Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Lee James, a prisoner at HMP Long Lartin, on 16 December 2020

A report by the Prisons and Probation Ombudsman

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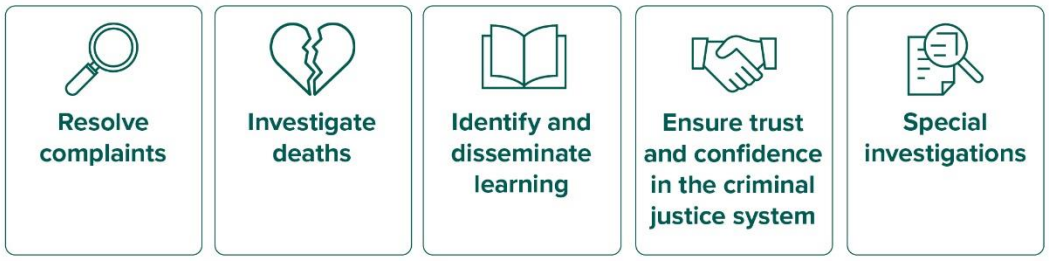
OUR VISION

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.

If my office is to best assist HMPPS in ensuring the standard of care received by those in prison is appropriate then our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.

Mr Lee James was found hanged in his cell in the segregation unit at HMP Long Lartin on 16 December 2020. He was 44 years old. I offer my condolences to Mr James' family and friends.

Mr James had been at HMP Long Lartin since July 2017 and in prison since 2008. During his time in prison, Mr James had been subject to suicide and self-harm monitoring (ACCT) procedures numerous times. He was subject to ACCT monitoring when he died.

My investigation found that, at the time of Mr James' death, there were deficiencies in ACCT management at Long Lartin. However, the Governor has undertaken work to improve the delivery of prisoner safety at the prison and both HM Chief Inspector of Prisons and the Independent Monitoring Board have found examples of good multidisciplinary work to support complex prisoners at risk of suicide and self-harm.

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

Adrian Usher
Prisons and Probation Ombudsman **October 2023**

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Summary

Events

1. Mr Lee James was remanded in prison on 9 January 2008, charged with murder. On 22 December 2008, he was sentenced to life imprisonment and received a tariff of 27 years.

2. Mr James was transferred to HMP Long Lartin on 12 July 2017, having spent time at HMP Belmarsh, Frankland and Full Sutton. Between July 2017 and April 2019, he was subject to suicide and self-harm monitoring procedures (known as ACCT), on six occasions after he said that he intended to harm himself.

3. On 26 November 2019, Mr James was transferred to HMP Belmarsh to facilitate visits with his mother, who was unwell. During his time there, he was found in his cell with a ligature around his neck. Staff started ACCT monitoring and placed him on constant supervision until 11 December.

4. On 15 January 2020, Mr James was transferred back to Long Lartin. Staff held an ACCT review, and he was supported under ACCT procedures until 22 January. Mr James was subject to ACCT monitoring a further four times between June and December 2020. On each occasion he told staff that he was concerned for his mother's health and was frustrated about his accumulated visits and possible transfer to facilitate these.

5. On 14 December, Mr James made threats towards a member of staff. Officers restrained him and moved him to the segregation unit. Prison staff started ACCT monitoring after Mr James said that he was going to kill himself. Staff checked him every hour.

6. On the morning of 16 December, an officer completed an ACCT check on Mr James. He recorded that he was asleep, and that he had noted movement. At 7.45am, the officer completed a further observation check. Mr James was in bed.

7. At 8.30am, another officer made an entry in Mr James' ACCT document and recorded that he had checked on Mr James. He recorded that Mr James was asleep on his left side and that he had noted movement. However, the officer later admitted that he had not checked Mr James as he should have done and had falsified the record. The officer resigned from his post while under investigation by HMPPS.

8. At approximately 9.05am, an officer went to Mr James' cell to give him his medication. When he entered the cell, he found Mr James suspended by a ligature around his neck. At 9.07am, the officer called a medical emergency code, staff attended and begun cardiopulmonary resuscitation (CPR). Nursing staff attended and noted signs that Mr James had been dead for some time. They decided to stop CPR at 9.15am. A prison GP confirmed his death at 9.30am. Paramedics arrived at around 9.45am.

Findings

9. Mr James had been in prison for many years when he died. He was a complex man who had been supported by ACCT procedures a number of times. He often threatened suicide or self-harm, and this was particularly likely when he felt frustrated by aspects of prison life. Generally, staff at Long Lartin tried to support him and were actively pursuing the transfer he so keenly wanted.

10. Mr James had been back at Long Lartin for several months when he died. In that time, he had been subject to ACCT procedures, including when he died, and staff had tried to balance the need to keep him safe with his obvious dislike for the additional monitoring required by the ACCT process.

11. Healthcare staff were not always as involved in the ACCT process or subsequent decisions as they should have been and there were missed opportunities for multidisciplinary working. Too many staff involved in Mr James' ACCT plans were not sufficiently trained. Since Mr James' death, the Governor has made a number of changes to the delivery of ACCT procedures and suicide and self-harm prevention at Long Lartin.

12. The clinical reviewer concluded that the clinical care Mr James received at Long Lartin was of a good standard and was equivalent to that which he could have expected to receive in the community.

13. Two members of staff involved in Mr James' care were subject to internal disciplinary investigations and subsequent police investigations (which ultimately did not result in criminal charges). One officer was given a final warning and the other resigned from the Prison Service.

Recommendation

- The Governor should provide the PPO with an update on the improvements in relation to safety and the management of the ACCT process that have taken place at HMP Long Lartin since December 2020.

The Investigation Process

14. HM Prisons and Probation Service (HMPPS) notified us of Mr James' death on 16 December 2020.

15. 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 us. No one responded.

16. Our investigation was suspended until 22 September 2022, to allow the police to conduct an investigation into staff actions and to be considered by the Crown Prosecution Service (CPS).

17. The investigator visited HMP Long Lartin on 12 October 2022. Copies of relevant extracts from Mr James' prison and medical records had already been obtained.

18. The investigator interviewed four members of staff at Long Lartin on 19 October.

19. NHS England commissioned a clinical reviewer to review Mr James' clinical care at the prison. The investigator and clinical reviewer conducted joint interviews with seven healthcare staff between 5 and 15 December 2022.

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

21. The Ombudsman's family liaison officer contacted Mr James' family in January 2021, to explain the investigation and to ask if they had any matters, they wanted us to consider. Ms Laing contacted the family again in September 2022, to inform them that our investigation had resumed.

22. The family asked the following questions:

    - Where was Mr James at the time of his death?
    - How had he taken his life?
    - What level of observations was he supposed to have been on; and
    - When was Mr James last observed?

    We have answered the family's questions in this report.

23. The family received a copy of our initial report, but no feedback was received regarding our findings or factual accuracy.

24. An inquest was concluded on 8 April 2024. The Coroner gave the cause of death as hanging by ligature, and concluded that:

    '… On the morning of 16th December 2020 Lee James died at HMP Long Lartin having been discovered suspended by a ligature attached to a window in his cell. It is admitted that the first ACCT case review on 14th December 2020 was chaired by

a prison officer who was not suitably trained to perform that role. It cannot be concluded that this failing possibly caused or contributed to Lee James' death on 16th December 2020. It is admitted that no ACCT observation check was carried out on Lee James between 0745hrs and 0905hrs on 16th December 2020, and that a false entry was made in the ACCT 'on-going record' at 0830hrs which made it appear as though an ACCT observation check had been carried out at that time. It cannot be concluded that this failing possibly caused or contributed to Lee James' death on 16th December 2020 ...'

Background Information

HMP Long Lartin

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

HM Inspectorate of Prisons (HMIP)

26. The most recent inspection of HMP Long Lartin was December 2022. Inspectors said that the standard of assessment, care in custody and teamwork (ACCT) case management documentation for prisoners at risk of suicide or self-harm was variable, but they found good examples of multidisciplinary work to support the individual care of some prisoners with complex needs. There had been some useful efforts to bring in families to support vulnerable prisoners.

27. The inspection also found that weekly Safety Intervention Meetings (SIM) were well attended and again evidenced appropriate multidisciplinary care planning for the most complex prisoners.

Independent Monitoring Board

28. 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 their most recent annual report, for the year to December 2022, the IMB reported that the safety policy was dictated by a safety strategy document which was issued in January 2022. Weekly safety intervention meetings (SIMs) to review management of individual prisoners at risk, and monthly safer custody meetings to manage performance, were chaired by the head of safety and equalities, and helped to maintain staff focus on safety issues. These meetings were well minuted and actions were pursued. In addition, safety staff attend weekly inclusion multidisciplinary team (MDT) meetings to consider complex cases.

Previous deaths at HMP Long Lartin

29. Mr James was the sixth prisoner to die at Long Lartin since December 201. Of the previous deaths, one was self-inflicted, two were from natural causes and two were drug related. There have been a further ten deaths at Long Lartin since Mr James' death, one of which was self-inflicted. There were no similarities between the findings in this investigation and those in earlier investigations.

Assessment, Care in Custody and Teamwork

30. 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

31. On 9 January 2008, Mr Lee James was remanded to HMP Belmarsh charged with murder. On 22 December, he was found guilty and sentenced to life imprisonment with a tariff of 27 years. He was 32 years old.

32. During his time at Belmarsh, Mr James was placed on suicide and self-harm prevention measures (known as ACCT) on two occasions, to provide additional support during to his ongoing court case and subsequent sentencing.

33. From November 2009 to June 2017, Mr James was transferred between HMP Frankland and Full Sutton. During this time, he was placed on ACCT monitoring after he took an overdose of prescribed medication and self-harmed. He was also placed in the segregation unit after he made threats to assault a member of staff and described feeling under threat from other prisoners because he believed they were aware of his offence. The victim of Mr James' offence was of Muslim faith, and Mr James believed that because of this, he was at risk from Muslim prisoners. Mr James was concerned about this throughout his time in prison, although there were no recorded incidents to substantiate his concerns.

HMP Long Lartin

34. On 12 July 2017, Mr James was transferred to HMP Long Lartin. His behaviour was generally good, and he engaged with offending behaviour programmes and targets. However, there were a number of times when he had disagreements with other prisoners, and his behaviour became difficult for staff to manage. As a result, he was placed on report for breaching the prison rules. (Prisoners who breach prison rules are placed on report pending an adjudication before a senior manager to determine whether they are guilty of the offence. If found guilty, they can receive a range of punishments including cellular confinement in the segregation unit.) Between July 2017 and April 2019, Mr James was subject to ACCT monitoring six times, after he told staff that he intended to self-harm. However, on these occasions he did not physically harm himself.

35. Mr James' mother was unwell. Mr James spoke to staff about his concerns about her poor health regularly, and he asked for accumulated visits so that he could see her more often. (This is when prisoners save their visits and apply to take them at a prison closer to their families. If granted, the prisoner is transferred to the requested prison for a period of time to enable them to receive visits from family members.) Mr James was transferred to HMP Belmarsh on 26 November 2019, for accumulated visits to see his mother and family.

HMP Belmarsh

36. On 29 November, Mr James asked to speak to a Supervising Officer (SO). He told the SO that prison staff had not been treating him with his expected level of respect and that he had issues with other prisoners. Mr James said that he believed that other prisoners knew why he was at Belmarsh and were out to get him. Mr James said that he was not eating the food as he one of the hotplate workers had given

him a smaller portion meal than expected and again said that he believed that this was because prisoners knew why he was there and were out to get him.

37. The SO recorded that Mr James seemed very agitated. He had only been at Belmarsh for three days, and the SO believed that he was experiencing paranoia. (The investigation found no evidence that would support Mr James' belief that he was under threat or that he had been treated differently by staff.) The SO recorded that Mr James had said that he felt things were getting to a point where he would have to do something, but he did not specify what he meant by this. He reassured Mr James and advised him to calm down until he had time to settle and get to know people and for them to get to know him.

38. On the morning of 2 December, Mr James pressed his cell bell. When staff attended, he was in a distressed state. He told them that he had attempted suicide by using a ligature and that he believed his life was in danger. Prison staff started ACCT procedures and moved him to the healthcare unit at Belmarsh under constant supervision. He remained under constant supervision until 11 December when observations were reduced to twice every hour.

39. Mr James was due to return to Long Lartin on 15 January 2020. Before leaving Belmarsh, staff held a multidisciplinary ACCT review, but Mr James refused to engage. Mr James said that he was not happy about his transfer and that he would go to 'extreme lengths' to sort things out. Mr James said, 'I might as well end it.' He said that this was because he was unable to see his mother and that he had been promised ten visits but had only seen her four times. Prison and healthcare staff tried to reassure Mr James and reminded him of the support that was available to him. A nurse attended the ACCT review. She wrote in Mr James' medical record that she had concerns about the level of risk Mr James posed to himself because of his worries.

HMP Long Lartin from 15 January 2020

40. On 15 January 2020, Mr James transferred back to Long Lartin. On his arrival, prison staff held an ACCT review. Mr James said that he wanted ACCT monitoring to stop and denied any intent to harm himself. Staff at the meeting decided to keep ACCT monitoring in place and set hourly observations until he had settled back into Long Lartin. Staff at the meeting talked to Mr James about the possibility of him returning to Belmarsh for further accumulated visits at some stage, and also the possibility of a transfer to HMP Manchester. Caremap actions included pursuing Mr James' possible transfer to another prison for accumulated visits. Mr James had settled back into the regime on B wing and those present at a further review on 22 January agreed it was appropriate to close the ACCT.

41. An officer, Mr James' key worker, held key work sessions with him between January and March. Although Mr James had settled back into Long Lartin, he continued to talk about his frustration with accumulated visits during his key work sessions. The officer recorded that Mr James had said that he was not expecting to return from accumulated visits at Belmarsh until March and felt angry about this. He was also still concerned about his mother's health. The officer recorded that Mr James could not understand why he had not been returned to Belmarsh yet and refused to accept that the COVID-19 pandemic had caused delays. Mr James said

that if his mother died while he was awaiting a move back to Belmarsh, he would do ‘something'.

42. In the early hours of the morning on 3 June, Mr James made scratches to his torso. He alerted staff, but when they went to his cell, he threatened to attack them if they opened his door. and refused any medical treatment. Two members of staff stayed outside his door for several hours and continued to talk with him and calm him down. Mr James told the staff that he was frustrated about not having his X-box and other issues within the prison. Staff started ACCT monitoring. They completed an assessment and conducted an ACCT review later that morning.

43. Mr James was open and honest about why he had self-harmed. He said that he was desperate to return to Belmarsh for accumulated visits and was unhappy on a wing with sex offenders. He asked if he could move to a different wing. Mr James told staff at the review meeting that a build-up of frustration had led him to cut himself, but that he was feeling a lot calmer. A caremap action for Mr James was to engage with the Inclusion Team (the mental health team at Long Lartin). Staff at the review meeting planned a further review for 5 June, but Mr James refused to attend. It was re-scheduled for 8 June.

44. The ACCT review took place as planned on 8 June. Mr James presented with a positive outlook, and he said that he had allowed himself to get wound up with current issues, but since harming himself, he had been concentrating on helping and supporting a fellow prisoner who had been diagnosed with cancer. Staff at the review meeting agreed to stop ACCT monitoring. His caremap actions were ongoing.

45. Throughout June and August, Mr James received positive comments for his behaviour and no concerns were raised about him or by him. However, at 11.15pm on 17 August, staff started ACCT monitoring after he made multiple long cuts to his arm with a razor. Nurses attended his cell and started to treat his wounds. After a few minutes, Mr James told them to stop because he did not want further medical attention. Mr James said that staff had lied to him and that he had had enough. Staff recorded that earlier that day, Mr James had asked to visit his friend in the healthcare unit, but healthcare staff said no because his friend had presented with COVID-19 symptoms, and they were waiting for the test results. Mr James reacted badly to this and felt that staff were lying to him.

46. At an ACCT review on 18 August, Mr James said that he was worried about his mother and wanted to know what was happening with his transfer to Belmarsh. He said that he had self-harmed out of frustration, but that he felt better now and did not want to be on ACCT procedures. Despite this, staff at the review meeting agreed that ACCT monitoring would remain in place until a further review.

47. The next ACCT review was held on 21 August. Mr James said that he was still worried about his mother and was eager to return to Belmarsh, where he would be closer to his family. Mr James said that he had self-harmed due to a build-up of frustrations and his underlying paranoia, but that he had no current thoughts of self-harm and was thinking clearly. Mr James said that he was aware of the support on offer should he need it and that he had an appointment with the Inclusion Team the following week. Mr James also told staff at the review, that he had had a constructive conversation with a member of the chaplaincy team the previous day

which was a great help. The review team discussed Mr James' level of risk and agreed to stop ACCT monitoring. Mr James remained under the care of a member of the Inclusion Team during his time at Long Lartin.

48. On 25 November, staff started ACCT procedures after Mr James made comments to staff about harming himself. The following day, he refused to attend the ACCT assessment. He said that he was angry that he was subject to ACCT monitoring and that he could not trust the staff on the wing. Staff at the ACCT review decided to continue with ACCT monitoring to allow him time to calm down and engage with a further review. The next day, he was placed on hourly observations.

49. On 30 November, staff held a multidisciplinary ACCT review. They discussed Mr James' various issues in depth and the reason ACCT monitoring was started. Mr James said that he wanted ACCT monitoring to stop as it served no purpose for him, and that if he decided to take his life, he would do so whether on an ACCT or not. Staff at the review meeting agreed to stop ACCT monitoring and they set a post-closure review for 6 December.

50. On 3 December, the member of the Inclusion Team went to see Mr James. Mr James talked about how unhappy he was, that the prison was making things difficult for him and that he had had enough. She tried to calm him down, but it had no effect. Mr James said, 'I am going to call my mum and tell her I have had enough, then I am going to do what I need to do'. She asked Mr James if he intended to kill himself and he replied 'no'. She then asked him if that was a promise and he replied, 'I can't make promises I can't keep'. She said that it was clear Mr James was in distress, and she told him that because of what he had said, she would have to start ACCT procedures. Mr James said, 'you do what you have to do'.

51. The member of the Inclusion Team spoke to the wing manager. They decided to put Mr James on twice hourly observations, and she made an entry in Mr James' ACCT document, which was in post closure. She made a note for the wing staff to contact her in the afternoon if they wanted her to attend a case review to identify how best to support Mr James. ACCT monitoring was officially re-started.

52. That afternoon, a Custodial Manager (CM) and a SO spoke to Mr James because he was unhappy about being placed on ACCT monitoring. When Mr James went into the wing office, he was shouting and very irate. The SO asked him to explain what he had said to the member of the Inclusion Team that led her to re-start ACCT monitoring. Mr James said that everything was fine, that he was fine, but that she approached him and wanted to talk to him about things he did not want to talk about. A further review was held on 4 December, chaired by a CM and the decision was taken to close the ACCT, and a post-closure review was planned for seven days' time.

53. On 9 December, a manager and a CM went to tell Mr James that they had refused his transfer to Frankland (where Mr James had been before) and that he would not be moving to another prison until after Christmas. Mr James was unhappy with the news and told them that he 'would not be here over Christmas' and left the room. The CM spoke to him again and asked him what he had meant by his statement and whether he intended to harm himself. Mr James said that he had no thoughts of harming himself, but that he was considering whether he would rather be located in the segregation unit as he was struggling on B wing and felt that he was being

constantly lied to. The CM said that, at that stage, he did not feel it was necessary to re-start ACCT monitoring, which was coming to the end of the post-closure stage, as he thought it could do more harm than good, given Mr James' previous reaction to ACCT monitoring. The CM recorded that staff would continue to monitor and support Mr James.

54. Over the next few days, Mr James' behaviour was recorded as being increasingly irate; he was fed up and abusive towards staff. On the morning of 14 December, staff restrained him after he became violent toward a member of staff and took him to the segregation unit to await a disciplinary hearing. A CM went to the segregation unit to speak to Mr James. He was concerned that being located in the segregation unit could increase his self-harm risk. Mr James said, 'I'll cut myself down here'. As a result, the CM started ACCT procedures.

55. The duty governor went to the segregation unit to approve Mr James' being located there. He spoke to Mr James at his cell door to check that he was all right. He returned to the office and completed all the paperwork, including the exceptional circumstances form, which is standard practice for anyone located on the unit while subject to ACCT procedures. He recorded that Mr James was to be observed five times per hour until the ACCT assessment and first case review had been completed.

56. Two SOs went to speak to Mr James around 90 minutes after he had arrived in the segregation unit, to complete the ACCT assessment and first case review. They recorded that Mr James said that he was very angry about being restrained, and although calmer, he remained unpredictable. Mr James told them that he had no imminent plan to self-harm. He talked about his plans for the future and his goal to transfer to another prison. They returned to the wing office to write up their respective parts of the ACCT document. They did not ask other staff to attend the ACCT review and they did not inform those involved in Mr James' care of its outcome. One of the SOs recorded that Mr James had asked for the ACCT procedures to stop, but that they had decided that they should continue. They set observations at hourly.

57. Mr James remained on the segregation unit, and over the next few days staff did not raise any concerns, and Mr James did not make any references to harming himself. Mr James remained on ACCT monitoring and continued to be observed hourly.

Events of 16 December

58. On the morning of 16 December, a SO was on duty in the segregation unit. The night staff gave him full handover at the start of his shift. They said that Mr James had been awake during the night and that they had spent a lot of time talking to him at his door. Mr James had been asking for e-cigarettes (vapes), so that was likely to be an issue for the day staff. At 6.55am, the SO completed an ACCT check on Mr James. He recorded that Mr James was asleep and that he had noted movement. He completed another routine observation check at 7.45am. He looked in Mr James' cell and initially did not see any movement. He saw that Mr James was in bed, and then he saw him pull the covers over himself.

59. That morning, Officer A was assigned to work in the segregation unit and was tasked with completing ACCT checks along with other general duties. The segregation unit was not his usual place of work. A senior manager asked Officer A to escort a prisoner from the unit to the reception area. On his return, he made an entry in Mr James' ACCT document at 8.30am. He recorded that Mr James was asleep on his left side and that he had noted movement.

60. At approximately 9.05am, Officer B went to unlock Mr James' cell so that he could collect his medication. He saw Mr James sitting at the back of the cell and that he was unresponsive. The officer called to other staff. They entered the cell and found Mr James suspended from the window at the back of the cell with a ligature around his neck. At 9.07am, a SO radioed a code blue (indicating a prisoner is unconscious or is having breathing difficulties). The SO and the other staff released Mr James from the ligature and started cardiopulmonary resuscitation (CPR).

61. Nursing staff attended at 9.07am and continued with CPR attempts. They attached a defibrillator to Mr James' chest which indicated that they must continue with CPR. Nurses described Mr James' appearance as very pale and waxy, his eyes were fixed, and they decided that any further attempts to resuscitate him would be futile. At 9.15am, nursing staff decided to stop CPR. They contacted a GP at Long Lartin, who attended and, at 9.30am, confirmed that Mr James had died.

62. At around 9.45am, paramedics arrived and were told that Mr James had died.

Contact with Mr James' family

63. A CM was appointed as the family liaison officer (FLO) for Long Lartin following Mr James' death. At 10.50am on 16 December, the CM asked HMP Maidstone, which was geographically closer to Mr James' next of kin, whether a FLO could visit Mr James' next of kin to inform them of his death. HMP Maidstone agreed to assist. At 1.00pm, the FLO from Maidstone informed Mr James' family of his death. The CM telephoned the family later that day and remained in regular contact with them over the next few weeks.

64. Long Lartin contributed towards the cost of the funeral in line with HMPPS policy.

Support for prisoners and staff

65. After Mr James' death, a prison manager debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support.

66. The prison posted notices informing other prisoners of the death and offering support. Staff reviewed all those prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr James' death.

Post-mortem report

67. The post-mortem report gave Mr James' cause of death as hanging by ligature.

Events following Mr James' death

68. Once the prison manager had finished the debrief, Officer A approached him and told him that he had not actually checked Mr James at 8.30am as he should have done, when he had made the entry in his ACCT document.

69. HMP Long Lartin conducted an internal investigation into Officer A's actions. He informed the investigation that he was not aware that he was supposed to be checking ACCT documents on 16 December, but that he had received training in the ACCT process and was aware of what was required of him. He also said that he thought that the ACCT process was 'just a paper exercise'. He resigned from the Prison Service in 2021, before the internal investigation had concluded. We did not interview him as part of this investigation.

70. HMP Long Lartin also carried out an internal disciplinary investigation into the actions of a SO for the way he managed the initial case review on 14 December. The Governor issued him with a final written warning.

71. Officer A and the SO's actions and their management and involvement in the ACCT process were referred to the police. West Mercia Police conducted an investigation and referred their findings to the Crown Prosecution Service (CPS). The CPS decided that there were insufficient grounds for criminal charges to be brought against them.

Findings

ACCT Management

72. Mr James presented as a complex and sometimes challenging man. Between 2017 and his death, he was monitored under ACCT procedures many times, including at the time of his death. Mr James often talked of killing himself, had attempted suicide at least once and had harmed himself several times. It seems his statements of intent and acts of self-harm followed periods of frustration or when he was coping less well with prison life.

73. Staff at Long Lartin were actively pursuing a transfer for Mr James and supported his requests for accumulated visits. They were hampered by Mr James' custodial history and the COVID-19 pandemic.

74. Generally, we found that the ACCT plans were managed in line with Prison Service Instruction 64/2011. Staff at Long Lartin were clearly trying to balance keeping Mr James safe with his strong resistance to being supported on an ACCT. At times, they believed that ACCT monitoring might increase the risk of him harming himself rather than provide him with support, as is the intention.

75. Healthcare staff were not as well represented at ACCT reviews or in key decisions about Mr James' risk as they should have been. The member of the Inclusion Team, who had worked with Mr James for some time, was not always invited to ACCT reviews or asked for her input. While prison staff involved in the ACCT management knew Mr James well, there are clear benefits to a multidisciplinary and collaborative approach.

76. The lack of multidisciplinary working was particularly evident on 14 December when two SOs completed the ACCT assessment and case review simultaneously at Mr James' cell door. At interview, one said that he was unable to say whether this was normal practice as he had not been trained in the case manager role. Because they completed Mr James' review and assessment at his door, there was no opportunity to involve those that knew Mr James, such as the member of the Inclusion Team or other staff from the mental health team. This would have provided the opportunity to fully assess his needs and risk.

77. Senior managers conducted an internal investigation into one of the SO's actions on 14 December 2020 and issued him with a final written warning.

78. The Head of Healthcare told us that the issues that existed with ACCT case reviews had improved since Mr James' death. He said that there was now 'healthy communication' between prison and healthcare staff. Nursing staff also reported that they felt confident in challenging prison officers on the issues around ACCT monitoring, opening ACCT documents and issues raised at assessments.

ACCT Checks

79. On 16 December, Officer A was required to complete welfare checks on all prisoners subject to ACCT monitoring. At 8.30am, he recorded in Mr James' ACCT document that he had looked in on Mr James, he was asleep on his left side and

that he had noted movement. Following Mr James' death, he told a prison manager that the entry he had made at 8.30am was false and that he had not observed Mr James at that time. The Governor suspended the officer from duty, and he later resigned from the Prison Service. In light of this, we make no further comment on his actions and make no recommendation.

ACCT training

80. At the time of Mr James' death, prison staff at Long Lartin were not appropriately trained in ACCT case management. Our investigation found that none of the staff who were recorded as case managers in Mr James' ACCT documents had undergone the appropriate training.

81. A prison manager told us that since December 2020, ACCT reviews were only completed by trained staff and that a database had been developed to show all staff who were case manager trained. All prisoners subject to ACCT monitoring are reviewed at the weekly safety meeting and those identified as needing a case manager are referred to the custodial manager. When staff start ACCT procedures, a case manager is allocated within 24 hours.

82. We acknowledge the improvements that a prison manager has put in place in relation to safety and the delivery of ACCT at Long Lartin. The investigator saw first-hand some of the changes that had taken place at Long Lartin and attended a meeting with the manager and the Independent Monitoring Board where they discussed the safety initiatives that had been implemented.

83. HMIP conducted an inspection of Long Lartin in December 2022, and the prison received a 'reasonably good' marking for safety. We make the following recommendation:

The Governor should provide the PPO with an update on the improvements in relation to safety and the management of the ACCT process that have taken place at HMP Long Lartin since December 2020.

Segregation

84. On 14 December, Mr James was physically restrained after he became violent towards a member of staff and was subsequently relocated to the segregation unit. A prison manager spoke with Mr James on the segregation unit before completing the safety algorithm and appropriately completed the necessary documentation (exceptional circumstances form) required when a prisoner on an open ACCT is located on the unit.

85. We are satisfied that staff followed the correct procedures and that the decision to segregate Mr James at that time was appropriate.

Clinical care

86. The clinical reviewer concluded that the clinical care Mr James received at Long Lartin was of a good standard and equivalent to that which he could have expected to receive in the community.

87. She was also concerned about the management of the ACCT process and the lack of involvement from healthcare staff. The clinical reviewer made a number of recommendations about record keeping and clinical supervision, which we do not repeat in this report, but which the Head of Healthcare will need to address.

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