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 Full Sutton in January 2014

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 investigation report into the death of a man who was found hanging in his cell in January 2014, at HMP Full Sutton. He was twenty eight years old. I offer my condolences to the man's family and friends.

One of my investigators had conduct of the case and a clinical reviewer reviewed the clinical care and treatment that the man received at Full Sutton. Staff at Full Sutton co-operated fully with the investigation.

The man was recalled to prison on 21 August 2012 for a breach of licence. He moved to Full Sutton on 17 May 2013, from HMP Dovegate. He was being managed under Prison Service suicide and self-harm prevention procedures when he transferred, after trying to hang himself at Dovegate some weeks earlier. He suffered from Asperger syndrome, dyslexia, dyspraxia and attention deficit and hyperactive disorder (ADHD). When he arrived at Full Sutton, he said he wanted a fresh start and staff ended the suicide and self-harm prevention procedures that day.

The man moved to the segregation unit on 3 September, as he said he was under threat from another prisoner. He remained there for over three months until he was moved to the prison's inpatient healthcare unit because his mental health had deteriorated. Prison staff assessed him as a high risk of harm to himself and he was managed under suicide and self-harm prevention procedures from 24 December.

On a morning in January 2014 at around 10.30am, an officer checked the man and found him suspended by a bed sheet attached to the upturned bed in his cell. The emergency response was very quick. Nurses attempted to resuscitate him but sadly, were unsuccessful. Paramedics arrived and at 11.14am confirmed that he had died.

While I understand that the man's behaviour had previously been challenging and difficult to manage, this was not the case at Full Sutton. I am concerned about the length of time he spent in the segregation unit and the effect on his mental health, particularly taking into account his disability. The investigation found that there was little evidence of efforts to reintegrate him back to a standard wing or to consider other suitable locations for him. I am also concerned that staff were not clearly briefed about his Asperger syndrome so that they could take this into account in how they managed and communicated with him.

At the time he died, the man had been recognised as at high risk of suicide and self-harm and was required to be monitored at least three times an hour. I am very concerned that staff did not record checks in the suicide and self-harm monitoring document at the time they made them, as Prison Service guidance requires. This appears to have been standard practice in the healthcare unit at Full Sutton and makes it difficult to be sure that checks were carried out at the required level of frequency.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman **October 2014**

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SUMMARY

1. The man was from a Traveller family. He suffered from Asperger syndrome and mild learning disabilities. He had been released on licence from a prison sentence in June 2012, but recalled to prison two months later for a breach of the conditions of his licence. He transferred to HMP Full Sutton on 17 May from Dovegate. He had previously self-harmed in the community and in prison. On 24 April 2013, he had attempted to hang himself at Dovegate after being told he could not have contact with his son. He was managed under Prison Service suicide and self-harm prevention procedures, known as ACCT and under Dovegate's anti-social behaviour procedures. When he transferred to Full Sutton he was still subject to ACCT procedures, but the ACCT was closed at a review on the day he arrived. There were no healthcare staff present.

2. On a day in September, the man told a mental health nurse that he felt under threat on his wing as other prisoners had pressurised him to take scissors from the workshop where he worked. He had refused and told officers about what had happened. Because of this he wanted to go to the segregation unit for his own protection. He moved to the segregation unit that day. An investigation did not find evidence to confirm that he was under threat on the wing. It was decided that he should move back to a standard residential wing but he refused to move. He remained in the restrictive environment of the segregation unit until 18 December. He found the lack of activity difficult and particularly missed going to the gym which he was not allowed to attend. He had relied on the gym to help him cope with his Asperger syndrome. In order to get him out of the segregation unit, the prison had tried to arrange a transfer to HMP Garth but Garth refused to take him

3. At a segregation review on 18 December, it was agreed that the man should move to the healthcare unit because his mental health appeared to be deteriorating. He was low in mood, tearful and talking about death. He moved to the healthcare unit that day but an ACCT was not opened at the time. On 24 December, a learning disability nurse and the man's mental health keyworker, opened an ACCT because he was concerned about the man's state of mind. An ACCT review on Christmas Day assessed his risk of harm to himself as high and he was regarded as a high risk until his death. Because of his risk, some items such as his belt and shoe laces were removed from him and he was required to be observed at least three times every hour.

4. On the morning in January, the man left his cell to have a shower and do his laundry. Officers said he did not appear to be any different from usual. The healthcare manager saw him at 9.45am and said he seemed as normal. An officer said he checked him at 10.00am but none of these checks were recorded in the ACCT document. At approximately 10.25am, an officer checked him and found him hanging by a bed sheet attached to the upturned bed in his cell. Two officers immediately went in, supported his weight and cut the ligature while another officer radioed an emergency code which alerted the control room to call an ambulance. Nurses attempted cardio pulmonary resuscitation but this was unsuccessful. Paramedics arrived, assessed him and at 11.14am, pronounced him dead.

5. We are concerned that the man, who had Asperger syndrome and learning disabilities, remained on the segregation unit for so long without the activity he needed to distract him. Prison staff recognised that this had led to a deterioration in his mental health, yet other than one request to another prison to take him, there was little evidence of any coherent plan to help him reintegrate to a standard wing or to provide him with occupation, other than a television. Although it did not affect the outcome for him, we are concerned that officers closed an ACCT the day he arrived at Full Sutton. This was just weeks after he had attempted to hang himself and before they had the opportunity to assess him properly with the benefit of healthcare input. This was a risky decision. Staff in the healthcare unit did not maintain the ACCT ongoing log contemporaneously but they said that they had checked him three times an hour. However, without a record made at the time of the check it is not possible to be sure that the checks took place at the required frequency. There was little evidence that the fact that he suffered from Asperger syndrome and had learning disabilities was taken into account in his management or that staff were aware of it and took it into account during their interactions with him.

THE INVESTIGATION PROCESS

6. The investigator issued notices informing staff and prisoners at HMP Full Sutton of the investigation and asking anyone who had relevant information to contact her. No one responded.

7. On 9 January, the investigator visited Full Sutton and obtained the man's prison and clinical records. She met the acting Governor, the Deputy Governor and the chair of the Independent Monitoring Board. She visited the healthcare unit and spoke to healthcare staff and to the prisoners who had lived either side of the man, who both said that he kept himself to himself.

8. NHS England appointed a clinical reviewer to review the man's clinical care and treatment at the prison. The clinical reviewer and investigator interviewed a number of staff at Full Sutton jointly.

9. The investigator informed HM Coroner for East Riding of Yorkshire of the investigation and we have sent the Coroner a copy of this report.

10. One of the Ombudsman's family liaison officers attempted to contact the man's family by telephone and letter to explain the investigation and allow them to identify any relevant matters they wanted the investigation to consider. The man's family did not respond.

11. The man's family received a copy of the draft report and indicated that they were satisfied with the findings.

HMP FULL SUTTON

12. HMP Full Sutton is a high security prison near York holding around 600 Category A and B prisoners. NHS East Riding of Yorkshire provides health services at the prison. There is an inpatient unit of six single cells and two safer cells and a crisis suite. There is a full-time GP.

Her Majesty's Inspectorate of Prisons

13. The most recent inspection of Full Sutton was an unannounced full inspection in December 2012. Inspectors were mostly positive about the prison but had some concerns about the operation of the segregation unit. Although they found improvements since the last inspection they were still concerned that there was insufficient focus on improving behaviour and helping men reintegrate into the wings. There was an apparent lack of care for the most marginalised and long term residents there. They found that some prisoners who were on ACCTs (suicide and self-harm prevention procedures) had been held in segregation without the exceptional circumstances required to justify this. There was a very limited regime with little stimulation for those who were held in the segregation unit for long periods and many prisoners complained about the lack of constructive work to keep them occupied. Inspectors were not assured that figures for those who had been segregated for their own protection were accurate. Prisoners did not have the required daily access to showers, exercise and telephones and had to apply in writing each day for these basic requirements.

14. Inspectors found that, although prisoners were generally dissatisfied with their access to and the quality of health services, the range and the quality of services were good. Facilities on the inpatient unit were good, but there was a lack of therapeutic intervention. Prisoners with learning difficulties were supported by a specialist nurse, and the healthcare department had produced staff awareness booklets to help identify learning disabilities. The quality of entries in ACCT documents was found to be generally adequate but some were noted to be too observational and did not reflect the quality of interaction inspectors observed.

Independent Monitoring Board

15. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help ensure that prisoners are treated fairly and decently. In its most recent annual report for the year to the end of October 2013, the IMB was concerned about the number of prisoners who remained segregated for longer than six months and the high prison population was exacerbating the problem. The Board was concerned about the high number of prisoners held in the segregation unit at any one time and the consequential impact on the regime there.

Previous deaths at Full Sutton

16. During 2012 and 2013 there were seven deaths at Full Sutton. Only one of these was self-inflicted and there was no significant similarity with that case and that of this man.

Assessment Care in Custody and Teamwork

17. 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 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.

Prison Rule.45

18. Prison Rule 45 relates to the segregation of prisoners for the good order of the prison or for their own protection. A Rule 45 Board sits at regular intervals to consider evidence to show that the prisoner should remain in the segregation unit or not. The Board decision provides continued authority for segregation for up to a maximum of 14 days. Another review should take place after 14 days.

Asperger syndrome

19. Asperger syndrome is a form of autism, which is a lifelong disability that affects how a person makes sense of the world, processes information and relates to other people. People with Asperger syndrome sometimes find it difficult to express themselves emotionally and socially. They can have difficulty understanding facial expressions and tone of voice and can be very literal in what they say and how they understand what is said to them. Many people with Asperger syndrome have difficulty in initiating and sustaining relationships which can make them very anxious. They can behave in what may seem an inappropriate way. They can find it hard to imagine alternative outcomes to situations and predict what will happen next and can be rigid and repetitive in their activities. They can develop an intense and sometimes obsessive interest in a hobby. People with Asperger syndrome are prone to depression.

KEY EVENTS

20. The man was sentenced to six years imprisonment on 11 August 2009 for a serious assault on a cell mate when he was serving a sentence at HMP Chelmsford. He was released on licence on 13 June 2012, but was recalled to prison on 21 August 2012, for aggressive behaviour at the Approved Premises (probation hostel) where he was living.

21. The man was from the Traveller community. He suffered from diagnosed Asperger syndrome, mild learning disabilities (dyslexia and dyspraxia) and Attention Deficit and Hyperactive Disorder (ADHD). He had a history of substance and alcohol misuse, acute psychotic episodes, depression and a suicide attempt. In 2004, when he was 18, a clinical psychologist diagnosed him as having an IQ of 74 (described as overall borderline ability) and Asperger syndrome, characterised by the following features:

    - Marked rigid behaviours including ritualistic hand washing and bathing (fear of smelling)
    - He only ate a limited range of food which had to be prepared by his mother
    - He wore particular clothes and liked them ironed in a particular way
    - He stared at himself in the mirror for long periods
    - He considered the meaning of anything in a literal sense
    - He liked to go to the gym regularly

22. The man spent time in a number of prisons and had a history of violence against prisoners and staff. He had previously tried to hang himself in prison and had been managed under ACCT procedures a number of times before. The most recent attempt was at Dovegate on 24 April 2013 after he was told he could not have contact with his son and assaulted the officer who informed him. He went to the segregation unit and was later found trying to hang himself from his cell light using a radio lead as a ligature. He told staff that he was in a very low mood because he had been told that he could not have contact with his son and had slapped the face of the officer who had told him this. An ACCT was opened and he was also monitored under anti-social behaviour procedures for three months. He was charged with a disciplinary offence for the alleged assault and remained segregated at Dovegate until he moved to Full Sutton on 17 May.

23. When he arrived at Full Sutton, a registered mental health nurse completed a routine health screen. He recorded that the man had been diagnosed with Asperger syndrome and seemed settled in mood and mental state. He noted that he was on an ACCT and referred him to the mental health in-reach team.

24. The registered mental health nurse assessed that the man was a high risk of harm to himself and should not be allowed to keep supplies of his medication in his cell. He assessed him as a high risk to other prisoners because of his history of violence. He then went to G wing, the induction wing.

25. At 1.45pm, the man attended an ACCT review chaired by a supervising officer (SO) and a wing officer. There was no healthcare representative at the review. He said that he had no thoughts of self-harm and could not

understand why he was on an ACCT. He asked the supervising officer to close the ACCT case manager and give him a fresh start. In contrast to the registered mental health nurse's assessment, the officers assessed the man's risk of suicide and self-harm as low. They noted that the actions in the caremap had been completed and closed the ACCT. A post-closure review was arranged for 24 May.

26. On 24 May, an officer held an ACCT post-closure interview with the man who was living on E wing. He said that his personal issues had been dealt with and that he had settled well at Full Sutton. He said he had applied for several jobs and was waiting for a gym induction. He told the officer that he had good family support and the ACCT remained closed.

27. A learning disability nurse was the man's mental health keyworker at Full Sutton. He first saw him on 2 June and noted that he seemed a little anxious. He said this was because he had not yet had a gym induction. He said that using the gym helped him cope but recognised that his gym induction might have been delayed because he was seen as a high risk to other prisoners and staff. He told the learning disability nurse that he was obsessed with numbers and that he needed routine. He said that he felt he would be able to settle at Full Sutton. The learning disability nurse arranged to see him again on 10 June.

28. On 10 June, the man attended gym and chaplaincy inductions and then saw the learning disability nurse. He told him that he had settled on the wing and had made some friends. He said that he was not sure why he had come to a high security prison, but acknowledged that it might be related to previous assaults on staff. The nurse asked him about a marker on his clinical record indicating that he was a "potential hostage taker" but he said he did not know what this was about. The nurse later found information that suggested that he had previously threatened to take a hostage if he was not allowed to go to the gym often enough. He said that he had applied for work and education and wanted to do an A level in mathematics. The nurse noted that overall he seemed calm and relaxed and his behaviour was appropriate. He arranged to see him again about two months later, unless the man asked to see him earlier.

29. On 17 June, the man told wing staff that he could not be bothered to go to an appointment for a hepatitis B injection. He did not attend an appointment with the learning disability nurse on 1 August but the reason was not recorded.

30. The learning disability nurse saw the man on 9 August, who said that he was finding it difficult to cope on the wing and was still coming to terms with being recalled to prison. He had a parole hearing coming up and was concerned that he would not be released. He said that he had applied to attend more gym sessions as one gym session a week was not enough and was making him anxious. The nurse noted that he seemed calm and relaxed and preferred to speak to staff who were not prison officers.

31. On 13 August, the man attended a disciplinary hearing (known as an adjudication) for the alleged assault on the member of staff at Dovegate. Because of the seriousness of the charge, the manager hearing the case decided to refer the charge to an independent adjudicator, a district judge,

who heard the case on 20 August, and then again on 30 September, when he dismissed the charge because the member of staff from Dovegate did not attend to give evidence.

32. In late August, the prison security department informed E wing staff that the man had written a letter to his family saying that other prisoners had asked him to take a hostage but he did not want to get involved with it. An officer spoke to the man who said that he was referring to an historical incident at another prison when he had taken someone hostage. The wing staff were asked to monitor the people he associated with.

33. On 3 September, the man told a mental health nurse that Muslim prisoners on the wing had pressurised him to take scissors from the workshop where he worked. He had refused to do this and told staff about it and he was now concerned about his safety on E wing. He told the nurse that he wanted to go to the segregation unit for his own protection.

34. The man was moved to the segregation unit that day. A nurse completed a safety algorithm (an assessment tool to decide whether the segregation unit is an appropriately safe location for a prisoner), and assessed that he was fit to remain on the unit until another assessment about the best and safest place for him to live was completed. Prison Service Order 1700 - Segregation, requires a segregation review board to be held after the first 72 hours of a prisoner's segregation and at least every 14 days afterwards to authorise further segregation if necessary and consider what the prisoner needs to do to return to standard prison accommodation. The PSO recognises that a person's mental heath is very likely to decline in segregation and review boards are expected to be alert for such signs. Those segregated for more than 30 days should have care plans that detail how their mental wellbeing is to be supported.

35. A segregation review board comprising of a prison manager, a member of the Independent Monitoring Board, a registered mental nurse and a supervising officer met on 4 September, to review the man's admission to the segregation unit. Because he was in the segregation unit for his own safety, he was allowed to have a television in his cell.

36. On 5 September, the man asked to see someone from the mental health in-reach team. A registered mental health nurse saw him and he told her he had a number of concerns and worries about the segregation unit. He said that:

- He was not sure about how to access things from the staff.
- He was worried about his family as he had not been able to telephone them since he came into the segregation unit and he normally called them every other day.
- His aunt had died the weekend previously and he wanted to contact his family.

The man asked to see someone from the in-reach team again after the weekend and for help at the next Rule 45 Board meeting. The registered mental health nurse spoke to the segregation staff who agreed to remind the man of things he needed to apply for every morning and help him to use the telephone. (Prisoners in the segregation unit at Full Sutton have to make

written daily applications to access basic regime entitlements such as exercise.)

37. On 10 September, the assessment of the best place for the man was completed. It was decided that he was not at specific risk from other prisoners and did not therefore need to remain in the segregation unit and could move to a normal wing.

38. On 11 September, a prison GP examined the man about an ongoing groin problem. He told the doctor that he had blood in his faeces, loose bowels, haemorrhoids, a sore throat and felt generally run down. He said that his diet was not good because he could not cook himself healthy food in the segregation unit. He wanted to go to the gym but was unable to do so from the segregation unit. The GP prescribed the man lansoprazole, a medication for gastric problems.

39. Later that day, another segregation review board was held. The board considered that the man was suitable to live on a standard residential wing, but not a vulnerable prisoners' wing because of his propensity to violence and his views on prisoners who had committed sexual offences. The man refused to move from the segregation unit.

40. The man remained in the segregation unit and continued to say that he would not move to a normal wing. At a segregation review board meeting on 26 September, he asked if he could be transferred to another prison because he had not settled at Full Sutton. He said that he found it difficult to cope with the restricted regime in the segregation unit and the lack of access to the gym but would ask for support if he needed it. The board authorised his continued segregation the population management team agreed to try to arrange a transfer but they said that the man's history of violence in prison would make this difficult.

41. On 3 October, the man told a prison doctor that he had been suffering from blackouts. The doctor thought that he looked well and asked staff to note any blackouts. There is no further mention of this issue in his clinical record.

42. At a segregation review board on 9 October, the man was tearful and said he was struggling to cope in the segregation unit. He said he had stopped going outside for exercise but did not have any thoughts of harming himself. The review board considered that he would benefit from a period of respite in the healthcare unit but he refused to go. Later that day, the learning disability nurse tried to speak to him in his cell, but he would not engage with him and said that he would start acting as he had done previously. He would not say what he meant by this. The nurse noted that he did not appear to be upset or distressed. The next day, 10 October, the nurse went to see the man again. He said that he was all right but refused to engage further. He did not raise any issues with segregation staff between 11 and 14 October.

43. A registered mental health nurse saw the man in the segregation unit on 15 October. He told her that he was still finding the environment and regime difficult and was anxious because of the uncertainty about his future. He was reluctant to go to the healthcare unit because he wanted to move from Full Sutton and have a fresh start. He said he now believed that other prisoners

had taken out a contract on him and he was suffering from increased stress and hallucinations. He said he had been hearing voices when the wind blew, which was happening because he was in segregation. The nurse asked the doctor to review him when he was on his segregation unit rounds. The doctor saw the man the next day but, other than a fungal nail infection, he did not note anything unusual.

44. A learning disability nurse carried out a mental well being check with the man on 21 November. He completed a careplan with objectives for him to 1) remain safe and stable while at Full Sutton, and 2) to liaise with the Probation Service regarding his resettlement on his pending release date (2 April 2015). The next mental well being appointment was set for 27 April 2014. There was nothing specific about helping him safeguard his mental health while in segregation.

45. At a segregation review board meeting on 4 December, the segregation unit manager said he would try and arrange to transfer the man to HMP Garth before Christmas. He continued to be authorised for segregation.

46. At a segregation review board on 18 December, the man said that he was still not settled and appeared tearful and subdued. He refused to go to a standard wing as he still believed that he was under threat. The segregation unit manager, who chaired the meeting, said that Garth had refused to take him and the board suggested that he should go to the healthcare unit for a period of crisis intervention. The segregation unit manager said that he could have his television there, which he did, and also he said that he should not be subject to a restrictive segregation unit regime. He enquired whether the man could attend the gym. Although he was not segregated because of any poor behaviour at Full Sutton, and had used the gym before he was segregated, the segregation unit manager had been told that he was not allowed to use the main gym because of his risk of violence to other prisoners.

47. The man moved to the healthcare inpatient unit later on 18 December. On 19 December, the healthcare manager explained the rules and expectations of him while he was in the healthcare unit to him. He suggested that it would be helpful for him if he associated with other prisoners instead of staying in his cell. He said that he did not want to mix with others because he did not know how he would respond to them and he could not assure the healthcare manager that he could comply with the healthcare unit rules. Because of the man's previous violent history, the healthcare manager assessed that he was a high risk of harm to other prisoners and that he would have to remain locked in his cell. Effectively this meant that he continued to be segregated.

48. On 21 December, the man told a registered mental health nurse that he could not cope being segregated as he was used to being busy and did not feel able to live in the segregation unit for long periods. He said that he would not harm himself but he was worried that if he returned to the segregation unit and had to stay there for months he would kill himself because he could not see any other way out. The nurse noted that he was tearful and told her that his mood was low. He had said that he was worried about interacting with other prisoners because he did not know how he would respond to them. The nurse encouraged him to talk to the staff in the healthcare unit if he felt low or if he felt like he would harm himself.

49. The registered mental health nurse spoke to the man again the next day, 22 December. He told her that he was feeling better than the day before and had spoken to his mother. He also talked about his relationship with his son. However, he said that if he was not transferred out of Full Sutton soon he would either kill himself or would go back to the wing and assault other prisoners. The nurse completed a security information report (SIR) about the man's comments and passed it to the security department. The population unit were still trying to find another prison which would take him.

50. The registered mental health nurse told that investigator that although the man had talked about killing himself, she did not consider he had any plans to do so and he had talked a lot about protective factors such as his son and the rest of his family and his release. She believed that as he was now out of the segregation unit and in a quieter, more relaxed environment, his risk was reduced. She said that she would have opened an ACCT immediately if she had believed he had intended to harm himself.

51. On 23 December, the man was tearful and asked a learning disabilities nurse what was going to happen to him. He said that he did not know how he felt and found it difficult to express himself. He told the nurse that he was hearing voices, like those he heard on the radio, which told him to assault staff. He mentioned prisoners on the wings who he believed had a contract out on him, and said that he could not trust anyone. He said that he could not make friends because he had Asperger syndrome. He explained that because he was constantly suspicious of other prisoners and staff he felt it necessary to carry a weapon and to attack first in case he was assaulted. The nurse agreed with him that he would stay in the healthcare unit and they would review how he felt the next day.

52. Later that afternoon, a doctor saw the man who was still tearful, and told the doctor that he did not feel safe on the wings. The doctor noted that being in the segregation unit had been detrimental to the man's mental health as, while he was there, he had been able to dwell on his problems because he did not have enough occupation to distract him. He said that he was not sleeping well and the doctor prescribed him zopiclone, a sleeping tablet.

53. On the afternoon of 24 December, Christmas Eve, the man told a learning disabilities nurse that the only thing that he could think about was whether to be buried or cremated. The nurse said that he did not have any plan to harm himself but was talking about death in more general terms. The nurse encouraged him to leave his cell and take a shower. However, he was concerned about his state of mind and opened an ACCT at 3.30pm.

54. A supervising officer completed an immediate action plan at 3.45pm with the following actions:

- For him to stay in a normal cell in the healthcare unit
- 3 observations and interactions an hour
- For him to be seen by a member of the mental health in-reach team daily
- For him to have telephone access
- For him to use supports such as Listeners. (Listeners are prisoners who trained by the Samaritans to support other prisoners in crisis.)

55. At 4.20pm, an officer completed an ACCT assessment. The man said that he felt he had had enough punishment in the segregation unit. At first he said that he did not have any thoughts of harming himself but wanted to be dead because he felt like a wreck. The officer noted in the ACCT document that the man looked low, spoke quietly, gave her little eye contact and was tearful. He later said that he was thinking of killing himself by hanging. Staff later removed his shoelaces and belt from him, to reduce the risk of him using them as a ligature. There is nothing in the records to indicate that the possibility of moving him to a safer cell, with fewer ligature points, was considered. He said that he had not had any family visits for 16 months and did not know how he was going to finish his sentence. He wanted to know if he would get a transfer and if this was being looked into.

56. The supervising officer held the first ACCT case review the next day, Christmas Day, which an officer and a registered mental health nurse attended. The man cooperated but was noted to be up and down about how he was feeling. He said he was still feeling suicidal and was hearing voices. However, he was also thinking about his future. A major concern for him was what would happen to him in the long term and where he might move. He was encouraged to talk to staff if he felt low. His observations remained at three each hour and his risk of self-harm was assessed as high. A caremap was completed with actions:

- The man to continue to engage with the mental health team
- The man to maintain contact with family by telephone. (He was given access to the telephone to call his family.)
- Staff to seek clarification about his future location. (The population manager was tasked with trying to arrange another transfer.)
- The man to see a specialist forensic doctor about his mental health needs. (An appointment was made for him to see a psychiatrist with a special interest in treating people with autism and learning disabilities for 6 January 2014.)

57. On Boxing Day, the ACCT records that the man said that he felt better. He had showered and shaved, but spent the morning sleeping, which he said was much improved. He watched television in his cell and said that he felt better since he had been in the healthcare unit but was worried that he might have to take zopliclone long term to sleep.

58. A doctor went to see the man on 27 December, because he was extremely upset. She said that he was crying uncontrollably and looked frightened; the tears were dripping down his face and clothes. He told her that he was hearing voices telling him to kill himself and to make a weapon to harm the prison staff. He said that he did not want to harm anyone but was very anxious in case the “voices won”. The doctor diagnosed a prolonged panic attack and a depressive disorder. The man refused to take anti-depressants but agreed to take propranolol to take the edge off his anxiety. The doctor told healthcare staff that if the man’s distress failed to settle substantially over the next day the on-call doctor should consider prescribing a short term low dosage of diazepam or olanzapine (both anti-anxiety medications). The doctor spoke to the on-call psychiatrist on the telephone, who agreed with her plan of treatment. She also ensured that an appointment had been made for

the man to see the specialist psychiatrist. The doctor did not make an entry in the ACCT record about the man's distress and there was no review of his level of risk.

59. On 28 December, the man told a learning disabilities nurse that he was feeling better, had showered and eaten a full meal and the unit staff had washed his clothes. He was still worried about getting a transfer but now wanted to go to Belmarsh so he could see his mother and his son as he had not had a visit for approximately 16 months. He still desperately wanted to go to the gym but was not allowed to because of his perceived risk to other prisoners.

60. On 29 December, the learning disabilities nurse noted that the man was visibly brighter. He had been doing some training in his cell and said he had no current thoughts of self-harm. He had asked if he could have his shoe laces back. The nurse said that they could discuss this at the ACCT review which was due the next day.

61. At the ACCT review on 30 December, a supervising officer, a nurse (from the mental health team) and a further registered mental health nurse (who contributed by telephone) agreed that the man's risk remained the same. Staff reviewed the ACCT caremap and kept the same objectives. The level of observations remained at three each hour. He engaged well and talked in depth about his issues. He said that he was eating and sleeping better in the healthcare unit. He talked about his future plans to live with his sister when he was released and said that he had work arranged in his cousin's gym. According to the records, he said that he was getting the best treatment that he had ever had. His clinical careplan was for him to remain in the healthcare unit for assessment and stabilisation in the short term and to determine what the plans were for transfer in the longer term. The review decided not to return the man's shoe laces and belt as he was still regarded as a high risk. He was also not allowed razors and had to be supervised when he shaved.

62. At around 8.25am on a day in January 2014, the man pressed his cell bell and an officer, who was at the unit morning meeting at the time, responded. The man asked if he could wash his clothes and the officer said he would arrange this after the meeting. At around 8.40am, two officers unlocked him so that he could take his washing to the laundry. They suggested he had also had a shower while he was out which he did. When he had finished his shower they passed the medication room and a nurse took the opportunity to give him his medication. She said that she had little communication and no eye contact with him.

63. The man put his dirty washing into the laundry room and then the officers took him back to his cell. On the way back, he asked one of the officers if he could help him with his canteen (prison shop) order which he had put it in the day before, but it had got lost. The officer said he would sort it out for him. About 20 minutes later, while the officer was taking another prisoner outside for a cigarette, he said he passed the man's cell and told him that his canteen was sorted and would be coming later that day. The man thanked him. Neither officer thought that there was anything unusual about him that morning. They both said he was usually quiet and polite but that he generally only gave them

one word answers and had little eye contact. When interviewed, both officers said they had not known at the time that the man had Asperger syndrome.

64. The healthcare manager saw the man around 9.45am. He noted that he had had a shower, had telephoned his mother and was getting his clothes washed. He wrote that the man "seemed as normal". An officer told the investigator that he also checked the man about this time. He said that he had his feet up, was watching television and seemed fine. A further officer told the investigator that he checked the man at 10.00am as he was walking to the staff room. He looked through the observation panel and saw him on the bed, looking at the floor. The officer said that the television was not on.

65. At approximately 10.25am, an officer went to make a cup of coffee. While returning to the staff room, he checked the man in his cell. When he opened the observation hatch he saw that he had upended his bed and had attached a ligature, made of a bed sheet, round his neck and had upended his bed and attached it to the top of the bed. The officer shouted to his colleague, and they immediately went into the cell. One officer held the man up while the other used his anti-ligature knife to cut the bed sheet. They shouted for a nurse, who was close by. An officer was outside the cell and radioed a code blue emergency. (A code blue emergency call is made when someone is in a life threatening situation and is unconscious or not breathing.) This was recorded at 10.35am and an ambulance was called at the same time.

66. The nurse checked the man for a pulse and started cardio- pulmonary resuscitation (CPR). A further nurse joined her and took over CPR while the first nurse to arrive on scene tried to obtain an airway. She did not immediately administer rescue breaths, because she had no protective airway at that point. A further nurse arrived with the resuscitation bag and shouted for someone to call a doctor and an ambulance again. A further nurse and the healthcare manager also arrived. They inserted an airway and fixed an ambu bag and attached a defibrillator to the man. (A defibrillator is life-saving device that gives the heart an electric shock in some cases of cardiac arrest.)

67. The defibrillator detected no shockable heart rhythm and the nurse continued CPR, for approximately 25 minutes and assessed him again. The man still had no carotid (neck) or femoral (groin) pulse, his eyes were fixed and dilated and there were no sounds from his heart. The nurses all agreed that they should stop CPR as it was futile and disrespectful to continue. Paramedics arrived at the prison at 10.58am, examined the man and, at 11.14am, pronounced him dead.

68. Staff informed the other prisoners in the healthcare unit that the man had died and offered them support. At 12.00pm, the staff who had responded to the emergency attended a hot debrief to discuss the handling of the emergency and to support those involved. Two officers were distressed about the man's death and went home after debrief. The prison's care team offered support to those who wanted it.

69. A family liaison officer arrived at the prison around 10.30am, and was immediately informed of the man's death. He then made enquiries about his next of kin's address and completed a risk assessment. Essex Police advised that he should inform the man's family by telephone.

70. At 1.53pm, the family liaison officer telephoned the man's mother to let her know her son had died. She was very distressed and put the telephone down. He tried to contact her again but there was no reply. At 1.57pm, the man's brother answered the telephone. The officer spoke to him about what had happened and explained his brother had died. The officer continued to liaise with the man's family and the prison contributed to the costs of the funeral in line with national guidance. On 14 January, the man's family visited the prison to see where he had lived.

ISSUES

Clinical Care

71. The man was referred to the mental health team when he arrived at Full Sutton and a learning disability nurse was allocated as his keyworker. The keyworker regularly reviewed the man when he was on the wing, in the segregation unit and when he moved to the healthcare unit.

72. After the man moved to the healthcare unit on 18 December it was recognised that his mental health had deteriorated, and an appointment was arranged with a Forensic Psychiatrist for 6 January. Sadly, the man died before he saw the psychiatrist. The clinical reviewer concluded the man received the same level of clinical care as he would have in the community.

73. The officers in the healthcare unit we interviewed were not aware that the man had Asperger syndrome. They were aware that he was a quiet prisoner who did not make eye contact and accepted this as being his personality. There were a number of particular autistic characteristics and behaviours associated with his Asperger syndrome which we believe that staff should have known about. This would have increased their level of understanding about him, helped them to manage him and could potentially have reduced the risk to himself or others. The clinical reviewer recommends that healthcare staff should be aware of the challenges associated with Asperger syndrome. We are aware that some proactive work has been done on this issue, and a staff information booklet produced. However, officers working with men with Asperger syndrome need to be briefed about the individual so that they can use the information practically. We make the following recommendation:

    The Governor and Head of Healthcare should ensure that staff working with prisoners with Asperger syndrome and other autistic spectrum disorders are briefed about the individuals and the implications for their management.

Assessment of risk of suicide and self-harm

74. When the man arrived at Full Sutton, he was being managed under ACCT procedures after attempting to hang himself at Dovegate. Staff carried out a review on the day he arrived at Full Sutton, and decided to close the ACCT. There were no members of the healthcare team available.

75. Although the man did not take his own life for some time after the ACCT was closed, we believe that this decision was premature. He had recently tried to hang himself and the officers who took the decision knew very little about him or the impact of his Asperger syndrome on his risk. Because of his Asperger syndrome, he needed routine, but, by moving prison, his routine would necessarily have been different and the ACCT review team did not take account of this. There was no healthcare representation at the review to advise about his care.

76. Prison Service Instruction (PSI) 64/2011 gives a mandatory instruction that ACCT documents should not be closed within 72 hours of a planned transfer.

While this is aimed primarily at the transferring prison – to make sure that ACCTs are not closed to facilitate a transfer – it makes sense for receiving prisons too. We consider that it is risky for an ACCT to be closed very quickly after a new prisoner arrives. Transfers are a change in circumstances at a time when the prisoner is at elevated risk of suicide or self-harm. We make the following recommendation:

The Governor should ensure that when a prisoner on an ACCT arrives at Full Sutton, the ACCT is not closed until the prisoner has had time to settle and there is clear indication at a multidisciplinary review that he is no longer at risk of suicide and self-harm.

77. An ACCT was opened at Full Sutton on 24 December, after the man had been in the healthcare unit for six days and staff became concerned about his state of mind. He was assessed as a high risk to himself and was subject to three observations each hour. A caremap was completed with four actions, all of which were ongoing at the time of his death. He was reviewed appropriately on two occasions. The same case manager and a member of the mental health team were present at these reviews. He remained assessed as at high risk of suicide and self-harm, with the same level of observations until his death. Although the reviews decided to remove some items such as his shoe laces and his belt he remained in a standard cell with many other items he could use as a ligature. There was no consideration at the reviews about whether he should have been moved to a safer cell.

78. We were very concerned that on the morning of the man's death that there were no written observations in the ACCT document after a member of night staff had made an entry at 7.10am. When we interviewed staff, they told us that they did not record each observation in the ongoing record, but made a summary of what had happened at each session, so that in a day there would be only three full entries. This is at odds with the guidance for recording observations in the ACCT document. This requires staff to follow the level of observations and conversations and record these immediately or as soon as practicable thereafter. As the staff did not make entries in the ACCT document close to the time they say they made the observations, it is not possible to be assured that the required level of observations were carried out. We make the following recommendation:

The Governor and Head of Healthcare should ensure that staff should record ACCT observations immediately or as soon as possible after they are made.

Location

79. The man moved to the segregation unit at his own request, and for his own safety, on 3 September. He remained there until 18 December although he had been assessed as suitable to live on a standard residential wing. When he moved to the healthcare centre on 18 December his living conditions still amounted to segregation. On a number of occasions he presented as tearful and distressed and told staff he was finding it hard to cope, particularly as he did not have access to the gym, which was a positive coping mechanism for him.

80. The man refused to go back to a standard wing as he strongly believed that he would be at risk. During his time in the segregation unit staff and mental health nurses saw him daily and his continuing stay there was reviewed every two weeks. It is apparent from the records that the man's mental health deteriorated while he was in the segregation unit. However, healthcare staff assessed him as fit and managers continued to authorise his continuing segregation. PSO 1700 requires that 'those segregated for more than 30 days should be subject to care plans that detail how their mental well being is to be supported'. Although it was recognised that the man's mental health was deteriorating, there was little evidence of a structured plan to help combat the effects of his segregation. When he moved to the healthcare unit he continued to be held in conditions tantamount to segregation. One attempt was made to move him to another prison but that was unsuccessful.

81. The PSO states that where a prisoner is segregated for his/her own protection the regime in the segregation unit "should be as full as possible and as close to the regime offered on normal location. Giving vulnerable prisoners something to occupy their time is likely to be a crucial part of safeguarding the welfare of those in segregation". There does not appear to have been any staged plan to reintegrate him gradually back to a wing and he had no occupation during his time there, although he clearly found it very difficult to cope with the restrictive environment. It is not apparent that his Asperger syndrome was taken into account.

82. The man particularly liked using the gym. This was a positive coping mechanism for him. However, while he was living in the segregation unit he was not allowed to use the main gym, although he appears to have used the gym without any problem since June to September. Segregation unit staff told the investigator that there was cardio vascular equipment in the segregation unit but could not confirm that he had access to it and there is no evidence he did.

83. The IMB and HM Inspectorate of Prisons both commented on the high numbers of prisoners held in the segregation unit and the limited regime, with little stimulation, offered to prisoners there. Inspectors found that prisoners in the segregation unit for their own protection were not identified separately from those who were there for punishment. We consider that holding a prisoner with known mental health issues in the segregation unit with such a restricted regime for over three months was excessive, even when the man had turned down alternative locations. More effort should have been made to move him from the segregation unit, by gradual reintegration if necessary. Efforts should have been made to give him a more active regime to help prevent the deterioration in his mental health. We make the following recommendation:

The Governor should ensure that prisoners held in the segregation unit have as full a regime as possible, that active efforts are made to reintegrate them to standard prison accommodation and that there are effective care plans to help prevent deterioration in mental health for those who stay longer.

Emergency response

84. When an officer saw the man hanging in his cell, he shouted for another member of staff and they entered the cell immediately. As they were in the healthcare unit, nurses were close by and began cardiopulmonary resuscitation (CPR) almost immediately. An officer radioed a code blue emergency which prompted an ambulance to be called automatically. Emergency equipment was brought to the scene quickly. CPR continued for 25 minutes until nurses decided to stop because he had not responded and it was evident that continuing would be futile. This was an appropriate decision and in line with resuscitation guidelines. The emergency response, although ultimately unsuccessful, was swift and professional.

RECOMMENDATIONS

1. The Governor and Head of Healthcare should ensure that staff working with prisoners with Asperger syndrome and other autistic spectrum disorders are briefed about the individuals and the implications for their management.

2. The Governor should ensure that when a prisoner on an ACCT arrives at Full Sutton, the ACCT is not closed until the prisoner has had time to settle and there is clear indication at a multidisciplinary review that he is no longer at risk of suicide and self-harm.

3. The Governor and Head of Healthcare should ensure that staff should record ACCT observations immediately or as soon as possible after they are made.

4. The Governor should ensure that prisoners held in the segregation unit have as full a regime as possible, that active efforts are made to reintegrate them to standard prison accommodation and that there are effective care plans to help prevent deterioration in mental health for those who stay longer.

Action Plan [man's name] HMP Full Sutton 13/01/14					
No	**Recommendation**	**Accepted/Not Accepted**	**Response**	**Target date for completion and function responsible**	**Progress (to be updated after 6 months)**
1	The Governor and Head of Healthcare should ensure that staff working with prisoners with Asperger syndrome and other autistic spectrum disorders are briefed about the individuals and the implications for their management.	Accepted	Subject to the prisoners consent, staff will work within the guidelines of medical in confidence to have relevant information when a prisoner becomes subject to ACCT procedures. Healthcare staff will attend ACCT reviews and contribute towards the caremap based on the consented information. In cases where attendance is not possible, they will be asked to provide a written contribution.	complete	
2	The Governor should ensure that when a prisoner on an ACCT arrives at Full Sutton, the ACCT is not closed until the prisoner has had time to settle and there is clear indication at a multidisciplinary review that he is no longer at risk of suicide and self-harm.	Accepted	The receiving manager of any new prisoner on an open ACCT will be responsible for ensuring a multi disciplinary review is held within forty eight hours of reception. The ACCT will only be closed once all the CAREMAP actions have been completed and the Case Review Team judges that the risk posed by the prisoner has reduced	complete	
3	The Governor and Head of Healthcare should ensure that staff should record ACCT observations immediately or as soon as possible after they are made	Accepted	The current process of management and checks of the ACCT documents are to be continued but with the caveat that where the frequency of checks require a specified number that there is an entry at handover/ takeover by staff that this has been done in accordance with the agreed frequency unless a significant event occurs and this must be recorded at the time or the earliest opportunity as opposed to handover of the ACCT.	complete	

Action Plan [man's name] HMP Full Sutton 13/01/14					
No	**Recommendation**	**Accepted/Not Accepted**	**Response**	**Target date for completion and function responsible**	**Progress (to be updated after 6 months)**
			Information was disseminated to Residential managers in relation to the first iteration of this action plan. This is now formalised in the publication of Staff information Notice Governor's order 003/2014 which requires staff to attend to the levels of observation as indicated on the front of the ACCT. Management checks will be conducted daily by the Orderly officer and or the Duty Governor to ensure the appropriate levels of observations are being recorded		
4	The Governor should ensure that prisoners held in the segregation unit have as full a regime as possible, that active efforts are made to reintegrate them to standard prison accommodation and that there are effective care plans to help prevent deterioration in mental health for those who stay longer	Accepted	Improvements to the Segregation regime are a continuous process with the well being of prisoners in mind. The review of the fortnightly GOoD process has already changed to ensure that more meaningful time is devoted to managing longer term and more complex cases, with a case management approach relevant to the individuals' circumstances overseen by a multi disciplinary team. The reintegration of prisoners to standard prisoner accommodation location is overseen by the Segregation unit Manager, with	complete	

Action Plan [man's name] HMP Full Sutton 13/01/14					
No	**Recommendation**	**Accepted/Not Accepted**	**Response**	**Target date for completion and function responsible**	**Progress (to be updated after 6 months)**
			consideration given to a phased return to standard prisoner accommodation for prisoners who have spent a long period in segregation. The Segregation unit manager coordinates the risk assessment process necessary to measure risk of harm to anyone including the prisoner who is segregated.		