Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Liam Lambert, a prisoner at HMYOI Glen Parva, on 24 March 2015

A report by the Prisons and Probation Ombudsman
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Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

Our Values

We are:

Impartial: *we do not take sides*
Respectful: *we are considerate and courteous*
Inclusive: *we value diversity*
Dedicated: *we are determined and focused*
Fair: *we are honest and act with integrity*

The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out **independent** investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

My office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Liam Lambert was found hanged in his cell at HMYOI Glen Parva on 19 March 2015 and died in hospital on 24 March. He was 20 years old. I offer my condolences to Mr Lambert's family and friends.

Mr Lambert had a range of difficulties in his life. He had come from Australia to seek a relationship with his father in the UK, but this had not worked out. He therefore had little external support as the rest of his family were in Australia. Some staff at Glen Parva gave him positive support, particularly substance misuse workers and members of the chaplaincy, who did their best to help him overcome his problems. However, I am concerned that procedures designed to safeguard prisoners at Glen Parva did not operate effectively. Mr Lambert was bullied and assaulted in the fortnight before he hanged himself, but these incidents were not investigated appropriately. He had been monitored as at risk of suicide and self-harm but these procedures were also ineffective and did not identify the full extent of his vulnerability or take practical action to help reduce his risk and support him. The monitoring ended shortly before Mr Lambert was found hanging in his cell, yet not all the agreed actions to help address his concerns had been completed.

We cannot know that more effective procedures in themselves would have been sufficient to prevent Mr Lambert's actions, but I am concerned that many of the issues the investigation identified have been found in previous investigations into deaths at Glen Parva. They also reflect many of the themes in a Learning Lessons Bulletin I published in July 2014, setting out issues from investigations into the deaths of young adult prisoners. Glen Parva needs to make sure these lessons inform the development of its safer custody strategy to help prevent future deaths.

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

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

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Summary

Events

1. Mr Liam Lambert was born and brought up in Australia. He had been diagnosed with attention deficit hyperactivity disorder (ADHD) when he was a child. He came to the UK in July 2013, when he was 18, to reconnect with his father. He became homeless and misused alcohol and drugs. On 29 January 2015, he was sentenced to 16 weeks in prison and arrived at Glen Parva on 4 February. He received medication to relieve drug and alcohol withdrawal symptoms. No-one assessed him as at risk of suicide and self-harm.

2. On 2 March, Mr Lambert moved to Unit 2 at Glen Parva. He reported being bullied and assaulted by three different prisoners who lived on the unit and this continued after staff moved him to another unit. On 12 March, staff began to monitor Mr Lambert under suicide and self-harm prevention procedures, known as ACCT, after he had self-harmed by cutting his arms.

3. On 13 March, Mr Lambert was involved in an incident when prisoners barricaded themselves in the TV room and was charged with a disciplinary offence. On 16 March, he received a suspended punishment but was placed on the basic level of the incentives and earned privileges scheme, which meant he had a restricted regime and lost access to facilities, such as a television. On 19 March, staff closed the ACCT, without arranging ongoing support or monitoring for bullying.

4. On the evening of 19 March, a night patrol officer found Mr Lambert hanged in his cell. He called for help but did not radio an emergency medical code. Staff quickly began cardiopulmonary resuscitation but it was five minutes before an ambulance was called and there was also a delay bringing emergency equipment. Paramedics took Mr Lambert to hospital. Sadly, he never regained consciousness. He died in hospital on 24 March.

Findings

5. The investigation found that Mr Lambert had been bullied and assaulted by other prisoners in the fortnight before he hanged himself. Staff did not investigate the incidents properly and did not follow the procedures to protect Mr Lambert. We have previously identified similar failures to protect vulnerable prisoners at Glen Parva and note that at the last inspection of Glen Parva in April 2014, HM Inspectorate of Prisons reported poor procedures for tackling bullying.

6. We found a number of deficiencies in ACCT procedures, including that staff underestimated Mr Lambert's level of risk at each case review and did not fully take into account and address the impact of bullying on his risk. Staff closed the ACCT, although Mr Lambert still had a number of outstanding issues, which had not been resolved. The decision to place Mr Lambert on the basic regime was taken in isolation, without any consideration of his vulnerability and whether this was compatible with caring for a young adult at risk of suicide and self-harm.

7. The staff who first found Mr Lambert hanging did not use the required medical emergency code. This led to a delay in calling an ambulance and meant that healthcare staff did not bring all relevant emergency equipment to the scene

immediately. Although we have made previous recommendations to Glen Parva about emergency procedures, the local protocol was not consistent with national instructions.

Recommendations

- The Governor should ensure that allegations of violence, bullying or intimidation are taken seriously, investigated and dealt with in line with local and national policies. Prisoners identified as at risk of violence from other prisoners should be effectively protected, and all staff who have contact with prisoners, should be trained in and confident about using the local safety strategy to challenge inappropriate behaviour.

- The Governor should ensure that staff manage prisoners at risk of suicide and self-harm in line with national guidelines. In particular:
  i. All staff in contact with prisoners identified as at risk of suicide and self-harm should be aware of this and be able to make appropriate entries in the ACCT document.
  ii. ACCT reviews should fully consider and record the impact of bullying on the risk of suicide and take appropriate action.
  iii. ACCT reviews should be multi-disciplinary, aware of all recent issues, and include all relevant people involved in a prisoner's care.
  iv. ACCT reviews should consider and record all known risk factors when determining the level of risk of suicide and self-harm or closing an ACCT.
  v. Caremap actions should address all identified issues to help reduce a prisoner's risk and the ACCTs should not be closed until the risk has reduced and all caremap actions have been completed.

- The Governor should ensure that foreign national prisoners, or those with close family abroad, can call their relatives in accordance with PSI 49/2011. Those assessed as at risk of suicide and self-harm should have additional calls as necessary.

- The Governor should ensure that decisions to demote prisoners at risk of suicide and self-harm to the basic regime are taken in conjunction with the ACCT process. Removal of privileges, such as a television, should be carefully assessed and recorded and take into account the likely impact on the health and welfare of the prisoner.

- The Governor should ensure that all prison staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies and that Glen Parva has a medical emergency response code protocol based on the PSI which ensures:
  i. Staff use the appropriate emergency code to effectively communicate the nature of a medical emergency;
  ii. Staff bring the relevant emergency equipment;

iii. There are no delays in calling, directing or discharging ambulances.

The Investigation Process

8. The investigator issued notices to staff and prisoners at Glen Parva informing them of the investigation and asking anyone with relevant information to contact him. No one responded.

9. The investigator visited Glen Parva on 30 March 2015. He obtained copies of relevant extracts from Mr Lambert's prison and medical records.

10. The investigator interviewed 23 members of staff at Glen Parva on 29 and 30 April and 1 May.

11. NHS England commissioned a clinical reviewer to review Mr Lambert's clinical care at the prison. He joined the investigator for interviews with healthcare staff on 1 May.

12. We informed HM Coroner for Leicester City and South Leicestershire of the investigation. We have sent the coroner a copy of this report.

13. Two of our family liaison officers contacted Mr Lambert's mother and stepfather to explain the investigation and to ask if they had any matters they wanted the investigation to take into account. They asked for the following questions to be considered:

    - Are prisoners whose families live abroad and cannot visit able to make telephone calls home?
    - When was Mr Lambert checked on the evening he hanged himself and how often was he supposed to be checked?
    - Why did he have a sheet to make a ligature?
    - Why did the chaplain who held Mr Lambert's funeral mention that he had taken his own life when relatives watching over the internet in Australia had not yet been told this?
    - Why were there no post-mortem examination or toxicology tests?
    - Why have previous investigations of deaths in custody not resulted in lessons being learned at Glen Parva?

14. Our family liaison officer has addressed a number of other matters with Mr Lambert's family in separate correspondence.

15. Our family liaison officer contacted Mr Lambert's father and his partner to explain the investigation and to ask if they had any matters they wanted the investigation to consider. Mr Lambert's father asked how long his son had been on his own when he hanged himself and whether staff should have checked him.

16. Our family liaison officer provided Mr Lambert's mother and step-father with our draft report. They responded through their solicitor. We have amended any factual errors they highlighted, but have otherwise replied to them in separate correspondence.

Background Information

HM Young Offenders Institution Glen Parva

17. HMYOI Glen Parva holds up to 808 convicted and remanded young adult men aged between 18 and 21. There are ten residential units each holding up to 80 prisoners. Leicestershire Partnership Trust delivers primary mental health services and Northamptonshire Primary Care Trust provides in-reach (acute) mental health services.

HM Inspectorate of Prisons

18. The most recent inspection of Glen Parva in April 2014, inspectors reported that the outcomes for young men remained unacceptable in too many areas, despite the efforts of a new governor. They found that Glen Parva was not safe. Assaults on prisoners and staff had risen by a quarter in a year. Efforts to tackle perpetrators and protect victims from bullying were largely ineffective. They found a direct link between the high levels of bullying and levels of self-harm but there was no prison-wide strategy to address this. Inspectors found that implementation of some Prisons and Probation Ombudsman's recommendations after previous deaths at Glen Parva had not been sustained in practice. Inspectors recommended improvements to ACCT procedures. They noted that some staff did not adequately challenge poor behaviour and the incentives and earned privileges scheme was inconsistent and ineffective. In contrast, they found that substance misuse services were very good and an example of best practice. Overall, inspectors found much to improve, but some signs that managers had identified the problems and were planning to address them.

Independent Monitoring Board

19. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to December 2014, the IMB reported that, despite the disappointing inspection report, there was a relentless focus on raising standards. However, the IMB commented that there was still considerable work to do to achieve sustained improvement. A new safer custody strategy had been introduced in October 2014 to address the inspectors' findings and recommendations from the Ombudsman.

Previous deaths at HMYOI Glen Parva

20. We have investigated eight other apparently self-inflicted deaths of young men at Glen Parva since 2010. These investigations identified some of the following themes:

- The lack of a clear and coordinated strategy to protect vulnerable young men and address the underlying issues distressing them.
- The problem of protecting vulnerable prisoners without a dedicated unit.
- Staff failing to recognise factors which raised the risk of suicide and relying too heavily on the man's outward appearance.
- ACCT case managers underestimating the level of risk at case reviews.

- Prisoners without support from outside family and friends having no money and getting into debt.
- The ACCT process failing to address bullying and debt issues.
- Incidents of bullying not being properly investigated or the perpetrators punished accordingly.
- Prisoners being automatically downgraded to the basic IEP regime after a single incident of bad behaviour, without consideration of the impact on the risk of suicide.
- Emergency procedures and delays in calling an ambulance.

Assessment, Care in Custody and Teamwork (ACCT)

21. Assessment, Care in Custody and Teamwork (ACCT) is the is the care planning system the Prison Service uses for supporting and monitoring prisoners assessed as at risk of suicide and self-harm. The purpose of the ACCT process 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 case reviews involving the prisoner. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

Official Prison Visitors

22. Official Prison Visitors (OPVs) are independent volunteers appointed by governors of prisons, who visit prisoners to offer friendship and support. Any prisoner can ask for an Official Visitor, but they are often used by prisoners who do not receive visits from family or friends.

Incentives and Earned Privileges (IEP) Scheme

23. Each prison has an Incentives and Earned Privileges scheme, which aims to encourage and reward responsible behaviour, encourage sentenced prisoners to engage in activities designed to reduce the risk of re-offending and to help create a disciplined and safer environment for prisoners and staff. Under the scheme, prisoners can earn additional privileges such as extra visits, more time out of cell, the ability to earn more money in prison jobs and to wear their own clothes. There are four levels, entry, basic, standard and enhanced.

Safer Prisons Support Plan and Early Intervention

24. Any member of staff at Glen Parva can open a Safer Prisons Support Plan for a prisoner thought to be at risk of bullying. When Mr Lambert was at Glen Parva, this consisted of a handwritten log of prisoners who were being bullied. Glen Parva does not operate support plans in tandem with ACCT, as bullying issues should be addressed in the ACCT process.

Key Events

25. Mr Liam Lambert was born and brought up in Australia. He was diagnosed with attention deficit hyperactivity disorder (ADHD) as a child and had behavioural problems at school. In July 2013, he came to the UK to see his father, a British citizen. Mr Lambert later became homeless and began to steal to buy drugs. On 29 January 2015, a Magistrates' Court imposed a 16 week prison sentence for 12 offences including assaulting an adult male, criminal damage, theft and sending threatening messages to his former partner. The court imposed a restraining order preventing Mr Lambert from contacting his former partner. The police had written on Mr Lambert's escort record that he was dependent on opiates and alcohol.

HMP Peterborough

26. Mr Lambert spent his first four days in prison at HMP Peterborough before he transferred to a young offender institution (YOI). When he arrived, staff noted that he was unemployed, of no fixed abode and had never been to prison before. He reported no mental health problems, history of self-harm or current suicidal thoughts and no one considered he was at risk of suicide or self-harm. Mr Lambert tested positive for cannabis and opiates and said that he had been drinking heavily for four months and had smoked heroin frequently in the previous five weeks. A doctor examined him and decided he did not need medication or monitoring for withdrawal symptoms. The next day, a nurse assessed Mr Lambert again at a secondary health screen and did not observe any symptoms of alcohol or drug withdrawal.

HMYOI Glen Parva

27. On 4 February, Mr Lambert transferred to HMYOI Glen Parva. Staff at Peterborough had noted on his escort record that Mr Lambert was a foreign national, had drug and alcohol problems and was not to contact his victim. Officer Tracey Arnold interviewed him in reception. He raised no concerns and said that he had no suicidal thoughts. An officer assessed him as suitable to share a cell.

28. A nurse assessed Mr Lambert, who said that he had used drugs since he was 16 and had recently been using ecstasy, heroin, crack cocaine and cannabis. He said he drank about 12 cans of high strength lager a day. The nurse did not identify any symptoms of withdrawal, but referred him to the Integrated Drug Treatment System (IDTS) team. He was allocated a cell in the prison's induction unit.

29. On 5 February, an Anglican chaplain saw Mr Lambert as part of the routine induction process. Mr Lambert registered as a Christian and asked to attend the weekly service and bible study classes. A nurse completed a secondary health assessment and a mental health nurse carried out a mental health triage assessment. Mr Lambert said that he had had ADHD as a child but had stopped taking medication when he was 16, as he no longer needed it. He said he had no current mental health problems or suicidal thoughts.

30. Staff from the IDTS team also saw Mr Lambert on 5 February. He told them that he was homeless and had been stealing to buy drugs and that he drank heavily. He said that his father in the UK had rejected him and he did not want to go back to his family in Australia. Mr Lambert said he had experienced tremors, sweats, stomach cramps and sniffles and said he was not sleeping well. A doctor prescribed hyoscine butylbromide to relieve stomach cramps. A member of the IDTS team added a substance misuse care plan to the clinical record and referred him to the Therapeutic Drug and Alcohol Service (TDAS, which offers services such as art therapy, acupuncture and music therapy to help manage substance misuse). On 6 February, Mr Lambert met his TDAS keyworker, Ms Gemma Shipley, and told her he had no thoughts of suicide or self-harm.

31. On 10 February, Mr Lambert asked the prison's managing chaplain for an official prison visitor because he had no family or friends to visit him. The chaplain added him to the waiting list. The scheme had only recently restarted at Glen Parva and, as there were only two visitors, Mr Lambert was not able to have a visit scheduled until 30 March. Mr Lambert asked for help with bereavement issues as a friend and his grandmother had both recently died and the chaplain referred him to a support service provided by chaplaincy volunteers. There is no record that Mr Lambert saw them.

32. On 12 February, staff reviewed Mr Lambert. Mr Lambert reported that he was sleeping badly and was anxious about the future. He was upset when he discussed his father, said that he had nobody else in the UK, and wanted to repair their relationship. A drug worker referred him to the chaplaincy for support and advised him to try relaxation exercises.

33. On 13 February, Mr Lambert punched his cell wall. Staff noted that he had done this out of frustration after being "caught collecting tobacco". A nurse checked his hand and gave him ibuprofen. That day, Mr Lambert telephoned a friend and said he would repay him money that he owed him when he was released. This was the only telephone call Mr Lambert made from Glen Parva. On 16 February, a member of the IDTS team saw Mr Lambert and noted that he no longer had withdrawal symptoms.

34. On 17 February, an immigration officer saw Mr Lambert. The officer agreed to check whether Mr Lambert had dual nationality and was therefore legally in the United Kingdom.

35. On 18 February, drug workers reviewed Mr Lambert as part of his substance misuse programme. He said he was having trouble sleeping, had no money and was finding it difficult without tobacco. He was hoping to get a letter from his father. He was emotional but said he did not have any thoughts of harming himself. On 19 February, Mr Lambert told a doctor that he had some issues with his cellmate (it is not clear what these were) and he was still not sleeping well. He told the doctor that he had found bible study classes useful. The doctor prescribed 20mg daily of citalopram (an antidepressant) for his low mood and to help with his sleep problems. On 23 February, Mr Lambert had an acupuncture session with a support worker from the Therapeutic Drug and Alcohol Service.

36. On 26 February, Mr Lambert appeared in court by video-link. He received a ten week custodial sentence for theft, to run concurrently with his current sentence. His release date was 1 April.

37. On 2 March, Mr Lambert moved to Unit 2, where he shared with another prisoner whom he soon got on well with. He remained under the care of the Therapeutic Drug and Alcohol Service and, on 4 March, he attended a relapse prevention group with the support worker.

38. On 5 March, Mr Lambert told a doctor that the citalopram was helping his mood; he had not experienced any side effects and he was sleeping better. Mr Lambert told the doctor that he was being bullied at mealtimes and only received small portions of food, which left him feeling hungry. The doctor did not report the alleged bullying to prison staff.

39. Later that day, Mr Lambert told an officer that he was being bullied when he collected his meals by the prisoner in charge of meals at the wing servery who had called him 'the servery snitch'. Mr Lambert was reluctant to come out of his cell. This was the officer's first week as a prison officer and she could not make an entry in Mr Lambert's record about this because she did not yet have access to the system. She did not know how to open an Early Intervention Plan (used to monitor alleged bullies at Glen Parva) and said she had asked a colleague to submit an intelligence report to the security department, but he did not. She recorded the incident in the unit observation book but did not report the alleged bullying to the unit manager and it was not investigated.

40. On 8 March, an officer introduced himself to Mr Lambert as his personal officer. (Personal officers are expected to get to know the prisoners they are responsible for, act as a first point of contact for any problems, help with resettlement issues and make regular entries in prisoners' records about their progress.) Mr Lambert told the officer that he was coping OK on Unit 2 and spoke about his family in Australia and in the UK. He said that he was not getting any visits but was trying to write to his mother. On 10 March, the chaplain saw Mr Lambert to discuss his forthcoming baptism.

41. At about 12.50pm on 12 March, Mr Lambert refused to go to the Acorn workshop where he had started working recycling plastic and cardboard. He said this was because he was 'getting grief' from other prisoners on Unit 2 and was afraid to come out of his cell. An officer began a Safer Prisons Support Plan and Mr Lambert named a prisoner who lived on the same landing and worked in the Acorn workshop who had been bullying him. The officer noted that Mr Lambert seemed vulnerable and withdrawn. The officer spoke to the unit manager and recorded this in the unit observation book and Mr Lambert's prison record. However, he did not name the prisoner in the Safer Prisons Support Plan, did not submit an intelligence report to the security department and did not inform staff in the Acorn workshop. No one challenged the prisoner or investigated the allegations against him and he continued going to the workshop.

42. At 2.15pm, a nurse saw Mr Lambert for a routine check-up and noticed some cuts on his forearm. Mr Lambert said that he had cut himself with a razor blade. Mr Lambert told her that he was being bullied and had been in a low mood for a week. He said his cellmate had been released that morning and he now had

nobody to talk to, as he had no contact with family or friends outside prison. He was reluctant to go to work because of the alleged bullying but was worried that he would lose his pay. She began ACCT suicide and self-harm monitoring procedures and referred him to the primary care mental health team.

43. A Supervising Officer (SO) completed an ACCT immediate action plan. He wrote that Mr Lambert had been under pressure from 'multiple offenders' since he arrived on Unit 2 and moved Mr Lambert to a shared cell on Unit 5. He asked staff to check Mr Lambert hourly when he was locked in his cell and to have three meaningful conversations with him, in the morning, afternoon and evening, until the first ACCT review. The SO closed the Safer Prisons Support Plan, as when a prisoner is assessed as at risk of suicide and self-harm, anti-bullying measures are expected to be taken forward as part of the ACCT process.

44. On 13 March, an officer assessed Mr Lambert as part of the ACCT procedures. Mr Lambert said that he was being bullied by servery orderlies and cleaners on Unit 2 and feared for his safety. He did not want to go to the workshop because the bullies from Unit 2 worked there. Mr Lambert said that this was why he cut himself. He said that he had been telling staff about this for days but nothing had been done. The officer noted that Mr Lambert was isolated and vulnerable.

45. Mr Lambert said that he was an easy target for bullies as he had no friends and had an Australian accent. He said that he had been having suicidal thoughts and had suffered from mental health problems for a long time. His drug and alcohol use had led to depression and he had once made deep cuts that might have been a suicide attempt. He said that he was struggling without any family support in the UK, had no accommodation available for his release and no money for tobacco or telephone credit. He asked for a smokers' pack (tobacco and cigarette papers usually issued to new prisoners in reception).

46. During the assessment interview, Mr Lambert was talkative and the officer did not think he seemed depressed. He said he had no current thoughts of suicide. The officer and Mr Lambert identified the following issues:

- Building relationships with staff and prisoners on Unit 5.
- Continuing to take his medication and work with the mental health in-reach team.
- Thinking about coping mechanisms to avoid self-harm.
- Using chaplaincy services for support.
- Contacting Nacro (an offender rehabilitation charity) for advice about accommodation.
- Looking at how he could contact his family in Australia.

47. At 1.30pm on 13 March, a SO held Mr Lambert's first ACCT case review with a mental health nurse, who had read Mr Lambert's clinical record. Mr Lambert said that he had reached rock bottom after being bullied on Unit 2 and had cut his arms because other prisoners were bullying him to hand over items he had bought from the prison shop. Mr Lambert planned to stay in the UK after his release and was looking forward to his grandfather visiting the UK in early April.

Mr Lambert said he did not have any current thoughts of suicide or self-harm and felt settled on Unit 5.

48. The mental health nurse recalled that Mr Lambert's mood was neither high nor low and he answered all the questions. She saw nothing to suggest that he had major issues and thought he seemed to be gradually improving. Mr Lambert had not yet been added to the Unit 5 medication list so he was not receving his citalopram and she sorted this out for him.

49. Despite Mr Lambert's recent self-harm, the ACCT review assessed Mr Lambert's risk of suicide and self-harm as low. The SO recorded two triggers: being a victim of bullying and not having any family support. He identified two issues for the ACCT caremap: attendance for medication and family contact. The SO recorded that both the actions to address these issues had been completed that day as Mr Lambert had been added to the medication list and that he had submitted a foreign national application to see if Mr Lambert was entitled to phone credit to telephone Australia. There were no other actions in the ACCT caremap to address the issues the officer had identified at the assessment interview. The mental health nurse noted in the clinical record that observations were kept as hourly, but this was not clear in the ACCT document. The SO set the next case review for 19 March. At about 3.00pm, a member of the Safer Prisons team spoke to Mr Lambert. He said that he felt happier on Unit 5 and could speak to staff if he needed to.

50. At 6.50pm on 13 March, Mr Lambert was in the TV room on Unit 5, when two other prisoners tried to barricade themselves in. They put razor blades in their mouths, threatened to swallow them and began making demands of staff. They refused to return to their cells. (A SO told the investigator that the prisoners put the blades in their mouths because they believe that staff are not permitted to restrain them in this situation.) Mr Lambert joined in, took a razor blade from one of the others and put it in his mouth. However, an officer persuaded him to cooperate and he spat the razor blade out and went back to his cell. The other prisoners were eventually restrained after they spat out the blades. Mr Lambert was charged with a disciplinary offence for his part in the incident.

51. The next morning, 14 March, an officer spoke to Mr Lambert and he talked about calling his grandfather in Australia. She said he spoke about the future and seemed happy. Because of the incident in the TV room, the SO and officer held a second ACCT case review at 10.10am. Mr Lambert said that he had 'jumped on the bandwagon' because he had hoped it would win him some status with other prisoners. He said that he had no current thoughts of suicide or self-harm. The review again assessed his risk of suicide and self-harm as low. The frequency of observations appears to have remained unchanged. Later, a member of the prison chaplaincy saw Mr Lambert for a pastoral visit.

52. On the morning of Sunday 15 March, an officer was escorting three Unit 2 prisoners and Mr Lambert back from the chapel. As he moved ahead of the group to unlock the door to Unit 2, one of the other prisoners slapped Mr Lambert across the face. The three prisoners went into Unit 2. The officer did not see the assault but noticed that Mr Lambert's eyes were red and watering. Mr Lambert identified his assailant. The officer took Mr Lambert to the healthcare centre,

where a nurse examined him and found he had no injuries. The officer did not submit an intelligence report to the security department, or make entries in the Unit 5 observation book or in Mr Lambert's prison record, but he recorded the incident in the ACCT document and informed the orderly officer. He charged a prisoner with a disciplinary offence for assault. This matter was still unresolved when Mr Lambert died.

53. At about 2.45pm, a mental health nurse assessed Mr Lambert. He recorded that Mr Lambert was talkative, had rated his mood as 5/10 and did not think that citalopram had really helped. He said that he had first self-harmed when he was 14 and did not have any current suicidal thoughts. The nurse asked about bullying but Mr Lambert did not mention anything. He said he felt supported by the chaplaincy, was looking forward to his grandfather visiting and planned to return to Australia after he was released. After this assessment, Mr Lambert was due to see his care coordinator once a week.

54. In response to the incident outside Unit 2, a SO held a third ACCT case at 3.45pm. There were no other members of staff present. Mr Lambert said that he had 'received a back hand to the face' but the other prisoner had not meant to hurt him. He said that he had no thoughts of suicide or self-harm and was happy and settled on Unit 5. The SO assessed his risk of suicide and self-harm as low. There is no record of any change in the level of observations.

55. On 16 March, Mr Lambert attended a disciplinary hearing with an adjudicating governor for disobeying a lawful order during the incident in the TV room. He apologised and said that he had been trying to win friends. Mr Lambert said he got on well with the SO and had been ashamed when the SO challenged him during the incident. He pleaded guilty to the charge and the adjudicating governor gave him a punishment suspended for three months (loss of 50 percent of his earnings, gym and association for seven days) because it was his first offence and he was due to be released soon.

56. Afterwards, a SO reviewed Mr Lambert's IEP level. Because the prison has a 'zero tolerance' approach to offences of concerted indiscipline, he demoted Mr Lambert to the basic level of the IEP regime for seven days. Mr Lambert was still able to go to work, make telephone calls, take exercise and have library books. However, he was not allowed a television, he was left locked in his cell during some association periods and he had reduced money to spend. The SO did not refer to the fact that Mr Lambert had been identified as at risk of suicide and self-harm and was being monitored under ACCT procedures.

57. Later on 16 March, the care co-ordinator tried to see Mr Lambert to review his mental health but he was not the unit at the time. Mr Lambert had been at a music therapy session in the chapel that afternoon. He then moved to a cell on the third landing of Unit 5, where he shared with another prisoner. A chaplain baptised Mr Lambert in the chapel that evening.

58. On 17 March, the care co-ordinator tried to see Mr Lambert but again he was unavailable and she planned to come to the unit to see him on 19 March. At 9.00am on 18 March, Mr Lambert went to the Acorn workshop for the first time since being monitored under ACCT procedures. Mr Lambert told the workshop instructors that a prisoner had bullied him. The instructors had not known about

this and they asked the activities department to find the prisoner alternative employment. The prisoner was already in the workshop and there were no officers to escort him from the workshop immediately.

59. At about 10.40am, the prisoners went to lock their tools away. An instructor was outside the locker room when he heard a bang. He saw the prisoner come out smiling, followed by Mr Lambert. Mr Lambert said that the prisoner had struck him on the head from behind, pushed him into the locker and tried to choke him. The instructor took Mr Lambert to see a nurse, who noted swelling behind his ear and marks on his wrist and elbow. He did not need any treatment.

60. The instructor charged the prisoner with a disciplinary offence of assault and began early intervention procedures so that staff would monitor his behaviour. He did not open a Safer Prisons Support Plan for Mr Lambert because he was already on an ACCT. He recorded the incident in the ACCT document and encouraged Mr Lambert to continue attending the workshop and assured him that the prisoner would not be working there again. He submitted an intelligence report to the security department naming both prisoners and made entries in their prison records. He informed the orderly officer and recorded the incident in the workshop observation book. When a SO saw Mr Lambert on the unit later, he said that Mr Lambert had downplayed what had happened and had said that he and the prisoner had just been messing about.

Thursday 19 March

61. That morning, Mr Lambert was due to see a GP for a medication review but went to an art therapy session in the healthcare centre instead. The TDAS worker had read the daily briefing and knew that Mr Lambert had been assaulted in the workshop the day before. She noticed a bruise under his eye and a lump behind his ear. She said that Mr Lambert had been anxious to know if anybody from Unit 2 would be attending. Three prisoners from Unit 2 were there but the prisoner who assaulted him was not among them.

62. Mr Lambert worked well and was engrossed in making a piece of artwork for the chaplaincy to thank them for their support. He talked about the next class and a support worker thought that he seemed to be looking forward to his release and was happier than she had seen him before. ACCT documents should accompany prisoners wherever they go. However, Mr Lambert's had not been brought to the class, so the staff from the Therapeutic Drug and Alcohol Service were unaware that he had been assessed as at risk of suicide and self-harm and was being managed under ACCT procedures. During the class, Unit 5 staff phoned to explain that he was on an ACCT and the therapeutic staff told them that Mr Lambert had had a good session.

63. The class finished at 11.30pm. As they left, Mr Lambert went to collect his antidepressants. A doctor walked past and told him that he had missed his medication review that morning. Mr Lambert apologised and filled out an application for another review, as the doctor had no available appointments that afternoon. Mr Lambert then went back to Unit 5.

64. At 2.00pm, a SO held the fourth ACCT case review, which a mental health nurse attended. The SO had not briefed the nurse, who had not met Mr Lambert

before, and did not check his clinical record before the review. The record of the review noted that Mr Lambert was bright and talkative. He said that the art class had helped him express his feelings. He wanted to change his medication as he thought that citalopram was not working. The nurse advised him to keep taking it and ask for a GP medication review.

65. Mr Lambert said that he was looking forward to his release. The SO warned him that he might not be released on 1 April, if his immigration issues were not resolved. Mr Lambert said he thought this would be sorted out at an immigration surgery on Tuesday 24 March. The SO added immigration issues to the caremap and, although the issue had not yet been resolved, he marked the action as complete. (The investigator contacted the Home Office Foreign National Offender Unit, who confirmed that they had been in the process of closing Mr Lambert's case and would not have detained him when his sentence expired because he had both UK and Australian citizenship. He would have been released as planned on 1 April.)

66. Mr Lambert said that he was settled on Unit 5 and no longer had any thoughts of suicide or self-harm. He said that he did not need ACCT support and he talked positively about the future. The SO and nurse agreed to end the ACCT procedures. SO Hayes told the investigator he was satisfied that all the risk factors he had been aware of had been addressed. The nurse said she had no concerns about Mr Lambert at the end of the review. The SO told Mr Lambert that he had scheduled a post-closure interview for 26 March.

67. There is no reference in the record of the final case review to the bullying Mr Lambert had experienced or the assault in the workshop the day before. However, the SO and nurse both told the investigator that they had discussed this with Mr Lambert. The nurse said that he had been angry that other prisoners picked on him and he felt it was unfair. However, the ACCT panel did not begin a Safer Prisons Support Plan to address any ongoing bullying issues.

68. That afternoon, Mr Lambert and his cellmate asked for separate cells. The cellmate told the investigator that Mr Lambert owed money to other prisoners for tobacco. Prisoners often insist that a cellmate inherits debt when the other prisoner is released. As he did not want to be burdened with Mr Lambert's debt, they agreed to ask for a move. They told an officer this was because they were not getting on. At about 4.30pm, Mr Lambert moved into cell 3 on the third landing, next door to his cellmate, who remained in cell 2. Mr Lambert's was a double cell, but he was alone in the cell.

69. Mr Lambert collected his citalopram as usual in the late afternoon and asked the nurse if the TDAS worker and support worker could give him his artwork to continue in his cell. After collecting his dinner, he was locked in his cell at about 5.15pm for the night. He was not allowed out for the evening association period as he was on the basic regime. At 5.45pm, his artwork was left in the unit office for him. At 7.15pm, Officer A checked that all prisoners were present in their cells. During this check, he said that both Mr Lambert and his cellmate pressed their cell bells and asked for razors. The officer could not find any and told them that they would have to wait until the morning.

70. At 7.50pm, Officer B started his night shift. At night staff on wings do not carry standard prison keys, but have a cell key in a sealed pouch for use in an emergency. The officer collected a sealed pouch from the gate. When he arrived on Unit 5, Officer B briefed him that Mr Lambert was no longer on an ACCT and had moved to the next cell. Officer B took Officer A's radio and collected an anti-ligature knife from the office safe.

71. Officer B began a roll count. When he reached Mr Lambert's cell, shortly after 8.00pm, he looked through the observation panel and saw him hanging at the back of the cell. Mr Lambert had tied one end of a bed sheet to the grille on the window and the other end around his neck.

72. Officer B went to the top of the stairs and shouted to Officer A, who came upstairs, looked through the observation panel and saw Mr Lambert hanging. He unlocked the cell with the keys he carried as a member of the day shift. At 8.05pm, as Officer A went into the cell, Officer B radioed the control room to request assistance. He did not use a medical emergency code, but thought he had said that a prisoner was hanging. However, no one else recalled this. The officer who was working in the control room broadcast the request for help across the radio network.

73. Officer A cut the sheet above the knot, lowered Mr Lambert to the floor and removed the rest of the ligature from around his neck. He checked Mr Lambert's airway and began chest compressions. Officer B tried to give rescue breaths but was unable to as Mr Lambert's tongue was sticking out. He then waited outside the cell while Officer A continued chest compressions.

74. Two nurses were in the healthcare centre when they heard the radio message. One nurse thought Officer B sounded panicky and they decided to go to Unit 5. They took an emergency response bag with them but as the officer had not used an emergency code blue, did not take oxygen or a defibrillator with them. (These are heavier items and kept in a separate trolley.)

75. Officer C heard Officer B's message and thought that something serious had happened. He responded and found him in a state of shock outside the cell. Officer A asked Officer C to call for medical assistance.

76. At 8.09pm, Officer C radioed, 'Medical assistance required – code blue'. He had to transmit the message twice. The officer in the control room asked if they needed an ambulance and Officer C confirmed this. At 8.10pm, the officer in the control room tried to call the emergency services from the control room, but could not get an outside line. (He said that this telephone had malfunctioned in the past.) There was a working telephone on the other side of the room, but he thought he should not leave the communications console. He could make internal calls, so he called a colleague in the gate area and asked him to call an ambulance, which he did immediately.

77. Another officer arrived and took over chest compressions from Officer A. The two nurses arrived and asked the officers to bring oxygen and a defibrillator. One nurse managed to perform rescue breaths and the other took over chest compressions. They had to turn Mr Lambert because he vomited. Two more nurses arrived with more emergency equipment including oxygen and a

defibrillator. A nurse then went to get a suction machine to remove vomit from Mr Lambert's airway. The nurses attached the defibrillator, but it advised them not to shock Mr Lambert. They continued cardiopulmonary resuscitation.

78. The first emergency response vehicle arrived at the gate at 8.23pm and a paramedic arrived in the cell five minutes later, at 8.28pm. An ambulance arrived at the gate at 8.25pm. In a statement to the police, one of the ambulance paramedics said that it took several minutes to get through the prison gates and that, once inside, the escorting officer made them park the ambulance and walked them slowly to Unit 5. The paramedic said that there was nobody waiting outside the unit to direct them inside. An emergency response doctor arrived shortly after.

79. A nurse helped the paramedics. They found it difficult to establish an airway but eventually the emergency response doctor managed to do so. Paramedics gave Mr Lambert three shots of adrenaline and a shock from the defibrillator and then found a pulse. At 9.15pm, the ambulance took Mr Lambert to hospital.

80. Mr Lambert had left a note in his cell, stating that he loved his family dearly but could not go on living and had had enough.

Contact with Mr Lambert's family

81. The managing chaplain acted as the prison's family liaison officer. When he first arrived at the prison, he found that Mr Lambert had given his father as his next of kin but had named his mother when the ACCT was opened. The Governor of Glen Parva, who had arrived shortly before Mr Lambert was taken to hospital, phoned Mr Lambert's father to let him know what had happened. She went to the hospital with the chaplain. They had planned to meet Mr Lambert's father at the hospital, but he was delayed. At 2.00am, he arrived at hospital with his partner, spoke to the escort officers who were with Mr Lambert, and left a short while later.

82. The Governor and managing chaplain had been unable to contact Mr Lambert's mother and stepfather that night because the telephone number Mr Lambert had given was incorrect. The Governor spoke to them the next morning, after she had arranged for the Australian police to contact them. They flew to England and arrived at the hospital at 1.50pm on Monday 23 March, where the Governor and chaplain met them. Mr Lambert never regained consciousness and, on Tuesday 24 March, the Governor and chaplain were present to support Mr Lambert's mother and stepfather when doctors switched off his life support machine. He was pronounced dead at 2.30pm. At the request of his mother and stepfather, his organs were donated.

83. On 26 March, a prison chaplain led a memorial service in Glen Parva, which Mr Lambert's mother and stepfather attended. The chaplain officiated at Mr Lambert's funeral the next day, which the Governor and managing chaplain attended. The prison arranged and paid for a video-link so that relatives in Australia could watch the service. Mr Lambert's mother and stepfather returned to Australia with his ashes on 30 March. The prison paid for the funeral, and reimbursed most of the costs incurred by Mr Lambert's mother and step-father.

84. The Governor had tried, but been unable, to contact Mr Lambert's father to break the news of his son's death. She was not able to contact him again before Mr Lambert's funeral, but later spoke to his partner and offered condolences.

Support for prisoners and staff

85. On 19 March, the duty governor debriefed the staff involved in the emergency response, to ensure they had the opportunity to discuss any issues arising and to offer support. The staff care team also offered support. Most of the staff we interviewed said they had received very good support from prison managers.

86. Night patrol staff kept an eye on the former cellmate. Staff reviewed prisoners assessed as at risk of suicide and self-harm in case they had been affected by Mr Lambert's actions.

Cause of death

87. A consultant in critical care medicine at the hospital confirmed Mr Lambert's cause of death as brain damage caused by a lack of oxygen resulting from hanging. The coroner was satisfied that there was no need for a post-mortem examination. As Mr Lambert had been in hospital for five days before his death, the coroner did not order toxicology tests because they would not have provided meaningful results.

Findings

Bullying

88. Mr Lambert named three different prisoners who he claimed were bullying him in the fortnight before he hanged himself. Staff recorded assaults on Mr Lambert by two of these prisoners. Prison Service Instruction (PSI) 64/2011 concerning the management of prisoners at risk of suicide and self-harm, to others and from others (Safer Custody), states:

> 'Every verbal or physical act of violence must be challenged. Appropriate sanctions for perpetrators must be applied robustly, in a fair and consistent manner. Victims must be supported and protected.'

89. Glen Parva's local safety strategy, issued in October 2014, sets out the following measures to deal with bullying:

- All assaults will be investigated by the safer prisons unit;
- Prisoners who are either victims of assault or bullying or who are vulnerable **must** be placed on a Safer Prisons Support Plan that is individual to their needs;
- Similarly, the perpetrator **must** be placed on early intervention measures if there is evidence of bullying [this now means a booklet is opened for the perpetrator, but this was not the case before Mr Lambert died];
- Staff should submit an intelligence report to the security department for all incidents so they can identify patterns of bullying;
- The member of staff should make an entry in the unit observation book;
- They should also make an entry in the victim's and perpetrator's prison records;
- All staff with prisoner contact will be required to undertake some level of safer custody training.

90. On 5 March, Mr Lambert told a doctor and an officer that a particular prisoner and other prisoners on Unit 2 were bullying him. The doctor was unaware of the prison's anti-bullying procedures and recorded the information in Mr Lambert's clinical record. This cannot be accessed by prison staff and he did not inform anyone separately. The officer was a new member of staff and had not been trained in the anti-bullying strategy and thought it was a manager's responsibility to open a Safer Prisons Support Plan. She made an entry in the unit observation book and asked another officer to submit an intelligence report to the security department but he did not do this. No one investigated the alleged bullying and no one challenged the prisoner about his behaviour.

91. On 12 March, Mr Lambert told an officer that another prisoner, who worked in the same workshop, was bullying him. The officer added Mr Lambert to a handwritten Safer Prisons Support Plan log (which was simply a list of prisoners considered to be vulnerable). He did not name the prisoner in the log but did in

Mr Lambert's prison record. The officer recorded the information in the unit observation book, but did not submit an intelligence report to the security department or alert the workshop instructors that they needed to keep an eye on the prisoner and Mr Lambert. Because staff opened an ACCT document a couple of hours later, they closed the Safer Prisons Support Plan. No one investigated the allegations against the prisoner and he continued to attend the workshop. The only action taken was to move Mr Lambert to Unit 5. The Head of Safer Prisons said that she expected staff to consider restricting the movements of the alleged perpetrator and not simply to relocate the victim. An officer spoke to Mr Lambert about the bullying by Unit 2 prisoners when he interviewed him for an ACCT assessment the next day, but he assumed his move had dealt with the problem.

92. On 15 March, a prisoner apparently assaulted Mr Lambert on the way back from the chapel. No one had warned the officer that Mr Lambert might be at risk from Unit 2 prisoners. He made an entry in the ACCT record, charged the prisoner with a disciplinary offence and informed a prison manager and Unit 5 staff. He did not submit a security intelligence report, make a note in the two men's prison records or record this in the unit observation book. There was no investigation of the alleged assault by the prisoner and the disciplinary charge was discontinued when he transferred to another prison shortly afterwards.

93. No one had advised the instructors that Mr Lambert was at risk of bullying and a prisoner was allowed to attend the workshop on 18 March. He allegedly assaulted Mr Lambert before the instructors could remove him from the session. The instructor began the early intervention process to monitor the prisoner and charged him with a disciplinary charge. He also made entries in Mr Lambert's and the prisoner's prison records, submitted an intelligence report to the security department, made an entry in Mr Lambert's ACCT document and in the workshop observation book and informed the duty manager. This was the only time the expected procedures were followed.

94. We are concerned that Mr Lambert was bullied or assaulted several times, but there were no formal investigations into these incidents and most members of staff did not complete the actions they should have done under Glen Parva's safety strategy. Failure to follow the required safer custody procedures meant that there was no overall coordinated approach to dealing with the problems Mr Lambert was experiencing from other prisoners. It seems likely that Mr Lambert was being bullied and threatened to re-pay tobacco debts but the lack of investigation at the time meant that the staff were unable to tackle the underlying cause. The ACCT procedures did not provide sufficient protection or support.

95. We note that at the last inspection HM Inspectorate of Prisons found that prisoners at Glen Parva were not safe and that efforts to tackle bullying were largely ineffective. Glen Parva has redesigned the Safer Prisons Support Plan and Early Intervention schemes since Mr Lambert died. We cannot judge whether the new system will be more effective, but during our investigation, we were concerned that few staff had been trained in how to identify and combat bullying in the prison. We make the following recommendation:

The Governor should ensure that allegations of violence, bullying or intimidation are taken seriously, investigated and dealt with in line with local and national policies. Prisoners identified as at risk of violence from other prisoners should be effectively protected, and all staff who have contact with prisoners, should be trained in and confident about using the local safety strategy to challenge inappropriate behaviour.

Managing the risk of suicide and self-harm

96. PSI 64/2011 and PSI 74/2011 (Early Days In Custody) both list a number of risk factors and potential triggers for suicide and self-harm. Mr Lambert had a number of these risks when he arrived in prison:

- It was his first time in prison.
- He had recently split up from his partner and was subject to a restraining order.
- His relationship with his father had broken down after he came to the UK.
- His mother and the rest of his family were in Australia and unable to visit.
- He had been sleeping rough and was likely to be homeless when released.
- He had been dependent on alcohol and drugs.
- He had reported bereavement issues.

97. Despite these risk factors, staff did not begin ACCT procedures at Peterborough or when Mr Lambert arrived at Glen Parva a few days later. Staff began ACCT monitoring on 12 March, after he made cuts to his arm.

98. The local safety strategy requires staff to hold a case review as soon as possible, if an ACCT trigger is activated or the prisoner is assaulted. Bullying was recorded as a trigger for Mr Lambert's self-harm. On 15 March, a SO followed the local policy and held a case review in response to the apparent assault by a prisoner. However, there was no case review on 18 March after the more serious alleged assault by another prisoner that morning.

99. National policy and the local safety strategy requires that ACCT case reviews should be multidisciplinary where possible and include relevant people involved in the prisoner's care. A mental health nurse attended the first and final case reviews (although neither were responsible for Mr Lambert's care). The SO held the third review, on 15 March, alone in response to the alleged assault by a prisoner. We recognise that this review was held at short notice on a Sunday afternoon but the SO could have invited the nurse who had just assessed Mr Lambert. The SO did not invite the Therapeutic Drug and Alcohol Service support workers or anyone from the chaplaincy to any of the case reviews, although Mr Lambert had a very good relationship with them. These were missed opportunities to ensure that Mr Lambert's concerns were identified and addressed, appropriate information was shared and that there was good, structured multidisciplinary support.

100. Each ACCT review assessed Mr Lambert as a low risk of suicide and self-harm. There was little evidence that the ACCT reviews fully considered the depth and range of his vulnerabilities, including the risk factors identified above and:

- His very recent self-harm by cutting.
- The barricading incident where he put a razor blade in his mouth (suggesting reckless impulsivity).
- The two alleged assaults and evidence of bullying.
- The imposition of the restricted basic regime.
- His lack of external support.

101. Guidance in the ACCT document itself prompts the case manager to assess the risk as raised if the prisoner has recently self-harmed. Had the SO assessed the risk as raised at the first case review, the succession of incidents over the next few days should then have seen Mr Lambert's risk level either maintained or possibly even increased to high. The low risk assessment suggests that the SO and other panel members did not recognise Mr Lambert's risk factors, were not sufficiently well informed about the new incidents of bullying and were overly reassured by his manner.

102. PSI 64/2011 contains a mandatory instruction that the case manager should not close the ACCT until all the goals and actions on the caremap have been achieved. The SO marked the goals on the ACCT caremap as complete as soon as he added them at the first and the final case reviews, without waiting to determine if the proposed measures had had a positive effect on Mr Lambert's mood. There were also several obvious issues, such as Mr Lambert's social isolation, his immigration status and accommodation on release that should have been added to the caremap with actions to address them.

103. The SO said that he and a nurse decided to close the ACCT on 19 March because they were reassured by Mr Lambert's mood and thought that his problems had been dealt with. While a prisoner's presentation is obviously important and reveals something of their level of risk, it is only one piece of evidence in judging risk. There is no evidence that the staff objectively evaluated all the risk factors when assessing Mr Lambert's risk of suicide and self-harm. On 19 March, he still had a significant number of outstanding risk factors, which should have identified his continuing vulnerability. He had been bullied by at least three different prisoners, most recently just the day before. He had been placed on the basic regime, had still not received any visits or made a telephone call to his family and was still waiting to see an official prison visitor. His cellmate, who he had become friendly with, had been released. He was waiting for confirmation that his dual nationality had been recognised and he would be released as planned. He had no money coming in from outside prison and this seems to have led him to fall into debt. He was also likely to be homeless when he was released.

104. The SO was unaware of some of Mr Lambert's risk factors. He did not know Mr Lambert was on the basic regime, as he would have done had he looked at Mr Lambert's prison record or the ACCT ongoing record. The SO is an offender

supervisor who is linked to Unit 2 and had therefore become the case manager when the ACCT was opened on that unit. He continued to chair all four case reviews after Mr Lambert had relocated to Unit 5. He was unfamiliar with day-to-day events on Unit 5 and seems to have relied too much on what Mr Lambert told him. Although PSI 64/2011 recommends continuity of case manager, and we rarely see this level of continuity, this is only beneficial if the manager has a good knowledge of the prisoner and his issues. It does not appear that the SO read the ACCT ongoing record or Mr Lambert's prison record. As noted above, he did not have the benefit of multi-disciplinary attendance at ACCT reviews of staff who were involved in Mr Lambert's day-to-day care.

105. Violence reduction should have been properly integrated into the ACCT process, but we found no evidence of this. The systemic failure to report the ongoing bullying undoubtedly undermined ACCT procedures, but the SO knew about the alleged assaults by two prisoners and bullying was recorded as a trigger in the ACCT document. Yet there is no reference in the final ACCT case review to the alleged assault by a prisoner and whether Mr Lambert was experiencing on-going bullying. The SO and nurse told the investigator that they did discuss this with Mr Lambert and were reassured by what he said. However, there is no evidence of this in the record of the review.

106. The SO closed the ACCT just one day after Mr Lambert had been assaulted, although this had been identified as a trigger for self-harm. It should have been evident that Mr Lambert remained vulnerable. We consider that this alone was sufficient grounds for the ACCT to remain open, regardless of the numerous other outstanding risk factors. We are concerned that staff at Glen Parva did not fully recognise the links between bullying and risk of suicide and self-harm. Bullying is a risk factor for all suicides but this is especially marked in younger people. The SO told the investigator that he would not have closed the ACCT if he had realised the full extent of the bullying, but this should have been established by reading the records, and involving people who knew him in the case reviews.

107. The local safety strategy requires that support remains in place for a prisoner once an ACCT is closed and recommends a Safer Prisons Support Plan to help the transition from the intensive support of an ACCT. Although we consider that the SO was wrong to close the ACCT, once he did so, he should have opened a Safer Prisons Support Plan for Mr Lambert. There was no structured support for Mr Lambert after the ACCT was closed.

108. Mr Lambert's family asked why he was allowed bed sheets in his cell when he was at risk. Items such as sheets, necessary for a prisoner's dignity and comfort, would be removed only in extreme circumstances when a prisoner is at very high risk of hanging. At the time he hanged himself, Mr Lambert was no longer assessed as at risk of suicide and self-harm, had never been regarded as a high risk and had never previously used a ligature to harm himself in prison. It is impossible to remove all items that prisoners might use as a ligature, without making living conditions intolerable. We are satisfied that there was no reason to remove any items from Mr Lambert's cell.

109. In our Learning Lessons Bulletin about the self-inflicted deaths of young adult prisoners, published in July 2014, we identified a number of lessons that resonate with Mr Lambert's circumstances. In particular, we highlighted how the break-up of relationships and separation from their families can disproportionately affect young adults because of their limited life experience. We also found 20% of 18-14 year olds who killed themselves had experienced bullying in the previous month, compared to 13% of other prisoners, and we identified the need to investigate and act upon bullying and always consider the impact on the risk of suicide and self-harm. We also recognised the impact of relocation within the prison and the anxiety provoked by immigration problems.

110. Sadly, this investigation found significant failings in the management of Mr Lambert's risk of suicide and self-harm. Violence reduction was not integrated into the case review process, case reviews were not held promptly in response to incidents of bullying and were not always sufficiently multidisciplinary. The ACCT panel was unaware of significant risk factors, caremap actions were marked as completed when this was not the case, and the assessment of the risk of suicide and self-harm was underestimated. The ACCT was closed prematurely without addressing Mr Lambert's risk factors or putting in place other measures to keep him safe. We make the following recommendation:

The Governor should ensure that staff manage prisoners at risk of suicide and self-harm in line with national guidelines. In particular:

- **All staff in contact with prisoners identified as at risk of suicide and self-harm should be aware of this and be able to make appropriate entries in the ACCT document.**
- **ACCT reviews should fully consider and record the impact of bullying on the risk of suicide and take appropriate action.**
- **ACCT reviews should be multi-disciplinary, aware of all recent issues, and include all relevant people involved in a prisoner's care.**
- **ACCT reviews should consider and record all known risk factors when determining the level of risk of suicide and self-harm or closing an ACCT.**
- **Caremap actions should address all identified issues to help reduce a prisoner's risk and the ACCTs should not be closed until the risk has reduced and all caremap actions have been completed.**

Family contact

111. Separation from his family, both his father in the UK and mother in Australia, was a clear risk factor for Mr Lambert. His mother asked us why he had not been able to telephone her in Australia. One of the goals on the ACCT care map was family contact, but Mr Lambert had still not telephoned his family or had a visit when the ACCT was closed. He had also been waiting over a month for an official prison visitor because the scheme had only two visitors who were in demand. The ACCT case manager had asked the safer prisons team whether Mr Lambert qualified for extra phone credit to call home, but he had still not

received an answer when he marked the goal as complete on 13 March, or when he closed the ACCT on 19 March.

112. As family contact had been identified as an issue on his ACCT care map to help reduce his risk, we would have expected the staff to have arranged calls for Mr Lambert, irrespective of whether he 'qualified' for phone credit. In fact, Mr Lambert should have been allowed a free telephone call to his family in Australia in line with PSI 49/2011, which covers prisoner communications. The PSI contains a mandatory provision that foreign national prisoners or those with close family abroad who have not had a social visit in the preceding month should be given a free five-minute phone call. Mr Lambert had not had any visits. We make the following recommendation:

The Governor should ensure that foreign national prisoners, or those with close family abroad, can call their relatives in accordance with PSI 49/2011. Those assessed at risk of suicide and self-harm should have additional calls as necessary.

Sources of support for Mr Lambert

113. Although there were significant problems with the way staff tackled bullying and managed Mr Lambert's risk of suicide and self-harm, we recognise that he also received some very good support at Glen Parva. He valued the services and help he got from the chaplaincy and decided to be baptised. He attended the weekly service as well as music therapy and Christian studies classes, which he said he found helpful.

114. Mr Lambert was monitored for 28 days to ensure successful withdrawal from drugs and alcohol when he first arrived at Glen Parva. The clinical reviewer found that Mr Lambert received care equivalent to that available in the community. He was treated promptly for his drug and alcohol misuse and any physical or mental health issues. Staff recorded appropriate care plans and Mr Lambert received good support from healthcare staff. He had a good rapport with the drug and alcohol support workers and on the day he hanged himself, he seems to have had a very positive and encouraging art class. He also got on well with his workshop instructors. More generally, he was well liked by the staff and was able to speak to them about some of his problems.

Incentives and earned privileges scheme

115. The incentives and earned privileges (IEP) scheme is intended to reward or punish ongoing behaviour rather than a specific disciplinary offence. Mr Lambert had been placed on the basic IEP regime when he died. In our Learning Lessons Bulletin about the basic regime, published in March 2013, we found that disproportionate numbers of self-inflicted deaths occur among those on the basic regime and that the use of this regime needs to be carefully coordinated within a wider plan of support for prisoners at risk of self-harm. In our Learning Lessons Bulletin about young adult prisoners, we found that 16% of 18-24 year olds were on the basic regime when they took their own lives, as opposed to 6% of older prisoners.

116. Glen Parva's local IEP policy requires managers to hold an immediate IEP review if a prisoner commits a zero tolerance offence, usually the most serious cases of misconduct. There is a strong presumption that the prisoner will be immediately downgraded to the basic regime. The policy also requires that, if a prisoner is at risk of suicide or self-harm, this should be considered at the IEP review.

117. After Mr Lambert was found guilty of a disciplinary offence for his part in the incident in the TV room, a SO held an IEP review and placed him on the basic regime. This meant he had a more restricted regime including loss of a television and association time on the landing with other prisoners.

118. Prison Service Instruction 30/2013, which governs the IEP scheme, allows for both a disciplinary punishment and a loss of privileges if a prisoner's behaviour falls significantly below expected standards. However, the PSI reminds governors that their local IEP scheme must consider the needs of prisoners who are vulnerable or at risk of suicide or self-harm. The withdrawal of privileges should be considered on a case by case basis and, where necessary, alongside ACCT procedures.

119. The SO's entry in Mr Lambert's prison record about the IEP review does not consider the risk of suicide and self-harm or mention that he was on an ACCT. Best practice would have been for the IEP review to have taken place as part of an ACCT case review, or at least for the case manager to have been involved. The decision to remove Mr Lambert's privileges was taken in isolation from the ACCT process and therefore did not comply with PSI 30/2013. We make the following recommendation:

The Governor should ensure that decisions to demote prisoners at risk of suicide and self-harm to the basic regime are taken in conjunction with the ACCT process. Removal of privileges, such as a television, should be carefully assessed and recorded and take into account the likely impact on the health and welfare of the prisoner.

Emergency Response

120. PSI 03/2013 about medical emergency response codes requires staff to use an emergency code when they find a prisoner in a critical condition, which should then automatically prompt control room staff to call an ambulance. Glen Parva's guidance, contained in its local safety strategy, requires staff at the scene to state that an ambulance is required as well as using the code. This is not a correct interpretation of the PSI and we have previously made recommendations to Glen Parva about this. The control room should call an ambulance immediately they receive an emergency code and should not delay by checking with staff at the scene. The PSI makes it clear that it is better to act with caution and request an ambulance that can be cancelled if it is later assessed as not required.

121. There was a delay in calling an ambulance when Officer B found Mr Lambert hanging. He did not immediately radio for help but first left the cell, shouted for Officer A and waited for him to come upstairs. It was not until Officer A went into

the cell that Officer B radioed to get further help. He knew the correct emergency code but was in a state of shock and forgot to use it. He asked for assistance and gave his location. However, this meant that other staff did not know that the nature of the incident they were attending. It was a further four minutes before Officer C arrived and radioed a medical emergency code blue (which indicates a prisoner is unconscious or not breathing). Before he called an ambulance, the officer in the control room checked with Officer C whether one was required. He could not get an outside telephone line in the control room and had to ask a colleague in the gate to call the emergency services. He said that there had been a recurring problem with this telephone.

122. Because Officer B did not radio a medical emergency code blue, nurses did not bring the emergency trolley containing the oxygen and defibrillator with them. This had to be collected after they reached the scene. They needed a suction machine to remove vomit from Mr Lambert's airway, but this was not on the trolley and had to be brought separately. The clinical reviewer noted that it is good practice to store all emergency equipment together.

123. One of the paramedics was so concerned about the slow response when he and his colleagues arrived at Glen Parva that he submitted an incident report to his managers. He also made his concerns clear in a police statement. There appeared to be a lack of urgency in getting paramedics to Mr Lambert's cell and this took too long. We make the following recommendations:

The Governor should ensure that all prison staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies and that Glen Parva has a medical emergency response code protocol based on the PSI which ensures:

- **Staff use the appropriate emergency code to effectively communicate the nature of a medical emergency;**
- **Staff bring the relevant emergency equipment;**
- **There are no delays in calling, directing or discharging ambulances.**

Family liaison

124. Family liaison after a death in custody is a sensitive and important role. In this case, we found several examples of good practice. The prison reimbursed most of Mr Lambert's mother and stepfather's costs, including their flights and hotel, and they arranged for the funeral to be broadcast to relatives on the internet. This was unusual and very considerate. Unfortunately, their efforts had an inadvertent outcome, as during the funeral service the chaplain who officiated mentioned that Mr Lambert had taken his own life. Not all of his relatives in Australia had been told and were upset to find out in this way. We sympathise with the chaplain and Mr Lambert's family. It was a mistake, but unless Mr Lambert's family had alerted the chaplain to this particular sensitivity, we do not consider he could have been expected to know this.

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