Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Geoffrey Hutton a prisoner at HMP Long Lartin on 8 February 2019

A report by the Prisons and Probation Ombudsman

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Our Vision

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

Our Values

We are:

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

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

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

Mr Geoffrey Hutton was found hanged in his cell at HMP Long Lartin on 8 February 2019. He was 39 years old. I offer my condolences to Mr Hutton's family and friends.

The investigation found that although Mr Hutton received good support from prison staff and the mental health and substance misuse services while at Long Lartin, his needs as a deaf prisoner were not properly addressed. We found that, in the absence of a dedicated disability liaison officer, there was no clear pathway for referral and liaison with social care services. Neither healthcare nor prison staff were aware of what should happen and vital assessments and support plans were not obtained from his previous prison.

Mr Hutton's behaviour was challenging at times. He was supported by Prison Service suicide and self-harm prevention measures (known as ACCT) on three occasions, including at the time of his death. The investigation found that the ACCT procedures were managed in line with national guidance, although caremap actions to support Mr Hutton should have been more specific and updated at every case review. I am particularly concerned that action to obtain specialist equipment to enable him to telephone his partner was not given greater priority.

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

Sue McAllister CB
Prisons and Probation Ombudsman **September 2019**

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Summary

Events

1. On 12 June 2018, Mr Geoffrey Hutton was remanded in prison custody charged with murder and sent to HMP Belmarsh. He was sentenced to life imprisonment with a 30-year tariff on 28 November, and moved to HMP Long Lartin on 19 December.

2. Mr Hutton was profoundly deaf. He had a long history of mental health and substance misuse issues and, before entering prison, he had tried to take his own life. After he entered prison, Mr Hutton was managed under Prison Service suicide and self-harm prevention procedures (known as ACCT) on three occasions after he expressed suicidal thoughts, was found with a ligature and after cutting his arms. Mr Hutton was being supported by the ACCT process at the time of his death.

3. At around 3.28am on 8 February 2019, the night patrol officer found Mr Hutton hanging at the back of his cell. Staff were unable to resuscitate him and at 3.56am stopped resuscitation attempts. At 4.12am, ambulance paramedics recorded that Mr Hutton had died.

Findings

4. We found that overall ACCT procedures were good: immediate action plans, assessments and case reviews were timely and well attended by a multidisciplinary team.

5. However, the actions on the caremap were not always reviewed or updated and the most significant issue identified - the need to obtain specialist equipment to enable Mr Hutton to use the telephone - was not resolved before he died. We consider that this action should have been given greater priority.

6. Belmarsh identified that Mr Hutton needed support as a deaf prisoner and put appropriate adjustments in place. However, when Mr Hutton was moved to Long Lartin this information was not shared.

7. Although Mr Hutton did receive support from prison and healthcare staff for his social care needs at Long Lartin, we found that there was no clear or established pathway for assessments and staff did not understand who was responsible for ensuring his needs were met.

8. As in a previous investigation at Long Lartin, we identified the need to ensure all staff attend a debrief after a death in custody.

Recommendations

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

    - all staff receive adequate and appropriate ACCT training;
    - staff are reminded to complete ACCT observations at irregular, unpredictable intervals; and

- staff set caremap actions that are specific, time bound and meaningful, aimed at reducing risk, and update them at each case review.

- The Governor and Head of Healthcare at Belmarsh should ensure that there is a clear process for ensuring social care plans are promptly shared when a prisoner is transferred.
- The Governor and Head of Healthcare at Long Lartin should:
  - review the process for referral for a social care assessment, ensuring that a clear pathway exists to ensure that timely assessment takes place; and
  - ensure any active care plans are obtained from the sending establishment.

The Investigation Process

9. The investigator issued notices to staff and prisoners at HMP Long Lartin informing them of the investigation and asking anyone with relevant information to contact her. No one responded.

10. The investigator visited Long Lartin on 15 February. She obtained copies of relevant extracts from Mr Hutton's prison and medical records and visited C Wing where she spoke to staff.

11. The investigator interviewed three members of staff and one prisoner at Long Lartin on 16 May. In addition, she interviewed three members of staff by telephone in May and three in June.

12. NHS England commissioned an independent clinical reviewer to review Mr Hutton's clinical care at the prison. The clinical reviewer conducted joint interviews with the investigator at Long Lartin.

13. We informed HM Coroner for Worcestershire of the investigation. The coroner gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

14. One of the Ombudsman's family liaison officers contacted Mr Hutton's family to explain the investigation and to ask if they had any matters they wanted the investigation to consider. Mr Hutton's family wanted to know what was in place to support Mr Hutton, what provision was made to assist with his disability (deafness) and the circumstances in which he was found. We have addressed their questions in this report.

15. We shared a copy of our initial report with Mr Hutton's parents and his partner. They did not identify any factual inaccuracies but raised a number of issues which we have responded to in separate correspondence.

16. The prison also received a copy of the report and did not identify any factual inaccuracies.

Background Information

HMP Long Lartin

17. HMP Long Lartin is a high security prison in the Vale of Evesham, Worcestershire. It holds up to 609 men across five main wings and two support wings. All prisoners are accommodated in single cells. The healthcare contract is held by Care UK, with mental healthcare subcontracted to South Staffordshire and Shropshire NHS Foundation Trust Mental Health Team.

HM Inspectorate of Prisons

18. The most recent inspection of HMP Long Lartin was in January 2018. Inspectors reported that the prison had made very good progress in meeting the Prisons and Probation Ombudsman's recommendations following investigations into three self-inflicted deaths at Long Lartin since 2014. Inspectors noted the management team were competent and effective.

19. Inspectors found relationships between staff and prisoners were confident and respectful. Healthcare was well led and work to support those with mental health needs was responsive and effective; waiting times were short and better than those found in equivalent community services.

20. In HMIP's survey, approximately 30% of prisoners at Long Lartin said they had a disability and prison records recorded a similar figure. New arrivals who reported disabilities were referred to the healthcare or education provider, depending on whether it was a physical or learning disability. Appropriate reasonable adjustments had been made for some prisoners. However, inspectors identified some unmet needs and the former disability liaison officer, whose role had ceased shortly before the inspection, told inspectors there were frequent delays in assisting prisoners. There was no carer scheme to support prisoners who needed extra support.

Independent Monitoring Board

21. 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 Long Lartin, for the year to 31 January 2018, the IMB noted the normally settled atmosphere at Long Lartin had been disturbed by periods of tension, including raised levels of violence against staff and prisoners.

22. The Board noted that both mental health and general nursing staff were below the agreed service level and there was no psychologist. They were also concerned prison staff had fallen significantly behind with data collection, recording and reporting on PNOMIS, the electronic prison record.

Previous deaths at HMP Long Lartin

23. Mr Hutton was the eighth prisoner to die at Long Lartin since June 2017. Of the previous deaths, six were self-inflicted, one was drug-related and one was a homicide. There have been two deaths since, one from natural causes and one awaits classification. We have previously made a recommendation about the

importance of holding a hot debrief for all those involved in the emergency response.

Assessment, Care in Custody and Teamwork

24. 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.

25. 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, multi-disciplinary review meetings involving the prisoner. As part of the process, a caremap (a 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.

26. 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, *Safer Custody.*

Incentives and Earned Privileges Scheme (IEP)

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

Key Events

28. On 12 June 2018, Mr Geoffrey Hutton was remanded in custody and taken to HMP Belmarsh, charged with murder. He was sentenced to life imprisonment on 28 November, with a minimum tariff of 30 years. This was his first time in prison.

29. Mr Hutton had a history of depression dating back to 2000 and in 2017, he had two informal admissions to secure mental health units due to his depressive illness. Mr Hutton also had a history of drug and alcohol misuse.

30. On his Person Escort Record (a document that accompanies all prisoners when they move between police stations, courts and prisons and that sets out the risks they pose), court staff recorded on the 'risk indicator' form that Mr Hutton had a history of attempted suicide and self-harm and was alcohol dependent. Police records show that when Mr Hutton was arrested, he had significant cuts to his arms and legs which were thought to be self-inflicted, although he claimed at the time they were not. A suicide and self-harm warning form was completed to accompany Mr Hutton to prison.

31. Mr Hutton was profoundly deaf and had cochlear implants (specialist electronic hearing aids) fitted in 2011. He suffered from Meniere's Disease (which can cause pressure or pain in the ear, severe dizziness or vertigo, hearing loss and tinnitus), as well as several skin conditions.

HMP Belmarsh

32. When he arrived at Belmarsh around 3.25pm, an officer completed Mr Hutton's reception assessment and recorded on the cell sharing risk assessment (CSRA) that because Mr Hutton was a category A prisoner (the highest security category) due to the nature of his offence and was high risk, he would be placed in a single cell until his previous convictions had been reviewed. (Mr Hutton was assessed the following day as a standard risk.) The officer noted that Mr Hutton had no immediate needs and had no thoughts of suicide or self-harm.

33. At 4.34pm, a nurse recorded in Mr Hutton's medical record that he had completed Mr Hutton's initial healthscreen. The nurse noted Mr Hutton's history of attempted suicide and that he had been in a secure mental health unit, that Mr Hutton said he had no issues with alcohol or drugs and that he declined to be referred to the substance misuse service. The nurse referred Mr Hutton to the prison doctor.

34. At 8.15pm, a prison GP examined Mr Hutton. He assessed Mr Hutton's wounds, redressed them and prescribed antibiotics for an infection (co-amoxiclav) and pain relief (co-codamol). He noted that Mr Hutton would need a charger for the batteries of his cochlea implant. Mr Hutton was referred to mental health services. Mr Hutton told all the prison and healthcare staff that he had contact with in his first week that he had no thoughts of suicide or self-harm.

35. On 15 June, a referral was submitted to the Royal Borough of Greenwich Social Services Department (RBGSSD) for Mr Hutton to have a social care occupational therapy assessment.

36. On 20 June, a nurse assessed Mr Hutton's mental health. He noted Mr Hutton's history of self-harm, but did not identify any significant mental health issues and assessed that immediate intervention from the Integrated Mental Health Team (IMHT) was not necessary. However, he referred Mr Hutton for counselling with Atrium Counselling Services, and requested a psychiatrist's opinion on medication.

37. On 25 June, the social care team assessed Mr Hutton. They found he needed adaptions to ensure that he could charge the batteries for his cochlear implants and needed ongoing access to contact lenses (to enable him to lip read), as spectacles interfered with his hearing implants.

38. On 27 June, RBGSSD agreed and shared an Interim Support Plan with Mr Hutton and Belmarsh. Mr Hutton was given chargers for his batteries, and arrangements were made for him to use the telephone during quieter times or in a separate room, assisted by staff from the safer custody team. In addition, he was provided with support from a care and support orderly (another prisoner) to help with his daily needs (collecting food, showering, etc) in case he felt dizzy. A psychiatrist documented a detailed assessment in Mr Hutton's medical record. He did not recommend any medication but arranged for Mr Hutton to be reviewed in one month.

39. On 23 July, a psychiatrist reviewed Mr Hutton and prescribed him an antidepressant (mirtazapine 15mg daily). Mr Hutton attended monthly counselling sessions with a counsellor from Atrium.

40. On 8 September, an officer radioed a code blue medical emergency (which indicates that a prisoner is unconscious or having difficulty breathing) when he found Mr Hutton having a seizure after smoking psychoactive substances (PS) through a tampered vape. A nurse attended and noted that Mr Hutton was lying on his bed, laughing, and his speech was slurred. The next day, a nurse went to check Mr Hutton, but he declined to be assessed and said he was fine.

41. On 21 September, after having had two negative entries on his prison record, Mr Hutton received a warning that he would be downgraded to the basic IEP level if he did not comply with the regime. The next day, an officer found Mr Hutton lying on his bed smoking PS through his vape. Mr Hutton was conscious and responding, but was under the influence. The officer removed Mr Hutton's vape. Mr Hutton was downgraded to the basic regime.

42. On 24 September, staff started suicide and self-harm prevention measures (known as ACCT) after Mr Hutton said he would hurt himself or an officer and that he was frustrated with his situation. On 28 September, a Custodial Manager (CM) reviewed Mr Hutton's IEP status. He noted in Mr Hutton's prison record that, although prison staff believed he had been under the influence of PS, Mr Hutton suffered from Meniere's disease and the symptoms could mistakenly be interpreted as him being under the influence. He was therefore put back onto the standard regime. The next day, the CM chaired the ACCT review attended by a nurse. The CM noted that Mr Hutton had apologised for the threats he had made, saying they were out of frustration, and that he had no thoughts of suicide or self-harm.

43. Over the next few weeks, staff recorded in Mr Hutton's prison record that he complied with the regime, a cell search had found nothing illicit and that he received a lot of support from prison staff to enable him to have contact with his partner.

44. Mr Hutton's social care support plan was regularly reviewed. On 7 November, it ended as Mr Hutton said he did not require the assistance of a support orderly as he wanted to be fully independent.

45. Mr Hutton's antidepressant medication was reviewed regularly. On 12 November, just before his trial started, a prison GP increased Mr Hutton's mirtazapine dose to 45mg daily and prescribed a short course of sleeping tablets (Zopiclone 7.5mg).

46. On 28 November, Mr Hutton was sentenced to life imprisonment with a 30-year tariff.

HMP Long Lartin

47. On 19 December, Mr Hutton was moved to HMP Long Lartin. A nurse completed Mr Hutton's initial healthcare screen and referred him to Inclusion (integrated mental health and substance misuse services). Mr Hutton continued to be prescribed an antidepressant. She noted that he required permission from security to have a battery charger for his cochlea implant in his possession.

48. An officer completed Mr Hutton's induction. He noted he had hearing issues and put him on the PEEP register (personal emergency evacuation plan). Mr Hutton was moved to F Wing.

49. On 21 December at 9.40am, a substance misuse worker completed the Inclusion induction, which focused upon harm reduction and minimisation of risks around Mr Hutton's substance misuse. A CM, who was a member of the safer custody team, emailed Belmarsh at 10.41am to request a copy of Mr Hutton's social care plan. Belmarsh did not respond.

50. At 7.30pm, an officer started ACCT procedures after Mr Hutton was found with a shoelace loosely tied around his neck during the evening roll check. A CM completed the immediate action plan and set hourly observations until Mr Hutton could be fully assessed. A nurse examined Mr Hutton and recorded in his medical record that he had threatened to smash up and flood his cell as he wanted to move to the segregation unit. An officer gave Mr Hutton a Bible and some religious reading material.

51. On 22 December at 11.00am, an officer completed the ACCT assessment. The officer noted that Mr Hutton said he was distressed because his hearing device was causing him problems. Mr Hutton said he had issues with drugs and alcohol in the community and that his life was chaotic, but that he had the support of his family and he felt listened to by staff. Mr Hutton said he had no current thoughts of suicide or self-harm, but wanted to move to C Wing as it was a quieter wing and would cause fewer problems with his hearing device. The officer recorded that he had referred Mr Hutton to the disability liaison officer (DLO). (The officer discovered after he made this entry that Long Lartin did not have a dedicated DLO.)

52. A Senior Officer (SO) chaired an ACCT review immediately after the assessment, attended by an officer and Mr Hutton. Staff assessed Mr Hutton's risk of suicide and self-harm as low. Mr Hutton told the CM that as well as his hearing issues, he was autistic and needed routine. Mr Hutton told the review it was his birthday the next day, and was disappointed as he had booked a visit at Belmarsh before he moved. The SO noted that Mr Hutton had written a note to staff that the light in his cell was causing interference and he wanted to move to C Wing. He added one issue to the caremap: for Mr Hutton to move to C Wing to reduce the noise interference on his hearing device.

53. On 23 December at 11.20am, a SO (F Wing) and a second SO (C Wing) held an ACCT review with Mr Hutton, after his move to C Wing. The first SO noted that Mr Hutton engaged appropriately during the review, said he was happier now he had moved to C Wing and that he had placed a shoelace around his neck out of frustration. Mr Hutton said he was not suicidal or wanting to self-harm, had books and a television with subtitles, and would speak to staff if he felt his frustrations building. Staff assessed that Mr Hutton's risk remained low, and reduced observations to one during the morning, afternoon and evening, and three random checks during the night.

54. The next day at 11.00am, a SO chaired an ACCT review, attended by acting an CM, a member of staff from Inclusion and Mr Hutton. Mr Hutton refused to start the review until the Imam had left. He said he was much more settled and had had a visit from his partner. Staff assessed Mr Hutton's risk of suicide and self-harm remained low and kept observations the same. They decided to keep the ACCT open for a further 24 hours to ensure Mr Hutton had no issues with his hearing or accessing the night sanitation.

55. On 25 December at 9.15am, Mr Hutton attended the Christmas service in the chapel. A SO chaired an ACCT review at 2.30pm, attended by an officer and Mr Hutton. Mr Hutton said he had no issues using the night sanitation system. The SO closed the ACCT.

56. On 1 January 2019 at 11.00am, the SO completed the ACCT post-closure review. The SO recorded that Mr Hutton said all his issues had been addressed, and that he felt well supported on the wing by staff, prisoners and chaplaincy staff.

57. On 4 January at 10.45am, Mr Hutton spoke to an officer and a CM from the safer custody team, and said that he was frustrated at Long Lartin and did not understand why he had been moved. The CM told Mr Hutton that he would ask his offender supervisor to visit him to discuss his sentence plan. Mr Hutton asked for a minicom (a small electronic typewriter and screen linked to a telephone system, enabling people with hearing or speech difficulties to send and receive messages) to assist with communication. The CM told Mr Hutton he would obtain some more information to see if this would be permitted in a high security prison.

58. On 6 January, a prison chaplain gave Mr Hutton a Bible and recorded that Mr Hutton had been attending the Catholic service.

59. On 7 January, the Head of Safer Custody and Equalities chaired a risk management meeting. The meeting, held monthly, discusses complex cases,

those who might be at risk of harm and those with specific needs, including those with disabilities and social care needs. It is designed to share information and agree the best way of managing certain prisoners with input from various departments across the prison, including healthcare, Inclusion and security. Mr Hutton was not discussed as part of the social care or complex cases agenda but the minutes note under Other Business, 'a CM to provide update on what measures we need to provide for Mr Hutton's hearing impairment.'

60. On 10 January, Mr Hutton told a nurse, that he was feeling frustrated and worried that he may harm someone out of frustration, but had no feelings of suicide or self-harm. Mr Hutton said his frustration was due to feeling isolated as he was unable to telephone anyone due to his deafness and there were no adaptations available to allow him to use a telephone with his hearing aids. She recorded in Mr Hutton's medical record that prison officers had been supportive and that they were concerned that his partner might be having doubts about their relationship. She concluded ACCT procedures were not necessary, but would be reviewed if Mr Hutton received bad news about his relationship.

61. On 11 January at 3.20pm, a recovery practitioner in Inclusion, assessed Mr Hutton. She recorded that Mr Hutton was feeling isolated due to the lack of facilities related to his deafness, resulting in frustration that he was unable to have a direct discussion with his partner. Mr Hutton told her that he was not using any illicit substances. She agreed to contact the prison DLO to explore options in dealing with his social care issues. A prison manager authorised staff to assist Mr Hutton using the telephone, as the device Mr Hutton had was not compatible with Long Lartin's telephone system.

62. On 14 January, the recovery practitioner noted in Mr Hutton's medical record that Long Lartin did not have a dedicated DLO and that this role was covered by CM Bent. She submitted a request to him for a social care referral.

63. On 20 January at 3.39pm, an officer recorded in Mr Hutton's prison record that he had radioed a code blue medical emergency after finding Mr Hutton fitting in his cell. The officer said Mr Hutton appeared dazed and, when asked, said someone had given him 'something', laughed, and said 'it was good'. A nurse assessed Mr Hutton and recorded that he was under the influence of an illicit substance. She checked Mr Hutton again at 4.54pm, and noted he was more alert and had eaten. The next day, Mr Hutton was downgraded to the basic IEP regime and placed on report. Over the next few days, Mr Hutton complied with the regime and had some positive entries recorded in his prison record. (Mr Hutton's adjudication was adjourned on 21 January, and was not concluded before he died.)

64. The recovery practitioner met with Mr Hutton on three occasions between 21 and 25 January, to complete his Inclusion assessment. She recorded in Mr Hutton's medical record that he said he had made four previous attempts to take his own life while under the influence of drugs or alcohol. She considered that Mr Hutton was potentially vulnerable to exploitation as he was the only person on the wing who was deaf. Mr Hutton said he wanted to engage with Inclusion, to explore options for improving his coping skills and to manage his illicit drug use.

65. On 22 January at 4.50pm, an officer recorded in Mr Hutton's prison record that he remained on the basic regime and had had his television removed. The officer noted that he had explained the IEP process and the expectations of the basic regime, and Mr Hutton said he understood and had no concerns or issues. The next day, Mr Hutton had been allocated to work in workshop 9, but was unable to enter the workshop as the security scanner created interference with his cochlear implant. He was returned to the wing until a solution was found.

66. On 26 January, at around 3.30am, a SO found Mr Hutton unresponsive in his cell with deep cuts to his wrists. The SO radioed a code red medical emergency (indicates severe blood loss) and an ambulance was requested. A nurse responded and recorded that Mr Hutton said he had attempted self-harm because he had missed his appeal deadline; he was angry at being moved from Belmarsh which was closer to family and friends; he was frustrated that due to his hearing issues he was unable to use the telephone; and he had been placed on basic IEP regime after his recent PS use. Mr Hutton refused to have his wounds stitched, but allowed paramedics to use steri strips to close the wounds and his arm was bandaged. The SO started ACCT procedures, and she completed the immediate action plan. Mr Hutton was moved to the healthcare unit at 5.40am; he was placed on constant supervision and given anti-rip clothing.

67. At 6.17am, an officer noted in Mr Hutton's ACCT that he had said, 'Why don't they just hang people instead of giving them 30 years.' He also spoke about going on hunger strike and asked if he would be force fed. Mr Hutton had a similar conversation with an officer at 7.10am. Mr Hutton told the officer that he wanted to transfer as he was frustrated that he was unable to talk directly to his family and friends. He said he did not recall cutting himself, but thought it may have been around 1.15am. At 9.26am, a nurse examined Mr Hutton who told her that the regime at Long Lartin was better, but he was too far away from his family and could be impulsive.

68. An SO completed the ACCT assessment at 10.20am. Mr Hutton told her that he struggled being away from his family, he had difficulties using the telephone and wanted to appeal against his sentence. Mr Hutton said he would refuse any medical intervention and would refuse food and fluids. Mr Hutton said that 'he has a sustained history of drug and alcohol abuse says that he blacks out and can't recall actions or events'. Mr Hutton said that he felt a 'burden to everyone'. He wanted to return to Belmarsh, was concerned about his hearing aid and wanted to have a television and radio.

69. Later the same day at 2.40pm, a security manager chaired the first ACCT review, which was attended by a SO the wing manager, a member of chaplaincy, an officer from safer custody and Mr Hutton. He said he did not take anything illicit on the wing the previous night, but said that he felt stressed and did not remember harming himself. Mr Hutton said he felt stressed being moved away from his family just before Christmas and felt isolated due to his hearing difficulties. The security manager told Mr Hutton she would see if she could arrange a videolink at Belmarsh with Mr Hutton's partner.

70. Staff at the ACCT review considered that Mr Hutton's risk of suicide and self-harm was raised. They reduced observations from constant to four times an

hour. They added three issues to the caremap: arrange videolink with Belmarsh, refer for a social care assessment, and arrange a visit for Mr Hutton at Long Lartin. Mr Hutton remained on basic IEP, but was given a television. At 3.35pm, Mr Hutton was moved to a standard cell in the healthcare unit and given clean clothing.

71. At 5.28pm, a SO noted in Mr Hutton's prison record that he was not being prescribed a sleeping tablet as there was no doctor on duty to prescribe. Mr Hutton was noted to be unhappy and said he wanted to move back to C Wing. At 6.10pm, the member of staff from chaplaincy recorded in Mr Hutton's prison record that she had spoken to him for over half an hour. Mr Hutton told her that he could not see the point in eating and that he had let his family and partner down. Mr Hutton said he continued to feel isolated due to his hearing difficulties. She gave Mr Hutton a Bible and some faith reading.

72. On 27 January, Mr Hutton attended the chapel for around an hour. At 10.20am, the security manager chaired an ACCT case review attended by two SO's, an officer, a nurse and Mr Hutton. Mr Hutton said he was 'up and down' but was pleased when the security manager told him he would be given a sleeping tablet. He said he did not feel ready to return to C Wing as he felt unsettled and that his main issue was getting used to his long sentence. A SO agreed to collect some of Mr Hutton's possessions from his cell. Staff assessed that Mr Hutton's risk had reduced to low and lowered observations to hourly.

73. At 5.10pm, Mr Hutton smashed his television, threatened staff if they opened the door and demanded to call his partner. A SO chaired an ACCT review at 5.25pm, attended by to officers. Mr Hutton refused to attend. Mr Hutton had told the SO that he was upset and angry because he had received an email from his partner ending their relationship. Mr Hutton refused to return a shard of plastic from the television. Staff assessed Mr Hutton's risk as raised and increased observations to four an hour.

74. On 28 January at 8.31am, the recovery practitioner recorded in Mr Hutton's medical record that he said he had attempted to ligature the previous evening. Mr Hutton reiterated his frustrations about the lack of a support plan to assist with his hearing impairment and the fact that he was still waiting to see a DLO. Mr Hutton told her that he was concerned that he had no recollection of cutting his arms or the attempted ligature, but he denied he had used illicit drugs. Mr Hutton said he had received a letter from his partner ending their relationship, that he was frustrated that his visits had been reduced from two a week (while on remand at Belmarsh) to two a month after being convicted, and now to one a month after being found using PS and downgraded to the basic regime. She noted that Mr Hutton accepted that he should remain on the inpatient wing with ACCT observations at four an hour.

75. A SO chaired an ACCT case review at 10.35am, attended by a substance misuse worker from Inclusion and Mr Hutton. The substance misuse worker asked Mr Hutton about a mark on his neck, but he said he did not recall ligaturing. Mr Hutton said he was upset the previous week due to 'family issues' but smashing his television and refusing to return the shard of plastic was about prison issues and that he wanted to speak to someone about his disability. Mr

Hutton said he did not know if he had thoughts of suicide or self-harm as he was still confused. Staff assessed that Mr Hutton remained at a raised risk of suicide and self-harm and kept observations at four an hour.

76. At 1.15pm, Mr Hutton told a prison chaplain, that he felt more isolated since the break-up of his relationship. The prison chaplain told a prison GP about his concerns, who said he would visit Mr Hutton.

77. At 1.29pm, the recovery practitioner, recorded in Mr Hutton's medical record that she had spoken to an administrator in the safer custody team, as she had not yet received an update on the social care referral or contact from the DLO. The administrator in the safer custody team said she would pass this information on to her colleague a CM. The recovery practitioner, also arranged for Mr Hutton to see the prison GP. At 2.49pm, an officer noted in Mr Hutton's prison record that he had apologised for his behaviour the previous day and that he appeared more settled.

78. At 4.54pm, a SO recorded that he reviewed Mr Hutton's basic IEP level. The SO noted that Mr Hutton had struggled to cope in the previous week, that he had smashed his television, threatened staff and refused food, all of which Mr Hutton later apologised for. The SO noted Mr Hutton would remain on the basic regime.

79. On 29 January, a prison GP assessed Mr Hutton. He prescribed a further short course of sleeping tablets (zopiclone) and a short course of diazepam to assist with reducing Mr Hutton's anxiety.

80. At 8.47am, the recovery practitioner noted in Mr Hutton's medical record that her colleague had contacted the safer custody team again to ask about progress with the social care referral and contact from the DLO. She noted that administrator in the safer custody team confirmed that a request for a minicom hearing loop had been made, a social care referral had been submitted and that Mr Hutton had been informed.

81. On 30 January at 11.19am, a nurse recorded that she examined Mr Hutton's arms. He did not want his wounds dressed. The nurse noted that Mr Hutton was chatty, in good humour, and had good eye contact. Mr Hutton told her that he felt his mental health had declined since his move to Long Lartin, that he remained frustrated about his hearing difficulties and less frequent contact with his friends and family, and that he did not remember the acts of self-harm. The nurse reassured Mr Hutton that the prison doctor would see him later and that he had an ACCT review scheduled.

82. At 11.20am, a nurse recorded in Mr Hutton's medical record that she and a prison GP had spoken to Mr Hutton during the earlier ward round and he had asked the prison GP for 'something as he is in crisis'. He agreed to review Mr Hutton's notes.

83. A SO chaired an ACCT review at 11.35am, attended by the recovery practitioner member of chaplaincy, a nurse and Mr Hutton. Mr Hutton said he had felt stressed earlier in the day, but had received a positive email from his partner and that he had accepted he would be at Long Lartin for some time. Mr Hutton said, having previously denied using PS, he had in fact been using illicit substances.

84. Mr Hutton spoke about training to become a Listener (prisoners trained by Samaritans to support other prisoners) or a support prisoner for men who have a hearing disability. Mr Hutton said he had had thoughts of self-harm but had managed these feelings. He remained concerned that he did not actually recall the act of harming himself. Staff kept observations at four an hour throughout the day and night. They updated the caremap to show that an email had been sent to a CM, who was the visits manager.

85. At 1.14pm, a prison GP recorded that he had seen Mr Hutton on his ward round and that he told him he was stressed, bored and frustrated that he could not vape in the healthcare unit. Mr Hutton said his antidepressant medication was helping a little and the prison GP told him he had been prescribed a sleeping tablet and anti-anxiety medication. At 2.19pm, he recorded that he had been asked to assess Mr Hutton as he was distressed, banging on his cell door and walls, concerned that he could not vape in the healthcare unit and that his 'mind is going crazy'. He increased Mr Hutton's anti-anxiety medication.

86. At 2.30pm, an officer recorded in Mr Hutton's ACCT that he threatened to assault staff to get moved to the segregation unit. At 2.57pm, a nurse recorded in Mr Hutton's medical record that Mr Hutton had made threats to staff that he 'has nothing to lose' as he was serving a long sentence and he will do something to get moved to the segregation unit and transferred from Long Lartin. Mr Hutton made direct threats to harm one particular officer. An intelligence report was submitted to security and Mr Hutton was only allowed out of his cell with three officers present, due to the threats.

87. At 6.10pm, a SO recorded that Mr Hutton had attended an ACCT review and said he had been stressed earlier in the day, but that staff had been helpful and he felt better and talked positively about his future. The SO reviewed the ACCT care plan and updated Mr Hutton that his partner had booked a visit at Long Lartin for 2 February (negating the need to organise a videolink at Belmarsh) and that he had had some property sent in. Mr Hutton spoke to Listeners at 6.25pm for around half an hour.

88. On 31 January, a safer custody manager chaired the risk management meeting. Mr Hutton was not discussed as part of the social care or complex cases agenda, but the meeting minutes note under Other Business, 'a CM to provide update on what measure we need to provide for Mr Hutton's hearing impairment.' There is no record of any progress made since the previous meeting on 7 January.

89. At 10.55am, the chaplaincy staff visited Mr Hutton and recorded in his prison record that they had had a positive chat, that she gave him some faith reading and a nature picture and an information leaflet from Phoenix Trust (an organisation that encourages spiritual welfare through meditation and yoga).

90. At 11.28am, the recovery practitioner went to see Mr Hutton, but due to the threats he had made towards staff, she spoke to him through his cell door. She recorded that Mr Hutton was smiling and talkative, but complained that he was being punished unfairly by being placed on the basic regime and that no one was attempting to help him or make adjustments for his disability. She noted that Mr Hutton was dismissive of any evidence given to the contrary.

91. At 11.52am, an officer noted on Mr Hutton's ACCT document that he could not return to C Wing as he had a small debt, but he did not want to move to the vulnerable prisoner wing.

92. At 5.10pm, a CM (duty manager) held an ACCT review before Mr Hutton was discharged from the healthcare unit back to C Wing. The duty governor and Mr Hutton attended. Staff noted Mr Hutton was talkative and keen to get back to the structure of living on a wing. They assessed Mr Hutton's risk of suicide and self-harm as low, and reduced observations to hourly. They updated the caremap with an action for the wing manager to check the details of Mr Hutton's basic IEP level. A SO recorded in Mr Hutton's prison record at 6.53pm that Mr Hutton was possibly under threat on C Wing as he had a small drug debt. Mr Hutton declined to move to the vulnerable prisoner unit. He was moved back to his cell on C Wing around 6.25pm. At 7.00pm, the SO recorded in Mr Hutton's ACCT that he was pleased to have moved back to C Wing and had no issues.

93. On 1 February at 10.20am, a CM chaired an ACCT review attended by a SO and Mr Hutton. Mr Hutton said he was grateful for the support, was pleased to be back on the wing and to have a cleaning job. Mr Hutton said he felt it was unfair that he remained on the basic IEP level, despite the fact he had been found under the influence of an illicit substance. Staff allowed Mr Hutton a television and kept observations at hourly.

94. At 3.10pm, the recovery practitioner met with Mr Hutton. She recorded in his medical record that he appeared upbeat after moving back to the wing from healthcare, that he had paid off his 'Spice' debt (a slang term for PS) and had been offered work supporting the wing cleaner. Mr Hutton had received the results of a mandatory drug test (MDT) which was positive for cannabis. Mr Hutton told her he was aware that the adjudicating governor could have sent him to the segregation unit for 28 days and kept him on basic, but said the Governor had agreed that he could have a fresh start and remain on C Wing. Mr Hutton told her that using PS had an impact on his behaviour and that ongoing use, in addition to the health risks, would continue to have an impact on his level of privileges. She recorded that Mr Hutton was happy that he had a psychiatrist appointment in March, and was generally feeling more positive, particularly as he had been in contact with his partner and thought a reconciliation was possible.

95. A SO chaired an ACCT review on 3 February at 10.30am, attended by an officer and Mr Hutton. Mr Hutton said he had had a good visit with his partner the previous day and that their relationship was 'back on track'. He said his small debt on the wing was now sorted. He continued to engage with the substance misuse team and was coming to terms with being away from his friends and family. Staff assessed his risk of suicide and self-harm as low and reduced observations to one meaningful interaction during the morning, afternoon and evening and three observations during the night.

96. On 4 February, at 1.44am, an officer noted in Mr Hutton's ACCT that Mr Hutton was slumped over in his bed in an unnatural position. There were no signs of self-harm and he suspected that Mr Hutton was under the influence of PS. Staff entered Mr Hutton's cell and roused him. They checked he was okay and then allowed him to sleep. When the officer checked Mr Hutton at 7.20am, he still

appeared ‘wobbly’ and did not respond to questions. Mr Hutton was told to lie back down on his bed.

97. Mr Hutton’s cell was searched and prison staff found paper and tampered vapes, which were tested and traces of PS were found. Mr Hutton was ordered to have a mandatory drug test (which was done on 6 February at 8.30am).

98. At 3.31pm, the recovery practitioner went to visit Mr Hutton after she was told he had been found under the influence. Mr Hutton told her that he often lapsed into using drugs when he felt unsettled, but wanted to develop his coping strategies. She noted that Mr Hutton still had his television, which he said he appreciated. Over the next few days Mr Hutton complied with the wing regime.

99. On 5 February, Mr Hutton replied to an email from his partner dated 3 February. His email was a chatty one about various aspects of his partner’s daily life and his relationship with his parents. Mr Hutton made no reference to being subject to ACCT procedures or that he had used illicit substances. Mr Hutton wrote that he had been busy cleaning the wing and he had more time out of his cell than he did at Belmarsh.

100. On 7 February at 10.20am, a SO chaired an ACCT case review attended by a CM (wing manager), two members of staff from Inclusion, a member of staff from chaplaincy and Mr Hutton. Staff noted Mr Hutton was progressing and that his mood was ‘upbeat’ and he had applied to attend gym sessions and used the equipment on the wing. They noted that a CM was progressing Mr Hutton’s social care assessment and that equipment to use the telephone might arrive in the next week. Staff assessed Mr Hutton’s risk of suicide and self-harm as low and kept observations the same. The SO scheduled the next review for 12 February.

101. At 1.43pm, the recovery practitioner noted in Mr Hutton’s medical record that he appeared ‘upbeat’ and that Mr Hutton was keeping busy and said he had ‘taken on board about taking responsibility’. She noted that Mr Hutton had been to the library for more books and attended the Quaker prayer group. She recorded that despite being on basic, Mr Hutton had been allowed to keep his television as a ‘reasonable adjustment’ and he had been allowed out of his cell to clean the wing which Mr Hutton said he enjoyed.

102. Mr Hutton told her that he had made an application to attend the gym, that catching up on his sleep had improved his mood and that he intended to return to Mass. Mr Hutton disclosed that he had a small debt on the wing, but appeared relaxed about the situation and said he would negotiate about repaying the debt with his canteen when he was off basic. She gave Mr Hutton an appointment for the following week. Throughout the day officers noted in Mr Hutton’s ACCT that he was in a good mood, worked hard cleaning the wing stairs and landing floors and received positive reports.

103. Closed Circuit Television (CCTV) shows Mr Hutton returned to his cell at 6.20pm. He spent a couple of minutes talking to prisoners in neighbouring cells and at 6.31pm, an officer locked him in his cell for the night. Prisoners on C Wing can ask to be let out of their cells to use the toilet during the night but Mr Hutton remained in his cell throughout.

104. At 7.40pm, an officer completed an ACCT check. He recorded in the ACCT ongoing record 'sat in chair, seems not with it – Oscar 1 [the operational night manager] informed.' At 7.49pm, the officer and an Operational Support Grade (OSG), the night patrol officer, went to Mr Hutton's cell and looked through the observation panel. The officer recorded on the ACCT ongoing record at 7.55pm: 'Mr Hutton is a lot more mobile, sat watching TV.' The OSG noted in the ACCT document at 8.00pm that he had taken over responsibility for ACCT observations.

105. At 8.31pm a CM who was the night manager, arrived on C Wing with a SO and two officers. They went to Mr Hutton's cell and spoke to him for around one minute. The CM and SO completed an ACCT review at 8.40pm. They noted: 'It was reported to me that Mr Hutton was not acting normally and could have taken a substance. I have spoken to Mr Hutton. He was responsive, stated he felt well and was eating food and watching TV. As he previously self-harmed when he had taken a substance I have increased his obs [observations] to hourly. To be reviewed again tomorrow with IMS [Inclusion].' The CM made an entry on the ACCT ongoing record at 8.42pm: 'ACCT reviewed. Obs increased to hourly.'

106. The OSG noted in the ACCT ongoing record at 9.47pm, 10.39pm, 11.31pm and 12.30am that Mr Hutton was in bed and appeared asleep.

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107. The OSG noted in Mr Hutton's ACCT at 1.28am: 'Sitting at his desk eating. No issues.' At 2.28am, he noted: 'lay RH [right hand] side in bed he appears asleep movement noted.'

108. At 3.34am, while checking cells on C Wing, the OSG arrived at Mr Hutton's cell. (CCTV footage shows the time as 3.22am but the CCTV times were 12 minutes slow.) He looked into the cell and immediately used his radio to call a code blue medical emergency as he could see Mr Hutton hanging. He walked away from the cell, but returned at 3.36am. Only managers carry keys at night and cells are remotely electronically locked so he was not able to enter Mr Hutton's cell until the control room released the lock.

109. At 3.37am, two nurses arrived at Mr Hutton's cell, quickly followed by the CM, the SO and three officers. Shortly afterwards, another officer who was a dog handler, arrived on C Wing. The CM used her radio to ask the control room to remotely unlock Mr Hutton's cell door. The CM said that she had to make the request several times, as the signal was weak because of the structure of the prison. Staff entered the cell at 3.39am.

110. An officer cut the ligature and, with assistance from another officer and the nurses, lowered Mr Hutton to the floor. Mr Hutton had used material from a laundry bag as a ligature which he had attached to a hook near the window at the back of his cell. Nurses started cardiopulmonary resuscitation (CPR) and the CM checked with the control room that an ambulance had been requested.

111. Mr Hutton was described by the CM in her statement as 'grey with no obvious signs of life'. A nurse recorded that Mr Hutton had no pulse, had a swollen airway which prevented them from inserting an airway, that his skin had started

to change colour and that Mr Hutton's mouth and legs were stiff. Nurses stopped CPR at 3.58am as it was evident Mr Hutton had died.

112. West Midlands Ambulance Service records show they received a request for an emergency ambulance at 3.34am. Paramedics arrived at the prison at 4.02am and at Mr Hutton's cell by 4.07am. They assessed him, noted that rigor mortis and blood pooling was evident and at 4.12am, recorded Mr Hutton had died.

Contact with Mr Hutton's family

113. Long Lartin appointed a CM as the family liaison officer (FLO). Mr Hutton's nominated next of kin was his partner. Due to the distance to her address, the FLO contacted HMP Chelmsford who agreed to break the news of Mr Hutton's death.

114. A trained FLO from Chelmsford, and her colleague travelled to Mr Hutton's partner's address, but there was no answer. They attempted to make contact by telephone, visited her last known place of work and enlisted the help of Chelmsford Police to break the news of his death at the earliest opportunity, but Mr Hutton's partner could not be located. The CM contacted her by telephone at 9.00pm and broke the news of Mr Hutton's death and offered the prison's condolences and ongoing support.

115. The prison contributed towards the costs of Mr Hutton's funeral, held on 28 February, in line with national policy.

Support for prisoners and staff

116. The Governor held a debrief for prison staff involved in the emergency response. Healthcare staff did not attend as they were handing over to the nursing day shift, but were supported by the healthcare provider.

117. The prison posted notices informing other prisoners of Mr Hutton's death, and offering support. Staff reviewed all prisoners considered to be at risk of suicide and self-harm, in case they had been adversely affected by Mr Hutton's death. The prison created a condolence book for Mr Hutton, which was given to his next of kin, and held a memorial service for him on 28 March.

Post-mortem report

118. A pathologist concluded that Mr Hutton died from hanging. Toxicology tests found traces of mirtazapine and diazepam (both of which he had been prescribed) within a therapeutic range, and that Mr Hutton had used PS before he died.

Findings

Assessment of risk of suicide and self-harm

119. Prison Service Instruction (PSI) 64/2011, *Managing prisoners at risk of harm to self, to others and from others* (*Safer Custody)*, lists a number of risk factors and potential triggers for suicide and self-harm.

120. Mr Hutton had some risk factors. He was serving life imprisonment with a long tariff, had a history of mental health issues and used illicit substances. Prison staff started ACCT procedures on three separate occasions, the last of which started on 26 January 2019, when Mr Hutton cut his wrists. Mr Hutton was still being monitored and supported under the ACCT process when he died.

121. We found overall that ACCT procedures were managed appropriately. On each occasion Mr Hutton self-harmed, or his risk of suicide was assessed to have increased, ACCT procedures were started. The immediate action plans, initial assessments and case reviews were all completed on time. The ACCTs were reviewed and observations appropriately changed when there was an assessed change in Mr Hutton's risk. We found that the contribution from healthcare and Inclusion to the ACCT review was to a good standard.

122. However, the detail of the caremap actions could have been improved with more specific information, particularly on the social care referral and obtaining a minicom, and for a named person to be given this responsibility. We are concerned that this key action remained outstanding on the caremap, with no progress recorded against it at any of the reviews. Mr Hutton repeatedly said he felt isolated because he could not contact his partner and we consider that obtaining the necessary equipment to enable him to do so should have been given greater priority.

123. The evening before Mr Hutton died, during a routine ACCT observation, an officer observed that Mr Hutton appeared 'not with it' and suspected he may have been under the influence of an illicit substance. The officer correctly informed the CM, the night manager.

124. The CM told the investigator that she was aware Mr Hutton had previously harmed himself while under the influence. She spoke to Mr Hutton through his observation panel, reviewed his ACCT in consultation with her colleagues and increased the number of observations to hourly. The CM told the investigator that Mr Hutton was responsive, engaged in conversation and that he was eating and watching the television. She said she did not specifically ask Mr Hutton if he had used drugs. She told the investigator that she had no concerns about Mr Hutton's well-being and that he did not appear to be under the influence of an illicit substance, so she did not consider it necessary to contact healthcare staff. The CM said Mr Hutton's cell was not searched for drugs, as during the night state this was not practical and that she had to consider the potential risks to staff welfare if they entered a cell and were exposed to secondary PS smoke.

125. We conclude that the CM responded appropriately when told Mr Hutton may have been under the influence and increased the ACCT observations. With the benefit of hindsight, it may have been prudent to have asked someone from

healthcare to assess him. However, given how Mr Hutton presented, we think it would have been difficult for staff to have predicted his actions.

126. The OSG told the investigator that he had never received any formal ACCT training, which is unacceptable. Every member of staff is required to undertake ACCT training, which is particularly crucial for those working alone at night on residential units. He completed his ACCT observation checks, although the last three were predictable and exactly one hour apart. We therefore 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 that:

- **all staff receive adequate and appropriate ACCT training;**
- **staff are reminded to complete ACCT observations at irregular, unpredictable intervals; and**
- **staff set caremap actions that are specific, time bound and meaningful, aimed at reducing risk, and update them at each case review.**

Mr Hutton's social care needs

127. PSI 32/2011 – *Ensuring Equality*, sets out out the framework for the management of equalities issues in prisons. The PSI no longer requires that a dedicated Disability Liaison Officer (DLO) should be appointed at an establishment and says that the necessary support provided to prisoners with disabilities could be distributed among other managers and staff if that is deemed more effective locally.

128. PSI 32/2011 says, 'Governors must ensure that efforts are made to identify whether a prisoner has a mental or physical impairment of any form… Governors must consider on an ongoing basis what prisoners and visitors with a range of disabilities might reasonably need and ensure that reasonable adjustments are made for disabled prisoners and visitors. Governors must consider whether prison policies and practices, the built environment, or a lack of auxiliary aids and services could put a disabled prisoner or visitor at a substantial disadvantage and if so must make reasonable adjustments to avoid the disadvantage. If a request for reasonable adjustments is made by a prisoner or visitor it must be considered and the outcome documented.'

129. Mr Hutton was profoundly deaf. His hearing difficulties required some adjustments to be made to his care to ensure that he was not disadvantaged by his disability. However, he was also a high-risk category A prisoner so any items he had in his possession had to be cleared by security which at times delayed these adjustments being made.

Belmarsh

130. The social care team based at the prison and the Royal Borough of Greenwich Social Services Department remained in close contact with Mr Hutton while he was at Belmarsh and, within the constraints of a high security prison and Mr

Hutton being a high-risk category A prisoner, we found the level of support Mr Hutton received at Belmarsh was of a good standard.

131. However, we found there was no evidence that the social care assessment and support plans by the RBGSSD were shared with Long Lartin. Although Mr Hutton transferred to Long Lartin on 19 December, the social care team were only told he had left Belmarsh on 8 January. It was recorded on Mr Hutton's social care notes, 'Informed that Mr Hutton has been transferred to another prison. Unclear which at this time.'

132. There needs to be a proactive response from safer custody and the social care team to ensure vital information about a prisoner's needs is promptly shared with the receiving establishment. We therefore make the following recommendation:

The Governor and Head of Healthcare at Belmarsh should ensure that there is a clear process for ensuring social care plans are promptly shared when a prisoner is transferred.

Long Lartin

133. A CM, who was a member of the safer custody team at Long Lartin, sent an email to the safer custody mailbox at Belmarsh on 21 December requesting Mr Hutton's social care plans and assessment, but never received a reply. He did not follow up this contact.

134. The safer custody manager at Belmarsh told the investigator that this email had been overlooked by an administrator. He told the investigator (and provided evidence) that Belmarsh have reviewed their processes and introduced a more robust system for ensuring the general safer custody mailbox is checked each day by a named person, who is responsible for signing a register to confirm the mailbox has been checked. All staff in safer custody have now been trained and given access to the general mailbox. As Belmarsh have already introduced a new process, we do not make a recommendation.

135. We found that there should have been a more proactive response by Long Lartin to obtain this vital information and follow up contact should have been made after the initial email to Belmarsh.

136. Attempts were made by healthcare and prison staff to contact the dedicated Disability Liaison Officer (DLO) about Mr Hutton's needs. Most staff interviewed were unaware the dedicated DLO role no longer existed at Long Lartin, which meant there were delays, and actions were not completed promptly as no-one had been identified as the single point of contact.

137. On 7 January, a CM was tasked with identifying Mr Hutton's needs at the risk management meeting. However, at the next meeting held on 31 January, there was no update provided or evidence of what specifically had been done to assist Mr Hutton. The CM told the investigator that he had liaised with the Ministry of Justice to obtain a minicom hearing loop for Mr Hutton, but that this had not been delivered at the time of his death. The CM added that Long Lartin really struggled accessing an audiologist, and that Care UK, the health providers, were aware of this, but were not very responsive when he sought information from them about the minicom.

138. The safer custody manager told the investigator that he would have expected staff at Belmarsh and Long Lartin to have been more proactive in obtaining and sharing information about Mr Hutton's needs. He said that there is often a misunderstanding about whether healthcare or prison staff are responsible for social care needs, and that there needed to be a better understanding of their respective functions and responsibilities.

139. He went on to say that Long Lartin needed to re-establish links with the County Council about referral and assessments for those prisoners with social care needs, as the current process was fragmented. He added that Long Lartin also needed to ensure that the person tasked with coordinating arrangements from the safer custody team is not redeployed to other duties.

140. We found there was no clear pathway at Long Lartin for referral and liaison with social care services and this was not equivalent with expectations in the community. We therefore make the following recommendation:

The Governor and Head of Healthcare at Long Lartin should:

- **review the process for referral for a social care assessment, ensuring that a clear pathway exists to ensure that timely assessment takes place; and**
- **ensure any active care plans are obtained from the sending establishment.**

Clinical care

141. The clinical reviewer concluded that the care Mr Hutton received from healthcare staff at Long Lartin was of a good quality and equivalent to the care he could have expected to receive in the community.

142. Mr Hutton had a history of depression dating back to 2000. When he arrived at Belmarsh, Mr Hutton had a full mental health assessment and attended regular sessions with the Atrium Team (counselling service). After he transferred to Long Lartin, Mr Hutton was seen by the recovery practitioner from Inclusion on 12 occasions between 11 January and 7 February 2019. Despite regular support from her, Mr Hutton continued to use illicit substances. The clinical reviewer found the standard of care provided by the integrated mental health and substance misuse services was good.

143. The clinical reviewer found that the emergency response carried out by healthcare staff was well delivered and the decision to stop CPR was in line with NHS England and Resuscitation Council guidelines.

Support for staff

144. Giving staff the opportunity to collectively discuss an incident and reflect on all aspects of how it was managed is fundamental to providing the prison with feedback on any issues that need to be addressed (or on good practice). It also provides those directly involved with an opportunity to process events. There is no evidence the duty governor held a debrief for all staff involved in the

emergency response, which is a mandatory requirement set out in PSI 09/2014, *Incident Management Manual.*

145. We identified the same issue in our last investigation into a death at Long Lartin. The prison's action plan in response to our recommendation says that the senior management team will be reissued with the guidance on hot debriefs and post-incident stress symptoms by August 2019. We do not, therefore, repeat the recommendation on this occasion.

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