Prisons & Probation
Ombudsman
Independent Investigations

Independent investigation into the death of Mr Colin Douglas a prisoner at HMP Long Lartin on 5 February 2018

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*

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

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

Mr Colin Douglas died in hospital on 5 February 2018 after being found hanging in his cell at HMP Long Lartin the previous day. He was 32 years old. I offer my condolences to Mr Douglas's family and friends.

Mr Douglas had a history of violence to prison staff and other prisoners. He also had a history of mental health problems and of attempted suicide and self-harm. Two weeks before his death he had taken a prison officer hostage with a bladed weapon at HMP Bristol and subsequently tried to hang himself. Staff at Bristol started suicide and self-harm prevention procedures (known as ACCT).

Mr Douglas was still being monitored under ACCT when he was transferred to Long Lartin nine days later and the monitoring continued at Long Lartin. He was initially held in the segregation unit, moved to the healthcare unit after a nurse assessed that he was not fit to be segregated, and then moved back to the segregation unit after it was decided that he could not be managed safely elsewhere.

I recognise that Mr Douglas was a very difficult prisoner to manage. Long Lartin faced a difficult decision about the best location for him given both the very real danger he posed to staff and other prisoners and the risk that his mental health would deteriorate if he was segregated. On balance, I consider the decision to segregate him was justified, although the alternative options considered were not fully recorded as they should have been.

The investigation identified some deficiencies in the ACCT management at Bristol and Long Lartin, although I was pleased to see that all but one of the ACCT reviews were multidisciplinary. I am concerned that Mr Douglas was able to use his shoelaces to hang himself at Long Lartin. They should have been removed from him under the ACCT process as prison staff were aware that he had used shoelaces in an attempt to hang himself in the past.

I am not satisfied that the decision to restrain Mr Douglas during his transfer to hospital was justified given his medical condition.

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 **January 2019**

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Summary

Events

1. Mr Colin Douglas was serving an Imprisonment for Public Protection (IPP) sentence with a minimum tariff of 9 years.

2. Mr Douglas had a history of violent outbursts and of making threats to staff, and he had assaulted staff on several occasions. He was transferred between prisons 14 times before being sent to HMP Long Lartin on 31 January 2018. Because of his poor behaviour, he had spent a significant amount of time in segregation units. He was also frequently monitored under Prison Service suicide and self-harm procedures (ACCT) after tying nooses, cutting himself and taking overdoses of illicitly obtained medication.

3. Before being moved to Long Lartin, Mr Douglas was at HMP Bristol. On 15 January 2018, staff started ACCT monitoring after Mr Douglas's sister contacted the prison to tell them that Mr Douglas had told her he was hearing voices and had talked of taking his own life and killing prison staff. They stopped monitoring the next day.

4. On 22 January, Mr Douglas took a prison officer hostage. He put a bladed weapon to the officer's throat and demanded to be taken to the gate. He was quickly disarmed and restrained, and taken to the segregation unit. On 23 January, he was found with a noose around his neck and staff restarted ACCT monitoring. He tried to hang himself again later the same day. He was transferred to Long Lartin on 31 January.

5. When Mr Douglas arrived at Long Lartin he was still subject to ACCT monitoring. He was placed in the segregation unit but a nurse assessed that his mental health would deteriorate if he remained segregated so he was moved to the healthcare unit. However, he was returned to the segregation unit the next day after it was decided that he could not be managed safely in the healthcare unit.

6. At around 12.20pm on 4 February, an officer went to Mr Douglas's cell to carry out an ACCT check and found him hanging by a ligature, made from shoelaces. Staff started cardiopulmonary resuscitation (CPR) and continued until the ambulance paramedics arrived. They requested an air ambulance to take Mr Douglas to hospital but this was refused by the duty governor for security reasons. Mr Douglas was taken to hospital by road ambulance and restrained using an escort chain, which was removed shortly after he arrived at hospital. Mr Douglas never regained consciousness and died in hospital shortly before 5.00am on 5 February.

Findings

7. Although we were pleased to see that the majority of ACCT reviews were multidisciplinary, we identified some deficiencies with the ACCT management at both Bristol and Long Lartin. In particular, we found that staff judged Mr Douglas's risk of suicide and self-harm poorly at times, did not properly review and update caremap actions, and did not consider involving Mr Douglas's sister in ACCT reviews. We also consider that staff at Long Lartin should have

removed Mr Douglas's shoelaces given that he had used shoelaces in a previous suicide attempt.

8. We consider that the decision to segregate Mr Douglas at Long Lartin, despite the nurse's assessment that it would be detrimental to his mental health, was justified given the risk he posed to others. However, there was no full written record of the alternative options considered and why they were discounted.

9. Mr Douglas was unconscious and not breathing unaided when he was taken to hospital. We consider that the decision to restrain him was not justified and the refusal to allow him to travel to hospital by air ambulance also failed to take account of his medical condition at the time. We also found there was a delay of 20 minutes between Mr Douglas being stretchered out of the segregation unit and him leaving the prison by ambulance.

Recommendations

- The Governors of HMP Bristol and HMP Long Lartin should ensure that staff manage prisoners at risk of suicide and self-harm in line with national guidelines, including ensuring that they:
  - consider all risk factors, including escalations in self-harm and deterioration in mental health, when assessing a prisoner's risk to themselves;
  - schedule case reviews at appropriate intervals, in line with the prisoner's level of risk;
  - set new, specific and meaningful ACCT caremap actions that are aimed at reducing a prisoner's risks to themselves;
  - involve the prisoner's family when that would be appropriate;
  - carry out observations at unpredictable times and make detailed, meaningful entries in the ongoing record; and
  - remove high risk personal items that the prisoner might use to harm himself.
- The Governor of HMP Long Lartin should ensure that staff record the full reasons for the decision to segregate a prisoner subject to ACCT monitoring, including alternative options considered and the reasons for discounting them.
- The Governor of HMP Long Lartin should ensure that decisions on the appropriateness of allowing prisoners to be transferred to hospital by air ambulance consider clinical need as well as security issues.
- The Governor of HMP Long Lartin should ensure that there are no unnecessary delays in discharging ambulances.
- The Governor and Head of Healthcare of HMP Long Lartin should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position, and that assessments fully take into account the health of the prisoner and are based on the actual risk the prisoner presents at the time.

The Investigation Process

10. The investigator issued notices to staff and prisoners at HMP Long Lartin informing them of the investigation and asking anyone with relevant information to contact him. One prisoner responded.

11. The investigator visited Long Lartin on 16 February. He obtained copies of relevant extracts from Mr Douglas's prison and medical records.

12. The investigator interviewed seven members of staff at HMP Bristol between 11 and 13 April. He interviewed 14 members of staff at HMP Long Lartin on 18 and 19 April. He also interviewed one member of staff by telephone on 21 February.

13. NHS England commissioned a clinical reviewer to review Mr Douglas's clinical care at Long Lartin and Bristol. She conducted joint interviews with the investigator at HMP Bristol on 12 April and at Long Lartin on 18 and 19 April.

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

15. One of the Ombudsman's family liaison officers contacted Mr Douglas's sister and mother to explain the investigation and to ask if they had any matters they wanted the investigation to consider. Their solicitor subsequently wrote to the investigator to ask:

    - whether Mr Douglas received appropriate mental health care and whether his care was handed over effectively when he was transferred from Bristol to Long Lartin;
    - whether Mr Douglas's ACCTs at Bristol and Long Lartin were managed properly;
    - whether the concerns raised by Mr Douglas's sister about Mr Douglas's mental wellbeing following her visit to Bristol on 10 January were acted upon appropriately;
    - whether there was any delay in finding Mr Douglas and giving him emergency care; and
    - why there was a delay in contacting the family after Mr Douglas was found and why they were initially told that Mr Douglas used shoelaces as a ligature but later told he used a sheet.

16. 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. The action plan has been annexed to this report.

17. Mr Douglas's family received a copy of our initial report. The solicitor representing them wrote to us pointing out some factual inaccuracies. The report has been amended accordingly. The solicitor also raised some issues that do not impact on the factual accuracy of the report, which we addressed through separate correspondence.

Background Information

HMP Long Lartin

18. HMP Long Lartin is a high security prison in the Vale of Evesham, Worcestershire. It can hold up to 621 men across six main wings and two support wings. However, one wing is currently closed (on rotation) due to ongoing works. 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.

HMP Bristol

19. HMP Bristol is a local prison, which can hold up to 614 sentenced and remanded men across six wings. It no longer has a separate healthcare unit; it has a reintegration unit, called the Brunel Unit, which holds prisoners with complex physical and mental health needs. Bristol Community Health and Hanham Health provide primary healthcare services. Avon and Wiltshire NHS Partnership NHS Trust provides mental health and substance misuse services. All wings have a treatment room staffed by a nurse and healthcare assistants during the day. There is a nurse and a healthcare assistant on duty at night.

HM Inspectorate of Prisons

HMP Long Lartin

20. The most recent inspection of HMP Long Lartin was in January 2018. Inspectors reported that staff-prisoner relationships in the segregation unit were good and reviews were detailed and multidisciplinary. In the previous six months, 38 prisoners on an ACCT had been held in the unit but the exceptional circumstances for holding them in segregation had not always been considered.

21. Inspectors reported that strategic management of suicide and self-harm prevention was good and ACCT case management for prisoners at risk of suicide and self-harm was implemented well. The quality of ACCT documentation was very good: care plans were completed and actioned, reviews were well attended and observational entries informative. Prisoners in crisis were generally positive about the care they received. 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.

22. Routine mental health referrals were reviewed weekly and prisoners accepted onto the caseload after assessment were assigned an appropriate caseworker. There was a duty worker for the team so urgent referrals could be seen rapidly within 48 hours, and frequently on the same day if significant risks were identified. Services were available five days a week. Waiting times were short and better than those found in equivalent community services. The team made effective contributions to relevant ACCT procedures and attended all initial ACCT assessments.

HMP Bristol

23. The most recent inspection of HMP Bristol was in March 2017. Inspectors reported that the number of ACCTs opened since the last inspection had nearly doubled and was far higher than at similar prisons. They noted that the quality of ACCT management was extremely variable and many documents were of very poor quality. Staff-prisoner relationships on the segregation unit were good. Since December 2016, members of the mental health team had attempted to attend all ACCT first case reviews. Prisoners with moderate to severe mental health needs received timely assessment and good levels of support. However, inspectors were not confident that those with lower level mental health needs were being met, which was particularly concerning given the high levels of self-harm at the prison.

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.

HMP Long Lartin

25. In its latest annual report for Long Lartin, for the year to 31 January 2018, the IMB once again expressed concern that men had been segregated while subject to open Assessment Care in Custody Teamwork (ACCT) documents, although the numbers had remained small. The Board was satisfied that there had been no reasonable alternative to segregation for these men, and that there were robust procedures in place to assess risk when they were initially segregated and to monitor their condition while they remained in segregation. The management and leadership of the unit and its staff had remained consistently good.

HMP Bristol

26. In its latest annual report for Bristol, for the year to July 2017, the IMB noted that the number of ACCTs opened had increased significantly. It expressed concern at the lack of attendance at first ACCT case reviews by healthcare staff. It continued to be concerned about the delay and interruption of planned mental health interventions for prisoners which had included some on ACCT. It noted that staff in the segregation unit continued to work extremely professionally and efficiently in a challenging environment.

Previous deaths at HMP Long Lartin and HMP Bristol

27. Mr Douglas was the fifth prisoner to die at Long Lartin since February 2015. Of the other four, one prisoner took his own life, two were murdered and one death is awaiting classification. Two prisoners have died since Mr Douglas's death. There were no similarities between the investigation into Mr Douglas's death and the previous deaths at the prison.

28. There have been 14 deaths at Bristol since February 2015. Seven prisoners took their own lives, four died from natural causes, two died from non-natural causes and one death is awaiting classification. We have made

recommendations to improve the management of the ACCT process in two previous investigations.

Assessment, Care in Custody and Teamwork

29. 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.

30. After an initial assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. Checks should be irregular to prevent the prisoner anticipating when they will occur. There should be regular, multidisciplinary review meetings involving the prisoner. As part of the process, a caremap (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.

31. 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, *Management of prisoners at risk from self, to others and from others (Safer Custody)*.

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 has to be satisfied that the prisoner is fit for segregation after an assessment by a member of healthcare staff.

33. Segregation unit regimes are usually restricted and prisoners are permitted to leave their cells only to collect meals, shower, make phone calls and have a daily period in the open air. A manager, a member of the chaplaincy team and a member of the healthcare team should visit the segregation unit daily and speak to each segregated prisoner to check their welfare. A doctor should visit at least every three days and a registered nurse on the other days to assess the physical, emotional and mental wellbeing of the prisoners and whether there are any apparent clinical reasons to advise against continuing segregation.

Incentives and Earned Privileges (IEP) Scheme

34. 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 reoffending 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

35. Mr Colin Douglas was released on licence from HMP Exeter on 11 February 2011. He was recalled to prison custody on 7 March 2011 after being charged with further offences, including false imprisonment, aggravated robbery and using a firearm to resist arrest. On 8 December 2011, he was given an Imprisonment for Public Protection (IPP) sentence with a minimum tariff of 9 years.

36. Mr Douglas was a very difficult prisoner to manage and was moved frequently around the prison estate. He had a history of violent outbursts and making threats to staff. Prison records say that on two occasions, in 2014 and 2015, he assaulted a prison doctor during a consultation because he was unhappy about not getting the medication he wanted. They also say that in January 2017, he assaulted an officer and a supervising officer (SO) in their office because he was unhappy at having been located on that wing. In October 2017, he threatened staff with an improvised weapon, a table leg with broken glass attached to one end. He was also involved in several assaults on prisoners and in causing damage to prison property, including 'smashing up' his cell on numerous occasions.

37. Because of his aggression and poor behaviour, Mr Douglas spent a significant amount of time in segregation units. He was also segregated after cell searches found illicit alcohol and drugs. He was frequently downgraded to the 'basic' regime under the Incentives and Earned Privileges (IEP) scheme.

38. Mr Douglas had a long history of opiate abuse and although he was put on a methadone programme, he continued to use illicit drugs in prison. He had a history of anxiety and depression and had attention deficit and hyperactivity disorder (ADHD), for which he was prescribed medication.

39. Mr Douglas was frequently monitored under suicide and self-harm prevention procedures (ACCT). He self-harmed by tying nooses and cutting himself, and on three occasions during 2014, he took overdoses of illicit medication.

HMP Bristol – October 2017 to January 2018

40. On 25 October 2017, Mr Douglas was moved to HMP Bristol.

41. On 8 January 2018, Mr Douglas attended a GP appointment with a prison GP. They discussed Mr Douglas's anxiety and the GP agreed to increase his mirtazapine dose from 15g to 30g. Mr Douglas said he had no thoughts of suicide or self-harm.

42. The same day, a nurse made a mental health referral for Mr Douglas because he had reported paranoid thoughts that people were talking about him and it was making him anxious. A social worker responded to the referral later that day. She said that because Mr Douglas was not known to secondary mental health services and was not displaying acute psychotic symptoms, he should see a GP. She noted that he had seen the prison GP that morning who had increased his mirtazapine prescription, that he would review this in two weeks and that he could then make an onward referral to mental health services if appropriate.

43. On 11 January, an officer spoke to senior mental health practitioner, on the wing. The officer said Mr Douglas had made threats to staff and had accused some staff of being 'out to get him'. He also said that Mr Douglas's sister had raised concerns about his mental state after she had visited him. She said that he appeared paranoid and he had hidden a razor blade in his mouth for self-defence. A nurse noted the response to the 8 January referral and advised the officer that it was appropriate to await the outcome of the medication review by the GP.

44. Later that day, Mr Douglas's sister telephoned the prison and spoke to a nurse. Mr Douglas's sister told the nurse that she was really worried about her brother, that she thought he was paranoid and that he might hurt someone. She and another nurse, a mental health practitioner, assessed him. Mr Douglas was only eating sealed food as he believed his food was being contaminated and he was not sleeping. He was scared that he might be schizophrenic like his father. Two nurses decided he should be referred to secondary services for a keyworker to build rapport and trust and noted that they hoped he would agree to medication to help with his paranoid thoughts. She told the investigator that Mr Douglas was guarded but came across as someone who was frightened and vulnerable.

45. On 12 January, Mr Douglas's sister sent an email to the prison saying that her brother was mentally ill, that he was hearing voices telling him that "everyone is against him and planning to get him" and that he was extremely dangerous without the mental health care he needed. He had talked to her about taking his own life and killing prison staff.

46. On 15 January, staff started ACCT monitoring on the basis of the email from Mr Douglas's sister. The Custodial Manager (CM) chaired an ACCT case review on 16 January with Mr Douglas. A nurse from the mental health team was in attendance, along with other staff. The CM noted that Mr Douglas said he had not been taking his medication when he saw his sister but was now taking it and feeling much better. It was agreed that the nurse would book a mental health appointment for Mr Douglas and he was happy with this. Staff decided to close the ACCT.

47. A nurse saw Mr Douglas on 18 January. He noted that Mr Douglas had been presenting with paranoid thoughts but assessed that he was now able to rationalise his thought processes. He considered that there was no need for secondary mental health services to become involved. The nurse noted that Mr Douglas was taking his antidepressants, was feeling okay and was eating appropriately.

48. The nurse saw Mr Douglas in passing on 19 January. He told her that he felt much better about things and had been eating more. The nurse thought he looked happier.

49. On 22 January, Mr Douglas took a prison officer hostage. He grabbed the officer, put a bladed weapon to the officer's throat and demanded to be taken to the gate. He was quickly disarmed and restrained and then taken to the segregation unit.

50. At 11.10am on 23 January, staff found Mr Douglas with a noose around his neck and they restarted ACCT monitoring. The duty governor chaired an ACCT review later that day. A senior mental health practitioner was in attendance,

along with other staff. She said that Mr Douglas was more guarded than before but still came across as frightened and vulnerable. He said he wanted to speak to his sister, so staff facilitated a telephone call. She was at work so Mr Douglas spoke to his brother-in-law. After that, his attitude was different. He said staff were “messing with him” and he refused to engage. Staff assessed Mr Douglas’s risk to himself as raised (on a scale of low, raised and high) and set observations at two per hour.

51. At 6.25pm, staff found Mr Douglas standing on his bed about to put a noose around his neck. Staff moved him to a cell on the Brunel Unit (an integration unit for prisoners with complex physical and mental health needs) and placed him under constant watch.

52. On 24 January, the CM chaired an ACCT case review. A nurse was in attendance, along with other staff. Mr Douglas was emotional because he had been told that he had an appointment with a psychiatrist and was worried that staff thought he was mad. The CM recorded that staff reassured him that he was not mad and that some medication might help him. Mr Douglas said he did not feel suicidal. Staff assessed his risk as high but took him off constant watch and put him on four observations every hour.

53. On 25 January, a specialist registrar in forensic psychiatry, assessed Mr Douglas. Mr Douglas told him that he had been worried about his thoughts for about 18 months and that he thought he had a psychotic illness, particularly because of his family history of schizophrenia. He had bought Olanzapine (an antipsychotic) illicitly in a previous prison that he thought had helped.

54. At the time of the consultation, Mr Douglas was taking Concerta (used to treat ADHD), amitryptiline and mirtazapine (both antidepressants). The specialist registrar in forensic psychiatry, advised that he should reduce and then stop the mirtazapine as it could cause delusions in some people. He considered prescribing an antipsychotic medication but wanted Mr Douglas to have blood tests and an electrocardiogram (ECG – a test to check the heart’s rhythm) first, because Mr Douglas had had an abnormal ECG in the past after one of his overdoses. He also noted that Mr Douglas had lost weight and he wanted to ensure that he was physically fit before prescribing an antipsychotic, which can have serious side effects. He discussed his proposed course of action with the senior consultant psychiatrist at the prison, who agreed. The specialist registrar in forensic psychiatry handed over Mr Douglas’s care to a prison psychiatrist.

55. At the ACCT case review later that day, the CM recorded that Mr Douglas was more settled. A nurse was in attendance, along with other staff. Mr Douglas’s mental health review had gone well that morning and they were looking at putting him on medication to help his paranoia, though the nurse noted that Mr Douglas wanted to take his own life as he did not want others to take it in a fight. Staff assessed his risk as low and dropped his observations to three during the day shift and hourly at night.

56. A nurse was unable to get a blood sample from Mr Douglas on 25 January because he was dehydrated. He had an ECG that day, which was normal. He refused to have a blood test on 26 January and there were insufficient prison staff available to unlock him for one on 29 January.

57. Mr Douglas continued to express violent and paranoid thoughts towards some officers. On 28 January, during an ACCT observation, staff saw that Mr Douglas had smashed up his stereo and made a weapon out of a shard of plastic, which he was holding to his neck. After staff failed to persuade him to hand over the weapon, they entered the cell in personal protection equipment and he gave them the weapon. Mr Douglas was moved to the segregation unit while his cell was searched. Staff found that he had been storing his medication. A nurse spoke to him and he admitted that he had not been taking his medication. He said he had not taken it because he thought people were trying to kill him.

58. A SO held an ACCT case review later that morning but no other staff were in attendance. He could not get Mr Douglas to engage as he was shouting threats through his cell door. The SO increased his observations to two per hour. Mr Douglas did not engage in either of the case reviews held on 30 and 31 January. The CM recorded that Mr Douglas was very confused and that he was sporadic in taking his medication which was affecting him mentally.

HMP Long Lartin

59. On 31 January, Mr Douglas was transferred to HMP Long Lartin. A nurse at Bristol spoke to a nurse at Long Lartin by telephone and explained Mr Douglas's mental health issues. The prison psychiatrist also telephoned Long Lartin and spoke to a nurse to emphasise the importance of Mr Douglas having blood tests before he was prescribed antipsychotic medication.

60. Mr Douglas was placed in the segregation unit on arrival at Long Lartin, at around 1.00pm. A nurse and primary care team leader conducted the Initial Segregation Health Screen. She did not have access to his medical records because Bristol had not released them, and all she had seen was his Person Escort Record (PER). She knew that he had been in the healthcare unit at Bristol, had been under the care of the mental health team and was a high risk prisoner. Mr Douglas told her that he had no thoughts of suicide or self-harm but she noted that he had transferred on an open ACCT. She recorded that, in her opinion, Mr Douglas's mental health would deteriorate significantly if he was segregated and concluded that there were clinical reasons not to segregate him. She discussed this with the governor in charge of the segregation unit, and they agreed to move Mr Douglas to the healthcare unit. He told the investigator that he knew Mr Douglas had tried to hang himself at Bristol and that as healthcare had concerns about his state of mind, he thought it would be safer to place him in the healthcare unit.

61. Mr Douglas was moved to the healthcare unit at around 4.40pm. At 5.00pm, a SO carried out an ACCT case review with Mr Douglas with another SO in attendance. They recorded that there was no change in Mr Douglas's risk level (raised) and kept observations at two per hour. Mr Douglas said that he had not been sleeping well but was feeling okay and had no thoughts of suicide or self-harm at that time.

62. The next morning, at the daily Governor's briefing, the Governor, questioned why Mr Douglas was in the healthcare unit. The governor in charge of the segregation unit, said that healthcare staff had concerns about keeping him in segregation and so he had decided to move him to the healthcare unit. When

interviewed, the Governor told the investigator that she was very clear with her staff that prisoners should be placed in the healthcare unit only if there was a clinical need for them to be there. She said that no one at the daily briefing could provide a clinical rationale for Mr Douglas being in the healthcare unit. She said they also discussed the risk Mr Douglas posed to staff, particularly female members of staff, and the difficulties of managing that risk in the healthcare unit, which had predominantly female staff members. She told the investigator that a collective decision was then made to move him back to the segregation unit. The governor could not recall whether anyone had told her that Mr Douglas had been assessed as not fit for segregation by healthcare staff. The governor in charge of the segregation unit told the investigator that the Governor said Mr Douglas should be returned to the segregation unit and instructed the duty governor to move him.

63. The same morning, 1 February, the mental health lead, and the substance misuse recovery practitioner, went to see Mr Douglas in healthcare. The substance misuse recovery practitioner told the investigator that she remembered him from his time at Long Lartin in 2013 and was shocked at how different he was. He had lost weight and seemed quite paranoid and worried, but he said he had no thoughts of suicide or self-harm. She noted in his medical record that an appointment with the psychiatrist needed to be booked for the following week.

64. At 10.00am, a SO held an ACCT case review with Mr Douglas. A nurse was also there. Mr Douglas had been told that he was being returned to the segregation unit. He thought he was going to be sent to a high security psychiatric hospital and that if he "is going to a mad house he is going to be killed". Staff assured him that he was not being sent to a secure hospital. He presented as paranoid, saying that staff at Bristol had been "messing about with him" and had placed microphones in his cell, which he had swallowed. He told the nurse afterwards that staff at Bristol had intentionally kept him awake at night to make him unwell, that they had told him he was going to be sent to hospital and that they had put a "receiver" in his cell to try to catch him out. He had swallowed this, which is why he had stopped eating because he wanted to keep it as evidence and not pass it in a bowel movement.

65. The same morning, a nurse conducted an ECG on Mr Douglas but was unable to get access to a vein to take a blood sample.

66. At 10.15am, the duty governor, chaired a Medical Recommendations Against Segregation Initial Case Review. (An Initial Case Review must be held if the duty governor considers that segregation is necessary despite there being healthcare reasons not to segregate.) A prison GP, a nurse and an SO also attended. The duty governor noted that the incident where Mr Douglas took an officer hostage at Bristol was of such a serious nature that the healthcare unit was not a suitable location for him and that he would be supported in the segregation unit using the ACCT process and with help from the Inclusion Team (mental health and substance misuse). The duty governor sent an email to two CMs, who were working as the prison's orderly officers that day, and told them that Mr Douglas had been given trainers without laces, as he had used shoelaces as a ligature in 2015.

67. An entry in the ACCT ongoing record at 11.05am says that Mr Douglas was refusing to go back to the segregation unit and was holding a plastic knife. He said that he was going to be sent to 'the mental hospital where they would kill him'. The duty governor spoke to him and persuaded him to hand over the knife.

68. At around 1.00pm on 1 February, Mr Douglas was returned to the segregation unit. He was unwilling to move voluntarily so officers restrained him, although he then walked calmly to the segregation unit in handcuffs. The Initial Segregation Health Screen was completed by a nurse. She recorded that Mr Douglas was awaiting transfer to an NHS secure setting (this was incorrect), that he showed signs of being acutely unwell but that, in her opinion, Mr Douglas's mental health would not deteriorate significantly if he was segregated. She concluded, though, that there were healthcare reasons not to segregate Mr Douglas at that time. She added, "Discussed and located in segregation due to security concerns. Will be supported by healthcare and mental health team."

69. A SO held an ACCT case review with Mr Douglas at 2.30pm. A member of the chaplaincy was also there. He recorded that Mr Douglas appeared very confused and could not really understand any of his questions. Mr Douglas said he "just needed to sort out in his head about where he is". He recorded Mr Douglas's risk to himself as high and noted that as he had just transferred to the unit, he would increase his observations to four per hour.

70. On 2 February, SO Wells held an ACCT case review with Mr Douglas. The governor in charge of segregation, the substance misuse recovery practitioner and a member of staff from the chaplaincy, attended. The SO recorded that there was no change in Mr Douglas's risk level and kept the level of observations the same. He scheduled the next case review for 5 February.

71. The substance misuse recovery practitioner told the investigator that Mr Douglas was very guarded during the ACCT case review and said very little. At the end, The SO asked Mr Douglas if he wanted to speak to the substance misuse recovery practitioner alone, and he agreed. He told her that he was hearing voices and was worried he was going mad. He was worried that staff wanted to send him to a mental health hospital and she considered that Mr Douglas was holding back what he really wanted to say because of this fear.

72. A Segregation Review Board was held on 2 February. The governor in charge of segregation recorded that Mr Douglas was to remain in segregation because he had taken a member of staff hostage. He recorded that Mr Douglas would need to meet and engage with mental health professionals before the next Segregation Review Board, scheduled for 12 February.

73. On the same day, a nurse recorded in Mr Douglas's medical record that he was due to be seen by the psychiatrist on Monday 5 February.

74. On the morning of 3 February, a nurse visited Mr Douglas to carry out his secondary health screening, which she conducted outside the cell door. Mr Douglas was cooperative initially and answered questions, but suddenly became agitated and verbally abusive when he started talking about the healthcare he had received at Bristol. She was unable to complete the health screening.

75. That afternoon, a nurse went to Mr Douglas's cell to conduct the secondary health screening but it could not be facilitated. He took Mr Douglas's physical observations and noted that the rest of the screening would be completed later. He noted that Mr Douglas was calm and stable but showed signs of anxiety.

Events of 4 February

76. At 10.15am, Mr Douglas refused his medication but then changed his mind and took it. At 11.30am, he asked an officer, during an ACCT check, if he could be moved to a standard wing but was told that, after what had happened at Bristol, that was not going to happen. He refused his lunch when it was offered at 11.55am. He was seen lying on his bed during the roll check at 12.10pm.

77. At around 12.20pm on 4 February, an officer went to Mr Douglas's cell to carry out an ACCT check and found him hanging by a ligature, made from shoelaces, attached to the window bars. At 12.25pm, he called a medical emergency code blue (indicating that a prisoner is unconscious or having problems breathing) over his radio and shouted for the SO who was in the segregation unit office. The control room called an ambulance as soon as they heard the code blue call. A SO and an officer, who was carrying out a constant watch on the cell opposite, responded immediately and all three entered Mr Douglas's cell. The SO supported Mr Douglas while the officer cut the ligature. The officer helped them to place Mr Douglas on the bed and the SO and the officer started cardiopulmonary resuscitation (CPR). The officer returned to his constant watch duty. Another officer arrived shortly afterwards and took over chest compressions from the first officer.

78. Three nurses responded to the code blue call and assisted with the CPR. They applied a defibrillator to Mr Douglas, which shocked him once. The ambulance paramedics arrived at the cell at 12.55pm and gave Mr Douglas fluids via a drip. Mr Douglas had a weak pulse and low blood pressure when he left the prison at 1.50pm by ambulance.

79. The ambulance crew had requested an air ambulance but this was refused by the duty governor for security reasons. Mr Douglas was accompanied by a SO and three officers (though not all them could fit in the ambulance) and restrained using an escort chain (a long chain with a handcuff at each end, one of which is attached to the prisoner and the other to an officer) during the transfer.

80. Mr Douglas arrived at hospital, Redditch at 2.10pm. Five minutes later, the escort officers asked for permission to remove restraints, which was granted by the governor in charge of segregation. They were not reapplied. Mr Douglas never regained consciousness and died in hospital shortly before 5.00am on 5 February.

Contact with Mr Douglas's family

81. On 4 February, the prison appointed a CM as the family liaison officer (FLO). He told the investigator he had difficulty contacting any family members because most of the telephone numbers in Mr Douglas's prison record were not recognised (though we note his ACCT document contained a valid number for one of his sisters). At around 4.00pm, he spoke to Mr Douglas's ex-girlfriend

who contacted one of his sisters. Mr Douglas's ex-girlfriend said she would travel to the hospital.

82. Mr Douglas's mother, sister and ex-girlfriend arrived at the hospital at around 9.00pm on 4 February and the FLO met them there. Mr Douglas's other sister arrived between 2.00am and 3.00am the next morning. Mr Douglas's mother and sisters were with him when he died.

83. Mr Douglas's funeral was held on 23 February 2018. The prison contributed to the funeral costs in line with national policy.

Support for prisoners and staff

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

85. The prison posted notices informing other prisoners of Mr Douglas'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 Douglas's death.

Post-mortem report

86. The post-mortem report shows that Mr Douglas died from cerebral hypoxia (reduced supply of oxygen to the brain) caused by hanging. Toxicology tests identified only therapeutic levels of medication.

Findings

Management of risk of suicide and self-harm

87. Prison Service Instruction (PSI) 64/2011, *Management of prisoners at risk from self, to others and from others (Safer Custody)*, sets out the processes that should be followed when an ACCT has been opened. This includes that case reviews should be multidisciplinary, that the case review team should regularly review the level of risk that a prisoner presents and that they should set caremap actions that are tailored to meet the prisoner's needs.

88. We saw some good practice in ACCT management at Bristol and Long Lartin. Every case review at Bristol, apart from one, was multidisciplinary and included a member of the mental health team. As Mr Douglas's mental health was such a key issue, we were pleased to see that there was regular input from mental health staff into discussions about how best to reduce his risk of suicide and self-harm. At Long Lartin, three out of the four case reviews were multidisciplinary (although a mental health nurse attended only one).

89. However, we identified some deficiencies in the management of the ACCT process. We found that the assessment of risk was poorly judged at times. On 24 January, the day after Mr Douglas had twice tried to hang himself at Bristol, his risk was assessed as high. Yet, on 25 January, less than 24 hours later, his risk was assessed as low and observations were reduced from four times per hour to three observations during the day and hourly at night. When deciding to reduce his level of risk, staff noted that Mr Douglas seemed more settled, that he had had a mental health review that morning that had gone well and that the mental health team were looking at putting him on medication to reduce his paranoia. We consider that this was not sufficient justification to reduce Mr Douglas's risk level from high to low so soon after two attempts to hang himself. He had not been prescribed any antipsychotic medication and none of his caremap actions had been completed.

90. We found that staff failed to add appropriate caremap actions to address Mr Douglas's risk. When Mr Douglas's ACCT was reopened on 23 January at Bristol, three caremap actions were added. They were not updated and only one further caremap action was added, which was on 1 February at Long Lartin, and this was to request a new PIN number for the PIN phone. There were 11 case reviews with Mr Douglas and we would have expected caremap actions to have been reviewed and updated more regularly than they were. We also consider that arranging antipsychotic medication for Mr Douglas was a key action for Long Lartin in terms of supporting him and managing his risk, and yet there were no caremap actions addressing this.

91. Mr Douglas's sister contacted HMP Bristol on 11 and 12 January to express her concerns about her brother's mental health and staff started ACCT monitoring a few days later. However, no consideration was given to involving Mr Douglas's sister in the subsequent ACCT case reviews. We note that staff did facilitate a telephone call to her, but she was at work and Mr Douglas was unable to speak to her. We consider that his sister could have provided valuable input to the case review process and staff should have considered involving her.

92. When Mr Douglas was returned to the segregation unit at Long Lartin on 1 February, his risk was assessed as high and his observations were increased to four per hour. At the ACCT case review the next day, 2 February, staff assessed his risk as unchanged. They scheduled the next case review for Monday 5 February. The investigator asked the governor in charge of segregation whether the case review had been scheduled to avoid the weekend. He said that case reviews were often held in the segregation unit over the weekend so that was not the issue, although the right professionals could not always attend. Given Mr Douglas's recent move to the segregation unit and staff's assessment that he was at high risk of suicide and self-harm, we consider that a case review should have been scheduled sooner.

93. Observations were generally conducted on Mr Douglas in line with the level of observations set and at irregular times, but there were periods, particularly at Bristol, where he was checked on the hour and half hour, which is not in line with PSI 64/2011. The PSI also states that it is vital that the ACCT ongoing record contains sufficient information about the progress and wellbeing of the prisoner. We found that the ongoing record lacked detail. There was minimal evidence that staff had actively engaged with Mr Douglas and the record of observations lacked substance in terms of recording his state of wellbeing.

94. We are also concerned that, although the duty governor had told other staff that Mr Douglas had been given shoes without laces, Mr Douglas hanged himself using shoelaces as a ligature. As Mr Douglas had used shoelaces to make ligatures in the past, we consider that his laces should have been removed as part of his ACCT management and we are disappointed that this did not happen. We make the following recommendations:

The Governors of HMP Bristol and HMP Long Lartin should ensure that staff manage prisoners at risk of suicide and self-harm in line with national guidelines, including ensuring that they:

- **consider all risk factors, including escalations in self-harm and deterioration in mental health, when assessing a prisoner's risk to themselves;**
- **schedule case reviews at appropriate intervals, in line with the prisoner's level of risk;**
- **set new, specific and meaningful ACCT caremap actions that are aimed at reducing a prisoner's risks to themselves;**
- **involve the prisoner's family when that would be appropriate;**
- **carry out observations at unpredictable times and make detailed, meaningful entries in the ongoing record; and**
- **remove high risk personal items that the prisoner might use to harm himself.**

Segregation

95. Prison Service Order (PSO) 1700, *Segregation*, states, 'Segregation should be used only as a last resort whilst maintaining a balance to ensure it remains an option for disruptive prisoners. This does include prisoners on an open ACCT

plan, but only when they are such a risk to others that no other suitable location is appropriate and where all other options have been tried or are considered inappropriate'. PSI 64/2011 states that prisoners on open ACCT plans must only be located or retained in segregation units in exceptional circumstances and that the reasons for segregation must be clearly documented and include the other options that were considered but discounted.

96. In a Learning Lessons Bulletin we published in June 2015, we examined learning from investigations into the self-inflicted deaths of prisoners who were segregated at the time of their deaths. We noted that segregation reduces some protective factors against suicide and should be used only in exceptional circumstances for those at risk of taking their own life.

97. Mr Douglas was placed in the segregation unit when he arrived at Long Lartin on 31 January. Around two hours later, he was moved to the healthcare unit after a nurse assessed that there were healthcare reasons not to segregate him and she and the duty governor in charge of segregation agreed it would be safer to move him. At the daily Governor's briefing the next morning, it was decided that Mr Douglas should be returned to the segregation unit and he was moved back there later that day. He was still on an ACCT and an Initial Segregation Health Screen again assessed that there were healthcare reasons not to segregate him. Nevertheless, prison staff decided that the segregation unit was the most appropriate location.

98. We recognise that Long Lartin was faced with a difficult decision about where to locate Mr Douglas. On the one hand, he was at risk of suicide and self-harm which was likely to be exacerbated by being segregated. On the other, he was a very difficult prisoner to manage, who had a history of hostage taking and serious assaults, and posed a very serious risk to staff.

99. We consider, on balance, that the decision to segregate Mr Douglas was justified. However, there should have been a full written record of the alternative options considered, why they were discounted and what the plan was for Mr Douglas's future management. We note that Mr Douglas hanged himself shortly after being told that there was no prospect of him being located on a normal wing. No minutes were taken at the daily Governor's briefing which meant that these discussions were not recorded anywhere. We make the following recommendation:

The Governor of HMP Long Lartin should ensure that staff record the full reasons for the decision to segregate a prisoner subject to ACCT monitoring, including alternative options considered and the reasons for discounting them.

Clinical care

Mental health

100. The clinical reviewer considered that Mr Douglas had a significant level of mental health assessment and support at Bristol, which was at least as good as that which he could have expected to receive in the community.

101. The clinical reviewer said it was unfortunate that Mr Douglas had to move prisons while he was being assessed for antipsychotic medication and before he could start treatment. However, she found that clinicians in Bristol handed over his care to Long Lartin appropriately and in accordance with Prison Service Order 3050, *Continuity of Healthcare for Prisoners*. She noted that Mr Douglas was not scheduled to see a psychiatrist at Long Lartin until 5 February, the day after his death. NICE guidelines state that antipsychotic medication should not be started in primary care without the input of a psychiatrist. She was satisfied that the level of healthcare Mr Douglas received in Bristol and Long Lartin was at least as good as he would have had from a crisis team in the community.

Physical health and substance misuse

102. The clinical reviewer found that the standard of physical healthcare Mr Douglas received, and the support with his substance misuse, was equivalent to that which he could have expected to receive in the community.

Emergency response

103. The clinical reviewer was satisfied that healthcare staff responded appropriately to the emergency code blue and that the resuscitation attempt was conducted efficiently by prison and healthcare staff. However, she considered that the decision of the duty governor not to allow Mr Douglas to be transferred to hospital in an air ambulance was hard to justify on health grounds given Mr Douglas's state of collapse. We note that the decision was made on security grounds with no consideration given to Mr Douglas's medical condition at that time. We make the following recommendation:

The Governor of HMP Long Lartin should ensure that decisions on the appropriateness of allowing prisoners to be transferred to hospital by air ambulance consider clinical need as well as security issues.

104. Prison records show that it took around 20 minutes for the ambulance to leave the prison. Records show that Mr Douglas was stretchered out of the segregation unit at 1.24pm but the ambulance did not leave the prison until 1.46pm. The prison has confirmed that this delay was caused by the need to brief the escort staff and there being insufficient room in the ambulance so a further fast response vehicle was needed. While this may have accounted for a short delay, these events should not have resulted in Mr Douglas remaining at the prison for 22 minutes. We make the following recommendation:

The Governor of HMP Long Lartin should ensure that there are no unnecessary delays in discharging ambulances.

Restraints

105. The Prison Service has a duty to protect the public when escorting prisoners outside prison, such as to hospital. It also has a responsibility to balance this by treating prisoners with humanity. The level of restraints used should be necessary in all the circumstances and based on a risk assessment, which considers the risk of escape, the risk to the public and takes into account the prisoner's health and mobility. A judgment in the High Court in 2007 made it clear that prison staff need to distinguish between a prisoner's risk of escape

when fit (and the risk to the public in the event of an escape) and the prisoner's risk when suffering from a serious medical condition. The judgment indicated that medical opinion about the prisoner's ability to escape must be considered as part of the assessment process and kept under review as circumstances change.

106. When Mr Douglas was discovered hanging in his cell on 4 February, he was unconscious. By the time he was taken to hospital, he had a weak pulse but was still unconscious and was not breathing unaided. Despite this, he was restrained using an escort chain during the transfer to hospital.

107. Although the risk assessment had been signed by a nurse, she had not completed it to show whether there were medical objections to the use of restraints or whether Mr Douglas's medical condition impaired his ability to escape. Prison staff assessed his escape potential and his risk to the public as high, despite Mr Douglas being unconscious and not breathing unaided at the time he left the prison.

108. We accept that Mr Douglas was a violent prisoner who posed a substantial risk to others. He was on a four-officer unlock at the time he died, because of the danger he posed. However, Mr Douglas was transferred to hospital while unconscious and not breathing and was accompanied by officers who would have been able to apply restraints if his condition had improved. The High Court judgment is very clear that the risk of escape must be assessed based on the prisoner's medical condition at the time. The risk assessment completed for Mr Douglas failed to take this into account. The use of restraints was clearly disproportionate in these circumstances. We acknowledge that the risk assessment was reviewed shortly after Mr Douglas's arrival at hospital and the decision was taken to remove restraints. Nevertheless, we make the following recommendation:

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

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