcare staff should ensure a consistent approach. As part of the plan and because he was considered vulnerable, the mental health team would continue to provide support for him although he did not have a mental illness.

40. The man moved to houseblock 1 on 23 June 2011, but wing staff quickly became concerned that his behaviour would make him vulnerable to assault by other prisoners. On 28 June, it was decided that he would sleep in a cell on the segregation unit but spend the day on houseblock 1 and be encouraged to attend support groups in the healthcare centre. The consultant forensic psychiatrist attempted to assess him on 7 July, but the man was "too disruptive". Nurses noticed he had lost a lot of weight in a short space of time. Attempts were made to weigh him regularly and he was given extra food.

41. On 18 August, a multi-disciplinary review panel noted that the man's behaviour had deteriorated in advance of his court appearance on 31 August. The panel thought that his behaviour would settle down after this. (The consultant forensic psychiatrist told the investigator that the man's behaviour became more extreme before court appearances because he wanted to be moved to a hospital).

42. Throughout August and September segregation unit staff raised concerns about the man's physical and mental health. On 15 September, a prison doctor saw him and said it was difficult to assess him. He noted that three psychiatrists thought that his behaviour was deliberate and that other staff had reported periods when he was lucid, polite and able to converse about art and literature.

43. Throughout October the man's behaviour continued to fluctuate between disruptive, verbally aggressive and polite and co-operative. His management plan was changed in November as his stays in healthcare were deemed detrimental to the in-patients, some of whom were frail or at risk or self-harm. After that the man stayed in the segregation unit.

44. A multi-disciplinary team review was held on 7 November. Segregation unit staff were concerned about the man's behaviour and physical presentation. The consultant forensic psychiatrist said he had known the man for five years and he was a classic "malingerer" who pretended to have psychotic episodes and other psychiatrists agreed that he was not mentally ill. Both alcohol induced dementia and schizophrenia had been ruled out after examination by specialists. The consultant forensic psychiatrist said he had previously had rational conversations with the man in which he had admitted that he was "working his ticket".

45. A prison officer told the meeting that the man spent only a couple of hours a night asleep and shouted and screamed continuously when awake. He urinated on his cell floor. The consultant forensic psychiatrist said he thought this was bad behaviour which the man hoped would lead to a transfer to a mental hospital. He said that the man was prepared to live in "unbelievably squalid" conditions and was prone to starving himself but this was nothing to

do with his mental health. He said he was sure that the man's behaviour would improve once he was sentenced, as had happened in the past.

46. The review panel agreed a new management plan. The man would no longer be taken to the healthcare unit for association periods in case he used this as an opportunity to ask other prisoners for tobacco. He would be moved between two cells in the segregation unit so the unoccupied one could be cleaned daily by the industrial cleaners, he would be weighed daily and given vitamins and extra food. He would be allowed extra time in the open air in the morning and afternoon to avoid him spending too much time in his cell. He would be offered a shower daily but officers would no longer be required to wash him. A senior officer explained the management plan to the man and he appeared to understand. Another review was scheduled for 14 November.

47. On 9 November, a senior officer wrote in the man's case notes that the new management plan was now in place but his behaviour had been worse since the review. The next review was held on 14 November. A nurse said the man had engaged well with her on 11 November. The SO said that segregation staff were happy to manage him but other prisoners found his behaviour very disruptive. He described the man's behaviour as neither better nor worse than before. One of the cells he was living in had running water and he flooded it frequently. The meeting agreed to turn the water off and give the man jugs of water instead but specified that staff must be careful that he did not become dehydrated. A further nurse said that the man's weight was more or less constant. Blood tests had been clear. He had refused a chest X-ray at hospital the previous week.

48. Entries in the man's case notes for the period 15 – 21 November show that his behaviour did not change. On 18 November, he flooded his cell and "swam" in the water and ate his teatime meal off the floor. On 22 November, another review was held. The panel noted that the man continued to be noisy throughout the night but had been quieter during the day. He received extra food and exercise periods in line with his management plan. He appeared to eat most of his meals but he had lost four kilograms in three weeks. He refused to take the vitamins and mirtazipine prescribed for him. He often refused to be weighed and would not let staff take blood samples.

49. The panel amended the man's management plan. A nurse agreed to try to persuade him to take his medication and provide a blood sample, and to give the segregation unit staff a food log to monitor his food intake. The prison doctor would review him twice a week. The manager responsible for the segregation unit went to explain the new plan to the man and found him sitting naked on his bed singing "row, row, row the boat".

50. The next panel review was held on 22 November, when it was noted that the man appeared to sleep for only a couple of hours a night. He had gained two kilograms since his previous review but did not take his medication regularly. He was told that he would appear at court the following Friday for sentencing, following which a decision would be made about his location. His behaviour was then described as "unacceptable" and he was escorted back to his cell.

51. The same day, the manager responsible for the segregation unit completed a report on the man as he had now spent over three months in the segregation unit. She said that he created a lot of noise every day by screaming and shouting and sometimes kicking his cell door for hours. He had destroyed fixtures and fittings in a number of cells and frequently flooded them. He often urinated and defecated on his floor and bed and washed his face in his toilet.

52. On 1 December, a senior officer (SO) wrote that the man had been quieter and better behaved since his last review but was still disruptive. On 9 December 2011, he was given an indeterminate sentence for public protection (IPP) for arson with intent to endanger life.

53. The man's case notes for the period 9 – 18 December showed that he had woken each night at about 2.00am and started screaming and banging. He drank water from his toilet cistern and frequently exposed himself to male and female staff. The next multi-disciplinary panel review was held on 12 December. The man refused to attend. The meeting noted that segregation staff had recorded all his meals in a log. He was receiving high calorie drinks and extra milk and had put on some weight. There had been no change in his behaviour since his sentence.

54. After the meeting, an operational manager went to see the man. She said that, although he had showered and the cell had been cleaned that day, there was debris across the floor and an extremely unpleasant smell. He was in bed. He appeared to be aware that he had gone to court but not aware of the outcome. The operational manager raised the possibility of a transfer to another prison and the man became increasingly agitated and said that he felt safe in his current cell.

55. The man's management plan was updated. As he was now a sentenced prisoner it was agreed to pursue a transfer to a training prison. This required proper planning with the receiving prison being given a comprehensive account of the man's behaviour and history. If his behaviour improved, the panel agreed to consider allowing him to go to the health centre as a day patient.

56. The man's last review at Holme House took place on 19 December. A prison officer said he was quieter but still displaying bizarre behaviour. He did not seem to understand the purpose of the review and was described as unpredictable. The officer said there were no specific concerns about his mental health.

Transfer to HMP Frankland

57. The next day, on 20 December, the man transferred to Frankland. There was a warning on his person escort record form which accompanies prisoners when they move, that he had been on an open ACCT form between 2 December 2010 and 7 January 2011, was at serious risk of self-harm according to his last assessment by his Offender Manager. He was also noted as a risk to others and should not share a cell.

58. The man was allocated a cell on J wing, one of the prison's standard residential wings. During the reception process, staff became concerned about his behaviour. He appeared unable to converse with them. The operational manager in charge of J wing tried to speak to the man but was unable to make himself understood. He decided that the man was not suitable for his allocated wing and should be taken to the segregation unit until it was decided how best to manage him and a mental health assessment completed.

59. That day, 20 December, a senior officer from Holme House faxed a form entitled 'Pre-transfer information from segregation' to Frankland. He wrote that the man had been managed in the segregation unit because of his behaviour. He said that he had poor personal hygiene and was oblivious to his move to Frankland, but that the psychiatrist and mental health team thought that he was not mentally ill but had been behaving strangely in the hope of receiving a lesser sentence. However, since he received an indeterminate sentence on 9 December there had not been any significant changes in his behaviour.

60. The head of safety and decency at Holme House emailed copies of the man's management plan and multi-disciplinary reviews to Frankland on 20 December. She recommended that he be held in the segregation unit initially with a view to moving him to a smaller residential unit once he had adjusted to his new surroundings.

61. A senior officer was on duty on the segregation unit when the man arrived there at 11.30am. A nurse completed a segregation health screen and said that there were no health reasons why he should not be segregated. The duty governor authorised that the man be placed in segregation for 72 hours pending a review on 23 December. The senior officer described the man's behaviour as "bizarre". He urinated in his cell and spread food around it. At 2.50pm, the senior officer opened a dirty protest checklist and log. At interview he explained that although the man was not on what was normally regarded as a dirty protest, the log was opened because he was living in unsanitary conditions and his cell needed to be regularly cleaned by specially trained cleaners.

62. At 3.41pm, an officer noticed the man trying to push a toothpaste lid into his eyeball. He continued to do this until staff had removed all of the clothing and utensils from his cell. The officer opened an ACCT and at 4.00pm, the senior officer and an officer agreed an immediate action plan. The man was to

remain in the segregation unit and be observed twice an hour and staff were to record conversations with him on every duty. He was to be given access to Listeners (prisoners trained by the Samaritans to offer confidential peer support) and to the Samaritans phone.

63. At 11.00am on 21 December, an officer, a trained ACCT assessor, tried to interview the man and assess him but he refused to participate. At 2.00pm, the segregation unit manager chaired a case conference to discuss the information received from Holme House. Two senior officers from the segregation unit, the clinical lead for the mental health team and a member from the offender management team all attended.

64. The case conference agreed that the clinical lead for the mental health team would provide segregation unit staff with a food and behaviour chart to monitor the man's eating habits, and would also make sure he was weighed weekly. At interview, staff commented on how thin he was. The segregation unit manager agreed to ask the prison's psychology department for their input. The senior officer was asked to contact the prison's biohazard team to arrange for the man's cell to be cleaned regularly. A further review was scheduled for 23 December. The clinical lead for the mental health team noted in the man's medical record that segregation unit staff would be told that he had no formal mental illness.

65. The segregation unit manager and the senior officer then held an action following assessment meeting as part of the man's ACCT. The man did not attend. They kept observations at twice an hour and recorded that he had been referred to the clinical lead for the mental health team. The senior officer completed the caremap section of the ACCT. The single goal was to try to persuade the man to engage with the ACCT process. Segregation staff and the duty ACCT assessor were tasked with making sure that he attended the next review on 23 December.

66. On 22 December, the segregation unit manager sent an email to the prison's psychologists. He attached the minutes from the case conference of 21 December and the information sent from Holme House. He asked for input from psychology including an assessment as soon as possible. He said that the clinical lead for the mental health team had been given a copy of a psychiatric report (it is not clear which one).

67. The same day at 2.53pm, a senior officer wrote in the man's case notes that he had washed his hands and face in his toilet, urinated on the walls, eaten his food off his urine soaked mattress, washed his clothes in his toilet and then wore them. He said it was difficult to see how the man could be moved as he did not communicate with staff and spat at the cell door when staff tried to speak to him.

68. A further senior officer spoke to the man at 5.37pm the same afternoon, 22 December. He said he had known the man for some time as he had worked at Holme House and knew that he was capable of sensible conversation. The officer said his cell had been flooded with about two inches of water and urine

but the man had since been out for a shower and had clean clothes, bedding and his cell cleaned. He said he had explained to him that he must improve his behaviour in order to progress at Frankland but was not sure he had understood.

69. The man's ACCT on-going record and segregation daily history sheets for 20 – 23 December record daily instances of the man shouting, screaming and banging or kicking his door or furniture, and displaying odd behaviour. On 22 December, he had a shower and clean clothes and his cell was cleaned. On 23 December, he covered himself in food when given a meal. He slept for no more than two or three hours a night.

70. The man attended an ACCT review at 2.15pm on 23 December with the segregation unit manager, a senior officer, officer, the clinical lead for the mental health team and a nurse. The man's contribution was recorded as limited and disjointed, but he said he had no thoughts of self-harm. Observations were reduced to one each hour with conversations to be recorded once each duty.

71. The same day, the segregation unit manager chaired a second case review. The duty governor, two senior officers from the segregation unit, a mental health nurse and a member from the IMB attended. The meeting discussed concerns raised by the IMB about the man's location in the segregation unit. The panel discussed moving him to the healthcare centre but this was rejected because of concerns about how staff there would cope with the dirty conditions he lived in. Concerns were also raised about the impact on the health of the other prisoners in the healthcare centre.

72. The segregation unit manager also chaired a segregation review board on 23 December to consider the man's continued suitability for segregation. This was attended by a member from the offender management team, the clinical lead for the mental health team, a mental health nurse, a senior officer from the segregation unit and a member from the IMB. The review decided that the man should stay on the unit and he should be encouraged to interact with staff. It was noted that, at Holme House, he was taken to the healthcare centre for association and it was acknowledged that his location on the segregation unit limited opportunity for interaction and support. It was decided that he would be taken to the healthcare centre each afternoon for an hour of association or to watch television. It was decided to discuss any potential risk factors with the security department before taking him to the healthcare centre. A further review was scheduled for 28 December.

73. The next day, 24 December, the senior officer in the segregation unit discussed the plan for the man to have daily association in the healthcare centre with a senior officer from the security department. The senior officer from the security department pointed out that the man had in the past attempted to assault nurses and grab keys. The senior officer from the segregation department discussed these concerns with an operational manager and they decided that the benefit to the man outweighed the senior officer from the security department's concerns. The senior officer from the

segregation unit agreed to brief officers in healthcare and ask them to write a report on the man's behaviour after each period of association.

74. Later that day, the man showered and was given a change of clothing. He put his dirty clothes on over his clean clothes but removed them when asked. The senior officer from the segregation unit explained that he would be going to the healthcare centre for association. The man became verbally aggressive and refused to go and the senior officer decided that it was not safe for him to go.

75. The man's ACCT on-going record for the period 24 – 28 December records that he continued to shout, scream, kick or bang things in his cell and urinate on his floor. After one episode in the night when he repeatedly shouted and banged his sink with his cup and shoe, staff reported that the other prisoners on the segregation unit threatened to smash their own cells unless he was moved. On 28 December, a member from the offender management team reported that he had rubbed dirt and tin foil into his eye when she tried to speak to him. He had a shower that day and talked to himself all the time.

76. At 9.30am on 28 December, another ACCT review took place. The man did not attend. His segregation review was held at the same time. The operational manager in charge of J wing chaired the dual purpose meeting. A senior officer from the segregation unit, a mental health nurse, a member from the IMB, the prison Chaplain and a member from the offender management team all attended. The chair said that the man was living in dirty conditions and was urinating in his cell and rubbing it on the walls. He said he had spoken to the man at the door of his cell with the member from the IMB but he made no sense in response. Although he had not harmed himself since the ACCT was opened, the number of observations was kept the same because of the nature of his behaviour. The operational manager in charge of J wing wrote on the caremap that the goal of persuading the man to attend reviews was no longer in place. A second goal of establishing the state of his mental health was agreed. The mental health nurse was given responsibility for contacting the consultant forensic psychiatrist at Holme House. The behaviour and food chart, proposed on 21 December, was given to segregation staff (it was completed until 19 January 2012). A further segregation review board was scheduled for 11 January.

77. At 8.40pm on 29 December, the man was moved under restraint to the special accommodation cell (a cell with no furniture apart from a raised platform used as a bed – known colloquially as a 'strip cell') after threatening staff and damaging furniture. He was seen to have cuts on his hands. A senior officer from the segregation unit completed a report of injury to prisoner form but stated that the man had not been injured during the incident. A nurse tried to examine the cuts but was unable to do so because the man was jumping on his bed and throwing objects at the open cell door. It does not appear that the cuts on the man's hands were as a result of deliberate self-harm.

78. The man's ACCT on-going record and his segregation daily history sheets for the period 29 December – 4 January suggest that his behaviour remained challenging, and that he still slept for only a few hours every night. He continued mostly to ignore staff when they spoke to him.

79. On 2 and 3 January, the man was quieter and spent more time in bed. On 3 January, staff went into his cell because he was underneath his blanket and they could not detect any movement. Staff removed his blanket and he agreed to have a shower and his cell was cleaned. He ignored a visit from the IMB and urinated in his cell.

80. On 4 January, the man was reported to be sitting on his bed rocking. At 2.20pm on 4 January, an ACCT review was held attended by a senior officer from the segregation unit, an officer and a member from the mental health team. The man did not attend. It was recorded that the main risk to the man's well-being was his poor personal hygiene and the conditions he lived in. The review concluded that this was not a conscious effort on the man's part to self-harm. In light of this, and the plan agreed between segregation unit management and healthcare to monitor the man's weight and general health, the meeting decided to close the ACCT. The caremap goal of contacting the consultant forensic psychiatrist was marked as completed, although there is no record that he had been contacted in the man's medical record.

81. A prison doctor examined the man in the segregation unit on 4 January. She wrote in his medical record that he did not appear to be in an extreme condition physically and recommended that nurses continue to weigh him when he agreed to shower.

82. On 6 January, the segregation unit manager chaired a case review attended by two operational managers, a member from the mental health team, the prison Chaplain, a member from the IMB and an officer. The segregation unit manager noted that the IMB, a visiting doctor and unit staff had all raised concerns about the man's behaviour. The plan to take him to the healthcare centre for daily association had been unsuccessful. The man's care and management plan involved segregation unit staff moving him between cells every two days so that they could be properly cleaned and so that he would have a shower. Mental health staff were working with segregation unit staff to offer support and had agreed to weigh the man when he had a shower. It was decided to hold further case conferences every two months unless an urgent meeting was required.

83. Frankland checked with Holme House's psychology department that they had no file on the man. A member from the mental health team wrote in the man's medical record that she had advised that he was issued with paper plates as he had been observed eating polystyrene ones. She added that unless his presentation changed significantly, no mental health assessment would take place as he was displaying familiar behaviour.

84. The man's segregation daily history sheets for the period 5 – 11 January report more of the same behaviour. The prison Chaplain wrote on the history sheet that the man would not talk to him and was speaking in a very confused and agitated way. He described the man's behaviour as "extremely bizarre". The next day staff noticed him washing his cell floor with water from his toilet. On 11 January, he was given a mop and brush and attempted to clean his own cell. He then agreed to go out to the exercise yard.

85. At 10.50am on 11 January, the segregation unit manager chaired a segregation review board. He recorded that the man did not comply with the unit regime, was loud and lived in dirty conditions. He noted that he was to be assessed by the psychology department. He was set a behaviour target of keeping his cell clean. The board agreed he should remain in the segregation unit and a review was scheduled for 25 January.

86. On 14 January, the man's care and management plan was updated. The new plan was outlined in an email from the man's personal officer to a senior officer. The man's personal officer said that although a prison doctor had raised some concerns on her segregation unit rounds, the consultant forensic psychiatrist's psychiatric assessment, that the man was not mentally ill, remained the basis for managing him. His personal officer advised that the man should not be managed on a different regime because of his bizarre behaviour. Although segregation unit staff had concerns about his health and weight, he said that the food log showed that he was eating well at present and healthcare staff were going to ensure that he was weighed once a week. Staff were advised to wear protective foot covers and gloves when in direct contact with him and make every effort to provide him with a daily shower. His personal officer said that mental health staff had been asked to re-assess the man as soon as possible.

87. According to the man's segregation daily history sheets for the period 12 – 19 January, he had a shower, clean clothes and went to the exercise yard on 12 January. The same day he was given a cardboard table for his cell. He had another shower on 13 January but kept his trainers on. He was weighed by healthcare staff who prescribed him protein drinks. On 14 January, he threw a cup full of liquid over an officer and staff went into his cell to remove items that he was likely to throw at them. On 17 January, he smeared butter on his feet while in bed. The next morning staff found that he had smeared excrement over his cell floor.

88. On an evening in January, the man was reported to be very quiet and spent most of the day lying on his bed. At 6.12pm a senior officer wrote in the man's record that he felt that his behaviour had steadily declined. He described him over the previous two days as reluctant to collect his meals and said he had no interaction with staff. He said that if the man did not have mental health difficulties then he was putting on an excellent act. In his opinion, the man's mental health had deteriorated. The last entry on the man's segregation history sheet, at 6.30pm, describes him as quiet.

The following day

89. An officer arrived for duty at 6.30am and completed a handover from the night patrol officer. He began the morning roll check – a count of all the prisoners during which some sign of life must be seen. At about 6.40am he checked the man's cell but could not see any sign of life. The officer called for assistance from the senior officer and together they went into the cell. The senior officer said the man was lying on his back in bed under the covers. His face was blue, he felt cold and he looked dead. The officer shook the man's foot but they could not get any response from him. The senior officer said that the man looked to have been peacefully asleep. As it was apparent that he was clearly dead, neither officer attempted to resuscitate him.

90. The senior officer radioed the control room to raise an alarm and to inform the duty governor. He sent an officer to the healthcare wing to collect a member of healthcare staff as the healthcare staff on duty at that time were night staff and did not carry their own keys. The senior officer said the duty governor arrived very quickly.

91. The emergency response nurse said she received an emergency message at 6.50am and arrived at the man's cell at 6.55am. She said he was cold and pale, had no pulse in his neck and his limbs were very stiff. She did not attempt cardiopulmonary resuscitation (CPR). An ambulance was called at 6.51am and paramedics arrived at the man's cell at 7.09am. They attached a defibrillator to him and it gave an asystolic reading, showing no electrical activity in his heart. They pronounced the man dead without attempting CPR.

92. The duty governor chaired a hot debrief (a meeting for those staff involved in finding the man) at 8.15am. Members of the prison's care and welfare team offered support. Segregation unit staff told the other prisoners on the unit that morning and they were reminded of the support available to them from Listeners and members of the Chaplaincy. All wing managers were contacted and asked to check prisoners subject to ACCT.

93. A family liaison officer from the prison was appointed and went to the man's brother's home to break the news of his death in person. Frankland offered financial assistance with the man's funeral. The family liaison officer attended on behalf of the prison.

94. A post-mortem examination was held on 21 January. There was no obvious cause of death. A subsequent toxicology report showed that the man did not have any alcohol or drugs in his system. The pathologist found no evidence of any injury, violence, natural disease or poison that could have caused or contributed to the man's death, but found a piece of cardboard measuring 30 x 25mm in his airway. It was not blocking his airway when found but was big enough to have done so in certain positions. In the absence of any other cause of death the pathologist concluded it was likely that the man died from blockage of his airway by a foreign body.

ISSUES

The man's management and care in prison

95. The man was clearly a very challenging prisoner to manage, behaving in an extreme and abnormal way throughout his time in prison. He was not diagnosed as suffering from any mental illness. The consultant forensic psychiatrist knew him from a previous period in a medium secure hospital and said at interview that he had several conversations with him, both then and at Holme House, in which the man admitted to feigning his symptoms. Several other psychiatrists and the mental health team at Holme House agreed. There are a number of entries in the man's prison record that show staff had rational conversations with him. Although he was not thought to be suffering from mental illness, because of his strange and distressing behaviour, the mental health team and nurses at Holme House monitored and cared for him to support the prison in managing him.

96. It was clear to the investigator that all staff involved with the man found him challenging but that considerable effort had been made to care for him as well as they could. A multi-disciplinary approach was taken to his management at both prisons with regular meetings attended by senior managers, healthcare staff, mental health staff and officers. Although he was not diagnosed with any mental illness the man was managed for several years as an in-patient in the healthcare centre at Holme House. He was moved to the segregation unit only after this was no longer an option. At Frankland, he was managed solely in the segregation unit. Daily efforts were made at both prisons to keep him and his cell clean and to offer him as full a regime as possible with increasingly limited success. Given his presentation and behaviour and without a diagnosis of mental illness it is hard to see what else could have been done.

97. The clinical reviewer concluded that the man received a consistently high standard of care while in prison from healthcare, mental health and prison staff groups. This level of care was commensurate with that he could have expected to receive in the community.

ACCT

98. An ACCT was opened for the man on the day he arrived at Frankland. Reviews and assessments were held regularly (and often in conjunction with segregation reviews, which ensured a good, multi-disciplinary attendance). The ACCT was closed on 4 January as the review panel considered that the man's behaviour was not aimed at harming himself.

99. It is not usual for prisoners on open ACCTs to be held in segregation units and we note that an IMB member raised the issue of the man's location there at the second ACCT review on 23 December. Some discussions were held about the possibility of moving him to the healthcare centre, but discounted because of concerns about managing his dirty conditions there and the impact on the health of other prisoners. We note that he had been managed for long

periods in the healthcare centre at Holme House but we are aware that this was not without difficulty and this had not been the case latterly. There is little doubt that he was extremely challenging to manage. Alternative accommodation had been considered and discounted and we are satisfied that there were sufficiently exceptional circumstances to justify the man remaining in the segregation unit while subject to suicide and self-harm monitoring.

100. We note that the mental health nurse had been asked at the meeting on 28 December to contact the consultant forensic psychiatrist at Holme House to establish the state of his mental health. A caremap target was set to that effect which does not appear to have been completed. There is a requirement in Prison Service guidance that ACCTs should not be closed unless all caremap actions have been completed, and we remind the prison of this. However, in this case we are satisfied that this action was simply to see whether the consultant forensic psychiatrist had any additional information which might have helped the prison develop a suitable care plan for the man rather than in itself being an action to support him. The consultant forensic psychiatrist's assessments and views were well documented in the man's medical record and it appears that the review team were almost clutching at straws to see whether there was anything else they could consider to help manage him. Exceptionally therefore, were are satisfied, that it was reasonable for the ACCT review to have concluded on 4 January that there was little evidence that the man had any deliberate intention to self-harm and to close the ACCT. As he remained under close scrutiny in the segregation unit and subject to multi-disciplinary reviews, closing the ACCT made little substantive difference to his management.

Emergency response

101. The officer on duty that morning was unable to get a response from the man during the morning roll check at 6.40am. He alerted the senior officer and they immediately entered the man's cell. At interview, the senior officer described him as blue and cold and said he was clearly already dead. He said the officer moved the man's foot to try to get a response and it was also clear from this that he was dead. Neither officer attempted CPR. The emergency response nurse was escorted to the cell and she also thought that the man was dead and rigor mortis was present. She did not attempt CPR either. Ambulance paramedics arrived at 7.09am and confirmed death.

102. In line with Prison Service guidance, the officers decided not to attempt CPR because it was apparent that the man had been dead for some time. We consider this was an appropriate decision and in line with European Resuscitation Council Guidelines which say that "Resuscitation is inappropriate and should not be provided when there is clear evidence that it will be futile …"

Cause of death

103. The post-mortem examination did not find any injury, violence, natural disease or poison that could have caused or contributed to the man's death. In the absence of these, the pathologist concluded that a piece of cardboard from the top of a juice carton found in the man's airway could have caused a blockage that resulted in his death. In the circumstances, we do not consider that the man's death was foreseeable or preventable.