

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# **Independent investigation into the death of Mr Matthew Harris, a prisoner at HMP Long Lartin, on 29 May 2022**

**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

**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 Matthew Harris died in hospital on 29 May 2022, two days after he was found hanging in his cell at HMP Long Lartin. He was 41 years old. I offer my condolences to his family and friends.

Mr Harris had been in prison custody for less than two weeks, and at Long Lartin for only three days, when he was found hanging. He was monitored using suicide and self-harm prevention procedures (known as ACCT) for the entire time and was under constant supervision until around an hour before he was found hanging.

I am satisfied that staff managed the ACCT procedures appropriately and that the decision to stop constant supervision on 27 May was a reasonable one in the circumstances.

The clinical reviewer was satisfied that the care that Mr Harris received was equivalent to that which he could have expected to receive in the community. However, she was concerned that the handover from healthcare staff at HMP Swansea, where Mr Harris had spent 11 days before his transfer, to healthcare staff at Long Lartin was inadequate.

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

**Kimberley Bingham**  
**Acting Prisons and Probation Ombudsman**

**January 2023**

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# Summary

## Events

1. On 16 May 2022, Mr Mathew Harris was remanded in prison custody, charged with murder, and sent to HMP Swansea.
2. Mr Harris arrived at Swansea with a suicide and self-harm warning form because he had been found with a possible suicide note. Reception officers started suicide and self-harm monitoring (known as ACCT) and placed Mr Harris under constant supervision. Apart from around a 24-hour period between 17 and 18 May, Mr Harris remained under constant supervision throughout his time at Swansea.
3. Mr Harris was moved to HMP Long Lartin on 24 May. Staff continued constant supervision.
4. At around 10.00am on 27 May, at an ACCT review, staff decided to stop constant supervision. They set ACCT observations at four an hour. Shortly after 1.00pm, staff moved Mr Harris from the constant supervision cell to a normal cell.
5. At 2.09pm, during an ACCT check, an officer saw Mr Harris with a ligature around his neck that he had attached to the window bars. Officers and healthcare staff tried to resuscitate him until ambulance paramedics took over. Paramedics administered adrenaline and Mr Harris's pulse returned, but he was not breathing on his own. They took him to hospital, where he was put on a ventilator in intensive care.
6. On 28 May, hospital staff assessed that Mr Harris was brain dead. He was kept on life support until the next day so that his organs could be donated. At around 6.30pm on 29 May, a hospital doctor confirmed Mr Harris's death, shortly after his life support was switched off.

## Findings

7. We consider that the decision to stop constant supervision was a reasonable one in the circumstances. Constant supervision is not supposed to be in place for a prolonged time because it can feel oppressive. We consider that at the ACCT review on 27 May, the multidisciplinary team appropriately assessed Mr Harris's risk and reached a reasonable decision based on the information they had at that time.
8. We also consider that staff managed the ACCT process well. The case reviews indicate that staff made concerted efforts to work with Mr Harris to understand and reduce his risk of suicide and self-harm and that healthcare staff were involved in the process.
9. The clinical reviewer found that the standard of care that Mr Harris received at Long Lartin was equivalent to that which he could have expected to receive in the community. However, she was concerned that the handover of Mr Harris's clinical care between Swansea and Long Lartin was inadequate.

## Recommendations

- The Head of Healthcare at Swansea should ensure that staff carry out a prompt clinical handover to the receiving prison when a prisoner is transferred with, significant health issues, including when they are assessed as being at high risk of suicide and self-harm.

## 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. No one responded.
11. The investigator visited Long Lartin on 4 and 5 July 2022. He obtained copies of relevant extracts from Mr Harris's prison and medical records.
12. The investigator interviewed seven members of staff. He invited one prisoner to be interviewed but they declined. He conducted most of the interviews in person while at Long Lartin on 4 and 5 July. The other interviews took place by video call on 23 June.
13. NHS England commissioned an independent clinical reviewer to review Mr Harris's clinical care at the prison. She interviewed a further two members of staff by video call on 18 October.
14. We informed HM Coroner for Worcestershire of the investigation. She gave us the results of the post-mortem examination. We have sent her a copy of this report.
15. The Ombudsman's family liaison officer contacted Mr Harris's mother to explain the investigation and to ask if she had any matters she wanted us to consider. Mr Harris's mother wanted to know what treatment Mr Harris had received in prison and what had led to his death.

## Background Information

### HMP Long Lartin

16. HMP Long Lartin is a high security prison in the Vale of Evesham, Worcestershire. It holds up to 609 men across five main wings and two support wings. All prisoners are accommodated in single cells. The healthcare contract is held by Practice Plus Group, with mental healthcare provided by Midlands Partnership Foundation Trust.

### HMP Swansea

17. HMP Swansea is a local prison that holds around 500 men and young adult men. Healthcare is provided by Abertawe Bro Morgannwg University Health Board.

## HM Inspectorate of Prisons

### Long Lartin

18. The most recent inspection of HMP Long Lartin was a scrutiny visit in February 2021. Inspectors found there had been a 57% reduction in self-harm incidents, falling from 439 incidents in 2019 to 189 in 2020. There had been a slight rise in incidents in early summer 2020, which appeared to be due to frustration about the COVID-19 restrictions, and a small number of more complex individuals.
19. However, only 53% of prisoners who had been monitored due to risk of suicide and self-harm (known as ACCT) felt cared for by staff. A review of ACCT documents showed some good care planning, but many reviews were not multidisciplinary. Also, examples were found of staff not conducting the required number of observations on prisoners who were monitored under ACCT procedures, and managers' quality assurance checks did not identify this failing.
20. Inspectors reported that each new arrival received a comprehensive interview to identify any safety concerns, but this often took place at the reception desk in a communal area, which could have inhibited the sharing of some information.

### Swansea

21. The last full inspection of HMP Swansea was in August 2017. Inspectors noted that in their survey, a third of prisoners said that they felt depressed, suicidal or had mental health problems on arrival. Inspectors noted that there had been four self-inflicted deaths since their previous inspection in October 2014, all within a week of arrival. Inspectors observed friendly interaction between reception staff and prisoners but found that reception risk assessments were not sufficiently rigorous and first night procedures were inconsistent.
22. A scrutiny visit in August and September 2020 noted that prisoners had continuing and significant mental health needs and that ACCT procedures required improvement. In particular, inspectors noted that careplan actions were signed off too soon or not actioned quickly enough. 'Quality' conversations were not

consistently considered to be of a reasonable standard and observation timings were often too predictable.

## **Independent Monitoring Board**

23. 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.

## **Long Lartin**

24. In its latest annual report covering the year ending 31 December 2021, the IMB noted that the past year had presented many challenges for the safer custody team, as officers were regularly deployed to other areas of the prison to meet staffing shortfalls. However, there had been excellent initiatives and the safer custody team had continued to demonstrate its commitment to supporting vulnerable and complex prisoners.
25. The annual report also said that recent inquests highlighted the need for improvements to the ACCT system and for better resourcing for safer custody. It concluded that there were not enough trained ACCT assessors and family liaison officers working as a stand-alone safety group which is essential to ensure consistency of approach. Further training for current staff members was in place for 2022. It was hoped that these issues would be addressed urgently so that prisoners most at risk could be given the level of support that they needed.

## **Swansea**

26. In its latest annual report covering the year ending 31 May 2021, the IMB noted that the number of self-harm incidents had decreased significantly, though the overall prison population had also reduced significantly. Those subject to ACCT monitoring were allocated key workers who carried out regular checks. There was now a further check in progress involving a member of the safer custody team. The number of ACCTs opened significantly reduced in May 2020. By July, the figures were increasing, which is believed to have coincided with the opening up of the prison. Despite the increase, numbers were still low. Although March 2021 saw a further increase in ACCTs, it was still below last year's figures. However, the number of ACCTs as a proportion of the prison population was higher than last year, at 13.2% compared to 10.4%.

## **Previous deaths at HMP Long Lartin**

27. Mr Harris was the eleventh prisoner to die at Long Lartin since May 2020. Two of the previous deaths were self-inflicted and the rest were from natural causes. There are no similarities between the recommendation made in this investigation and those made in the investigations into the previous deaths.

## **Previous deaths at HMP Swansea**

28. There were three deaths of prisoners at Swansea between May 2020 and May 2022. Two were self-inflicted and one was unascertained. There are no similarities between our investigation findings in those cases and our findings in our investigation into Mr Harris's death.

## **Assessment, Care in Custody and Teamwork (ACCT)**

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. 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 carried out at irregular intervals to prevent the prisoner anticipating when they will occur. Regular multidisciplinary review meetings involving the prisoner should be held.

## Key Events

30. On 16 May 2022, Mr Mathew Harris was remanded in prison custody, charged with murder, and sent to HMP Swansea. It was not his first time in prison.
31. Mr Harris arrived at Swansea with a suicide and self-harm warning form as he had been found with a possible suicide note. He was also acting bizarrely and had a history of mental health issues, including suicide attempts. He also had a history of substance misuse and was prescribed an opiate substitute (buprenorphine). Reception officers started suicide and self-harm prevention procedures (known as ACCT) and placed Mr Harris under constant supervision (one-to-one observation).
32. The next day, at the first ACCT review, staff stopped constant supervision and set observations at four an hour, in addition to two conversations a day.
33. On 18 May, staff held another ACCT review and restarted constant supervision. Staff noted that Mr Harris had become withdrawn, was not eating, and was giving away his vape pens. Staff made a priority appointment for Mr Harris to see a psychiatrist on 25 May. (However, it was later decided that Mr Harris would be moved to another prison, and the psychiatric appointment should take place after the transfer.)
34. Between 19 and 24 May, Mr Harris had five ACCT reviews, and the mental health team visited him. Mr Harris told staff that he had thoughts of suicide and self-harm all the time but would not act on them. He said he felt paranoid that someone would kill him, he felt sad and found it difficult to relax because his head was full of thoughts.

## HMP Long Lartin

35. Mr Harris was moved to HMP Long Lartin on 24 May. He remained under constant supervision.
36. A nurse completed Mr Harris's reception health screen. She noted that Mr Harris engaged well but appeared overwhelmed and tearful at times. She noted that Mr Harris understood why he was under constant supervision but that he appeared fed up with it.
37. Mr Harris was located in the constant supervision cell in the healthcare unit. (Constant supervision cells are basic and have a transparent Perspex door through which staff can observe the occupant.) Healthcare staff at Long Lartin contacted Swansea's healthcare department and asked them for a handover about Mr Harris.
38. On 25 May, a healthcare administrator noted that she had received information about Mr Harris from a nurse at Swansea. She did not know Mr Harris and had contacted the community substance misuse team for information. They had said that they had no psychiatric reports for Mr Harris, that he had declined an assessment with their consultant psychiatrist and there was nothing in his presentation that ever caused them concern.

39. Later that day, two nurses saw Mr Harris for his second health screen and a mental health review. They noted that Mr Harris appeared tearful at times, felt low, and he said that he had been getting very little sleep. He said that he had thoughts of self-harm but no current intent. A nurse offered Mr Harris a course of sleeping tablets, which he accepted.
40. At 3.15pm, the Head of Safety chaired an ACCT review. The two nurses and a prison chaplain attended. The Head of Safety recorded that Mr Harris engaged well throughout the review but appeared confused at times. Mr Harris said he liked the staff at Long Lartin and felt supported by them. He told staff that he was struggling to get his head around his offence. Staff agreed to give him a TV and reading material. They agreed to keep Mr Harris under constant supervision as he had just arrived at Long Lartin and there was limited information about him.
41. On 26 May, an officer recorded that Mr Harris had been polite to staff, but it was difficult to engage him in conversation. He noted that Mr Harris had asked multiple times to stop being monitored under constant supervision.

## **Events of 27 May**

42. On 27 May at 10.00am, the Head of Safety chaired an ACCT review which Mr Harris, healthcare staff, a member of the IMB and a prison chaplain attended. The Head of Safety recorded that Mr Harris was polite and engaged well during the review, was eating and drinking well, taking his medication, and agreed to go to the exercise yard. Mr Harris had not harmed himself, and there had been no additional concerns raised since his last review. Mr Harris told staff that if he had any future thoughts about harming himself, he would tell them.
43. Mr Harris asked to be taken off constant supervision as he did not like the environment and wanted a standard cell. Staff decided to stop constant supervision and set observations at four an hour, with three conversations a day. They also noted that Mr Harris had a psychiatric appointment booked for 31 May.
44. Shortly after 1.00pm, staff moved Mr Harris from the constant supervision cell to a normal cell on the healthcare unit. During the move, Mr Harris took a plastic bag from a trolley that was on the wing landing.
45. At 2.09pm, Officer A went to Mr Harris's cell to carry out an ACCT check. When he looked in, he saw Mr Harris had a ligature around his neck and had attached it to the window bars in his cell. He quickly went to get Officer B from the wing office, which was just across the hall from Mr Harris's cell. Both officers then quickly went into Mr Harris's cell, and Officer B called a medical emergency code blue over the radio at 2.09pm. The control room called an ambulance at 2.10pm.
46. Both officers cut Mr Harris down and laid him on the floor. They noticed that Mr Harris had put hard-boiled eggs and plastic in his mouth and nose. They removed these items and started cardiopulmonary resuscitation (CPR).
47. A nurse arrived at the cell, followed by other healthcare staff. She noted that Mr Harris had no pulse and was not breathing. Staff used a defibrillator on Mr Harris, but it did not detect a shockable rhythm. An officer removed more hard-boiled egg,

wrapped in plastic, from Mr Harris's mouth. A nurse used a suction machine to remove any objects still left in Mr Harris's mouth and nose and gave him oxygen.

48. The air ambulance landed outside the prison at 2.33pm, and a further two ambulances arrived at the prison gate at 2.40pm. The air ambulance crew attended Mr Harris's cell at 2.42pm, followed by the other ambulance crews at 2.47pm.
49. Ambulance paramedics administered adrenaline and Mr Harris's pulse returned, but he was still not breathing on his own. At 3.24pm, an ambulance crew took Mr Harris to hospital.
50. At 11.50am on 28 May, Mr Harris's family arrived at the hospital to visit him. At 12.51pm, hospital doctors told them that Mr Harris was brain dead. Mr Harris's family agreed to donate his organs for transplant.
51. On 29 May, after the police and the Coroner gave clearance, doctors removed Mr Harris's organs ready for transplant. They turned off his life support and at around 6.30pm, confirmed his death.

### **Contact with Mr Harris's family**

52. On 27 May, the prison appointed a prison manager as the family liaison officer (FLO). He telephoned Mr Harris's family and told them that Mr Harris was in hospital.
53. On 28 May, the FLO attended the hospital to support Mr Harris's family. He maintained contact with Mr Harris' family over the following weeks, offering support and advice.
54. The prison contributed to the costs of Mr Harris's funeral in line with national policy.

### **Support for prisoners and staff**

55. After Mr Harris's death, the Head of Safety and a Trauma Risk Management practitioner debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support.
56. The prison posted notices informing other prisoners of Mr Harris's death and offering support.

### **Post-mortem report**

57. The doctor gave Mr Harris's cause of death as hypoxic ischaemic encephalopathy (brain damage caused by lack of oxygen to the brain) caused by cardiac arrest (when the heart stops pumping blood around the body) which in turn was caused by hanging. The Coroner accepted the cause of death given by the hospital doctor and no post-mortem examination was carried out.

## Findings

### Management of Mr Harris's risk of suicide and self-harm

58. Prison Service Instruction (PSI) 64/2011, Management of prisoners at risk of harm to self, to others and from others (Safer Custody), sets out the procedures (known as ACCT) that should be followed when a prisoner is identified as being at risk of suicide and self-harm.
59. Mr Harris was supported using ACCT during the whole time he was in prison. Staff started ACCT monitoring when Mr Harris arrived at Swansea and continued it when he was moved to Long Lartin on 24 May. We consider that Long Lartin managed the ACCT process well. The case review records show that staff made concerted efforts to work with Mr Harris to understand and reduce his risk of suicide and self-harm, and that healthcare staff were involved in the process.
60. We are satisfied, having viewed the CCTV footage for 27 May, that officers carried out four checks an hour on Mr Harris after staff stopped constant supervision.

### The decision to take Mr Harris off constant supervision

61. PSI 64/2011 says that constant supervision must only be in place for the shortest time possible and used as a last resort. It says that this is important because constant supervision can feel oppressive and may be distressing for the prisoner.
62. Mr Harris was placed on constant supervision when he arrived at Swansea on 16 May and apart from around 24 hours between 17 and 18 May, this continued at Swansea until his transfer to Long Lartin on 24 May. Staff at Long Lartin continued constant supervision until around 1.00pm on 27 May.
63. At the case review at 10.00am on 27 May, Mr Harris asked to be taken off constant supervision as he said that he found it uncomfortable and did not need a staff member watching him. A multidisciplinary team at the case review, which included healthcare staff, decided to stop constant supervision. We consider that this decision was reasonable in the circumstances. Mr Harris had been on constant supervision for an extended period of time, he had not self-harmed and there was no indication that he was at imminent risk of suicide. He remained on four observations an hour so was still subject to frequent checks.

### Clinical care

64. The clinical reviewer was satisfied that the physical and mental healthcare that Mr Harris received at Long Lartin was equivalent to that which he could have expected to receive in the community. However, she was concerned that the handover from Swansea to Long Lartin was inadequate. The information provided was based solely on information from the community substance misuse team and contained nothing about the clinical care and assessments that Mr Harris had received at Swansea. We recommend:

**The Head of Healthcare at Swansea should ensure that staff carry out a prompt clinical handover to the receiving prison when a prisoner is transferred with significant health issues, including when they are assessed as being at high risk of suicide and self-harm.**

## **Inquest**

65. The inquest, heard between 12 and 20 June 2023, concluded that Mr Harris died from suicide.

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