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 Long Lartin in July 2013

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 the investigation into the death of a man who was found hanging in his cell at HMP Long Lartin in July 2013. He was 25 years old. I offer my condolences to his family and friends.

A clinical review of the man's care whilst at Long Lartin was undertaken. The prison cooperated fully with the investigation.

In 2009, the man received an indeterminate sentence for an offence of arson. He was diagnosed with paranoid schizophrenia for which he was prescribed medication. For the first few years in custody at HMP Stafford, he appeared to settle and caused few concerns. In September 2012, he allegedly seriously assaulted another prisoner and was later charged with attempted murder. He was moved to HMP Dovegate and, in June 2013, to Long Lartin.

The man's mental health nurse, who had coordinated his care at Stafford and Dovegate, drew the attention of the mental health team at Long Lartin to his care needs and asked them to contact her for further information. This was never done and the mental health staff at Long Lartin failed to engage effectively with him. This meant that they were not apprised of the identified need to keep him fully occupied for the sake of his mental health. Instead, he had no job at Long Lartin and therefore little money. He began to be monitored under suicide and self-harm prevention procedures on 18 June, after he told an officer that he intended to harm himself if he could not get any tobacco. He also became a nuisance on his wing pestering other prisoners for tobacco and coffee. He was moved to the segregation unit ostensibly for his own protection, but without assessment of the appropriateness of segregation for a prisoner at risk of suicide and self-harm. Although the move was originally intended to be for only a few days, there was no exit plan and he remained in the segregation unit with a particularly impoverished regime until his death two weeks later.

The investigation has identified a number of serious shortcomings in mental health care, suicide prevention procedures and management of the segregation unit at Long Lartin. Overall, I do not consider that the man was appropriately supported at the prison. It is concerning that many of the issues identified have previously been highlighted by this office and by Her Majesty's Inspectorate of Prisons. Urgent action needs to be taken to address these failings.

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 **April 2014**

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SUMMARY

1. The man was 25 years old when he died. He was Polish and the accounts of his proficiency in English differed significantly between prisons and individuals. He had been in prison since 2009 and had been diagnosed with paranoid schizophrenia early that year. He had periods of unstable behaviour and occasionally refused his medication, which was given through a depot injection every two to three weeks. He found it difficult to cope without tobacco but, providing he could work and earn money, his behaviour usually stabilised.

2. In September 2012, the man allegedly assaulted another prisoner while at HMP Stafford and was moved to HMP Dovegate. He was later told that the police intended to press charges for attempted murder.

3. On 7 June 2013, the man transferred to HMP Long Lartin. He had been under the care of the same mental health nurse throughout his time at Stafford and Dovegate and when he transferred she asked healthcare staff at Long Lartin to contact her so that she could advise them on his care. No-one at Long Lartin did.

4. The man had transferred from the segregation unit at Dovegate and had no prison job and no other source of money so he could not buy tobacco from the prison shop. When the initial supply of tobacco he was given when he arrived at Long Lartin ran out, he demanded more and asked other prisoners for tobacco.

5. On 18 June, the man began to be monitored under suicide and self-harm prevention procedures (ACCT) after he threatened to self-harm if he could not get tobacco. He was locked in his cell and became vey agitated. Staff would not let other prisoners give him tobacco. He had refused to take his depot injection for some days and a mental health assessment had been requested but this was never carried out.

6. Because the man had been pestering other prisoners for tobacco, there was some concern that he was not safe on the wing. On 21 June, a senior manager decided to move him to the segregation unit for his own protection. He was told that if he agreed to take his depot injection this would be for a short time and he could then move to another wing. Although he had been assessed as at risk of suicide and self-harm there was no consideration that the segregation unit, which should be used only in exceptional circumstances for prisoners at risk was not an appropriate location. Although he agreed to have the depot injection that day, it was not administered until 24 June.

7. The segregation unit procedures were poor and it was incorrectly recorded that the man had been segregated because of his poor behaviour. He had a very restricted regime and did not even have a radio in his cell to distract him. Safeguards to protect prisoners in the segregation unit failed and his needs were consistently overlooked by staff involved with his ongoing segregation, his ACCT reviews and his day to day care. Despite daily visits to the segregation unit by a number of managers, chaplains and healthcare staff no one questioned why he

was held there when he was on an open ACCT and neither did representatives of the Independent Monitoring Board.

8. In July, after two weeks in the segregation unit, the man was found hanging in his cell. There was a slight delay in healthcare staff arriving at the cell while they went to get emergency equipment and there was also a delay in an ambulance being called.

9. The investigation identified a number of deficiencies at Long Lartin. The man should not have been located in the segregation unit; ACCT procedures were poor, as was support from the mental health team.

THE INVESTIGATION PROCESS

10. The investigator issued notices to staff and prisoners at Long Lartin informing them of the investigation and inviting anyone with information to contact him. He interviewed thirty members of staff and spoke to ten prisoners. He obtained all relevant documents from the man's time in prison. He gave feedback to the Governor after the interviews about the emerging findings of the investigation.

11. NHS England, Shropshire & Staffordshire Area, commissioned a clinical reviewer to review the clinical care the man received at Long Lartin.

12. A copy of this report has been sent to HM Coroner.

13. One of our family liaison officers contacted the man's family, who identified no specific issues for the investigation to cover. Although the family were informed that the draft report was available, they did not wish to receive a copy.

HMP LONG LARTIN

14. HMP Long Lartin is a high security prison holding category A and B adult men who have been sentenced to at least four years imprisonment. Worcestershire Health and Care NHS Trust provide mental health services at Long Lartin. Mental health nurses work with general nurses to provide a service covering the spectrum of mental health conditions from mild depression to severe and enduring illnesses such as schizophrenia.

HM Inspectorate of Prisons

15. HM Inspectorate of Prisons' (HMIP) most recent inspection of Long Lartin was an unannounced full follow-up inspection in August 2011. Inspectors noted that the number of prisoners being monitored under ACCT procedures was comparable to other high security prisons but too many were in the segregation unit without exceptional circumstances to justify this. Inspectors recommended that prisoners on ACCT should be held in the segregation unit only in exceptional circumstances.

16. HMIP reported that ACCT documents were of variable quality and many of them were poor with little indication of a caring or constructive approach to prisoners in crisis. Caremaps were found to be particularly limited, ACCT reviews were often not multidisciplinary, monitoring entries were too predictable and mainly observational. There was insufficient staff refresher training in ACCT procedures.

17. HMIP found the segregation unit regime very limited with disinterested staff. Prisoners in the segregation unit had nothing meaningful to do and most were locked in their cells for nearly all of the day. The quality of entries in segregation history sheets were assessed as generally poor and showed little awareness or care about the personal circumstances of prisoners.

Independent Monitoring Board Report

18. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who oversee all aspects of prison life to help ensure prisoners are treated fairly and decently. In its most recent annual report, for 2012/13, the IMB were concerned that 39 prisoners identified as at risk of suicide and self-harm had been held in the prison's segregation unit during the year.

19. The IMB reported that the segregation unit staff strove to meet the individual needs of its varied population and the unit balanced the need for safety with the need to allow prisoners to progress back to normal wings. The IMB noted that in practice it was difficult to move on from the segregation unit.

Previous self-inflicted deaths at HMP Long Lartin

20. The man's death is the fourth self-inflicted death that the Ombudsman has investigated at Long Lartin since 2004. In a previous report, we identified the need to ensure that healthcare staff are aware of the mental health needs of prisoners when they transfer. We have also previously recommended that ACCT checks should not be at predictable times.

Assessment Care in Custody and Teamwork

21. Assessment, Care in Custody and Teamwork (ACCT) is the Prison Service process for supporting and monitoring prisoners at risk of harming themselves. The purpose of the 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. Checks should not be carried out at predictable intervals to prevent the prisoner anticipating when they will occur. Part of the ACCT process involves assessing immediate needs and drawing up a caremap to identify the prisoner's most urgent issues and how they will be met. Regular multi-disciplinary reviews should be held. The ACCT plan should not be closed until all the actions of the caremap have been completed.

KEY EVENTS

22. The man was a Polish national who had lived in the United Kingdom for a number of years. He had previously served a number of sentences in young offender institutions.

HMP Lincoln

23. On 10 January 2009, the man set fire to a Jehovah's Witnesses Hall and was remanded into custody at HMP Lincoln. He received an indeterminate sentence for public protection with a minimum period to serve of one and a half years before he could be considered for release. He was diagnosed with paranoid schizophrenia and was prescribed flupentixol (depixol), an anti-psychotic medication. (The medication is usually given by injection every two or three weeks and is slowly released through the body - often referred to as a depot injection.) At Lincoln he was identified as at risk of suicide and self-harm and monitored under ACCT procedures several times. It was noted that his mental health deteriorated if he did not receive his medication and that his "poor English" prevented him from describing his symptoms clearly.

HMP Stafford

24. In October 2009, the man transferred to HMP Stafford. During 2010 his condition remained stable; he took his medication as prescribed and was reviewed frequently by the prison psychiatrist using interpretation services. He spoke often to his mother in Poland, worked and got on with staff and prisoners.

25. Throughout 2011, the man's mental health remained stable and his English continued to improve. Staff monitored him under ACCT procedures for a week in December, after he made a number of superficial cuts to his left arm, apparently because of tensions with his cell mate. In early 2012, he appeared to be settled. He worked in the prison's gardens, and was reported to be polite and appropriate. In February, he was monitored under ACCT procedures again when he said he would harm himself after his cell mate moved and he lost contact with his mother. He settled again when he got a new cell mate, and re-established contact with his mother.

26. On 15 September 2012, the man had an altercation with another prisoner. An officer reported that he had been acting bizarrely and had threatened her. The officer feared he might assault someone and noted that his behaviour was totally out of character. Healthcare staff assessed he was not fit for segregation and he remained on the wing. The next day, he was involved in a fight, although a nurse noted that he appeared to have been the victim of an assault. Again his behaviour was regarded as out of character. On 17 September, he told his allocated community psychiatric nurse that he had intervened when another prisoner was being assaulted. The nurse noted that he showed no sign of mental illness or symptoms of extreme anxiety and talked calmly. It was agreed that he should have a full psychiatric assessment. (He was assessed by a

psychiatrist on 1 November.)

27. On 18 September, the man allegedly assaulted the prisoner who had been his previous assailant. The other prisoner received serious cuts to his throat. The incident was reported to the police and he was held in the segregation unit. He was described as calm and without emotion. An officer noted that his behaviour and mental health seemed to have deteriorated rapidly in just two weeks.

HMP Dovegate

28. On 24 September 2012, the man was moved to HMP Dovegate where his community psychiatric nurse continued to have responsibility for coordinating his care. She liaised with mental health colleagues at Dovegate and indicated he had no symptoms of psychosis and that there was no evidence that he intended to harm himself. She advised that, because of his mental health problems, he needed a prison job or other activities to keep him occupied.

29. In early October, the man was served with a deportation order which was later put on hold when he was subsequently charged with the attempted murder of the prisoner he had allegedly assaulted at Stafford prison. On 9 October, the community psychiatric nurse noted that he was annoyed and angry as he had no prison job and consequently no money or tobacco. She was concerned as he had previously said he would harm himself if he could not get any tobacco. On 23 October, she noted that he was still not working and was frustrated and angry about having no money, On 1 November the prison psychiatrist, who had previously assessed him at Stafford, noted that he showed no psychotic symptoms and that his English had improved. However, an officer noted that his behaviour was sometimes odd and unpredictable.

30. On 13 December, the man refused to have his depot injection but agreed to have it a few days later. The community psychiatric nurse noted that because of the nature of his illness he required occupation and distraction and that being locked in his cell was not good for him and he found it difficult to cope with having no money.

31. The nurse noted that throughout January 2013 the man showed no symptoms of psychosis but was in a sombre mood, bored on the wing. At the time he had only part-time work and the nurse described him as desperate for more work. On 12 February, he asked to move wings to be near other Polish prisoners. The next day he self-harmed and said that he had felt isolated, but had not intended to kill himself. An ACCT was opened but closed the next day when he was allowed to move wings. After he moved wings officers described him as quiet but demanding and noted that he had racist tendencies. On 19 February, she noted he still showed no symptoms of psychosis but was angry and frustrated that he had no prison job and no money.

32. On 21 February, the psychiatrist saw the man and noted that it was difficult to assess his mental state without an interpreter. He described him as inappropriate, over-familiar and distracted and noted a concerning deterioration

in his presentation. The doctor considered the possibility of a move to the prison's healthcare unit but this was discounted. On 28 February, the psychiatrist assessed him again, this time with an interpreter. He said he was not hearing voices but he agreed that his mood had changed recently. The doctor admitted him to the prison's acute assessment unit (AAU) for enhanced observation and possible referral to hospital.

33. On 3 March, the man ran out of tobacco and demanded that other prisoners should give him theirs. He punched and banged on his cell door and threatened to "kick off". He was taken by force to the segregation unit. He returned to the wing after several days in the segregation unit. On 7 March, the psychiatrist noted an improvement in his presentation, but recorded that it was difficult to conduct a full mental health examination as he had no interpreter. Over the following weeks he appeared to be more settled.

34. On 16 April, it was noted that the man was calm, polite and settled. He now had a prison job, caused staff no concerns and remained in contact with his family. However, on 31 May a nurse described him as elated and agitated and sexually inappropriate. She noted that his eyes were dilated. She advised that he was a high risk of harm to others when he was unwell or under the influence of illicit substances so he was taken to segregation unit.

35. On 4 June, the man told the nurse that he could not remember much about the incident which had led to him being segregated. He agreed to give a urine sample for a drug test which tested negative for illicit substances. The nurse noted that he did not appear distressed or anxious and displayed no evidence of paranoia He was the same when she saw him two days later. He later smashed his radio against the cell door but the next day he was noted to be compliant with the segregation unit regime.

HMP Long Lartin

36. On 7 June the man transferred to Long Lartin as part of an arrangement to help move prisoners on from segregation units. At his reception health screen, he said he had no suicidal thoughts and that he was able to communicate in basic English. He was allocated to Perrie Red, one of the prison's standard residential wings.

37. The community psychiatric nurse made an entry in his electronic medical record at 1.30pm to brief healthcare staff at Long Lartin. She noted that the man had been diagnosed with paranoid schizophrenia and was currently under the care of secondary mental health services and that his new mental health team needed to view his care plans. She said that his recent behaviour had been bizarre and unusual for him. She gave her telephone number and asked that someone from Long Lartin should contact her at Dovegate for further information.

38. At a first night interview it was noted that the man said he felt depressed, that he had a history of self-harm and he needed help to write in English. A Senior Officer later submitted a security report in which he said that he had appeared

"spaced out during interview" and appeared to be under the influence of drugs. A drug test did not indicate that he had taken any illicit substances.

39. Later that afternoon, a prison accounts clerk noted that the man had only £4.19 in his prison account. He had been given two "smoker's packs" (tobacco and cigarette papers) when he arrived which cost £8.18, so therefore owed the prison money. As he had no funds at the time he was not allowed to order any goods from the prison shop that week. (During his time at Long Lartin he never had a prison job, so received only £2.50 a week unemployment pay, one pound of which was deducted to pay for his television. He made some small spends but never had enough money to order tobacco.)

40. On 10 June, the mental health multidisciplinary team weekly review and referral meeting discussed the man. His case was allocated to one of the prison's psychiatric nurses. The nurse noted in his medical records that he had had previous input from the mental health in-reach team at Dovegate, that there were minor concerns about suicide and self-harm and that he was receiving depot injections for previously diagnosed paranoid schizophrenia. An alert was put on his record that he was a known racist. No one contacted the in-reach team at Dovegate to find out more information.

41. The man refused to have his depot injection that afternoon, as he said it made him feel sleepy. The nurse noted that although he appeared very alert he was worried about his surroundings, his eye contact was poor and that he was nervously picking at his arms and hands. She suggested that another nurse should see him.

42. On 11 June, two nurses saw the man. (One nurse told the investigator that this meeting was not a mental health assessment.) He noted that the man was articulate and had a good understanding of English and that there was no evidence of thought disorder or psychosis, but he described him as subdued with poor eye contact. He again refused to have his depot injection. (The injection was a day late at this point.) The nurse referred him to the prison's psychiatrist to confirm his diagnosis. He told the investigator that he did not speak to the mental health nurse at Dovegate, as she had requested, as he believed that another nurse had done so. (It is not clear why he thought that this as there was no indication that the nurse had contacted Dovegate.) When asked by the investigator why he had not completed a mental health assessment he thought he could have been on leave at the time. However, the records show this was not the case.

43. There was little information recorded about the man's first ten days on Perrie Red. An officer who worked on the wing told the investigator that the man was quiet and introverted and kept his head down. He said the man spoke in "broken English" but he could understand most things. The officer said he conversed with another Polish prisoner, but he later moved off the wing. He said there was nothing to suggest that he was being bullied or that he was bullying other prisoners.

44. Another Perrie Red officer said the man was very much a loner on the wing and went from one prisoner's cell to another presumably trying to get cigarettes and coffee. She believed he should not have been on the wing as he appeared vulnerable. She said that it was not possible to have a normal conversation with him as he did not speak very good English.

45. On 17 June, an officer submitted a security information report stating that the man's behaviour had been "erratic" since he had arrived on the wing and that his interaction with prisoners and staff was limited and strained. She did not elaborate on what she meant by "erratic". The officer noted that previous information in his case history notes suggested he was a challenging prisoner prone to strange and disruptive behaviour. At a mental health team meeting that day, the prison's mental health team leader was asked to carry out a mental health assessment with him. This assessment did not take place.

46. The man's solicitor wrote to him, on 18 June, to advise that he was due to appear at Crown Court on 12 July in relation to the incident at Stafford prison and that this would effectively stop his deportation to Poland from proceeding. (The letter was sent to Dovegate and it is not clear if he ever received it but he knew about the court case and the effect on his deportation.)

47. On the morning of 18 June, the prison psychiatrist and the mental health team leader saw the man and noted that although no interpreter was available he managed a twenty minute conversation and understood what was being said. He said he did not know why he had moved from Dovegate and denied taking drugs at the prison. He said he did not want to have his depot injection as he did not like having his bottom touched. He said he did not have any psychotic symptoms. He wanted to be deported back to Poland, but was aware that pending court proceedings in July, at which he intended to plead not guilty, would delay this. The psychiatrist noted that he needed to be monitored closely and that the team leader would liaise with Dovegate's mental health team for further information. A further assessment, at which an interpreter was to be present, was booked for two weeks later. The team leader did not contact Dovegate. When interviewed, she said she believed that this was because she went on leave after this date. However, records show that she was on leave for the six days before this and did not take any further leave until after his death.

48. Later that afternoon, the man asked two officers for a smoker's pack. Officer A said he stared aggressively at Officer B and became very agitated when they told him he could not have one unless he ordered one from the prison canteen. They said he asked if he had to hurt himself to get one and said he had cut himself before.

49. Because of what the man had said, an officer on the wing opened an ACCT at 5.00pm. The officer noted that the triggers for him to self-harm was "being short of tobacco" and "not getting something he wants". He was to be observed hourly. At 5.15pm, he was locked in his cell which the officers recorded was for his own safety and for the safety of others. The officers first searched his cell to remove any razors, but found none. He then kicked his cell door repeatedly and

shouted for two hours. Officer B charged him with a disciplinary offence for "using threatening, abusive or insulting words or behaviour".

50. Officer A said that a number of prisoners thought that staff were over-reacting and wanted to give the man some tobacco. He said that, while he understood this, the officers took the view that this would be rewarding him for making threats.

51. A custodial manager said he tried to contact the duty governor to have the man moved to the segregation unit because he was being so disruptive on the wing but was unable to speak to him at the time. He said that when he was given his meal at 6.35pm he had calmed down and was compliant.

52. Prisoner A told the investigator that the man had been banging on his cell door wildly that afternoon, shouting that he would kill himself if he was not given tobacco. He alleged that a number of officers were laughing and joking outside his cell, taunting him. He said that some officers responded to his threats that he would kill himself by saying, "Let him do it" and that Officer B said, "Do it". He said that the next day an officer taunted him by asking, "Are you still here" and "are you still alive".

53. Four other prisoners on the wing we interviewed gave similar accounts to that of Prisoner A about the inappropriate comments officers made during the incident. They said the officers stopped them from giving the man tobacco. Another prisoner on the wing said the man was a nuisance as he was always asking for tobacco. He believed that it was complaints from other prisoners that had led to him being locked in his cell.

54. A SO chaired the man's first ACCT case review, which was held at 11.20am on 19 June. A nurse attended. It was recorded that the man was articulate, lucid and focussed and that there was no evidence of psychosis or thought disorder. He said that his behaviour the previous day was an isolated event and would not be repeated. When interviewed, the SO said that he was not aggressive, had seemed calm and said nothing to indicate that he was at risk of harming himself. Observations were set at a minimum of three times a day with nightly checks made at the same time as category A prisoners were checked. Two ACCT caremap objectives were set. The first indicated that regular psychiatric support was required and the second that he was to remain on the wing and have regular contact with staff in order to express his feelings. Both objectives were considered to be on-going. His behaviour the day before was mentioned at the review but there was no reference to the problem of getting tobacco which appears to have been the underlying cause or to him getting a prison job which would have kept him occupied and allowed him to earn money to pay for tobacco.

55. Although ACCT assessments are expected to take place before the first review, at 11.30am a nurse interviewed the man for an ACCT assessment. He noted similar comments to those recorded during the ACCT case review. The nurse added that a psychiatrist was seeing him regularly, that he wanted to be

repatriated to Poland and that he had a history of impulsive and aggressive behaviour. At interview, the nurse said he could not recall him talking about his need for tobacco. He said that if he had presented with psychotic symptoms he would have been admitted to the healthcare centre immediately.

56. At 12.20pm, an officer noted in the man's ACCT record that there were no issues with him but he described his behaviour on the wing as "odd". Later that afternoon a prisoner told officers that he thought the man should be moved off the wing as he kept annoying other prisoners by asking them for tobacco. At 6.30pm, an officer noted that he had spent most of his time that day locked in his cell, but when he was unlocked for an association period he had gone from cell to cell appearing to borrow coffee and tobacco from others, and "appears very erratic".

57. On 20 June, two prisoners told Officer B that the man was in danger on the wing as he was unsettling other prisoners by demanding coffee and tobacco from them. The officer noted that he had no money in his prisoner account and was therefore unable to pay back any debts incurred.

58. A SO told the investigator that the man was constantly trying to obtain tobacco from other prisoners and some prisoners had said that something unpleasant would happen if the situation continued. He said he was keen to get him moved off the wing as he did not consider that it was the best place for him. He said he spoke to him several times to tell him that staff were trying to sort the situation out.

59. The SO said that he asked an operational manager to speak to the man as he was visibly upset and frightened. The SO believed he needed to be moved and he said the operational manager assured the man that he would be moved. He said that the operational manager and an officer had both agreed that locking him in his cell was not satisfactory and something had to be done, but the operational manager was not prepared to move him to the segregation unit. At interview, the SO said that the possibility of moving him to the healthcare centre or to a vulnerable prisoner wing was discussed but it was agreed that in the meantime he should be kept locked in his cell on the wing.

60. The operational manager noted in the duty governor's record, at 4.10pm, that the man remained locked in his cell as he was under threat from other prisoners and that the security department was looking to locate him on an alternative wing.

61. At 5.45pm, the man pressed his cell bell and showed an officer that he had made a number of cuts to his left arm with a razor blade. Another officer noted in the wing observation book that, when the man was asked to hand over the razor blade, he produced what appeared to be a small coffin made from matchsticks with a note on the top saying "RIP to the dick you used to see". He then passed the blade under the cell door. A nurse attended but he would not let her clean and dress his wounds, so she left some dressings in his cell. The level of his required ACCT observations was raised to one an hour.

62. At 5.55pm, a SO e-mailed managers and other colleagues about the man's circumstances. He said he needed to be relocated to a more suitable area and that, in the meantime, he recommended that he should remain locked in his cell for his own safety until suitable alternative accommodation could be found.

63. The SO chaired an ACCT review at 6.15pm on 20 June in the man's cell. A custodial manager and an officer, who was noted as the man's personal officer, also attended. There was no healthcare representative. The SO said that he was verbally aggressive at first but calmed down. He noted that he appeared to be suffering from nicotine withdrawal and was unhappy about being locked up.

The man's segregation

64. In the early hours of 21 June, a SO sent an e-mail to operational managers at the prison, to say that some officers had raised concerns with him about the man's bizarre behaviour on the wing. The nature of the behaviour was not described.

65. At 9.00am, an unidentified officer wrote in the man's ACCT on-going record, "…when observed came to door and asked for cigarette. Told him this was not possible and he said okay. No issues at present".

66. At 10.45am, the duty governor that day wrote in the Duty Governor Record that the man had moved to the segregation unit due to threats from others prisoners and that this had been arranged by a manager. At 10.58am, the manager replied to the SO's earlier e-mail and said "I know the info is now coming in, but this prisoner is likely to end up in the seg quite quickly – can I ask we get the pre-transfer info as soon as possible as it would appear due to his behaviour he is at risk from others".

67. The man's third ACCT review took place at 10.52am on 21 June. Despite the duty governor noting at 10.45am that he had moved to the segregation unit, the review too place on Perrie Red and was chaired by a SO. Another SO and a nurse also attended. At the review, he said that one of the wing cleaners had wanted to fight him and that he had self-harmed because he had no tobacco and cutting himself made him feel better. He wanted to move F wing, where he said there was another Polish prisoner. He made some racist remarks about staff and prisoners. The SO told him that he was going to the segregation unit and that if he took his medication it would not be for long. He said that he agreed and was not threatening to staff at any time during the review. The nurse said that he had agreed to take his medication on the basis that he would have the option of moving to either E or F wing. She noted in his medical record, "Officers agreed to this being considered in exchange for him being moved to the segregation unit in the meantime".

68. The SO decided that the man's observations should be reduced from every hour to once every two hours. His next ACCT review was scheduled for 24 June. There were no reasons recorded in the ACCT plan to explain the exceptional circumstances that justified moving him to the segregation unit while he was on

an open ACCT as Prison Service instructions require.

69. At interview, the SO said that the decision to move the man had been taken by the duty governor before the ACCT review. (The duty governor had signed the authorisation but the other duty governor's note in the duty governor's record said that the move had been arranged by a manager.) The SO said that the man was happy to go to the segregation unit and to take his medication. He accepted that he was not medically trained, but he considered that the man's poor behaviour was caused by him not taking his medication, not because he had no tobacco. He could not recall if he had checked to see if he had had any tobacco at the time or whether the ACCT review had considered getting him a further smoker's pack. The nurse told the investigator that not having tobacco was a big issue for him and it was that which had caused him to be stressed. She could not recall if anything was done about the issue of tobacco at the ACCT review or if he was offered a smoker's pack.

70. At 11.10am, the nurse completed an Initial Segregation Health Screen form and assessed the man as fit to be segregated. The form was countersigned by the duty manager later that afternoon. The nurse told the investigator that she had approved his segregation as at the time he gave no indication that he was at risk of self-harm and he had no psychotic symptoms. She said she had no reason to think that his health would deteriorate further if he were segregated and she did not consider that he needed to be admitted to the healthcare unit as an inpatient. The nurse said he was happy to go to the segregation unit as he had been told it was only for a couple of days and then he would move to E or F wing.

71. The nurse said that she had got the impression that the man would stay in the segregation unit for only a couple of days. She said that she would not have expected him to have stayed longer as he had not been moved there as a punishment. The SO said that the length of time that he would spend in the segregation unit did not cross his mind.

72. The man moved to the segregation unit at 11.40am. It was noted in the segregation observation book that he had been located there for his own protection. At 12.00pm, an entry in the ACCT on-going record noted that he had asked for tobacco but was not given any.

73. At 3.00pm on 21 June, the duty governor authorised the man to be segregated until 24 June. The reason given was "Prison Rule 45 own interest – he claims he is under threat from others. A risk assessment to be completed before a decision is made to his location". A SO completed a risk minimisation plan for prisoners in the segregation unit, using a standard pro forma document with the sections completed in advance with generic text and not specific to him as it should have been. There was no reference to the fact that he was on an ACCT. The plan was not signed by the duty governor.

74. The nurse spoke to the man through his cell door at 5.34pm. She noted in his medical record that he had agreed to have his depot injection, believing he would then be moved back to Perrie Red. She told him that it was not possible to have

the injection that day and he would not be moving back to the wing that evening. She told the investigator that she could not recall why he did not have the depot injection that day. She said that he had asked for a smoker's pack and she thought he wanted to return to the wing that evening so he could get tobacco, which was a big issue for him. The nurse believed that he now regretted agreeing to go to the segregation unit.

75. At 7.30pm, the man pressed his cell bell and asked for a smoker's pack. He was told that he would not get any tobacco that evening. At 10.05pm, the nurse noted in his medical record that she had seen him again and that he had asked for a smoker's pack. She suggested that he should speak to the manager in charge of the segregation unit about this.

76. On the morning of 22 June, a chaplain saw the man and noted that he had raised no concerns. The nurse said that he was again asking about tobacco. She told the investigator that at the time this was his only concern. She said she would have informed segregation unit officers of this but she did not take it any further. At 11.15am, an officer noted in the segregation daily history sheet that he had referred a request from him for a smoker's pack to the SO.

77. On 22 June, an officer noted that the man had been extremely aggressive, misused his cell bell and had spent periods of the day banging on his cell door. Because of his behaviour he was not allowed time in the open air for exercise. That afternoon, he was given some of his property from his cell on Perrie Red.

78. On the morning of 23 June, an officer reported that the man had been abusive to him from behind his cell door. At 9.30am, a nurse had gone to give him his depot injection but he was very agitated and said he would not have the injection unless he was given some tobacco. She noted that segregation unit staff were aware of the issue and were trying to resolve it. At 10.00am, the duty governor on noted that he was banging on his cell door asking for a smoker's pack and that a SO would deal with the matter. At around 3.00pm, an officer told him that he was not going to be given a smoker's pack. He told the officer to "fuck off", for which the SO gave him a written IEP warning. He gave him a further written warning when he was abusive to him when he issued the first warning.

79. The SO told the investigator said he had understood that the man had previously been given a number of smoker's packs and it had been decided that he would not be issued any more. (There is no evidence that he was given any smoker's packs other than the two he received when he first arrived on arrived on 7 June.)

80. At 2.28pm, a prison chaplain noted that the man had asked him for a smoker's pack and that staff were aware of his needs. At 4.00pm, an officer told him that he would not be allowed a shower because of his earlier behaviour. At 5.05pm, he asked for a copy of Prison Service Order 1700, which outlines segregation unit procedures. He was told that he would have to submit an application the next morning.

81. On the morning of 24 June, a doctor saw the man in the segregation unit and he asked when he would be getting his depot injection. (The doctor noted in his medical record that this would be arranged.) He said that otherwise he was okay. An officer noted later that day that he was shouting and banging on his cell door. A form to authorise his continued segregation was filled in on 24 June. Only one SO's name appears on the form for the review board, but at interview he said he had not been present. It does not appear than any review actually took place. The form incorrectly indicated that he was not on an ACCT and that the reason for his initial segregation was for good order or discipline because of his poor custodial behaviour and outburst of abuse towards staff. It was noted on the form that he was aware of the reasons for his continued segregation. The authorisation was not signed by the duty governor until fours days later, on 28 June.

82. At 2.25pm on 24 June, a SO held the man's fourth ACCT review. No other member of staff attended. The SO noted that he had informed the man's personal officer that the man wanted to speak to him, that he said he was coping and that there were no issues of self-harm. The SO scheduled the next ACCT review to take place on 28 June. There was no reference to his caremap.

83. On the morning of 25 June, the man asked a nurse for his depot injection and he asked to be transferred from Long Lartin. At interview, the nurse said she recalled that he was very frustrated about not having tobacco and he did not consider he was getting everything that he was entitled to in the segregation unit. However, he was much calmer. She gave him his depot injection at 3.30pm. At 3.50pm, an officer noted that he remained segregated for his own interest and continued to show outbursts of bizarre behaviour. He had been outside for exercise and had had a shower that day.

84. On 26 June, the chaplain noted in the ACCT document that the man had said that he had had enough of the segregation unit and wanted to return to the wing. An officer later noted that he had had good interactions with staff during that day. A doctor saw him that evening and had no concerns.

85. The man's personal officer told the investigator that he had learnt he had been appointed as personal officer on the afternoon of 26 June, when he returned to work from holiday. He said that the man asked him for a television and a radio. He said that he told him to "fuck off" when he told him that because he had only recently arrived in the segregation unit he would probably not be able to have them.

86. A nurse saw the man on the morning of 27 June and he said he had no issues for healthcare staff to attend to. The chaplaincy and other visitors to the segregation unit had no concerns. An officer noted that he had had a shower, had been outside for exercise and had been more cooperative towards staff.

87. On 28 June at 3.30pm, a SO chaired the man's fifth ACCT case review. An officer attended but there was no healthcare representative. The SO noted that she had spoken at length with him, who was not very talkative, but he had

maintained eye contact. He told the SO that he was feeling all right. He agreed that he would tell staff if he felt low or had any thoughts of harming himself. His caremap was not reviewed and, as at other reviews, there was no consideration of other issues that might affect his risk such his forthcoming court attendance and his parole review.

88. At the end of June, there were a number of disruptive prisoners in the segregation unit who were causing substantial damage to the unit and staffing levels were under strain. A SO told the investigator that at the time it would have been a frightening place to be. An officer said that it was not a good place to be as some prisoners were on dirty protest, cells were being damaged and flooded and the unit was very noisy. He was not involved in any of the disruption or protests.

89. At 8.50am on 30 June, an officer noted in the ACCT on-going record that the man was not engaging with staff although they had made efforts to speak to him. At 10.05am, a chaplain noted that he had requested some phone credit and that the segregation staff were aware of this. (It was later noted that he had asked for £2.00 to be put on his phone account and had not requested the use of any other facilities. It does not appear that his telephone account was credited and he made no telephone calls while he was at Long Lartin.) During the day, he was told that, following a hearing on 19 June, the Parole Board had decided not to direct his release from prison or recommend a transfer to open conditions.

90. On 1 July, a doctor saw the man and identified no concerns. An officer noted that during the day he had been moved out of a high control cell (usually used for disruptive prisoners who are a risk to staff) to a standard cell in the unit, and that he was compliant and in good spirits. It is not clear when he was placed in a high control cell, why or for how long.

91. On the 2 July, a SO held the man's second review for continued segregation. He noted that he had not attended a board before and was unaware of the reasons for his segregation. Representatives from the IMB, the chaplaincy and healthcare were among those who attended. As at the earlier review, the reason for his segregation was indicated as under Rule 45 for good order or discipline although the original authorisation had been for his own protection. It was noted that his behaviour continued to be strange and bizarre. He said that he wanted to return to the wing and did not know why he had been segregated. It was then noted that this was because other prisoners had made threats against him. The SO asked the security department to undertake a risk assessment within seven days to establish if he should return to one of the prison's main wings or a vulnerable prisoner wing. A nurse said that he had mental health issues and tended to refuse his medication. The review noted that he was due to attend court on 12 July. He asked if could have some tobacco and matches and was told his request would be looked into. The review concluded that he should remain in the segregation unit until his next review on 9 July. It was noted that he was on an open ACCT, but no one at the review questioned whether this meant he should not be held in the segregation unit.

92. When interviewed, the SO said he did not get the impression that the man was in imminent danger of taking his life but the chaplain thought that he appeared "strikingly vulnerable" at the review and his "… general demeanour was of somebody very vulnerable … and (he) seemed quite agitated".

93. A prisoner in the segregation unit at that time said that the man often banged his cell door begging officers for tobacco and matches, but was told that he could not have any. He said this aggravated him further and that this pattern of behaviour continued frequently until he died. He said that he had heard him tell the manager responsible for the segregation unit at the time that he had "had enough".

94. Another prisoner in the segregation unit at the time said the man often rang his cell bell and asked officers for matches. He alleged that an officer responded by telling him "You will get fuck all because you are on punishment". He said the man was generally quiet and appeared to be no problem except when he wanted to smoke. He said that the man did not even have a radio. A prisoner who was in a cell above the man's said that his behaviour was erratic and he would bang his cell door asking for tobacco and matches. He said officers just would laugh at him.

95. An officer noted that evening that the man continued to show bizarre behaviour but he did not specify in what way. No further concerns or issues were noted by segregation unit staff that day or during the night.

Events of the incident

96. At 10.00am an unsigned entry in the ACCT on-going record noted that the man seemed to be in a "decent spirits". A doctor saw him later and he said that he was okay.

97. The chaplain saw the man at 2.30pm. She noted in the ACCT on-going record that he had asked for matches, but that she had explained to him that this was not an issue the chaplaincy could help with. She told the investigator that the way that he had asked for matches was different from previous times as if daring her to give him some, in a mischievous sort of way.

98. The segregation daily history sheet noted that the man had a normal regime that day, including a shower in the afternoon. An officer told the investigator that the man had asked him to pass him some tobacco from another prisoner but he had told him that this was not allowed. The officer said the segregation unit was exceptionally busy that day. He said that cells had been damaged and the day was chaotic. He said it could have been quite frightening and threatening for a vulnerable prisoner.

99. At 5.11pm, an officer noted in the man's case history that he had asked everyone who had gone to his cell door for matches. The officer noted that his behaviour was bizarre and he appeared unsettled. Staff were on their guard as he appeared unpredictable. At interview, the officer said he was quite agitated and

looking round, appearing a “bit hyper”.

100. The officer, who had had no previous contact with the man, noted in his ACCT record that at 6pm he was lying on his back, leaning up against the wall. He said that this was not a planned ACCT check and he just happened to look through his door at the time. At 6.48pm, CCTV footage shows that he gave a cursory glance into the cell. He told the investigator that he was confident that he saw him at this time and thought he was lying on the bed. He was unsure whether he was in the same position as he had been in at 6.00pm.

101. An officer began a roll check in the segregation unit at 7.55pm. When she reached the man’s cell at 8.04pm, she saw him hanging from the window bars. She shouted immediately for help and radioed an emergency code blue (which indicates that a prisoner is unconscious, not breathing or with breathing difficulties). Three officers who were in the nearby segregation unit staff room, responded immediately. A nurse confirmed that she had received the emergency call.

102. On the way to the man’s cell, one officer also made radioed an emergency code blue call. The officers entered the cell. An officer cut two ligatures, made from bed sheets, from around the man’s neck and they laid him on the cell floor. He asked for an ambulance to be called and another officer radioed the control room at 8.06pm and asked for an ambulance to be called.

103. The officer was unable to find any signs of life and the officers began cardiopulmonary resuscitation (CPR). The officers took it in turns to deliver chest compressions.

104. At 8.06pm, a nurse and a Healthcare Assistant (HCA) arrived in the segregation unit, collected emergency resuscitation equipment from an office on the landing above and went into the cell a minute later at 8.07pm. The nurses were satisfied that the officers were performing chest compressions appropriately and administered oxygen and attached a defibrillator. (An automatic external defibrillator measures electrical activity in the heart and issues audible instructions about management of the patient including whether or not an electrical shock should be given to re-establish an effective heart rhythm.) However, it could trace no electrical activity and advised that no shock should be given. Staff continued CPR until paramedics arrived at 20.45pm. The man was pronounced dead at 8.57pm.

Hot debrief

105. A hot debrief was held for staff to allow those involved in the emergency incident to give staff the opportunity to share their feelings and offer support. Most of those involved said they found it helpful and that they had received good support from the prison’s care and welfare team. However, some of the staff involved, including healthcare staff, said they had not been invited to attend.

Family Liaison

106. The man's brother lived in the Republic of Ireland and the police agreed to arrange to break the news of his brother's death. The prison's family liaison officer subsequently spoke to him to offer condolences and support. In line with Prison Service guidance, Long Lartin contributed to the repatriation of the man's body to Poland and to funeral expenses.

ISSUES

Mental health care

Handover of care

107. The man had been diagnosed with and treated for paranoid schizophrenia for a number of years. From the time of his transfer to Stafford in October 2009 and when he was at Dovegate his mental health care was provided by South Staffordshire and Shropshire NHS Foundation Trust. The community psychiatric nurse co-ordinated his care. The clinical reviewer highlighted the nurse's good practice. He noted that she responded to his needs promptly when he was placed in segregation, reviewed him regularly and ensured that his care plans and risk assessments were up to date. Although he allegedly assaulted a prisoner at Stafford in September 2012, for most of this period he was stable, generally compliant in taking his medication and interacted appropriately with those he came into contact with.

108. When the man transferred to Long Lartin, the community psychiatric nurse made an entry in his medical record advising healthcare staff at Long Lartin to review his medical records and care plans and to contact the mental health team at Dovegate for further information. She gave her telephone number for this purpose. A nurse agreed with the prison psychiatrist that she would contact the mental health team at Dovegate for further background. She did not follow this up and neither did the man's allocated community psychiatric nurse. As a result, mental health staff at Long Lartin were unaware that he was likely to become very frustrated if he could not work and have money to pay for tobacco, or that his community psychiatric nurse had advised that he needed occupation and distraction because of the nature of his illness.

109. The clinical reviewer considers that the healthcare staff at Long Lartin should have contacted the community psychiatric nurse to gain a better understanding of the man and his needs. We agree this should have been done to help ensure appropriate continuity of care. He notes that it is common practice in the community to have a handover when a patient moves from one area to another and there were clearly missed opportunities to gather more information and develop a relationship with him and a proper understanding of his needs. We make the following recommendation:

The Head of Healthcare should ensure that a member of the mental health team contacts previous providers of mental health care to facilitate appropriate continuity of care when prisoners with diagnosed severe mental illness and other significant mental health problems arrive at Long Lartin.

Assessment and ongoing care

110. The man's first significant contact with the mental health team at Long Lartin was on 11 June, when two nurses reviewed him. When interviewed, one nurse said a care plan would have been raised at the meeting, but there is no evidence that this happened. The prison psychiatrist and the mental health team leader saw the man on 18 June and two nurses attended ACCT reviews on 19 and 21 June. These were the only interactions that he had with the mental health team at Long Lartin. The only other contact he had with healthcare staff was during routine rounds in the segregation unit.

111. In the light of the severity of his illness and reports of bizarre behaviour, it is a concern that the man had such limited contact with the prison's mental health team. He did not have a mental health assessment at Long Lartin, even though the prison's suicide and self-harm prevention policy requires an assessment within twenty-four hours for all prisoners on an open ACCT placed in the segregation unit. This is all the more concerning as he had a diagnosed severe mental illness. Nor is there any evidence that a care plan was drawn up.

112. The man's care was allocated to a nurse to coordinate. However, the clinical review notes that there seems to have been little evidence of a coordinated approach and no comprehensive assessment was made of his needs. This was despite the fact that he had refused to take his depot injection and had spent a period of thirteen days in the segregation unit. The nurse suggested to the investigator that he had been on leave at about the time that his care was allocated to him, but the evidence is that this was not the case.

113. No one appears to have coordinated the man's care at Long Lartin. This meant that no one had identified how important tobacco was to him, that he found boredom very difficult to cope with and he needed to be gainfully employed. His community psychiatric nurse had previously identified that being locked in a cell all day without occupation was not good for him due to the nature of his illness yet this was not taken into account. The clinical reviewer concludes that, "basically, no one had completed a comprehensive holistic assessment". He suggested there was a need for more effective clinical supervision at Long Lartin. We make the following recommendation:

The Head of Healthcare should ensure that all prisoners with a severe mental disorder have an up to date mental health assessment backed up by well coordinated and effective care plans which are regularly reviewed and actively supervised.

Delay in administering depot injection

114. The man received depot injections every three weeks to help avoid the onset of symptoms of psychosis. At previous prisons, he often refused his depot injection but his community psychiatric nurse usually persuaded him to take it. On 10 June, he refused his injection. He then requested it on 21 June, but this was not administered until 25 June, some four days after he had requested it and fifteen

days after it was due.

115. The clinical reviewer notes in his clinical review that a mental health nurse did not see the man for many days before this and there were no attempts to persuade him to take it. The need for his injection would have appeared as a 'task' on SystmOne (the electronic medical records system) and would have been evident to anyone looking at his records. He reports that it is concerning that no concerted effort was made to persuade him to take the injection and no one thought to contact his previous CPN to gain an insight into what might have persuaded him to have it.

116. The clinical reviewer concludes that the delay in administering the depot injection by fifteen days was inexplicable. The nurse agreed that this was not followed up with him after he first refused the injection on 10 June. The clinical reviewer concludes that the administering of the depot injection should have been part of a care plan that a mental health coordinator should have taken ownership of. We make the following recommendation:

The Head of Healthcare should ensure that nurses responsible for coordinating mental health care follow up missed medication with patients as part of an active care plan approach.

ACCT procedures

117. The investigation found that there were many deficiencies in the operation of ACCT procedures and it is a concern that some staff, such as the nurse who completed the man's initial segregation health screen, had never received any formal ACCT training. As she had not been trained, she was unaware that prisoners on open ACCTs should be held in the segregation unit only in exceptional circumstances. Other procedural problems suggest that there is a general need for staff training.

118. Prison Service Instruction (PSI) 64/2011 which governs ACCT procedures notes that the process is "necessarily prescriptive". When the man's ACCT was first opened, an ACCT assessment interview should have been held before the first case review yet the records show that the assessment was completed after the review. The purpose of the assessment is to help the ACCT review identify the most pressing needs and the most appropriate actions to meet those needs. Although the ACCT had been opened specifically because he had threatened to self-harm because he had no tobacco, this was not identified as an issue either at his assessment interview or at the review. Neither was the fact that he had no activity to keep him occupied or a prison job with which he could earn money to buy tobacco and make telephone calls.

119. The first case review is required to appoint a case manager at a minimum grade of senior officer, who is expected to chair subsequent reviews to provide continuity. This helps to ensure that reviews are chaired by someone who knows the prisoner and their identified issues. The man had five ACCT reviews between 19 June and 28 June yet a different senior officer chaired each one.

The PSI requires that where possible case reviews should be multi-disciplinary. Only two of five were and one of the reviews had only one member of staff present, the senior officer chairing the review.

120. Despite the man's diagnosed mental illness, there was no mental health or other healthcare representation at the reviews on 20 June, 24 June and 28 June. These were further missed opportunities to identify whether his mental health was deteriorating. There is no evidence that healthcare staff were formally notified and invited to these reviews. At interview, one of the nurses said that they were usually requested to attend ACCT reviews via the radio carried by the duty mental health nurse for crisis call outs. We do not know whether this was done for the reviews where there was no healthcare presence, but summoning nurses to attend reviews in this way is inappropriate and does not ensure that the care coordinator for the person involved attends.

121. We were concerned to note that the required level of ACCT observations was reduced from hourly to two hourly just at the time that the man was transferred to the segregation unit. It is difficult to understand this decision at that stage as PSI 64/2011 clearly sets out the risks of segregating a prisoner who is on an ACCT. ACCT checks were carried out at very regular intervals when he was in the segregation unit and at the same time as routine segregation checks making them too predictable.

122. ACCT reviews appeared perfunctory and there was no discussion of other issues that might affect the man's level of risk such as the fact that he had an imminent parole review and that he was facing a further serious criminal charge of attempted murder. He was diagnosed with paranoid schizophrenia which is recognised to increase the risk of suicide by 50 times and was also clearly suffering from nicotine withdrawal. (We deal with the matter of access to tobacco as a separate issue below.) The two caremap targets for regular psychiatric support and for him to have frequent contact with staff were inadequate to address his risk but nevertheless were not discussed at case reviews and remained unchanged throughout five reviews. Despite the first target, he did not receive the psychiatric support he needed. There were references throughout the ACCT documentation to "bizarre behaviour" but the nature of this was not explained and he was never referred for a mental health assessment, even when he was moved to the segregation unit as the local policy required. PSI 64/2011 identifies that factors such as regular participation in regime activities are "fundamental to reducing risk" and requires this to be addressed in completing the caremap but his lack of activity was never discussed. No practical steps to address his underlying issues were identified.

123. It is concerning that we found shortcoming in every area of the ACCT process. We make the following recommendation:

The Governor should ensure that prison staff manage prisoners at risk of suicide or self-harm in line with national guidelines, including:

- **Setting ACCT caremap targets which address the cause of the individual's distress and which are reviewed and updated at each ACCT review;**
- **Considering all known risk factors when determining the level of risk of self-harm;**
- **Holding multidisciplinary case reviews with a consistent case manager and which include all relevant people involved in a prisoner's care;**
- **Completing ACCT documents fully and accurately; and**
- **Providing ACCT training for all staff including healthcare staff.**

Segregation

124. Prison Service Order (PSO) 1700, Segregation sets out mandatory requirements and guidance to governors to ensure the security and safety of those living and working in prison segregation units. The PSO highlights that there are a disproportionately high number of self-inflicted deaths in segregation units and clearly states that prisoners on an open ACCT should only be segregated when they are such a risk to others that no other suitable location is appropriate and then only in exceptional circumstances. PSI 64/2011 – Safer Custody – reinforces thus and says that "prisoners on open ACCT plans must be located or retained in Segregation Units only in exceptional circumstances". Long Lartin's own local Segregation Unit strategy also clearly states this. HM Inspectorate of Prisons specifically criticised the number of prisoners on ACCT in the segregation unit at Long Lartin during their inspection in 2011. At the time of his death, the man was one of five prisoners on ACCT plans in the segregation unit.

125. On 20 June, the duty governor that day decided that it was not appropriate to move the man to the segregation unit. The possibility of moving him to the healthcare unit or one of the vulnerable prisoner wings was suggested but it was decided that he would remain on Perrie wing at that point. The next day, another manager was noted to have agreed that he should go to the segregation unit but it was another duty governor who authorised the segregation in his own interest. No exceptional reason to justify moving him to the segregation unit while on an open ACCT was given. It appears that it was originally intended to be a short-term move and he was told that if he agreed to take his medication they would move him to another wing. As noted earlier, Long Lartin's suicide and self-harm prevention policy states that a mental health assessment must be undertaken within 24 hours for all prisoners on an open ACCT who are placed in the segregation unit but this was not done. It is a particular concern that this was not done as he had a diagnosed serious mental illness and his community psychiatric nurse had previously identified that his illness meant that being locked in a cell all day without occupation was not good for him. A mental health assessment at that stage might have helped flag up that segregating him was inappropriate. It is clear that he was not regarded as a risk to others and had been segregated in his own interests, so he should not have gone to the segregation unit even if there were exceptional circumstances. We make the following recommendation:

The Governor should ensure that mangers do not authorise segregation for prisoners on open ACCTs unless there they are a risk to others and there are exceptional circumstances which are fully recorded in the ACCT document and the authorisation form. When this happens, an urgent mental health assessment should be completed.

126. At first, staff in the segregation unit appeared to be aware that the man was segregated for his own protection. A combination of factors resulted in his specific circumstances being overlooked and his needs being ignored. The use of generic, pre-printed forms in the segregation unit which were not tailored to the needs of individual prisoners did not help and the reasons given for his continued segregation were incorrect. His care in the segregation unit was not appropriate to his needs. It is of particular concern that he spent an unrecorded number of days in a bare, high control cell without even a radio to occupy him. Segregation unit staff told the investigator that high control cells were usually used for prisoners who have assaulted staff on the wings. It is not clear why he was placed into one of these cells as there were other cells were available. It is possible that this reinforced the perception of officers in the segregation unit that he was segregated because he was a risk to others, rather than because he was at risk from others.

127. The man received IEP warnings for his behaviour while he was in the segregation unit. We consider that some of these were inappropriate in the light of his circumstances and his mental health. As well as having no tobacco, he did not have a television or radio or anything else to help occupy him. The records indicate that he was denied access to outside exercise and to a shower as unofficial punishments. We know that for a period of several days during his time in segregation, the atmosphere on the unit was loud and frightening because of the behaviour of a number of disruptive prisoners held there. We have seen little evidence that staff on the unit, or senior managers who visited the unit, considered the impact that this combination of facts would have had on a man suffering from a serious mental illness, who had been assessed as at risk of self-harm.

128. No one who visited the segregation unit during the man's stay, including senior managers, healthcare professionals, Independent Monitoring Board members, or staff from the prison chaplaincy seems to have questioned the appropriateness of him remaining in the unit while he was on an open ACCT. As there were at least four other prisoners on open ACCTs in the segregation unit at the time, it does not appear that this was regarded as exceptional at Long Lartin. It is a particular concern that his vulnerability was not identified at segregation reviews and no one challenged his continued segregation. Although two segregation reviews were ostensibly recorded it does not appear that the first review on 24 June ever happened which is a serious matter. The senior officer's name which appears on the form says he was not present, only a pre-printed 'GOV' appears to indicate who chaired the review and the authorisation was not signed by a manager until four days later. The attendance of a healthcare representative is a mandatory requirement of PSO 1700 but as it is apparent the review did not take place, this did not happen.

129. On 2 July, a manager chaired a segregation review. He noted that the man had not attended a previous board and was unaware of the reasons for his initial segregation. These were again erroneously recorded as for good order or discipline. Representatives from the chaplaincy, healthcare and a member of the Independent Monitoring Board attended but again there is no record that any of them questioned the appropriateness of his continued segregation. The chaplain told the investigator that he looked very vulnerable but she seemed unaware of the technicalities of the segregation procedures and that she would be able to challenge segregation.

130. The nurse who attended said she had not read the man's previous medical record entries before attending the review. She believed that all that needed to be noted was that he was known to the mental health team and he had been allocated a community psychiatric nurse. Had she read the notes, she would have seen that another nurse had indicated that he had agreed to go to the segregation unit to take his depot injection on 21 June and was not expecting to stay there for more than a couple of days. She might then have questioned why he was still there. We consider that the attendance of healthcare representatives at segregation reviews (and ACCT reviews) is important but they should know the prisoner and ideally be their care coordinator. Unless they have relevant knowledge of the prisoner being discussed or have briefed themselves appropriately beforehand, the attendance of healthcare staff at such reviews brings little benefit and in some cases could be unhelpful if ill-informed advice is relied on.

131. Senior managers and some staff at Long Lartin acknowledged that there had been a number of difficulties in the segregation unit in the months preceding the man's death. They said that there was a lack of experienced and permanent staff working on the unit and the unit appeared to have been suffering as a result of this. During our investigation we were encouraged to see that the failings within the unit were acknowledged and that a new senior manager was appointed to lead the segregation unit, but it is apparent that there was some very lax practice at the time.

132. The procedures outlined in PSO 1700 are specifically intended to safeguard prisoners who are segregated. This is in recognition of the fact that segregation from others can have a detrimental effect on the physical and mental health of prisoners and so must be appropriately managed and risk assessed. It is concerning that senior managers at the prison, despite being aware of the problems in the segregation unit, did not ensure that the necessary safeguards were in place to protect prisoners such as the man. We make the following recommendation:

The Governor should ensure that the requirements of PSO 1700 in relation to segregation are followed and that all managers and staff responsible for prisoners in the segregation unit understand their responsibilities to safeguard prisoners and promote their wellbeing and fair treatment. In particular:

- **Authorisations for segregation should be completed promptly and accurately with full reasons given to justify the segregation;**
- **Official visitors to the segregation unit including healthcare staff, chaplains and managers should satisfy themselves that there are appropriate exceptional reasons when a prisoner on an open ACCT is segregated and record this in the segregation daily log;**
- **Healthcare representatives at segregation reviews should be fully briefed about relevant aspects of the prisoner's health needs and where possible should be the person responsible for the individual's care;**
- **All attendees at segregation reviews should understand the purpose of the review and be confident about challenging continued segregation when they have concerns about a prisoner's vulnerability.**

Access to tobacco

133. Obtaining tobacco was a major issue for the man and remained so until his death on 3 July. As noted above, this matter was not satisfactorily addressed through mental health reviews or ACCT procedures and was compounded by his segregation.

134. The man arrived at Long Lartin with only a small amount of money in his prison account which was not enough to pay for the tobacco he was issued with at reception. Subsequently, he had an income of only £1.50 a week after he had paid for his television and so was unable to order any further tobacco from the prison shop. He appears to have been heavily dependent on tobacco. On 18 June, he asked staff for a smoker's pack and, when they refused, he threatened to harm himself, which he did on 21 June. He made repeated requests for tobacco over the following weeks but was not given any and nothing was done to address his financial situation to enable him to buy any.

135. An officer said it takes a minimum of two weeks for a prisoner to get a prison job after they arrive and that this also depended on vacancies and risk assessments. Extra smoker's packs were issued only in exceptional circumstances. At interview, several officers and senior officers said they did not have the authority to issue smoker's packs and this would be for senior managers to decide. A SO said that this was a frequent problem but there was no clear guidance about what to do and that the response would be a matter for the individual duty governor at the time. On 20 June, the SO noted that the man was suffering from nicotine withdrawal.

136. Nicotine is a highly addictive substance and people dependent on nicotine need a certain level to function normally each day. A sudden reduction in nicotine intake disturbs the balance of the central nervous system and causes withdrawal symptoms such as craving for tobacco, irritation, anger, anxiety, depression and restlessness. Nicotine replacement products can help relieve nicotine cravings and withdrawal symptoms and these can also be alleviated by prescription

medication. The man was locked in a cell without anything to occupy him for most of the time and the lack of other distractions is likely to have exacerbated his symptoms. We are concerned that no one appeared to have addressed this issue with him – particularly as he was diagnosed with schizophrenia when the likelihood of suicide is regarded as 50 times greater than non-sufferers.

137. The man was a foreign national who had very limited contact with his family. Without a prison job he was deprived of the means to buy tobacco, a matter which seems to have been continually overlooked. We recognise that smoking is a major health problem in itself and it is difficult for prisons to be seen to be encouraging prisoners to smoke, but in this case enabling him to buy some tobacco would appear to have been the lesser of two evils. As access to tobacco was such an issue to him, and he had a severe mental health condition, we consider that he should have been prioritised for a job which would have allowed him the choice. Failing that, some arrangement should have been made to allow some credit until he was given a job. In the absence of this, it is a concern that no one did anything to help him deal with his nicotine withdrawal symptoms such as by providing nicotine patches. As with a number of the other failings in his care, senior managers, officers and healthcare staff all missed opportunities to identify practical steps that could have helped to improve his situation. We make the following recommendation:

The Governor and Head of Healthcare should ensure that there are appropriate arrangements to support vulnerable prisoners with no funds who are dependent on tobacco, by prioritising allocation to jobs, giving advances of wages and/or providing nicotine replacement therapy.

The emergency response

138. An officer called the emergency code blue at 8.04pm. The emergency response nurse arrived at the segregation unit two and a half minutes later and took a further minute before they got to the man's cell. When they arrived at the segregation unit, the nurses had to run past the cell to collect an emergency response bag and a defibrillator kept in a small room on the landing above. As the emergency equipment was in an unlocked room, accessible to segregation unit staff, it should have been collected and taken to the cell ready for the emergency response nurses when they arrived.

139. When the emergency code blue was called at 8.04pm the control room did not request an ambulance automatically in response. An officer radioed the control room two minutes later at 8.06pm to ask for an ambulance to be called. Prison Service Instruction (PSI) 03/2013 Medical Emergency Response Codes, which was issued at the beginning of February 2013 required governors to have a medical emergency response code protocol based on the instruction by the end of February 2013. This should instruct staff how to communicate the nature of a medical emergency using agreed emergency codes and ensure that the control room calls an ambulance automatically as soon as an emergency code is called.

140. At the time of the man's death on 3 July, Long Lartin did not have a protocol for calling an emergency code as it should have done. On 22 July, an order was issued requiring the control room to call an ambulance automatically when emergency codes red or blue are called. It did not give any further instructions or information to staff such as how to ensure that the relevant emergency equipment is taken to the scene or about access for ambulances as the PSI requires. While we welcome the fact that there is now a clear instruction to call an ambulance immediately in an emergency, we consider that further guidance is needed to ensure that all staff understand their responsibilities and roles. We make the following recommendation:

The Governor should ensure that all prison staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies and that Long Lartin's Medical Emergency Response code protocol complies with PSI 03/2013 and:

- **Provides guidance to staff on efficiently communicating the nature of a medical emergency;**
- **Ensures staff called to the scene attend as quickly as possible and bring the relevant equipment; and**
- **Ensures there are no delays in calling, directing or discharging ambulances**

Staff culture

141. Several prisoners on Perrie Red wing made allegations about the way staff treated the man on 18 June when he was locked in his cell and the next day. Prisoners said that officers laughed at him and made inappropriate and goading comments encouraging him to harm himself. The investigator interviewed staff against who these allegations were made, all of whom denied any wrongdoing. We found that some of the prisoner witnesses gave credible accounts but without some independent corroboration it is not possible to know exactly what happened. The investigator was shown an internal investigation into a number of issues on the wing which indicated that there were some managerial concerns about staff culture which we expect are being addressed.

142. We also found evidence of some poor staff culture in the segregation unit at the time which managers have acknowledged was a problem. We also note the concern of HM Inspectorate of Prisons, at the last inspection of Long Lartin in November 2011, that some prisoners perceived – and inspectors' observed – poor relationships and engagement between prisoners and uniformed staff. The Inspectorate recommended that the prison should take action to improve the negative perceptions of prisoners about relationships. We make the following recommendation:

The Governor should ensure that all prison staff deal with prisoners fairly and decently and understand their overriding responsibilities to support and protect prisoners, particularly those who are vulnerable.

RECOMMENDATIONS

1. The Head of Healthcare should ensure that a member of the mental health team contacts previous providers of mental health care to facilitate appropriate continuity of care when prisoners with diagnosed severe mental illness and other significant mental health problems arrive at Long Lartin.

2. The Head of Healthcare should ensure that all prisoners with a severe mental disorder have an up to date mental health assessment backed up by well coordinated and effective care plans which are regularly reviewed and actively supervised

3. The Head of Healthcare should ensure that nurses responsible for coordinating mental health care follow up missed medication with patients as part of an active care plan approach

4. The Governor should ensure that prison staff manage prisoners at risk of suicide or self-harm in line with national guidelines, including:

    - Setting ACCT caremap targets which address the cause of the individual's distress and which are reviewed and updated at each ACCT review;
    - Considering all known risk factors when determining the level of risk of self-harm;
    - Holding multidisciplinary case reviews with a consistent case manager and which include all relevant people involved in a prisoner's care;
    - Completing ACCT documents fully and accurately; and
    - Providing ACCT training for all staff including healthcare staff.

5. The Governor should ensure that mangers do not authorise segregation for prisoners on open ACCTs unless there they are a risk to others and there are exceptional circumstances which are fully recorded in the ACCT document and the authorisation form. When this happens, an urgent mental health assessment should be completed.

6. The Governor should ensure that the requirements of PSO 1700 in relation to segregation are followed and that all managers and staff responsible for prisoners in the segregation unit understand their responsibilities to safeguard prisoners and promote their wellbeing and fair treatment. In particular:

    - Authorisations for segregation should be completed promptly and accurately with full reasons given to justify the segregation;
    - Official visitors to the segregation unit including healthcare staff, chaplains and managers should satisfy themselves that there are appropriate exceptional reasons when a prisoner on an open ACCT is segregated and record this in the segregation daily log;
    - Healthcare representatives at segregation reviews should be fully briefed about relevant aspects of the prisoner's health needs and

where possible should be the person responsible for the individual's care;
- All attendees at segregation reviews should understand the purpose of the review and be confident about challenging continued segregation when they have concerns about a prisoner's vulnerability.

7. The Governor and Head of Healthcare should ensure that there are appropriate arrangements to support vulnerable prisoners with no funds who are dependent on tobacco, by prioritising allocation to jobs, giving advances of wages and/or providing nicotine replacement therapy.

8. The Governor should ensure that all prison staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies and that Long Lartin's Medical Emergency Response code protocol complies with PSI 03/2013 and:

    - Provides guidance to staff on efficiently communicating the nature of a medical emergency;
    - Ensures staff called to the scene attend as quickly as possible and bring the relevant equipment; and
    - Ensures there are no delays in calling, directing or discharging ambulances

9. The Governor should ensure that all prison staff deal with prisoners fairly and decently and understand their overriding responsibilities to support and protect prisoners, particularly those who are vulnerable.

ACTION PLAN:

No	Recommendation	Accepted/Not accepted	Response	Target date for completion	Progress (to be updated after 6 months)
1	The Head of Healthcare should ensure that a member of the mental health team contacts previous providers of mental health care to facilitate appropriate continuity of care when prisoners with diagnosed severe mental illness and other significant mental health problems arrive at Long Lartin.	Accepted	▪ When a patient is identified at the reception screen to have used mental health services, in addition to the continuous medical record contained within system one: the reception nurse will fax a request any community provider for a précis of previous history and a discharge summary. ▪ The allocated key working will then ensure that this is followed up by telephone contact sending establishment within 7 days of reception.	31st March 2014	
2	The Head of Healthcare should ensure that all prisoners with a severe mental disorder have an up to date mental health assessment backed up by well coordinated and effective care plans which are regularly reviewed and actively supervised.	Accepted	▪ All patients taken onto a mental health case load will have comprehensive and holistic care programme assessment to assess their clinical need and provide the basis for a plan of care. All will be designed in partnership with patient by their key worker who will act as the case manager.	31st March 2014	

			▪ This process will be audited via the read code system the quality will be audited by a monthly review of a random selection of case notes		
3	The Head of Healthcare should ensure that nurses responsible for coordinating mental health care follow up missed medication with patients as part of an active care plan approach.	Accepted	▪ There is an existing missed medication policy. All patients who have missed supervised medication are discussed at the lunch time meeting and followed up by the appropriate member of staff.	Complete	
4	The Governor should ensure that prison staff manage prisoners at risk of suicide or self-harm in line with national guidelines, including: a) Setting ACCT caremap targets which address the cause of the individual's distress and which are reviewed and updated at each ACCT review; b) Considering all known risk factors when determining the	Accepted	▪ A new Head of Safety was appointed on 19 August and she has made a marked improvement to the segregation unit and ACCT process. ▪ New procedures have been implemented following the death of the man, which include more frequent Rule 45 boards and a specially designed pro-forma to record the exceptional circumstances ▪ (a)Management of care maps have improved and staff are more aware of the requirements of making effective care maps and this is	Complete Complete Complete	

	level of risk of self-harm; c) Holding multidisciplinary case reviews with a consistent case manager and which include all relevant people involved in a prisoner's care; d) Completing ACCT documents fully and accurately; and e) Providing ACCT training for all staff including healthcare staff		overseen by the safer custody team on a weekly basis with specific feedback to senior managers for remedial action. Notices have been issued to staff. A Notice to Staff has been issued ▪ (b)(c) Multi agency reviews are now taking place with input on every case review from healthcare – whether in person or in consultation with a named professional which is documented as part of the case review. ▪ (d) Regular management checks are carried out on the quality of ACCT documents after a new management check sheet was introduced. ▪ (e) Two staff have been trained to deliver Safer Custody training and are delivering this weekly in house. Two additional staff are also to be trained. They will have completed this training by May 2014 – this will allow the establishment to deliver a full and effective training package for all staff of all discipline. ▪ (e) All healthcare staff will receive ACCT training	Complete Complete 31 May 2014	
5	The Governor should ensure	Accepted.	▪ A new Proforma has been devised	Complete	

	that mangers do not authorise segregation for prisoners on open ACCTs unless they are a risk to others and there are exceptional circumstances which are fully recorded in the ACCT document and the authorisation form. When this happens, an urgent mental health assessment should be completed.		to ensure that all "exceptional circumstances" are considered and every alternative location considered before locating someone in the Seg Unit. ▪ A new algorithm will be completed if an ACCT is opened on someone already located in the Seg Unit alongside the Proforma. ▪ All official visitors to the segregation unit will have to sign daily to say they have seen the exceptional circumstances that they agree with them. If they do not then a full case conference will be held.	Complete 31 January 2014	
6	The Governor should ensure that the requirements of PSO 1700 in relation to segregation are followed and that all managers and staff	Accepted			

	responsible for prisoners in the segregation unit understand their responsibilities to safeguard prisoners and promote their wellbeing and fair treatment. In particular: a) Authorisations for segregation should be completed promptly and accurately with full reasons given to justify the segregation; b) Official visitors to the segregation unit including healthcare staff, chaplains and managers should satisfy themselves that there are appropriate exceptional reasons when a prisoner on an open ACCT is segregated and record this in the segregation daily log; c) Healthcare representatives at segregation reviews should be fully briefed about relevant aspects of the prisoner's health needs and where possible should be the person responsible for the individual's		a. Algorithms are completed by both healthcare and a competent operational manager within two hours. A governor's order has been issued and is monitored by the Head of Safety. b. A new system is being introduced where any official visitor who sees a prisoner on an ACCT in the Seg signs daily to say they have seen the exceptional circumstances and agree the continued segregation is appropriate. c. Head of Healthcare to deal. However checks by managers at reviews will ensure knowledge and understanding of nurse prior to the review.	Complete 31 January 2014 31 January 2014	

	care; d) All attendees at segregation reviews should understand the purpose of the review and be confident about challenging continued segregation when they have concerns about a prisoner's vulnerability.		d. To be monitored by Head of Safety/ACCT Chair but also a Notice to Staff to be issued.	31 January 2014	
7	The Governor and Head of Healthcare should ensure that there are appropriate arrangements to support vulnerable prisoners with no funds who are dependent on tobacco, by prioritising allocation to jobs, giving advances of wages and/or providing nicotine replacement therapy.	Accepted	▪ For Segregation unit prisoners - The new Head of Safety now approves/ declines all applications for smokers pack irrespective of whether funds are available or not. She makes a decision on the relevant back ground history of the individual and has daily contact on the Seg Unit with a good working knowledge of all individuals on there. ▪ Vulnerable prisoners who require a job to support them will be allocated to employment early via the Labour Board. This could be in a workshop or a wing based role. ▪ Head of healthcare will ensure availability of nicotine replacement therapy	Complete 31 January 2014 Complete 31 January 2014	

8	The Governor should ensure that all prison staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies and that Long Lartin's Medical Emergency Response code protocol complies with PSI 03/2013 and: a) Provides guidance to staff on efficiently communicating the nature of a medical emergency; b) Ensures staff called to the scene attend as quickly as possible and bring the relevant equipment; and c) Ensures there are no delays in calling, directing or discharging ambulances	Accepted	a. A governor's order has been issued making it routine practice for the control room manager to automatically call an ambulance for any code blue or code red incident. b. Attendance in cell with equipment was 3min 19 seconds not the stated 10 minutes. Due to the distance between healthcare and the Segregation unit emergency bags will be relocated onto the ground floor where nurses enter the unit; this will ensure that there is no delay in arriving at the scene due to having to carry heavy bags over a long distance. c. A governor's order has been issued making it routine practice for the control room manager to automatically call an ambulance for any code blue or code red incident.	Complete Complete Complete	
9	The Governor should ensure that all prison staff deal with prisoners fairly and decently	Accepted	▪ All staff are now interviewed before being appointed to the Seg Unit to ensure that they are suitable to work	Complete	

	and understand their overriding responsibilities to support and protect prisoners, particularly those who are vulnerable.		there in line with the PSI. ▪ All staff are approved by the Governing Governor following interview. ▪ IPD training is completed by everyone working in the Seg Unit to ensure they have the knowledge and skills to work with this demanding population. ▪ Anyone displaying behaviours that do not correspond with the ethos of the unit will be removed.		