

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of a prisoner at HMP Long Lartin on 18 January 2015

**A report by the Prisons and Probation Ombudsman
Nigel Newcomen CBE**

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We are:

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This is the investigation report into the death of a man, who died from an overdose of tramadol at HMP Long Lartin on 18 January 2015. The man was 37 years old. I offer my condolences to the man's family and friends.

An investigator was appointed. A clinical reviewer reviewed the care of the man at the prison. Long Lartin cooperated fully with the investigation.

In October 2011, the man was sentenced to life imprisonment for the murder of a friend. He had been monitored as at risk of suicide or self-harm for a short time when he was on remand before sentencing, but never after that. The man had been at Long Lartin since February 2012. He had a number of serious physical health issues, including Marfan syndrome, and was prescribed antidepressants and tramadol for pain. He had regular appointments with a mental health nurse and a psychiatrist.

The man had a number of risk factors for suicide, including his offence, depression, his long-term illness, low esteem and feelings of hopelessness. From September 2013 onwards, the man talked to the mental health nurse about suicidal thoughts, but reassured the nurse and the psychiatrist that he would not act on these thoughts. They did not consider he needed to be monitored as at risk of suicide. Healthcare staff did not tell other prison staff that the man was having difficulty coping, or that he had Marfan syndrome and its implications for managing him.

On the morning of Sunday 18 January, officers found the man dead in his cell. He had cut his wrist and it was apparent that he had been dead for some time. Post-mortem and toxicology tests found that the man had died from an overdose of tramadol.

I am concerned that healthcare staff relied too heavily on the man's assurances he would not act on his suicidal thoughts rather than making a full holistic assessment of his risk using all the information available. I also consider that they should have shared more information with prison staff about the man's physical and mental health so they could have been alert to any difficulties. While it would not have affected the outcome for the man, I am concerned that there was a significant delay before control room staff called an ambulance, after being alerted to the emergency.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman

September 2015

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Summary

Events

1. On 13 May 2011, the man was charged with the murder of a friend and was remanded to HMP Bedford. He suffered from Marfan syndrome, which affects the body's connective tissue and meant he was very tall. He had multiple health complications as a result, including a mechanical heart valve. He was prescribed warfarin (to thin the blood) and tramadol (for pain relief).
2. In October 2011, the man was monitored under suicide and self-harm prevention procedures (known as ACCT) when he handed his medication to staff and said he did not want to take the easy way out. This was the only time he was managed under ACCT procedures. On 21 October, he was sentenced to life imprisonment. In February 2012, he moved to Long Lartin.
3. In September 2012, a doctor prescribed him antidepressants. From October 2013, the man began to see a mental health nurse frequently because of his depression, but consistently said he had no suicidal thoughts. In July, a psychiatrist began to see the man, as his mood had deteriorated. He continued to see the nurse and the psychiatrist and told them he had thoughts of suicide but did not want to act on them. He had low self-esteem, which was not helped by being unable to get clothes and shoes to fit him.
4. The man had two periods of crisis, in September and December 2014, when he talked about suicide. The mental health nurse considered that the man was always at underlying risk of suicide, but she did not detect his risk as heightened or imminent in the weeks before his death and did not begin ACCT procedures. Prison staff said that they had not noted any signs that the man was distressed. Officers said they were unaware that he had reported suicidal thoughts and did not know that he had Marfan syndrome.
5. At about 8.40am, on 18 January, officers found the man unresponsive on his bed. He had cut a wrist and there was a lot of blood on the floor. They thought he was dead and radioed an emergency but no one called an ambulance until 12 minutes later. Nurses reached his cell quickly, assessed that the man was dead and did not attempt resuscitation. Paramedics arrived and confirmed the man's death. The post-mortem concluded that the man had died from an overdose of tramadol.

Findings

6. We consider that it would have been prudent for the mental health nurse and the psychiatrist to have begun ACCT procedures when they identified the man as at increased risk of suicide during his periods of crisis, to ensure he had appropriate support. They relied too much on the man's assurances that he did not intend to

kill himself, rather than his underlying risk factors. Because no one had opened an ACCT, other prison staff were unaware of the man's risk.

7. We also consider that healthcare staff should have shared more information with prison staff about the man's Marfan syndrome and the implications for him and his management. Although it would not have affected the outcome for the man, we are also concerned that, as we have found previously at Long Lartin, staff did not follow national instructions and call an ambulance immediately the emergency medical code was broadcast.

Recommendations

- The Governor and Head of Healthcare should ensure that all staff are aware of their responsibilities to manage prisoners at risk of suicide or self-harm in line with national guidelines. In particular, staff should:
 - Have a clear understanding of their responsibilities and the need to record and share relevant information about risk.
 - Open an ACCT whenever a prisoner has expressed suicidal intent or has other significant risk factors.
 - Record and explain decisions not to open an ACCT when prisoners express thoughts of suicide.
- The Governor and Head of Healthcare should ensure that there are appropriate arrangements to share important information about prisoners' health with relevant prison staff to enable their safe management on the wings.
- The Governor should take active steps to ensure that control room staff fully understand their responsibilities in an emergency and call an ambulance as soon as a medical emergency code is received.

The Investigation Process

1. The investigator issued notices to staff and prisoners at Long Lartin, informing them of the investigation and inviting anyone with information to contact her. No one responded.
2. The investigator obtained the man's prison and healthcare records and interviewed eleven members of staff and four prisoners. The investigator listened to the telephone calls the man made during his last month at Long Lartin and watched CCTV footage of the emergency response. The investigator obtained information from four other members of staff by email.
3. NHS England commissioned a clinical reviewer to review the clinical care the man received at Long Lartin. The clinical reviewer joined the investigator for some of the interviews with staff.
4. We informed HM Coroner for Worcestershire of the investigation and have sent him a copy of this report.
5. One of our family liaison officers, contacted the man's family. They did not identify any specific issues for the investigation to cover but wanted to know more about the circumstances of the man's death. The man's family received a copy of the draft report. They did not make any comments.

Background Information

HMP Long Lartin

8. HMP Long Lartin is a high security prison, near Evesham, in Worcestershire. It has eight main wings and holds up to 622 adult men serving sentences of at least four years.

HM Inspectorate of Prisons

6. The most recent inspection of Long Lartin, in October 2014, assessed the prison as reasonably safe and respectful. Incidents of self-harm were relatively low, although there had been two self-inflicted deaths since the previous inspection in 2011. Inspectors concluded that support for those in crisis was mixed and case management and care for those at risk of suicide and self-harm needed to improve.
7. Inspectors noted that substance misuse staff worked closely with others to minimise the diversion of medication such as tramadol. About a quarter of patients were prescribed controlled medication and spot checks often found prisoners with medication they had not been prescribed. However, inspectors found that the administration of medication they observed was safe and well supervised. Clinical staff reviewed prescribing practice when required.

Independent Monitoring Board

8. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help ensure prisoners are treated fairly and decently. The IMB annual report for the year to January 2014 commended Long Lartin for remaining a decent institution but noted a need for improvement in several areas, including the need to tackle an increase in trading prescribed medication in the prison.

Previous deaths at HMP Long Lartin

9. Since 2010, there have been fourteen deaths at Long Lartin, including that of the man. Four of these were self-inflicted, one was a homicide and the remainder were due to natural causes. We have previously recommended that all known risk factors are taken into consideration when assessing a prisoner's risk of suicide and self-harm and that staff should call an ambulance automatically when there is a medical emergency. We make similar recommendations in this report.

Assessment, Care in Custody and Teamwork

10. Assessment, Care in Custody and Teamwork (ACCT) is the care planning system the Prison Service uses for supporting and monitoring prisoners assessed as at risk of suicide and self-harm. The purpose of the ACCT process is to try to determine the level of risk posed, the steps that might be taken to reduce this and the extent to which staff need to monitor and supervise the prisoner. Levels of supervision and interactions are set according to the perceived risk of harm. There should be regular multi-disciplinary case reviews

involving the prisoner. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

Key Events

11. The man murdered a friend on 7 May 2011. He surrendered to police two days later and was remanded to HMP Bedford on 13 May. When he arrived, he said he had never had any thoughts of suicide or self-harm. He was withdrawing from drugs, including heroin, and began a methadone detoxification programme.
12. The man told a nurse that he had Marfan syndrome, a genetic disorder that affects the body's connective tissue, heart, blood vessels, bones, joints and eyes and for which there is no cure. People with Marfan syndrome are often tall, with long arms and legs. The man had a mechanical heart valve fitted in 2002. Mechanical valves are very strong and can last a lifetime, but can damage red blood cells as they pass through the open valves. This meant that the man had to take warfarin (an anti-blood clotting drug).
13. The man had an implantable cardiac defibrillator (ICD) fitted in January 2011 to control rapid heartbeat. ICDs are battery-powered devices that deliver an electrical shock to restore normal rhythm when a life-threatening arrhythmia (irregular heartbeat) is detected. ICDs are similar in size to a pacemaker and are placed under the skin of the upper chest outside of the ribcage.
14. Treatment for Marfan syndrome focuses on managing the symptoms and reducing the risk of complications. The man was 6ft 10 inches, and had a low body mass index (BMI). He had annual health reviews and nurses monitored his weight by using the MUST (malnutrition universal screening tool), which considers a person's BMI and any recent weight loss or illness to determine any possible issues with malnutrition. A score of two and above indicates a problem with maintaining a stable body weight. The man frequently scored two or over. The man was prescribed pregabalin and tramadol in prison to relieve the pain caused by various symptoms of Marfan syndrome.
15. A psychiatric report, prepared for his court appearance in July 2011, noted that the man had self-harmed and had reported suicidal thoughts in the past. On 1 August, The man pleaded guilty to murder and his case was adjourned for sentencing. He returned to Bedford and entries in his prison record over the following months indicate that staff considered him well behaved and polite.
16. On 5 October, the man gave his medication to staff. He said it was too tempting to kill himself and he did not want to take the easy way out. He said he felt low and withdrawn while he waited to be sentenced for murder and his mood had deteriorated since he had finished taking methadone three weeks earlier. He said that he had constant pain in his back, legs and ankles and knew that he would be in prison for a long time. Staff opened an ACCT document the next day, and closed it on 11 October, when they considered that the man's mood had improved.
17. On 21 October, the man was sentenced to life imprisonment with a minimum period to serve of 16 years before he could be considered for release. (This was later reduced to 15 years on appeal.) The man returned to Bedford. He said he had expected the sentence, and had no thoughts of suicide or self-harm.

18. On 29 February 2012, the man moved to HMP Long Lartin as a planned transfer from a local prison. In May, he moved to F Wing (a general residential wing) and began working in the kitchen. Prisoners and staff told the investigator that he was a popular, private and polite man.
19. On 13 September, a registered mental health nurse assessed the man. It is not clear whether he asked to see her or if someone had referred him. The man told the nurse that he had attempted suicide by taking an overdose when he was fifteen years old but had no current thoughts of suicide. He said he felt low, had a reduced appetite, and had a history of depression for which he had previously taken fluoxetine (an antidepressant). On 17 September, a GP represcribed fluoxetine. Over the following months, a healthcare assistant frequently reviewed the man's mental health.
20. On 15 October, the nurse wrote to the F Wing Senior Officer to explain that the man had a serious medical condition, a mechanical heart valve and an ICD as his heart could stop. The nurse asked that, if the man rang his cell bell, wing staff should respond as if it was an emergency and call healthcare staff. None of the wing staff the investigator spoke to said that they had been informed of this.
21. The man had frequent appointments and care plan meetings with doctors and nurses because of his Marfan syndrome. Most appointments were with the nurse. He had regular International Normalised Ratio (INR) tests, to measure how effectively the warfarin was working. An optometrist, cardiologist and dentist examined the man once a year.
22. A nurse frequently assessed the man's nutrition. The man found it difficult to maintain his body weight and had a negative body image. GPs sometimes prescribed a nutritional supplement. The nurse said that the man also had access to extra food as he worked in the kitchens, and bought items from the prison canteen and cooked on his wing.
23. In February 2013, a nurse discharged the man from mental health services, as he said he no longer wanted to engage with them. In September 2013, he had an operation on his arm, related to Marfan syndrome. He was in a lot of pain and his mood worsened. A nurse noted in his medical record that if his mood did not improve they would discuss the man with the mental health team.
24. On 4 October, the nurse assessed the man after he asked to see a nurse because he was finding it difficult to cope with depression. They discussed his low self-esteem, his deteriorating physical health, his lack of contact with his family and his difficult childhood. The nurse saw the man frequently. He consistently told her he had no thoughts of suicide or self-harm.
25. An officer became the man's personal officer in November 2013. Personal officers are expected to get to know the prisoners they are responsible for, act as a first point of contact for any problems and make regular entries in their records about their time at the prison. The officer told the investigator that he never thought that the man was at risk of suicide or self-harm and did not notice a change in him while he was at Long Lartin. He said that the man was popular and generally seemed quite cheerful. He said the man had some days where he seemed a bit "out of sorts" which he thought was due to migraines. Officers did

- not know that the man had Marfan syndrome. He was unaware that the man was under the care of a mental health team or that he suffered from depression.
26. On 12 December, the man told the nurse that he had received less support from his family over the last year. The man did not receive any visits while he was at Long Lartin. The nurse said the man always found it difficult to cope with depression and had a strong sense of self-hatred about the things that he had done and the way he had treated everybody, including his family and friends. She said that he had low self-esteem because of his Marfan syndrome and being very thin.
 27. On 9 February 2014, the nurse noted in the man's medical record that he was very low in mood. On 26 February, the man told the nurse that he had many troubles that he could not disclose to her. She noted he had poor eye contact and was depressed. The nurse told the investigator that she considered opening an ACCT almost every time she saw him, but she did not do so after she discussed the man's risk factors with him and he assured her he had no thoughts of suicide and did not want to kill himself.
 28. Security reports during February and March indicated that a prisoner who worked in the kitchen might be being bullied. The man had missed some work sessions in the kitchen, so the officer in charge of the kitchen spoke to him to try to establish whether he was being bullied. The officer noted that the man had some bruises on his head but he would not say how he got them; he said that he felt he was an easy target. He told her that he was coming through it and felt safer when he was locked in his cell. Staff supported the man as a victim under the prison's anti-social behaviour policy but did not take action against any other prisoners, as the man had not identified them and there was no further information to indicate who was responsible. No one considered whether this meant he was at risk of suicide and self-harm.
 29. On 26 March, the man told a nurse that he was unhappy that he had not received warfarin or had an INR test since 24 January. He also said that he had not received fluoxetine since 8 March. He told her that he had asked for his medication a number of times. He had an INR test the same day and received his warfarin. He decided he did not want to start taking fluoxetine but, at the beginning of May, he changed his mind and began taking it again.
 30. The man saw the nurse every three weeks or so. They discussed his family and his negative body image. The man was unhappy that, he could not get clothes that would fit him, from the prison catalogue. The nurse noted in the man's medical record that he was often low in mood or anxious and felt guilty about things he had done in the past. He said he had no thoughts of suicide or self-harm. On 2 June, another nurse increased the man's dose of fluoxetine, as he did not think it was working well. On 22 June, the nurse referred him to a psychiatrist as she felt that fluoxetine was not helping his depression and his mood was gradually getting worse.
 31. Healthcare staff discuss cases at a weekly multidisciplinary meeting attended by nurses, psychiatrists, pharmacists and the psychologist. The nurse said that she spoke about the man frequently at these meetings, as did the pharmacist. The pharmacist and the nurse told the investigator that the man was very good at

- concealing his emotions and could appear positive with others but then become tearful with the nurse.
32. On 25 June, an officer noted that the man had lost weight, was anxious, depressed and stressed. He said he had nothing to look forward to or back on. The officer told the man that he would ask about his clothing issues. He did not do anything about him being depressed or stressed.
 33. On 10 July, a psychiatrist, assessed the man for the first time. He noted that the man had been depressed since he was fifteen, but his symptoms, especially his anxiety, had got worse over the previous six to twelve months. The man said he had no current thoughts of suicide or self-harm but said that such thoughts were sometimes at the back of his mind. He said he did not want to kill himself, as he did not want to let his family down. The psychiatrist reduced the man's dose of fluoxetine and began him on sertraline, another antidepressant. The nurse continued to see the man approximately every two weeks.
 34. Another prisoner had lived in the cell next to the man since 2012. They worked in the kitchen together and became close friends. The prisoner told the investigator that the man had always suffered with depression and had his "down times". The prisoner had talked to the man about the effects of Marfan syndrome. The man told him that his mother and other people in his family had died from it before they were 50 years old. The man thought he would never get out of prison and would die before he was released. The prisoner asked the man if he would kill himself, but the man said that he did not have the balls. The prisoner said they had had this conversation around July 2014 and it was the only time they had talked about suicide.
 35. On 21 August, the nurse and the psychiatrist assessed the man together. The man said he thought sertraline had helped slightly but he was experiencing distressing mood swings, which caused him to become suddenly tearful. He said he had no thoughts of suicide or self-harm. The doctor stopped the man's fluoxetine and increased the dose of sertraline.
 36. An officer spoke to the Head of Reception and the Head of Safer Custody to try to get better clothes for the man, but was unsuccessful. The officer said that the man felt he was being "singled out". At the end of August, he advised the man to make an application to the Governor or make a formal complaint. It does not appear that the man did this and there is no evidence that this issue was resolved before the man died.
 37. On 15 September, a drug worker, assessed the man as another prisoner had told her he was concerned about him. The drug worker recorded that the man seemed okay, and she had no imminent concerns about him. They agreed to meet again in a few days.
 38. The nurse told the investigator that, at around this time, she thought the man's risk of suicide had increased as he spoke about suicide as an option and appeared hopeless. She said that they discussed his risk factors, such as his depression and feelings of hopelessness. He told her that he did not want to kill himself and had no plans. The nurse said that she explained the ACCT process to the man and he said he was very uncomfortable with it, as he did not want

other people to know he needed extra support. The nurse therefore decided not to open an ACCT.

39. On 17 September, the nurse met the man twice to support him. She recorded that he had excessive mood fluctuations, felt very stressed and useless and sometimes thought it would be easier to give up. She noted that his suicidal thoughts were fleeting and he said he did not want to kill himself at that time. The man said he was finding it difficult to cope on the wing, his mood worsened at night, he was sleeping badly and had nightmares but he did not want sleeping tablets. He talked about suicide as a last resort. The nurse offered to move him to the healthcare unit for extra support but he declined.
40. The next day, the psychiatrist assessed the man. He noted that the man was apprehensive, panicky, had low self-esteem, a lack of confidence, feelings of hopelessness and doubts about whether he had any future. The man said he had no thoughts of suicide or self-harm, as he had too much to lose. The psychiatrist advised the man that sertraline might take a while to work. The man again declined a move to the healthcare unit. The doctor increased the man's sertraline, prescribed a short course of lorazepam (to reduce anxiety) and referred the man to psychological services. The doctor was aware that the man had fleeting suicidal thoughts but did not believe he needed to open an ACCT. He told the investigator that he considered the nature of these thoughts, the protective factors the man had and that he was engaging with mental health professionals. The man took lorazepam for a few days but then stopped as he said it was making him feel "wired".
41. On 19 September, the man was distressed and crying. The nurse assessed him and agreed that he did not need to attend a cardiac review he had scheduled at hospital that day. The drug worker met the man a number of times over the next week and noted that he continued to be very low in mood.
42. The nurse reviewed the man weekly for the next three weeks and referred him to the psychology team. The man said he was finding it difficult to see a way forward but was not planning to end his life. By 11 October, he said that he was feeling a little better in himself and thought sertraline was helping, although he still had difficulty sleeping.
43. In November, the man started getting his tramadol in the evening rather than in the morning as previously. Tramadol is an opiate medication, which is often traded in prisons. Prisoners are not allowed to keep supplies in their possession and the man had to collect it each day from the medication hatch. As a safeguarding measure, prisoners have to take and swallow the tablets in front of a prison nurse. The man told the prisoner that taking tramadol at night was keeping him awake and "driving him mad". He wanted to get it in the morning again. However, a doctor told him this would not make any difference as the tablets worked for 24 hours and therefore it would make no difference if he took them at night. The man told the prisoner that sometimes he would only get one hour's sleep at night and he had started sleepwalking.
44. On 15 November, the nurse assessed the man, who said that he felt better some days but he still had mood swings. He was happy to have psychological support. He said he had been offered heroin on the wing but had refused it. The drug

worker also saw the man twice in the next two weeks. He told her he had not been feeling very good which he thought was connected to the change in his medication. The nurse assessed him again on 5 December. He told her he had been struggling to cope for two weeks and felt mentally and physically drained. The nurse noted that the man had taken sertraline for five months but his anxiety seemed more severe and he was uncertain about the future.

45. The nurse assessed the man on 19 December. She noted he was distant, had no control over his low mood and found it difficult to remain determined not to give up. He was eating only one meal a day and not sleeping well. He felt as if nothing was changing. The man said he was worried about his ability to hold on. The nurse asked the psychology department when his assessment would take place. (He does not appear to have had one before he died). The nurse told the investigator that prisoners often waited months for an assessment as the waiting list was long.
46. The next day, the psychiatrist assessed the man, who said he was not feeling good, was depressed, low, tired, felt worthless and had low self-esteem and confidence. He said he had been finding excuses not to work in the kitchen, had reduced motivation and energy, was tearful and had a low appetite. He reported difficulties sleeping, was clenching his teeth at night and was possibly sleep walking. He said he had no thoughts of suicide and self-harm. The doctor prescribed a short course of lorazepam to help reduce his anxiety. The man was keen to try an alternative to sertraline. The psychiatrist said he would need to check whether he could take other antidepressants because of his heart issues caused by Marfan syndrome. He said he would chase the man's psychology appointment.
47. The officer spoke to the man on 24 December. He noted that the man had told him everything was all right, except that he was having strange dreams. The nurse assessed the man again on 27 December. She noted that he was more relaxed and that lorazepam had helped his anxiety.
48. On 30 December, kitchen staff noticed that the man was moving slowly and had pinpoint pupils. Another officer thought he was not fit to work in the kitchen. He took the man to the wing and spoke to a GP, who thought that the man was over-sedated and reduced his dose of lorazepam. A nurse spoke to the man, who wanted to stay in his cell for the rest of the day. He told her he was depressed and not sleeping or eating well. She sent a message to the nurse asking her to review the man as soon as possible.
49. The nurse assessed the man on 3 January 2015. He said he was very anxious and had not had any lorazepam since his dose was reduced, as the pharmacy did not have the correct medication available. The nurse said she would try to get his medication for him. A doctor prescribed diazepam instead, which the man received the next day.
50. On 4 January, the man rang a friend. (For security, all telephone calls are recorded but staff listen to only a random selection, unless there is a particular targeted concern.) The investigator listened to the call and he told his friend he could not "handle it" in Long Lartin and had not left his cell for four days over the Christmas period as he was so depressed. He said that due to a regime change

he would not be able to move from Long Lartin for at least two years. The man said the tablets he was taking made him feel like he was going to panic and he was ready for something bad to happen. He said he was seeing the doctor that week for a medication review and after that, he might feel stronger again.

51. On 5 January, the nurse assessed the man, who said he felt much better since taking diazepam and felt more settled. The kitchen manager said he seemed much better when he came back to work in the kitchen the next day. The man apologised to her for his behaviour, and said he had not realised how his medication had affected him. The kitchen manager said the man's moods varied and that he had previously told her about his depression, being prescribed warfarin and other health issues. She said he seemed to be in a more positive mood for the next two weeks. The kitchen manager said that she never had any concerns about the man being at risk of suicide or self-harm.
52. On 7 January, the psychiatrist and the nurse saw the man together. The psychiatrist said the man was more positive, chattier and less anxious, and thought that he had responded well to diazepam. The man said he had no thoughts of suicide or self-harm. The psychiatrist told the man that he could either continue taking the same medication or continue taking diazepam and change his antidepressant. He gave the man some information about the potential benefits and risks of each medication and asked the man to consider the options. The doctor noted the man was still waiting for a psychology assessment, which he asked the nurse to chase. The psychiatrist said the man seemed satisfied with this plan and was talking about his future.
53. On 8 January, at a multidisciplinary team meeting, the nurse asked a psychologist, to prioritise the man's assessment. The psychologist offered the man an appointment on 19 January. This was the only multidisciplinary meeting where the man was mentioned in the minutes. The man telephoned his brother that day and said that he had felt a lot less tense since he had begun taking diazepam.
54. On 9 January, the officer noted in the man's prison record that he had been having migraines recently, and had been sleeping a lot. The officer asked the man about his medication issues, and said the man just shrugged his shoulders. The officer said that the man raised no other issues with him and he did not know that the man was seeing a psychiatrist and a mental health nurse.
55. The nurse assessed the man that day and noted that he seemed more stable in mood. The man said that it was good that he had no medication in his possession, as this would be how he would kill himself if he decided to. However, the nurse noted that he said he had no thoughts of suicide or self-harm and said that he was "a million miles from that place". The man said he wanted to change his antidepressant to escitalopram and keep taking diazepam. Nurse Flint noted in the man's medical record that she had not opened an ACCT as in her assessment he was not actively suicidal. They talked about the man's fears about suicide and he seemed focussed on the future. They also discussed his concerns that sessions with a psychologist might lower his mood. The nurse booked the tests needed for him to change medication.

56. On 14 January, another nurse assessed the man. She noted that he appeared brighter. He said that the diazepam had reduced his anxiety and tension. The nurse said that, although the man had been quite low in mood for some time, at this appointment he joked and seemed more like how he was when he first came to Long Lartin. The nurse told the investigator that she never had any concerns that the man was at risk of suicide or self-harm.
57. On 16 January, the kitchen manager said the man was insistent that he finish some painting in the kitchen that day. She said this was unusual for him as he was normally very laid back. This was the last day he worked in the kitchen.
58. On Saturday 17 January, an officer said the man played pool in the early afternoon. She was working in the office and, in line with the usual procedure, he brought his old razor to swap for a new one. This was routine and did not give her any cause for concern. The officer said she told the man that he looked well and he said he was all right. He then went to cook a meal.
59. At about 4.00pm, the prisoner and the man played snooker. Another prisoner sat with them, talking until about 4.30pm. The second prisoner said the man seemed his normal self and was laughing. He said the man had bought cookies from the prison canteen that day and gave them to other prisoners, which he had not done before. The second prisoner said that the man did not mention any thoughts of suicide or self-harm and he thought that the man was the last person who would kill himself.
60. At around 4.30pm, the prisoner went to the man's cell with him and the man gave him a packet of cookies. The prisoner said the man seemed happy and when he was feeling down, he would stay in his cell in bed with the curtains drawn and the door locked, which he had not done that day.
61. Another prisoner, said he spoke to the man for three or four minutes before officers locked them up for the evening. He asked the man whether he was playing the guitar again, and the man said that he was. The prisoner said the man seemed quite jovial.
62. At 4.50pm, the officer locked the man in his cell for the night. Around 7.45pm, another officer did the evening roll check, to check that all prisoners were in their cells and well. He could not specifically remember checking the man but he was certain that he was alive at the time.
63. At 6.10am on 18 January, another officer was doing the morning roll check. She looked through the observation panel in the man's door and switched on the cell night light. She said he was lying in bed, slightly propped up, with a blanket partly covering him. One of his legs was protruding from the blanket and his right arm was up against the wall. She could not say that the man was breathing at the time, but nothing appeared unusual and she carried on with the roll check.
64. At around 8.40am, the officer began unlocking the prisoners on F Wing. CCTV shows that she looked through the observation panel and unlocked the man's cell at 8.41am. She carried on to the next cell but immediately went back to the man's cell as she thought something about him did not look right. She called to the officer, who immediately came to the door, and they went in. The officer said

the man was lying on the bed with his legs apart and his right arm against the wall. He looked grey and his chest was not moving. The man did not respond to them and his body was cold.

65. As they were not carrying a radio, the first officer shouted to the other officer, on the other side of the landing, to call a code blue. (A code blue is an emergency call used in circumstances such as when a prisoner is unresponsive, unconscious or has breathing difficulties.) The officer did not hear and ran to the cell. When he saw the man, he radioed a code blue at 8.42am. The officer then locked the other prisoners, who had been unlocked, back into their cells.
66. The officer noted that the blood had pooled in the man's fingers and he was stiff. She and another officer thought that the man had died and they decided it would not be possible to resuscitate him. The officer then noticed there was a large amount of blood on the floor and realised the man had some curtain material wrapped round his left wrist, which was resting over a bowl filled with blood on the floor. At 8.43am, the two officers left the man's cell and one officer stood at the cell door.
67. The nurse was designated to respond to any emergencies that day. She heard the code blue on her radio and immediately went from C Wing to E Wing where the message had said the emergency was. When she got to E Wing, there was a correction over the radio that the emergency was on F Wing. She arrived at the man's cell at 8.44am.
68. Two nurses were in the dispensing room for E and F Wings when they heard the code blue. They went to get the emergency equipment and then went to the man's cell, arriving at the same time as a nurse. The nurse went into the cell first, noted the man's colour and position and believed he was dead. She was upset and, as there were two other nurses there, left the cell.
69. The two nurses assessed the man and noted he was cold, had no pulse, was not breathing and his pupils were fixed and dilated. They saw that the man had cut his wrist and wrapped it in material. They were sure the man was dead and so did not attempt resuscitation. They left the cell and an officer locked it. At 8.53am, Supervising Officer (SO) asked an operational support grade, to telephone 999 and ask for an ambulance. The ambulance arrived at the prison at 9.06am. At 9.18am, the paramedics confirmed the man had died.

Contact with the family

70. An SO acted as the prison's family liaison officer. The man had named his brother as his next of kin, but a routine police risk assessment advised a police escort to visit him, which might take some time. The Family Liaison Officer established that the man's aunt had visited him more recently than his brother. To avoid further delay, the Family Liaison Officer, the prison chaplain went to inform the man's aunt, who agreed to let his brother know. The next day, the Family Liaison Officer telephoned the man's brother to offer condolences. The prison offered a contribution to funeral costs, in line with national policy.

Support for prisoners and staff

71. A custodial manager, asked officers to inform prisoners on the wing of the man's death individually at their cell doors and to offer them the support of a Listener outside their cell. (Listeners are prisoners trained by the Samaritans to offer confidential support to other prisoners.) The prisoner said that when the officer told him the man had died, he felt lost knowing he was locked in a cell with his friend's body in the cell next door. He did not think of asking to move, as he was so upset. In retrospect, he said it would have been helpful if he could have gone into a friend's cell. The officer said the prisoner did not want to speak to a Listener and he had told him to ring his cell bell if he wanted to speak to someone.
72. Another prisoner, told the investigator that he had asked to speak to the prisoner after the officer told him that the man had died, as he knew he would be upset. The officer said he had asked the custodial manager if the prisoner could go to the prisoner's cell, but she had not allowed it. The custodial manager did not recall this request, but said that, for security reasons, she could not allow prisoners in each other's cells. The officer said he had told the prisoner this and offered him a Listener, but the prisoner said this did not happen.
73. Most prisoners said they had felt well supported after the man's death. Healthcare, kitchen and wing staff told the investigator they had made efforts to speak to the man's friends. After the man died, some prisoners recalled that he had given some of his belongings to other prisoners the day before he died. Staff reviewed all prisoners who were being monitored under ACCT procedures, in case they had been affected by the man's death.
74. At 12.00pm on 18 January, the Head of Operations, debriefed the staff involved in the emergency response and offered them support. A critical incident debrief was held a few weeks later.
75. On 27 January, over 100 staff and prisoners attended a memorial service for the man. They raised £700 in his memory.

Post-mortem report

76. The post-mortem report indicated that the man died of tramadol toxicity. Although prison staff and paramedics had described a "catastrophic bleed", the pathologist noted that the cut to the man's left wrist was relatively superficial and did not result in any damage to veins or arteries.

Findings

Identification of risk of suicide and self-harm

77. There are recognised risk factors that raise the risk of suicide and self-harm which are set out in Prison Service Instruction (PSI) 64/2011, Safer Custody. Those relevant to the man are:
- He was serving a life sentence for murder.
 - He had thoughts of suicide and had attempted suicide in the past.
 - He had a difficult childhood.
 - He was depressed and receiving care from a psychiatrist and mental health nurse.
 - He had a chronic physical illness which caused him pain
 - He had low self-esteem and feelings of hopelessness.
78. In 2014, we published a thematic report on risk factors in self-inflicted deaths in prisons. We identified several key lessons that prisons should use to help them manage prisoners at risk of suicide and self-harm. These included considering evidence of risk of suicide and self-harm and balancing this against a prisoner's presentation, understanding that a prisoner's level of risk is not fixed and can move depending on other events, and that healthcare staff should be confident in initiating and using ACCT. We discuss these issues in this report.
79. While he was at Long Lartin, the man seems only to have disclosed the extent of his distress to the nurse and the psychiatrist. Most wing staff said they were not aware that the man suffered from depression and none of the officers we interviewed knew that he had suicidal thoughts. While we understand that the man was a private person, wing staff's lack of knowledge about him was surprising and a concern. The nurse said she knew some risks factors were relevant to the man, including suicidal thoughts. However, she did not believe he would act on these thoughts and therefore did not open an ACCT. The psychiatrist said that, when deciding whether to open an ACCT, he assessed the nature of the suicidal thoughts as well as the protective factors individuals had and the help they have sought from professionals.
80. The nurse said that the man's reluctance to be managed within the ACCT process would not have made her less likely to open one, even though it might have jeopardised her relationship with him had she done so. She considered that the man was always at some risk of suicide but told the investigator that, although the man was often low, she did not have any reason to think that he might kill himself and that, even in hindsight, she would not have done anything differently. The nurse said the man was sometimes hopeless and not positive about getting released from prison, but he did not want to kill himself and the thought of doing so had repulsed him.

81. Prison Service Instruction (PSI) 64/2011 Safer Custody, has a mandatory instruction that “Any prisoner identified as at risk of suicide or self-harm must be managed using the Assessment, Care in Custody and Teamwork (ACCT) procedures.” However, we recognise that when a prisoner has a long-standing underlying risk of suicide and self-harm, it makes deciding in what circumstances to open an ACCT more difficult.
82. Although we accept that these were matters of clinical judgement, we consider that both the psychiatrist and nurse should have opened an ACCT when the man had two particular periods of crisis, in September and December 2014, when he spoke of suicide as an option. Although this might not have prevented him killing himself in January, it would have alerted other staff to his risks, identified a need for wing officers to monitor the man more closely and helped identify and address the issues that were causing him distress. These issues were not all to do with his mental health and included matters such as his inability to buy suitable clothing from the prison catalogue, which affected his self-esteem. We consider it would have been helpful to use the multi-disciplinary approach, which ACCT procedures should deliver and share information with all those involved in his care.
83. PSI 64/2011 indicates that staff should only disclose confidential clinical information with the consent of the prisoner. However, healthcare staff have a duty to pass on information that involves issues of patient safety, vulnerability or immediate risk to self or others to relevant staff. In situations where the prisoner’s safety is compromised but they are unable or unwilling to give consent, then health professionals have a duty of care and the relevant information may be disclosed to others.
84. There is no evidence that healthcare staff asked the man if they could share information about him with wing staff, even though some of this information indicated that he might be at risk of suicide and self-harm. The nurse said that she could share information with officers if a prisoner was in crisis, but she did not think that it was necessary for the man. She told the investigator that he was a very private man and this might have influenced how much information she shared with officers.
85. In the two weeks leading up to his death, staff and prisoners reported that the man seemed a lot happier and more positive. He felt the diazepam was working. PSI 64/2011 notes that staff should be aware that when a prisoner’s depression lifts slightly they might be more likely to commit suicide. Healthcare staff had not opened an ACCT and wing staff did not seem to know that the man was depressed and was potentially at risk of suicide. However, we accept that, although the man’s general risk factors remained, there was little to suggest he was at raised risk of suicide immediately before his death and needed additional support. We do not consider that staff could reasonably have predicted or prevented his death.
86. Staff judgement is fundamental to the suicide and self-harm prevention system, which relies on them using their experience and skills, as well as local and national assessment tools, to determine risk. However, we are concerned that healthcare staff relied too heavily on the man’s assurances he would not act on

his suicidal thoughts rather than making an assessment taking into account all his risk factors and the information available and ensuring that he was properly supported. Wing staff, who were responsible for supporting the man on a day-to-day basis, did not know that he was depressed or had suicidal thoughts. Without effective communication and information sharing about prisoners' risk of suicide and self-harm, it becomes more difficult to assess the risk. We make the following recommendation:

The Governor and Head of Healthcare should ensure that all staff are aware of their responsibilities to manage prisoners at risk of suicide or self-harm in line with national guidelines. In particular, staff should:

- **Have a clear understanding of their responsibilities and the need to record and share relevant information about risk.**
- **Open an ACCT whenever a prisoner has expressed suicidal intent or has other significant risk factors.**
- **Record and explain decisions not to open an ACCT when prisoners express thoughts of suicide.**

Clinical Care

87. The clinical reviewer concluded that the healthcare team at Long Lartin did everything they could to manage the man's Marfan syndrome. He said that the man received care equivalent to that he could have received in the community.
88. The clinical reviewer found that the man received appropriate medication for depression, which was suitable for his health problems. He saw a mental health nurse and psychiatrist frequently and it was clear that the psychiatrist provided information about possible medication options, and that the man was appropriately referred to mental health and psychology teams.

Information sharing about Marfan syndrome

89. In October 2012, a nurse wrote to the F Wing senior officer (SO) stating that the man had a serious medical condition, a mechanical heart valve and an internal cardiac defibrillator. She asked that if the man rang his cell bell, staff should treat it as an emergency and call healthcare staff. This is the only example of healthcare staff sharing information with wing staff. None of the officers the investigator spoke to were aware of this note. They did not know the man had Marfan syndrome, took warfarin, or was receiving mental health support.
90. The clinical reviewer said in his clinical review that it would have been reasonable for healthcare staff to have shared information about the man's physical health with other staff as, because the man was taking warfarin, any cut would need to be taken seriously. He added that anyone with Marfan syndrome should not undertake strenuous exercise.
91. We consider that healthcare staff should at least have asked the man if they could share information about him with officers responsible for his care. Healthcare staff gave some information about managing the man's condition in 2012, but there is little evidence that the SO passed the information to other

officers (although some seemed aware that he had a pacemaker and that they needed to be careful when they searched him). The only copy of this information we have seen was in the man's medical record. We make the following recommendation:

The Governor and Head of Healthcare should ensure that there are appropriate arrangements to share important information about prisoners' health with relevant prison staff to enable their safe management on the wings.

Warfarin

92. We were concerned that between January and March 2014, the man did not have a weekly INR test and did not receive his warfarin. Since then, healthcare staff have introduced a standard operating procedure, which sets out that, on the same day, nurses conduct an INR test, doctors prescribe the correct dose of warfarin and nurses book a further test. We are therefore satisfied that this issue has been addressed.

Tramadol

93. The pathologist concluded that the man died due to tramadol toxicity. The man had been prescribed tramadol for pain relief for some years, but the clinical reviewer noted that the level of tramadol in the man's blood found during the post-mortem toxicology test was too high to have been due to prescription use. It therefore seems likely that the man took an overdose of tramadol.
94. The man collected his tramadol every evening. He was expected to take it and swallow it in front of a nurse. Healthcare staff should report any prisoner they suspect of concealing or giving their medication to another prisoner, but there were no such reports for the man. It is not clear how the man obtained enough tramadol to overdose on it, but it is possible that he pretended to take the tablets when he was given them and saved them for later. It is also feasible that he obtained some from other prisoners.
95. Since the man's death, prisoners have to drink a whole cup of water with their medication in front of a member of healthcare staff to make sure they swallow it. The clinical reviewer found that Long Lartin now has satisfactory arrangements in place for the issuing of controlled medication.

Emergency Response

96. PSI 03/2013, Medical Response Codes, requires governors to have a medical emergency response code protocol and states that all prison staff must be made aware of and understand the protocol and their responsibilities during medical emergencies. The instruction states that, when a medical emergency is called, the control room should call an ambulance immediately and there should be no requirement to wait for a member of healthcare staff or a manager at the scene to confirm that an ambulance is needed. Long Lartin has a protocol with the local ambulance service, in line with the national instruction, which makes it clear that staff should call an ambulance immediately and should not wait for additional information before doing so.

97. The officers and nurses responded quickly and competently to the emergency when they discovered the man unresponsive. Although there was a short delay in calling a Code Blue emergency, as neither of the officers who found him had a radio, staff alerted the control room as promptly as they could. However staff in the control room, did not call an ambulance for another 12 minutes. While this would not have changed the outcome for the man, we are concerned that there was such a delay, which in other emergencies could be critical. We have made several recommendations about this issue following previous investigations into deaths at Long Lartin but it is evident that the practice has not changed.
98. The member of staff in the control room said that she was unaware of the local protocol or that she should call an ambulance automatically after staff call an emergency. She said she did not immediately call the ambulance because she did not know if the emergency was on E or F Wing, and that she called the ambulance when the SO instructed. The SO confirmed that control room staff usually waited until an SO asked them to call an ambulance.
99. The investigator spoke to the Deputy Governor on 19 February 2015 about this issue. The next day, the prison reissued an Operational Governor's Order (from August 2014), which set out the mandatory actions staff needed to take in accordance with PSI 03/2013. The Governor emailed this order to all staff, posted it on the prison intranet and sent paper copies to each department. However, it is apparent that merely issuing an instruction had little effect previously. We consider that all staff working in the control room should be fully briefed about their responsibilities. We make the following recommendation:

The Governor should take active steps to ensure that control room staff fully understand their responsibilities in an emergency and call an ambulance as soon as a medical emergency code is received.

Support for prisoners

100. Most prisoners the investigator spoke to said they had felt well supported after the man's death. Both healthcare staff and officers had made sure they spoke to those closest to the man and offered them ongoing support. Listeners were also available. The man's friend said he found it difficult being locked in his cell all afternoon. It is unfortunate that staff did not allow him to speak to another friend who asked to see him, which we believe should have been considered. However, we are satisfied that, overall, staff offered prisoners a satisfactory level of care.

Action Plan

| No | Recommendation | Accepted/Not Accepted | Response | Target date for completion and function responsible | Progress (to be updated after 6 months) |
|----|--|-----------------------|---|--|---|
| 1 | <p>The Governor and Head of Healthcare should ensure that all staff are aware of their responsibilities to manage prisoners at risk of suicide or self-harm in line with national guidelines. In particular, staff should:</p> <ul style="list-style-type: none"> ▪ Have a clear understanding of their responsibilities and the need to record and share relevant information about risk. ▪ Open an ACCT whenever a prisoner has expressed suicidal intent or has other significant risk factors. ▪ Record and explain decisions not to open an ACCT when prisoners express thoughts of suicide. | Accepted | <p>The decisions on whether to open an ACCT will be based upon national guidelines, and take into consideration, the documented known information within the core records and the sharing of information with and between healthcare clinicians.</p> <p>Prisoners identified as at risk of suicide or self-harm are managed in line with national instructions and PSI 64/2011 guidance.</p> <p>This includes:</p> <ul style="list-style-type: none"> ▪ Ensuring that all staff receive training and are confident in the ACCT procedures; ▪ Holding multi-disciplinary case reviews involving all relevant people in the decision making; ▪ Completing ACCT documents fully and accurately, including triggers and realistic, relevant CAREMAP objectives; ▪ All staff to update the ongoing record. Ensure observations and interactions are following the prescribed level as determined by the case reviews; ▪ Conducting an ACCT review whenever there is a clear sign, or concerns raised, that risk has changed; ▪ Using enhanced case reviews for people who present complex issues and behaviours. | Complete Head of Safety and Equality/ Head of Healthcare | |
| 2 | The Governor and Head of Healthcare should ensure that there are appropriate arrangements to share important information about prisoners' | Accepted | The Head of Safer Prisons & Healthcare Clinical lead will ensure that all relevant information about mental health and risk of suicide and self-harm is discussed at Mental Health MDT meeting and summarised in the individual | Complete Head of Safety and Equality/ Head of | |

| | | | | |
|--|-----------------|--|--------------------------|--|
| <p>health with relevant prison staff to enable their safe management on the wings.</p> | | <p>prisoner's SystemOne notes .</p> <p>Subject to the prisoners consent, information sharing protocols to be implemented (within the guidelines of medical in confidence) to share known information , including physical, mental and hidden (learning) disabilities to assist in the support & management of prisoners on the residential units.</p> <p>Prisoners supported by ACCT documents, Healthcare and/or Mental Health and/or Substance misuse services identified as key workers will attend ACCT reviews and contribute towards the CAREMAP.</p> <p>In cases where attendance is not possible, they will be asked to provide a written contribution, the ACCT will not be closed unless Healthcare/Mental health have contributed towards the decision to close the ACCT.</p> | <p>Healthcare</p> | |
| <p>3 The Governor should take active steps to ensure that control room staff fully understand their responsibilities in an emergency and call an ambulance as soon as a medical emergency code is received</p> | <p>Accepted</p> | <p>As per PSI 03/2013, Medical Emergency response codes are in place. Governor's order has been re-issued and published to inform all staff of this instruction and their responsibilities during medical emergencies.</p> <p>Control Room staff have been briefed in relation to their actions/response if a medical emergency (code red or blue) is called and a copy of the instruction is placed on the Control room desk. A global email has also been sent to all HMP Long Lartin staff outlining the medical emergency response protocol</p> | <p>Complete Governor</p> | |