

A Report by the  
Prisons and  
Probation  
Ombudsman  
Nigel Newcomen CBE

**Investigation into the death of a man at HMP Long  
Lartin in September 2014.**

## ***Our Vision***

*'To be a leading, independent investigatory body,  
a model to others, that makes a significant contribution to  
safer, fairer custody and offender supervision'*

This is the investigation report into the death of a man who was found hanged in his cell at HMP Long Lartin on 26 September 2014. The man was 31 years old. I offer my condolences to the man's family and friends.

The investigator carried out the investigation. NHS England commissioned a clinical reviewer to review the man's clinical care at the prison. Long Lartin cooperated fully with the investigation.

In May 2014, the man was sentenced to 16 years in prison for the attempted murder of his former partner. He had been at HMP Chelmsford on remand since August 2013 and remained there until he transferred to Long Lartin on 4 September 2014. While he was at Chelmsford, staff had monitored the man as at risk of suicide and self-harm for several periods, but he appeared to have settled and said he did not intend to harm himself. When he arrived at Long Lartin, staff did not consider him at risk of suicide and self-harm and he spoke positively about the future. Although he was upset that he was not able to contact his children, he said he was coming to terms with this. A mental health nurse assessed him on 23 September and did not consider he was at risk of suicide and self-harm.

During a routine check early in the morning of 26 September, the orderly officer, responsible for the operation of the prison that night, and a night patrol officer found the observation panel on the man's cell door covered from the inside. The man did not respond to their calls and the orderly officer asked other staff to attend. They went into the cell and found the man had used torn bedding to hang himself from the light fitting. It was evident that the man had been dead for some time and resuscitation would not be possible. Paramedics arrived and confirmed the man's death.

I am satisfied that, while the man appears to have had underlying factors which made him an ongoing risk of suicide and self-harm, there was little to indicate to staff at Long Lartin that he was at imminent risk of suicide at the time of his death. I do not consider that staff at Long Lartin could reasonably have been expected to foresee or prevent the man's actions on 26 September.

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**

**April 2015**

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## SUMMARY

1. In August 2013, the man was remanded to HMP Chelmsford, charged with the attempted murder of a former partner. In May 2014, he was convicted and sentenced to 16 years in prison. The man was managed under Prison Service suicide and self-harm prevention procedures, known as ACCT, for four separate periods at Chelmsford because of his low mood and minor self-harm. However, despite the man's charge of attempted murder, history of alcohol abuse and previous self-harm, there is no evidence that these were considered as factors that could increase his risk at the time he arrived.
2. On 4 September 2014, the man transferred to HMP Long Lartin as part of his standard sentence progression. At a health screen when he arrived, the man told a nurse about his previous self-harm but said he had no current thoughts of suicide and self-harm. The nurse had no significant concerns about him, but noted he had a history of depression and referred him for a mental health assessment.
3. On 23 September, a mental health nurse assessed the man. She was aware of his episodes of low mood and minor self-harm at Chelmsford and wanted to see whether he needed additional support from the mental health team at Long Lartin. They spoke about external support and the man said his father visited him but he did not have any contact with his child, which appeared to be his major concern. He told the nurse that he was coming to terms with this, as he had not seen him for a year. The nurse did not consider the man was at risk of suicide or self-harm or that he needed further support from the mental health team.
4. During a routine roll check at 5.30am on 26 September, the night orderly officer and a night patrol officer found that the man's had obscured the observation panel on his cell door. They asked for additional staff to attend. When other officers arrived about ten minutes later, they opened the cell and found the man hanging by torn bedding from the light fitting. The orderly officer radioed an emergency code blue and the control room immediately called an ambulance. Staff cut the ligature from around the man's neck and laid him on the floor. A nurse assessed the man and found clear indications that he had been dead for some time. Paramedics arrived and confirmed his death.
5. The man's risk of suicide and self-harm should have been identified when he first arrived at Chelmsford. As we have made recent recommendations to Chelmsford about improving assessment of risk at reception, we do not repeat one here. Subsequently, his risk was recognised and he was supported under ACCT procedures a number of times. By the time the man arrived at Long Lartin, he appeared relatively settled. Although he had ongoing concerns about contact with his children, staff at Long Lartin discussed these matters with him. The man's offence and circumstances would have suggested some level of ongoing risk, but there was little to indicate that he was feeling suicidal at the time and he talked about the future. We consider that it would have been difficult for staff at Long Lartin to have anticipated or prevented the man's actions on 26 August. We make no recommendations.

## THE INVESTIGATION PROCESS

6. The investigator issued notices to staff and prisoners at Long Lartin, informing them of the investigation and inviting them to contact him if that had relevant information. No one responded.
7. The investigator visited Long Lartin on 30 September. He met the Governor and obtained copies of the man's prison and medical records. The investigator interviewed eleven members of staff at Long Lartin in October and November.
8. The investigator informed HM Coroner for Worcester of the investigation who provided the results of the post-mortem examination. We have sent the Coroner a copy of this report.
9. One of the Ombudsman's family liaison officers contacted the man's father to explain the investigation process and to invite him to identify any relevant issues for the investigation to consider. The man's father wanted to know, in view of his previous self-harm, whether prison staff had been monitoring his son as at risk of suicide and self-harm at the time of his death.
10. The man's family received a copy of the draft report. The solicitor representing them wrote to us pointing out some factual inaccuracies and omissions. The report has been amended accordingly. They also raised a number of questions that do not impact on the factual accuracy of this report. We have provided clarification by way of separate correspondence to the solicitor.

## **HMP LONG LARTIN**

11. HMP Long Lartin is a high security prison, near Evesham, in Worcestershire. It has eight main wings and holds up to 622 category A and B adult men serving at least four years imprisonment. .

### **HM Inspectorate of Prisons**

12. HM Inspectorate of Prisons' most recent inspection of Long Lartin was in October 2014 and has yet to be published. At the previous inspection in August 2011, the inspectorate reported that reception procedures were good, risk issues were indentified and immediate needs on arrival were met. Safer custody was generally good and recommendations made in PPO reports were being addressed.

### **Independent Monitoring Board**

13. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help ensure prisoners are treated fairly and decently. In its most recent annual report, for 2013/14, the IMB was concerned that a high proportion of men on ACCTs were held in the segregation unit and relatively few were inpatients in the healthcare unit.

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

14. The last self-inflicted death at Long Lartin was in July 2013. There were no significant similarities with the findings of that investigation and the man's death.

## KEY EVENTS

### HMP Chelmsford

15. On 26 August 2013 was remanded to HMP Chelmsford charged with the attempted murder of his former partner. He was subject to a restraining order preventing him from contacting his former partner and their son.
16. A registered mental health nurse (RMN), carried out an initial health screen and noted that the man's escort record had indicated that he was an alcoholic. The mental health nurse recorded that the man appeared cheerful and communicated well. The man said that he had had no previous mental health problems, had never harmed himself before and had no current thoughts of suicide or self-harm. The mental health nurse referred the man to the Integrated Drug Treatment Service (IDTS) because of his alcohol problems. There is no record that anyone in reception considered whether the man's risk factors, such as the charges he was facing and his alcohol problems, increased his risk of suicide and self-harm.
17. A locum doctor saw the man briefly and recorded that his reported daily alcohol intake was between 16 and 20 cans of lager. He said that he had not had any alcohol for four days. The doctor examined him and did not identify any signs of alcohol withdrawal. He considered that the man did not need any medication to relieve withdrawal symptoms at the time.
18. On 28 August, a nurse saw the man for a secondary health screen and a substance misuse assessment. Despite what he said when he arrived, the man said that he had harmed himself by cutting his wrists three years previously, when he was in prison. He said he had no current thoughts of self-harm. He told the nurse that at first he had thought he could sweat the alcohol out of his body but was now suffering from withdrawal symptoms.
19. The nurse did not consider that the man was at risk of suicide and self-harm but arranged for him to move to the IDTS wing for alcohol detoxification treatment. No one else re-considered the man's risk in the light of his disclosure of previous self-harm and his alcohol withdrawal. IDTS staff monitored the man's withdrawal symptoms for the rest of August.
20. On 2 September a healthcare support worker referred the man to the counselling service at Chelmsford, known as 'Atrium', after he became tearful during a routine appointment. She did not open an ACCT at the time as he said he had no thoughts of suicide or self-harm.
21. On 17 September, the healthcare support worker began ACCT monitoring after the man said that he had taken 110 ibuprofen tablets. He told the doctor that he had saved up the tablets and that worries about his offence and imprisonment had been building up over the previous few days. Staff closed the ACCT on 29 September, when they were satisfied that he was no longer at risk.
22. Staff managed the man under ACCT procedures three more times while he was at Chelmsford. The next occasion was for four days between 17 January and 21 January 2014, when the man was distressed because he was in debt

to other prisoners, and feared for his safety. Staff moved the man to the vulnerable prisoners' wing and closed the ACCT when he said he felt safer there.

23. When the man was sentenced to 16 years imprisonment, staff opened an ACCT on 23 May, as a precautionary measure for someone facing a long time in prison. They closed the ACCT six days later, when the man appeared to have settled and stated that he had no intent to self-harm. On 26 August, an officer opened an ACCT after the man made superficial cuts to his left arm after staff told him he could not attend work. At a case review, the man said that he felt stupid and had misunderstood the reasons why staff had kept him on the wing. He said he had no intention to take his own life and staff closed the ACCT the same day.

### **HMP Long Lartin**

24. On 4 September 2014, the man transferred to HMP Long Lartin as a planned transfer from a local prison. When he arrived, a nurse carried out an initial health screen and noted that the man had previously self-harmed, but had no current thoughts of suicide or self-harm. As GPs at Chelmsford had prescribed the man medication for depression, the nurse completed a Threshold Assessment Grid (TAG), which assesses the severity of mental health problems. The man scored two on the scale which indicated he had no urgent mental health problems. The nurse made a routine referral to the mental health team.
25. On 15 September, an officer introduced himself to the man as his offender supervisor. The offender supervisor recorded that the man acknowledged that he had a shaky start to his time in prison, but now wanted to get on with his sentence. The man told the offender supervisor that he accepted responsibility for his offence, but was appealing against the length of his sentence.
26. On 16 September, the offender supervisor and a probation officer working in the prison's public protection unit went to see the man as he had applied for contact with his child from his most recent relationship, whose mother was the victim of his offence. The probation officer told the investigator that, in the meantime, staff monitoring his phone calls had also found that he was trying to get in touch with a previous partner and their child, indirectly through a third party. The woman had previously indicated through the police that she did not want the man to contact her. The probation officer spoke to the man about this and explained that this was a breach of his child protection and harassment restrictions. She gave the man a written warning.
27. The probation officer said that the man appeared angry when she told him he was in breach of the restrictions, but she advised him to speak to a family law solicitor if he wanted to pursue contact with his children. She reminded him that there was a court restraining order to prevent him contacting his other ex-partner and child. The probation officer asked whether there were other children in his family he might want to contact. He asked about his nieces and nephews. The probation officer told him he would need to apply and give reasons why the contact would be beneficial to them.

28. The man sent the probation officer an application form two days later, but the application was not for contact with his nieces and nephews; it was for the child she had warned him not to contact. She replied to say that he had been advised to seek contact through a family law solicitor.
29. The probation officer said that she had not listened to the man's phone calls, but she had read the transcripts. She knew that he had seemed to find it difficult to cope about a week before, but said since then there had been nothing to suggest he was at risk of suicide or self-harm. In calls made by the man after his contact with the probation officer, he spoke to his father about doing the alcohol awareness course and asked his father to check out family law solicitors. There was nothing to indicate that he was distressed about contact with his children.
30. On 23 September, the nurse, assessed the man's mental health as a result of the reception nurse's referral on 4 September. She said the mental health team usually aimed to see patients within 14 days, dependent upon their TAG score. The man's low TAG score indicated a routine referral and no immediate concerns. The nurse was aware of the man's history of low mood and minor self-harm at Chelmsford. He told her that his father was supportive and visited him. The nurse considered his main problem was not having contact with his children, but the man told her that he was coming to terms with this, as he had not seen them for a year.
31. The nurse did not identify anything during the assessment that suggested to her the man might be at risk of suicide or self-harm. She asked him about his recent self-harm and the man had glossed over it and said it was nothing. In general, she thought he had seemed positive about the future and had talked about getting a prison job. He mentioned that he had always been a poor sleeper, and she referred him to the prison's sleep clinic, but concluded that he did not need any further input from the mental health team.
32. The cells on D wing do not have toilet facilities. At night and other times when prisoners are locked in their cells, they have to use an intercom connected to the control room, to ask to be let out of their cell to use the toilets on the wing. The control room unlocks the door electronically. Each landing has a locked gate with no staff present and only one prisoner is allowed out at a time. Night staff on the wing monitor the CCTV which covers the landing.
33. On the evening of 25 September, the man asked to use the toilet at approximately 11.00pm. The CCTV shows the man leaving and returning to his cell within 10 minutes. The night patrol officer on D wing, who monitored the CCTV that night, did not have any concerns about him at the time.
34. At 5.30am on 26 September, the Supervising Officer (SO) who was the assist orderly officer that night, assisting in the operation of the prison, went to D wing to help the night patrol officer complete a roll count to check that all prisoners were present in their cells.
35. When the SO and the night patrol officer got to the man's cell, they found that he had covered the observation panel from inside. The SO said he tried to get a response from the man by knocking on the door and rattling the door handle for a couple of minutes, but without success. He asked the night

patrol officer to carry on with the roll check, and he phoned the control room and asked for more staff to come.

36. The SO said he phoned the control room rather than using his radio, as other staff would be reporting prisoner numbers from roll check on other wings over the radio at the time. He did not know what the situation was, but he wanted to get additional staff quickly, so he could open the cell and thought there might have been a delay if he had tried to radio.
37. Two officers said that they received a radio message at 5.35am asking them to go to D wing. When they arrived, the SO explained the situation. While waiting for the officers to arrive, the SO had collected a key to the inundation point in the cell door. (Inundation points allow prison staff to put a hose into a cell when there is a fire, without opening the door. At other times, they are covered by a locked circular cover.) The SO had removed the inundation point cover just as two officers arrived. When they looked into the cell, they could see the man suspended from the ceiling light with torn bedding tied around his neck. The SO immediately radioed a code blue emergency at 5.41am. He asked the control room staff to release the electronic lock on the man's cell and went in. The control room then called an ambulance.
38. The officer supported the man's body while the SO cut the ligature. They laid the man on the floor and the SO cut the remainder of the bedding material from around the man's neck. An officer said that the man's limbs were stiff and there was discolouration in his lower body. A nurse arrived just as the officers had lowered the man to the floor. The nurse examined the man and found no signs of life. He told the staff that there was rigor mortis, which indicated that the man had been dead some time and it would therefore be inappropriate and of no benefit to attempt resuscitation.
39. A first responder paramedic arrived at the prison at 5.58am. Paramedics attached a heart monitor to the man that indicated no activity. At 6.10am, paramedics formally confirmed his death.

#### **Actions after the man's death**

40. An operational manager debriefed the staff involved in the emergency response shortly after the man's death and members of the staff care team offered support. Staff informed the prisoners on the wing that the man had died and offered them the support of the chaplaincy team if they needed it. Staff reviewed prisoners subject to ACCT suicide and self-harm monitoring, in case they had been adversely affected by the news of the man's death.
41. Because of the distance, the prison contacted HMP Chelmsford and arranged that someone from Chelmsford would visit the man's father to inform him of his son's death. A custodial manager from Chelmsford and a prison chaplain, the visited the man's father that morning and explained what had happened and offered condolences. The man's father said that he was not surprised by the news and that he had always expected something like this to happen.
42. Long Lartin's family liaison officer phoned the man's father later that day and offered sympathy and explained what would happen next. The family liaison

officer liaised with the Coroner, funeral directors and the man's family to coordinate arrangements and to keep them informed. In line with national guidelines, the prison offered a contribution towards funeral costs.

43. After receipt of the draft report the man's father told the investigator that he did not feel that he received adequate support from Long Lartin following the death of his son. He said that it had been difficult for him to retrieve his son's personal property and that this had added to his distress at an already difficult time.
44. Managers at Long Lartin told the investigator that, after the man's death, some prisoners had suggested that he might have been a victim of bullying on D Wing and had been involved in an altercation with another prisoner in the days before his death. The investigator examined the information from the prisoners. The information is very vague and the prisoners did not give any names, which made it very difficult to follow up. The incident referred to seems to have been a minor one-off confrontation about canteen deliveries (orders from the prison shop) when the man's order went astray for a while. He later received it and there is no evidence that he had been specifically targeted. No one had reported any bullying before his death and the man had not mentioned it to staff. None of the staff were aware of the allegations previously and there is no other evidence indicating that the man was being bullied or that his action were result of this.

## ISSUES

### Medical care

45. The clinical reviewer, was satisfied that there were no root causes to the man's death related to the delivery of healthcare services. He did not consider that there was anything to suggest that mental health services could have anticipated or done anything to prevent the man's death. The clinical reviewer concluded that the standard of physical and mental healthcare, the man received in prison was equivalent to that he could have expected to receive in the community.

### Management of risk

46. PSI 64/2011 which outlines safer custody procedures for prisons, lists a number of factors which can increase prisoners' risk of suicide and self-harm. These include:
- Relationship problems.
  - Alcohol/Drug Misuse.
  - History of self-harm.
  - Longer sentence than expected.
  - Mental illness diagnosis (e.g. depression, bipolar disorder, schizophrenia)
  - Change in status (e.g. conviction, sentencing)
  - Offence, particularly those charged with violence against another person, especially against family members or partners
  - Early days in custody and following each transfer.
47. We are concerned that no one identified the man as at risk of suicide and self-harm when he first arrived at Chelmsford and there is little evidence that his range of risk factors were taken into account and considered in the round, He had been charged with attempted murder of the mother of his son, he was dependent on alcohol (and subsequently treated for alcohol detoxification) and had a history of self-harm. These factors would have increased his risk, yet staff all seem to have relied on his demeanour and assurances that he did not intend to harm himself. We have identified this issue as a concern in other recent investigations into deaths at Chelmsford and the prison say it has changed its reception procedures as a result. We therefore do not repeat our previous recommendations to Chelmsford.
48. The man was later identified and managed as at risk of suicide and self-harm on four separate occasions at Chelmsford. The investigation found that staff managed the ACCT process reasonably well and staff from various agencies involved with the man's care attended ACCT case reviews. Staff devised caremaps to help reduce his risk and followed up the required actions. Post-closure reviews were held after each ACCT ended to check there were no further concerns. .
49. When the man arrived at Long Lartin, a nurse asked him about his history of self-harm and the man spoke openly about previous incidents and the reasons. The most recent had been just a week earlier, when he had made superficial cuts to his wrist, and the ACCT had been closed the same day. He said he had no current thoughts of suicide or self-harm and spoke positively

about his future. Transfer to a new prison and the first days at a new prison is a risk factor for suicide and self-harm but the nurse did not consider that the man was at risk and did not believe he needed to be managed under ACCT procedures.

50. As the man had been diagnosed with depression, the reception nurse referred him to the mental health team for a routine assessment. On 23 September, a nurse assessed him and considered that the man seemed positive. Although he told her that he was upset that he was unable to have contact with his children, he said that he was coming to terms with this. He also said that he was positive about getting on with his sentence and expected to receive visits from his father while he was at Long Lartin. The man again said he had no thoughts of suicide or self-harm and the nurse did not identify any concerns about his risk when she assessed him.
51. The man's offender supervisor, and the probation officer, from the prison's public protection unit, both spoke to the man soon after he arrived at Long Lartin about child protection restrictions. These prevented him from contacting a previous partner and his child. He also had a restraining order barring him from contacting his ex-partner, who was the victim of his offence, and their child. The probation officer said that when she spoke with the man about this it was clear that he was angry, but he did not express this verbally and she did not consider this indicated he was at risk of suicide and self-harm. The offender supervisor noted that the man had talked about the future, including taking part in some offence related courses and appealing about the length of his sentence. He thought the man's outlook was positive and had no concerns about his well-being.
52. By the time the man arrived at Long Lartin, he appeared relatively settled and motivated to get on with his sentence. He hoped to have his sentence length reduced at appeal. Although staff at Long Lartin do not appear to have considered explicitly that the lack of contact with his children was a factor which increased his risk of suicide and self-harm, they discussed these matters with him. The man indicated that he was coming to terms with the situation and did not appear unduly distressed. The mental health nurse, who saw him three days before his death, had no concerns about him. We consider it would have been very difficult for staff at Long Lartin to have anticipated the man's actions on 26 September.

### **Emergency response**

53. We are satisfied that there was a quick emergency response on the morning of 26 September. The control room called an ambulance automatically when they received the code blue call, in line with national and local instructions. All the staff we interviewed were aware of the appropriate emergency procedures.
54. It was evident from the presence of rigor mortis that the man had died some hours previously. We consider that the staff made an appropriate decision not to attempt resuscitation.
55. Although all the staff involved followed appropriate emergency procedures, in line with current national instructions, the investigator noted that the local

contingency plans for dealing with a death at the prison were not up to date. He fed this back to the Governor who agreed that they would be updated. As this did not make affect the emergency response, we do not make a formal recommendation.