

**Investigation into the circumstances surrounding the  
death of a man at HMP Gartree  
in March 2007**

**Report by the Prisons and Probation Ombudsman  
for England and Wales**

**July 2008**

This is the report of an investigation into the apparently self-inflicted death of a man while in the custody of HMP Gartree on 7 March 2007. I pass on my sincere sympathies to the family for their loss. The man, who was aged 23, was found in his cell, during a prison lockdown. He was taken to hospital where he was pronounced dead at 8.15pm.

I offer my sincere sympathies to the family for their loss. I am sorry for the delay in producing this report and thank the family for their patience.

I appointed an investigator from my team to investigate the circumstances surrounding the death of this man on my behalf, with assistance from one of her colleagues. The lead investigator received excellent and timely support from Gartree's Business Delivery Manager. I would also like to thank the Governor for her support during the investigation.

I am grateful to the doctor, appointed by Leicestershire County and Rutland Primary Care Trust to conduct the clinical review into the man's medical care while he was in prison.

The man was serving an indeterminate sentence for public protection following a conviction for robbery. The seriousness of the offence was never in question and his repeated offending meant that he was deemed a danger to the public. However, he also had a history of mental health problems and prolific self-harm. His behaviour in prison was poor. In other words, he was a man who was a danger both to himself and others.

All prisoners with indeterminate sentences face an uncertain future not knowing how long they will spend in prison. I am particularly concerned about the effect this uncertainty has on someone with such poor coping skills and mental health problems. This was compounded by the lack of purposeful activity while he was on the prison's induction wing. However, I am pleased to note the level of individualised support that he received at Gartree.

Given its wider implications for the indeterminate sentence and the way the Prison Service handles prisoners who are both vulnerable and a threat to staff and others, I believe this to be one of the most important reports I have issued during 2007-08. I make 11 recommendations.

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## SUMMARY

The man was remanded to HMP Leicester on in July 2006, charged with robbery. It was not his first time at Leicester and staff knew him well. Due to his repeat offending he was identified as a potential life prisoner. He was seen by the lifer team to prepare him for the possibility of receiving an indeterminate sentence for public protection.

During his previous sentences at Leicester he had been looked after by the prison's mental health inreach team. (Inreach teams are multi-disciplinary teams that offer specialised mental health support to prisoners. While they may provide for prisoners with a wide range of mental health needs, their principal focus is likely to be on those with severe and enduring mental illness.) Diagnosed with a personality disorder, the man thought he was suffering from schizophrenia and would not engage with treatment. However, he had not been diagnosed with schizophrenia or any severe and enduring mental illness in any of the psychiatric assessments he had had over the years. Since the man was not suffering from a severe and enduring mental illness and due to his reluctance to engage with treatment, the inreach team did not supervise him during this time in prison.

The man's time at Leicester was characterised by his disruptive behaviour and self-harming. He cut himself repeatedly and refused medical treatment. The man would often damage his cell and threaten staff. He was subject to suicide prevention procedures for most of his time at Leicester. He was also frequently segregated as punishment for his poor behaviour, but seemed to respond well to the discipline of segregation. From early in his remand period, he wanted to be transferred to the Personality Disorder Unit at a nearby mental health secure unit. The inreach team did not support his application so the man referred himself.

On 6 November 2006, the man pleaded guilty to the offence of robbery and was given an indeterminate sentence for public protection with a tariff set at three years. He was reportedly shocked and told his father shortly afterwards that he felt that the demands of the sentence meant that "as far as he was concerned, he got life". Due to his poor coping skills and his apparent keenness to progress with his sentence, staff at Leicester worked hard to get him a swift transfer to a training prison so that he could start his sentence plan as soon as possible and work towards being considered eligible for parole. He was transferred to Gartree in December.

Gartree continued his suicide prevention measures for a short time while he settled at the prison. Like all new prisoners, the man was accommodated on the induction wing. He awaited his sentence planning board, which was due to be held three months after his arrival, in accordance with national procedures. Apparently due to his fear of failure, he refused to undertake the Genesis programme, a course designed to familiarise prisoners with Gartree's rules and regimes. Until he had completed the programme, the man could not take part in education or work. Staff noticed that he spent a lot of time on his own, in his cell or watching other prisoners associate. He complained of being bored. It came to light after his death that the man might have been bullied on the wing.

The inreach team at Leicester had written to Gartree about the man's mental health needs and his ongoing self-referral to the mental health secure unit. Gartree's Head of Healthcare decided to support his application to the Personality Disorder Unit, in consultation with a Consultant Forensic Psychiatrist at a mental health unit. His medication was stopped to assist in an accurate assessment of his mental health needs.

For the first few weeks of his time at Gartree he did not self-harm. However, at the beginning of 2007 he started to cut himself. The Prison Service procedures to support prisoners at risk of suicide were initiated accordingly. A pattern of cutting himself and refusing treatment began and escalated. By 1 March, he seemed to have reached crisis point and was moved to the healthcare centre and placed on constant supervision. He remained on constant supervision until 5 March, when he was moved from the gated cell used for constant supervision and observed at least once every half an hour.

Two days later (7 March 2007), Gartree was subject to security measures that meant that all prisoners were locked in their cells for the whole day and could only be released one by one with permission from a senior prison officer. The man had told staff that he did not like being locked in his cell. He was found in the morning with a bandage wrapped around his neck, but gave it to staff quite willingly when asked. A suicide prevention case review at 3.00pm that afternoon had to be held through his cell door due to the security procedures. The Head of Healthcare and Primary Care Mental Health Team Leader conducted the review. His risk level was not adjusted and he was still to be checked every half an hour. The chaplain visited at 5.45pm and found him very depressed. The chaplain made staff aware of this.

At around 7.00pm that evening, the Health Care Senior Officer checked him and found him lying face down on the floor with a ligature around his neck. After getting permission over the radio, she entered the cell with a colleague and checked for his vital signs. Despite the efforts of staff to resuscitate the man, he was not revived and was transferred to a nearby hospital. He was pronounced dead at 8.15pm. The prison's response to his death was timely and appropriate.

In this report I make recommendations about family liaison following a death in custody. I also make several recommendations for the Head of Healthcare to take forward, although I recognise the existing good liaison between the mental health inreach team and officers on the wing. I make two recommendations about suicide prevention policy and other recommendations about medical response efforts following an emergency.

## THE INVESTIGATION PROCESS

1. I appointed a lead investigator to conduct the investigation into the circumstances surrounding the death of the man. The assistant investigator visited Gartree in the days following the death of the man to collect his prison records and clinical files. Notices were sent to the prison to invite prisoners and staff to contact the lead investigator with any information they thought was relevant to the investigation. Two prisoners responded to this invitation and they were interviewed.
2. A doctor was appointed by Leicestershire County and Rutland Primary Care Trust to conduct a review into the clinical care that the man received while he was at Gartree. I would like to thank the doctor for his contribution.
3. After a thorough review of the paperwork, the lead and assistant investigator visited Gartree in April and May on several occasions to interview staff and prisoners. The investigation team was joined by the clinical reviewer to conduct joint interviews with healthcare staff.
4. One of my family liaison officers contacted the family of the deceased at the start of the investigation. She offered them the opportunity to be involved, which they were keen to accept. Throughout the investigation, they have shared their issues with us. I trust that this investigation report addresses these concerns as far as possible.

## HMP GARTREE

5. Gartree is a category B training prison for adult males who have been given a life sentence. Usually the first stage of a prisoner's life sentence is spent at Gartree. It can accommodate up to 575 prisoners and is split into six main wings (A, B, C, G and H wing).
6. B wing was opened as a designated induction wing in July 2006. All new prisoners go to B wing and remain there until they have completed their sentence planning boards, held around three months after their arrival, in accordance with national procedures.
7. The most recent announced inspection of Gartree was carried out by Her Majesty's Chief Inspector of Prisons in May 2005. The Chief Inspector said that the prison had "deteriorated significantly since the last inspection" which had taken place in 2001. She recognised the new pressures that indeterminate sentences had placed on the lifer system as a whole, but felt that Gartree needed to "focus on its core objective: working with life-sentenced prisoners, in a secure environment, to reduce the risks they pose to society".
8. The inspection team found that prisoners received "good support" for their mental health and my investigation also found this to be the case. There are mental health nurses appointed as liaison for each wing, and officers were confident with the advice that they received from healthcare staff. The healthcare centre was found to be adequate, although in need of some communal areas to encourage association.
9. Gartree has a 24-hour inpatients unit. Next to that unit, there is a day surgery that operates between 9.00am and 5.00pm for prisoners with appointments to see a doctor. Only the doctor can prescribe medication. There are also treatment hatches on the wing where prisoners can see a nurse without an appointment. The triage nurse can either make an appointment for the prisoner to see a doctor or give the prisoner paracetamol where appropriate.
10. It is important to note that the inspection took place before B wing was made into an induction wing. This investigation found evidence that work has been done to adapt to the younger, more transient population that Gartree now accommodates as a result of the introduction of the indeterminate sentence. Sentence planning processes are in place although, as elsewhere in the prison system, these systems are struggling to cope with the short tariffs received by some prisoners. This means that prisoners with short tariffs cannot be given the opportunity to complete the courses judged necessary to reduce their risk of reoffending before the end of their tariff and they can be considered for parole. There are simply not enough courses to meet prisoners' needs. This has led to an increased sense of frustration among the prison population at Gartree.
11. In a recent ruling (post-dating the man's death) the Court of Appeal has judged that there are not enough national resources to enable prisoners to progress through indeterminate sentences within their tariff. There are insufficient

courses available in prisons across the country. In response, the Prison Service is revising the system to relieve the pressure in the lifer estate.

## KEY EVENTS

### The man at Leicester

12. The man was remanded to HMP Leicester in July 2006. Leicester is one of the smallest local prisons and can only hold up to 385 prisoners. It has one accommodation building which looks like a single prison wing from the outside. Inside, the accommodation is divided by internal walls and stairs. Residential accommodation is found on the upper three landings. The segregation unit is located on the lowest landing, in the same area as the behavioural improvement landing (BIL).
13. A first reception healthscreen identified that the man was undergoing treatment for testicular cancer and that he had a diagnosed personality disorder. (This screen determines if the prisoner has any urgent medical issues that need immediate attention, or ongoing issues that may need to be referred to another medical department.) The man told staff that he was taking 2mg of Risperidol (a drug used for the acute treatment of psychotic illness and schizophrenia). The Care Programme Approach (CPA) Coordinator for Leicestershire Criminal Justice Services, called his community supervisor to confirm this. She found that the man had stopped taking this medication in June because it had served no therapeutic purpose. She told my investigator, “the consultant who had originally prescribed it felt that he didn’t need it and that was why it was discontinued”. On 1 August, the CPA Coordinator wrote a memorandum for the attention of all attending doctors, as follows:

“Please do not prescribe any psychiatric medication for [the man] – no matter how he may present – until you speak with inreach. He has no mental illness and is on no psychiatric medication at present ... despite what he says.”
14. During interview, the CPA Coordinator explained that the man had been assessed by a number of psychiatrists who concluded that he had a personality disorder but not a severe and enduring mental illness. She described the man as “well-versed” and someone who could present himself as having a mental illness. She told my investigator that she had put the note in the clinical record as a word of caution because it would not have been in his best interests to take medication he did not require.
15. The man had been at Leicester on three previous occasions. His history of mental health problems and prolific self-harm was noted on the reception documents, although it was recorded that his presented as “jovial and sociable”. He was located on the residential wing.
16. Due to the fact that he used a weapon when committing his offence and his history of repeat offending, he was identified as someone who might receive an indeterminate sentence. (An indeterminate sentence is a life sentence, where a minimum tariff is given, but the prisoner must satisfy the Parole Board that he is fit for release and does not pose any threat to the community. A prisoner’s risk factors are identified by psychological assessments and they are required

to complete prison courses that might help to reduce their risk and improve their chances of being considered for parole.) As a potential life prisoner, Leicester's lifer team visited the man when he first arrived at the prison to explain the possibility of receiving a life sentence and how an indeterminate sentence worked.

17. Despite his familiarity with Leicester's regime from his previous sentences, he completed the induction process informing him of the rules and regime at Leicester. He was assessed as suitable to share a cell. It was thought preferable that he had a cellmate because company would help him to cope with any thoughts of self-harm.
18. After six days, he threatened a member of staff and found himself without association or private cash. This was the beginning of a destructive pattern of behaviour at Leicester. The Head of Residence responsible for the segregation unit said that his behaviour was challenging for staff. She described her experience of the man as follows:

“ ... it was difficult to get to the root of the problem but he was someone you would see on that circle and he would be on normal location and then he would move to segregation or he would move on to the behaviour improvement landing, go through stages of good behaviour and bad behaviour.”
19. On 17 August, a concern and keep safe form was raised. (This form is the first stage of the Assessment, Care in Custody and Teamwork (ACCT) system. The system is used if staff are worried that a prisoner might be at risk of suicide or self-harm.) It is recorded on the form that the man told staff he “felt let down by his inreach nurse, nobody has been to see him since his arrival in prison, he has told me that he had self-harmed by burning his left arm”.
20. In accordance with the ACCT process, the man was assessed the next day. He told the officer that he had received a bad letter from his grandmother, but that he over-reacted. He was disappointed that he had self-harmed because he was enjoying his job, got on with his cellmate and was aiming to reach enhanced status which he had never achieved before. However, he did ask to be referred to the mental health inreach team so that he could better deal with news like that from his grandmother. Following the staff assessment, his ACCT document was closed the same day.
21. On 22 August 2006, a member of the inreach team explained to the man that he did not have a severe and enduring mental illness. Moreover, as he also had not engaged with treatment from the inreach team on his previous sentence, he did not meet its criteria and would not be looked after by the inreach team on this sentence. On hearing this news, he told staff that he would “go back to his old ways, then” and set fire to his jumper. No ACCT document was raised on this occasion.

22. Another concern and keep safe form was raised on 6 September, although the officer who raised the form wrote: "... been on numerous ACCT documents. Uses the document to obtain the attention he seeks."
23. The ACCT assessment took place and, on this occasion, remained open. During the assessment interview, the man said that "he sometimes does this because he wants to die and that he also uses it as a release of frustration". During the ACCT case review on 20 September (a multi-disciplinary meeting where the prisoner's risk is reviewed to see whether any changes need to be made to their level of supervision), the man asked to be taken off the ACCT document. He was described as "relaxed and good humoured" during the review. Nevertheless, his ACCT document remained open because staff felt that his self-harm could be "reactive" and was unpredictable.
24. Just two days later, the man wrote the following letter in his cell:

"I am writing because I'm losing control of my head. I'm currently on remand for robberies. I robbed that many people it's unbelievable. I didn't even spend the money I either gave it away or just ripped it up. I done all these crimes hoping someone at the mental health service will listen to me ... I have prepared all sorts of weapons in my cell. I carry a blade on me at all times. Prison isn't going to help me, I need psychiatric help..."

The letter is not addressed to anyone and was found by officers on the same day that he wrote it. The man was subject to an adjudication on 25 September and was relocated to Leicester's segregation unit, despite being on an open ACCT document. Due to the number of adjudications that the man had at Leicester, it is difficult to determine from the records which adjudication related to which disruptive episode. (An adjudication is the hearing that takes place when a prisoner breaks the rules, with a prison governor acting as the adjudicator.) An ACCT case review took place on the same day and he remained on an open ACCT document.

25. On 26 September, a nurse interviewed the man about his application to the local secure mental health unit, which has a Personality Disorder Unit (PDU). The man told staff that he wanted to be referred to receive treatment for his personality disorder. The nurse explained to him that he needed to be referred by the inreach team, and this was unlikely given that his history did not show any signs of "underlying mental illness". The nurse wrote in his clinical record: "He may attempt to feign mental illness (voices hallucinations etc) in order to be prescribed psychotic medication."
26. At Leicester, the segregation unit and BIL are located in the same area of the prison but serve different functions. A governor explained to my investigator that the segregation unit is used for "problematic prisoners" who are being held before they have been adjudicated or for reasons of good order or discipline. The BIL is for prisoners with poor behaviour who have been placed on the lowest level of incentives scheme (the basic regime). Once on the BIL, a prisoner can work his way through behavioural targets, and gradually make his

way back onto ordinary location in a residential wing. The man was given the opportunity to move from the segregation unit to the BIL on 1 October, but he refused. He told staff that he could not be bothered and then flooded his cell. It was decided that he was fit for cellular confinement and he was given five days as a punishment. The next day the man set fire to paper in his cell and was found fit for cellular confinement again. He did not appear at his adjudication on 4 October, but wrote a letter saying that he had flooded his cell because he had a voice in his head telling him that he should kill a member of staff before they 'get to him'. The letter ends: "just gimme a razor and I'll cut my throat and be done with it". His security level was reviewed and it was decided that there should be three officers present every time his cell door was opened, due to the threats to staff safety. There is a note in his clinical record to say that he was fit to stay in the segregation unit.

27. The man self-harmed on 6 October, but refused treatment. Four days later, he "extensively damaged his cell" by flooding it and smashing the toilet seat on the wall. He was moved to another cell. He was given 14 more days on the segregation unit as a punishment and no canteen (access to the prison shop). A note in his wing history sheet said: "acting like a kid, been treated like one". His ACCT document remained open. By this time, the man had been reassessed and three members of staff were no longer required to be present when he was unlocked from his cell.
28. On 15 October, the man jumped on top of a ventilation unit in protest at his lack of canteen. In an ACCT review the following day, he would not talk about anything except the loss of his canteen. The ACCT document was not closed "because of the manner in which he deals with problems and because of his unpredictable behaviour". The following day, he set fire to his mattress. The next day the man wrote on his own wall with blood, but refused any treatment from healthcare staff. Throughout this time, the man was located in the segregation unit on an open ACCT document.
29. Four days later, on 19 October the man willingly went to an appointment at the Teratoma Clinic at a local hospital and it was noted that he remained "generally well". He returned to a residential wing on ordinary location. However, just two days later, he was moved to the BIL. The initial segregation safety screen was completed and the nurse agreed that, despite his apparent mental health problems, his mental state would not significantly deteriorate in segregation. (An initial segregation safety screen is a form completed by a nurse or doctor when a prisoner is moved to the segregation unit. It is designed to discover if there are healthcare reasons against holding a prisoner in the segregation unit and to provide a 'snapshot' of the prisoner's wellbeing at the time.)
30. His ACCT document was closed on 24 October. He was reluctant to engage with staff during the review, although he did talk about his cancer treatment.
31. On 6 November, the man appeared at Leicester Crown Court. He had pleaded guilty to robbery at his court appearance on 27 July. He was given an indeterminate sentence for public protection, with a tariff of three years. The time that he had spent on remand was taken into consideration, so he only had

two years and 91 days left before his tariff was completed. During the course of the investigation, the father told my Senior Family Liaison Officer, that he spoke to his son shortly after he had received his sentence. The man told his father that he thought he would be unable to complete what was required of him to be considered eligible for parole. He described his sentence as a "life sentence". When he returned to Leicester, he appeared shocked but told staff that he was all right.

32. The man went back on to ordinary location when he returned from court, but within two days he was located in the segregation unit for smashing up his cell. He initially refused treatment for the injuries he sustained during his protest, but eventually healthcare staff did treat him.
33. The following day, 7 November, an ACCT document was opened again. The man had smeared the glass observation panel with his own blood and refused to talk to staff. Staff from the lifer team tried to interview him about how he was feeling regarding his sentence, but he refused to speak to them. An entry in his wing history on 9 November was as follows:

"Whilst talking to his co-accused, the co-accused told me that [the man] was going to mess around so that he could get "nuttled" off, i.e. mental. The co-accused told me that he spoke to the man in court and that is when he told him."

The co-accused apparently told staff, that the man wanted to get transferred to a mental health unit because he thought it would be easier than spending his sentence in prison. However, when my investigation team spoke with the co-accused he said that he believed the man had schizophrenia. The man told his co-accused that he offended because he preferred to be in prison rather than in the community.

34. On the man's concern and keep safe form, dated 10 November, it is noted that he had cut open his old wounds and smeared blood around his cell. He was upset about his life sentence. On completion of the form, an officer described the man as "immature, self-harms when things do not go his own way". The man would not participate in the ACCT assessment interview, so the document was only partially completed, but the ACCT remained open. The same day as the ACCT assessment, he received seven days in the segregation unit with no television and no canteen as punishment for the damage he had caused to the cell.
35. The following day (11 November) a governor spoke to the man about his sentence. After the discussion, he made the following entry in the wing history of the man:

"Spoke with the man and explained indeterminate sentence to him and difficulty with his request for ship out. Advised him that if he progressed through his cellular confinement and BIL then I will try and negotiate something with population management – highlighted could be difficult with 2 yr 3 mth tariff. Seemed to take this on board."

Later that day, the observation panel in the door of the man was covered with blood stained paper. A note of this was made in his ACCT document.

36. The Lifer Principal Officer (PO) requested a transfer for the man to a training prison on 13 November and recommended Gartree as the most local lifer prison. Following the failed attempt to interview the man on 9 November, an officer from the lifer team came to interview the man on 13 November to find out how he felt about his sentence. In the record of this interview, the lifer officer said that the sentence was “unexpected” but that the man seemed to have accepted it. She said that he was aware that he might spend a long time in prison. She noted that he had a long history of adjudications and his behaviour was considered “poor”. She drew attention to his long history of self-harm and possible mental illness. The officer also observed: “in my opinion [the man] does not appear to consider jail a punishment, he has no home and there is evidence in his pre-sentence report that he commits offences to return to jail.”
37. The erratic behaviour of the man continued while he was waiting for news of his transfer. On 14 November, intelligence came to light about his threats to take a governor hostage if he was moved out of Leicester. The following day, the man again smeared his cell walls with blood. Just one day later, he set fire to his cell, then flooded his cell and then refused food and medication. On 17 November, he was given seven days segregation and the next day that was increased to 21 days without association. He remained on an open ACCT document due to his continued self-harm.
38. A governor adjudicated upon the man on a few occasions. He described him as “a disruptive influence” on the prison’s regime and said that he was “labour intensive”. He described the balance that had to be struck between a prisoner’s wellbeing and the effective running of the prison. When talking about his decision to segregate the man, the governor said:

“the man was a disruptive influence, quite immature and I think very comfortable with the segregation unit at HMP Leicester, certainly. I don’t believe that it had a negative effect on his mental well being.”
39. During this time, the man wrote to Rampton Hospital. This was one of a number of letters believed to have been sent by the man to various mental health establishments at that time:

“I am writing because I need help because I am losing my head. I am asking because the prison will not help me. I hear voices telling me to kill people I have dreams where I’m killing people. I smash my head off the wall every night. I cut my wrists. I lose my temper all the time. I don’t know what to do anymore. I should just do myself in properly. I got life the other week because the courts are saying I’m a danger, but I tried saying I done my crime because it is a plea for help. I had told my doctor to send me to a secure environment but he would not listen to me so I signed myself out before I done something over the

top. If I don't get help now I'm gonna end up doing myself in because I know I won't have a chance of parole otherwise. Will you please give me a chance to do something right for once in my life please."

40. A doctor at Rampton Hospital contacted Leicester prison and Leicester's CPA Co-ordinator went to see the man on 22 November. She explained to the man that his unacceptable behaviour would be wrongly reinforced if he were to get a transfer to the secure mental health unit because he showed little indication that he wanted to address his mental health. She said that there were concerns about whether he would be able to succeed in a therapeutic environment like the PDU, which she described as "quite stressful for people having to deal with their problems". The co-ordinator said that the regime was particularly strict at the secure mental health unit. She was concerned that he struggled to follow prison rules, and would find it hard to adapt to the demands that regime would place on him. The co-ordinator also referred to the failed placement at the drug and alcohol treatment centre in Norfolk in March 2006. She said that the man's failure to cope with the regime there was a further indication that he would not adapt to treatment at the secure mental health unit.
41. The CPA coordinator arranged for the visiting Cognitive Behavioural Therapist to visit the man when he was next at Leicester. The coordinator told my investigator that she wanted to see how well the man engaged with cognitive behaviour therapy, which might be a measure as to how he would respond to mental health treatment at the personality disorder unit.
42. At his ACCT case review on 26 November, he told staff that he was pleased to be progressing from the segregation unit onto the BIL. He said he wanted to work through all of the behavioural stages.
43. The man spent most of 29 November in a quiet mood, but tried to self-harm later in the day by tying a strip of sheet tightly around his wrist twice. The strip had to be removed by staff.
44. A senior officer convinced the man to remove the bandage, which he said he had tied to prevent himself from deliberately self-harming. The senior officer wrote in his ACCT document: "I believe that compounded with his present sentence, he has now admitted to me that he fears results of further blood tests reference his cancer returning."
45. On 30 November, the lady from the inreach team recorded that a decision had been made not to support the application of the man to the PDU because of his disruptive behaviour.
46. The Prison Service Population Management Unit (PMU) is based in London. One of its roles is to identify where there are spaces in the lifer estate so that prisoners who have received a life sentence can move from local prisons to training prisons to begin their sentence plans and work towards parole. The Lifer PO explained that the PMU inform the prison of the number of spaces available and the prison then decides who to move. After the man was sentenced, he explained to him how an indeterminate sentence worked,

including the work he would need to do to be considered for release on his tariff. He was looking forward to his transfer to Gartree because he felt he was “treading water” at Leicester until he could get to Gartree to start addressing his offending behaviour. The PO remembered the man asking him when he was going to be transferred every time they passed each other in the corridor. It was thought to be in his interests to keep him within the Midlands area, if possible. The man was a high-risk prisoner with one of the shortest tariffs imposed on any prisoner at Leicester. As part of the ongoing support for the man, the PO prioritised his transfer and he was scheduled to move on 5 December.

47. On 3 December, the PO conducted a pre-transfer interview with the man. He acknowledged that the man “can at times be resource intensive, demanding and confrontational, this is normally borne out of frustration and lack of coping skills. Is currently on an open ACCT document.” As part of the interview process, the prisoner’s thoughts are captured. The man told the PO the following:

“is looking forward to his transfer to Gartree so as he can begin to address his risk issues and get some stability to his life and work towards a successful parole upon completion of his tariff.”

48. On 5 December, the man had a pre-transfer ACCT case review. He was positive during the interview and thought that the transfer was an opportunity for him to have a fresh start. A senior officer noted on the record of the case review that the man “was advised that his future is in his hands”.

49. The man was transferred to Gartree later that day. Upon arrival, he had a first reception healthscreen and was referred for a mental health assessment. The healthscreen also noted that he was subject to ACCT procedures and that his ACCT document had transferred with him. The man was located in a single cell (all cells are single at Gartree) on B wing, which is the induction wing. All new prisoners are located on the induction wing, where they follow a programme to familiarise themselves with Gartree’s regime. A prisoner will be on the induction wing at least until their sentence planning board has taken place, around three months after they arrive at the prison. When asked to describe how the induction wing differed from other wings in the prison, the senior officer, who worked on the wing, said:

“I would actually liken it more to a local prison because most of the prisoners who are on the wing have come from a local prison fairly recently. Unlike other prisoners who have been at Gartree for quite a long period of time, some as much as five or six years and the other wings tend to be a little bit more quiet, although with the current indeterminate sentences that we are getting, not as quiet as it used to be.”

50. The next day, a note was made in the man’s wing history that he “seemed to have settled in well on the wing, mixing well with other prisoners”. A receiving establishment must hold an ACCT case review when a prisoner on an open

ACCT document is transferred between prisons. The case review was held on 6 December and it was decided that the ACCT should remain open while he settled in.

51. A member of the inreach team wrote to the Head of Healthcare at Gartree, about the man's transfer on 6 December. The CPA Co-ordinator set out her concerns about the man and his "misperception that he is mentally ill". She confirmed that the inreach team at Leicester was not supporting his application to the mental health secure unit. She wrote:

"He also appeared to have a very limited understanding of the PDU and how difficult the therapeutic process could be. He had been told by another inmate who had attended the PDU (and failed) that it was a place where he could do courses not available in the prison."

52. Following a transfer, staff at the receiving establishment must assess a prisoner on an open ACCT document. A Health Care Officer (HCO) undertook the man's ACCT assessment on 8 December. He described him as a "protestor" and noted that he was to be seen by the primary care mental health team. When my investigation team spoke to the HCO at interview, he could not remember the assessment. He said that he would have meant that the self-harmed in order to achieve a particular aim.
53. During the ACCT case review on 12 December, the man was observed as still being positive about his transfer to Gartree. On the same day, he received a letter from a psychiatrist at the secure mental health unit in response to a letter that he had apparently written directly to apply for a place at the Personality Disorder Unit. The psychiatrist advised him to speak to the mental health inreach team at the prison about coordinating an application. It would be more appropriate for the referral to be made by them than by the man himself.
54. At this time, the man had a swollen jaw from a dental abscess and was receiving treatment. There is also a treatment hatch on the central corridor between wings where prisoners can see a nurse if they have booked an appointment the previous day. The triage nurse can either make an appointment for the prisoner to see a doctor or give the prisoner paracetamol where appropriate. A prisoner can see a member of the healthcare team on the wing if they need to without an appointment for physical or mental health problems. (Paracetamol does not need to be prescribed, but can be issued by nurses who work in the treatment hatch on the wing.) On 13 December, he was discovered to have 46 paracetamol tablets in his cell. When questioned, he told the Registered General Nurse (RGN) that he got the paracetamol from the wing, but was adamant that he did not want her to take a blood sample. The RGN said that he displayed no symptoms, but she scheduled an appointment for him to see the doctor.
55. On 14 December the then head of the inreach team, met the man to complete his mental health assessment. She described him as "immature and impulsive", but found no evidence of a "major mental illness". She also spoke to him about his application to the secure mental health unit, raising the

concern that he would not be able to cope in a restrictive environment like the Personality Disorder Unit. She was also concerned about how he would react if he went to the mental health secure unit, but did not successfully complete treatment there. Nonetheless, she wanted a second opinion and referred the man to a consultant forensic psychiatrist for consideration of his suitability for the Personality Disorder Unit. Following his assessment, it was determined that the man was to receive input from the inreach team in relation to his application to secure mental health unit, but his main contact would be the primary care mental health team. A member of the primary care mental health team is affiliated to each wing. The nurse who was the primary care mental health nurse for B wing while the man was there, and she had regular contact with him on the wing.

56. Many staff who spoke to my investigation team described the man as being a quiet man who seemed quite withdrawn on the wing. He spent the majority of time in his cell. His personal officer said he knew him “no better or worse than any prisoner”. He described the man as “very quiet and someone who just gave basic responses”. Another officer who also works on B wing. remembered the man in the association room watching people play pool, but never played himself. He did not think that he had any particular friends and was struck by how few personal possessions he had in his cell, where he spent most of his time alone.
57. On 15 December, The man told another B wing officer officer on B wing, that he was bored. He said that there was less to do at Gartree than at Leicester. The Genesis programme is an induction programme designed to ensure that each prisoner is familiar with the regimes at Gartree and what is expected of him during their time at the prison. A prisoner can work or attend education during the induction period, but they must complete the Genesis course first. The Genesis course can take between two and three weeks depending on the availability of staff. Prisoners must also undertake the sentence planning board before they can start their sentence plan and work towards addressing their offending behaviour. Until such time as they have addressed their offending behaviour, it is unlikely that the Parole Board will consider them as eligible for parole, regardless of their tariff. Sentence planning boards do not sit until three months after a prisoner has arrived at a training prison. This is so that the prisoner has an opportunity to settle into the prison and the appropriate assessments can take place.
58. An officer on B wing spoke to the man about completing the Genesis programme, but he seemed “laid back” about completing it. The man seemed to be happy to stay in his cell and did not seem very “outgoing”. The officer on B wing told my investigators that, if he had completed his Genesis course, there would have been opportunities for the man to attend workshops and education classes, although there was not much employment available for prisoners on B wing. However, because there are a number of unemployed prisoners on B wing, the officer explained that there is an additional association period to encourage prisoners to come out of their cells and associate with each other.

59. A senior officer chaired an ACCT case review on 19 December and it was decided to close his ACCT document. He was observed to be settling in well and had made no more threats of self-harm. The senior officer reminded the man that, despite not being on an open ACCT document, he could still approach staff because they were there to support him.
60. Over Christmas 2006, the man's grandmother sent him some money as a gift. The family have asked the investigator to check that he got this money and that he spent it on himself. My investigator requested this information from the prison but has not received it, at the time of finalisation of the report. A prisoner on B wing who asked to speak to the investigation team, said he remembered the tracksuit that the man had bought with the money. He seemed very pleased at the time that he had bought it. However, a couple of weeks after the man had the tracksuit, a prisoner noticed that he was wearing his old clothes and asked him where his tracksuit had gone. The man told the other prisoner that he had sold his tracksuit for two ounces of tobacco. The prisoner said that £10 was the prison value of the tobacco and asked the man why he had sold an expensive tracksuit for such a small amount. He said that he owed two other prisoners two ounces of tobacco and so gave them the tracksuit to settle his debt. The prisoner confronted the other prisoners on the man's behalf, because he felt that they were taking advantage. The prisoner gave them two ounces of tobacco and returned the tracksuit to the man. The prisoner asked the man to talk to him if he had any more problems. The prisoner did not bring the matter to staff's attention because he thought it had been resolved.
61. Another ACCT document was opened on 1 January 2007. The man was lying on his bed, refusing to speak to staff about what was bothering him. He had written on his cell wall in blood and then wiped the blood clean himself. He refused to be interviewed for the ACCT assessment the next day, but agreed to engage on the following day. He said that he had not considered self-harm or suicide since he had been at Gartree. He told staff that he did not feel he needed staff support or mental health team support. He said that ACCT "did his head in". After consultation with wing staff, the ACCT document was closed.
62. An appointment was made for the man to be assessed by the Consultant Forensic Psychiatrist from the secure mental health unit on 10 January. On 8 January, the man tried to cancel the appointment. He would not give a reason, although the Head of Healthcare, told my investigator that she thought that he was afraid of failure. The Head of Healthcare also said that she thought he might struggle with the regime at the mental health secure unit, but that it was a good idea for him to be properly assessed by psychiatrists for his suitability. Healthcare staff were advised by the Head of Healthcare not to cancel the appointment until the last minute in case he changed his mind.
63. On 9 January, a concern and keep safe form was raised. The man told staff that he was hearing voices, and he burnt his arm while in his cell. An officer conducted the ACCT assessment interview on the same day and made the following observation:

“He does not want to see healthcare/mental health. He says it doesn’t work, he has seen them at previous establishment ... I asked if he wanted to do all of his tariff as bang up he just shrugged. The man says he feels positive, has good self-esteem and good confidence. I would disagree if you were looking at his appearance and demeanour.”

(‘Bang up’ is an informal expression referring to being behind the cell door.)

64. The man told the officer who conducted the ACCT assessment that he did not want an ACCT document opened because his self-harm was an instant release and he felt immediately better. Nevertheless, she opened an ACCT document because she felt he posed a significant enough risk to himself. She also encouraged him to partake in the Genesis programme so that he could start to attend education and enjoy more purposeful activity.
65. The man did see the Consultant Forensic Psychiatrist for a long appointment on 10 January. He wrote a lengthy entry in his clinical record. Of particular note, the psychiatrist recognised that the man presented a “chronic high risk of serious deliberate self-harm, not to kill himself, but may inadvertently”. Unfortunately, the psychiatrist did not pass this information onto wing staff managing his ACCT process, nor was this recorded anywhere except in his clinical record. A senior officer told my investigators that this would have been useful information about risk. The head of Healthcare told my investigator that the psychiatrist thought the man might benefit from a referral to the personality disorder unit.
66. The next day, the man asked to see the Head of Healthcare to discuss his appointment with the psychiatrist. During interview, the Head of Healthcare told my investigator that it was not common practice for the Head of Healthcare to respond to individual prisoners’ requests to see her. However, she had worked with him when he was a young offender at HMYOI Glen Parva. She was his mental health key worker then and remembered him well from that time. She agreed to see him because she thought it would be helpful for him and it would give her the opportunity to explain that her role was different at Gartree, although there would be other staff to support him. He told the Head of Healthcare that he was happy with the interview with the psychiatrist on 10 January and he agreed to continue working with healthcare staff. Three days later, the RMN from the inreach team wrote to request an assessment of the man for a transfer to the secure mental health unit following psychiatrist recommendation.
67. A healthcare officer was dispensing treatment just outside B wing on 13 January. When the man came to collect some more medication for his toothache, the HCO noticed that the man had taken a week’s worth of medication in four days, and explained that it would be dangerous to give him more in case of an overdose. The HCO recalled that the man was not happy with that advice but accepted it. The HCO was called over the next day because the man said that he had injured existing scars in his groin area. The HCO described him as being “pretty much guarded, as normal really”. The man refused to show his groin area and there were no signs of blood on his

clothing. At the end of the exchange, the man asked for co-codamol, but the HCO explained that he could not prescribe co-codamol because it contained paracetamol and it might still cause an overdose.

68. Two days later, the man seemed agitated and asked to see HCO because he said he had agreed to come and see him but did not attend. The man was anxious to have access to painkillers. The HCO saw him and again refused his request for co-codamol. He told my investigation team, "I will not give anybody under those circumstances a continuation of the medication that we think he could have a high blood level of."
69. The next day, the man asked to see the Head of Healthcare. She did not see him that day because she wanted to reduce his expectations about how much he could realistically see her on a one-to-one basis in her new role. However, the Head of Healthcare did go and see the man on the wing the following day. He had a broken tooth and was unhappy with the level of medication he was receiving. The Head of Healthcare managed to secure an emergency dental appointment and the man visited the dentist on 19 January and had the tooth removed.
70. The same day, the man wrote to the Head of Healthcare asking for the microchip in his head to be removed "because it's telling him to kill him, kill that, do this and do that. He says that he can't take it any more." She told my investigator that she believed this letter was written before the man's tooth was removed and that the dental appointment would have solved the crisis. The man spent the next two evenings speaking to a Listener. (A Listener is a prisoner who has been trained by the Samaritans to help other prisoners who are struggling to cope. They listen to a prisoner's problems in confidence and can stay with a prisoner for any length of time.)
71. An ACCT case review was held on 23 January. It was agreed to keep the ACCT document open until after he had completed his education assessment, which was imminent. The man appeared to be upbeat during the review. However, on the morning of 25 January, he was found in his cell having written 'why?' on his cell floor in his own blood. When asked by an officer whether he had cut himself, he replied that he had not but said that "you lot will be sorry". At the end of the exchange, he asked to speak to the Head of Healthcare again.
72. The Head of Healthcare came to speak with the man the following day. He asked her about the progress of his application to the mental health secure unit. She explained that the assessment process was underway and she would do all she could to support his application. The then head of the inreach team helped the man to complete the application form. He wrote:

"I'm a self-harmer, hear things, I get paranoid. No self-confidence. I would like to try to become a better person. I don't want to hate and hurt myself."

73. At the ACCT case review later that day, it was discovered that the man had not attended the education assessment because he was in a “bad mood”. The ACCT document remained open.
74. On 31 January, the man was again found in his cell with writing in what appeared to be blood on his cell wall. It read: “If I die then, she will die too.” When he was asked if he was okay, he said he was. He was reclining on his bed. An RMN spoke to him following this incident and he told her that he would cut an artery one day. The RMN advised him not to do this. She saw the man again on 2 February and talked to him about how he could cope with stressful situations. He agreed that his self-harm was impulsive. He asked the RMN about his referral to the mental health secure unit and she noted that his hopes were building about being transferred.
75. A prisoner at Gartree died due to natural causes on 5 February 2007. The man did not know the deceased. In line with standard procedure, all prisoners on open ACCT documents were reviewed, including the man. He was regarded as “fine at present”.
76. The RMN saw the man again on 6 February. She asked him about his recent episodes of self-harm and he could not explain why he had done them. He said he did not intend to kill himself by self-harming, although did admit that he put himself at risk. The RMN again encouraged the man to get out of his cell more by engaging with education. He seemed “non-committal” about this suggestion.
77. His ACCT document was closed on 9 February following a case review. He had stopped self-harming, but it was a concern that he still had not completed his Genesis induction programme and was not passing his time constructively. It was noted that he had recently got a radio in his cell, which seemed to have helped him.
78. On 12 February, the man told staff that he had taken 94 paracetamol tablets over the weekend. Prisoners can refuse medical treatment, but they must sign a disclaimer to this effect. He signed a disclaimer to refuse treatment. The following day, he agreed to see a new doctor who had just started to work at the prison, on an occasional basis. The man said that he was okay now and would not need an examination. The doctor was unsure whether the man had actually taken the tablets as he was lucid and alert and did not have the appearance of having overdosed. He did not have an enlarged stomach, although it was tender. (An enlarged liver with vomiting and right upper quadrant pain is often a sign of overdose.) The man’s ACCT document remained open.
79. Five days later, the man was assessed by a mental health nurse who had just started as the head of the Primary Care Mental Health Team at Gartree. He spoke to the man about his self-harm and he told him that he was hearing voices. The Head of the Mental Health Team remembered the man as not “being very keen to talk” on that occasion, but he seemed calm. He agreed to see him three days later.

80. The next morning, the man posted a note under his door. It was discovered by an officer towards the end of her night shift. The note said, "I have slashed up. Now I'm ready to hang myself." An ACCT concern and keep safe form was raised. The man had not only written this note but had cut his arm and written "fuck off" in blood on the walls of his cell.
81. An HCO completed the man's assessment interview on this occasion, but again, during interview with my investigator, could not recall the exchange. He recorded that the man was reluctant to engage in conversation but thought that the personality disorder unit "was the answer to all of his prayers". The HCO same concluded that the man was in a "not wanting to die" stage. He required "a long-term commitment from all members involved with his care and to avoid over-medicalising his current issues".
82. The same day, the man agreed to start working with the Head of the Primary Care Mental Health Team and he described the man as someone who was "really actively disturbed". This made him a priority. The man told the team leader that he was frustrated with his sentence and the fact he had not yet had his sentence planning board. The mental health team leader thought that he would find the demands of an indeterminate sentence "quite a struggle", but he wanted to get him busy to help his mental state. However, the man did not seem keen to participate in the activities they discussed because he seemed "despondent".
83. On 20 February, a piece of bed sheet was found on the floor of his cell. It was removed and an entry was made in the ACCT ongoing record. The following day, the man was interviewed by an occupational therapist, about his application to the mental health secure unit. The occupational therapist met the man in the large association area on B wing. He had been asked to see him because there was a staff shortage in the inreach team at the time and he was covering. He told my investigator that he was asked to reassure the man that his application to the secure mental health unit was still being processed. He told the occupational therapist that he did not want to be at Gartree or to work, and that he would "kick off" if he was not moved. At the conclusion of their meeting, the occupational therapist noted in the ongoing ACCT record and clinical record that, "[the man] needs to respond to clear boundaries and less frequent input. He needs to decide whether he is going to address these problems or not."
84. On 22 February, the man bought two packets of tobacco and was observed by staff handing them over to another prisoner. This might have been an indication that he was in debt or being bullied by the other prisoner. Gartree's violence reduction policy includes an anti-bullying strategy. If staff suspect that a prisoner is being bullied, an anti-bullying document is opened and both the bully and the target of bullying are monitored. No anti-bullying document was opened for the man because, at this stage, staff did not suspect that he was being bullied. They were simply monitoring the situation. They asked him if he was all right and made an entry in his ACCT record.

85. An ACCT case review was held on 23 February. The man refused to attend, but the review was held anyway in accordance with procedure. The ACCT remained open. The man asked to see the Head of the Primary Care Mental Health Team on the same day and so he went over to B wing. The man told the nurse he knew he was not going to the mental health secure unit. During interview, mental health team leader did not seem certain as to the stage his application for the mental health secure unit had reached. The man told Head of the Mental Health Team he was frustrated, but the nurse explained that there was no treatment for being frustrated. The man would have to be patient and engage with what purposeful activity there was available to him to improve his mood.
86. On 24 February, an officer noticed that there was blood on the bed sheets. The man swore at the officer, who called the healthcare staff. Again, the man refused to show his injuries and signed a disclaimer to refuse treatment.
87. The man asked to see the wing's mental health nurse again on 25 February. He wanted to cancel the appointment for his assessment by the mental health secure unit. He told her that, as he could not comply with prison rules, they would not accept him and that he could not cope with that rejection. He told her that he had cut his arms and legs, but refused to show anyone. The nurse asked him to reconsider cancelling the appointment. Again, healthcare staff did not cancel the appointment in the hope that the man would change his mind in the meantime.
88. On 26 February, the man asked the wing mental health nurse to cancel his oncology appointment (which was to check up on the testicular cancer treatment he had received the previous year). He told the nurse that he did not want to see the oncologist because he had been cutting his genitals and did not want the doctor to see the injuries. Despite her attempts to persuade him of the benefits of seeing the oncologist, the nurse eventually asked the man to sign a disclaimer the following day to show that he had refused. She made an appointment for him to see the doctor at the prison.
89. Blood was discovered on his door and on his sheets two days later. He showed staff at the treatment hatch his self-harm wounds but refused treatment. He told staff that he was all right, but agreed to see the wing's mental health nurse the following day. An entry was made to that effect in the ACCT medical record.
90. On 1 March, the man's bed sheets were again found to have blood on them. This was the fourth episode of self-harm recorded within a week, which was far more frequent than usual. Although initially reluctant, he agreed to see healthcare staff and had his wound dressed by the Primary Care Mental Health Nurse. He told her that he intended to "extract an artery from his arm, says he is hoping to kill himself". After the man had his wound dressed, he was asked to return to B wing but refused. Primary Care Mental Health Nurse remembered that he would often describe the sense of release he got from self-harm. That day, she recalled, "he did say that he wasn't getting such a release". The Primary Care Mental Health Nurse said that she became more

concerned about him after he said that. If the man was not getting the release he needed from self-harm:

“There was a chance he could go deeper and further and, even if he didn’t intend to really mean to kill himself, he could easily do far more damage, accidentally.”

91. At around 7.00pm, the Duty Governor at the time, was asked to attend healthcare. He ordered the man to return to B wing, explaining that he would be punished if he did not. The Primary Care Mental Health Nurse remembered it was at this point that he told staff he had swallowed four razor blades. Immediately, staff held an ACCT case review. The decision was made to locate the man in the healthcare centre on constant supervision and for a full review to take place the following morning. The Primary Care Mental Health Nurse said that he was asked to go to hospital so that an x-ray could be carried out, but again he refused treatment. He signed a treatment disclaimer form to this effect. She said that the constant supervision was as much related to his level of risk as to monitoring any physical symptoms of internal injuries.
92. At the case review the following day, it was decided to keep the man on constant supervision over the weekend and for the situation to be reviewed again on Monday 5 March. There are two constant supervision cells at Gartree, both located in the healthcare centre. They are gated cells and an officer will either sit directly outside the cell, supervising and interacting with the prisoner, or watch the prisoner via a camera in the cell on a television in the healthcare staff office. (Only officers may carry out constant supervision. They do not have special training but all officers will have an understanding of how to carry out constant supervision from the basic ACCT training.)
93. During the four days that the man was constantly supervised, a case review was held every day. On 4 March, he told the officers and an RGN at the case review that he had swallowed some of his plastic cutlery. (Metal cutlery is not allowed in Gartree and plastic cutlery is used throughout the prison by staff and prisoners.) An officer told my investigator that when she was constantly supervising the man, she noticed him sitting in the corner playing with some cutlery. She did not see him swallow any cutlery. When the man made this claim to the RGN, he handed the nurse a full set of broken cutlery. She said that she asked staff to look out for signs of discomfort, but did not believe that the man had swallowed any cutlery because he had handed a full set over. (In fact, at post mortem, six plastic spoons were found in his intestine. There is no evidence to determine when he swallowed them.)
94. On 5 March, the Head of the Primary Care Mental Health Team and the Head of Healthcare attended an ACCT case review with the man in the healthcare centre. The decision was made to reduce his observation level from constant supervision to no less than half hourly interactions. During interview, the Head of Healthcare explained the decision to reduce his observations:

“My long term plan was to stabilise him in healthcare. Get him off the constant watch which I think at the next review he did say it was

intrusive and I was part of that review and we did change the level of observation because it's difficult to do any therapeutic work with a constant watch, because you have to have the officer with you at all times so the one to one is limited."

95. The Head of Primary Care Mental Health Team was asked to see the man and assess his mental health. On 6 March, he spoke to the man about how he was feeling. The man told the Head of Primary Care Mental Health Team that he was having dreams about his family dying and this was making him confused. He also saw himself killing his family in his dreams. The man appeared angry about self-harming. The mental health team leader wrote a full record of his assessment in the clinical record.

### **7 March 2007**

96. A Health Care Senior Officer (HCSO) and HCO started their day shifts on 7 March. Due to a security alert, the prison was "locked down" at the beginning of the day. (A locked down state requires that all prisoners are locked in their cells until the security alert has been dealt with.) The Deputy Governor told my investigator that senior management had been informed there were weapons in the prison and had requested a lockdown to search the prison. HCSO described the impact the lockdown had on healthcare staff. She said that prisoners who would normally collect their medication from the healthcare centre were not allowed out of their cells. As a result, healthcare staff had to leave the centre and distribute medication and see to prisoners' healthcare needs around the prison. Staff told my investigators that the man was checked at least three times an hour, in accordance with his ACCT observation levels.
97. The man told staff that he did not like being locked in his cell. The Head of Healthcare explained that younger prisoners, especially those familiar with Young Offender Institutions where there is more time spent out of cell, do not react well to the isolation of being locked in their cells for a long period of time. The man was no exception. He was checked every half an hour and was observed lying on his bed or smoking a cigarette. The Head of Healthcare said that being locked in a cell can be stressful for some young men. The man had told her of childhood memories of claustrophobic situations and it was her opinion that he found it difficult to be locked in his cell.
98. At 8.45am that morning, HCSO found the man in his cell with a bandage draped around his neck. The HCSO convinced him to hand her the bandage. The man gave her no reason for having the bandage around his neck and she told my investigator during interview that he seemed relaxed about giving it to her when she asked. The HCSO knew that his ACCT was due to be reviewed later in the day. She made staff aware about the bandage and made an entry in his ACCT document so that it would be considered during the review. However, the HCSO told my investigator that she did not think that he was at an increased risk of suicide because he seemed relaxed about handing over the bandage.

99. The HCSO remembered seeing him come out of his cell on a couple of occasions that day for his meals. Observations in the ACCT document support this. Each time a cell was unlocked in the prison, permission had to be sought from the orderly officer by radio request. Healthcare were allowed to carry on with their routine, but on 7 March the cells in the healthcare centre had yet to be searched so prisoners were still only allowed out of their cell one at a time.
100. His next ACCT case review took place at 3.00pm that afternoon. Just before the review (at 2.55pm), the Head of Healthcare noted that he had handed a bandage over to staff in reference to the HCSO comments earlier in the day. The Head of Healthcare led the case review, which was conducted through his cell door due to the lockdown. During interview, she described the circumstances of the review as “difficult” because it could not be conducted in private. The man told staff present that he felt particularly stressed due to the lockdown situation. During interview, the Head of Healthcare said that she did not ask him about the bandage that was found around his neck earlier that day. She did not interpret the bandage as an act of self-harm. She said:
- “If he wanted to self-harm he would have self-harmed and he would not leave you in any danger that you missed something, including severely burning his arm and good cutting if I can say, not just scratching. It would be a proper job.”
101. The Head of Healthcare and the Head of the Primary Care Mental Health Team decided that the observation levels of the man should remain at least at half-hourly intervals. The Head of Healthcare said that because he had not obviously self-harmed by cutting himself as he normally would, she did not think that he was so stressed that his ACCT observation level needed to be returned to constant supervision.
102. The chaplain visited the man at around 5.45pm and spoke to him through the door. He remembered him being reluctant to talk to him, only really speaking when the chaplain asked if anyone was likely to be visiting him soon. The man told the chaplain that his grandmother would be coming to see him. (His grandmother kept in touch with him throughout his time in prison and visited him regularly. The man told other prisoners and staff how much the visits meant to him.) The man soon became guarded again and seemed annoyed with himself for engaging in conversation at all. The chaplain said that the man did not seem to be hinting at any future action when he said “tell them to let me die”. Instead, he described the man as despondent.
103. At around 7.00pm, the HCSO checked on the man. His was the first cell she went to because it was the first cell she came across. At first, she just looked through the window in the door but she could not see much. She adjusted the observation panel so she could get a better view. The HCSO saw the man lying face down on the floor, with his head at the end of the bed and his face turned away from the door. She called to him several times but got no response. She immediately thought that something was wrong.

104. The HCSO's colleague, an HCO returned to the healthcare centre at the same moment and she called to him for assistance. She said that she could not get any response from the man, but at that stage she was not sure whether the situation was serious. Due to the lockdown in the prison at that time, the HCSO had to radio the communication department to ask for permission to enter the cell. She told my investigator that she knew she would not have been able to enter the cell by herself but, because her colleague had just returned to the healthcare centre, she could enter with the orderly officer's permission. The HCSO spoke to a PO who said, "if you feel it's an emergency then go in". As she could not get a response from the man, the HCSO judged it was indeed an emergency. Despite the lockdown, it only took around one minute for staff to enter the cell.
105. The man was lying in quite a straight line, facing away from the cell door. He did not appear to be moving. The HCSO and the HCO tried to get a response by shaking him. He did not respond. They rolled him over and noticed that there was some blood on the right side of his face and the floor. There was a ligature around his neck that was not attached to anything. While the HCSO supported his head, the HCO removed the ligature from around his neck. He then went to get the emergency grab bag from the outpatients' unit. (An emergency grab bag contains equipment that might be required in an urgent medical situation, for example, dressings or an ambubag.)
106. An officer who was carrying out constant supervision of a prisoner who was located in the cell next door. He could not stop his constant supervision, but volunteered to call an ambulance and radio for assistance when the HCSO first found the man. Having made the emergency radio call, the officer was concerned about the welfare of the high-risk prisoner he was observing and drew a screen across the gate of the cell. He tried to keep the other prisoner's mind occupied by playing Monopoly with him.
107. The HCSO checked the vital signs of the man and found no pulse. She commenced chest compressions. The HCO returned with the ambubag. The cardio-pulmonary resuscitation (CPR) efforts were continued until the paramedics arrived. The HCO recalled that "at some point" during the resuscitation efforts, he and the HCSO shouted for someone to get the defibrillator from the outpatients' unit. When it was brought to them, they applied the defibrillator to try to start his heart. The machine informed them that there was no pulse and an electric shock should not be administered.
108. The ambulance arrived at approximately 7.30pm. By this time, the PO had placed a radio call requesting all POs and the Duty Governor to go to healthcare to attend an emergency. During interview, she said that she knew that there were a number of POs who had stayed on duty to assist with the lockdown. She knew that they were extra staff, not normally detailed, so thought they would be best placed to help with the emergency (for example by escorting the ambulance).
109. When the ambulance arrived, there were four POs on the healthcare centre and the Duty Governor had attended the cell. One of the POs assisted the

HCSO and the colleague with CPR until the paramedics took over. One of the POs arranged for another officer and HCSO to escort the man in the ambulance to hospital. Two officers continued administering CPR in the ambulance, under the supervision of the paramedic. Both officers felt confident in administering CPR, although it was unusual that they were required to do so when there was a paramedic present. One of the POs accompanied the ambulance driver in the front of the ambulance. The ambulance left Gartree at 7.50pm and arrived at the hospital at 8.07pm.

110. During interview, the PO explained that she was frustrated by hospital staff because they did not keep her informed about the condition of the man. Eventually, the paramedic who had attended the prison told her that he would find out what was happening. It was then that a doctor from the hospital approached the PO and asked how long CPR had been administered before the ambulance arrived. She replied that it had been administered for around 15 minutes. Sadly, the man could not be revived and a doctor pronounced the man's death at 8.15pm.

### **Prisoner support**

111. On the morning of 8 March, the Head of Healthcare gathered all of the prisoners in the healthcare centre together to break the news that the man had died. She asked two chaplains to attend for extra support. The prisoners returned to their cells and the chaplains returned that lunchtime. The Head of Healthcare had arranged candles at one end of the healthcare centre. Each of the prisoners lit a candle in his memory, and a chaplain led prayers.
112. A senior officer on the induction wing visited a prisoner on his cell on B wing on 8 March and told him that the man had died. She also broke the news to another prisoner, who described the staff on the induction wing as "brilliant" and felt that he was well supported.

### **Staff support**

113. There was no formal hot debrief following the discovery. This was a considered decision by the Deputy Governor. She felt it important that key staff were able to go home and rest as soon as possible. She told my investigators that she spoke to all key members of staff individually. (The purpose of a hot debrief is to give staff the opportunity to share their feelings following involvement in a traumatic incident.) All the staff involved told my investigation team that they felt well supported. (The clinical reviewer considers that hot debriefs might not be an effective measure to deal with post-traumatic stress.) While I would normally recommend that a hot debrief takes place to provide structured support to staff following a death in custody, I am satisfied that on this occasion, the decision not to hold such a debrief was a proper one. It was not an oversight, but a decision in the best interests of those staff members involved.
114. A concern was raised in interview by Deputy Governor that the demands of the police who attended immediately after the man's death were difficult to meet at

a time of low staffing levels. Following a death in custody, the police are obliged to carry out a full investigation as quickly as possible to rule out any suspicious circumstances. I appreciate that this might place strain on the prison and suggest that a protocol between Gartree and their local police might be developed so that it is clear what is expected following any future deaths in custody.

115. Despite prisoners often going that hospital, one of the POs told my investigators that she felt the hospital staff overlooked her. She asked about the man's condition but was not given much information about what was happening. As a matter of good practice, the Governor may wish to write to the hospital with these concerns.

### **Family contact**

116. The man's mother was informed of her son's death at 2.00am on 8 March by local police. The decision for the police to inform the family was made following a police risk assessment. Unfortunately, this led to a delay in notifying Anthony's mother of her son's death. The mother then broke the news to his grandmother and his father. In accordance with policy, a prison should make every effort to notify a family in person. I appreciate the difficulties, especially at night, but I think it was regrettable that the notification was made by the police and not the prison.
117. A prisoner's personal information, including who they have listed as their next of kin, is kept on a central database, known as Local Inmate Data System (LIDS). All prisons have access to the information on LIDS. When the man arrived at Leicester, he would have been asked to identify his next of kin. He told staff that his father was his next of kin and gave them his contact details. LIDS was not checked until the appointed family liaison officer checked it two days after contact had been initiated with two other members of his family. This oversight caused a delay in informing the next of kin that he had died. With this in mind, I make the following recommendation:

**The Governor must ensure that the listed next of kin are the first to be informed of a death in custody.**

118. Once he had returned to work, the appointed family liaison officer, a senior officer, contacted the family and arranged for them to visit the prison. He was trained in family liaison before his arrival at Gartree and, at the time of the investigation, was the only officer who had been through the Prison Service's bespoke training in family liaison. He liaised with the members of the family for the weeks following the man's death, and kept a comprehensive log of his efforts (in line with good practice). However, the family have raised some serious concerns with the Senior Family Liaison Officer in my office about not being able to contact the prison appointed family liaison officer. The family told the investigation team that they had "given up" trying to contact the prison. I understand that, in the weeks following the man's death, he was delivering training and therefore unavailable to take the family's calls. The appointment of an individual officer to act as a liaison for the family is meant to ensure

continuity for the family and make it easy for them to contact the prison. This was not achieved on this occasion.

**The Governor should arrange for the training of other family liaison officers to ensure that someone is personally available to families in the weeks following a death in custody.**

119. The man's family have been further distressed by a misunderstanding about the circumstances of his death. The Prison Service has a centrally-based Press Office. Following his death, a governor contacted the Press Office to let them know the circumstances. The Governor attended the emergency response and was fully briefed about what had happened to the man. Nevertheless, the Prison Service released a statement saying that the man had been found with his ligature attached to a window. The ligature was not attached to the window but had been pulled tightly by himself around his neck until he lost consciousness. It is likely that he then fell to the floor, where he sustained injuries to the right side of his face. The man did not regain consciousness. The post mortem found that the cause of death was hanging, because he used a ligature to restrict his breathing. The Prison Service's press release led to avoidable confusion about his death. Understandably, this made it hard for the family to feel that they really knew what happened, and they began to question the truth of the information they received from the prison.

**The Prison Service Press Office should ensure that all press releases regarding deaths in custody are accurate and approved by a governor at the prison concerned.**

120. In addition to the family's confusion about how the man died, rumours they have heard in the community have led them to question whether he died in suspicious circumstances. I am satisfied that this was not the case. Before my investigation can get underway, the police must satisfy themselves that there is no third party involvement. The police have informed this office that there were no suspicious circumstances and, for this reason, they were happy for my investigation team to proceed. During the course of the investigation, I have discovered no evidence to suggest that there was any third party involvement in his death.
121. The man's family have also raised concerns about rumours of bullying at Gartree, the treatment that he received for his mental health problems, and the delay in transferring the man to a mental health setting. These matters are addressed in the Issues section of this report which now follows.

## ISSUES

### The man's time at Leicester

122. The man spent a difficult time at Leicester. Staff recorded that he was a “drain on resources” and he spent much time in and out of the segregation unit. He was also identified as a risk to himself and therefore on an open ACCT document for a lot of his time. The initial segregation safety screen is completed every time a prisoner is segregated. The main part of the form is completed by a member of the healthcare staff who determines whether it is safe to hold the prisoner in the segregation unit. My investigator spoke to a nurse about completing the man's segregation safety algorithm, which she did on a number of occasions. She said that the man did appear to have mental health problems. However, she knew him from previous sentences and understood that he responded well to the stricter regime on the segregation unit. She had no concerns about his mental state deteriorating in the segregation unit because she felt that segregation often stabilised his mood.
123. According to Prison Service Order (PSO) 2700, the location of a prisoner who is subject to ACCT procedures on a segregation unit must be authorised by a governor. (PSO 2700 is the order that governs the management of prisoners considered to be at risk of suicide or self-harm.) On the back of a segregation safety algorithm, there is space for a governor to sign off the nurse's recommendation. A governor must sign off for every prisoner who is on an open ACCT document who is segregated. The form reads: Prisoners on an open ACCT plan must only be located in segregation or special accommodation under exceptional circumstances.
124. My investigator, spoke with two governors about the segregation of prisoners on an ACCT document. Both governors had countersigned segregation safety screens when the man was segregated. One of the governors explained that a balance must be struck between security and the risk that the prisoner presents. Segregation for prisoners on an open ACCT is avoided if at all possible but, if the severity of behaviour and the risk to other prisoners or staff is too great, a prisoner must be segregated. She said that staff look at the behaviour of the prisoner and, if they are on an ACCT document, whether that behaviour can be effectively managed on a residential wing. The governor said that “a lot of weight” is attached to the healthcare recommendation about the safety of segregating a prisoner on an open ACCT document when making this decision.
125. The man's disruptive episodes were frequent, as were his episodes of self-harm. Although Leicester appropriately documented each adjudication, it is difficult to determine from the records which adjudication record related to which disruptive episode because of the frequency of his poor behaviour. During interview, the governor was clear that “a prisoner would never be placed on report for self-harming or anything to with self-harming”. The 2nd Governor also assured my investigator that a prisoner is never punished for self-harming. There is no evidence to suggest that the man was adjudicated for self-harming.

However, he was adjudicated shortly after episodes of self-harm on more than one occasion.

126. The governor Slater described the review process for a prisoner on an open ACCT document being segregated. First, there is a segregation review board to determine how the prisoner's behaviour should be managed while he is in the segregation unit. Following that meeting, an ACCT case review is held to review a prisoner's risk. She explained that, while their purposes are different, the processes run side-by-side and are often attended by the same prison staff.
127. I acknowledge that the man seemed to react well to the segregation unit at Leicester. However, I am extremely concerned that he was so frequently segregated at times of crisis and while actively self-harming. Indeed, he self-harmed on several occasions while he was in the segregation unit. While segregation reviews and ACCT reviews serve different purposes, his self-harming behaviour should not have been divorced from his destructive behaviour.
128. PSO 2700 has recently been revised by the Prison Service and will be implemented by April 2008. The revised PSO makes provision for the management of 'at-risk prisoners' whose behaviour is particularly challenging. The man would have fulfilled the criteria to engage this part of the PSO. It requires that an enhanced case review, with representatives from the prison's senior management team, should meet to discuss all components of the care of a prisoner. I hope that this will encourage a coordinated approach to all the needs of an at-risk prisoner such as the man.

### **The man's sentence**

129. When the man received his indeterminate sentence, he spoke to his father and said the requirements were beyond him. He feared failure and was overwhelmed by the thought of having to successfully complete a number of courses. He told his father that he thought of it as a life sentence. Staff at Leicester prepared him for his sentence and spoke to him at length after he received it. In accordance with procedure, they asked him how he felt about it and talked him through the opportunity he had been given for a fresh start. Staff even prioritised his transfer to Gartree in recognition of his inability to cope with frustration. I am pleased to note the proactive approach that staff at Leicester took to securing an early transfer to a lifer prison so that the man could work towards release.
130. The man told the Head of Healthcare that he was overwhelmed by the requirements of an indeterminate sentence. The Head of Primary Care Mental Health Team thought that he would "struggle" with the sentence. Another prisoner on B wing, told us how the man was "depressed" with his sentence.
131. The man received a lot of support in the short time he was at Gartree, but the requirements of the sentence seemed to a number of staff, and to the man himself, to be beyond his reach.

## **The man's time on B wing at Gartree**

132. A senior officer who had been on B wing for 13 or 14 months since it opened as an induction unit. There are two other senior officers on B wing. In his role, the senior officer is responsible for managing the wing. There is often a high level of anxiety on a prison induction wing, associated with a period of adjustment to the regime of the prison. Mental health staff at Gartree told my investigators that they have more contact with prisoners on B wing than any other. The senior officer said that B wing was the busiest wing in the prison, especially since the introduction of the indeterminate sentence.
133. The senior said that a prisoner's first point of contact with concerns about how an indeterminate sentence works would be their personal officer. He said that he does speak to all prisoners who have an indeterminate sentence to explain it to them. Prisoners often arrive at Gartree with high expectations that they will be released on tariff, but prisoners not understanding indeterminate sentence was not a "widespread problem" and affects only a minority of prisoners. He did not recall specifically talking to the man about his sentence, but thought that he would have done so as a matter of course.
134. The sentence planning process takes place while a prisoner is on B wing. Prisoners' risks are identified through their probation assessment documentation, post-sentence report and psychological assessments. This process dictates what programmes they must attend during their sentence. The sentence planning board is not held until three months after a prisoner arrives into the lifer estate. This is to give the prisoner time to settle in, and for staff to carry out necessary assessments to determine each prisoner's needs so that they can be appropriately addressed through their sentence plan.
135. Until they have had the sentence planning board, prisoners cannot work or attend education courses and this leaves a shortage of purposeful activity. Once a prisoner's sentence plan has been drawn up, they are then able to attend courses or choose to work in the prison to earn some extra money. Even when a prisoner has gone through his board, he has to go on a waiting list for the courses identified to reduce his risk of reoffending and increase his chances of being considered for parole. The lack of courses for prisoners in the lifer estate is not a problem confined to Gartree and has been the subject of important court decisions. The Prison Service has issued new guidance (Prison Service Instructions 7/2008) designed to move prisoners with short tariff indeterminate sentences into more appropriate accommodation as quickly as possible.
136. It is clear that the man felt intimidated and confused by his sentence. The open-endedness and uncertainty of it provided little structure for someone who had few coping mechanisms to draw on. Although he did not have a severe and enduring mental illness, his symptoms were such as to have caused him great anxiety about achieving the demands of his sentence. His fear of failure, compounded with his lack of confidence, meant that staff felt that, without immense support, he would have found it difficult to deal with the progressive stages he needed to achieve his freedom and rehabilitation. Another prisoner,

located in a cell near the man on B wing, approached my investigation team to raise some concerns. He thought that the man might have had a mental illness and said that he was definitely not cut out for prison. He said that if the man was working, it might have kept his mind occupied and that could have helped him. The other prisoner described how the man got depressed with his sentence. He said that he lost interest in himself. When the head of the Primary Care Mental Health Team met with the man, one of his main objectives was to get him busy to keep his mind occupied. The man was withdrawn on the wing and spent a lot of time in his cell. Despite the mental health team leader's recommendation, there are no recorded efforts to engage the man in purposeful activity.

**The Governor should consider the introduction of short courses for the period before a prisoner's sentence planning board can be held, to ensure that prisoners have the opportunity for purposeful activity.**

137. Once a prisoner has his sentence planning board, he is placed on the waiting list for the courses identified as necessary to address his offending behaviour. My investigation team spoke to a senior officer who developed the waiting list system for education courses at Gartree. The senior officer said that the waiting list has been devised so that the percentage of prisoners at Gartree who have an indeterminate sentence is proportionately represented on the waiting list. That is, if 30 per cent of the prison population had an indeterminate sentence, 30 per cent of places on the waiting list would be prisoners with indeterminate sentences. This is to make the system fair both for prisoners with indeterminate sentences and for prisoners who have a mandatory life sentence who also need to complete courses to progress through their sentence. The senior officer said that prisoners have to wait three months for their sentence planning board. Prisoners who have short tariffs may cause a bottleneck as they need to progress through the sentence planning board quickly in order to meet the requirements of their sentence plan within tariff. The senior described prisoners as always being frustrated with slow progress through the system. He said that there is a problem with prolific offenders who have been given an indeterminate sentence, because they are used to serving their minimum tariff and then being released. That expectation has now been challenged by the indeterminate sentence. The emphasis on rehabilitation has been undermined by the lack of opportunity for a prisoner to complete the identified courses within tariff.
138. A prisoner expressed concern about the man's wellbeing while he was on B wing. He said that the man appeared young and was the kind of prisoner who might be targeted by bullies. The prisoner said that he thought staff were approachable, but he did not tell them about his concerns for the man until he had been taken to the healthcare centre on Thursday 1 March. It was the night that prisoners received their pay and other prisoners on B wing were asking where the man was because he was in debt to them. They asked the prisoner where he was because they wanted their tobacco back. The prisoner told the staff that he was concerned that the man was in debt and that he could not keep paying off what the man owed. It was the prisoner's opinion that he went to hospital to get away from his debt on that occasion.

139. All staff told my investigators there was no intelligence that the man was being bullied or in debt on the wing until after he had died. Even after he had died, there were rumours but no credible sources of information. The man did not mention problems on the wing to healthcare staff or officers and found it difficult to trust authority figures. This might have meant that he would not have felt comfortable approaching staff with a problem. All staff also said that they were confident with the violence reduction strategy and had used it where they suspected a prisoner of being bullied. The prisoner asked an officer to go to healthcare to speak to the man to tell him that the prisoner was worried about him. When asked about this by my investigators, the officer said that he did not pass the information on because he could not be sure whether he was being used to send a veiled threat.
140. It is a matter of serious concern that the man might have been bullied while he was on the induction wing. However, following investigation, it seems that anti-bullying procedures were in place and staff were confident with violence reduction policy and procedures. I am satisfied that he had the appropriate avenues of support open to him, should he have chosen to use them. Not only could he have approached wing staff, but he was also seen frequently by healthcare staff. If he was bullied, it is unfortunate that he was unable to trust staff sufficiently to approach them about his concerns. My investigation was unable to find any evidence to determine whether he was in fact bullied or not.

### **The man's primary medical needs**

141. Staff at Gartree and Leicester repeatedly dealt with the man's refusal to be treated for reported episodes of self-harm. It seems that this was part of his pattern of self-harming. The last example of this refusal was when he said that he had swallowed razor blades. The Primary Care Mental Health Nurse told my investigator that there were no physical signs that he had internal injuries, but one of the reasons that he was put under constant supervision was to ensure he was appropriately monitored in case he developed signs of internal injury. It is unlawful for staff to treat a prisoner who does not consent to treatment. The records show that appropriate effort was made to explain to the man the impact of his refusal of treatment. Staff ensured that he signed a refusal of treatment form. The clinical reviewer was asked to consider whether his refusal of treatment was handled appropriately. He concluded:

“My opinion is that the man ... could not be compelled to take treatment for the overdose or any other self-harming event, such as his alleged swallowing of razor blades on 1 March 2007. The healthcare staff took all the action they could to monitor him and to encourage him to have appropriate investigations and treatment. They documented these offers and the man signed to confirm he had refused them.”

142. He was entitled to repeatedly refuse treatment for the injuries he sustained while he was self-harming, just as he was entitled to refuse to engage with treatment to check on the remission of his testicular cancer. Efforts were made by staff at Leicester and Gartree to encourage the man to have treatment. Staff

also tried to discuss with him why he refused. I agree with the clinical reviewer that staff took appropriate steps once he had refused treatment.

143. My investigation team spoke to a HCO who had previously dispensed treatment outside B wing on 13 January at length about his exchanges with the man regarding paracetamol. He explained that there is an audit system in place to make it difficult for prisoners to get hold of too much paracetamol. However, these systems were not fail-safe. On one occasion, the man was found with 46 tablets in his cell. On another occasion, he told staff he managed to take a significant amount of paracetamol, although this could not be confirmed due to his refusal to be examined. The HCO described a "culture" that used to exist at Gartree of prisoners getting hold of co-codamol for illicit purposes. He said that a security-led spot-check system had stopped that culture, but staff were alert to prisoners asking for co-codamol too regularly.
144. The doctor who carried out the clinical review examined the issue of paracetamol and was surprised that so much was issued on a daily basis. He was also concerned that prisoners might be able to obtain paracetamol from each other on an unsupervised basis. The doctor questioned the use of such medication for people with the background of self-harm that the man had. However, he concluded, that in his case, "the healthcare staff took all the action they could to monitor him and to encourage him to have appropriate investigations and treatment".

**The Head of Healthcare should carry out a full review of the systems for the dispensation of paracetamol and co-codamol on residential wings.**

#### **The man's mental health needs**

145. The man was diagnosed with a personality disorder. A personality disorder is a deeply ingrained way of behaving in certain social or stressful situations that differs from what is considered to be the norm. It is not a mental illness, although a lot of people with personality disorders also have mental illness. Deliberate self-harm, anxiety and depression can all be symptoms of a personality disorder. In order to receive treatment from a prison's mental health inreach team, a prisoner would normally have a severe and enduring mental illness, for example schizophrenia. After several psychiatric assessments in recent years, he was not considered to be suffering from a severe and enduring mental illness. The man struggled to understand this.
146. When he was told that the inreach team at Leicester would no longer supervise his treatment, he took the news badly. However, he was looked after by the Head of the Primary Care Mental Health Team and the Primary Care Mental Health Team Nurse, the nurse detailed to work with prisoners on B wing when needed. He seemed to engage with this treatment to some extent. He saw the mental health team leader on a number of occasions and could have access to wing mental health nurse most days. The inreach team did work with the man in respect of his application to the mental health secure unit.

147. The man had tried to apply to the mental health secure unit while he was at Leicester. The CPA Co-ordinator wrote to the Head of Healthcare detailing his background when he was transferred to Gartree, and indicated that his application was not being supported by mental health inreach staff at Leicester. She attached his self-referral. In her letter, the CPA Co-ordinator explained that the man showed little understanding of the demands of the PDU and she thought it unlikely that he would succeed in such an environment due to his inability to cope with rules or authority. Despite that letter, his application to the mental health secure unit was started afresh in Gartree. The Head of Healthcare described her motivation, as follows:

“He was stuck betwixt and between because I can’t let him out unless he’s done offending behaviour programme’s so I was trying to get him through, not an easier route and I don’t mean that disrespectfully but a different route that was going to be more gentle, i.e. the hospital route.”

The Head of Healthcare went on to say that she was not sure that the man would have been accepted at [the mental health secure unit]. His inability to engage with staff at Gartree might have prevented him from benefiting from treatment at [the mental health secure unit], but she told my investigators that she thought it was “worth a try”.

148. On 23 February 2007, the man told the Head of the Primary Care Mental Health Team that he knew his application was not going to be successful. In fact, the Head of Healthcare told my investigation team that his assessment had been scheduled to take place three days after his death. His confusion about the progress of his application does not appear to be well founded. The occupational therapist, was specifically asked to reassure the man that the application was in hand and did so on 20 February. It is likely, on balance, that he was being pessimistic about his chances of being accepted to the mental health secure unit, rather than not feeling informed about its progress. The man also told the mental health wing nurse that he was afraid of failing at the personality disorder unit. His efforts to cancel the appointment might have been to pre-empt a failure in the assessment process.

149. The Head of Healthcare told my investigator that the man was being looked after “medication free” as far as possible. The doctor who carried out the clinical review reflected that, “it was appropriate that the man did not receive any drugs for his voices as these were not true schizophrenic symptoms”. The Head of Healthcare explained that, in consultation with the Psychiatrist, she was wary of “over-medicalising” the man. She had known him from a young age and, during interview, recognised that “he had been on every medication I think known to man”. The Head of Healthcare was concerned that the symptoms of early onset schizophrenia can be masked by medication. I am pleased to note that the man’s best interests were prioritised over issuing medication with a view to minimising the disruption his behaviour caused on the wing.

150. In his clinical review, the doctor recognised good practice:

“The Health Care Staff at Gartree have good systems in place to try and help people such as the man and this is exemplified by the attention he received from the Primary Mental Health Team and the Health Care Manager. The links with a Primary Mental Health Care worker and a wing are useful and educational for the staff on the wings. These examples of good practice are to be commended.”

I agree that the model for appointing a mental health liaison worker for each wing seemed to improve the confidence of staff and enabled there to be continuity of care for prisoners on each wing. The wing’s mental health nurse, was able to establish a good relationship with the man which continued on his transfer to the healthcare centre.

### **The man’s level of risk**

151. Following a mental health assessment on 10 January 2007, the Consultant Forensic Psychiatrist, made a lengthy entry in the man’s medical record. He identified him as being a high risk of “inadvertently” killing himself, but this was not passed on to staff on the wing. Head of Healthcare, said that there is no formal system for communicating information between a patient’s medical record and staff on the wing. However, she felt that communication was good enough between staff that officers would have known about the psychiatrist statement. In fact the senior officer for B wing, did not know anything about it. The Head of Healthcare acknowledged the need for a formalised communication of information, such as risk of self-harm or accidental suicide.

**The Head of Healthcare and Governor must ensure communication between wing and healthcare staff is improved to ensure that all staff are aware of crucial information about a prisoner’s level of risk.**

152. The man claimed that he had swallowed razor blades on 1 March 2007, while in the healthcare centre. Rather than returning him to the wing, the decision was made to admit him to the healthcare centre and keep him under constant supervision. This was partly because the man refused to go to hospital for an x-ray and the Primary Care Mental Health Nurse wanted to monitor his physical condition. However, staff were also concerned about the level of risk that the man presented at that time. He was under constant supervision for five days.
153. My investigator spoke to a number of staff who carried out the constant supervision on the man. None of them noticed him swallowing any of the plastic cutlery that he had been issued to eat his meals. However, while there were no signs of razor blades at post-mortem, the examination did show that he had swallowed a number of plastic spoons. It is not possible to determine when he swallowed the spoons, but there is a possibility that he did so while under constant supervision. A registered nurse remembered him handing her some broken cutlery when he was on constant supervision and saying that he had swallowed some of it. She said that he handed her a full set and none of the cutlery was missing. She said that he had not eaten the set that he had handed to her. When asked what she would do if a prisoner made such a claim, the nurse responded:

“Monitor him, if he showed any signs or symptoms, stomach problems anything like that I would have obviously got a doctor in or sent him out [to hospital].”

154. An officer remembered the man playing with some cutlery in the corner of his cell during her shift of constant supervision. She said that during constant supervision, she never lost sight of him but that there were occasions, given the layout of the cell when he was not completely in her vision. She was certain that he would not have been able to swallow cutlery while she carried out her constant supervision. The man used plastic cutlery throughout his time at Gartree. There is insufficient evidence to determine whether he swallowed the cutlery while on constant supervision.
155. On 5 March, the constant supervision was reduced to intermittent observations. The Head of Healthcare explained that the level had to be reduced in order to enable therapeutic interventions with the man to help him recover from his traumatic episode on 1 March. A review was held on 7 March, attended by the Head of Healthcare, Head of Primary Care Mental Health Team and the man. Both the Head of the Primary Care Mental Health Team and Head of Healthcare were aware that he had been found with a ligature that morning, which was a departure from his self-harming pattern. The man had told staff that he did not like being locked in his cell. Staff had told Head of Healthcare that the man was coping badly with the lockdown. The Head of Healthcare and the Head of Primary Care Mental Health Team are mental health nurses. They both agreed it was in the man’s interest to continue with the lower level of observations so that they could begin to work with him therapeutically. Besides this, Head of Healthcare told my investigators she thought it was “not necessary” to put him on constant supervision. The man would have done a “proper job” of self-harming if he was responding to increased stress levels.
156. While it is unlikely that the man would have had the opportunity to kill himself if he was on constant supervision, it is difficult to argue that Head of Healthcare and Head of Primary Care Mental Health Team decision was unreasonable. They are both mental health professionals and assured my investigators they thought that they were acting in his best interests. The case review had to be conducted through the door due to the lockdown situation. This meant that this discussion would have been overheard by other patients and staff not participating in the review. Due to the sensitive subject matter of an ACCT case review, I make the following recommendation:

**The Head of Healthcare should ensure, as far as possible, that ACCT reviews are always be held in a private environment.**

157. No ACCT observations were recorded between the case review at 3.00pm and the chaplaincy visit at 5.45pm. There is no way to evidence whether any checks were made on the man during this time. An officer, who was carrying out constant supervision for the cell next door to the man’s cell, said that staff spoke to him more often than every half an hour. An HCSO remembered checking the man that afternoon. Although she was working in the healthcare

centre, Head of Healthcare said that she was not sure that the checks had been done because it was a very busy day.

**The Head of Safer Custody must ensure that contemporaneous records of ACCT observations are kept for all prisoners on ACCT documents, in accordance with ACCT procedure.**

158. The chaplain told my investigator that requesting ACCT case reviews fell outside of his role. He said that he told the staff in the healthcare office that he was concerned that the man seemed miserable and wrote an observation in his ACCT record. The chaplain had been trained in ACCT procedures and it was surprising that he did not feel able to trigger a review to alter the man's ACCT observations.

**The Head of Safer Custody should remind all staff that anyone can raise a concern about a prisoner's level of risk, open an ACCT or request an ACCT case review.**

### **Prison lockdown**

159. While it is a matter of regret that prisoners must be locked in their cells for prolonged periods, such measures are necessary on occasion in the interests of security. I cannot criticise Gartree for acting upon security intelligence which might have placed the safety of staff and prisoners under threat. However, as a consequence, the man's isolation on 7 March would not have helped his mental state.
160. I agree with the clinical reviewer that arrangements could be made on such occasions to prioritise the cells that are searched first. The doctor that carried out the clinical review wrote:

“Security policies could be reviewed by the senior management to look at the issues of Health Care being checked early and the policy of needing to telephone for permission to enter a cell during lockdown, even two minutes delay can be critical in a life-threatening situation.”

While I do not think that the practice of radioing the orderly officer in any way delayed the prison's response when they found the man (I consider this issue in more detail below), it must be recognised that there are prisoners in the healthcare centre who are there because they are in crisis and need enhanced supervision. With this in mind, I make the following recommendation:

**The Governor should review the security policy to prioritise searching the healthcare centre in a lockdown situation.**

161. Despite the prison being in a lockdown state, the investigation found no evidence that this unreasonably delayed entry into the man's cell. Moreover, it is the clinical reviewer's opinion that a delay in entering the cell would not have made a difference to the outcome in this case. However, in future cases, any

delay caused by the prison being locked down might mean the difference between life and death.

### **Emergency response efforts**

162. The defibrillator was not retrieved from the outpatients unit with the emergency grab bag, despite the fact that the defibrillator was located next to it. The HCO said that his priority was to commence CPR. The same HCO told my investigation team that the defibrillator was applied and instructed not to shock. The clinical reviewer considered the matter of defibrillation and stated: “the earlier defibrillation takes place, the higher the chance of survival”. While there is no clear evidence that earlier use of the defibrillator would have affected the outcome in this case, I agree with the clinical reviewer’s recommendation that:

**The Head of Healthcare should review local emergency response policy to ensure that a defibrillator is taken without delay to any life-threatening situation.**

163. The clinical reviewer has also recommended that CPR training should be considered for staff to ensure that there are CPR trained officers in all areas of the prison. While I agree with the importance of CPR training among prison staff, both members of staff who assisted in the ambulance had actually been CPR trained within the past three years because they are new officers. These staff members were asked to continue their CPR efforts in the ambulance. While this might have been difficult in the circumstances, both staff members told my investigators that they felt confident in the use of CPR.

## CONCLUSION

164. The man had difficulty trusting staff. The Primary Care Mental Health Nurse described how, "I always got the feeling that he wanted to tell somebody something but he just never could." As a result, no one really felt that they knew him. When asked whether she thought the man meant to take his own life, the Primary Care Mental Health Nurse said that she was surprised that he did it. However, she acknowledged that Gartree might have overwhelmed a young prisoner like him, who was already intimidated by his indeterminate sentence and was in a prison exclusively for lifers. The man had been identified as at a high risk of accidentally killing himself through self-harm.
165. In his clinical review, the doctor recognised that people who deal with stressful situations by cutting, hanging or burning themselves have a 3 per cent chance of death from their activities. Given the unusual method of strangulation, the man may not have intended to die. However, his death was caused by a method of self-harm that was outside of his normal pattern of behaviour. He had moved to the healthcare centre that week and made the subject of constant supervision in response to an apparent crisis. He told the chaplain that staff should "let him die". The man's referral to mental health secure unit was reaching a crucial stage of assessment and he had decided it would fail. He was overwhelmed by his sentence. Manifestly, it is not possible to determine what the man was thinking before he died. But, it will be for the Coroner and his jury to decide whether the man intended to end his life.
166. The wider implications raised by the sad facts related in this report concern the indeterminate sentence itself and the way that the Prison Service copes with prisoners deemed unsuitable for mainstream mental health services, and considered a danger both to themselves and others. I make no formal recommendation, but this is a report that might usefully be read within the new NOMS Agency and in the Ministry of Justice as a whole.

## RECOMMENDATIONS

1. The Governor must ensure that the listed next of kin are the first to be informed of a death in custody.
2. The Governor should arrange for the training of other family liaison officers to ensure that someone is personally available to families in the weeks following a death in custody.
3. The Prison Service Press Office should ensure that all press releases regarding deaths in custody are accurate and approved by a governor at the prison concerned.
4. The Governor should consider the introduction of short courses for the period before a prisoner's sentence planning board can be held, to ensure that prisoners have the opportunity for purposeful activity.
5. The Head of Healthcare should carry out a full review of the systems for the dispensation of paracetamol and co-codamol on residential wings.
6. The Head of Healthcare and Governor must ensure communication between wing and healthcare staff is improved to ensure that all staff are aware of crucial information about a prisoner's level of risk.
7. The Head of Healthcare should ensure, as far as possible, that ACCT reviews are always be held in a private environment.
8. The Head of Safer Custody must ensure that contemporaneous records of ACCT observations are kept for all prisoners on ACCT documents, in accordance with ACCT procedure.
9. The Head of Safer Custody should remind all staff that anyone can raise a concern about a prisoner's level of risk, open an ACCT or request an ACCT case review.
10. The Governor should review the security policy to prioritise searching the healthcare centre in a lockdown situation.
11. The Head of Healthcare should review local emergency response policy to ensure that a defibrillator is taken without delay to any life-threatening situation.