

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# **Independent investigation into the death of Mr Scott McLellan, a prisoner at HMP Frankland, on 24 February 2022**

**A report by the Prisons and Probation Ombudsman**

## OUR VISION

**To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.**

## WHAT WE DO



## WHAT WE VALUE



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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 Scott McLellan was found hanging in his cell at HMP Frankland on 24 February 2022. He could not be resuscitated and died of pressure on the neck as a result of hanging. He was 40 years old. I offer my condolences to his family and friends.

Mr McLellan arrived at Frankland in 2016 and seemed settled there. However, on 4 January 2022, staff started suicide prevention procedures (known as ACCT), when they noticed that Mr McLellan had become very low in mood. They continued ACCT procedures until 1 February.

My investigation found that the ACCT procedures were mostly well managed, but I am concerned that mental health staff were not present when the decision was taken to stop ACCT monitoring. Mr McLellan's wing was in lockdown due to COVID-19 and there was confusion about who was allowed on the wing.

Mr McLellan's close friend, who lived on the same wing, said he was shocked at Mr McLellan's death as he did not expect him to take his life at that time. I am satisfied that staff would not have known that Mr McLellan was at imminent risk of suicide.

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**

**October 2022**

# Contents

Summary .....	1
The Investigation Process.....	3
Background Information.....	4
Key Events.....	5
Findings .....	10

# Summary

## Events

1. In September 2015, Mr Scott McLellan was sentenced to 22 years in prison for sexual offences. He was moved to HMP Frankland on 6 May 2016.
2. On 4 January 2022, an officer started suicide and self-harm monitoring (known as ACCT) for Mr McLellan as he seemed very low. He told staff that the anniversary of his first suicide attempt in 2015 was approaching. He said that he would normally get through this period by keeping busy, but the reduced regime due to COVID-19 was making this difficult. Staff continued ACCT monitoring until 1 February when Mr McLellan said he was dealing with his issues and was no longer in crisis.
3. An officer held an ACCT post-closure review with Mr McLellan on 14 February. He was satisfied that Mr McLellan was much happier and did not need to be monitored using ACCT.
4. On the afternoon of 24 February, staff found Mr McLellan hanging in his cell. They tried to resuscitate him but were unsuccessful. At 2.01pm, a prison GP pronounced that Mr McLellan was dead.
5. A close friend of Mr McLellan, who lived on the same wing, said he was shocked at McLellan's death as he had no idea that Mr McLellan was contemplating taking his life at that time.

## Findings

6. We are satisfied that in the few weeks before his death, Mr McLellan gave no indication to staff that he was at imminent risk of suicide.
7. We found that the ACCT procedures were mostly well managed. However, we are concerned that mental health staff were not at all the ACCT reviews, including the final one when staff decided to stop ACCT monitoring. Staff wrongly believed that mental health staff were not allowed onto Mr McLellan's wing as it was in lockdown due to a COVID-19 outbreak. Not only did they not invite them, but they also failed to obtain input by telephone.
8. Mr McLellan also missed a GP appointment on 24 January due to the misunderstanding about the COVID-19 restrictions. A prison GP did not see him until 17 February. Although the GP agreed to increase Mr McLellan's antidepressant medication, he forgot to action it and it was not picked up until four days later. The GP attributed this to a heavy workload and human error. We have not made a recommendation but note the clinical reviewer's concerns about this.

## Recommendations

- The Governor and Head of Healthcare should ensure that staff hold multidisciplinary ACCT reviews, to include healthcare staff, where possible.
- The Governor and Head of Healthcare should ensure that a process is in place to enable healthcare professionals to access prisoners in the event that a wing becomes isolated due to COVID-19 or other infections.

## The Investigation Process

9. The investigator issued notices to staff and prisoners at HMP Frankland informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
10. The investigator obtained copies of relevant extracts from Mr McLellan's prison and medical records.
11. The investigator interviewed eight members of staff and a prisoner on 11 and 21 April, and 12 May.
12. NHS England commissioned an independent clinical reviewer to review Mr McLellan's clinical care at the prison. She jointly interviewed seven members of staff and a prisoner.
13. We informed HM Coroner for County Durham and Darlington of the investigation. The Coroner gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.
14. We shared our initial report with HM Prison and Probation Service (HMPPS). There were no factual inaccuracies.
15. We provided Mr McLellan's next of kin with a copy of our initial report. There were no factual inaccuracies.

## **Background Information**

### **HMP Frankland**

16. HMP Frankland is a high security prison. It holds up to 852 men. There is 24-hour inpatient care. Spectrum CIC Healthcare provides primary care, GP, substance misuse and pharmacy services. Tees, Esk and Wear Valleys Mental Health Foundation Trust provides mental health services.

### **HM Inspectorate of Prisons**

17. The most recent inspection of HMP Frankland was in January 2020. Inspectors reported that levels of self-harm had risen and were higher than similar prisons. They said that the issue needed greater prioritisation. Inspectors found the quality of ACCT documentation was variable, despite efforts to improve this. The Safer Custody meeting was poorly attended which meant useful data was not shared.

### **Independent Monitoring Board**

18. 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 30 November 2021, the IMB reported that the number of self-harm incidents had reduced by approximately 25 per cent from the previous year. This compared favourably with other prisons in the Long-Term High Security Estate.

### **Previous deaths at HMP Frankland**

19. Mr McLellan was the eighteenth prisoner to die at Frankland since February 2020. All the previous deaths were from natural causes.

### **Assessment, Care in Custody and Teamwork**

20. 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. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011. 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.
21. 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.

## Key Events

22. In February 2015, Mr Scott McLellan was remanded in prison custody, charged with sexual offences. In September, he was sentenced to 22 years in prison. He was moved to HMP Frankland on 6 May 2016.
23. Prison staff monitored Mr McLellan using suicide and self-harm prevention procedures (known as ACCT) on two occasions in 2015, the first when he arrived in prison and the second when he tried to hang himself a couple of weeks later. There were no further suicide attempts after Mr McLellan moved to Frankland and he seemed settled there. Staff and prisoners described him as cheerful and talkative. He was also a Listener (a prisoner trained by the Samaritans to support prisoners in crisis).
24. On 23 December 2021, Officer A noticed that Mr McLellan seemed low. Mr McLellan said there were a few upcoming dates which affected his mood, but he said he had no thoughts of suicide or self-harm. The officer suggested he should speak to a fellow Listener and that he should continue to speak to staff. She recorded that she had no concerns at that time.
25. Officer A spoke to Mr McLellan again on 1 January 2022, as he was still not his usual talkative self and was not engaging with his peers as he usually did. Mr McLellan became tearful and said he had some trigger dates coming up, such as family birthdays. Mr McLellan said he had previously dealt with these by harming himself. He said he had had thoughts of suicide since his early 20s and though he did not currently have those thoughts, he felt low. She encouraged Mr McLellan to talk to his peers, other prisoners and staff, if he felt at risk of harming himself. He said he would. Mr McLellan said he was concerned about his ongoing migraines and nosebleeds but felt comfortable on A Wing and had people he could talk to. The officer told wing staff about this conversation.
26. Three days later, on 4 January, Mr McLellan told Officer A he still felt low. He did not reply when she asked whether he had thoughts of suicide. She started ACCT monitoring. Mr McLellan was unhappy about this and did not speak to Officer A for a while.
27. On 5 January, a senior officer (SO) met Mr McLellan for the first ACCT case review. However, as the SO had been unable to get anyone from the mental health team to attend, he deferred the case review to the next day. He put Mr McLellan on two observations an hour and three conversations a day.
28. Later that day, Mr McLellan refused a mental health assessment, but a prison GP prescribed an antidepressant (sertraline).
29. On 6 January, the SO held the ACCT review with Mr McLellan. Two mental health nurses attended. Mr McLellan was very emotional and said the trigger was the anniversary of his first suicide attempt in 2015. He said he dealt with these feelings every year and was usually able to work his way through it by keeping busy. However, due to the restricted regime caused by COVID-19, he was struggling. He said he had a plan to end his life. As staff were concerned that Mr McLellan was at

imminent risk of suicide, they placed him under constant supervision. They also removed him from Listener duties.

30. The duty governor held the next review on 7 January. Two mental health nurses attended the review. Mr McLellan was much calmer than the previous day and said he did not think he needed to remain under constant supervision and that four checks an hour would be enough. He said he had realised how much support he had on the wing and the impact his death would have on others, which had changed his thought process. One nurse expressed concern about the drastic change in Mr McLellan since the previous day and recommended he should remain under constant supervision. Staff decided that Mr McLellan would remain under constant supervision during patrol states and nights but checked four times an hour at all other times.
31. The duty governor held a brief ACCT review on 8 January. He noted that mental health staff were not available. Mr McLellan said he felt positive and did not need to remain under constant supervision. He noted that there would be a full review on 10 January, that the mental health team would attend and there would be a full discussion then.
32. At the ACCT review on 10 January, Mr McLellan said that he was finding constant supervision intrusive. He said that he had now been prescribed antidepressants, was dealing with his suicidal thoughts and had been referred to a counsellor. He had also been prescribed a nasal spray for his nosebleeds and headaches. Staff agreed that Mr McLellan should be taken off constant supervision and set observations at four an hour with three meaningful conversations a day.
33. A custodial manager (CM) held an ACCT review on 17 January. She noted that the mental health team could not attend. Mr McLellan said he felt much better and asked if his level of observations could be reduced as he no longer needed that level of support. He also asked if he could resume Listener duties. Staff agreed to this and reduced his observations to one an hour with three meaningful conversations a day.
34. At the next case review on 20 January, Mr McLellan appeared cheerful and relaxed. He said he was pleased to have been reinstated onto the Listeners rota. He expressed concern about continuing migraines and nose bleeds but said healthcare staff were investigating this. Mr McLellan said that his thoughts of suicide and self-harm were always present, but he had lived with them for years and had no current plans to act on them. He said he spoke daily to his friend and fellow Listener, who was a positive and calming influence. Mr McLellan asked for his observations to stay the same for a few more days, to which staff agreed. They scheduled the next case review for 25 January. However, an interim review was held on 21 January, due to the death of another prisoner at Frankland. (Mr McLellan said he had not known the prisoner and felt okay.)
35. Staff held the next ACCT review on 25 January. No healthcare staff attended. (Members of the mental health team told the investigator that they were no longer invited to Mr McLellan's ACCT case reviews.) Mr McLellan's wing had become a COVID-19 outbreak site, so he had missed an appointment with a prison GP. Staff said this would be rearranged.

36. A SO met Mr McLellan for an ACCT review on 1 February, with a CM. (When interviewed, the SO said he was unable to ask anyone else to attend as the wing was in lockdown due to a COVID-19 outbreak and non-essential staff were not permitted on the wing.) Mr McLellan mentioned a key date was coming up and that he always felt low in the lead up to it but was now dealing with it and did not feel in crisis. He said he had no plans, thoughts or intentions of suicide or self-harm. The SO and CM agreed to end ACCT monitoring.
37. A SO met Mr McLellan for an ACCT post-closure review on 14 February. Mr McLellan said he was in a much better place and much happier, and no longer felt he needed ACCT support. He said that he knew who to speak to if he needed to in future and thanked staff for their support. The ACCT remained closed.
38. A prison GP saw Mr McLellan on 17 February (rearranged from 24 January). Mr McLellan said he had no thoughts of suicide or self-harm, but said he felt “snappy”. They discussed a nasal spray for his migraines, and Mr McLellan asked for his sertraline dose to be increased. The GP increased it from 50mg to 100mg. However, this was not actioned until another GP review took place on 21 February.
39. At 5.56pm on 22 February, Mr McLellan made his last telephone call to a Samaritan involved in the Listener scheme. They discussed another Listener possibly breaking confidentiality, which the Samaritan said she would investigate. They then spoke about upcoming Listener training, which Mr McLellan said he was happy to attend.

## **Events of 24 February 2022**

40. A friend spoke to Mr McLellan in the medication queue during the morning. They had a laugh and a joke, and the friend said he would see Mr McLellan later that afternoon for a chat.
41. Officer A had worked on A Wing that morning and said that Mr McLellan asked her if it was true that she was leaving. She said she was not leaving the prison but was moving to another wing. She assured Mr McLellan that he would continue to receive support from A Wing staff. Mr McLellan seemed happy with this.
42. Officer A unlocked Mr Burnett’s cell for lunch at approximately 12.10pm, and noticed it was in darkness. Mr McLellan said he had a headache and was not hungry. She asked a colleague to try to persuade Mr McLellan to collect his lunch, but he did not collect it.
43. Officer A returned from lunch at 1.35pm. As she passed Mr McLellan’s cell, she saw an envelope poked through a gap in the door addressed to her, which had not been there earlier. She added the envelope to the bottom of a pile of television magazines and an ACCT document she was carrying. She then began to distribute the magazines.
44. Officer A arrived at Mr McLellan’s cell at approximately 1.40pm. She opened his cell door observation panel and saw Mr McLellan suspended from the window bars from a dressing gown cord he had used as a ligature. She immediately shouted for staff assistance and another officer rang the wing’s alarm bell. She could not radio a medical emergency code blue as she was unable to join the radio net due to

heavy traffic of staff logging in after lunch. A code blue was called by another member of staff, although the investigator could not identify who this was.

45. Officer B, who was on the wing, immediately joined Officer A, and they went into Mr McLellan's cell. Officer A used her anti-ligature knife to cut the ligature, and the officers laid Mr McLellan on the floor. Officer A could not feel a pulse in Mr McLellan's neck, so immediately began to give chest compressions while Officer B cleared Mr McLellan's airway and gave rescue breaths.
46. A nurse had heard the alarm bell on A Wing at 1.42pm. As she was the nurse covering the healthcare response radio, she immediately went to the wing. She said she heard a medical emergency code blue while on her way.
47. The nurse arrived at Mr McLellan's cell and saw two prison officers giving him CPR. She told them to continue, while she inserted an i-gel and bag to give Mr McLellan oxygen.
48. A prison GP arrived at Mr McLellan's cell with a healthcare assistant at 1.45pm. CPR was ongoing, one officer giving chest compressions and another giving rescue breaths. A defibrillator was not advising any shocks. Two more nurses arrived at the cell. CPR continued for another 19 minutes when, at 2.01pm, all staff agreed CPR should stop and the GP pronounced Mr McLellan's death. Paramedics arrived at Mr McLellan's cell at 2.02pm and confirmed that Mr McLellan had died.

### **After Mr McLellan's death**

49. Officer A did not read the note that Mr McLellan had left her and was unaware of its contents until after his death. It said he wanted everyone to think he was in a good place, that it was not her fault, but her leaving had messed up his head. He said it would have happened sooner or later. He concluded the note with goodbye in Polish.

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

50. A SO was appointed as family liaison officer. He tried to contact Mr McLellan's next-of-kin, but the telephone number recorded in Mr McLellan's prison record was incorrect and the address did not exist. The prison's police liaison officer discovered Mr McLellan's family had moved to Scotland. They were unwilling to disclose their address to the prison, so Police Scotland delivered the news of Mr McLellan's death.
51. The prison contributed to the cost of Mr McLellan's funeral, in line with national instructions.

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

52. After Mr McLellan'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.

53. The prison posted notices informing other prisoners of Mr McLellan'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 McLellan's death.

### **Post-mortem report**

54. The post-mortem report concluded that Mr McLellan died from pressure on the neck due to hanging.

# Findings

## Assessment of Mr McLellan's risk of suicide and self-harm

55. 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 staff should follow when they assess that a prisoner is at risk of suicide and self-harm.
56. Officer A started ACCT monitoring on 4 January 2022, when Mr McLellan's mood changed, and he seemed low. Most of the ACCT reviews, observations and ongoing entries were well managed. However, some ACCT procedures were not always managed correctly.
57. PSI 64/2011 says that healthcare staff should always be invited to the first case review and that case reviews should be multidisciplinary where possible. There was no healthcare input to the first case review on 5 January, although a SO rescheduled it for the next morning, when mental health nurses attended. However, mental health staff were not at all Mr McLellan's ACCT case reviews, and they did not attend any after 20 January. Mental health staff told the investigator that they thought Mr McLellan's ACCT had been closed, as they knew nothing about any subsequent reviews.
58. Mr McLellan's wing was in lockdown at that time due to a COVID-19 outbreak. Wing staff said they thought healthcare staff were not allowed on the wing as they were not essential staff. This was incorrect.
59. We are concerned that Mr McLellan's ACCT was closed on 1 February, with no healthcare input. Even though wing staff wrongly thought healthcare staff were unable or unwilling to visit the wing, they should have at least requested their input by telephone. We recommend:

**The Governor and Head of Healthcare should ensure that staff hold multidisciplinary ACCT reviews to include healthcare staff where possible.**

## Clinical care

60. In addition to mental health nurses not attending Mr McLellan's later ACCT case reviews due to a misunderstanding about the COVID-19 restrictions, Mr McLellan also missed an appointment with a prison GP on 24 January. He did not get to see the GP until 17 February. We recommend:

**The Governor and Head of Healthcare should ensure that a process is in place to enable healthcare professionals to access prisoners in the event that a wing becomes isolated due to COVID-19 or other infections.**

61. When a prison GP saw Mr McLellan on 17 February, he agreed to increase Mr McLellan's antidepressant medication from 50mg to 100mg. However, the increase was not actioned until 21 February, when Mr McLellan saw another GP. When interviewed, the GP said he must have forgotten to send the increase request to the

pharmacy. He attributed this to a heavy workload and human error. We do not make a recommendation but note the clinical reviewer's concerns about this.

62. The clinical reviewer found that the care Mr McLellan received for his physical health was equivalent to that which he could have expected to receive in the community. However, she found that his mental health care was not equivalent.

## **Emergency response**

63. Staff who found Mr McLellan were aware they needed to radio a medical emergency code blue but were unable to do so as the traffic on the prison network was too heavy. Officer A called for staff assistance and immediately went into Mr McLellan's cell, while another officer pressed the wing's alarm bell. There is a record that a code blue call was made at 1.44pm, but the investigator was unable to determine who called this.
64. Staff knew the process for calling an emergency code but were unable to do so. They focused on going into Mr McLellan's cell and giving CPR. We do not make a recommendation about this but wanted to bring the difficulty of accessing the radio net to the Governor's attention.

## **Inquest**

65. At the inquest, held on 15 February 2024, the jury concluded that Mr McLellan died by suicide.

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