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Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Peter Connelly a prisoner at HMP Garth on 13 March 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 Connelly was found hanged in his cell in the segregation unit at HMP Garth on 13 March. He was 41 years old. I offer my condolences to Mr Connelly's family and friends.

Mr Connelly had a long and complex mental health history and had spent time in secure hospitals. His mental health deteriorated at Garth and he was referred for a transfer to a secure hospital under the Mental Health Act in December 2018 and February 2019. He was segregated and was being monitored under Prison Service suicide and self-harm prevention procedures (known as ACCT) for two months before he died. We found some failings in the way ACCT procedures were managed.

I recognise the challenge in finding a suitable location for Mr Connelly. A secure hospital did not support his admission and he did not meet the admission criteria to the Prison Service's regional inpatients facility. I accept that, in the circumstances, Garth had little option other than to segregate Mr Connelly, even though this was clearly not an appropriate environment for him.

I note that the clinical reviewer considered that, if Mr Connelly had been in the community, he would have been sectioned under the Mental Health Act and admitted to a secure hospital, and concluded that the healthcare Mr Connelly received was not, therefore, equivalent to that which he could have expected to receive in the community.

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

Elizabeth Moody

Deputy Prisons and Probation Ombudsman December 2019

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Summary

Events

1. Mr Peter Connelly was serving a life sentence in prison for manslaughter (committed in 2003 while on day release from a secure psychiatric hospital).

2. He had a long history of poor mental health and during his sentence he was frequently managed under suicide and self-harm prevention procedures (known as ACCT). In 2017 and 2018, he spent time in a secure psychiatric hospital.

3. In August 2018, Mr Connelly was discharged from the psychiatric hospital and returned to prison. In October, he was transferred to HMP Garth. In December, a visiting consultant psychiatrist considered that Mr Connelly was showing symptoms of psychosis and made an urgent referral to the psychiatric hospital for a transfer under the Mental Health Act. This request was rejected by the psychiatric hospital.

4. On 16 January 2019, Mr Connelly was moved to the segregation unit temporarily for a disciplinary hearing for refusing a drug test. He refused to leave the segregation unit and began a dirty protest. On 18 January, suicide and self-harm procedures (known as ACCT) were started after he told staff he intended to kill himself on 31 March. He said he was hearing voices and was at war with the spirit world. Managers decided that he should, exceptionally, remain in the segregation unit while attempts were made to transfer him to a secure hospital or the Prison Service's regional inpatients facility at HMP Preston.

5. On 26 February, Mr Connelly was again referred to the psychiatric hospital and a hospital psychiatrist completed an assessment on 11 March. (The result was not received until after Mr Connelly's death but did not recommend that he be admitted.)

6. At 11.00pm on 13 March, an officer carrying out an ACCT check found Mr Connelly hanging from a ligature made from a bedsheet. Staff and paramedics tried to resuscitate Mr Connelly, but at 11.20pm it was confirmed that Mr Connelly had died.

Findings

7. There were a number of failings in the management of ACCT procedures. Staff did not consider all of Mr Connelly's risk factors when assessing his risk of suicide, and so did not set observation levels to reflect that risk.

8. The ACCT caremap was not updated and reviewed at each case review and did not include specific actions to reduce Mr Connelly's risk. ACCT observations were at regular and predictable intervals, something we have criticised before at Garth, which meant that Mr Connelly could have anticipated when he would be checked by staff.

9. Prisoners being managed under ACCT should only be segregated in exceptional circumstances. We accept that Garth had no alternative but to keep Mr Connelly in the segregation unit while they tried to find a more suitable location for him. However, segregation review boards did not take place every 14 days to assess whether Mr Connelly was coping with segregation which is not in line with national policy. We are also concerned that staff did not provide him with a radio during the two months he spent in segregation.

10. We recognise the challenge in finding a suitable location for Mr Connelly. We note that the clinical reviewer considers that, if Mr Connelly had been in the community, he would have been sectioned under the Mental Health Act and admitted to a secure psychiatric hospital. The clinical reviewer has, therefore, concluded that Mr Connelly's healthcare was not equivalent to that he would have received in the community.

11. We share the clinical reviewer's concern that segregated prisoners are automatically excluded from admission to the Prison Service's regional inpatients facility at Preston, which severely limited the options available to Mr Connelly if he could not be transferred to a secure hospital.

12. We have considered the additional information provided by HMP Garth during the initial consultation report and are satisfied that the admission criteria for the regional inpatients facility does not exclude segregated prisoners. We are concerned that healthcare staff at Garth were unaware of this.

13. The officer who found Mr Connelly hanging did not use a medical emergency code. This caused a six-minute delay in calling in an ambulance.

Recommendations

- The Governor should ensure that staff manage prisoners at risk of suicide and self-harm in line with national guidelines. In particular, staff should:
  - set effective caremap objectives which are specific, time bound and meaningful, aimed at reducing risk and updated at each case review.
  - record and take into account all known risk factors and triggers at case reviews and set a level of observations which appropriately reflects that risk;
  - vary the times of ACCT checks, while remaining within set observation periods, to avoid prisoners being able to predict when they will be checked.

- The Head of Healthcare should ensure that healthcare staff are aware of the admission criteria for the regional inpatients facility at HMP Preston and that prisoners in the segregation unit are referred when appropriate.

- The Governor should ensure that segregation review boards take place at least every 14 days in accordance with PSO 1700.

- The Governor should ensure that segregated prisoners are provided with appropriate distraction material and radios are ordered as a matter of urgency.

- The Governor should ensure that all staff are aware of and use the appropriate emergency response code when they discover an apparent medical emergency.

The Investigation Process

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

15. The investigator visited Garth on 21 March 2019. She obtained copies of relevant extracts from Mr Connelly's prison and medical records and interviewed one member of staff.

16. The investigator interviewed 11 members of staff at Garth on 30 and 31 May.

17. NHS England commissioned a clinical reviewer to review Mr Connelly's clinical care at the prison. The investigator and clinical reviewer jointly interviewed prison and healthcare staff.

18. We informed HM Coroner for Lancashire and Blackburn with Darwen of the investigation. He gave us the results of the digital autopsy report. We have sent the coroner a copy of this report.

19. We contacted Mr Connelly's brother, to explain the investigation and to ask if he had any matters he wanted the investigation to consider. He raised no issues.

20. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out some factual inaccuracies and this report has been amended accordingly.

Background information

HMP Garth

21. HMP Garth is a Category B training prison holding up to 846 men, many serving indeterminate sentences for public protection (IPP), life sentences, or other long sentences. Lancashire Care Foundation Trust provides health services, while NHS Greater Manchester Mental Health Trust provides the mental health team, which provides an integrated clinical substance misuse and mental health service.

HM Inspectorate of Prisons

22. The most recent inspection of HMP Garth was in December 2018 and January 2019. Inspectors reported that segregation was used frequently and the unit was usually full. Segregation was now well monitored and managed. The large number of prisoners with complex needs and challenging behaviour were managed much better than previously and support for them had improved.

23. Inspectors found that the management of prisoners at risk of suicide or self - harm (known as ACCT) was reasonably good. However, ACCT case managers were not consistently involved and did not always attend reviews. Decisions to locate prisoners on an ACCT in the segregation unit were well recorded and justified.

Independent Monitoring Board

24. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to November 2017, the IMB reported that there had been a 73% increase of prisoners on ACCTs. The segregation unit had the highest number of men on ACCT documents in the prison.

Previous deaths at HMP Garth

25. Mr Connelly was the tenth prisoner to die at Garth since March 2017. Of the previous deaths, three were self-inflicted, two were drug-related and four were from natural causes. There have been two natural causes deaths since Mr Connelly's death.

26. In May 2019, we recommended that staff should set appropriate caremap actions for prisoners being managed under ACCT procedures, that caremap actions should be reviewed at each case review and that staff should vary the times of ACCT checks.

27. HMPPS accepted our recommendations. Garth said they would issue guidance to staff about the completion of caremaps and a Notice to Staff to about completing ACCT checks at irregular intervals. The target date for completion was July 2019.

Assessment, Care in Custody and Teamwork (ACCT)

28. 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.

29. 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 (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.

30. 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.

Residential Support Unit (RSU)

31. Garth has a Residential Support Unit for prisoners who cannot live on normal prison wings but who do not need to be housed in the Vulnerable Prisoners Unit (which is used to house prisoners convicted of sex offences). Prisoners in the RSU include those whose offences might make them vulnerable to attack from other prisoners (such as those who have committed offences of violence against older people), prisoners who have accrued debts, and those who are victims or bullying or are under threat. The RSU runs a normal regime, with prisoners able to work in the RSU's own workshops and to take exercise without mixing with the general prisoner population.

Segregation units

32. Segregation units are used to keep prisoners apart from other prisoners. 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 an operational manager at the prison who must be satisfied that the prisoner is fit for segregation after an assessment by a member of healthcare staff. Segregation unit regimes are usually restricted and prisoners are permitted to leave their cells only to collect meals, wash, make phone calls and have a daily period in the open air.

33. The segregation unit at Garth has 28 cells and two special accommodation cells.

34. In 2015, we published a Learning Lessons bulletin that highlighted the potentially damaging effects of segregation on prisoners who may be at risk of suicide or self-harm.

Care Programme Approach

35. The Care Programme Approach (CPA) is an NHS system of delivering community mental health services to individuals diagnosed with a severe mental illness or other vulnerabilities such as a history of violence or self-harm. Someone who needs CPA support should have a formal written plan that outlines any risks and a CPA care coordinator to organise and review the plan.

Key Events

36. In December 2003, Mr Peter Connelly was sentenced to life in prison for manslaughter. He committed his offence while on authorised day release from a secure psychiatric hospital while detained under the Mental Health Act.

37. Mr Connelly had a long history of self-harm and prison staff monitored him under suicide and self-harm prevention procedures (known as ACCT) on 61 occasions between December 2003 and his death in March 2019. This was either because he had harmed himself, was thought to be vulnerable to doing so or had attempted to take his own life.

38. Between March and September 2017 and July and September 2018, Mr Connelly was admitted to a psychiatric hospital, a medium secure psychiatric unit, for treatment under the Mental Health Act. Hospital doctors prescribed Mr Connelly a depot injection (which slowly releases antipsychotic medication into the body over a number of weeks).

39. On 28 August 2018, Mr Connelly was discharged from the secure unit and was sent to HMP Bullingdon. He was transferred back to Garth on 5 October 2018. He was located in a single cell on the residential support unit (RSU).

40. Mr Connelly had been in Garth on two occasions before and prison and healthcare staff knew him well. A member of staff from the prison's mental health team, accepted Mr Connelly onto their caseload. Mr Connelly refused to have his depot injection once he left hospital and returned to prison (there is no provision within the MHA to compel a prisoner to accept treatment). Mr Connelly's prescribed medication included olanzapine (an antipsychotic) and fluoxetine (an antidepressant). The mental health team managed Mr Connelly under the NHS Care Programme Approach (CPA - used to coordinate the care of patients with complex mental health disorders).

41. An officer was given the role as Mr Connelly's keyworker. He noted that Mr Connelly appeared to have settled well on the wing and was working in a prison workshop.

42. On 14 November, a nurse from the prison's mental health team, assessed Mr Connelly and noted that he engaged well. Mr Connelly told the nurse that he was experiencing auditory and visual hallucinations. He said that he was concerned about his transfer from hospital and felt that he needed to stay in hospital for a longer period. Mr Connelly denied any thoughts of suicide or self-harm.

43. On 3 December, Mr Connelly refused to attend an appointment with a nurse. She noted that Mr Connelly was at an increased risk of disengaging with the mental health team and made a referral to a visiting consultant forensic psychiatrist.

44. On 7 December, the visiting consultant forensic psychiatrist assessed Mr Connelly. He considered that Mr Connelly was delusional and was displaying symptoms of psychosis. Mr Connelly continued to refuse his depot injections and the consultant forensic psychiatrist was concerned that healthcare staff

could not guarantee that Mr Connelly would take his anti-psychotic medication. He said that this would result in a rapid and dangerous decline in Mr Connelly's mental state. He considered that Mr Connelly needed an urgent referral to the psychiatric hospital.

45. On 11 December, the consultant forensic psychiatrist wrote to a consultant psychiatrist at the psychiatric hospital. The consultant psychiatrist responded the same day and queried the validity of Mr Connelly's symptoms and said that he believed Mr Connelly might be pretending. He also wrote that he was concerned that Mr Connelly had made threats to kill him and another doctor and considered that Mr Connelly's behaviour might be due to illicit drug use. He recommended that the mental health team at Garth should continue to engage with Mr Connelly.

46. The consultant forensic psychiatrist responded to the consultant psychiatrist's letter and said that in his clinical opinion Mr Connelly had a schizophrenic illness and would need another referral if he stopped complying with his antipsychotic medication and relapsed further.

47. On 20 December, a CPA meeting took place. A nurse from the prison's mental health team noted that Mr Connelly had little insight into his mental health issues and continued to respond to unseen stimuli and voices. The same day, Mr Connelly started a dirty protest on the RSU. The consultant forensic psychiatrist noted that Mr Connelly's behaviour reinforced his view that he was schizophrenic and asked the mental health team to assess him every week.

48. On 28 December, Mr Connelly told a nurse that he had stopped his dirty protest because he had 'won the fight with the demons'. He asked to move to the segregation unit to prepare for an upcoming fight in March 2019. Prison staff told Mr Connelly that he did not meet the criteria for the segregation unit and that he would stay on the RSU.

49. On 4 January 2019, the consultant forensic psychiatrist saw Mr Connelly and noted that he was taking his prescribed medication and had improved moderately. He said that Mr Connelly remained at risk of deterioration if he stopped taking his medication. He asked the mental health team to review Mr Connelly every two weeks.

Move to the segregation unit on 16 January

50. On 15 January, Mr Connelly refused to submit to a random mandatory drugs test. At 9.30am on 16 January, he went to the segregation unit for a disciplinary hearing. Mr Connelly refused to return to the RSU and was charged with failing to obey a lawful order. Mr Connelly started a dirty protest in the holding cell. The prison did not proceed with the disciplinary hearing. There was no security intelligence to suggest that Mr Connelly was taking illicit substances.

51. A nurse completed the initial health screen segregation review and advised against Mr Connelly's segregation. A prison manager held a multidisciplinary team (MDT) meeting to consider Mr Connelly's segregation. He noted that Mr

Connelly was segregated for his own protection and could not be returned to the RSU without the use of force. The nurse said that segregating Mr Connelly for a short period would enable the mental health team to offer support, and for the consultant forensic psychiatrist to consider another referral to a secure hospital or the regional inpatients facility at HMP Preston. The MDT decided that Mr Connelly should, exceptionally, stay in the segregation unit and have access to distraction material, including a radio.

Events from 18 January

52. On 18 January, Mr Connelly told a nurse that he planned to end his life on 31 March, so that he could be with his children in the spirit world. Mr Connelly said his children were born on the segregation unit and they were suffering without him being there. (There is no evidence that Mr Connelly had any children.) Mr Connelly refused to see the consultant forensic psychiatrist and denied any thoughts of suicide or self-harm.

53. At 12.00pm, a nurse began ACCT procedures. At 12.10pm, a prison manager completed Mr Connelly's immediate action plan and placed him on five observations an hour. (Prisoners who are subject to ACCT monitoring in the segregation unit are initially placed on five observations an hour at Garth until they have a multidisciplinary case review.)

54. Mr Connelly refused to sign his immediate action plan. A prison manager reviewed Mr Connelly's segregation and decided that his segregation should continue on exceptional grounds.

55. At 10.45am on 19 January, a member of staff carried out an ACCT assessment. Mr Connelly refused to engage. The assessment did not record the date Mr Connelly said that he intended to end his life and there is no evidence that the member of staff considered Mr Connelly's mental health history to assess his level of risk.

56. A Custodial Manager (CM) was assigned as Mr Connelly's ACCT case manager. At 11.00am, a Supervising Officer (SO) completed the first case review. Mr Connelly refused to engage with the assessment and his observations remained at five an hour. No issues were noted on Mr Connelly's caremap.

57. On 20 January, a CM chaired an ACCT case review. Mr Connelly's risk of suicide or self-harm was recorded as high and his observations remained at five an hour. The CM noted Mr Connelly's refusal to engage as an issue on his caremap.

58. The next day, the Head of Safer Prisons chaired an ACCT case review. Mr Connelly refused to engage and a SO spoke to him at his cell door. Mr Connelly said that he had no immediate plans to end his life but planned to do so in the future. The Head of Safer Prisons noted that Mr Connelly had not self-harmed and made a referral to the complex case review meeting. She also noted this as an action on his caremap. Mr Connelly's risk was assessed as remaining high, but his observations were reduced to two an hour because

the ACCT case review did not consider that he was at immediate risk of suicide or self-harm.

59. On 24 January, Mr Connelly was discussed at the morning meeting. The Head of Healthcare told the investigator that she told the staff present, which would have included a CM, that the consultant forensic psychiatrist. was considering making another referral to the psychiatric hospital.

60. On 29 January, a CM chaired an ACCT review. Mr Connelly refused to engage but spoke to the CM and a SO at his cell door. Mr Connelly said that he had no plans to self-harm and asked to move cells. His risk level and observations were assessed as unchanged. The CM included Mr Connelly's refusal to engage in the ACCT process and his request to move cells as issues on his caremap.

61. On 31 January, a prison manager reviewed Mr Connelly's segregation and noted that the segregation unit was the safest place for Mr Connelly because of his poor mental health. He noted that Mr Connelly's segregation should continue on exceptional grounds.

62. On 2 February, Mr Connelly started a dirty protest because he was not allowed to move cells. An interim ACCT review took place on 3 February, to consider whether Mr Connelly's risk had changed in response to the death of another prisoner. Mr Connelly's risk level and observations were assessed as unchanged.

63. On 4 February, a CM chaired an ACCT review, the first review he had attended as Mr Connelly's case manager. The CM chaired another case review on 7 February. At both reviews he noted that Mr Connelly was on a dirty protest and that his level of risk and observations remained unchanged. The CM did not update Mr Connelly's caremap or consider why Mr Connelly's behaviour had deteriorated. Mr Connelly ended his dirty protest on 9 February.

64. On 11 February, Mr Connelly attended an ACCT case review. He told a CM that he believed that the devil had set a trap under his cell to catch him. The CM assessed Mr Connelly's risk level as raised and increased his observations to three an hour. As Mr Connelly had ended his dirty protest, he was moved to another cell.

65. On 14 February, a prison manager reviewed Mr Connelly's segregation and noted that his segregation should continue on exceptional grounds. He recorded that the next segregation review should take place on 28 February. There is no evidence that prison staff reviewed Mr Connelly's segregation again before his death.

66. On 18 February, Mr Connelly attended an ACCT review chaired by a CM and attended by a nurse. The CM noted that Mr Connelly was confused and spoke about the spirit world and a war he was fighting. He denied any thoughts of self-harm. The CM reduced Mr Connelly's level of risk to low and his observations to two an hour.

67. On 19 February, the consultant forensic psychiatrist assessed Mr Connelly and noted that his condition had not improved. He decided to refer Mr

Connelly to the psychiatric hospital again. He told the investigator that he also considered making a referral to the regional inpatient's facility at HMP Preston, but that he decided against this because Mr Connelly's current location in the segregation unit meant he did not meet their admission criteria.

68. On 22 February, Mr Connelly refused to attend an interim ACCT case review after a death in custody. His level of risk and observations were assessed as unchanged. On 26 February, a CM chaired an ACCT case review. Mr Connelly said that he had come to the segregation unit to die. Mr Connelly's level of risk and observations were left unchanged.

69. On 26 February, the consultant forensic psychiatrist made another referral to the psychiatric hospital. A consultant psychiatrist agreed to assess Mr Connelly and arranged for a psychiatrist, at the psychiatric hospital, to complete an assessment on 11 March.

70. On 28 February, Mr Connelly asked an officer for a radio. The officer noted in Mr Connelly's ACCT record that he was told that the segregation unit did not have any radios and had ordered some.

71. Mr Connelly's last ACCT review before his death was held on 7 March and was chaired by a prison manager. Mr Connelly refused to engage. Mr Connelly and a nurse from the prison's mental health team, spoke to Mr Connelly at his cell door. His risk level and observations were unchanged.

72. The same day, the consultant psychiatrist emailed the consultant forensic psychiatrist and said that if the psychiatrist agreed that Mr Connelly required admission to a secure hospital, he would ask the NHS to consider a facility closer to Garth, rather than a transfer to the Oxford area.

73. On 11 March, a psychiatrist saw Mr Connelly but did not provide the prison with the outcome of her assessment. (The assessment was received after Mr Connelly's death and did not recommend admission to the psychiatric hospital.) A nurse noted that Mr Connelly engaged well but continued to express psychotic symptoms.

Events of 13 March

74. Mr Connelly's ACCT record says that staff completed their two checks an hour and Mr Connelly did not raise any concerns. At 7.30pm, an officer came on duty in the segregation unit and took responsibility for Mr Connelly's ACCT checks. At 8.30pm, 9.30pm and 10.30pm he recorded on Mr Connelly's ACCT record that he had completed two observations an hour. At each check, he recorded that Mr Connelly was lying on his bed awake and he did not record any concerns. The officer told the investigator that another officer completed the 10.30pm ACCT check on his behalf.

75. CCTV shows an officer arriving at Mr Connelly's cell at 10.00pm. He shone his torch into the cell and left shortly after. The investigator was unable to review the CCTV at Garth after 10.00pm because the recording was unavailable. In his statement, the officer said that he went to Mr Connelly's cell at 11.00pm and found that he had partially covered his observation panel.

He saw Mr Connelly hanging from the ceiling light with his feet off the floor. The officer radioed for assistance and two officers immediately attended.

76. Both officers entered Mr Connelly's cell. An officer used his anti-ligature knife to cut the ligature. At 11.04pm, another officer radioed for assistance from healthcare staff. At 11.06pm, an officer asked the control room to call an ambulance.

77. At 11.07pm, a nurse arrived and noted that Mr Connelly did not display any signs of life. He attached a defibrillator which did not detect a shockable rhythm. Two officers started cardiopulmonary resuscitation (CPR). At 11.14pm, the paramedics arrived and took control of Mr Connelly's care. At 11.20pm, they confirmed that Mr Connelly had died.

Contact with Mr Connelly's family

78. An officer was appointed as family liaison officer (FLO) and identified Mr Connelly's mother as his next of kin. Because Mr Connelly did not have contact with his mother, Thames Valley Police provided the prison with her home address.

79. The FLO and an officer visited Mr Connelly's mother and informed her of her son's death. They offered condolences and support. Mr Connelly's brother acted as the family contact.

80. In line with Prison Service guidance, the prison offered a contribution to the cost of Mr Connelly's funeral.

Support for prisoners and staff

81. After Mr Connelly's death, a prison manager debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

82. The prison posted notices informing other prisoners of Mr Connelly's death, and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Connelly's death.

Post-mortem report

83. A digital autopsy report showed that Mr Connelly died from asphyxiation by hanging, meaning that he died from a lack of oxygen due to hanging.

84. Toxicology tests did not detect any drugs in Mr Connelly's system.

Findings

Management of Mr Connelly's risk of suicide and self-harm.

85. Mr Connelly had a long history of self-harm and was regularly managed under the ACCT suicide and self-harm prevention procedures. We are satisfied that ACCT case reviews were multi-disciplinary, with a member of the mental health team in attendance.

86. Prison Service Instruction (PSI) 64/2011 on safer custody, requires all staff who have contact with prisoners to be aware of the triggers and risk factors that might increase the risk of suicide and self-harm, and take appropriate action. (The risk factors were also listed in our thematic report published in 2014.) Those that applied to Mr Connelly included previous self-harm, history of mental health problems, recent contact with psychiatric services, irrational behaviours and a recent discharge from a psychiatric in-patient facility.

87. Prison staff began the ACCT procedures after Mr Connelly told a mental health nurse, he intended to take his own life on 31 March. We consider that the ACCT procedures did not effectively support him because the overall management of the ACCT was poor and not fully in line with PSI 64/2011. The date when Mr Connelly said he intended to take his own life was not highlighted as a trigger in his initial assessment and there is no evidence that staff investigated if this date was significant or if Mr Connelly had children.

88. Caremaps should reflect the prisoner's needs, level of risk and the triggers of their distress. Instructions say they should aim to address issues identified in the ACCT assessment interview and later reviews, and consider a range of factors including health interventions, peer support, family contact and access to diversionary activities. Each action on the caremap should be tailored to the individual needs of the prisoner, be aimed at reducing risk and be time bound. We do not consider there were appropriate caremap actions aimed at reducing Mr Connelly's risk.

89. We consider that Mr Connelly's caremap was inadequate and contained no direct actions to help progress his transfer to a secure hospital or a prison inpatients facility, the main things that could have helped to reduce his risk. Although Mr Connelly was displaying evidence of psychotic behaviour, staff did not identify this as an issue in Mr Connelly's caremap and his caremap was not always reviewed at ACCT case reviews. The caremap also failed to identify more straightforward issues, such as the fact that Mr Connelly did not have a radio.

90. A CM, Mr Connelly's case manager, did not consistently attend his ACCT case reviews and it is a cause for concern that he told the investigator that he did not know that healthcare staff were considering another referral to a secure hospital. We consider that Mr Connelly's assessed level of risk did not always reflect his behaviour and the CM's decision to lower his risk level and frequency of observations was not justified.

91. The CM told the investigator that he decided to lower Mr Connelly's risk level and observations because he was not concerned that Mr Connelly was going

to kill himself. He described Mr Connelly's delusions about the spirit world as consistent throughout his ACCT reviews. The CM said he did not know about the plan to refer Mr Connelly to a secure hospital or that Mr Connelly's previous referral in December 2018 was rejected. For this reason, he did not include the plan to transfer Mr Connelly to a secure hospital as an issue on his caremap. We find it difficult to understand why the CM was not aware of the discussions about referring Mr Connelly to a secure hospital.

92. We are also concerned that ACCT checks were carried out at regular and, therefore predictable intervals, contrary to the guidance in PSI 64/2011. In addition, staff did not always record on the ACCT document when they had completed an ACCT check.

93. The Head of Safer Prisons at Garth told us that the prison had recognised that ACCT management needed to improve. In response to previous recommendations we made in May 2019, staff were receiving training and refresher training in ACCT management, and in July 2019, Garth issued a staff information notice to remind staff that ACCT checks should be irregular and unpredictable. While we acknowledge that Garth has already taken steps to improve the ACCT process, we recommend that:

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

- set effective caremap objectives which are specific, time bound and meaningful, aimed at reducing risk and updated at each case review;
- record and take into account all known risk factors and triggers at case reviews and set a level of observations which appropriately reflects that risk;
- vary the times of ACCT checks, while remaining within set observation periods, to avoid prisoners being able to predict when they will be checked.

Segregation

94. Prison Service Order 1700 sets out the procedures to follow when segregating prisoners. A qualified healthcare professional (nurse or doctor) must complete a Segregation Safety Algorithm (safety assessment) for all segregated prisoners. The purpose is to take a snap shot assessment of a prisoner's mental health when deciding whether to segregate them. The aim is to exclude very mentally unwell or suicidal prisoners from segregation in all but the most exceptional of circumstances.

95. The second page of the initial segregation health screen says that prisoners on an ACCT must be located in the segregation unit only in exceptional circumstances, where there is such a risk to others that no other location is suitable and when these other options have been tried or are considered inappropriate.

96. Prisoners who are managed under ACCT procedures are particularly vulnerable and locating them in segregation units should be avoided wherever possible. PSI 64/2011 says that '*prisoners on open ACCT plans must only be*

located or retained in segregation units only in exceptional circumstances. The reasons must be clearly documented in the ACCT plan and include other options that were considered but discounted'.

97. Mr Connelly failed the healthcare algorithm but managers considered that his circumstances were sufficiently exceptional to justify his continued stay in the segregation unit. He refused to return to the RSU and prison managers noted that staff could not remove him from the segregation unit without the use of force. Staff took the view that Mr Connelly's increasingly psychotic behaviour meant he could not be managed safely in other areas of the prison.

98. At interview, prison and healthcare staff told the investigator that the segregation unit was clearly an unsuitable location for Mr Connelly but, despite their best efforts, they were unable to find a more suitable location such as a secure psychiatric hospital or the Prison Service regional inpatients facility. Staff described this as a recurring issue for prisoners with complex mental health issues.

99. We recognise that finding a suitable location for Mr Connelly was extremely challenging for prison staff and we accept that, in the circumstances, they had no option but to keep him segregated, at least while he remained on a dirty protest. However, we are concerned that this effectively excluded him from transferring to the regional inpatients unit. We have more to say about this below.

100. We are also concerned that Mr Connelly did not have a radio while he was segregation. When his segregation was exceptionally authorised on 15 January, it was decided that he should have distraction activities including a radio. However, there is no evidence that he was ever given a radio and when asked for one on 28 February, six weeks after he was first segregated, he was told there were none available at the prison.

101. Prisoners who are segregated and are least able to access regime activities, must have the opportunity to occupy or distract themselves. This is particularly the case for prisoners who are segregated for long periods, like Mr Connelly, and for those who are on an ACCT and/or mentally unwell, again like Mr Connelly. We are concerned there is no evidence that prison staff attempted to find Mr Connelly a radio or that he had access to one for the eight weeks he was in the segregation unit. We do not consider that this was acceptable. We recommend that:

The Governor should ensure that segregated prisoners are provided with appropriate distraction material and radios are ordered as a matter of urgency.

102. PSO 1700 also says that segregation reviews must take place at least every 14 days. An operational manager should chair the view and their attendance is mandatory. A healthcare representative or a member of the mental health team is also required to attend. The last segregation review board for Mr Connelly took place on 14 February, four weeks before his death. Although we recognise that prison staff and healthcare staff were seeing Mr Connelly regularly in line with his ACCT plan, it is particularly important that segregation

review boards take place in accordance with PSO 1700 to ensure that staff assess whether a prisoner is coping with segregation. We recommend that:

The Governor should ensure that segregation review boards take place at least every 14 days in accordance with PSO 1700.

Mental health

103. Mr Connelly was well known to the mental health team at Garth. The clinical reviewer found that mental health staff attempted to engage with Mr Connelly in the challenging circumstances of the segregation unit and during his dirty protests. He considered that the mental health team's involvement in the ACCT process was good.

104. In January 2016, we published a thematic review of lessons to be learned from our investigations into self-inflicted deaths in prisons, where mental health issues were involved. In the report, we noted that where a secure hospital had been identified as the best environment to deliver appropriate care for acutely ill prisoners, we would expect all possible steps to be taken by the prison and the hospital to ensure this takes place within the 14-day target. We also noted that prisons needed to be extra vigilant about the care of prisoners who are being considered for or are awaiting transfer to a secure hospital.

105. PSI 50/2007 (*Transfer of prisoners to and from hospital under sections 47 and 48 of the Mental Health Act 1983*) and NHS England's '*Good Practice Guide – The transfer and remission of adult prisoners under s47 and s48 of the Mental Health Act*' set out the process for transferring a prisoner to hospital under the Mental Health Act. The NHS guidance recommends that all such transfers take place within 14 days of the Secretary of State issuing a warrant for transfer. In October 2007 a revised version of '*Procedure for the transfer of prisoners to and from hospital under sections 47 and 48 of the 'Mental Health Act (1983)*' was issued. This document acknowledges there had been unacceptable delays in transferring prisoners and provides a best-practice flowchart for all key stakeholders.

106. Prisoners have to meet two criteria before they can be transferred to a secure mental health unit:

- The prisoner is suffering from mental illness or severe mental impairment of a nature or degree which warrants detention in a hospital for medical treatment.
- The prisoner is in need of urgent treatment (the person would have required inpatient treatment had they been in the community).

107. Two independent reports by a medical practitioner, one of whom has to be approved under section 12(2) of the Mental Health Act (1983), need to assess the same form of mental disorder and the need for inpatient treatment before the Secretary of State can issue a warrant for transfer. These assessments are valid for two months. The PSI and best-practice flow-chart clearly say that the MoJ Mental Health Casework Section (MHCS) must be informed when a prisoner is first assessed as needing to transfer to a mental health unit.

108. In December 2018, a consultant forensic psychiatrist made an urgent referral to for a transfer to the psychiatric hospital which was rejected without Mr Connelly being seen in person. At interview, he said he believed Mr Connelly had a schizophrenic illness and that he disagreed with a consultant psychiatrist, at the psychiatric hospital, who suggested that Mr Connelly's behaviour might be due to illicit drug use. There was no evidence that Mr Connelly was using illicit drugs in the prison. In February 2019, the consultant psychiatrist arranged for a psychiatrist at the psychiatric hospital, to complete an assessment on 11 March.

109. The consultant forensic psychiatrist told the investigator that he received a copy of the psychiatrist's assessment after Mr Connelly's death. She agreed that Mr Connelly might have a diagnosis of schizophrenia but did not recommend admission to the psychiatric hospital. She recommended an increase in Mr Connelly's antipsychotic medication and a transfer to an inpatients facility at a prison. If this was not feasible, she agreed that admission to a secure hospital local to Garth should be considered because Mr Connelly no longer had a connection with the Oxford area.

110. The clinical reviewer found that when a transfer to the psychiatric hospital was not agreed, Mr Connelly remained at Garth in the RSU. In January 2019, following Mr Connelly's disorderly behaviour, he remained in the segregation unit, despite failing the healthcare algorithm, as there was no other location at Garth available to accommodate him safely. In February 2019 when a second referral was made to the psychiatric hospital, he remained in the segregation unit as there continued to be no alternative accommodation.

111. Mr Connelly was not eligible for a transfer to the regional inpatients facility at HMP Preston because they will not accept prisoners who are segregated. This immediately excludes prisoners with severe mental health problems, such as Mr Connelly, who are located in a segregation unit.

112. The clinical reviewer concluded that the care Mr Connelly received at Garth was not equivalent to that which he could have expected to receive in the community. He considered that, if Mr Connelly was in the community, he would have been sectioned under the Mental Health Act and admitted to a secure psychiatric hospital.

113. We are concerned that once the psychiatric hospital rejected Mr Connelly's referral, the prison did not have the option of a transfer to the regional beds facility at Preston. We share the clinical reviewer's concern that the pathway for access to the regional healthcare beds at Preston does not allow for individual assessment of a prisoner's needs and those located in a segregation unit are automatically excluded.

114. During the initial report consultation period, the Governor of HMP Preston provided us with a copy of the Regional Beds Admission and Discharge Policy which was developed by NHS England and sets out the admissions criteria for the regional healthcare beds at Preston. At interview, the Head of Healthcare at Garth, told us that the protocol for admission to the regional inpatients facility was set by the healthcare team at Preston, with an exclusion that they

will not accept prisoners who are segregated at the time of their referral. The consultant forensic psychiatrist also shared this view.

115. While we are satisfied that the policy does not list segregation as a reason not to admit a prisoner, we are concerned that healthcare at Garth did not make a referral for Mr Connelly to the regional inpatients facility because they considered that he would not be accepted because he was segregated. We recommend that:

The Head of Healthcare should ensure that healthcare staff are aware of the admission criteria for the regional inpatients facility at HMP Preston and that prisoners in the segregation unit are referred when appropriate.

Emergency response

116. Prison Service Instruction 03/2013 requires governors to have a two-code medical emergency response system. As is usual, Garth use code blue to indicate an emergency when a prisoner is unconscious, or having breathing difficulties, and code red when a prisoner is bleeding. Calling an emergency code should automatically trigger the control room to call an ambulance and healthcare staff to attend with the correct equipment.

117. When an officer went to Mr Connelly's cell to carry out an ACCT check at 11.00pm on 13 March, he saw Mr Connelly hanging from the ceiling light. The officer should, therefore, have immediately radioed a code blue emergency code but instead called for staff assistance.

118. The officer told the investigator that he did not call a code blue because he was shaken and his priority was to enter Mr Connelly's cell and cut him down. His failure to use an emergency code meant that healthcare staff did not respond immediately and the control room did not call an ambulance until another officer provided an update after they entered Mr Connelly's cell (about six minutes after the officer first saw Mr Connelly hanging). While the failure to use an appropriate emergency code may not have affected the outcome for Mr Connelly, any delay in calling an ambulance when there is a medical emergency could be crucial in future incidents. We recommend that:

The Governor should ensure that all staff are aware of and use the appropriate emergency response code when they discover an apparent medical emergency.

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