

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Gary Sheehan, a prisoner at HMP Hull, on 21 June 2020

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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

OGL

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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 Gary Sheehan died on 21 June 2020, after he was found hanging in his cell at HMP Hull. He was 51 years old. I offer my condolences to Mr Sheehan's family and friends.

Mr Sheehan was serving a sentence of Imprisonment for Public Protection (IPP) and was eight years over his minimum tariff when he arrived at Hull in June 2020. At his previous prison, HMP Full Sutton, he had spent almost three months self-isolating in his cell as he thought he was under threat from other prisoners.

In March 2020, the Parole Board recommended that Mr Sheehan could move to open conditions (Category D) but he was instead moved to Hull, a Category B prison, where he continued to tell staff that he was under threat from other prisoners. Staff started suicide and self-harm prevention procedures (known as ACCT) when Mr Sheehan self-harmed on 20 June.

The investigation found that the ACCT procedures were managed appropriately. It also found that staff at both Full Sutton and Hull offered appropriate support to Mr Sheehan when he said he felt threatened by other prisoners. However, the investigation found that healthcare staff at both prisons could have done more to ensure his compliance with his mental health medication. We also found that staff at Full Sutton did not clearly communicate to Mr Sheehan the reason why he was moved to Hull and not to an open prison as recommended by the Parole Board.

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

February 2021

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Summary

Events

1. In June 2010, Mr Gary Sheehan was given an Imprisonment for Public Protection (IPP) sentence, with a minimum tariff of 24 months, for robbery. In December 2017, he received a further 12 months imprisonment for absconding and possession of a bladed article. He was moved to HMP Full Sutton in July 2018.
2. In March 2019, staff moved Mr Sheehan to the vulnerable prisoners (VP) wing after he said he was being threatened by other prisoners.
3. On 20 March 2020, the Parole Board recommended that Mr Sheehan should be moved to a Category D open prison to prepare him for release. On the same day, Mr Sheehan told staff that he felt under threat on the VP wing and he began to self-isolate in his cell.
4. On 6 May, healthcare and prison staff met to discuss appropriate support for Mr Sheehan as he continued to self-isolate. Although staff found no evidence that he was under threat, they agreed that he should be encouraged to take his prescribed medication for anxiety and depression and that a longer term plan to manage his concerns at Full Sutton was needed.
5. On 8 June, Mr Sheehan was moved to HMP Hull. Reception staff noted no current concerns about suicide or self-harm and assessed him as suitable to have his prescribed medication in-possession.
6. On 18 June, staff moved Mr Sheehan to the VP wing after he said he was under threat from other prisoners. Two days later, Mr Sheehan cut his wrists after alleging that he remained under threat from other prisoners on the VP wing. Staff started suicide and self-harm procedures (known as ACCT).
7. On 21 June at around 3.50pm, during an ACCT check, staff found Mr Sheehan hanging in his cell. Staff called a medical emergency code and started cardiopulmonary resuscitation (CPR). Healthcare staff attended shortly afterwards and continued with CPR. Paramedics arrived and took over resuscitation attempts, but they were unsuccessful and they pronounced Mr Sheehan's death at 4.45pm.

Findings

8. We found that staff at Hull managed the ACCT procedures appropriately.
9. We found no evidence that staff at Full Sutton told Mr Sheehan why he was moving to Hull rather than to open conditions as recommended by the Parole Board. However, we consider that the move to Hull was reasonable as a short-term measure and was probably not a significant factor in Mr Sheehan's death.
10. We found that, on balance, staff at Full Sutton and Hull investigated Mr Sheehan's allegations that he was being threatened by other prisoners and supported him as far as they could with the information available to them.

11. However, we consider that healthcare staff at Full Sutton and Hull did not do enough to monitor and encourage Mr Sheehan's compliance with his antidepressant medication.

Recommendations

- The Governor at Full Sutton should ensure that, where a decision is made not to implement a Parole Board recommendation, this decision is clearly communicated to the prisoner and appropriately recorded.
- The Heads of Healthcare at Full Sutton and Hull should ensure that staff monitor prisoners' compliance with medication, particularly mental health medication, by those self-isolating.

The Investigation Process

12. The investigator issued notices to staff and prisoners at HMP Hull informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
 13. The investigator obtained copies of relevant extracts from Mr Sheehan's prison and medical records.
 14. NHS England commissioned an independent clinical reviewer to review Mr Sheehan's clinical care at the prison.
 15. The investigator and clinical reviewer interviewed five members of staff at HMP Hull and two members of staff at HMP Full Sutton. Due to coronavirus restrictions, the interviews were conducted by telephone between September and November 2020.
 16. We informed HM Coroner for East Riding and Kingston Upon Hull of the investigation. We have given the Coroner a copy of this report.
 17. We contacted Mr Sheehan's mother and sister to explain the investigation process and to ask if they had any matters they wanted the investigation to consider. Mr Sheehan's mother and sister wanted to know:
 - How frequently was Mr Sheehan being checked?
 - Did staff investigate his allegations that he was being threatened?
 - Was he on hunger strike and, if so, did staff log this?
 - Why was he on antidepressants and could the medication have caused suicidal thoughts?
 - Was there a delay in informing the family of his death?
- We have addressed these issues in the report.
18. We shared our initial report with HM Prison and Probation Service (HMPPS). They identified no factual inaccuracies but provided some more up-to-date information on IPP prisoners; paragraph 32 has been amended accordingly.
 19. We sent copies of our initial report to Mr Sheehan's mother and sister. They found no factual inaccuracies.

Background Information

HMP Hull

20. HMP Hull is a local prison that holds up to 1,056 men in ten wings. City Healthcare Partnership provides health services at the prison. The prison has a wellbeing unit to support prisoners with complex needs, which are difficult to meet in the normal prison environment. The unit includes a specialist palliative care cell. GP surgeries are held four days a week, with an out of hours service at other times.

HMP Full Sutton

21. HMP Full Sutton is a high security prison near York, that holds up to 626 adult men. Spectrum Community Health CIC provides a range of integrated health services. Healthcare staff are on duty 24 hours a day. An inpatient healthcare unit, with six beds, provides full nursing care for patients, including a palliative care suite.

HM Inspectorate of Prisons

HMP Hull

22. The most recent inspection of Hull was in March/April 2018. Inspectors found an increase in prisoners taking their own lives and incidents of self-harm. Although they acknowledged that the prison was working hard to tackle this, inspectors were concerned about the quality of casework for those in crisis and felt there was a greater need to offer support to vulnerable prisoners. Despite an increase in violence, inspectors noted that most prisoners felt safe, respected and knew of someone they could turn to for help. Inspectors found strong leadership and a positive staff culture which helped to maintain reasonably good outcomes for prisoners during challenging times.

HMP Full Sutton

23. The most recent inspection of Full Sutton was in February/March 2020. Inspectors reported that in terms of safety, Full Sutton had the lowest levels of violence in the high security estate with a comparatively small proportion of prisoners (22%) saying they felt unsafe. Challenge, Support and Intervention Plans (CSIPs) were well used. However, HMIP's survey found that prisoners with mental health problems (44%) had more negative views of their treatment, including their safety, than others.

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 Hull

25. In its latest annual report, for the year to March 2020 the IMB reported that prisoners were treated fairly and humanely and every effort was made to prepare them for release. The Board reported a reduction in violence, self-harm and substance misuse, and noted that staff provided prisoners with a continuous level of helpful support.

HMP Full Sutton

26. In its latest annual report, for the year to 31 December 2019, the IMB said the prison had a high emphasis on safety and security, but the number of prisoner-on-prisoner assaults had risen from 27 in 2018 to 38 in 2019. They noted that potential violence was proactively managed and that 240 challenge, support and intervention plans (CSIPs) were opened to investigate allegations of violence or bullying during the reporting year. The board noted that staff shortages had occasionally compromised the full provision of healthcare services, although waiting times to see a GP were comparable to those in the community.

Previous deaths

HMP Hull

27. Mr Sheehan's death was the 13th at Hull since June 2018. Of the previous deaths, six were from natural causes, five were self-inflicted and one is awaiting classification. We found no similarities between the previous investigations and our investigation into Mr Sheehan's death.

Full Sutton

28. There have been eight deaths at Full Sutton since June 2018. Six of the deaths were from natural causes, one was self-inflicted and one was a homicide. We found no similarities between the previous investigations and our investigation into Mr Sheehan's death.

Assessment, Care in Custody and Teamwork (ACCT)

29. Assessment, Care in Custody and Teamwork (ACCT) is the Prison Service care-planning system 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 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 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 on the caremap have been completed.
30. All decisions made as part of the ACCT process and any relevant observations about the prisoner should be written in the ACCT booklet, which accompanies the

prisoner as they move around the prison. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011, Management of prisoners at risk of harm to self, to others and from others (Safer Custody).

Imprisonment for Public Protection (IPP)

31. Sentences of Imprisonment for Public Protection (IPPs) were created by the Criminal Justice Act 2003 and started to be used in April 2005. They were designed to protect the public from serious offenders whose crimes did not merit a life sentence. Offenders sentenced to an IPP were set a minimum term (tariff) of imprisonment, after which they can apply to the Parole Board for release. The Parole Board will release an offender only if it is satisfied that they no longer pose a risk to the public. IPP sentences were abolished in December 2012. However, as at 30 September 2020, there were still 1,895 IPP prisoners and 94% of these were over tariff.

Key Events

32. On 14 June 2010, Mr Gary Sheehan was given an Imprisonment for Public Protection (IPP) sentence, with a minimum tariff of 24 months, for robbery.
33. On 4 December 2017, while he was a prisoner at HMP Kirklevington Grange (an open prison for Category D prisoners – the lowest security category for those who can be reasonably trusted not to try to escape), Mr Sheehan absconded from prison and was also found to be in possession of a bladed article. He received a further 12 months imprisonment and was returned to closed conditions.

HMP Full Sutton

2018-19

34. Mr Sheehan was moved to HMP Full Sutton, a high security prison that holds Category A and Category B prisoners, on 19 July 2018. (Category A prisoners are those whose escape would be highly dangerous to the public or national security for whom the aim is to make escape impossible. Category B prisoners are those who do not require maximum security but for whom escape must be made very difficult.)
35. On 22 February 2019, a mental health nurse saw Mr Sheehan after he made a self-referral to the mental health team. Mr Sheehan told the nurse that he was experiencing symptoms of anxiety and paranoia and felt that other prisoners were going to harm him. He declined input from the mental health team but the nurse provided him with self-help materials and a doctor prescribed sertraline for anxiety.
36. On 7 March, staff moved Mr Sheehan to the vulnerable prisoners (VP) wing after he said he was being threatened by other prisoners. Mr Sheehan did not give staff any information about the prisoners he thought were threatening him and staff were unable to investigate his allegations further. Mr Sheehan settled on the VP wing, started work and engaged in regular sessions with his key worker. Mr Sheehan's key worker noted no concerns about him.

2020

37. On 10 February 2020, Mr Sheehan told his key worker that the Parole Board were considering him for Category D status again. His key worker noted that Mr Sheehan felt positive about this and was looking forward to his forthcoming parole review.
38. On 15 March, Mr Sheehan barricaded himself in his cell and told staff that he was under threat from other prisoners. He allowed staff to come into his cell to speak to him about his concerns but he refused to give any details of the people who he alleged were threatening him. He said he had started taking his anxiety medication again and felt this may have affected him. He asked to remain locked in his cell for his own safety and to have his meals brought to him. Staff agreed to do this and started a Challenge, Support and Intervention Plan (CSIP) to support Mr Sheehan as a potential victim of violence.

39. On 20 March, the Parole Board approved Mr Sheehan's move to a Category D open prison to prepare him for release. They recommended a move to Kirklevington Grange.
40. On the same day, Mr Sheehan barricaded himself in his cell again and asked to be moved from the VP wing due to perceived threats from other prisoners. Staff contacted healthcare and a mental health nurse attended the wing to speak to Mr Sheehan along with prison staff. Mr Sheehan said he had stopped taking his medication and staff encouraged him to take it. Staff assured Mr Sheehan that he was safe in his cell on the VP wing.
41. Over the following weeks, staff continued to support Mr Sheehan on a CSIP, including daily monitoring, but he continued to refuse to give staff details of those he believed were threatening him. Staff brought his meals to his cell and offered him the option to come out for daily showers and telephone calls but he declined.
42. Mr Sheehan was given sertraline every 28 days to keep in his cell. Records show that staff escorted him to and from the pharmacy to collect a new supply on 26 March, but he did not collect any more after that.
43. Following concerns raised by wing staff about Mr Sheehan's mental state and failure to collect his medication, prison and healthcare staff held a multidisciplinary safety intervention meeting on 6 May to discuss his continued self-isolation. Staff noted that Mr Sheehan had exhibited similar behaviour in other prisons and that he did not appear to be distressed by the ongoing situation. Healthcare staff noted that there was no evidence of psychosis or delusional behaviour. Staff agreed that Mr Sheehan should be encouraged to take his medication and that a separate discussion should take place to review his longer term management.
44. Records from the prison's population management unit show that plans were made to move Mr Sheehan to Kirklevington Grange, as recommended by the Parole Board, but they refused to accept him as he had previously absconded from there. Staff tried to move Mr Sheehan to other lower category prisons but, due to risk issues around arson and threats to female staff, he was not accepted by any of them. As Mr Sheehan was not a high security prisoner and he was continuing to feel threatened at Full Sutton, staff decided to move him on to another prison as part of his sentence progression and to help him feel safer. However, we found no evidence that this information was communicated to Mr Sheehan.

HMP Hull

June 2020

45. On 8 June, Mr Sheehan was moved to HMP Hull, a Category B prison. Reception staff noted no current concerns about suicide or self-harm and assessed him as suitable to have his sertraline in-possession. The reception officer noted that Mr Sheehan said he felt anxious as he had his Category D status and had been expecting to go to Kirklevington Grange. Mr Sheehan was allocated a cell on the induction wing. COVID-19 rules relating to newly-arrived prisoners meant that Mr Sheehan needed to remain on the induction wing for 14 days.

46. On 15 June, Mr Sheehan's solicitor sent an email to the prison saying that Mr Sheehan had told them he was under threat from prisoners on the induction wing. The solicitor alleged that Mr Sheehan's life was "in immediate danger", that he was distressed and that he wanted to move to the VP wing. Staff spoke to Mr Sheehan and assured him that he was safe on the induction wing and there was no evidence that he was under threat. Mr Sheehan said he wanted to stay in his cell and did not want to come out to collect his meals. He asked staff to provide him with breakfast packs and said that he had enough food in his cell. Staff noted that Mr Sheehan understood he could move to the VP wing once he had completed 14 days on the induction wing.
47. On 17 June, a Supervising Officer (SO) spoke to Mr Sheehan who continued to have concerns about his safety. The SO noted that Mr Sheehan may have been experiencing situational anxiety and paranoia following his move from Full Sutton. He advised Mr Sheehan on how to make a self-referral to the mental health team and suggested he may need to have his medication reviewed. He told Mr Sheehan that his meals could not be brought to him in his cell so he encouraged him to come out of his cell to collect them.
48. On 18 June, staff moved Mr Sheehan to the VP wing as his anxiety worsened and he said he was not eating as he thought something had been put in his food.
49. On 20 June at around 6.45am, Mr Sheehan rang his cell bell and staff responded to find that he had cut his wrist. Healthcare staff attended and dressed his wounds. Staff started suicide and self-harm prevention procedures (known as ACCT).
50. A SO chaired Mr Sheehan's first ACCT review on 20 June at 11.00am. The review was also attended by a nurse, another SO and an officer. Mr Sheehan said that he had cut his wrist as he was under threat from prisoners at Hull. Staff again explained to him that there was no evidence that he was under threat and suggested he may be experiencing paranoia. Mr Sheehan agreed this might be possible and told staff that he had stopped taking his medication. Staff encouraged Mr Sheehan to start taking his medication again and included this as a caremap action. They also encouraged him to come out of his cell to collect his meals and get some exercise.
51. The nurse assessed that Mr Sheehan did not require a formal mental health assessment or any ongoing input from the mental health team. Mr Sheehan said he had no intention to harm himself or to take his life. Staff assessed his risk of suicide and self-harm as low and set observations at three conversations during the day and three checks during the night.

Events of 21 June

52. ACCT observation records show that the prison chaplain and a safer custody officer saw Mr Sheehan on the morning of 21 June. He said he was fine but he did not want to talk. Staff carried out ACCT checks on Mr Sheehan at 11.00am, 12.35pm and 1.15pm. He had refused to come out of his cell to collect his lunch but told staff he had eaten noodles that he had prepared himself. At the 1.15pm check, he handed staff a note addressed to the wing manager.
53. At around 1.30pm, a SO and an officer who knew Mr Sheehan from Full Sutton went to talk to him about the note he had written. In the note, he said he could hear

prisoners talking about him and that, when he had collected his lunch the previous day, prisoners were scowling at him. He said he did not feel safe. The SO spoke to Mr Sheehan about his ongoing concerns and assured him that staff and trusted prisoners were listening out and had heard nothing to suggest that he was under threat. Mr Sheehan said that it was probably all in his head and the SO said he did not appear to want to engage further.

54. At around 3.47pm, while carrying out the next ACCT check, an officer found Mr Sheehan hanging from the window bars in his cell. He had used a sheet as a ligature. Staff immediately cut him down and called a code blue (a medical emergency code which tells the control room that a prisoner is unresponsive or not breathing and that an ambulance needs to be called immediately) and started cardiopulmonary resuscitation (CPR). Healthcare staff arrived around five minutes later with emergency equipment. Prison and healthcare staff continued with CPR until paramedics arrived. Despite continued efforts of nearly an hour to resuscitate Mr Sheehan, paramedics pronounced his death at 4.45pm.

Contact with Mr Sheehan's family

55. Mr Sheehan's mother, who lives in Australia, was listed as his next of kin. At around 5.00pm (UK time) on 21 June, the prison's family liaison officer (FLO) contacted Mr Sheehan's mother by telephone to tell her that her son had died. The FLO noted that she asked Mr Sheehan's mother if there was any family in the UK that she should liaise with. Mr Sheehan's mother said she would contact her daughter (Mr Sheehan's sister). The FLO subsequently liaised with both Mr Sheehan's mother and his sister as next of kin.
56. The prison contributed to the cost of Mr Sheehan's funeral in line with national instructions.

Support for prisoners and staff

57. A prison manager debriefed the staff who were involved in the response when Mr Sheehan was found. The staff care team also offered support.
58. The prison posted notices informing other prisoners of Mr Sheehan'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 Sheehan's death.

Post-mortem report

59. At the time of writing this report, the post-mortem and toxicology reports had not been received from the coroner. However, the provisional cause of death was due to hanging.

Findings

Management of Mr Sheehan's risk of suicide and self-harm

60. Prison Service Instruction (PSI) 64/2011, Management of prisoners at risk of harm to self, to others and from others (Safer Custody), gives guidance to staff on how to identify, manage and support prisoners who are at risk of harm to themselves or others. It sets out the procedures (known as ACCT) that must be followed whenever staff assess that a prisoner is at risk of suicide or self-harm. The instruction highlights the need for ACCT reviews to be multidisciplinary and for healthcare staff to attend the first review.
61. We found that staff at Hull managed Mr Sheehan's ACCT appropriately and in accordance with PSI 64/2011 after he cut his wrists on 20 June 2020. The first review was multidisciplinary, records were clear and comprehensive, and observations were appropriate to Mr Sheehan's level of risk. Although Mr Sheehan took his life while being managed under ACCT procedures, we consider that staff's assessment of Mr Sheehan's level of risk was appropriate, and that the management of the ACCT procedures was reasonable. We therefore make no recommendation.

Violence reduction and self-isolation

62. From 2018, Mr Sheehan began making allegations that he was under threat from other prisoners. Records show that he often asked to be segregated for his own safety, but he did not provide staff with any information to enable them to investigate his allegations. We are satisfied that staff at Full Sutton and Hull put appropriate measures in place to address Mr Sheehan's concerns and to support him to the best of their ability, with the information available to them. Although Mr Sheehan continued to self-isolate at Hull and refused to leave his cell to collect his meals, we are satisfied that he was able to prepare food for himself and was offered the opportunity to leave his cell for showers, exercise and to make phone calls if required.
63. We found that the decision to move Mr Sheehan from Full Sutton to Hull was based partly on an attempt to make him feel safer and to end his ongoing self-isolation. However, during our investigation, we found no evidence that anyone at Full Sutton explained the reason for him moving to Hull rather than to a Category D prison (as agreed by the Parole Board) or explained the reasons why he was not accepted by Kirklevington Grange. While we accept that there were reasonable grounds to transfer him to Hull as a short-term measure on grounds of safety, we found that staff at Hull were unable to provide him with the reasons for this move as they were not clearly recorded by staff at Full Sutton.
64. Mr Sheehan told staff that he was self-harming because of his, almost certainly imaginary, fears that he was under threat from other prisoners. However, it seems likely that the move to Hull, rather than to an open prison, was likely to be a further source of anxiety and concern for him and it is unacceptable that the reasons for this move were not properly communicated to him before he was transferred to Hull. We recommend:

The Governor at Full Sutton should ensure that, where a decision is made not to implement a Parole Board recommendation, this is clearly communicated to the prisoner and appropriately recorded.

Mental health and medication

65. We are satisfied that staff at Full Sutton and Hull offered Mr Sheehan appropriate support for his mental health and advised him on how to make a self-referral if needed. During his time at Full Sutton he was assessed by the mental health team and found to be lucid with no signs of a mental health illness.
66. However, the clinical reviewer noted that although Mr Sheehan was prescribed sertraline (an antidepressant that also has a calming effect), he did not take it consistently which may have nullified its effects. Given Mr Sheehan's levels of anxiety and continued self-isolation, we are concerned that healthcare staff at both prisons did not do more to ensure his compliance with his mental health medication. We recommend:

The Heads of Healthcare at Full Sutton and Hull should ensure that healthcare staff monitor prisoners' compliance with medication, particularly mental health medication, by those self-isolating.

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