

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Lenny Cawt, a prisoner at HMYOI Aylesbury, on 16 May 2020

A report by the Prisons and Probation Ombudsman

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 Lenny Crawt was found hanged in his cell at HMYOI Aylesbury on 16 May 2020. He was 19 years old. I offer my condolences to Mr Crawt's family and friends.

Mr Crawt was transferred to Aylesbury from HMP High Down around two weeks before his death. On the morning of the transfer, he was tearful at the prospect and said he would harm himself if it went ahead. While some positive, supportive action was taken, I am concerned that no one appeared to consider whether it would be appropriate to start suicide and self-harm prevention procedures.

Staff at Aylesbury appropriately referred Mr Crawt to the safer custody and mental health teams and recorded their concerns that he might be vulnerable and that he appeared anxious and panicked about mixing with other prisoners. On the last day of his life – which was the first day on which he could socialise with the general population after a mandatory two-week quarantine due to COVID-19 prevention measures – Mr Crawt did not leave his cell at all. Despite concerns about his potential vulnerability, no prison staff had any meaningful contact with Mr Crawt that day and no one identified that his isolation might indicate an increased risk of suicide and self-harm.

I am also concerned about aspects of the emergency response, particularly a delay of around a minute and a half before anyone tried to resuscitate Mr Crawt after his ligature was cut.

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

Sue McAllister CB
Prisons and Probation Ombudsman

July 2021

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Summary

Events

1. On 19 July 2018, Mr Lenny Crawt was remanded in custody to HMP Pentonville, charged with murder. He had recently turned 18 years old. In February 2019, he was transferred to HMP High Down and, the following month, sentenced to life in prison.
2. Mr Crawt settled well at High Down and was described by staff as a friendly young man who got on well with other prisoners. From January 2020, he lived on the same spur as his brother, with whom we were told he had a particularly close relationship.
3. On 1 May, staff told Mr Crawt that he was to transfer to HMYOI Aylesbury that day. Mr Crawt became tearful and said that he would harm himself or take an overdose if he was forced to move. He then barricaded his cell. After removing the barricade, staff unlocked Mr Crawt's brother and let them speak, after which Mr Crawt agreed to go to Reception with the officers.
4. Mr Crawt's brother packed his belongings for him and was permitted to go to Reception to say goodbye. An officer told us that Mr Crawt was very tearful in Reception. The duty manager said that Mr Crawt was calm before the transfer and accepted that he had to move.
5. On arrival at Aylesbury, Reception staff referred Mr Crawt to the mental health and safer custody teams. Due to COVID-19 regulations, he had to spend his first two weeks at the prison in quarantine. He was allowed to leave his cell each day for exercise, but often chose not to. Staff at Aylesbury told us that Mr Crawt appeared mature, but they were concerned that he might be vulnerable or a potential target for gangs when his quarantine period ended. They also recorded that he was reluctant to mix with other prisoners and panicked at the thought of this.
6. On 15 May, Mr Crawt's quarantine period ended. He did not leave his cell all day and did not therefore collect his medication or lunch, nor did he have exercise, spend time with his peers, or have a shower.
7. At around 5.40am on 16 May, the night patrol officer found that Mr Crawt had hanged himself. He unlocked the cell, removed the ligature and radioed a medical emergency code, but did not begin cardiopulmonary resuscitation (CPR). Around a minute and a half later, other officers arrived and began CPR. Paramedics later confirmed that Mr Crawt had died.

Findings

Identifying the risk of suicide and self-harm – HMP High Down

8. Mr Crawt was very upset at the prospect of transferring to Aylesbury and threatened to harm himself if the transfer went ahead. While prison staff took some action to address this – and allowing his brother to spend time with him both in his cell and in Reception was particularly good practice – they did not

consider starting Prison Service suicide and self-harm prevention procedures, known as ACCT. Mr Crawl's statements and actions could also have been better communicated to Aylesbury.

Identifying the risk of suicide and self-harm – HMYOI Aylesbury

9. Despite identifying that he might be vulnerable and appeared withdrawn and anxious about mixing with other prisoners, no prison staff had any meaningful contact with Mr Crawl on his first day after quarantine, when he apparently did not leave his cell all day. This was a missed opportunity to identify any concerns he had or any increased risk of suicide and self-harm.

Emergency response

10. While the night patrol officer promptly unlocked Mr Crawl's cell and cut the ligature, he did not begin CPR and instead waited for colleagues to arrive. There was also a delay before the control room telephoned for an ambulance.

Recommendations

- The Governor of HMP High Down should ensure that all staff have a clear understanding of their responsibilities to manage and support prisoners at risk of suicide and self-harm in line with national guidelines, including that:
 - Staff record, share and consider all relevant information about risk and start ACCT procedures when indicated.
 - Reception staff amend the PER when new risk information is available ahead of a transfer, and directly contact the receiving prison when required.
- The Governor of HMP High Down should ensure that a copy of this report is shared with CM A and Officer C and that a senior manager discusses the Ombudsman's findings with them.
- The Governor of HMYOI Aylesbury should ensure that staff have meaningful contact with prisoners who have finished their reverse cohorting period, identify those who might be vulnerable to suicide and self-harm, and start ACCT procedures when necessary.
- The Governor of HMYOI Aylesbury should ensure that all prison staff are made aware of and understand their responsibilities during medical emergencies, including that:
 - Staff initiate basic life support promptly when needed.
 - Control room staff call an ambulance as soon as an emergency code is broadcast.
- The Governor of HMYOI Aylesbury should ensure that a copy of this report is shared with OSG B, and that a senior manager discusses the Ombudsman's findings with him.

The Investigation Process

11. The investigator issued notices to staff and prisoners at HMYOI Aylesbury informing them of the investigation and asking anyone with relevant information to contact him. No one responded.
12. The investigator obtained copies of relevant extracts from Mr Crawl's prison and medical records.
13. The investigator interviewed ten members of staff at Aylesbury in June and July. He also interviewed three staff at HMP High Down on 15 June.
14. NHS England commissioned a clinical reviewer to review Mr Crawl's clinical care at the prison. The clinical reviewer and investigator jointly interviewed healthcare staff. All the interviews were conducted by video link or telephone because of the restrictions during the COVID-19 pandemic.
15. We informed HM Coroner for Buckinghamshire of the investigation. The Coroner gave us the results of the post-mortem examination. We have sent him a copy of this report.
16. The Ombudsman's family liaison officer contacted Mr Crawl's mother, to explain the investigation and to ask if she had any matters she wanted us to consider. She had no specific questions about the circumstances of Mr Crawl's death.
17. The investigator spoke to Mr Crawl's brother, who had lived on the same wing as him at High Down. Mr Crawl's brother asked why his brother was transferred to Aylesbury, and whether prison staff should have started ACCT procedures when he was transferred.
18. We shared the initial report with Mr Crawl's mother and brother. They did not make any comments.
19. We also shared the initial report with HM Prison and Probation Service (HMPPS). They highlighted some inaccuracies and we have amended this report accordingly. The action plan has been annexed to this report.

Background Information

HM Young Offender Institution (YOI) Aylesbury

20. HMYOI Aylesbury has capacity for up to 440 young adult men aged 18-20, who are serving the longest sentences for their age group in the country. Since May 2019, the prison has been operating at a reduced capacity, holding up to 209 young men, after it was placed in special measures by HM Prisons and Probation Service (HMPPS) due to serious concerns about safety at the prison.
21. Care UK provide physical health services and Barnet, Enfield and Haringey Mental Health Trust provide mental health services.

HM Inspectorate of Prisons

22. The most recent inspection of HMYOI Aylesbury was in October 2019. Inspectors reported that reception and first night processes were reasonably good, although induction was not always timely and prisoners frequently missed sessions. Inspectors also found that 27 per cent of prisoners currently felt unsafe at Aylesbury, and 53 per cent had felt unsafe at some time at the prison. The rate of assaults was higher than at their previous inspection, although Inspectors noted that they were generally less serious in nature.
23. Inspectors reported that levels of self-harm had reduced since their last inspection and was lower than at comparable prisons. They found that the mental health team was skilled and had built a good rapport and trust with prisoners. Mental health referrals were triaged and assessed promptly.

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 March 2019, the IMB reported that levels of self-harm had increased by around 50 per cent compared to the previous reporting year. They also reported that prisoner on prisoner assaults had more than doubled during the year.

Previous deaths at HMYOI Aylesbury

25. There has been one other death at Aylesbury since 2011, when a young man took his own life in March 2019. There are no significant similarities between this young man's death and Mr Crawl's.

Assessment, Care in Custody and Teamwork [ACCT]

26. ACCT is the Prison Service care-planning system used to support prisoners at risk of suicide and self-harm. The purpose of ACCT is to try to determine the level of risk, how to reduce the risk and how best to monitor and supervise the prisoner. After an initial assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. Checks should be irregular to prevent the prisoner anticipating when they will occur. There should be regular multi-disciplinary review meetings involving the prisoner.

27. As part of the process, a caremap (plan of care, support and intervention) is put in place. The ACCT plan should not be closed until all the actions of the caremap have been completed. All decisions made as part of the ACCT process and any relevant observations about the prisoner should be written in the ACCT booklet, which accompanies the prisoner as they move around the prison. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

Reverse Cohort Units

28. During the COVID-19 pandemic, HMPPS took steps to help prisons to manage the threat of large numbers of prisoners and staff becoming infected and to reduce the likelihood of the infection spreading throughout the prison system. All prisons were required to establish designated areas for specific groups of prisoners. One of these areas, known as a Reverse Cohort Unit, provided for the temporary separation of newly arrived prisoners for up to 14 days to allow the prison to be sure that the individual did not have symptoms of COVID-19.
29. During their 14-day 'reverse cohorting' period, prisoners have daily healthcare observations taken. They must receive a minimum of 30 minutes time in the open air every day, have access to a telephone, and access to a shower at least once a week. At the end of the reverse cohorting period, prisoners who are not symptomatic are allowed to mix with the general population.
30. At Aylesbury, prisoners in the Reverse Cohort Unit have all three meals delivered to their cell. They have an in-cell telephone and have daily access to showers and time in the open air.

Key Events

31. Mr Lenny Crawt spent the latter part of his childhood as a looked-after child. On 19 July 2018, a few weeks after his eighteenth birthday, Mr Crawt was remanded in custody to HMP Pentonville. He was charged with a murder committed around two years earlier. This was his first time in prison.
32. On his first night in custody, Mr Crawt said that he had no thoughts of suicide and self-harm. He stated that he used crack cocaine, heroin and cannabis in the community but refused to be referred to the substance misuse team.
33. Mr Crawt's brother told us that Mr Crawt told him that he had tried to take his life when he was at Pentonville. Mr Crawt did not tell his brother any further details about this incident, and there is no record of it in his prison records.

HMP High Down

34. On 5 February 2019, following a court appearance, Mr Crawt was transferred to HMP High Down. He did not raise any issues on arrival, and again said he had no thoughts or history of self-harm.
35. On 12 March, Mr Crawt was sentenced to life in prison, with a minimum time to serve of 15 years. On his return from court, Mr Crawt said that he was expecting a longer sentence and that he was finding prison easier than he expected.
36. On 16 August, a prison GP assessed Mr Crawt after he requested an appointment due to recent anxiety. Mr Crawt told the prison GP that he had taken propranolol (medication for anxiety) in the community (his medical records do not support this) and that he was keen to try it again. The prison GP prescribed the medication.
37. On 9 October, Mr Crawt requested a medication review as he said that propranolol was no longer effective. He was put on the waiting list for a GP appointment but there is no record that he saw the GP for a review.
38. On 19 December, a mental health nurse assessed Mr Crawt. He recorded that Mr Crawt said he had experienced depression in the past and that he was currently prescribed propranolol, which he found ineffective. Mr Crawt said he felt tearful, irritable and intolerant of others. He said he had thought about self-harm in the past but that he did not intend to act on this. She recorded that he would book an appointment for Mr Crawt in the prison's depression clinic. There is no record that Mr Crawt attended the clinic.
39. In January 2020, Mr Crawt moved onto the same spur as his brother and from 20 February, they lived two cells apart. Officer C told us that Mr Crawt and his brother were inseparable. He said that Mr Crawt worked serving meals to other prisoners and described him as friendly, chatty and happy and said that he got on well with other prisoners.

1 May 2020

40. Prisoners at High Down who have received long sentences are usually transferred to other prisons to progress through their sentence and to make space at High Down for new receptions from court. It is standard practice, for security reasons, that prisoners are not told of an impending transfer until the morning that the transfer is scheduled. Mr Crawt was scheduled to transfer to HMYOI Aylesbury on 1 May.
41. An Offender Management Unit manager at High Down told us that Mr Crawt's brother was also originally listed for transfer to Aylesbury. However, the Offender Management Unit at Aylesbury asked that he be removed from the list because he was very close to his 21st birthday, at which point he would need to transfer to an adult prison.
42. Officer C told us that he told Mr Crawt about the transfer because he felt that they had a good rapport. He told us that Mr Crawt said that he would not make the transfer and that he would harm himself or take an overdose if staff tried to make him move.
43. Officer C said that he then telephoned a Custodial Manager (CM) A, the duty manager, for advice. He said that CM A asked him to get a group of staff together and take Mr Crawt to Reception "before he did himself any harm". CM A told us that he issued this instruction to ensure that Mr Crawt was supervised and to therefore reduce the risk he posed to himself.
44. Officer C said that he returned to Mr Crawt's cell with four other staff and found that Mr Crawt had barricaded the door. The staff forced the door open and Officer C and a Supervising Officer (SO) went in to speak to Mr Crawt. Officer C said they explained the reasons for the transfer and that Mr Crawt struggled to accept it. He said that staff unlocked Mr Crawt's brother, who then spent around five minutes speaking to him, after which Mr Crawt agreed to go.
45. Mr Crawt's brother told us that Mr Crawt was upset, crying, and said that he did not want to move. He said that they spoke to the officers about whether they could postpone the transfer and were told that Mr Crawt should go to Reception and speak to the officer in charge there.
46. The staff then escorted Mr Crawt to Reception. Officer C said that Mr Crawt was "very upset and teary" in Reception. As is standard practice, the staff searched Mr Crawt, during which he handed them a razor blade.
47. CM A then spoke to Mr Crawt. He told us that Mr Crawt was calm and did not appear distressed or upset. Mr Crawt said that he did not want to transfer away from his brother, and CM A said that he explained the reasons for the transfer. He told us that his view was that Mr Crawt did not want to leave his brother but accepted that it had to be done.
48. Mr Crawt's brother had packed Mr Crawt's property in his cell and was then allowed to bring it to Reception and to say goodbye. He told us that Mr Crawt was calmer than earlier but said that he would harm himself if he was transferred. Shortly afterwards, Mr Crawt left High Down.

49. Officer C wrote a record of the events in Mr Crawl's electronic prison record. He told us that he did not consider starting ACCT procedures when Mr Crawl threatened to harm himself, as his main consideration at the time was ensuring that he was safe and was not going to immediately hurt himself. CM A told us that Mr Crawl did not say anything to him about harming himself, and his view was that his earlier threat had been dealt with.

HMYOI Aylesbury

50. An officer interviewed Mr Crawl when he arrived at Aylesbury. He told us that he read Officer C's note in Mr Crawl's prison record before speaking to him. The officer told us that Mr Crawl appeared to be very mature. He said that Mr Crawl told him that he had never had a mental health diagnosis but thought he might have depression. Mr Crawl said that he would rather not be at Aylesbury and did not want to leave his brother. The officer said that Mr Crawl was more mature than other young men he usually interviewed and that he did not give any indication that he would harm himself. He referred Mr Crawl to the mental health team and safer custody team.
51. In his referral, the officer wrote that Mr Crawl was "quiet, and could potentially be targeted and become vulnerable if moved to a more active wing". He told us that by this he meant that Mr Crawl did not know anyone else in the prison and had no gang affiliations, and experience told him that similar individuals had been targeted by gangs.
52. A nurse assessed Mr Crawl and noted that he told her he had no history of self-harm and no thoughts of this. She noted that he was prescribed propranolol and that Mr Crawl told her this was for "panic attacks". The nurse told us that she did not know what had happened at High Down that morning, as healthcare staff do not have access to the electronic prison record and it was not recorded in the PER or in his medical record. She also referred Mr Crawl to the mental health team.
53. On 2 May, a safer custody officer spoke to Mr Crawl. The officer recorded that Mr Crawl had a mature attitude and said that he wanted to "keep his head down". He recorded that Mr Crawl had no issues. The officer told us that Mr Crawl had no obvious risk factors for suicide or self-harm.
54. On 5 May, the Head of Safety, referred Mr Crawl to the mental health team. Her referral stated that Mr Crawl had "anxiety and depression", and that he came across as mature "but could be quite vulnerable". She told us that her referral was a word for word copy of the officer's safer custody referral.
55. On the same day, the healthcare team held a multi-professional case conference to discuss Mr Crawl's referral. He was accepted onto the team's caseload and referred for assessment.
56. On 6 May, a mental health nurse assessed Mr Crawl. Due to COVID-19 restrictions, the assessment took place by telephone rather than face-to-face. The nurse recorded that Mr Crawl said he felt "okay" but had experienced a panic attack yesterday. He also described symptoms of depression. Mr Crawl said that he was usually outgoing but panicked if he had to mix with others. Mr

Crawt said that he had never attempted suicide and did not engage in self-harm. He said that he was prescribed propranolol but wanted to try an antidepressant instead as had been suggested at High Down.

57. The nurse discussed the assessment with a prison psychiatrist. The prison psychiatrist prescribed a course of sertraline (antidepressant medication).
58. On the same day, prison staff discussed Mr Crawt at the weekly Safety Intervention Meeting (SIM). The SIM discuss prisoners identified as vulnerable to identify any additional support that might be provided. Since COVID-19, they also discuss all newly arrived prisoners in the Reverse Cohort Unit. The minutes recorded that Mr Crawt had no current issues and was under the care of the mental health team. The Head of Safety told us that the attendees were satisfied that all relevant referrals had been made for Mr Crawt.
59. On 6 May and 8 May, Mr Crawt chose to remain in his cell and not have any time in the open air. From 10 May and every day after that until his death, he chose to remain in his cell rather than exercise.
60. On 10 May, an officer held a keyworker session with Mr Crawt. He recorded that Mr Crawt appeared withdrawn and was not interested in socialising with other prisoners. The officer recorded that he would monitor Mr Crawt. He told us that Mr Crawt appeared to have no interest in pursuing anything in prison, even trivial things such as purchasing items from the prison shop, although he appeared calm and to have “a good head on his shoulders”.
61. On 11 May, the prison psychiatrist spoke to wing staff about Mr Crawt. She recorded that he was doing well, taking his medication, and there were no concerns at the time.
62. On 13 May, a nurse conducted a telephone review with Mr Crawt. She recorded that he said he was doing “okay” and that his medication was effective, but that he still felt anxious especially around crowds. The nurse recorded that his risk of self-harm was low. She recorded that he would remain on the mental health team’s caseload and referred him to the prison’s anxiety education and discussion group.
63. On 14 May, the nurse completed the last day of Mr Crawt’s daily clinical observations. She recorded that he appeared stable and said that he felt well in himself. The nurse noted that she had told Mr Crawt that as it was the last day of his quarantine, he was expected to come out of his cell the next day. The nurse told us that Mr Crawt appeared normal and there was nothing that gave her cause for concern.
64. As well as declining time in the open air, Mr Crawt also chose not to leave his cell for a shower on 14 May.

15-16 May 2020

65. On 15 May, Mr Crawt’s two-week period of isolation ended. He could now spend time mixing with other prisoners in ‘association’ periods and was expected to collect lunch from the wing servery rather than having it delivered to his cell. (The evening meal was still delivered to prisoner’s cells.) Mr Crawt was also

expected to attend the healthcare centre each day to collect his medication, whereas previously it had been delivered to his cell.

66. Mr Crawl did not go to the healthcare centre to collect his medication. An officer told us that she went to Mr Crawl's cell and told him that he was required to go but he said he did not want to. She said that she telephoned healthcare to explain this to them.
67. A nurse said that she spoke to a wing officer to ask why Mr Crawl did not collect his medication and was told that it was because he had gone out for exercise instead. However, the wing refusal log showed that Mr Crawl did not leave his cell for exercise that day.
68. As well as not taking exercise, Mr Crawl did not have a shower and did not collect his lunch. It appears that he did not leave his cell all day. No members of staff recorded that they had spoken to him.
69. An Operational Support Grade (OSG) B was the night patrol officer on 15 to 16 May. He visited all cells on the wing three times during the night to complete welfare checks on prisoners, the last of which was at around 3.30am on 16 May. OSG B told us that Mr Crawl was sitting on his bed at the earlier checks, and he could not remember what he was doing at the last check.
70. At around 5.40am, OSG B began his fourth welfare check. He told us that he found that Mr Crawl had covered the cell door observation panel, and that he could not get a response from him when he shouted and banged on the door. OSG B said that he then looked through the gap in the side of the door and could see Mr Crawl sitting on his bed, with a ligature tied around his neck that was attached to the window bars.
71. At 5.43am, OSG B radioed a medical emergency code blue, indicating a life-threatening situation. He then unlocked the cell, went in and cut the ligature. OSG B said he checked for a pulse and could not find one. He did not start cardiopulmonary resuscitation (CPR) and waited outside the cell for support from colleagues.
72. Around one minute and forty seconds after OSG B opened the cell, two officers arrived and began CPR. A CM arrived shortly afterwards and radioed for an emergency ambulance. The control room operator telephoned for an ambulance at 5.47am.
73. At 5.56am, paramedics arrived and took over the resuscitation. At 7.08am, they confirmed that Mr Crawl had died.

Contact with Mr Crawl's family

74. A prison family liaison officer (FLO), telephoned Mr Crawl's mother and informed her of his death. (Family liaison officers would normally break the news of a death in person but were instructed to do so by telephone during the COVID-19 pandemic.) The FLO also contacted High Down and asked a family liaison officer there to inform Mr Crawl's brother.

75. Aylesbury contributed to the costs of Mr Crawl's funeral in line with Prison Service instructions.

Support for prisoners and staff

76. After Mr Crawl's death, an operational 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.
77. The prison posted notices informing other prisoners of Mr Crawl's death and offering support.

Post-mortem report

78. A post-mortem examination identified the cause of death as external neck compression due to hanging.

Findings

Identifying the risk of suicide and self-harm

79. Prison Service Instruction (PSI) 64/2011, which governs ACCT suicide and self-harm prevention procedures, requires all staff who have contact with prisoners to be aware of the risk factors and triggers that might increase the risk of suicide and self-harm and take appropriate action. Any prisoner identified as at risk of suicide and self-harm must be managed under ACCT procedures. PSI 64/2011 also states that any information that becomes available which may affect a prisoner's risk of harm to self must be recorded and shared, to inform proper decision making.
80. We have considered whether staff at Aylesbury and High Down should have recognised Mr Cawt as at risk and begun ACCT procedures to support him.

HMP High Down

81. Mr Cawt had some risk factors for suicide and self-harm. He was sentenced to life in prison, he had previously used drugs and he was prescribed medication for anxiety. Most significantly, he was tearful and threatened to self-harm when told that he would be transferred to Aylesbury away from his brother, with whom we were told he had a very close relationship. PSI 64/2011 identifies transfer between prisons and a lack of social support as potential triggers and risk factors for suicide and self-harm.
82. There was some good practice on the morning of Mr Cawt's transfer, particularly the involvement of his brother both on the wing and in Reception. Nevertheless, we are concerned that Officer C told us that he did not consider starting ACCT procedures and that CM A thought that Mr Cawt had accepted the transfer and the issue was therefore resolved. We think that staff should have been more aware of Mr Cawt's increased risk of suicide and self-harm and considered starting ACCT procedures.
83. We are also concerned about information sharing between High Down and Aylesbury. Officer C made a good entry in Mr Cawt's electronic prison record (NOMIS case notes) outlining the morning's events. However, no one amended the PER (which was completed the day before) and there was no consideration to telephoning Aylesbury to highlight what had happened. This meant that Aylesbury's Reception nurse (who does not have access to the electronic prison record) did not know about Mr Cawt's new risk factors. We make the following recommendation:

The Governor of HMP High Down should ensure that all staff have a clear understanding of their responsibilities to manage and support prisoners at risk of suicide and self-harm in line with national guidelines, including that:

- **Staff record, share and consider all relevant information about risk and start ACCT procedures when indicated.**

- **Reception staff amend the PER when new risk information is available ahead of a transfer, and directly contact the receiving prison when required.**

The Governor of HMP High Down should ensure that a copy of this report is shared with CM A and Officer C and that a senior manager discusses the Ombudsman’s findings with them.

HMYOI Aylesbury

84. PSI 64/2011 identifies that the early days after a transfer, and feelings of intimidation, loneliness, or anxiety are potential risk factors or triggers for suicide and self-harm.
85. Reception staff at Aylesbury appropriately referred Mr Crawl to the safer custody and mental health teams (and three separate referrals were made to the mental health team in his first days at the prison). He was promptly assessed by both teams. Several staff identified that Mr Crawl was withdrawn, reluctant or panicked about mixing with other prisoners, and potentially vulnerable to bullying, and for most of his second week of quarantine, he chose not to leave his cell for exercise or his weekly shower. As his medication and food was delivered to his cell during the quarantine period, this meant that he did not leave his cell at all. We consider that this should have raised concerns.
86. On his first day after quarantine, Mr Crawl did not leave his cell at all and therefore missed activities, including medication and lunch. It does not appear that any member of staff spoke to him all day – other than to briefly ask why he had not collected his medication – and no one identified that this behaviour might indicate increased vulnerability or an increased risk of suicide and self-harm.
87. Given their concerns about his potential vulnerability and anxiety about mixing with other prisoners, we would have expected staff to have paid particular attention to Mr Crawl’s behaviour in his first days after quarantine. Instead, there is little evidence that they had any meaningful interaction or engagement with him. Staff engagement is particularly important at such times and, without such contact, it is more difficult for staff to identify whether a prisoner has any issues or might be more vulnerable to suicide and self-harm. We make the following recommendation:

The Governor of HMYOI Aylesbury should ensure that staff have meaningful contact with prisoners who have finished their reverse cohorting period, identify those who might be vulnerable to suicide and self-harm, and start ACCT procedures, when necessary.

Emergency response

88. We have some concerns about the emergency response on the morning of 16 May. When he found Mr Crawl hanging, OSG B appropriately unlocked the cell, cut the ligature and radioed a medical emergency code blue. However, he did not begin CPR and instead waited outside the cell for colleagues. This led to a delay of around a minute and a half until CPR began. OSG B told us that he is

trained in first aid, and we consider that all prison staff should have some awareness of when and how to begin CPR.

89. PSI 03/2013 says that governors must have a medical emergency response code protocol to ensure that prisons call an ambulance immediately in a life-threatening medical emergency. The PSI explicitly says that control room staff should automatically call an ambulance whenever there is an emergency code and it must not be a requirement for a member of the prison healthcare team or a duty manager to attend the scene before emergency services are called. Aylesbury's Notice to Staff 46/18 (Response to Code Red and Code Blue Situations) reflects this and states (in bold font) that when a medical emergency is radioed, an ambulance must be called immediately.
90. There was a delay of around four minutes after OSG B radioed an emergency code until the control room operator telephoned for an ambulance. It appears to have been prompted by a CM making a second radio call, explicitly requesting an ambulance.
91. We cannot know whether a prompter, more effective response would have made a difference to the outcome for Mr Cawt but early intervention when someone is found hanging can save their life. We make the following recommendation:

The Governor of HMYOI Aylesbury should ensure that all prison staff are made aware of and understand their responsibilities during medical emergencies, including that:

- **Staff initiate basic life support promptly when needed.**
- **Control room staff call an ambulance as soon as an emergency code is broadcast.**

The Governor of HMYOI Aylesbury should ensure that a copy of this report is shared with OSG B, and that a senior manager discusses the Ombudsman's findings with him.

**Prisons &
Probation**

Ombudsman
Independent Investigations