Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Kelvin Speakman a prisoner at HMP Hewell on 9 May 2016

A report by the Prisons and Probation Ombudsman
Nigel Newcomen CBE

PO Box 70769
London, SE1P 4XY
Email: mail@ppo.gsi.gov.uk
Web: www.ppo.gov.uk
T | 020 7633 4100
F | 020 7633 4141

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 Kelvin Speakman was found hanged in his cell in the segregation unit at HMP Hewell on 25 April 2016. He was taken to hospital where he died on 9 May. Mr Speakman was 30 years old. I offer my condolences to Mr Speakman's family and friends.

Mr Speakman harmed himself prolifically in prison and managing him safely was a significant challenge. During his seven months at Hewell, there were 48 recorded incidents of self-harm, 33 of them by tying ligatures around his neck to self-strangulate. I recognise that the nature and frequency of Mr Speakman's self-harm made it difficult for prison staff to prevent his death, but enhanced case review procedures were not used consistently and Mr Speakman did not have the required mental health assessments to safeguard against his continued segregation. I am concerned that, again, procedures designed to protect such vulnerable prisoners did not operate effectively at Hewell. I do not consider that the use of restraints was justified when Mr Speakman was taken to hospital unconscious and in a serious condition.

Mr Speakman was serving an indeterminate sentence, was almost six years past his minimum term, and was frustrated about his lack of progress towards release. His death is a sad reminder of the stress and uncertainty that prisoners serving indeterminate sentences can face.

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 **February 2017**

Contents

Summary

Events

1. In June 2007, Mr Kelvin Speakman was remanded to prison charged with arson. In October 2007, he received an indeterminate prison sentence for public protection with a minimum period to serve of two years. Mr Speakman had a personality disorder and substance misuse problems. He cut his arms and wrists throughout his life, attempted suicide, once by jumping out of a window and once he tried to crash a car. Mr Speakman also tried to strangle himself many times in prison and openly acknowledged using illicit drugs, specifically New Psychoactive Substances (NPS).

2. Mr Speakman spent a number of years in different prisons but the Parole Board never directed his release. His last parole review, on 1 September 2015, considered Mr Speakman should do further psychological work. Mr Speakman was frustrated at this decision and told staff he was going to hang himself. The night manager began Prison Service suicide and self-harm monitoring arrangements (known as ACCT). On 11 September 2015, Mr Speakman transferred to HMP Hewell.

3. Mr Speakman was supported by ACCT arrangements until 25 March 2016 when staff assessed that his risk of suicide or self-harm had reduced because he had not self-harmed for over a month and was engaging with staff. He was also segregated for much of his time at Hewell.

4. On 5 April, Mr Speakman assaulted an officer. Later on 5 April, officers found Mr Speakman with a ligature tied to his bed and began ACCT procedures again. These remained in place until his death.

5. On 6 April, Mr Speakman was segregated for assaulting the officer. He remained segregated until he hanged himself. A prison manager requested a mental health assessment but this did not happen. On 25 April, an officer found Mr Speakman hanging in his cell with sheets tied around his neck and radioed a code blue emergency. Staff immediately began cardiopulmonary resuscitation. Paramedics arrived, found a pulse and took Mr Speakman to hospital. Mr Speakman was unconscious when he left the prison, but a prison manager considered it was necessary to use restraints. Officers eventually removed the restraints, but reapplied them several times when Mr Speakman became aggressive in the hospital. Eventually, officers permanently removed restraints. Mr Speakman appeared to be recovering but his condition rapidly deteriorated on 8 May and he died on 9 May.

Findings

6. Mr Speakman was frustrated about his lack of sentence progression and was a challenging prisoner for Hewell to manage. Much of the care offered to him by individual staff was good. Nevertheless, there were some deficiencies in the management of ACCT procedures to support him. The investigation found that:

    - Enhanced case management was not consistent;
    - ACCT reviews were not sufficiently multidisciplinary;

- Caremap actions were not targeted and therefore effective at reducing Mr Speakman's risk.

7. Prison Service instructions require prisoners being managed under ACCT procedures and held in the segregation unit, to have a mental health assessment within 24 hours. A mental health assessment was requested but did not happen.

8. We are concerned that Mr Speakman was restrained when he left the prison on 25 April.

9. Given the nature and frequency of Mr Speakman's self-harm, he was always at high risk and it would have been difficult for staff at the prison to have prevented his death.

Recommendations

- The Governor should ensure that staff manage prisoners at risk of suicide or self-harm in line with national guidelines, including ensuring that:
  - Prisoners at risk are not held in the segregation unit unless all other options have been considered and excluded and there are fully documented reasons to explain the exceptional circumstances.
  - Case reviews are multidisciplinary and include all relevant people involved in a prisoner's care, including mental health staff where appropriate and healthcare staff attend all first case reviews.
  - The enhanced case review process is used when appropriate.
  - Staff set ACCT caremap actions which are aimed at reducing prisoners' risks to themselves and review them at each case review.

- The Governor and Head of Healthcare should ensure that prisoners being monitored under ACCT procedures who have been segregated have an urgent mental health assessment.

- The Governor should ensure that all staff undertaking risk assessment for prisoners taken to hospital understand the legal position on the use of restraints and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.

The Investigation Process

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

11. The investigator visited the prison on 17 May 2016, and obtained copies of relevant extracts from Mr Speakman's prison and medical records

12. NHS England commissioned a health professional to review Mr Speakman's clinical care at the prison.

13. The investigator interviewed 14 members of staff and two prisoners. The clinical reviewer joined the investigator for some of the interviews with staff. At the initial report stage, the National Offender Management Service (NOMS) responded to the recommendations. That response has been annexed to this report.

14. We informed HM Coroner for Worcestershire of the investigation who gave us the cause of death. We have sent the coroner a copy of this report.

15. One of the Ombudsman's family liaison officers contacted Mr Speakman's brother to explain the investigation. Mr Speakman's brother and the solicitor representing his family wanted the investigation to consider the following points:

    - Mr Speakman's segregation.
    - The mental health support he received.
    - Staff's use of restraints while Mr Speakman was in hospital.

    Mr Speakman's brother received a copy of the initial report. He pointed out some factual inaccuracies and/or omissions. This report has been amended accordingly. Mr Speakman's brother also raised a number of issues/questions that do not impact on the factual accuracy of this report and have been addressed through separate correspondence.

Background Information

HMP Hewell

16. HMP Hewell is an amalgamation of two prisons, the former HMP Blakenhurst, and HMP Hewell Grange. The Hewell Grange site continues to operate as an open prison and the Blakenhurst site is a secure, local prison. Mr Speakman was at the Blakenhurst site which comprises six houseblocks, holding around 1,100 men. Care UK provide health services at Hewell. Worcestershire Health and Care NHS Trust provided health services until 31 March 2016.

HM Inspectorate of Prisons

17. The most recent inspection of Hewell was in September 2016. Although the report for this inspection has not yet been published, the inspectors found the quality of the ACCT process was not robust. Quality assurance arrangements were only just beginning to address some of these deficiencies. Prisoners told the inspectors that they received good support from staff. Some of the cells in the segregation unit were not very clean. Inspector found staff in the segregation unit to be friendly and but efforts to support the significant number of prisoners with complex needs was inadequate. The integrated mental health team provides a basic and developing service.

18. During the previous inspection, in July 2014, inspectors found that ACCT case reviews were often not multidisciplinary and healthcare staff had not attended any of the reviews they examined. Inspectors noted that many triggers for suicide and self-harm recorded in ACCT documents focused on past rather than future events that could prompt suicide or self-harm. Relationships between prisoners and staff were generally good but inspectors found that the personal officer scheme did not work effectively and many prisoners said they did not have a personal officer. Progress on implementing PPO recommendations from investigation into deaths at the prison had been slow. Prisoners did not have good access to healthcare appointments, especially to see a GP. Inspectors found mental health services were adequate, but prisoners had no access to professional counselling.

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 last published annual report in 2014, the IMB noted that, in recent years, there had been a significant increase in incidents of self-harm and bullying. They reported that staff were more vigilant, with increased numbers of prisoners supported for risk of suicide and self-harm.

20. The IMB reported that the segregation unit was full most of the time. The average time prisoners spent in the segregation unit had increased.

Previous deaths at HMP Hewell

21. Mr Speakman's was the sixth self-inflicted death at Hewell since January 2014. We have previously raised concerns about the management of the ACCT process, an issue we have identified again in this investigation.

Assessment, Care in Custody and Teamwork

22. 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.

23. 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.

24. 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.

Segregation unit

25. Segregation units (sometimes known as care and separation units, as is the case at Hewell) are used to keep some prisoners apart from others. This can be because they feel vulnerable or under threat from other prisoners or if they behave in a way that prison staff think would put people in danger or cause problems for the rest of the prison. They also hold prisoners serving punishments of cellular confinement after disciplinary hearings. Segregation is authorised by a prison operational manager who has to be satisfied that the prisoner is fit for segregation after an assessment by a member of healthcare staff. Segregation unit regimes are restricted and prisoners are usually permitted to leave their cells only to collect meals, wash, make phone calls and have a daily period in the open air. The segregation unit at Hewell comprises 26 single cells. Each cell has an emergency call button and when this is pressed a light flashes outside the cell and it activates a buzzer which can be heard throughout the unit.

New Psychoactive Substances (NPS)

26. NPS are an increasing problem across the prison and immigration detention estates. Many NPS contain synthetic cannabinoids, which can produce experiences similar to cannabis. NPS are usually made up of dried, shredded plant material with chemical additives and are smoked. They can affect the body in a number of ways including increasing heart rate, raising blood pressure, reducing blood supply to the heart and vomiting. Psychological effects can include psychosis and hallucinations, depression and suicidal thoughts, antisocial or paranoid behaviour and emotional and erratic behaviour.

27. As well as emerging evidence of dangers to both physical and mental health, there are other links to suicide or self-harm. Trading in these substances, while in custodial settings, can lead to debt, violence and intimidation.

28. In July 2015, we published a Learning Lesson Bulletin about the deaths associated with use of NPS. We identified dangers to physical and mental health,

as well as risks of bullying and debt and possible links to suicide and self-harm. The bulletin identified the need for better awareness among staff of the dangers of NPS; the need for more effective drug supply reduction strategies; better monitoring by drug treatment services; and effective violence reduction strategies because of the links between NPS and debt and bullying.

Indeterminate Sentence for Public Protection

29. The indeterminate sentence for public protection was created by the Criminal Justice Act 2003, but abolished in 2012. It was intended for prisoners whose offending was considered dangerous, but not so dangerous that they qualified for a life sentence. Prisoners serve a minimum term of imprisonment, after which the offender can be considered for release if they can satisfy the Parole Board that their risk of reoffending has sufficiently reduced.

Key Events

30. On 25 June 2007, Mr Kelvin Speakman was released from prison on licence, but he tried to set fire to his mother's house the same day. The police charged Mr Speakman with arson and his licence was revoked.

31. Mr Speakman arrived at HMP Forest Bank on 27 June. Mr Speakman told healthcare staff that he was suffering from post traumatic stress disorder (PTSD) following childhood sexual abuse, depression and anxiety and complained of hearing voices. A consultant forensic psychiatrist assessed him and found no evidence of a serious mental illness. He recorded that Mr Speakman had a personality disorder, probably of an emotionally unstable (or borderline) personality disorder type with some traits of a dissocial (or antisocial) personality disorder. An unstable personality disorder is characterised by poor self image, inability to maintain and develop relationships and impulsive behaviour. Dissocial personality disorder traits are characterised by a disregard for, or violation of, the rights of others with little or no remorse for their actions.

32. On 10 October, Mr Speakman received an indeterminate prison sentence for public protection with a minimum period to serve of two years. This meant he was eligible to be considered for release from 10 October 2009, if the Parole Board was satisfied that he was no longer a risk to the public. Mr Speakman was held at a number of prisons and transferred to HMP Featherstone in April 2015. While in prison, Mr Speakman was supported by Prison Service suicide and self-harm monitoring procedures (ACCT) after he self-harmed and threatened to kill himself on a number of different occasions.

33. In June 2015, Mr Speakman was referred to the mental health in-reach team at Featherstone. A specialist registrar was concerned about Mr Speakman's mental state and referred him to a medium secure hospital, in the North of England, for an urgent assessment with a view to arranging a transfer under Section 47 of the Mental Health Act 1983. (Section 47 allows the transfer of a sentenced prisoner to hospital for treatment, if treatment is successful them the prisoner will return back to prison to end their sentence.) In her referral letter, the specialist registrar recorded that, in addition to his personality disorder, she thought Mr Speakman was moderately to severely depressed with psychotic features, resulting in an ongoing risk of suicide and self-harm.

34. In his response to the specialist registrar, Dr A, a consultant forensic psychiatrist at the medium secure hospital, said he did not think that Mr Speakman would meet their admission criteria. Dr A suggested that Mr Speakman continue with antidepressant medication and that he should access prison psychology services to deal with issues relating to childhood sexual abuse. Dr A suggested that Mr Speakman could be referred in the future to the medium secure hospital, if his mental health deteriorated.

35. At a parole hearing on 1 September, Dr B, a consultant psychiatrist, identified that the sexual abuse Mr Speakman experienced as a child had resulted in post traumatic stress disorder (PTSD) symptoms. Again, Dr B suggested that Mr Speakman could benefit from treatment in a secure hospital under Section 47 of the Mental Health Act.

36. On 2 September, staff began ACCT procedures when Mr Speakman told them he would hang himself and threatened to “cut up”. He said he was worried about the outcome of his parole hearing and said he was being kept awake by noisy prisoners in neighbouring cells. The one issue recorded on the ACCT caremap was for Mr Speakman’s medication to be reviewed. On 10 September, a nurse re-referred Mr Speakman to Dr A.

37. On 11 September, Mr Speakman transferred to HMP Hewell. The safer custody departments at the prisons arranged the transfer. Mr Speakman transferred on an open ACCT, with five observations an hour in place. Mr Speakman talked to Ms C, clinical team manager, about killing himself and told her that he had been diagnosed with an unstable personality disorder. She admitted him to the prison inpatient unit, where he continued to be managed under ACCT procedures with regular case reviews.

38. Mr Speakman was not happy about transferring from Featherstone. Between 14 September and 27 October, he cut himself 11 times and tried to hang himself on four occasions. He remained subject to ACCT monitoring and his level of risk was reviewed each time he self-harmed or tried to kill himself. There are no actions recorded in his caremap during this period, implying that staff took little action to actively reduce his risk.

39. On 22 September, Mr Speakman saw Mr D, a support worker from the substance misuse service at the prison. Mr D provides one to one support, dealing with the psychosocial aspects and relapse prevention strategies of drug treatment. Mr D told the investigator that Mr Speakman openly admitted to using New Psychoactive Substances (NPS) and that NPS is a significant issue within the prison. There is no evidence that Mr D notified officers or submitted a security incident report about Mr Speakman’s substance misuse. Beyond Mr D’s work it is not clear that the prison took any action to address Mr Speakman’s use of NPS and the implications for his risk and safety.

40. On 12 October, Hewell received the decision of the Parole Board. They concluded that Mr Speakman was a high risk of reconviction and a high risk of future harm to others. Mr Speakman was informed about the decision on the same day.

41. On 14 October, Mr Speakman moved to the segregation unit because he had refused to follow an order and assaulted an officer when he was returned to his cell. He was given a punishment of seven days cellular confinement in the segregation unit as a result. Mr E, the Head of Safety, completed the segregation paperwork to record the exceptional reasons to segregate a prisoner on an ACCT. He noted that Mr Speakman had refused to move to a normal wing and could not be admitted to the inpatient unit. Mr Speakman was subject to five ACCT checks an hour. During the evening of 15 October, the duty governor decided to manage Mr Speakman under constant supervision as he was making ligatures and attempting to hang himself. As there were no available constant supervision cells in the inpatient unit, Mr Speakman moved to a constant supervision cell in the segregation unit.

42. On 21 October, Mr E held an ACCT case review with Mr Speakman, Mr F, the mental health lead, Mr G from the chaplaincy, and Mr H, from the IMB. Mr E agreed to let Mr Speakman spend some time on a standard houseblock, with a view to him leaving the segregation unit. Mr E recorded that Mr Speakman had to

remain in the segregation unit, even though he had served his punishment of seven days cellular confinement. Mr E noted that there was still nowhere else to accommodate his constant supervision, so he approved his continued segregation for the good order or discipline of the prison.

43. On 22 October, Mr Speakman saw Dr I, the prison's visiting forensic consultant psychiatrist. He recorded in Mr Speakman's medical record that he did not see any evidence of a major mental illness and that he believed Mr Speakman's behaviour was as a consequence of his personality disorder. He noted that the prison was waiting for the outcome of Mr Speakman's referral to the medium secure hospital.

44. On 25 October, Mr E held a case review with Mr Speakman, Mr F and an SO. Mr E recorded that Mr Speakman appeared keen to move out of the segregation unit and said he had no thoughts of suicide or self-harm. Observations were reviewed and set at four per hour. On 26 October, Mr Speakman moved to houseblock six, a standard houseblock.

45. On 10 November, Mr Speakman saw Dr J, from the medium secure hospital. In her report, Dr J concluded that admission to hospital under Section 47 of the Mental Health Act would not be appropriate. However, she recommended that Mr Speakman should be treated through the personality disorder pathway within the prison service. She recommended referral to a Psychologically Informed Planned Environments (PIPE) unit. (PIPE units were established as part of the personality disorder pathway by the National Offender Management Service (NOMS), to provide dedicated environments for the treatment of personality disorder within the prison system.)

46. While on houseblock six, staff noted on several different occasions that they suspected Mr Speakman was under the influence of illicit substances. On 14 November, Mr Speakman told an officer that he had smoked NPS. There is no evidence that staff took any particular action in response. It is not clear whether staff considered inviting Mr D to ACCT case reviews, but he did not attend any.

47. During the afternoon of 23 November, Mr D saw Mr Speakman. He told Mr D he had not yet completed the in-cell relapse prevention work Mr D had given him. Over the next few weeks, Mr Speakman continued to work with the substance misuse team. He regularly saw Mr D but did not complete any of the relapse prevention work he was given.

48. On 10 December, Mr Speakman moved from houseblock six to houseblock one, at his request. On 12 December, Mr Speakman was segregated again because he was suspected of passing something to another prisoner. He said that he was several years over his minimum prison sentence and had nothing to live for; later that day, he tried to hang himself. Between 12 to 31 December 2015, Mr Speakman cut himself once and tried to hang himself nine times. He was moved to the segregation unit on 14 December and staff decided he should be constantly supervised again. They noted that there were still no available constant supervision cells anywhere else in the prison. Mr Speakman remained under constant supervision in the segregation unit until 4 February 2016.

49. On 4 February, prison and healthcare staff met for a multidisciplinary meeting. They discussed referring Mr Speakman to a PIPE unit. As prisoners will not be

accepted onto the PIPE programme from a segregation unit, staff planned to move Mr Speakman to a standard houseblock. When they told Mr Speakman, he refused to listen or participate in the ACCT case review. The multidisciplinary team decided to end the constant supervision and reduce checks to five times an hour. Over the next 21 days, while still in the segregation unit, he tried to hang himself 14 times and cut himself 21 times. Staff recorded their ongoing attempts to support and encourage Mr Speakman and on 12 February, he agreed to work in the prison gardens for a couple of hours every day, with a view to starting full time work in due course.

50. On 24 February, Mr Speakman told Mr D he had not taken any illicit drugs and was regularly taking his medication. On 29 February, staff reduced the frequency of ACCT checks to three an hour.

51. On 7 March, Mr Speakman moved to a shared cell on houseblock two. On 16 March, after a period of positive and settled behaviour, a supervising officer assessed Mr Speakman as at a low risk of suicide and self-harm, and reduced the frequency of checks to once each shift and once an hour at night.

52. On 25 March, SO K held a case review with Mr Speakman, two members of the IMB, and Officer L. SO K recorded that a member of healthcare staff had submitted written information but could not attend in person. SO K noted that Mr Speakman had not self-harmed for over a month, had a good relationship with his cellmate and was looking at moving to a PIPE unit. SO K decided to end ACCT monitoring. The post closure interview was scheduled for 1 April but did not take place.

53. On 29 March, Mr Speakman saw Mr D while he was working in the gardens. He told Mr D he enjoyed the work and was not taking any illicit substances.

54. During a random search on 5 April, staff found that Mr Speakman had a mobile phone. He assaulted an officer and was placed on report. During the afternoon, SO K decided to restart ACCT procedures after Mr Speakman tied a ligature to his bed. He tried to hang himself six times between 5 April and his admission to hospital on the 25 April.

55. On 6 April, staff moved Mr Speakman to the segregation unit to attend a disciplinary hearing for assaulting the officer. The hearing was adjourned to await the outcome of a police investigation. Mr E completed the segregation paperwork setting out the exceptional circumstances to segregate Mr Speakman while on an ACCT. Mr E recorded that there was a risk that segregating Mr Speakman would cause his self-harm behaviour to escalate, but that he had seriously assaulted an officer and senior managers agreed that he needed to spend a period of time in the segregation unit. Mr E set the frequency of observations at five an hour.

56. On 8 April, Mr E held an ACCT case review and segregation review with Mr Speakman, Nurse M, from the mental health team, Ms N from the chaplaincy team, SO O and a member of the IMB. This was the first case review held since SO K had restarted ACCT procedures on 5 April. Mr E noted that Mr Speakman was agitated, aggressive and threatening. He explained to Mr Speakman why he had been segregated and they discussed a phased reintegration back to another houseblock. Mr Speakman said he was being forced to self-harm by being held in

the segregation unit. Mr E assessed Mr Speakman as at a raised risk of suicide and self-harm and kept the frequency of checks at five an hour. Mr E did not make any entries on the ACCT caremap.

57. After the review, Mr E discussed Mr Speakman with the manager of the mental health team. They discussed Mr Speakman's long history of self-harm, fluctuating mental health and the current management plan. They agreed that Mr Speakman did not currently need a mental health assessment, but that staff would refer him to the mental health team if his presentation changed.

58. On 12 April, Mr D saw Mr Speakman for the last time. Mr Speakman told Mr D that he had been using NPS regularly and that he had not completed any of the relapse prevention work Mr D had given him.

59. On 14 April, SO P held an ACCT review with Mr Speakman and SO R. A nurse spoke to SO P before the review, but did not attend. Mr Speakman said that he was settled in the segregation unit and wanted to remain there until a transfer to a houseblock could be arranged. He asked to see a Listener who had previously supported him. (Listeners are prisoners trained by the Samaritans to offer to support to their peers.) Ms P assessed Mr Speakman as at a raised risk of suicide and self-harm, reduced the frequency of observations to two an hour but did not make any entries on the caremap. We do not know whether staff arranged for the Listener to talk to Mr Speakman.

60. On 15 April, Ms Q, Head of Residence, held a case review and segregation review with Mr Speakman, a nurse and Ms N. Mr Speakman was upset and agitated during the review but agreed to continue to spend periods on a houseblock to help his reintegration. Ms Q assessed Mr Speakman as at a low risk of suicide and self-harm, but did not change the frequency of observations. She did not update the caremap.

61. On the evening of 16 April, Mr Speakman cut his arm. Staff arranged for Listener A to come to the unit and talk to Mr Speakman. After they had talked, Mr Speakman seemed calmer. Later that night, Mr Speakman talked to the duty Listener for ten minutes, but was upset that he had not been able to speak to Listener A. He became threatening and staff later had to go into his cell to remove a ligature from around his neck. Staff did not hold an ACCT review the next day.

62. On 18 April, Mr E held an ACCT and segregation review with Mr Speakman and SO R. Nurse M spoke to Mr E beforehand but did not attend the case review. Mr E told Mr Speakman that they were considering moving him to a lower security prison, but Mr Speakman was very unhappy about this. Mr E reviewed Mr Speakman's level of risk and changed it to raised. He did not change the frequency of observations or update the caremap.

63. The next day, 19 April, Mr Speakman tried to attack SO R. That afternoon, staff found Mr Speakman on his cell floor with a ligature tied around his neck. Healthcare staff attended but thought Mr Speakman was feigning unconsciousness and Nurse S stayed in the unit to monitor Mr Speakman. Later that afternoon, Nurse S saw Mr Speakman tying a ligature to a light fitting in his cell. The ligature broke and Mr Speakman threw himself on the floor. Nurse S checked Mr Speakman and recorded no concerns about him.

64. On 20 April, Mr E held a case review with Mr Speakman, SO K, and two officers. Nurse M spoke to Mr E but did not attend the case review. Mr Speakman said he was frustrated that staff had suggested transferring him to a lower security prison that did not offer the rehabilitation course he needed to progress towards release. Mr Speakman calmed down during the review and Mr E noted that the review ended positively. He assessed Mr Speakman as at a raised risk of suicide and self-harm and made no entries on the caremap.

65. On 23 April, SO R held a case review with Mr Speakman and SO T. No one from the healthcare department attended or contributed to the review. SO R recorded that Mr Speakman was unwell and had asked to postpone the review. SO R noted that Mr Speakman had been in good spirits the previous day, and assessed his risk as low. He rescheduled the case review for 25 April.

66. On 24 April, Mr Speakman spent time on houseblock one in the morning and afternoon.

25 April 2016

67. On the morning of 25 April, Mr Speakman painted a cell in the segregation unit. That afternoon, SO U held a case review with Mr Speakman and an officer. A nurse spoke to SO U before the review but did not attend. SO U recorded that Mr Speakman was in good spirits and that his risk remained low. SO U changed the frequency of observations to once every two hours. He did not update the caremap.

68. At around 5.10pm, an officer found Mr Speakman with a plastic bag over his head. The officer and SO U convinced Mr Speakman to remove the bag. Mr Speakman said he was upset that he had not been allowed to go to houseblock one that afternoon.

69. At around 5.30pm, SO U held a case review with Mr Speakman. No other staff attended, although a custodial manager and SO U had discussed Mr Speakman beforehand. Mr Speakman accused staff of playing mind games with him and threatened to destroy his cell. SO U assessed Mr Speakman as at raised risk and increased the frequency of observations to two an hour. He did not make any entries on the caremap.

70. At about 6.10pm, Mr Speakman asked to speak to a Listener. Staff brought the duty Listener to see Mr Speakman, who then refused to speak to him.

71. At around 6.38pm, Officer V checked Mr Speakman and saw him hanging from a ligature, made from a sheet, attached to the light fitting in his cell. Officer V radioed an emergency code blue (indicating a prisoner is unconscious, not breathing or having difficulty breathing). The control room called an ambulance immediately. Officer V and Officer W went into Mr Speakman's cell. Officer V cut the ligature and the staff lowered Mr Speakman to the floor. Nurse S and Nurse X arrived quickly after and started cardiopulmonary resuscitation. They attached a defibrillator to Mr Speakman's chest but it did not recommend a shock. After two rounds of resuscitation, Mr Speakman began breathing again.

72. The paramedics reached Mr Speakman's cell at 6.56pm and took over Mr Speakman's treatment. At 7.20pm, Mr Speakman was transferred to the

ambulance and taken to the local hospital. Ms Y, a manager, completed an initial risk assessment and concluded that Mr Speakman posed a high risk of escape and a high risk to the public. She decided that three officers should accompany Mr Speakman in the ambulance and that he should be restrained by an escort chain. (An escort chain is a long chain with a handcuff at each end, one of which is attached to the prisoner and the other to an officer.) Healthcare staff did not contribute to the risk assessment. Once Mr Speakman had been admitted to hospital and had been sedated, the restraints were removed.

Contact with Mr Speakman's family

73. After Mr Speakman went to hospital, staff tried to phone his brother, who he had named as his next of kin. The telephone number recorded in Mr Speakman's prison file was incorrect, so the prison asked the police to tell him Mr Speakman was in hospital. Mr Speakman's brother phoned the prison on 26 April, and arrived at the hospital on the same day.

74. On 26 April, hospital staff reduced Mr Speakman's sedation and began to wake him up. Mr Speakman was very agitated and sometimes had to be held down by prison and hospital staff. When his behaviour became particularly difficult to manage, prison staff reapplied handcuffs and the escort chain.

75. On 6 May, Mr Speakman became agitated and SO R, who was one of the staff present at the hospital, had to reapply restraints. Mr Speakman's brother was concerned that SO R had used unnecessary force. SO R told the investigator that he had used reasonable force to prevent Mr Speakman from hurting himself or hospital staff. The Prison Service investigated SO R's actions and concluded that he had acted reasonably. There was no CCTV covering Mr Speakman's ward.

76. On 7 May, Mr Speakman's condition deteriorated and he was diagnosed with an infection. He died at 5.30pm on 9 May, with his brother at his bedside. The prison contributed towards the cost of Mr Speakman's funeral, in line with national instructions.

Support for prisoners and staff

77. No one debriefed the staff who had been involved in the emergency response after Mr Speakman was found hanging, or after his death. However, the staff were offered the support of the prison's care team after Mr Speakman died.

78. The Governor issued notices to staff and prisoners informing them of Mr Speakman's death. Officers and members of the chaplaincy team supported prisoners. Staff reviewed prisoners who had been assessed as at risk of suicide and self-harm in case they had been adversely affected by Mr Speakman's death.

Post-mortem report

79. A post-mortem examination found the cause of death was pneumonia caused by a hypoxic brain injury and ligature suspension (hanging). Toxicology tests were not carried out due to the length of time between Mr Speakman's hanging and his death.

Findings

Managing Mr Speakman's risk of suicide and self-harm in the segregation unit

80. When Mr Speakman arrived at Hewell in September 2015, he was eight years into an indeterminate sentence and five years past his minimum term (the period he had to serve before he could be considered for release). The Parole Board had assessed him as unsuitable for release or for open conditions. It is clear that Mr Speakman was frustrated and concerned by his lack of progression towards release. He had not yet completed any offending behaviour courses and the Parole Board had assessed him as unsuitable for release or for open conditions. It is apparent that his lack of progression towards release was a major concern for Mr Speakman and prison staff had been unable to allocate him to suitable programmes. He also had a history of substance misuse, mental health problems and suicide attempts and self-harm. He was being supported by suicide and self-harm monitoring arrangements when he arrived and the transfer was arranged by the safer custody teams at Featherstone and Hewell.

81. In October 2015, Mr Speakman was moved to the segregation unit for two weeks. He was segregated again from 12 December until 7 March 2016, and was under constant supervision for most of that time. He was segregated again on 5 April, and remained there until he was found hanging on 25 April. On each occasion, he was supported by ACCT procedures.

82. Prison Service Instruction (PSI) 64/2011, which covers safer custody, requires that prisoners assessed as at risk of suicide and self-harm should be held in segregation units only in exceptional circumstances and that the reasons must be clearly documented in the ACCT record and include other options that were considered but discounted. The first time Mr Speakman was segregated, Mr E noted that he had refused all alternative locations. When staff decided he needed constant supervision, they recorded that there were no other available constant supervision cells in the prison. In April 2016, Mr E recorded that Mr Speakman had to be segregated because he had seriously assaulted an officer. While we are surprised at the lack of available constant supervision cells at Hewell at the time, we acknowledge that senior staff did consider whether Mr Speakman could safely be located elsewhere in the prison, and concluded that there were no other options.

83. Prisons have the discretion to manage the most severely disruptive, volatile and difficult to manage prisoners under an enhanced case review process. Enhanced case reviews are designed to allow staff to respond to more effectively to the prisoner's individual needs to provide a flexible but consistent approach to changing the prisoner's behaviour and managing their risk. When a prisoner's behaviour is particularly challenging or they are subject to constant supervision for eight days or more, PSI 64/2100 states they should be managed with the additional input of an enhanced case review.

84. Management by an enhanced review includes more specialists and a higher level of operational management. With the complexity of Mr Speakman's behaviour, it would have been appropriate to consider an enhanced case review approach. Between 14 October and 25 April, staff held 81 ACCT reviews with Mr Speakman. Mr E chaired or was present at 39 of those and we acknowledge that a senior

prison manager chaired a number of the others, particularly when Mr Speakman was segregated. However, we consider that a more consistent high-level approach from an enhanced case review team might have resulted in more regular attendance by mental health staff at reviews and a more coherent approach to managing Mr Speakman's behaviour.

85. The reviews appeared to be principally about containment of Mr Speakman's risk with little evidence of agreed strategies being developed to respond to Mr Speakman's difficulties. PSI 64/2011 requires caremaps to reflect the prisoner's needs, level of risk and the triggers of their distress. There were no new entries in Mr Speakman's caremap after 21 March. We are concerned that staff did not identify specific issues, such as Mr Speakman's lack of progression, his sentence plan, location, use of NPS or mental health on the caremap which, if addressed, might have helped reduce his level of risk. Caremap actions are fundamental to the ACCT process.

86. PSI 64/2011 expects case reviews to be multidisciplinary where possible. Although Mr Speakman had mental health problems and was being considered for transfer to a secure hospital, healthcare staff only attended 39 of the 81 reviews after 14 October, and made a verbal or written contribution in 15 others. Mr Speakman worked with Mr D to address his substance misuse, but Mr D did not attend any case reviews. 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. At the last case review, SO U did not invite anyone from the healthcare team, despite the recorded sudden deterioration in his behaviour, and held the case review alone, which is poor practice and contrary to the instructions in the PSI.

87. PSI 64/2011 requires that a case review must be held within 24 hours of an ACCT being opened. The first case review after the ACCT reopened on 5 April did not take place until three days later on 8 April. Mr E could not explain why the case review was delayed.

88. Mr Speakman was always at risk of suicide; he often said that he wanted to be dead and his self-harming behaviour increased the risk of his accidental death. Ultimately, it is very difficult to prevent someone who makes a determined decision to kill himself from carrying out that plan, without making living conditions so restrictive as to be inhumane. Overall, we consider that staff at Hewell made reasonable efforts to manage Mr Speakman's risk. Nevertheless, PSI 64/2011 notes that 'The ACCT process is necessarily prescriptive and it is vital that all stages are followed in the timescales prescribed'. The investigation identified a need for improvements in aspects of ACCT procedures outlined above. We make the following recommendation:

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

- **Prisoners at risk are not held in the segregation unit unless all other options have been considered and excluded and there are fully documented reasons to explain the exceptional circumstances.**
- **Case reviews are multidisciplinary and include all relevant people involved in a prisoner's care, including mental health staff where appropriate and healthcare staff attend all first case reviews.**

- **The enhanced case review process is used when appropriate.**
- **Staff set ACCT caremap actions which are aimed at reducing prisoners' risks to themselves and review them at each case review.**

Mental health

89. Mr Speakman had a history of complex mental health problems, including a personality disorder, which may have contributed to his impulsive and risky behaviour. At Hewell, Mr Speakman was assessed by mental health nurses and forensic psychiatric specialists, who concluded that he did not have a severe mental illness. He was assessed as unsuitable for transfer to a secure hospital under the Mental Health Act. Latterly, staff were pursuing transferring Mr Speakman to a PIPE unit, although he was equivocal about this idea. The clinical reviewer concluded that the standard of healthcare Mr Speakman received at Hewell was equivalent to what he could have expected to receive in the community.

90. As noted above, prisoners being monitored under ACCT procedures should be located in segregation units only in exceptional circumstances. When this happens, Prison Service Order (PSO) 1700, which details the procedures to follow when segregating prisoners, requires that such prisoners should have a mental health assessment within 24 hours. This did not happen in this case. Mr E contacted the mental health team on 8 April (two days after Mr Speakman was segregated for the second time) and requested a mental health assessment for Mr Speakman. The mental health team did not conduct a mental health assessment for Mr Speakman. Ms Nheta told Mr E that Mr Speakman could be supported by the primary healthcare team. As mentioned previously, Mr Speakman had regularly seen Dr I and it had been recommended that he move to a PIPE unit. Mr Speakman's mental health was not assessed as national instructions require. We make the following recommendation:

    The Governor and Head of Healthcare should ensure that the prisoners being monitored under ACCT procedures who have been segregated have an urgent mental health assessment.

Sentence progression and transfer

91. Mr Speakman was nine years into an indeterminate sentence and seven 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 Speakman.

Substance misuse and New Psychoactive Substances (NPS)

92. Mr Speakman had a long history of substance misuse before he arrived in custody. When he moved to Hewell, he was referred to the substance misuse team and saw Mr D frequently. Mr Speakman told Mr D he had used NPS while at Hewell, including on 12 April 2016. He told Mr D on a number of occasions that he intended to take action to deal with his substance misuse, and Mr D encouraged him to complete relapse prevention work. However, Mr Speakman told Mr D several times that he had not completed any of the relapse prevention work and his engagement with substance misuse services appeared to sporadic. Because of

the length of time between Mr Speakman hanging himself in prison and his death, the post-mortem examination did not include toxicology tests, so we do not know if Mr Speakman had recently used NPS or other illicit substances at Hewell.

93. In July 2015, we published a Learning Lessons Bulletin about deaths associated with the use of NPS. We identified dangers to physical and mental health, as well as risks of bullying and debt and possible links to suicide and self-harm. The bulletin identified the need for better awareness among staff of the dangers of NPS; the need for more effective drug supply reduction strategies; and better monitoring by drug treatment services. It is important that prisons do all they can to eradicate the use of new psychoactive substances and other illegal drugs.

The use of restraints

94. When prisoners have to travel outside of the prison, a risk assessment determines the nature and level of security arrangements, including restraints. The Prison Service has a duty to protect the public but this has to be balanced with a responsibility to treat prisoners with humanity. Any restraints used should be necessary and decisions should be based on the security risk taking into account factors such as the risk of escape, the risk to the public and takes into account the prisoner's health and mobility.

95. A judgment in the High Court in 2007 made it clear that prison staff need to distinguish between the prisoner's risk of escape when fit (and the risk to the public in the event of an escape) and the prisoner's risk when suffering from a serious medical condition. The judgement indicated that prison staff must take into account medical opinion about the prisoner's ability to escape and keep this under review as circumstances change.

96. We recognise that in an emergency, it might not be possible for staff to complete a full medical assessment and it is preferable to get the prisoner to hospital quickly and review the risk assessment later if necessary. However, we are concerned that when Mr Speakman was taken to hospital on 25 April, a manager decided he should be restrained by an escort chain, although it was clear that he was unconscious and in a very serious condition. We make the following recommendation:

    The Governor should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.

97. After he had regained consciousness, Mr Speakman's behaviour in hospital was sometimes difficult to manage as he was agitated, threatening and aggressive towards staff. Mr Speakman's family were concerned about the use of restraints in hospital and were concerned that staff had used unreasonable force to restrain Mr Speakman. We understand that his behaviour was difficult to manage and posed a risk to himself and hospital staff. The restraints were permanently removed when Mr Speakman's condition deteriorated. We are satisfied that, after Mr Speakman regained consciousness, restraints were appropriately applied, although we appreciate that it must have been difficult for Mr Speakman's family to watch him being restrained while clearly unwell.

Prisons & Probation Ombudsman
Independent Investigations

PO Box 70769
London, SE1P 4XY
Email: mail@ppo.gsi.gov.uk
Web: www.ppo.gov.uk
T | 020 7633 4100
F | 020 7633 4141