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 in December 2014 while a prisoner at HMP Long Lartin

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 hanged in his cell at HMP Long Lartin in December 2014. He was 56 years old. I offer my condolences to his family and friends.

NHS England reviewed the man's clinical care in prison. The prison cooperated fully with the investigation.

The man had a long history of mental health problems and had been in prisons or mental health units almost constantly since 1982. In August 2014, the man refused to leave the segregation unit at HMP Frankland until he was transferred to another prison. He was still in the segregation unit in November, when he cut his arm and was monitored under Prison Service suicide and self-harm prevention procedures. A move to Long Lartin was agreed and the man left Frankland on 1 December and stayed overnight at HMP Leeds on the way. In the early morning, he was found with a noose around his neck and said he had wanted to kill himself. On 3 December, the day after he arrived at Long Lartin, staff moved him to the prison's healthcare unit, as they were concerned about his mental health. Staff continued to monitor the man as at risk of suicide and self-harm, but regarded him as at low risk. On an afternoon in late December, an officer found the man had hanged himself in his cell. Prison staff and paramedics attempted to resuscitate him and established a pulse. On the way to the hospital, the man suffered a cardiac arrest and died.

The man's history would indicate that there was always an underlying risk of suicide. Although he was being monitored as at risk at the time of his death, I am satisfied that there was little to indicate that he was at heightened or imminent risk of suicide or that staff at Long Lartin could have anticipated his actions. However, the investigation identified a number of areas for improvement, including the management of suicide and self-harm procedures, the importance of communicating risks between prisons on transfer and the need to take into account the effects of segregation for vulnerable prisoners at risk of suicide and self-harm. I am also concerned that, as I have previously found at Long Lartin, staff did not call an ambulance as soon as a medical emergency was called.

Nigel Newcomen CBE
Prisons and Probation Ombudsman **August 2015**

CONTENTS

Summary

The investigation process

HMP Long Lartin

Key events

Issues

SUMMARY

1. The man had spent most of his adult life either in prison or detained in mental health units. He had been convicted of two offences of rape in 1982 and in 1986. In 1994, he was convicted of the attempted murder of a psychologist in a medium secure unit.

2. In August 2014, the man refused to leave the segregation unit at HMP Frankland until he was transferred to another prison. On 1 November, he cut his arm and staff began monitoring him under Prison Service suicide and self-harm prevention procedures, known as ACCT. He remained segregated at Frankland until 1 December, when he transferred to Long Lartin. He stayed at HMP Leeds for one night on the way, but Frankland had not informed Leeds of his risk in advance. In the early morning of 2 December, he was found with a noose around his neck and said he had intended to kill himself.

3. The man arrived at Long Lartin on the afternoon of 2 December, but Leeds did not alert Long Lartin to his suicide attempt. Staff read about it in the ACCT document. The next day they moved him to the prison's healthcare unit where he was constantly supervised. Over the next days, staff reduced his level of observations until 7 December, when he was observed once an hour.

4. Over the next weeks, staff said that the man often appeared agitated and it was sometimes difficult to follow what he was saying. At other times, he was more lucid. A psychiatrist reviewed the man three times at Long Lartin, the last time on 23 December. He did not think that the man was at imminent risk of suicide but thought he was suffering from a manic episode and was considering referring him to a mental health unit if he did not settle.

5. The man was frustrated that smoking in the healthcare unit was prohibited, and, at 12.50pm on 28 December, he flooded his cell when he was told that he would have to wait for officers to return from lunch before he could have a cigarette. (Although an officer had earlier allowed him to have some cigarettes in his cell.) At about 2.20pm, an officer found the man hanged by a twisted bed sheet tied to the window frame. The officer radioed an emergency code and called for help. The control room did not call an ambulance until a manager asked for one, three minutes later. Nurses began cardiopulmonary resuscitation. Paramedics arrived and took over emergency treatment. Paramedics detected a pulse and decided to take the man to hospital. On the way, the man had a cardiac arrest and died.

6. Although the man had been identified as at risk of suicide and self-harm, we consider that staff at Long Lartin could not reasonably have predicted or prevented his actions. However, we are concerned about the length of time the man was segregated at Frankland, including when he was assessed as at risk of suicide or self-harm, without evidence that other locations had been considered. Communication about the man's risk was poor when he transferred between prisons and case reviews at Frankland and Long Lartin were not consistently chaired. We repeat concerns about the need to call an ambulance immediately in a medical emergency.

THE INVESTIGATION PROCESS

7. We issued notices to staff and prisoners at HMP Long Lartin, informing them of the investigation and inviting them to contact the investigator if they had relevant information. No one responded.

8. On 7 January 2014, the investigator visited Long Lartin and obtained copies of the man's prison and healthcare records. He later interviewed 12 members of staff and two prisoners.

9. The man informed HM Coroner for Worcester of the investigation and we have sent him a copy of this report.

10. NHS England reviewed the man's clinical care at Long Lartin.

11. One of the Ombudsman's family liaison officers contacted the man's mother to inform her of the investigation and to ask if she had any issues that she wanted the investigation to consider. She had no specific issues for the investigation to take into account. She received a copy of the draft report but did not raise any further issues or comments on the factual accuracy of this report.

HMP LONG LARTIN

12. HMP Long Lartin is a high security prison. It has eight main wings and holds up to 622 category A and B adult men serving at least four years imprisonment.

HM Inspectorate of Prisons

13. The last inspection of Long Lartin was in October 2014. Inspectors found that the inpatient unit housed some of the most vulnerable and isolated men in the prison, but the support was inadequate and lacked direction with no permanent clinical input. There was no therapeutic regime and prisoners were routinely locked in their cells for most of the day. The number of self-harm incidents at the prison was comparatively low and management checks of ACCT documents had improved standards in some areas of care planning, but not all demonstrated consistently good standards. Inspectors were concerned about the quality of care for prisoners on ACCTs in the inpatient unit, which they said was particularly poor. Inspectors considered that the lack of regime contributed to feelings of isolation and alienation which might have led to further self-harming behaviour.

Independent Monitoring Board

14. Each prison has an Independent Monitoring Board of unpaid volunteers from the local community who help ensure that prisoners are treated fairly and decently. In their 2014/15 annual report, the IMB described the regime for prisoners in the healthcare unit as restricted but moderately decent. They were concerned that not all prisoners in the healthcare unit were there for healthcare reasons.

Previous deaths at Long Lartin

15. The man's death was the third self-inflicted death at Long Lartin since July 2007. In the investigation into a death in July 2013, we found there was a delay in an ambulance being called and made a recommendation about this. We made a further recommendation about this after a further self-inflicted death at Long Lartin in January 2015,

Assessment, care in custody and teamwork (ACCT) procedures

16. Assessment, Care in Custody and Teamwork (ACCT) is the care planning system the Prison Service uses to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk posed, the steps that might be taken to reduce this and the extent to which staff need to monitor and supervise the prisoner. Levels of supervision and interactions are set according to the perceived risk of harm. There should be regular multi-disciplinary review meetings involving the prisoner. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

KEY EVENTS

17. The man was born in 1958. He was admitted to a psychiatric unit for four weeks in 1973 and over the next two years had four further psychiatric admissions. In 1975, the man went to prison for criminal damage and arson.

18. In 1982, the man was convicted of rape. He was released on licence in 1986 but within a few months, he was rearrested for another rape. His final conviction was for the attempted murder of a female psychologist at a secure mental health unit in 1994. He was sentenced to life imprisonment with a minimum period to serve of 12 years before he could be considered for release. The man continued to be regarded as a risk to the public and was never judged suitable for release. He spent the remainder of his life in prison, with some periods in mental health units.

19. In late 1989, the man was diagnosed with schizophrenia while at Ashworth High Security Hospital, but other psychiatrists later questioned this diagnosis. They considered that he had a number of personality disorders, including anti-social, paranoid and avoidant personality disorders with traits of schizoid and borderline personality disorders.

20. At a sentence-planning meeting at HMP Whitemoor on 10 January 2013, the man said that he felt he was too high a risk to society to be released at that time. He thought he would be of retirement age before he would be ready for release. In July 2013, he told a mental health nurse that he had thought about killing himself for some time. He said he would not take his life while his mother was alive but after that, it would be the right time. He said he had let many people down, felt tired and had “had enough”.

21. On 25 September 2013, the man transferred to HMP Frankland. On 30 July, his offender supervisor noted that the man felt aggrieved at being in Frankland, as he thought that the prison was not helping him with his sentence progression. The offender supervisor also noted that the man refused to do any offending behaviour programmes at Frankland.

22. On 2 August, the man was taken to the segregation unit for a disciplinary hearing, after he refused to go to work. Once there, he said he would not leave the segregation unit until he was transferred to another prison. He remained in the segregation unit and in early September, he asked a custodial manager (CM) what was happening about his transfer. The CM told him that the Frankland’s population management unit (PMU) was trying to identify a suitable prison. The CM told the investigator that the man wanted to move to a lower security prison but he needed to remain in a high security prison.

23. The man continued to refuse all sentence-planning options offered to him. The CM said that that the man seemed to have a mix of mental health and behavioural problems. Sometimes he would talk rapidly and jump from one thought to another. At other times, he threatened other prisoners and occasionally spat at staff. He sometimes claimed other prisoners were shouting out of their windows to him, but he accepted that he was paranoid and that the shouts were not directed at him. The CM said that the man had outbursts of poor behaviour, but

then would calm down and apologise. The CM knew that the man had harmed himself in the past, but did not think he was at risk of suicide at the time. Prison staff held segregation review boards every two weeks to consider whether the man should remain segregated. Each time, they agreed that the man should remain in the segregation unit because he had threatened to kill other prisoners if he was sent back to a residential wing. They noted that the man wanted a transfer, but understood that it would be some time before this happened.

24. On 1 November, the man cut his arm and told an officer that voices had told him to do this. He refused to allow a nurse to examine the injury. The officer began ACCT procedures and staff were required to check the man twice an hour. Healthcare staff agreed to admit the man to the healthcare unit as an inpatient. On 3 November, a nurse recorded that the man had refused all nursing interventions in the healthcare unit.

25. On 4 November, another nurse completed a segregation algorithm. He noted that the man was on an ACCT and had self-harmed. The nurse assessed the man as fit to return to the segregation unit. The nurse tried to assess the man's mental health in his cell, but the man was dismissive. The nurse considered that the man was calm and there was no reason not to segregate him.

26. Frankland's Head of Segregation, recorded that the segregation unit was a suitable location for the man and recorded in his daily segregation record that she would pursue a suitable transfer. She did not give any exceptional reasons for holding a prisoner on an ACCT in the segregation unit or indicate what other options she had considered. At the segregation review board that day, an operational manager noted that the man was reassured that the Head of Segregation would be talking to other prisons later that month about a possible transfer. The review did not explicitly consider whether the segregation unit was a suitable location for a prisoner on an ACCT.

27. At first, the man would not engage in the ACCT process but, on 6 November, he agreed to attend an ACCT case review. He said he did not feel safe at Frankland, did not trust staff and was waiting for a transfer to another prison. The man's caremap had four actions, one of which was his request to transfer. The review assessed the man as being at raised risk of suicide and self-harm (from three options of low, raised or high). His observations remained at two an hour.

28. At the next ACCT review on 10 November, the panel noted that the man was much better. He said that he had no further thoughts of suicide or self-harm. The panel chair assessed the man's risk as low and agreed to reduce his observations to one an hour.

29. At an ACCT review on 17 November, staff noted that the man was a lot more upbeat. He said that he was content for the level of observations to be reduced, but did not want the ACCT closed. Although it was a caremap action, there is no record that the review discussed his transfer. His level of observations was reduced to one an hour at night, with staff required to have and record three conversations with him during the day.

30. Frankland's Head of Segregation said that the high security prisons have a monthly conference call to discuss prisoners who have been segregated for three months or more. They aim to swap prisoners in the hope that a move to a new prison will help the prisoner settle and return to a residential wing. At a conference call on 20 November, Long Lartin agreed to take the man.

31. At an ACCT review at Frankland on 26 November, the chair noted that the man had declined to attend. The staff agreed that ACCT observations were a good support mechanism for the man while he remained in the segregation unit.

32. On 1 December, the man left Frankland to transfer to Long Lartin. A nurse assessed him and noted that he was medically fit for transfer. The man did not have an ACCT review before he left Frankland. Frankland's Head of Safer Prisons told the investigator that this was a mistake and he should have had a review that morning. Escort vans rarely travel directly from Frankland (in County Durham) to Long Lartin (in Worcestershire), so the man was taken to HMP Leeds for the night.

33. At Leeds, the man had a cell in the first night centre and staff observed him hourly through the night. Frankland's Head of Safer Prisons said that Frankland's population management unit had known the day before the transfer that the man would be moving on 1 December and would stay at Leeds for one night. However, no one contacted Leeds in advance to let them know that the man would be spending the night there on his way to Long Lartin and that he was subject to ACCT monitoring.

34. At 5.30am on 2 December, at an ACCT check, an officer found the man putting a noose around his neck. Officers went into the cell and took the noose from him. A nurse examined the man and noted that he was not injured. He told her that he had had enough and wanted to die. The man was moved to a safer cell (with no obvious ligature points), and officers checked him twice an hour, until he left for Long Lartin at 11.00am.

35. Leeds' Head of Safety said that the man's actions on the morning of 2 December would usually have prompted an ACCT review to consider his risks and whether he needed additional support. However, this did not happen before he left the prison. No one from Leeds contacted Long Lartin to warn them that the man had tried to kill himself by hanging that morning and that his risk was therefore heightened, as should have happened.

36. When the man arrived at Long Lartin at 3.30pm, a reception nurse assessed him. Healthcare staff at Leeds had not released the man's electronic clinical records that morning, as they should have done, so the reception nurse had to rely mainly on what the man told him. The reception nurse did not check the man's ACCT document, and so did not know that staff had found a noose that morning. The reception nurse noted a lot of old scars on the man's neck and arms. The reception nurse told the clinical reviewer that the man showed some signs of being mentally ill; he appeared disorientated and was talking rapidly. The reception nurse referred the man for a mental health assessment but gave him a

low score of four (indicating low urgency which did not properly reflect his mental health history and history of self-harm).

37. Long Lartin's Head of Safer Prisons told the investigator that a reception manager had telephoned her on 2 December to say that she was concerned to read in the man's ACCT record that he had been found with a noose at Leeds that morning. Long Lartin's Head of Safer Prisons went to see the man, who was sitting on a chair, rocking. She said he spoke rapidly, had a strong accent and did not seem to form his words clearly, as he had no teeth. She could not understand what he was saying. Long Lartin's Head of Safer Prisons arranged an ACCT review.

38. A supervising Officer (SO) chaired the ACCT review. The man said that he suffered from psychosis, anxiety and sleep deprivation. He said that this had caused him to attempt suicide in the past and to self-harm as a means of coping. (The man had been managed under ACCT procedures many times after previous acts of self-harm.) The SO assessed the man's risk as high and set his observations at one an hour. He arranged a further ACCT review for the next day.

39. On 3 December, Long Lartin's Head of Safer Prisons chaired the ACCT review. The man's named nurse was at the review and Long Lartin's Head of Safer Prisons said the man interacted well with him. The man described himself as "scum". He said that he was not feeling well and said he thought this was "payback" for his actions in the past. Long Lartin's Head of Safer Prisons decided the man should be admitted to the healthcare unit and be constantly supervised.

40. At an ACCT review on 4 December, the man said that he did not have any thoughts of suicide or self-harm and did not feel that he needed to be constantly supervised. The review agreed to reduce his observations to three every hour and he moved to another cell in the healthcare unit. A nurse who was at the review, noted in the man's clinical records that he had said he had not been sleeping well at Frankland and had become confused with thoughts that people were trying to kill him. He had said he was now feeling a little better.

41. The man's named nurse said that his remit was the care of learning disabled and mentally ill prisoners. On 8 December, he recorded a lengthy discussion with the man who told him about several different antipsychotic medicines that he had received in the past. The man had said his current antipsychotic, chlorpromazine, was ineffective, and he viewed taking any antipsychotic as a failure.

42. At ACCT reviews on 5 and 7 December, the man again said that he had no thoughts of suicide or self-harm. At both reviews, the staff assessed the man's risk as low. They noted his behaviour was slightly strange, but there were some positive signs. On 7 December, the man spoke about wanting to make changes to his life and move on. On 5 December, the review reduced the man's level of observations to two an hour on 5 December and, on 7 December, they were further reduced to one an hour.

43. On 9 December, Long Lartin's consultant forensic psychiatrist, saw the man, who told him that he wanted to move on, but was also scared at the prospect of

leaving prison. The man said he did not want to kill himself. The consultant forensic psychiatrist noted that he would see the man in two weeks. In the meantime, he should have a mini-mental examination and the mental health team should request records from his previous hospital admissions. There is no evidence that the mental health team requested these records.

44. The man had an ACCT review on 10 December with an SO, an officer and two mental health nurses, including the man's named nurse. The SO recorded that the man appeared confused and at one point seemed to be engaged in two or three conversations at one time. The SO noted that the man was not taking his medication. The staff agreed to keep the man's observations at one an hour.

45. On 12 December, the man's named nurse carried out a mini-mental examination. The man scored 30 out of 30, showing that he had no memory problems. The man's named nurse noted that the man was more relaxed than when they last met on 10 December, but he was still agitated and jumped from one subject to another, when they talked.

46. Another SO chaired an ACCT review on the afternoon of 12 December, and was accompanied by a nurse. The nurse said that she had been aware of the man, as staff had discussed him at team meetings. At the review, he was very agitated and breathing rapidly. He seemed to have a lot of things to say but everything came out in a jumble. She advised him to try walking up and down the corridor and to try to catch his breath, but he told her to stop interrupting. The panel kept the man's observations at one an hour. The nurse said that although the man was agitated, there was no indication that he was having suicidal thoughts.

47. On 13 December, a nurse doubled the man's dose of chlorpromazine from two 25mg tablets each day to two 50mg tablets, because the man was talking to himself all night. She noted that the consultant forensic psychiatrist was due to review the man four days later.

48. At an ACCT review on 14 December, an SO noted that the man was much more settled and coherent. The man said that he was happy to be in the healthcare unit and would be seeing the consultant forensic psychiatrist on the coming Wednesday. His observations remained at one an hour.

49. On 17 December, the consultant forensic psychiatrist saw the man and noted that he spoke rapidly and excitedly and it was difficult to understand the words he was using; it was only possible to interrupt the man for brief periods. The consultant forensic psychiatrist diagnosed a manic episode and asked the man to try a different type of antipsychotic medication, but the man insisted on chlorpromazine. The consultant forensic psychiatrist further increased the dose from two 50mg tablets each day to two 100mg tablets. The consultant forensic psychiatrist ordered blood tests as he wondered whether the man's behaviour might have been due to a physical health, rather than a mental health, problem.

50. At an ACCT review on 18 December, an SO noted that the man was more lucid than he had been at previous reviews, but his conversation was still very

rambling. The review assessed the man's risk as low and kept his observations at one an hour.

51. At an ACCT review on 22 December, the man said that he had no thoughts of suicide or self-harm. He said he was feeling more settled, which he thought was due to the increased dose of chlorpromazine. The man said that he now felt he was talking to staff rather than talking at them. The review panel decided that the man remained low risk and kept his observations at one an hour.

52. The consultant forensic psychiatrist saw the man for the final time on 23 December. He recorded similar symptoms as previously, such as pressured speech, but also noted that the man had improved since the last consultation. The consultant forensic psychiatrist noted that he would see the man again in a week and would consider referring him to a mental health unit if he did not settle. The consultant forensic psychiatrist told the clinical reviewer that there was no indication that the man was having suicidal thoughts. He said that there were two other prisoners in the healthcare unit at the time who were waiting for transfers to a mental health unit, whose needs were more acute.

53. On 24 December, a CM chaired an ACCT review, with the man's named nurse, an officer and a drug team worker. The CM noted that the man said he had had no thoughts of suicide or self-harm. He recorded that the man seemed more settled but had still spoken at random. The review assessed the man's risk as low and kept his observations at one an hour.

54. Prisoners in the healthcare unit are not allowed to smoke in their cells. The first officer told the investigator that he often took the man to the exercise yard for a cigarette break. He estimated that he had probably done so about 20 to 30 times up to 24 December, when he went on leave. He said the man used to talk non-stop, often about his past, including when he had been at Long Lartin years before. The first officer said that the man seemed resigned to remaining in prison indefinitely but he always seemed in good spirits. He also seemed to be thinking about the future as he was filling in a prison shop order and had asked about the possibility of getting a cleaning job.

55. A nurse spoke to the man on the afternoon of 25 December. She thought he appeared distracted but his speech was clearer and there was nothing to cause her concern. He said that he had spoken to his mother and that he had been very impressed with the standard of the Christmas meal.

56. On 27 December, the man threatened to kill the first officer who opened his cell and the first SO went to speak to him. The first SO told the investigator that this was the first time he had met the man. He said that he found the man difficult to deal with. He spoke in a random way and told the first SO that he had been sexually abused as a child, was being bullied by nurses and prisoners and wanted to contact solicitors, judges and the police as his cell was a crime scene. The first SO said that he had understood from the healthcare staff that this was typical behaviour for the man.

57. The first SO chaired an ACCT review later that morning with two officers, a chaplain and a nurse. He held the review in the man's cell as, because of the man's behaviour that day, it would make it easier to withdraw if he became violent. The first SO said that the man was much the same at the review as he had been earlier. He noted that the man would not listen or cooperate. The staff assessed the man's level of risk as low but kept his observations at one an hour.

58. The nurse at the review said that the man had been more confrontational that day. He said that he did not understand why he could not smoke in the healthcare unit. She had tried to explain that he would not be able to smoke if he was in a hospital, but he would not accept this. The nurse said she thought that the man needed the support he received through ACCT procedures, but she did not think he was at risk of suicide.

59. The man's only family contact was his mother. He telephoned her every few days and his last call to her was on the afternoon of 27 December. He told her that he was okay for money but asked her to send him some stamps.

60. An officer who worked several night shifts in the healthcare unit towards the end of December said he spent some time talking with the man. The night officer said that sometimes it was possible to understand what the man was saying, but a lot of the time he would just allow the man to talk without understanding him. The man would often ask to go out for a cigarette and the night officer would have to explain to him that he would have to wait for the day staff to arrive the next morning. The night officer was on duty on the last night of the man's life. He said that the man had been no different that night and gave him no cause for concern.

61. A prisoner at Long Lartin who was a cleaner in the healthcare unit said he made a point of speaking to all of the prisoners while doing his work. He said that he spoke to the man every day and thought he was clearly mentally unwell. The man had told him that his father had sexually abused him when he was a child and that he would hang himself one day. The cleaner did not tell staff, as the man only mentioned this as something he would do in the future.

62. A prisoner who was in the cell next to the man said he had known him for 20 years. He said that the man had always had mental health problems but he was more unwell this time than he had ever been before. The man had told him that he was going to kill himself, but the man's neighbour did not tell staff.

63. A part-time chaplain at Long Lartin also worked as a GP in the community. He told the investigator that he had met the man a number of times when visiting prisoners in the healthcare unit. The chaplain told the investigator that it was always very difficult to follow the man's conversation, partly because of his North East accent and enunciation, but also because he rambled from one topic to the next. The chaplain said that he had last seen the man at midday on 28 December, when he seemed to be bright and cheerful, although his conversation was even more garbled than usual. The chaplain said that there was nothing about the man's demeanour to indicate that he was at imminent risk of harming himself. He noted in the man's ACCT document that all was well.

64. The second officer told the investigator that she dealt with the man a number of times. She said that he was hard to understand but she would stand at his cell door and let him talk. At around 11.30am on the man's last day he called to her as he wanted to smoke. Because it would be several hours before the man would be able to go outside, and he seemed agitated, the second officer allowed him to roll five cigarettes to smoke in his cell during the lunch period.

65. At 12.50pm, the man rang his cell bell and asked the lunchtime patrol officer for a cigarette. The lunchtime patrol officer told him that he would have to wait for the officers to return from their lunch break. The lunchtime patrol officer walked away from the cell, but a minute or so later, he saw water coming from the cell. The man was deliberately flooding the cell, by blocking his basin and refused to stop. The lunchtime patrol officer radioed a manager, who came to the healthcare unit to turn off the man's water and electricity.

66. CCTV footage shows that the first SO went to the man's cell at 2.03pm. The man had pushed his mattress against the door, which obscured the observation panel. The first SO opened the serving hatch and pushed the mattress down. The man was standing by the window at the back of the cell. The first SO went to the unit office and told the second officer that he was concerned that the man had soaked his sheets and blankets. He asked her to try to persuade the man to accept dry bedding.

67. The second officer said that she went to the man's cell at 2.19 pm, looked through the observation panel and saw that he had a ligature around his neck. She shouted to the first SO who radioed a code blue emergency. The first SO unlocked the door, pushed the mattress and a cupboard out of the way and supported the man's body, while the second officer began to cut the ligature. The second officer said that the man had used a tightly wound sheet which was very thick and difficult to cut through. Another officer had come to the cell and helped cut through the sheet. The officers lowered the man to the floor.

68. A nurse arrived at the cell with an emergency equipment bag just as the man was being lowered to the floor. Three other nurses also arrived. The first nurse said that the man appeared lifeless and they immediately started cardiopulmonary resuscitation. They checked the man with a defibrillator (a life saving device that gives the heart an electric shock in some cases of cardiac arrest) but found no shockable heart rhythm. The chaplain had also heard the code blue and went to the cell and helped with emergency treatment. At 2.22pm, a manager radioed the control room to confirm an ambulance was needed. The first paramedic arrived at 2.46pm and two more arrived nine minutes later. They took over the man's treatment and gave him five injections of adrenaline. At 3.20pm, the paramedics detected a pulse and decided to take the man hospital. On the way, he suffered a cardiac arrest and at around 4.20pm was pronounced dead.

Contact with the man's mother

69. The man's mother lived in County Durham. Because of the distance, Long Lartin contacted Frankland, which was the prison closest to her home. At 6.30pm, two members of staff from Frankland went to see the man's mother and informed her

of his death. Long Lartin contributed towards the cost of the man's funeral, in line with national Prison Service guidance.

Support for staff and prisoners

70. Two managers at Long Lartin debriefed the staff involved in the emergency response and offered them the support of the prison's care team. Staff reviewed all prisoners being managed under ACCT procedures in case they had been affected by The man's death. Staff offered additional support to the prisoner cleaner and the man's neighbour.

Post-mortem report

71. The man's cause of death was given as hanging. The toxicology results showed that the man had not taken any illicit or non-prescribed medication.

ISSUES

Management of ACCT procedures

72. Staff appropriately began ACCT procedures after the man self-harmed at Frankland on 1 November and the man continued to be managed under ACCT procedures at Long Lartin until he died. When he first arrived at Long Lartin, staff assessed his risk as high, when they noted that he had tried to hang himself at Leeds, earlier that day. (Although it is concerning that the nurse who first assessed the man at Long Lartin did not consult the ACCT document and was unaware of this.)

73. Subsequently, once the man had settled at Long Lartin, officers and healthcare staff assessed him as at low risk of suicide and self-harm. The man had psychiatric assessments and frequent case reviews and there was little to indicate that he was at imminent risk of suicide at the end of December. The psychiatrist last saw the man on 23 December, and was not concerned about his risk. He said that there was no indication that the man was having suicidal thoughts at the time. While the man's history would suggest that he would always have an underlying risk of suicide, we are satisfied that at the time of his death, there was little to indicate to staff that he was at heightened or imminent risk.

74. We consider that staff could not have anticipated or prevented the man's actions and that he received generally good support through the ACCT process. However, we are concerned about some aspects of the operation of ACCT procedures at both Frankland and Long Lartin. The man had 20 ACCT reviews between 2 November and 27 December. The reviews were generally multidisciplinary, but there was little consistency of attendees and, in particular, of case managers. This was the case at both Frankland and Long Lartin. Seven different case managers chaired the eight ACCT case reviews at Frankland, while ten different case managers chaired the 12 ACCT case reviews at Long Lartin. Particularly when managing people with complex histories and mental health problems, such as the man, it is important to provide consistent and continuous care. We make the following recommendation:

    The Governors of Frankland and Long Lartin should ensure that prisoners at risk of suicide and self-harm have multidisciplinary ACCT case reviews with a consistent case manager and which include all relevant people involved in the prisoner's care.

Communicating information about risk on transfer

Frankland to Leeds

75. Frankland's population management unit (PMU) knew on 30 November that the man would be moving to Long Lartin on 1 December and that he would stay overnight at Leeds on the way. No one briefed Leeds about the man before he arrived, although the man had not been regarded as suitable to move out of the high security estate, was always liable to difficult behaviour and was being managed under ACCT procedures at the time. We consider Frankland should

have briefed staff at Leeds about the man and the fact the he was on an ACCT, so that Leeds could prepare to accommodate the man safely. Frankland's Head of Safer Prisons said that there are now new arrangements to make sure that such information is passed on to receiving prisons when prisoners have an overnight stop during a prison transfer.

76. Transfer between prisons is a known trigger for suicide and self-harm listed in PSI 64/2011. For this reason, Leeds should have been alerted to the man's arrival. We also agree with Frankland's Head of Safer Prisons, that staff should have held an ACCT case review before he left the prison. This should have considered whether he was well enough to transfer and whether there needed to be any change to the frequency of his observations, taking into account the risk of transfer and the risk when arriving at a new prison. Frankland's Head of Safer Prisons thought that the reason no review was held before the man's transfer was that the supervising officer on duty in the segregation unit that day, did not usually work there and had not realised that the man was leaving. She said that managers have been reminded about the need for reviews before transfer.

Leeds to Long Lartin

77. At 5.30am on 2 December at Leeds, an officer checking the man found him putting a noose around his neck. The man said that he had wanted to die. Staff moved him to a safer cell and increased the frequency of ACCT observations. No one held an ACCT review before he left Leeds at 11.00am and no one contacted Long Lartin to let them know what had happened. The Head of Safety at Leeds told the investigator that procedures have since been put in place to ensure such information is passed on. We make the following recommendations:

The Governors of Frankland and Leeds should ensure that when prisoners subject to ACCT procedures are transferred, all relevant information about their risk is passed in advance to the receiving prison and that ACCT reviews are held to make sure that additional risks associated with the transfer have been considered and discussed with the prisoner.

Segregation

78. Officers at Frankland started ACCT monitoring for the man on 1 November when he cut his arm, while he was in the segregation unit. He was admitted to the healthcare unit, but quickly discharged back to the segregation unit where he remained until his transfer on 1 December. The man was still subject to ACCT monitoring when he was transferred. He did not have a mental health assessment within 24 hours of the ACCT being opened, as we would expect for a prisoner in segregation, as he refused to engage. There is no record of any consideration that he should remain in the healthcare unit because of his risk of suicide and self-harm.

79. Prison Service Order (PSO) 1700, which governs segregation processes, makes clear that prisoners in segregation units are usually those who are most difficult and often those who are most vulnerable. PSO 1700 requires that prisoners on an open ACCT should only remain in segregation under exceptional

circumstances such as them being a risk to others, where no other location is appropriate and where all other options have been tried or are considered inappropriate. It says that particular care should be given to authorising continued segregation of a prisoner on an open ACCT and that continued segregation should occur only in exceptional circumstances and an ACCT case review must take place at the same time as the segregation review board.

80. PSI 64/2011 - Safer Custody, also requires that:

> *"Prisoners on open ACCT plans must only be located or retained in Segregation Units only in exceptional circumstances. The reasons must be clearly documented in the ACCT Plan and include others options that were considered but discounted."*

81. There is no evidence that staff at Frankland considered the man's circumstances to be exceptional, or that alternative accommodation was considered at any time. Nothing was recorded about this in the ACCT document. Frankland's Head of Segregation said that the man had regular multidisciplinary ACCT case reviews, which considered whether he was fit to remain in segregation. However, there is no reference to any discussions about the man's ongoing segregation or alternative accommodation in the records of ACCT case reviews. Neither is there any evidence of such discussion at the fortnightly segregation review boards.

82. We acknowledge that the man was a difficult prisoner to manage. His death did not occur in a segregation unit, but prolonged segregation is known to have a detrimental effect on a person's mental health. Although not originally on an ACCT, the man had been held in segregation for three months at the time he self-harmed and four months by the time of his transfer. PSO 1700 requires that prisoners segregated under Prison Rule 45 for more than 30 days should be "subject to care plans that detail how their mental well being is to be supported". We have found no evidence of such a plan. We are concerned that no one at Frankland identified that his self-harm might have been a result of a deterioration in his mental health caused by his continued segregation and there was no care plan. No one recorded any exceptional reasons for the man remaining in the segregation unit, as PSI 64/2011 requires. In June 2015, we issued a learning lessons bulletin about the particular vulnerabilities of prisoners in segregation units and the need to ensure that prison staff followed the safeguards designed to protect such prisoners. We make the following recommendation:

The Governor of Frankland should ensure that prisoners assessed as at risk of suicide or self-harm are not held in the segregation unit unless all other options have been considered and excluded and there are fully documented reasons, including at segregation reviews, to explain the exceptional circumstances. Prisoners on ACCT, and all prisoners who are segregated for more than 30 days, should have effective care plans to help prevent deterioration in mental health.

Emergency response

83. The second officer radioed a code blue as soon as she found the man hanged. This should have resulted in the control room calling an ambulance immediately. However, one was not called until a manager radioed the control room three minutes later.

84. Prison Service Instruction 3/2013 requires that governors must have a medical emergency response code protocol to ensure that an ambulance is called automatically in a life-threatening medical emergency. The PSI explicitly states that when a medical emergency is called over the radio network, an ambulance must be called immediately and local procedures should ensure this. It says it should not be a requirement for a member of healthcare staff or a manager to attend the scene before emergency services are called.

85. In an investigation into a death at Long Lartin in 2013, we also found that staff did not call an ambulance immediately. We made a recommendation which the prison accepted and said that they had implemented. There was a further death at Long Lartin a month after the man's death where there was again a delay in calling an ambulance. It is unacceptable that there are still delays at Long Lartin in calling emergency ambulances; the sooner paramedics are able to attend to prisoners in an emergency, the more likely it is that they will be able to be saved. We make the following recommendation:

The Governor of Long Lartin should take active steps to ensure that control room staff call an ambulance immediately an emergency medical code is called.

Clinical care

86. The clinical reviewer noted that the man was stressed and disturbed when he arrived at Long Lartin. He appeared to be in an episode of mania, which did not settle significantly. The clinical reviewer thought this was due at least in part to the man's reluctance to accept the alternative antipsychotic medicine recommended by the consultant forensic psychiatrist. She considered that the care provided by the mental health team at Long Lartin was probably better than that he would have received in the community. The clinical reviewer has made some additional recommendations in her clinical review about the management of the inpatient unit, which the Head of Healthcare will need to address.

RECOMMENDATIONS

1. The Governors of Frankland and Long Lartin should ensure that prisoners at risk of suicide and self-harm have multidisciplinary ACCT case reviews with a consistent case manager and which include all relevant people involved in the prisoner's care.

2. The Governors of Frankland and Leeds should ensure that when prisoners subject to ACCT procedures are transferred, all relevant information about their risk is passed in advance to the receiving prison and that ACCT reviews are held to make sure that additional risks associated with the transfer have been considered and discussed with the prisoner.

3. The Governor of Frankland should ensure that prisoners assessed as at risk of suicide or self-harm are not held in the segregation unit unless all other options have been considered and excluded and there are fully documented reasons, including at segregation reviews, to explain the exceptional circumstances. Prisoners on ACCT, and all prisoners who are segregated for more than 30 days, should have effective care plans to help prevent deterioration in mental health.

4. The Governor of Long Lartin should take active steps to ensure that control room staff call an ambulance immediately an emergency medical code is called.