Prisons & Probation
Ombudsman
Independent Investigations

Independent investigation into the death of Mr James Flynn, a prisoner at HMP Guys Marsh on 27 April 2015

A report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

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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*

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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 James Flynn was found hanged in his cell at HMP Guys Marsh on 27 April 2015. He was 34 years old. I offer my condolences to Mr Flynn's family and friends.

Earlier in April, Mr Flynn had been monitored as at risk of suicide and self-harm, but for less than a day. There were procedural flaws with the operation of the suicide and self-harm prevention procedures and they were ended without adequate assessment of Mr Flynn's outstanding risk. On the day he died, Mr Flynn talked about feeling unsafe, but gave no details. In response, and without proper consideration, a manager arranged for him to transfer to another prison the next day. This would not have met his sentence plan needs. The investigation found that, on the night Mr Flynn died, staff did not act with sufficient urgency to safeguard him after an initial act of self-harm. After Mr Flynn died, the prison informed his father by telephone rather than in person, contrary to national guidance.

Mr Flynn was serving an automatic life sentence with a minimum period to serve of just over two years and had been in prison since 2005. At the time of his death, he had served eight years more than his minimum term. Despite completing a number of offending behaviour programmes, he had just received a further parole rejection. Mr Flynn had a number of other concerns in his life, including the recent death of his mother, and appears to have begun to despair of ever being released. His death is a sad reminder of the stress and uncertainty that prisoners serving indeterminate sentences can face. Mr Flynn had a number of other risk factors, which heightened his risk of suicide, including that he came from the Traveller community, and I am concerned that the prison failed to identify and address these risks and give him the support he needed.

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

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

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Summary

Events

1. In 2005, Mr James Flynn received an automatic life sentence with a minimum period to serve of two years and one month. He had successfully completed a number of offending behaviour programmes, but the Parole Board had never considered his risk sufficiently reduced to direct his release. He had been moved back from open prison because of concerns about his behaviour and had been at Guys Marsh since April 2014. He became increasingly frustrated about his lack of progress towards release. Mr Flynn sometimes used illicitly obtained subutex and had sought help to end his dependency. Mental health staff had diagnosed him with a form of attention deficit hyperactivity disorder (ADHD) and with depression, but he would not take prescribed medication for either condition. Mr Flynn was from the Irish Traveller community and close to his family. His mother died in December 2014, which hit him hard. That month he was refused parole and later found out that his father had cancer.

2. On 9 April 2015, Mr Flynn said that he felt like killing himself and staff began Prison Service suicide and self-harm prevention procedures, known as ACCT. A manager ended ACCT monitoring the same day without holding a required multidisciplinary review. Mr Flynn subsequently experienced sudden variations in moods. On 27 April, Mr Flynn said he felt unsafe and asked to move to another unit or another prison. A manager arranged a transfer to another prison for the next day. That evening, he cut his wrist and said he was going to kill himself. An officer left his cell to contact the night manager, who told him to open an ACCT. When the officer went back to his cell after about ten minutes, he found the observation panel covered and could not get a response from Mr Flynn. The officer asked the night manager to attend but did not make the urgency of the situation clear. When the manager and other staff arrived, they opened the cell and found that Mr Flynn had hanged himself. They were unable to resuscitate him and paramedics declared him dead shortly after they arrived.

Findings

3. The investigation found that the case manager ended ACCT procedures prematurely and unilaterally without appropriately dealing with the issues identified on the caremap or considering all of Mr Flynn's risk factors. This meant he did not get the support he needed.

4. Mr Flynn was understandably concerned about the length of time he had spent in prison and his lack of progress towards release. However, earlier on the day of his death, a manager organised an ad hoc and unsuitable transfer, which was due to take place the next day. Mr Flynn was preoccupied about this on the evening he died. We are concerned that this would not have allowed Mr Flynn to fulfil his sentence plan objectives and was likely to have further prolonged his stay in prison. It seems that Mr Flynn was also aware of this. There is little evidence that anyone investigated Mr Flynn's concerns about his safety, which he referred to on the day he died.

5. We are satisfied that Mr Flynn received an appropriate standard of healthcare at the prison. However, in March 2015, a psychiatrist prescribed ADHD medication, which Mr Flynn declined to collect. No one informed the psychiatrist, which was a missed opportunity for another intervention.

6. On the day he died, Mr Flynn made some unspecific comments that he felt unsafe but gave staff no details. We have found no evidence that Mr Flynn was being bullied at the time of his death but note that it was alleged that he had been subject to racist abuse and attacked shortly after he arrived at Guys Marsh. The prison does not include issues about Travellers and other minority groups in its local anti-bullying policy.

7. We have serious concerns about the management of Mr Flynn's risk, after he initially self-harmed by cutting his wrist on the night he died. An officer should have stayed at Mr Flynn's cell door to observe and reassure him after he threatened to kill himself. When Mr Flynn covered the observation panel in his cell door and did not respond, staff should have regarded this as an emergency and responded urgently. Instead, the response was too slow. The prison informed Mr Flynn's father of his death by telephone rather than in person, contrary to national policy.

Recommendations

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

  - ACCT case reviews should be multidisciplinary and include all relevant people involved in a prisoner's care.
  - Reviews should record and take into account all the known risk factors and triggers when considering the risk of suicide or self-harm, including those of minority groups such as Travellers.
  - Caremap actions should be specific and meaningful to address the underlying causes of a prisoner's distress and reduce their risk.
  - ACCT monitoring should continue until the risk is reduced and all caremap actions have been completed.

- The Governor should ensure that decisions about the routine transfers of prisoners serving indeterminate sentences are taken at sentence planning meetings, where possible, and best meet their needs, in line with the instructions in PSO 4700.

- The Governor should ensure that staff report and challenge all indications of potential bullying in accordance with the local 'Tackling Anti-Social Attitudes' policy and that the policy reflects bullying associated with Travellers and other minority groups in the prison.

- The Head of Healthcare should ensure that prescribing clinicians are informed when prisoners do not collect their medication.

- The Governor should ensure that staff monitor prisoners who self-harm until they are satisfied that it is safe to leave them and that they take immediate and urgent action when a prisoner at risk of suicide and self-harm is not visible and does not respond to a check.

- The Governor should ensure that families are informed in person of a prisoner's death, where possible by a member of staff from the prison, and that further contact with families follows the requirements of PSI 64/2011.

The Investigation Process

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

9. The investigator visited Guys Marsh on 5 May. He obtained copies of relevant extracts from Mr Flynn's prison and medical records and interviewed two prisoners.

10. NHS England commissioned a clinical reviewer to review Mr Flynn's clinical care at the prison.

11. The investigator interviewed 21 members of staff and one prisoner at Guys Marsh in June and July. The clinical reviewer joined the investigator for interviews with healthcare staff on 12 June.

12. We informed HM Coroner for Dorset of the investigation who gave us the results of the post-mortem examination. The coroner commissioned additional toxicology tests in the light of information from our investigation. We have sent the coroner a copy of this report.

13. One of the Ombudsman's family liaison officers contacted Mr Flynn's father to explain the investigation and to ask if he had any matters he wanted the investigation to consider. He asked for more information about the night his son died, specifically what happened after he cut his wrist and how prison staff had managed his risk of suicide and self-harm. He asked if prison staff should have gone into his son's cell immediately on the evening of 27 April, as soon as there were concerns about him. He was unhappy that no one had had informed him of his son's death in person but the prison had telephoned instead. He said that his son had been frustrated by his lack of progression towards release and asked for more detail about this.

14. The family liaison officer sent Mr Flynn's relatives a copy of the draft report. Due to circumstances beyond their control, they were unable to read and respond to our findings before we issued the final report.

15. NOMS responded to our draft report with an action plan which we have annexed to this final report.

Background Information

HMP Guys Marsh

16. Guys Marsh holds up to 579 men who are usually nearing the end of their sentence. Single cells comprise about two thirds of the accommodation. Dorset University Healthcare Foundation Trust provides primary and secondary mental healthcare and commission another agency, EDP, to provide Integrated Substance Misuse Services. Healthcare staff are on duty on weekdays but not in the evenings or weekends.

HM Inspectorate of Prisons

17. The most recent inspection of HMP Guys Marsh was in November 2014. Inspectors were very critical and described the prison as in crisis. Levels of violence were three times higher than at the last inspection and many prisoners told inspectors that they did not feel safe. Violence was driven by the supply of drugs including subutex and synthetic cannabinoids (also known as new psychoactive substances). Prisoners said it was easy to get drugs and alcohol. As a result, they got into debt with organised gangs, with the debts enforced by violence and threats. There was no strategy to tackle these issues.

18. There were some positive findings from the inspection. Relationships between staff and prisoners were mostly good and inspectors noted that some staff worked hard to engage with prisoners and address their needs, especially with lifers. The prison had a prisoner-led system for identifying Gypsy, Romany or Traveller prisoners and an equality representative consulted them to identify needs. The quality of ACCT documents for prisoners assessed as at risk of suicide and self-harm was generally good and prisoners being managed under ACCT procedures were mostly positive about their care. The chaplaincy played an important and effective role. There was a high level of mental health need and mental healthcare was good and improving.

19. Inspectors found the overall management of resettlement was disjointed and inadequate. Offender supervisors had infrequent contact with prisoners and too many did not have up-to-date sentence plans.

Independent Monitoring Board

20. 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 November 2014, the IMB reported concerns about the availability of drugs and associated violence and debt, but described the prison as decent and humane.

Previous deaths at HMP Guys Marsh

21. The last self-inflicted death at Guys Marsh was in 2006. We have investigated three deaths from natural causes at the prison more recently, but there were no issues relevant to the circumstances of Mr Flynn’s death.

Assessment, Care in Custody and Teamwork

22. Assessment, Care in Custody and Teamwork, known as ACCT, is the Prison Service care-planning system used to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk, how to reduce the risk and how best to monitor and supervise the prisoner. After an initial assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. Checks should be irregular to prevent the prisoner anticipating when they will occur. There should be regular multidisciplinary review meetings involving the prisoner. As part of the process, a caremap (plan of care, support and intervention) is put in place. The ACCT plan should not be closed until all the actions of the caremap have been completed. All decisions made as part of the ACCT process and any relevant observations about the prisoner should be written in the ACCT booklet, which accompanies the prisoner as they move around the prison. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

Key Events

23. On 8 February 2005, Mr James Flynn received an automatic life sentence with a minimum period to serve of two years and one month for wounding with intent to cause grievous bodily harm. (Automatic life sentences were imposed between October 1997 and April 2005 for those convicted of a second serious violent or sexual offence.) The victim of his offence was his former partner. Mr Flynn spent time at a number of prisons and completed seven offending behaviour programmes. These were:

    - Prison - Addressing Substance Related Offending (P-ASRO)
    - Enhanced Thinking Skills (ETS)
    - Healthy Relationship Programme (HRP)
    - Family Man course
    - Controlling Anger and Learning to Manage it (CALM)
    - Control Of Violence and Anger in Impulsive Drinkers (COVAID)
    - Self-Change Programme (SCP)

24. In April 2013, Mr Flynn transferred to HMP Prescoed, an open prison, after a Parole Board recommendation. In July, he tested positive for drugs and was moved back to a closed prison. In October 2013, he transferred to another open prison, HMP Leyhill but, on 4 April 2014, he was moved back to closed conditions after managers decided he was unsuitable for open conditions because he had allegedly been bullying other prisoners and dealing drugs. After spending five days at HMP Bristol, he was transferred to HMP Guys Marsh.

25. After he arrived at Guys Marsh, members of the mental health team saw Mr Flynn frequently. On 11 April, he told a mental health support worker, that he thought he had attention deficit hyperactivity disorder (ADHD). He said he had no thoughts of suicide or self-harm. On 19 May, a nurse assessed him using standard questionnaires for symptoms of depression and anxiety. The assessments indicated that he was severely depressed. Mr Flynn said that he had been sexually and physically abused when he was a child. On 23 May, a doctor prescribed Mr Flynn citalopram (an antidepressant).

26. On 8 July, Mr Flynn told the nurse that he did not want to take antidepressants and the nurse agreed to offer ongoing support instead. The same day, staff started monitoring Mr Flynn under the prison's violence and anti-bullying procedures, known as Tackling Anti-Social Attitudes (TASA), after a prisoner had claimed that Mr Flynn and another prisoner were bullying him and planning to assault an officer. On 15 July, the nurse saw Mr Flynn again when he said he was having paranoid thoughts. The nurse again assessed him as severely depressed with high levels of anxiety.

27. On 16 July, Mr Flynn told a substance misuse worker that he was misusing subutex (an opiate substitute). On 22 July, he began a lofexidine detoxification programme. (Lofexidine alleviates the symptoms of withdrawal from opiates. Mr

Flynn completed the programme at the end of July.) The same day, staff stopped monitoring Mr Flynn under the TASA process.

28. On 28 July, Mr Flynn's offender supervisor, had a video conference with Mr Flynn and his offender manager (probation officer) in the community. The offender supervisor noted the negative effect that long-term imprisonment was having on Mr Flynn's mental health. Mr Flynn said that he was depressed, disillusioned and despondent and wanted to be in an open prison. However, he accepted that his own behaviour had made this difficult. The offender supervisor asked him to think about how he could use his time in prison constructively.

29. On 5 August, Mr Flynn told the nurse that he was anxious about his forthcoming parole hearing, which was planned for the beginning of September. The nurse tested Mr Flynn for ADHD and the results suggested residual ADHD. (This meant his condition had continued into adulthood but was less pronounced.) On 12 August, Mr Flynn began a naltrexone treatment programme, at his request. (Naltrexone is used to manage alcohol and opiate dependence by blocking their effects.) On 3 September, Mr Flynn's parole hearing was adjourned for further reports. On 15 September, the nurse referred Mr Flynn to the mental health in-reach team to investigate his possible ADHD diagnosis.

30. On 15 October, a doctor wrote in Mr Flynn's clinical record that he had told him he was not being supported, feared for his life and that violence on the living units was severe. There is no record that Mr Flynn reported this to other prison staff and neither did the doctor. On 21 October, Mr Flynn was due to see the nurse but left the waiting room before his appointment saying that his head was all over the place. On 30 October, staff began monitoring Mr Flynn under the TASA procedures after another prisoner alleged that Mr Flynn had been taunting him about his offence. Staff monitored him for 14 days but found no further evidence of this.

31. On 31 October, a nurse from the mental health in-reach team assessed Mr Flynn. He found some traits of ADHD but no abnormal or paranoid thoughts, no suicidal thoughts and no evidence of psychosis or a mental illness. He referred Mr Flynn to a speciality doctor in adult psychiatry, who saw him on 26 November. She diagnosed residual features of adult ADHD and traits of emotionally unstable and anti-social personality disorder. Mr Flynn said he would not consider suicide because of his Catholic upbringing in the Irish Traveller community. The doctor prescribed an initial low dose of methylphenidate which Mr Flynn had to collect from the medication hatch. (Methylphenidate treats impulsive behaviour and restlessness and can improve focus and concentration.)

32. On 4 December, a Parole Board panel at Guys Marsh commended Mr Flynn for the way he had coped with the setback of a return to closed conditions. However, they thought that he needed to complete further work in a closed prison to ensure that he could be safely managed in the community. They said that Mr Flynn should complete further work, possibly of a specialist nature. (His offender manager had suggested a PIPE unit – Psychologically Informed Planned Environments – which are smaller, more controlled units run by specially trained staff with an understanding of personality disorders. They are not a treatment intervention but are designed to maintain previous achievements in programmes

and help prisoners progress.) Mr Flynn's next parole hearing was scheduled for June 2016.

33. Mr Flynn was due to see the doctor again on 10 December but asked to rebook the appointment because he had family issues. Mr Flynn's mother was terminally ill and prison chaplains arranged for him to telephone her before she died on 6 December. On 11 December, staff began monitoring Mr Flynn under the TASA process because they suspected him, and some other prisoners, of bullying a man for a long-standing debt. Mr Flynn was monitored for 14 days but staff found no evidence of his involvement. On 23 December, prison officers escorted him to his mother's funeral.

34. On 1 January 2015, Mr Flynn's personal officer, noted that Mr Flynn had had a difficult month but he had shown incredible strength and maturity. He was enthusiastic about his new job as a unit painter. On 2 January, Mr Flynn told a nurse from the primary mental health team that he had stopped taking methylphenidate because he was feeling no benefit. He was not sure that he wanted to engage with the mental health in-reach team.

35. On 2 February, the nurse noted that Mr Flynn had worked well with the substance misuse team and had coped well with the bad news he had received recently. On 13 February, Mr Flynn spoke to the offender supervisor about concerns he had about his offender manager. The offender supervisor said he would support him in a request for a new offender manager as he considered he was stagnating and not progressing in his sentence. He noted the need to find positive things to do before Mr Flynn's next parole review. Mr Flynn spoke about time passing, his mother's death and that his father was now seriously ill. (At the end of March, Mr Flynn's family told him that his father had been diagnosed with cancer.) He said that, with the passage of time, his immediate family was fading away and he was scared that this might make it more difficult to be released, as the Parole Board would consider he lacked stable family support. He became upset and cried. The offender supervisor noted that he thought it had been helpful for Mr Flynn to speak about these issues and he would be able to talk about them in confidence with the Roman Catholic chaplain.

36. On 18 March, Mr Flynn saw the doctor after deciding to re-engage with the mental health in-reach team. The doctor noted he was restless, fidgety and talkative. He said he had stopped taking methylphenidate because he thought that it might negatively affect a future parole review. The doctor encouraged Mr Flynn to begin taking it again at the same low dose. Mr Flynn told the doctor that he was misusing subutex again. The doctor had no concerns about Mr Flynn's risk of suicide or self-harm and saw no evidence of low mood or anxiety to warrant prescribing antidepressants. Mr Flynn was under the care of both the in-reach team and the primary mental health team and the doctor planned to see him again. After this appointment, Mr Flynn did not collect methylphenidate again. On 25 March, the personal officer told the substance misuse team that Mr Flynn had started using subutex again. Mr Flynn wanted to begin a lofexidine detoxification programme again and a nurse made an appointment for him on 2 April. Mr Flynn did not attend. The appointment was rebooked for 9 April.

37. On 4 April, the officer noted in the unit observation book that Mr Flynn was very up and down in his mood. The personal officer recorded in his case notes that day that Mr Flynn had had more bad news that month, as he had learnt that his father had cancer. More positively, he had spoken to his new offender manager. He noted that Mr Flynn engaged well with staff but needed to engage with substance misuse services better.

38. On 7 April, unit staff telephoned Mr Flynn's substance misuse worker as he seemed to be under the influence of a sedative. She went to see him but he was sleepy, apparently sedated, and was slurring his words. She told him to go to bed and sleep it off.

39. On 9 April, the substance misuse worker reminded Mr Flynn that he had an appointment with a nurse that day. He refused to provide a urine sample for a drug test, became paranoid and angry. He was verbally abusive to the substance misuse worker and accused her of manipulation. Officers were worried for her safety so she left the unit. The substance misuse worker informed the duty custodial manager and the safer custody team what had happened. She did not think that Mr Flynn had been under the influence of alcohol or drugs.

40. Officers noted that Mr Flynn seemed very down and he told two officers that he felt like taking his own life. At 12.25pm, one of the officers began ACCT procedures, for prisoners at risk of suicide and self-harm. At 1.00pm, a custodial manager completed an ACCT immediate action plan in which he instructed staff to have a conversation with Mr Flynn in the morning, afternoon and evening and check him every two hours when he was locked in his cell at night.

41. At 1.50pm, the Reverend who knew Mr Flynn quite well, assessed him as part of the ACCT procedures. Mr Flynn told him that he was having a tough time because of his parole refusal, his mother's death and his father's cancer diagnosis. His father was having a biopsy that day. He told the Reverend that he took drugs, usually subutex. He said he did not have any thoughts of suicide or self-harm, but was at a low ebb, was fed up sitting in jail and had given up fighting the system. He did not know what else he could do to progress and was frustrated about the recommendation that he should move to a prison with a PIPE unit and how long that would take. He said that he felt sorry for himself but would not give up. Mr Flynn said he was astonished that an ACCT had been opened and thought other prisoners would see it as a sign of weakness. He said that he would not engage with the process and asked for the ACCT to be closed.

42. That afternoon, the Reverend told the custodial manager, who was the ACCT case manager, that he thought that Mr Flynn had problems but was not in crisis, and had made an impulsive remark to officers. The Reverend thought that Mr Flynn would have been honest about thoughts of suicide or self-harm, as they knew each other well. The Reverend did not think that Mr Flynn was a risk to himself.

43. At 3.00pm, Mr Flynn went to his prearranged appointment with the nurse. He said he was misusing subutex and tramadol, seemed agitated and frustrated and said that he was prepared to smash up the unit to get to the segregation unit. He tested positive for subutex. He refused to discuss his mental health but wanted

to begin a detoxification programme. The nurse thought that Mr Flynn was more settled by the end of the meeting. He did not mention any thoughts of suicide or self-harm. The nurse prescribed zopiclone (a sleeping pill) for three days as an interim measure before Mr Flynn started a 10-day lofexidine programme on Monday 13 April. (Substance misuse nurses do not work at weekends. Detoxification programmes start on Mondays so they can monitor the first stages of withdrawal.)

44. At about 5.40pm, the custodial manager went to Wessex House, Mr Flynn's residential unit, to hold the first ACCT case review. The custodial manager said he knew Mr Flynn quite well and had spoken at his most recent parole hearing. He was aware that Mr Flynn was frustrated about his lack of progression towards release. Although ACCT reviews are required to be multidisciplinary and attendance of a member of healthcare staff is mandatory for a first review, no other staff attended the review. The custodial manager had telephoned the nurse, who said that the mental health nurses were finishing their shifts, but there were no serious mental health concerns about Mr Flynn and he was due to see them regularly. The custodial manager said he spoke to his wife, who was an officer on Wessex House, for an update about Mr Flynn. The custodial manager told the investigator that the unit officers were busy when he started the review, and in any case, Mr Flynn had not wanted other staff to attend.

45. The custodial manager told the investigator that he thought that Mr Flynn had behaved aggressively to the substance misuse worker because he did not want to tell her about his subutex misuse. He thought that his remark to officers about killing himself had been impulsive and not serious. After Mr Flynn admitted in the case review that he had been misusing subutex, the custodial manager said he became calmer. Mr Flynn told him that he was not getting enough help from the substance misuse and healthcare teams.

46. The custodial manager recorded in the ACCT document that Mr Flynn was waiting for the results of his father's biopsy and the outcome might be a trigger or warning sign to prompt immediate review. He entered two issues on the ACCT caremap (actions designed to reduce risk): to meet with the substance misuse team and the mental health team. The custodial manager marked both as complete at the end of the case review. In explanation, the custodial manager said that he had already spoken to the nurse about Mr Flynn's mental health and said that he had spoken to the head of the substance misuse team, the next day. Although the custodial manager did not speak to the head of substance misuse team until the next day, he said that he was satisfied that Mr Flynn was being supported for his mental health and drug problems. The custodial manager thought that subutex misuse was Mr Flynn's main problem and that he did not need to be monitored under ACCT procedures, as he was starting a detoxification programme. The custodial manager told the investigator that he had absolutely no concerns about Mr Flynn after the ACCT review. He said he had been light-hearted during the case review and was not in a low mood. The custodial manager decided that Mr Flynn's risk of suicide and self-harm was low, and he closed the ACCT on his own. Although he had recorded the outcome of Mr Flynn's father's biopsy as a possible trigger for suicide or self-harm, he did not arrange any further support.

47. On 10 April, the substance misuse worker saw Mr Flynn to take his blood pressure. He said that he did not want to work with the substance misuse team further after he had completed his detoxification programme. On 14 April, Mr Flynn threatened another prisoner when he thought he had been stealing from his cell. The other prisoner moved to another unit. On 15 April, Mr Flynn told the Independent Monitoring Board (IMB) that he wanted to transfer to Fontmell House, a resettlement unit for prisoners on the enhanced level of the prison's incentive and earned privileges scheme, which had better facilities. Mr Flynn said that his application was being blocked by a member of staff who had told him that they did not accept life sentenced prisoners. The IMB member told the investigator that Mr Flynn was cheerful and engaging and did not appear to be unhappy or struggling to cope. He praised the help the personal officer and the custodial manager had been giving him. The IMB member spoke to the personal officer who said that he was helping Mr Flynn with his application for Fontmell House. She raised the issue at the IMB meeting later that day and added it to the weekly report to the Governor. The same day, Mr Flynn shouted an apology to the substance misuse worker out of his window. She went to see him and said he seemed healthier and embarrassed by his recent behaviour.

48. On 16 April, the custodial manager saw Mr Flynn for an ACCT post-closure review. He said the meeting was short as Mr Flynn did not want to be there. He was bantering and joking and the custodial manager thought he seemed back to normal. The custodial manager had no concerns about his risk of suicide or self-harm. Mr Flynn said that he could turn to staff on Wessex House and other Travellers for support. He said he had a new offender manager who was going to help him with his sentence progression.

49. On 20 April, an officer helped Mr Flynn to telephone his offender manager to discuss his next parole hearing. The nurse prescribed zopiclone for three days from 21 April. On 21 April, the substance misuse worker saw Mr Flynn for a substance misuse review. He said he felt that the prison was out to get him and was setting him up but he did not explain in what way. He was emotional when he discussed his past. He said he was confused and wanted to talk to somebody openly about his childhood. As the substance misuse worker is not a trained counsellor, she did not want to discuss such a sensitive subject with him further. She gave him some in-cell work to distract him. She told the investigator that she thought she had telephoned the mental health team, but there is no record of this. On 22 April, Mr Flynn completed the lofexidine programme for withdrawal from subutex.

50. On 23 April, unit staff asked someone from the healthcare team to see Mr Flynn because he had been crying. The member of staff went to see Mr Flynn in the chapel, where he was talking to the Reverend and a friend. The friend was also the Traveller and safer custody representative. Mr Flynn sobbed uncontrollably and seemed to be breaking down. The member of staff said she had never seen him like this before. He said that he had had enough of everything, was very anxious about parole, did not think he was able to do another course, felt beaten by the system and did not think he was ever going to be released. He said that he had lost his mother some months earlier and now his father was ill, he did not know what to do.

51. The friend suggested that Mr Flynn might join the Kainos Community on Mercia House as an alternative to the longer PIPE programme. (The Kainos programme is an accredited twenty-four week therapeutic community programme with a hybrid model of intervention. The work is based on Christian principles.) The member of staff tried to get him to calm down. She did not think he had taken drugs but felt that he was just expressing raw emotion. She said that she would speak to the healthcare team about supporting him. The Reverend helped Mr Flynn telephone his uncle, who agreed to help him find a solicitor, and then his father. The Reverend said that the calls seemed to have helped and that Mr Flynn seemed relieved.

52. Afterwards, Mr Flynn lit a candle for his mother and appeared jovial. The member of staff did not consider opening an ACCT because Mr Flynn had not given any indication that he was considering harming himself. Despite his distress, it never crossed her mind that he might be suicidal. She went back to the healthcare centre and spoke to a nurse about Mr Flynn.

53. The friend asked the acting Head of Residence and Safer Custody, to talk to Mr Flynn about his sentence progression. The friend thought that Mr Flynn was at breaking point and might take out his anger on others. He suggested to the acting Head of Residence and Safer Custody that Mr Flynn should move to Fontmell House. The acting Head of Residence and Safer Custody went to see Mr Flynn but Mr Flynn was immediately verbally aggressive towards him. They had not met before. The acting Head of Residence and Safer Custody said he asked his friend to calm Mr Flynn down and planned to speak to him the next day.

54. At about 7.00pm, an officer responded to Mr Flynn's cell bell and spoke to him through the door observation panel. He was emotional and upset and said he had done so many courses he could not do another. The officer is a trained ACCT assessor and considered opening an ACCT. She asked the custodial manager in charge of the operation of the prison that night to speak to Mr Flynn and they went to his cell. He said he was fine and that he had just been having a daft moment. The custodial manager talked to him about the purpose of spending time in a PIPE unit and he seemed to settle down. The officer said that Mr Flynn was now chatty and like a different person. She was reassured about him and did not open an ACCT. She wrote in his prison record that he was currently very up and down.

55. On 24 April, the Reverend spoke to Mr Flynn in the chapel. He was agitated again. Another prisoner from the Traveller community came and spoke privately to Mr Flynn for a while. This prisoner later told the Reverend that Mr Flynn had been crying and that there were a lot of things going on for him. However, Mr Flynn said that things were clearer and making more sense when he left the chapel. The Reverend thought that he seemed more positive and was moving forward. That day, the acting Head of Residence and Safer Custody said he tried to see Mr Flynn but he was not on the unit at the time. The officer checked Mr Flynn after his emotional outburst the previous day. Mr Flynn reported no concerns and seemed fine.

56. On 26 April, Mr Flynn asked to speak to the orderly officer in charge of the prison, but the orderly officer was too busy to see him that day.

Monday 27 April

57. Early on 27 April, Mr Flynn saw the acting Head of Residence and Safer Custody from his window and asked when he was coming to speak to him. The acting Head of Residence and Safer Custody promised to see him that afternoon. At 10.00am, Mr Flynn spoke to the Roman Catholic chaplain, in the chapel. He was agitated, restless and anxious. He said that he had had enough, nobody was listening to him and he wanted to leave Wessex House. He did not say what the problem was but the chaplain thought he might be under pressure on the unit. Mr Flynn said he wanted to move to Fontmell House and then to transfer out of the prison. He did not mention suicide or self-harm and the chaplain, an ACCT assessor, did not think he needed the support of ACCT procedures. The chaplain phoned the orderly officer and asked him to speak to Mr Flynn about a possible move or transfer. Mr Flynn left the chapel before the orderly officer arrived. The chaplain told the orderly officer that Mr Flynn wanted a move to Fontmell House or a transfer to another prison.

58. At about 11.00am, the orderly officer went to speak to Mr Flynn who said that he wanted to move because he had got himself into trouble and feared for his safety. He did not give any other details when the orderly officer asked for more information. As they were talking, there was a serious disturbance on the unit and a prisoner flooded and barricaded his cell. The orderly officer left to oversee this incident.

59. The nurse was due to see Mr Flynn that morning at 11.30am. He had arranged an appointment after Wessex House staff had said they were concerned about Mr Flynn's recent low moods. Mr Flynn did not attend the appointment and no reason was recorded.

60. The duty governor attended the incident on Wessex House. While he was there, Mr Flynn and some of his friends spoke to him. Mr Flynn said that he needed to get off the unit because other prisoners were driving him mad and acting like children. He said that he might as well transfer to another prison. His friends told the duty governor that he should "get him out of here." The duty governor asked Mr Flynn where he wanted to move, and he suggested HMP Channings Wood.

61. The duty governor had already arranged for some prisoners to transfer out of Guys Marsh the next day. As there was space on the van, he offered Mr Flynn the opportunity to transfer to HMP Dartmoor. Normally, prisoners wanting a transfer have to speak to their offender supervisor and submit an application to ensure that this is in line with their sentence planning objectives but there was nothing written about Mr Flynn's proposed transfer. There is no PIPE unit at Dartmoor. The duty governor told the investigator that he would not normally agree to a transfer so readily, but had agreed because Mr Flynn's friends had been so vocal in their support of him moving. That afternoon, the orderly officer spoke to the duty governor about Mr Flynn's request for a move. The duty governor said that he had already spoken to Mr Flynn and arranged a transfer. The orderly officer told the Reverend that Mr Flynn was transferring to Dartmoor.

62. That afternoon, Mr Flynn went to the healthcare centre and asked to see the nurse, as he had missed his morning appointment. The nurse assessed Mr Flynn and scored him very high on the scale of depression and anxiety. The next day, after Mr Flynn's death, the nurse wrote a retrospective entry to give further detail of their consultation. He thought that Mr Flynn was neglecting himself, as it did not appear that he had showered or shaved or was wearing clean clothes. Mr Flynn had not wanted to take antidepressants. He had said he was not having any suicidal thoughts, but he was very emotional and upset and said he wanted to move to a different unit. The nurse thought that Mr Flynn's mental state had deteriorated since he had last seen him. Mr Flynn said that his appetite was poor and he was not sleeping much. Mr Flynn said that prison staff were trying to stitch him up and he was 'being set up to fail' but would not expand on this. He said he was worried about his safety from other Travellers and wanted to move to another part of the prison. The nurse said he would support a move.

63. The nurse arranged another appointment with him and referred him to the doctor. Mr Flynn refused to see a GP or take any medication. The nurse did not think that Mr Flynn had been taking his ADHD medication. He did not think that Mr Flynn was under the influence of any drugs.

64. At about 2.30pm, the acting Head of Residence and Safer Custody went to Wessex House and spoke to his friend, who said that Mr Flynn seemed to be in a better state of mind. The acting Head of Residence and Safer Custody spoke to Mr Flynn, who apologised for his behaviour the week before. The acting Head of Residence and Safer Custody said he seemed to have calmed down and was focussed on his sentence progression. He said that he knew exactly what he needed to do to progress and asked to transfer to another prison so he could continue to stay off drugs. He praised the friend for helping him and said that he wanted to join the PIPE scheme for his sentence progression. The acting Head of Residence and Safer Custody promised to look into a transfer, which would depend on which prison had a PIPE unit. The acting Head of Residence and Safer Custody said that Mr Flynn seemed positive and was talking about the future. He did not say anything about thoughts of suicide or self-harm. He shook the acting Head of Residence and Safer Custody's hand and thanked him. The acting Head of Residence and Safer Custody had no concerns about him. He spoke to the Head of the Offender Management Unit, about a transfer for Mr Flynn and she said that she had spoken to the duty governor about this.

65. The friend went to see Mr Flynn. He said Mr Flynn was tearful and felt the system had failed him as he had not got any help when he had asked. He felt that release was now impossible because he had to go to a PIPE unit and there was no light at the end of the tunnel. The friend told Mr Flynn he would see him the next morning to help him with his resettlement plan. He said Mr Flynn seemed enthusiastic about this and was hoping for a fresh start away from Wessex House. (The friend and Mr Flynn were unaware of the transfer to Dartmoor the next day.) The friend said Mr Flynn seemed in better spirits when he left. Although he had been upset while they talked, the friend said he saw no indication at all that Mr Flynn might be suicidal.

66. All prisoners were locked up by 6.00pm on 27 April. An officer normally worked in reception but worked a shift alone on Wessex House from 6.00pm until

9.00pm. As part of his reception duties, he checked which prisoners were transferring the next day and noted that Mr Flynn was among them. Between 6.30pm and 7.00pm, the officer went to Mr Flynn's cell and spoke to him through the observation panel. He told him to pack his belongings because he was transferring to Dartmoor the next day and Mr Flynn asked for some bags.

67. The officer took some bags to the cell and they spoke at the door for a few minutes. Mr Flynn asked why he was transferring to Dartmoor and asked whether staff would use force if he refused to comply. The officer told him he would face a disciplinary charge if he refused to transfer. Mr Flynn said he was worried about the PIPE programme and that it might delay his release. The officer encouraged him to do the programme, but Mr Flynn became more anxious. He said that he did not know what to do and shouted to prisoners in neighbouring cells, asking whether he should stay or go. Another prisoner shouted back that they should talk at their windows. Mr Flynn said that he needed to get out of Guys Marsh and that his time there was done. The officer told Mr Flynn that they could talk again about the transfer in reception the next morning. Mr Flynn did not mention any suicidal thoughts and the officer had no concerns for his safety.

68. The personal officer took over from the officer on Wessex House at about 8.45pm. The personal officer knew Mr Flynn well, as he had been his personal officer since December. That night the custodial manager in charge of the prison was acting as the orderly officer. Three officers were the assistant orderly officers.

69. During the routine roll check at the start of the night shift, the personal officer spoke to Mr Flynn, who said he had been having a difficult time lately. He asked the personal officer for more information about Dartmoor, including what courses were available. He was concerned that a move there might be a backwards step for him. The personal officer tried to reassure him that this was a chance for a fresh start. At 8.55pm, the personal officer went to the office and telephoned the orderly officer for information about Dartmoor for a prisoner who was transferring there. He did not name Mr Flynn. The orderly officer gave him some basic details about Dartmoor but said that the prisoner would need to speak to staff in the morning.

70. Mr Flynn then pressed his cell bell and the personal officer went to his cell again. Mr Flynn asked to be let out so they could speak privately without the prisoners in the cells nearby overhearing. The personal officer explained that he was not allowed to do that when working alone at night. Mr Flynn then asked to speak privately to the orderly officer. At 9.05pm, the personal officer phoned the orderly officer, who said that he could not open Mr Flynn's cell during the night but would talk to him in the morning at the end of his shift. As an alternative, the personal officer wrote Mr Flynn a note and posted this and some blank paper under his door. He hoped that this would allow Mr Flynn to communicate privately by writing down his concerns. He promised to collect the note later.

71. A few minutes later, the personal officer responded to Mr Flynn's cell bell again and found that Mr Flynn had made a superficial cut to his left wrist (the police later found a plastic knife with blood on it) and he was holding a pair of metal tweezers to his throat. He mouthed the words, 'Help me'. The personal officer

said, ‘Don’t do that, I’m going to get help.’ Mr Flynn nodded, signalled his agreement with a thumbs up and sat on the bed. In his handwritten notes made immediately after the emergency, the personal officer said that Mr Flynn had threatened to kill himself. He did not mention this in his subsequent statement to the police and we have been unable to interview him as he has been away from work since.

72. The personal officer left the cell and went back downstairs to the unit office. He told the police that he did this to maintain Mr Flynn’s confidentiality, rather than radioing from outside the cell. At 9.15pm, he telephoned the orderly officer and told him that Mr Flynn had cut his wrist. The orderly officer told the investigator that he could not remember whether the personal officer had said that Mr Flynn had threatened to kill himself. The orderly officer told the personal officer to open an ACCT document and said that he would come to Wessex House within the hour to complete an ACCT immediate action plan. The personal officer opened an ACCT document in the unit office. He logged onto the computer to find Mr Flynn’s details and wrote in the triggers section, ‘paranoia from drug withdrawal and transfer to HMP Dartmoor’. He completed the ‘concern and keep safe form’, in the ACCT document and wrote a paragraph setting out what had happened at the cell door.

73. Mr Flynn spoke to his neighbour, the other prisoner through his cell window. The prisoner said that he had said that he was going to kill himself by cutting his throat. Mr Flynn covered the observation panel in his cell door. At 9.24pm, the prisoner pressed his cell bell and, when the personal officer responded, told him that Mr Flynn had cut his jugular vein and was bleeding. He asked the personal officer to open Mr Flynn’s cell door. The personal officer said he tried to reassure the prisoner that, as far as he knew, Mr Flynn had only made a small cut to his wrist. The personal officer then knocked and kicked on Mr Flynn’s door and tried to get a response, but after about 90 seconds still got no reply. He could not see into the cell.

74. At 9.25pm, the personal officer radioed the control room from outside Mr Flynn’s cell and asked staff to attend Wessex House. An officer answered him and then tried to locate the orderly officer, who was elsewhere in the prison. The personal officer did not indicate any urgency in his radio call or any concerns about a possible escalation in self-harm and he did not use an emergency code. In his notes made after the incident, the personal officer said that he did not go into the cell alone because he considered the situation unknown and dangerous. He knew that Mr Flynn had a history of aggressive behaviour.

75. The personal officer went back to the unit office and telephoned the control room. The officer answered and the personal officer said that Mr Flynn had covered his observation panel and he could not get a response. He asked to speak to the orderly officer. The orderly officer had been trying to fix a computer problem, came back to the control room about a minute later, and spoke to the personal officer.

76. The orderly officer told the two officers that they were going to Wessex House. He collected keys for the other two officers from the secure cabinet and changed his white shirt to a blue PE top because he knew that Mr Flynn had cut himself.

They walked to Wessex House. One officer did not think that there was an emergency and presumed that they were going to open the cell and speak to Mr Flynn. The prisoner saw them walking across and shouted out of his window for them to hurry up because somebody was dying.

77. At 9.33pm, the officers arrived on Wessex House and went upstairs to Mr Flynn's cell, where the personal officer was waiting. The orderly officer could not get a response so he unlocked the cell and went in. He found Mr Flynn had hanged himself using the curtain attached to the window. He was kneeling on the floor. All of the staff were shocked as none had anticipated that Mr Flynn might have taken his own life. There was a pool of blood on the cell floor. Mr Flynn had cut his wrist but was also bleeding from his nose.

78. One officer supported Mr Flynn's weight while the orderly officer cut through the curtain tied around his neck and they lowered him to the floor. The officer, who had up-to-date training in cardiopulmonary resuscitation, gave chest compressions and the orderly officer, a trained first aid instructor, initially tried to give breaths using a mouth shield. After about three minutes of attempting cardiopulmonary resuscitation, the orderly officer stopped giving breaths and told the personal officer to ask for an ambulance.

79. At 9.34pm, nine minutes after the personal officer had originally asked for help, he radioed the officer and asked for an ambulance. He did not use an emergency code. The officer had been waiting for advice from the scene and telephoned the ambulance service. The officer telephoned her with more information. At about 9.36pm, the personal officer sent two further radio messages stressing that a 'blue light' emergency ambulance was required. At 9.37pm, he radioed to ask for someone to bring a defibrillator. The personal officer took over chest compressions for a couple of minutes before the officer started again.

80. The officer went to the prison gate to escort the paramedics to Wessex House. The first emergency response vehicle arrived at the gate at 9.45pm and the paramedic reached the cell at 9.47pm. While an officer continued chest compressions, the paramedic attached a defibrillator which repeatedly advised not to shock. The paramedic gave oxygen using a bag valve mask.

81. An ambulance arrived at the gate at 9.56pm and the two paramedics reached Mr Flynn's cell at 10.06pm. They took over chest compressions from the officer. A third vehicle arrived at the gate at 10.06pm. At 10.14pm, the paramedics pronounced Mr Flynn dead.

82. On a chair in the cell, Mr Flynn had daubed in blood, 'I'm sorry, forgive me.' The order of service from his mother's funeral in December was on his bed. When the police attended and the Reverend came to the cell to pray for Mr Flynn, they noticed handwritten graffiti on the identity card outside his cell door which read 'As gay as hell.'

Contact with Mr Flynn's family.

83. The chaplain acted as the prison's family liaison officer and had driven to the prison as soon as he was contacted. He had previously spoken to Mr Flynn's

family when his mother was dying. The next of kin contact details in Mr Flynn's record were out of date and incomplete, so the chaplain went to the chapel to look at the risk assessment he had completed for the funeral escort in December.

84. At 11.15pm, the duty governor told the chaplain to telephone Mr Flynn's father and break the news of his death. The duty governor decided not to visit Mr Flynn's family or ask the police to visit them. He was aware that these are the preferred methods of contact, but said he wanted to break the news quickly because he was worried that other prisoners from the Traveller community would contact Mr Flynn's family using illegal mobile telephones. The chaplain called Mr Flynn's father and told him that Mr Flynn had died and gave his condolences. He then telephoned Mr Flynn's sister. There was no reply but she called back very quickly and the chaplain explained what had happened.

85. Mr Flynn's family visited the prison on 29 April and 5 May. The chaplain represented the prison at Mr Flynn's funeral which took place on 14 May. In line with Prison Service instructions, the prison contributed to the costs of the funeral.

Support for prisoners and staff

86. An officer took over from the personal officer on Wessex House for the rest of the night. At 7.45am on 28 April the Governor debriefed the staff involved in the emergency response to allow them the opportunity to discuss any issues arising. He offered them his support and that of the staff care team.

87. After Mr Flynn died, staff checked all prisoners subject to ACCT procedures every 30 minutes until staff held full case reviews the next morning, in case they had been adversely affected by Mr Flynn's death.

Post-mortem report

88. The post-mortem examination found that Mr Flynn died from hanging. Toxicology tests produced negative results for all substances, including new psychoactive substances.

Findings

Managing the risk of suicide and self-harm

89. On Thursday 9 April, staff began ACCT procedures after Mr Flynn threatened suicide. He had not previously harmed himself at Guys Marsh or given any indication of having suicidal thoughts. Although Prison Service Instruction (PSI) 64/2011 requires a multidisciplinary approach for case reviews and it is mandatory for a member of healthcare staff to attend the first ACCT review, the custodial manager was the only member of staff present at the case review which he held after healthcare staff had gone home. It was poor practice for the custodial manager to hold an ACCT review and end ACCT procedures acting on his own. Even when multidisciplinary attendance is not possible, it is implicit that ACCT reviews, which are based on teamwork, involve more than one member of staff.

90. The custodial manager recorded in the ACCT document that the outcome of Mr Flynn's father's biopsy might be a trigger for self-harm, but he closed the ACCT that day when Mr Flynn did not know the result of the biopsy. There is no further record of the outcome of the biopsy in the ACCT document, in the post-closure interview or in Mr Flynn's prison record. We consider that closing the ACCT before Mr Flynn had learnt of the biopsy result was inadvisable and premature. This was especially so as Mr Flynn had lost his mother so recently.

91. PSI 64/2011 requires that staff close an ACCT only after all of the caremap actions have been completed and the panel considers that the risk has reduced. The custodial manager closed the ACCT on his own, five hours after it had been opened, without any evidence that Mr Flynn's risk had decreased. He marked the caremap issues relating to drug misuse and mental health as complete. He said he had spoken to the nurse about Mr Flynn's mental health before the case review, but he did not speak to the substance misuse team manager until the day after he had closed the ACCT. He did not record these discussions in the ACCT document and there is no note of them in Mr Flynn's clinical record. The caremap did not address some of Mr Flynn's other risk factors, such as considering bereavement counselling or dealing with his frustration about his lack of sentence progression.

92. The custodial manager said he had known Mr Flynn and it possible that his assumed knowledge about Mr Flynn, and Mr Flynn's insistence that the ACCT was unnecessary, influenced his objective decision-making. None of the staff involved believed that Mr Flynn was at risk of suicide and we are concerned that, when the custodial manager closed the ACCT on 9 April, he placed too much emphasis on Mr Flynn's apparent mood rather than an objective assessment of his outstanding risk factors. These included:

    - He had voiced suicidal thoughts earlier that day.
    - His mother had died in December and his father was undergoing treatment for cancer with an unclear prognosis.
    - He misused drugs in prison.
    - The Parole Board had recently refused release and had not recommended a move to an open prison.

- He was eight years past his tariff (minimum term to serve) and said that he could not face completing any more offending behaviour programmes.
- He had been diagnosed with depression and residual features of adult ADHD and exhibited extreme emotions and mood swings.
- He had raised, but not yet addressed, sexual abuse he said he experienced in childhood.

93. More generally, in a Learning Lessons Bulletin about the deaths of Travellers in prison, published in January 2015, we identified that there is evidence that Travellers are at an increased risk of suicide in the community and prisons should consider this when assessing risk. There is no evidence that this or the above factors were considered. 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:

- **ACCT case reviews should be multidisciplinary and include all relevant people involved in a prisoner's care.**
- **Reviews should record and take into account all the known risk factors and triggers when considering the risk of suicide or self-harm, including those of minority groups such as Travellers.**
- **Caremap actions should be specific and meaningful to address the underlying causes of a prisoner's distress and reduce their risk.**
- **ACCT monitoring should continue until the risk is reduced and all caremap actions have been completed.**

Sentence progression and transfer

94. Mr Flynn was ten years into an indeterminate sentence and eight years past his tariff (the period he had to serve before he could be considered for release). The Parole Board usually expects a successful period in an open prison before it will direct the release of a life-sentenced prisoner. It is apparent that his lack of progression towards release was a major concern for Mr Flynn and, understandably, this played on his mind a lot. He often said he felt hopeless about this. He recognised that his own behaviour had led to the Parole Board's decision to keep him in a closed prison, but he frequently told staff and other prisoners that he was frustrated about being asked to undertake further offending behaviour work when he had done so many courses already. It was planned that Mr Flynn would transfer to another prison to be assessed for and participate in a Psychologically Informed Planned Environment (PIPE) if suitable. Only a small number of prisons in England and Wales have PIPE units, which offer relatively long-term interventions.

95. On 27 April, Mr Flynn suddenly asked for a transfer. He and his friends were insistent that he needed to move. He said he felt unsafe but did not explain why. Mr Flynn said that he would like to move to another house in the prison but was prepared to move to another prison. The duty governor was organising moves to other prisons for the next day and arranged for him to transfer to Dartmoor at the same times as other prisoners. No one discussed this with Mr Flynn of informed him of the move until the evening of 27 April. Mr Flynn appeared to be anxious

about this and asked his personal officer a number of questions about the move, including what would happen if he refused to go. Mr Flynn seemed to recognise that a move to Dartmoor would not be progressive for him and would set back his prospects for release even further.

96. Unless a move is urgent because of security reasons, the prisoner's own disruptive behaviour or serious concerns about their safety, transfers of indeterminate sentenced prisoners in particular should be planned. We do not consider an urgent transfer was needed. Prison Service Order (PSO) 4700, the Indeterminate Sentence Manual, says 'When considering the transfer of any ISP (indeterminate sentenced prisoner), the priority must be to allocate to a prison which best meets the ISP's sentence plan targets.' The PSO says that in most cases the decision about which prison would best meet their needs should be made at a sentence-planning meeting, taking into account the views of the offender manager (home probation officer). It requires the sending prison to ensure that the intended prison best meets the prisoner's needs and where there is doubt, clarification should be sought before a transfer is decided.

97. We are concerned that this transfer decision did not take into account Mr Flynn's major concern, his sentence progression, and was not in line with the instructions in PSO 4700. He needed to go to a prison where he could be assessed for and participate in a PIPE unit, which would not have been possible at Dartmoor. On the evening of 27 April, Mr Flynn realised that a move to Dartmoor would be likely to be detrimental to his interests and no one was able to reassure him about this.

98. The duty governor told us that he thought he was acting in Mr Flynn's best interests. However, we consider that the transfer was unorthodox, unhelpful and unplanned. It was not in line with Mr Flynn's sentence plan targets and might have had major implications for his progression. The reasons Mr Flynn had given for requesting a move had not been investigated and might have been dealt with by moving him to another residential unit in Guys Marsh. We are also concerned that the proposed move did not take into account Mr Flynn's continuity of healthcare. He was under the care of the mental health team but no handover had been planned. We make the following recommendation:

The Governor should ensure that decisions about the routine transfers of prisoners serving indeterminate sentences are taken at sentence planning meetings, where possible, and best meet their needs, in line with the instructions in PSO 4700.

Bullying

99. Prison staff suspected Mr Flynn of bullying others three times at Guys Marsh but there was no clear evidence of this. He also mentioned that he feared for his safety on Wessex House, but did not explain in what way and did not give any further information about this. It is not therefore possible to know whether his concerns were well founded. On the day he died, Mr Flynn again said he felt unsafe and asked to leave the unit. He did not give any specific information but in his retrospective entry in Mr Flynn's medical record, the nurse wrote that he had issues with other Travellers.

100. Guys Marsh has a Tackling Anti-Social Attitudes policy, which requires staff to submit an intelligence report to the security department whenever a prisoner reports bullying. This allows allegations of bullying to be collated, challenged and investigated. Staff did not submit any intelligence reports after Mr Flynn reported feeling unsafe on 27 April, as they should have done, We recognise that there was little firm information about Mr Flynn's concerns and, even if there had been, it is unlikely that any investigation would have resulted that day. However, it is important that all such information about feelings of safety is reported and examined to help identify whether there are worrying patterns of alleged behaviour that need further examination.

101. A homophobic message was found on the ID card outside Mr Flynn's cell. We do not know when the graffiti was put there or whether it was definitely intended for Mr Flynn. There is no evidence in Mr Flynn's records that he was the victim of homophobic bullying or that he self-identified as gay. Such homophobic abuse is often used generically, particularly by less mature people, and might not have related to his sexuality. On the day he died, Mr Flynn had indicated to the duty governor that he wanted to move from the unit, not because of bullying, but because other prisoners were "acting like children". It is possible that such behaviour was what he was referring to.

102. Mr Flynn was from the Irish Traveller community. Our recent Learning Lessons Bulletin about the deaths of Travellers in prison found that bullying was sometimes a factor. Travellers in the community often experience discrimination. In prison, this can manifest itself as insulting and threatening behaviour, intimidation or bullying. We note from Mr Flynn's records that in May 2014, another prisoner attacked him and allegedly used racist abuse. Mr Flynn gave a number of different reasons for wanting a move on 27 April. At one point, he said he was worried about his safety from other Travellers. We have not been able to substantiate that Mr Flynn had any reason to be concerned about his safety. However, we note that, although Guys Marsh holds a number of Traveller prisoners, there is nothing specific in the local policy for tackling antisocial attitudes about the need to be alert for potential bullying issues with Travellers and other minority groups. We make the following recommendation:

The Governor should ensure that staff report and challenge all indications of potential bullying in accordance with the local 'Tackling Antisocial Attitudes' policy and that the policy reflects bullying associated with Travellers and other minority groups in the prison.

Clinical care

103. Mr Flynn repeatedly misused subutex and underwent two lofexidine detoxification programmes at Guys Marsh, one not long before he died. Toxicology tests after Mr Flynn's death were negative for any drugs, including subutex and new psychoactive substances. Mr Flynn therefore does not appear to have been under the influence of substances when he died, or have taken any in the days before his death. This in itself might have affected his mood. Mr Flynn had been assessed as severely depressed and GP had prescribed antidepressants but he refused to take them or medication for ADHD.

104. Some prisoners and staff we spoke to thought that Mr Flynn misused drugs to self-medicate and control his moods. The friend, who knew Mr Flynn well, said that he tended to be calmer when he used drugs. It appears that at the time of his death Mr Flynn had been making an effort to stay off drugs. Staff and prisoners told us that drugs were widely available at Guys Marsh and one of the reasons Mr Flynn gave for asking for a transfer to another prison was to help him avoid drugs.

105. The clinical reviewer, who reviewed the clinical care Mr Flynn received at Guys Marsh, considered that he had good access to substance misuse services and the mental health team. She was satisfied that Mr Flynn's care was equivalent to that he would have received in the community. Mr Flynn's diagnosis of residual features of adult ADHD might have accounted for some of his changeable moods and impulsive behaviour but he refused methylphenidate prescribed to treat these symptoms. The doctor had re-prescribed methylphenidate in March but Mr Flynn then did not collect it. This was his choice, just as it would be in the community, but the doctor only found this out by checking his record after he died. She said that, had she known, she would have offered him another appointment to discuss treatment options. While the clinical reviewer noted that this was unlikely to have had any bearing on the outcome, it is important that external specialists as well as healthcare staff working in prison are informed when medication they have prescribed is not collected. We make the following recommendation:

The Head of Healthcare should ensure that prescribing clinicians are informed when prisoners do not collect their medication.

Managing the emergency on the evening of 27 April

106. At 9.15pm on 27 April, Mr Flynn cut his wrist and his personal officer said he threatened to kill himself. The personal officer then left his cell and went to the office to telephone the orderly officer. He then spent about nine minutes filling in an ACCT document, as the orderly officer had advised. As Mr Flynn had self-harmed and threatened to kill himself, we consider he should have stayed at the cell door to observe him and reassure him. He should have radioed the orderly officer to attend immediately. The personal officer said that he left to telephone the orderly officer to preserve Mr Flynn's confidentiality. We consider that, while this was well meaning, he should have placed priority over Mr Flynn's safety rather than his privacy.

107. When the personal officer went back to Mr Flynn's cell and found his observation panel blocked and could not get a response from him, he radioed the control room for assistance. He did not say the situation was urgent and did not use an emergency medical code (which would have alerted other staff to attend urgently with emergency equipment and the control room to call an ambulance immediately). He went back to the office and telephoned the orderly officer.

108. While he waited for other staff to arrive, the personal officer did not open Mr Flynn's cell, despite his self-harm and threat to kill himself. The personal officer said that that the observation panel was blocked so he did not know what was waiting for him behind the door. He said he knew that Mr Flynn had a history of

sometimes unpredictable and aggressive behaviour so thought it better to wait for help to arrive. Subject to a personal risk assessment, we would expect a member of staff to go into a cell alone if they believed that someone had seriously harmed themselves, but we accept that the personal officer did not know what had happened and therefore do not criticise him for this. However, he should have made sure other staff attended immediately to open the door.

109. We are concerned that the staff did not treat the situation with sufficient urgency. This meant that it took over ten minutes from the time that the personal officer found Mr Flynn had covered his cell observation panel and was not responding, until an ambulance was called. Neither the personal officer nor the orderly officer seemed to recognise that this was a likely escalation in self-harm and the orderly officer was slow to respond. He went to change his top before going to Wessex House and he and the other two officers did not hurry. When they unlocked Mr Flynn's cell and found he had hanged himself, they immediately began cardiopulmonary resuscitation but did not call an ambulance for a further three minutes. No one had used an emergency medical code, which meant that the staff had to request a defibrillator separately.

110. We consider that the staff collectively failed to keep Mr Flynn safe and communication between them was poor. The personal officer should not have left the cell without first ensuring that Mr Flynn was safe and the night manager should have attended immediately. There was a failure to recognise the possibility of an escalation in self-harm and to ensure that emergency services were called as quickly as possible. We make the following recommendation:

The Governor should ensure that staff monitor prisoners who self-harm until they are satisfied that it is safe to leave them and that they take immediate and urgent action when a prisoner at risk of suicide and self-harm is not visible and does not respond to a check.

Family liaison

111. On the duty governor's instructions, a chaplain broke the news of Mr Flynn's death to his father by telephone. The duty governor considered that this was the only means of ensuring that the prison told Mr Flynn's family first, before they learnt of his death by other means. He was concerned that other Traveller prisoners in Wessex House would call them using illegal mobile telephones. Mr Flynn's father was upset about being informed by telephone and we agree it was inappropriate.

112. Prison Service Instruction 64/2011 gives instructions to prisons about informing families after a prisoner dies. It acknowledges that it is important that this is done quickly but states that, wherever possible, a family liaison officer should go to break the news in person. Mr Flynn's father lives about 90 miles from Guys Marsh so this was possible, although it would probably have been after midnight by the time prison staff arrived. The PSI states that, if a visit is not possible, then the prison should ask the police or a family liaison officer from another nearby prison to break the news in person, but this was not done. We are also concerned that, although Mr Flynn's family visited the prison twice shortly after

his death, no one from the prison offered to visit Mr Flynn’s father at his home to offer support and advice. We make the following recommendation:

The Governor should ensure that families are informed in person of a prisoner’s death, where possible by a member of staff from the prison, and that further contact with families follows the requirements of PSI 64/2011.

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