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A Report by the  
Prisons and  
Probation  
Ombudsman  
Nigel Newcomen CBE

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**Investigation into the death of a man  
in January 2014 at HMYOI Lancaster Farms**

## ***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 hanging in his cell at HMYOI Lancaster Farms in January 2014. He was 20 years old. I offer my condolences to the man's family and friends.

The investigation was carried out by an investigator. A clinical reviewer reviewed the clinical care the man received at the prison. Lancaster Farms cooperated fully with the investigation.

The man had an extensive history of self-harm, usually by cutting. Since being recalled to custody in January 2013, he had attempted to hang himself three times. He had frequently been supported under suicide and self-harm prevention procedures at previous prisons before he arrived at Lancaster Farms in November 2013. Staff continued this support when he first arrived at Lancaster Farms and again after he harmed himself on two further occasions. On 23 January 2014, the man assaulted another prisoner with a pool cue and, at a disciplinary hearing the next morning, he was punished by a loss of earnings and access to a range of regime facilities. Shortly before 3.00pm that day, an officer found him hanging in his cell.

The investigation found that prison staff correctly opened suicide and self-harm prevention procedures for the man when he harmed himself. However, staff did not always manage him in accordance with national guidance: not all reviews were multidisciplinary, not all contact with the man was documented and the level of monitoring did not always match the level of risk. The fact the man had been identified as at risk of suicide and self-harm was not considered when he was punished for the assault on the other prisoner, as it should have been.

I recognise that it can be difficult and frustrating for prison staff to have to deal with the seemingly intractable problem of someone who harms themselves repeatedly, sometimes in an apparent attempt to get what they want. However, there is a need to ensure that support measures remain focused on identifying and reducing risk. We cannot know whether it would have been possible to prevent the man's actions, but I am concerned that the frequency of monitoring on the day that the man died did not reflect his level of assessed risk. While the man had generally good mental health support, the clinical reviewer has identified some areas where improvements could be made.

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

**Nigel Newcomen CBE**  
**Prisons and Probation Ombudsman**

**September 2014**

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## SUMMARY

1. On 18 February 2013, the man was recalled to custody and was sent to HMP Doncaster. He was 20 years old and had a history of mental health problems, self-harm and alcohol abuse and had previously served custodial sentences. On 20 February, the man transferred to HMP Moorland and then, on 30 July, to HMYOI Deerbolt. Members of the mental health team, prison doctors, and the visiting psychiatrist at both Moorland and Deerbolt assessed him and prescribed medication. The man harmed himself and attempted suicide while he was at Moorland and Deerbolt and was supported under Prison Service suicide and self-harm prevention measures (Assessment, Care in Custody and Teamwork, known as ACCT) on eight separate occasions.
2. The man transferred to HMYOI Lancaster Farms on 13 November after he said he was under threat from other prisoners at Deerbolt. An ACCT was open when he transferred and was closed on 18 November. When the man harmed himself again on 29 November, an ACCT was opened and remained in place until 27 December. The man had regular interventions with the mental health team and with the chaplaincy to help him deal with his ongoing grief at the death of his father. He also received help for his drug problems. He said he had difficulties controlling his anger. On 30 December, the man was involved in a fight with another prisoner and was moved to another wing.
3. On 17 January 2014, the man harmed himself again and another ACCT was opened. At a review the next day, the man was assessed as at raised risk of self-harm but observations were set at only once each morning, afternoon and evening and hourly at night. On 23 January, the man assaulted a prisoner with a pool cue and was charged with a disciplinary offence.
4. On the morning of 24 January, the man was punished by a loss of earnings and association and removal of a range of other regime facilities, including his television. The manager who conducted the hearing was unaware that the man had been identified as at risk of suicide and self-harm so did not take this into account when deciding on the punishment. At 2.47pm, an officer found the man hanging in his cell and called for emergency medical assistance. Officers and healthcare staff performed cardiopulmonary resuscitation (CPR) until paramedics arrived. At 3.51pm, the paramedics confirmed that the man had died.
5. The investigation found that the man was appropriately managed under ACCT procedures. He received a significant amount of support from the chaplaincy, drug services and the mental health team to help him come to terms with his problems. However, we are concerned at the level of observation set on 18 January when the man had been recognised as at heightened risk of suicide and self-harm. Not all the case reviews were multi-disciplinary and we are concerned that members of the mental health team were not always involved in reviews, particularly when ACCTs were closed. Although officers did not follow the required procedures for notifying a medical emergency there was no delay in the emergency response. We make three recommendations.

## THE INVESTIGATION PROCESS

6. The investigator issued notices to staff and prisoners at Lancaster Farms, informing them of the investigation and inviting anyone with relevant information to contact him. No-one responded.
7. The investigator visited Lancaster Farms on 3 February and obtained copies of the man's prison and healthcare records. NHS England appointed a clinical reviewer to review the man's clinical care. The investigator and the clinical reviewer, interviewed 18 members of staff and two prisoners at Lancaster Farms. The investigator gave initial written feedback to the Governor on 10 March about the preliminary findings of the investigation.
8. The investigator informed the local Coroner of the investigation who provided a copy of the post-mortem report. We have sent the Coroner a copy of this investigation report.
9. One of the Ombudsman's family liaison officers contacted the man's family to inform them about the investigation and to invite them to ask any questions or raise any concerns which they wanted the investigation to consider. The man's family asked whether he had self-harmed, and whether he was being monitored. They wanted to know what care he had received for his mental health problems and if his sentence had been increased. They asked for information about a blister pack of tablets that they said had been found beside the man, and whether he had vomited. We have not been able to discover whether a blister pack was found in the man's cell but the toxicology report found no evidence that he had taken any drugs other than the medication he was prescribed. All other questions are addressed within the report. The man's family received a copy of the draft report as part of the review period and identified no factual inaccuracies. The family, having considered the investigation findings however, were alarmed that a recommendation had been repeated from a previous Ombudsman's investigation and had concerns about the mental health provision at Lancaster Farms.

## **HMYOI LANCASTER FARMS**

10. HMYOI Lancaster Farms has four main residential units housing a maximum of 530 convicted young adult men (aged 18-21), mostly from the North West of England. Health services are provided by Lancashire NHS Foundation Trust. Inspire North Lancashire provides an integrated drug and alcohol assessment, treatment and rehabilitation service.

## **HM Inspectorate of Prisons**

11. HM Inspectorate of Prisons conducted an unannounced inspection of Lancaster Farms in June 2011. Inspectors found that the level of violence was high, and they were not convinced that all information about violent incidents was fully investigated and acted on. They described residential officers as not being fully engaged in monitoring and addressing all aspects of violence and bullying, and noted that the tackling bullying strategy was not always understood or properly applied. There was too much reliance on adjudications and use of force, and inspectors reported that the number of adjudications was too high and punishments sometimes too severe. The suicide and self-harm prevention work was described as impressive, staff engaged with prisoners and the personal officer scheme was effective. Inspectors noted that there was little substance abuse at the prison.

## **Independent Monitoring Board**

12. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help ensure that prisoners are treated fairly and decently. In its most recent annual report for the period ending 31 January 2014, the IMB reported that the number of serious violent incidents had reduced and most of the violent incidents that occurred were spontaneous.
13. The IMB reported that suicide and self-harm prevention procedures operated efficiently, with good links between the Safer Custody Team and the officers undertaking assessments and reviews. The IMB noted that a mental health nurse saw all prisoners at reception screening, and 80% to 90% of their ongoing cases came from this initial assessment. Other prisoners with severe and enduring mental health issues were seen by psychiatrists.

## **Assessment Care in Custody and Teamwork (ACCT)**

14. ACCT is the Prison Service process for supporting and monitoring prisoners at risk of harming themselves. The purpose of the ACCT 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. Checks should be at irregular intervals to prevent the prisoner anticipating when they will occur.
15. Part of the ACCT process involves assessing immediate needs and drawing up a caremap to identify the prisoner's most urgent issues and how they will be met. Regular multi-disciplinary reviews should be held. The ACCT plan should not be closed until all the actions of the caremap have been completed.

## **Previous deaths at Lancaster Farms**

16. There have been two previous deaths at Lancaster Farms since the Ombudsman began investigating deaths in prisons in 2004; the first in 2005 and the other in 2007. Both were self-inflicted but there were no significant similarities with the circumstances of the man's death. After the death in 2005, we made a recommendation that managers should take the individual circumstances of the young person, including mental health issues and their level of vulnerability, into account. In this case, we have found a similar issue. After the death in 2007, we made recommendations about the ACCT process, to ensure that ACCT plans remained open until all issues had been identified and effectively managed through appropriate case reviews. We also made a recommendation about immediately calling an ambulance in an emergency.

## KEY EVENTS

17. The man was released from prison on licence on 21 January 2013, but failed to stay at a hostel where he was required to live. His licence was revoked and, on 18 February 2013, he was recalled to custody. He went to HMP/YOI Doncaster. His release date was 1 June 2014.
18. The man had alcohol, drug and mental health problems and a prolific history of self-harm. His father had died in front of him when he was about nine years old. The man said that he thought his father had taken drugs but he had died of MRSA (a 'superbug').
19. A member of the mental health team at Doncaster, carried out an initial health screen. The man said that he smoked up to 20 cigarettes a day, had used cannabis in the past, and had previously self-harmed by making superficial cuts to his arms when he was stressed. He said that he had last harmed himself 12 months earlier and had no current thoughts of suicide or self-harm. The man said that he was not on any prescribed medication. The mental health nurse recorded that the man appeared fit and well but ,because of his history of self-harm, she booked a follow up review.
20. At the review on 22 February, the mental health nurse recorded that the man had no thoughts of self-harm. She noted that there was no need for a further review unless he wanted support from the mental health team.
21. On 20 March, the man transferred to HMP Moorland, where he had regular interaction with the mental health team. Staff supported the man under ACCT procedures three times while he was at Moorland when he said his relationship with his girlfriend had ended. The first ACCT was opened on 20 April, after the man placed a noose around his neck, and was closed on 7 May. The second was opened on 8 May after the man made a cut to his chest, and was closed on 13 May. The third ACCT was opened on 18 June after the man opened the wound on his chest and an old wound on his left thigh. It was closed on 26 July.
22. On 30 July, the man transferred to HMYOI Deerbolt. The next day, a nurse a member of the mental health team, assessed his mental health. The man told her that he had no thoughts of suicide or self-harm and was happy to be at Deerbolt. The nurse recorded that he had self-harmed and made a ligature while at Moorland.
23. Between 31 July and 7 November, the man had 26 interventions with a member of the mental health team. A consultant psychiatrist saw him on 2 September after nurses had assessed him as suffering from severe depression. The psychiatrist recorded that the man had attempted to hang himself when he was 10, after his father died. He had a history of self-harm, but no history of psychiatric illness. The psychiatrist recommended antidepressants but did not suggest ongoing psychiatric reviews. The psychiatrist prescribed sertraline (an antidepressant).

24. During this period, prison staff supported the man under ACCT procedures four times. The first ACCT was opened on 23 August, when the man had made a cut to his arm. It was closed on 26 August. The second was opened on 6 September, because the man had cut his leg and had made a ligature. This ACCT was closed on 18 September. The third ACCT was opened on 20 September after the man had been found with superficial cuts to his abdomen and ligatures made from bedding. This ACCT was closed on 9 October. The fourth ACCT was opened on 17 October because the man cut his left thigh. The ACCT was closed on 24 October.
25. On the morning of 8 November, the man was taken to the segregation unit because he had damaged his cell. A nurse and doctor saw the man and recorded that there were no medical concerns that prevented him being segregated. At 2.30pm, an officer went to the man's cell in response to him pressing his cell bell and found that the man had reopened the wound on his left thigh. The officer opened an ACCT and a nurse cleaned and dressed the wound.
26. A custodial manager completed an immediate action plan and decided that the man should be constantly supervised. He recorded that the man was aware that he could speak to the Samaritans or a Listener (a prisoner trained by the Samaritans to support other prisoners in distress) and that the duty governor would come to see him. The custodial manager completed an ACCT caremap which identified that the man was concerned about threats from other prisoners and wanted a transfer.
27. An officer conducted an ACCT assessment interview. The man said that he had been moved to the segregation unit because he had damaged the table in his cell. He had reopened the wound because he was fed up and wanted a transfer from Deerbolt. He said he had some problems with prisoners who had recently moved to Deerbolt from Moorland. The man said that he sometimes wanted to die because of problems in the past. He said he would not move to any of the wings and would harm himself again if that happened and had had thoughts of taking another prisoner hostage. The man reiterated that he wanted a transfer anywhere away from Deerbolt.
28. At 3.10pm the head of safer custody and decency, held the first case review. The officer attended but there was nobody present from the healthcare team, a mandatory requirement of the ACCT process. The head of safer custody and decency recorded that the man's level of risk of suicide and self-harm was raised and the risk of taking a hostage was high. The head of safer custody and decency decided that the man should be moved to the healthcare centre and would remain constantly supervised.
29. On 9 November the head of residence, held an ACCT review which a Supervising Officer (SO) and an officer attended. Again, there was no one present from the healthcare team. The man said that he would refuse to move from the healthcare unit as he felt under threat from prisoners who had arrived from Moorland. He said he had not thought about harming himself since the previous day. He said he got angry and was unsure whether he would self-

harm in the future. He repeated that he would take a hostage to get a transfer from Deerbolt. The review concluded that the man remained at raised risk of suicide and self-harm, but reduced the level of observation from constant to four an hour. A further review was set for two days later.

30. On 11 November, the head of safer custody and decency held an ACCT review which an officer and a member of the mental health team, attended. The man still refused to move from the healthcare unit and that he would take a prisoner hostage if he did. The review concluded that the man remained at raised risk of suicide and self-harm and made no change to the level of observation. A review was set for the next day. The head of safer custody and decency updated the caremap to record that observations were four an hour and that attempts were being made to arrange a transfer.
31. On 12 November, the head of safer custody and decency held an ACCT review which a custodial manager an officer and nurse attended. The man continued to refuse to leave the healthcare unit and again threatened to take a hostage. The head of safer custody and decency told the man that they were trying to transfer him to another prison. The review panel concluded that the man remained at raised risk of suicide and self-harm and did not change the level of observation. A further review was set for the next day.
32. On 13 November the head of reducing reoffending, chaired the ACCT review which the acting head of the offender management unit, two officers and a nurse attended. The man was told that he would be transferred to HMYOI Lancaster Farms that day. The man said that he was happy about this and felt that a new start would help him. He said he had no thoughts of suicide or self-harm.
33. The nurse contacted an occupational therapist, and member of the mental health team at Lancaster Farms, to give a verbal handover about the man's care. The occupational therapist recorded that the man was prescribed sertraline, had repeatedly self-harmed and had recently been constantly supervised. He had a self-inflicted wound on his thigh which he re-opened, was currently on an ACCT with observations at four times an hour.
34. The safer custody manager at Lancaster Farms, told the investigator that Deerbolt had asked him if he would accept two prisoners who wanted to transfer because of problems that had followed them from previous establishments. The safer custody manager said that he read the man's prison record and was aware of his problems. He had agreed to have the man at Lancaster Farms to give him a new start.
35. When the man arrived at Lancaster Farms later that day, the safer custody manager met him in reception and held an ACCT review with a custodial manager. The man said that he was happy to be at Lancaster Farms and had no thoughts of suicide or self-harm. He said he had been a 'nightmare' at Deerbolt because of the issues he had with other prisoners who had arrived there from Moorland, and he had been desperate to move prisons. The man said he had no issues with any prisoner at Lancaster Farms and wanted to

remain there until he was released. The review concluded that the man was now at low risk of suicide and self-harm and reduced the level of observations to two an hour for the remainder of the day and hourly from night time onwards. A further review was set for the next day. The safer custody manager updated the caremap to reflect that the man had now transferred and would be on a standard residential unit, the level of observations had been reduced and he would work with the mental health team.

36. The occupational therapist also saw the man in reception. He told her that he was pleased to be at Lancaster Farms and was relieved that there had been a hand over from the mental health team at Deerbolt. The occupational therapist spoke to the safer custody manager and was aware of the changes made to the ACCT and agreed that a member of the mental health team would attend the ACCT review the next day.
37. On 14 November, the safer custody manager held an ACCT review which a member of the mental health team, attended. The man said he had self-harmed at Deerbolt in order to get a transfer. He said that he did not have any thoughts of suicide or self-harm, he was aware of how to access support if he needed it and he would work with the mental health team. The review concluded that the man remained at low risk of suicide and self-harm and reduced the level of observations to two observations each morning, afternoon and evening and hourly during the night. A further review was set for 18 November.
38. Later that day, an offender supervisor, saw the man to introduce himself and discuss the man's sentence plan. The man said that his behaviour at his previous prisons had not been good and he had got in to a fight with another prisoner at Moorland which had caused further problems as the prisoner's brothers were at Deerbolt. The man said he had no issues with debt, gangs or drugs and had accommodation in Wakefield for when he was released. The officer recorded that the man had numerous adjudications (disciplinary hearings) at his previous prisons and was currently on an ACCT. The man said he hoped the ACCT would be closed at the next review and he would continue to work with the mental health team.
39. On 18 November, a SO held an ACCT review which a nurse, and two officers attended. The man said that he felt he was doing fine at Lancaster Farms and had settled in well. He said he had no issues with other prisoners or any thoughts of suicide or self-harm. The review concluded that the man's risk of suicide and self-harm had significantly reduced and the ACCT should be closed. An ACCT post-closure review (which is held to check that the prisoner remains at low risk of suicide or self-harm) was set for 25 November.
40. Later that day the man saw a substance misuse co-ordinator for a charity, Inspire. The substance misuse co-ordinator recorded in the Inspire records that at this initial meeting she discussed with the man what the service could offer to help him. The man said he was happy to work with the substance misuse co-ordinator and they arranged another session for 2 December.

41. On 25 November, an SO held an ACCT post-closure review. A nurse contributed by telephone and an officer was present. The man said that he had made friends, was attending a college course and had no thoughts of harming himself. The SO noted that the man was working with the mental health team and would receive ongoing support. The ACCT remained closed.
42. Later that morning, two nurses saw the man for a mental health assessment. The man said his mood had lifted and he had not self-harmed since he had arrived at Lancaster Farms. He said he had traumatic memories of significant events in his life. The man said that he had been bullied at school and had once retaliated by stabbing a pupil in the eye with a pair of scissors. He had been permanently excluded from that school and finished his education in a behavioural unit. The man said that his personality had changed; he became a bully, abused alcohol and drugs and got involved in crime. The man said that the death of his father had affected him badly and he had not spoken to his mother since. He said he had three brothers and one sister but did not speak to any of them. He had a good relationship with his grandparents and said he would already be dead if it had not been for them. The man looked forward to seeing his four year old daughter when he was released in June. He said his main problem was anger, which built up to a point where he had to act, usually by harming himself.
43. The nurse recorded that the man showed no sign of distress and she found no evidence that he had any psychotic symptoms. She noted that the man had felt unable to discuss further the significant events in his life that had affected him, but he did not have any thoughts of suicide or self-harm.
44. On the morning of 29 November, the man self-harmed by re-opening the wound on his thigh. A prison doctor, and the clinical lead for the mental health team, saw the man who said that he had been very angry as the previous day had been the 11<sup>th</sup> anniversary of his father's death. He said he was in low mood, had a poor appetite and would probably self-harm again later, but he was not suicidal. The prison doctor recorded that the man was depressed and at risk of further self-harm. He prescribed an increase in sertraline from 50mg to 100mg, to be reviewed in two weeks. The clinical lead for the mental health team opened an ACCT document and completed the concern and keep safe form. He recorded that the man had re-opened an old wound on his leg and was in low mood. However, while he had ongoing thoughts of self-harm, the man said that he was not thinking of killing himself.
45. The SO completed the immediate action plan. He recorded that the man did not want to move to a different cell and was aware of how to get support. The SO set the level of observation at hourly until the first case review.
46. At 1.30pm, an officer conducted an ACCT assessment interview with the man in his cell. She recorded that she had found a ligature attached to the window bars of his cell. The man told her that his father had died 11 years previously and, the day after his father's death, he had tried to kill himself by hanging. His grandfather found him and had cut him down. He said he blamed himself for his father's death and wanted to be dead as he had nothing to live for. An

officer recorded that the man should be moved to a safer cell (a cell designed with minimal ligature points), and that she had suggested that he considered talking to the chaplaincy for bereavement counselling and continued working with the mental health team.

47. At 2.45pm, the SO held the ACCT first case review. An officer attended but there was no one present from the mental health team. The SO concluded that the man was at raised risk of self-harm and moved him to a safer cell. The level of observation remained unchanged and it was recorded that he should be closely supervised when he was given a razor. The next review was set for 6 December. The SO recorded on the caremap that he had referred the man to the chaplaincy and that the man would continue working with the mental health team.
48. Later that afternoon a member of the chaplaincy team, saw the man in response to the SO's referral. The man told her that previous bereavement counselling had not achieved anything. He said he did not get any visits as his family did not want anything to do with him. The reverend recorded that the conversation was strained and that the man made poor eye contact throughout. The reverend suggested that the man settled in at Lancaster Farms before considering any future bereavement counselling.
49. On 1 December, a nurse saw the man for a mental health review. The man said that he was angry about his father's death. He told the nurse that he felt hatred towards his mother, as her partner had abused him after his father's death. The man said that he found it easier to talk to women and did not want a male member of staff to be his key worker.
50. On 2 December, the substance misuse co-ordinator saw the man for a follow up session. The man said that he was feeling low because of the anniversary of his father's death and had used ecstasy and cannabis in the past few days. He said he understood that this would have affected his mood and might have caused him to self-harm. The substance misuse co-ordinator recorded that the man did not receive any visits and suggested the Living with Loss course to help him with his bereavement. The man agreed to think about it.
51. The next day, 3 December, the occupational therapist told the man that she was his allocated key worker from the mental health team. The man told her he had been in a low mood since the anniversary of his father's death. He had refused to go to work as he was unable to settle. The occupational therapist advised him to go to work so that he would have something to occupy him and she would enquire what other work or courses the man could do. The man said that he was keen to spend time with the chaplaincy.
52. On 4 December, the occupational therapist and the Reverend both saw the man. The occupational therapist recorded that she had agreed a care plan with him and they agreed to meet fortnightly. The man agreed to maintain mood, thought and behaviour diaries, to go to work and the gym and to work with the chaplaincy for support. A doctor would review his prescription for

antidepressants. The Reverend recorded in the man's prison record that she had seen the man to start bereavement counselling.

53. On 6 December, the man did not attend an appointment with the doctor. There is no record of the reason or whether any steps were taken to follow this up. Later that afternoon, the SO held an ACCT review which a nurse attended. The man said he still felt fed up and angry all the time, although he did not know why. He was working with the mental health team and the chaplaincy and would continue to do so. He said that he did not have any thoughts of suicide or self-harm. The review concluded that the man was at low risk of self-harm but should remain in the safer cell. The level of observation was changed to one each morning, afternoon and evening and every two hours during the night.
54. On 9 December, the substance misuse co-ordinator saw the man for an Inspire session. She recorded that they had discussed the man's use of alcohol and the effects this had on him. The man said that he wanted to change for his daughter's sake, for himself and for his family. On 12 December, the Reverend had a bereavement counselling session with the man and recorded that he appeared to be coping much better. She noted that he was on the waiting list for the Living with Loss course which would begin early in 2014. On 13 December, the man did not attend another appointment with the doctor.
55. At 2.00pm on 13 December, a custodial manager, held an ACCT review with no other staff present. The custodial manager recorded that the man was still working with the mental health team, was settled and had developed positive relationships with other prisoners and with staff. The custodial manager was aware that Christmas might be a difficult time for the man and did not plan to make any changes at that time. He assessed that the man remained at low risk of self-harm and made no change to the level of observation. The next review was set for 20 December.
56. As the ACCT review had taken place in her absence, a nurse went to see the man on the wing later on the afternoon of 13 December. The man said that he felt tired because he had had a nightmare in the night, which was why he had missed his GP appointment. He said that his mood was better and he had no thoughts of self-harm. The nurse explained that his appointment with the doctor that morning had been to review his medication and she would make another appointment.
57. On 17 December a prison doctor, reviewed the man's medication with him. The man said that he felt fine and the frequency of his angry moods had reduced. The doctor did not change the prescription of sertraline. The occupational therapist then reviewed the man. He had not completed the diaries as he had agreed and she encouraged him to do so.
58. On 19 December, an SO held an ACCT review which the occupational therapist and the Reverend attended. The man said that he had not self-harmed since the ACCT had been opened and he was pleased to be doing a cookery course in the mornings and an employability skills course in the afternoons. He said

he had no thoughts of self-harm and would continue to work with the mental health team and chaplaincy. The review concluded that the man was at low risk of self-harm and that the ACCT should be closed. The ACCT post-closure interview was set for 27 December.

59. On 23 December, the man had an appointment to see the doctor as he had complained of bad headaches, but refused to attend as he was on the cookery course at the time. Later that afternoon the man saw a nurse as he had a bad headache. She gave him paracetamol and made another appointment for him to see a doctor.
60. On 27 December, the man saw a doctor and told him that he experienced a shooting pain in his head at random times and these lasted for 20 to 30 minutes at a time. The doctor recorded that the man's symptoms were possibly caused by the increased dose of sertraline. The doctor prescribed 10mg propranolol (for migraine and severe headache) to be taken three times a day for a month.
61. That afternoon, a SO and the occupational therapist held an ACCT post-closure review. The man said that he had no thoughts of harming himself and he was able to manage his emotions much better. He said that he loved cooking and enjoyed going to the gym.
62. On 30 December, the man argued with another prisoner in the lunch queue. Officers intervened to prevent the man assaulting the other prisoner. The Governor, held a disciplinary hearing and decided that the man should move to Windermere residential unit from his current unit.
63. On 5 January 2014, the occupational therapist saw the man for a mental health review. She recorded that the man had not self-harmed since 29 November but she thought that he remained at medium risk of further self-harm as the death of his father and other family issues were the reasons that caused him to self-harm. The occupational therapist noted that the man had little contact with his family and did not receive any visits. Prison records confirm that the man did not have any visits while he was at Lancaster Farms. His last telephone call was to his grandparents, on 29 December.
64. On 8 January, the man saw a prison doctor, as he had a pain in the left side of his head that made him feel sick, and had lost his appetite. The doctor diagnosed migraine and dyspepsia (chronic pain in the upper abdomen) and prescribed imigran (for migraine) and omeprazole (for dyspepsia).
65. On 14 January, the man saw another prison doctor. He said that the pain in his head was worse and he was being sick three to four times a day. The man said that he had no other concerns and his depression had not increased. The doctor prescribed metoclopramide (for vomiting) and nefopam (for pain).
66. On the morning of 17 January, the occupational therapist saw the man for a mental health review. He told her that he was suffering from headaches and the medication he had been prescribed was not working. He said he had decided not to attend the cookery workshop any more because he did not want

to have access to knives while he felt so angry. He denied having any thoughts of suicide or self-harm. He said that since he had been moved to another residential unit there was no one from his home area and he wanted a transfer to a prison closer to home in West Yorkshire. The occupational therapist discussed different anger management techniques with the man, but he said he did not want to use any.

67. Later that afternoon, the man re-opened the wound on his left thigh and an Officer opened an ACCT. The man said that he was frustrated and anxious. The officer recorded on the concern and keep safe form that the man appeared to have calmed down, but that he had opened the ACCT because of the man's history of self-harm. The safer custody manager completed the immediate action plan. He noted that a member of the healthcare team had treated the wound to the man's thigh and he was aware of how to access the Samaritans and Listeners. The safer custody manager set the level of observations at hourly.
68. On 18 January, an officer interviewed the man for an ACCT assessment. The man said that he had suffered from nightmares about his father's death and had headaches. He said that he felt angry and knew he would not be able to control himself. He self-harmed by cutting himself to relieve stress, but had no thoughts of suicide and did not want to die. The man said that the only thing that kept him going was his daughter as he had no support from his family.
69. Later that morning, an SO held the first ACCT review with an officer. No one from the healthcare team was present and the SO had not contacted them. The SO recorded that the man had significant issues, was under the care of the healthcare team and had been prescribed antidepressants. The review concluded that the man was at raised risk of self-harm, but reduced the level of observation to one each morning, afternoon and evening and every hour during the night. The next review was set for 25 January.
70. The SO completed the caremap. He referred the man for counselling with the chaplaincy and to the mental health team for help with coping strategies. He noted that the man would receive ongoing care from the healthcare team for depression and pain relief and that he knew how to access support.
71. On 22 January, the substance misuse co-ordinator saw the man for another Inspire session. The man described how the smallest thing could make him very angry and how his thoughts would then turn to his father's death and his mother leaving which made him "see red". The man said that he was currently being supported on an ACCT. The substance misuse co-ordinator asked the man to keep an anger diary for the next week and they would discuss his anger at the next session.
72. Later that afternoon, the man had a video link meeting with a member of staff from the probation service. The officer was also present and noted that the man was in good spirits and had asked about the parole review process. The member of staff from the probation service explained to the man that a report would be completed for the Parole Board by the end of January which would

include details of his behaviour throughout his whole of his time in custody and not just at Lancaster Farms. The date of the Parole Board hearing had not been set. The man was aware that he would be released on 1 June, if the Parole Board did not agree an earlier release date.

73. During evening association on 23 January, the man was playing pool and had an argument with another prisoner. He hit him over the head with a pool cue and then broke the pool cue on the staircase. The other prisoner was not injured and did not want the police to be called. The events were captured on CCTV and the man was charged with a disciplinary offence of assault.
74. On 24 January, the head of security and operations, held an adjudication (disciplinary hearing). Contrary to Prison Service instructions, the head of security and operations did not have access to the man's ACCT document when conducting the adjudication, as it was in the residential unit office. The man admitted he had hit the prisoner over the head with the cue. He said that the other prisoner had taunted him all week, but that he was not being bullied by him.
75. The head of security and operations found him guilty and gave him a punishment of 14 days loss of association, 21 days loss of canteen and private cash, 21 days reduction in earnings of 80%, 21 days loss of the use of a television and 14 days loss of going to the gym. He told the investigation that this was the middle 'tariff' for this offence as the man had admitted his guilt. The head of security and operations did not recall whether he knew that the man was on an ACCT at time, but he knew that there was no ACCT document in the adjudication room. The head of security and operations said that ACCT documents should accompany adjudication paperwork, and if it had done he would have entered the outcome of the adjudication in the ACCT document. However, he said that the outcome would not have been any different had he known that the man was being supported on an ACCT. The head of security and operations said that the punishments started immediately.
76. An officer told the investigator that she had spoken to the man when he returned to the wing after the adjudication. She said that he had seemed to be in a really good mood and said he was fine. The substance misuse co-ordinator recorded that the man had seen that she was on the wing and had come over to speak to her. He said that he had begun to complete his anger diary but had been involved in a violent incident with another prisoner and was concerned that this might affect his parole hearing. The substance misuse co-ordinator told the man that she would see him on 27 January. She said that he seemed content with that.
77. An officer told the investigator that as it was cell cleaning day on Friday mornings, she let him clean his cell after he had spoken to the substance misuse co-ordinator before locking him in his cell. At 12.00pm, the officer recorded in the man's ACCT document that he had been at an adjudication in the morning and was now lying on his bed.

78. The officer came on duty at 1.30pm that day. She told the investigator that she usually worked on Buttermere unit, but was detailed to work on Windermere unit that day and had never met the man. On Friday afternoons, officers issue canteen (prison shop) orders to prisoners. At about 2.45pm, the officer said she arrived at the man's cell to give him his order. The cell was dark and it took her a couple of seconds to realise that the man was sitting by the window with a ligature, made from a bed sheet, around his neck. He was not moving. The officer said that she went into shock and shouted to another officer who was a few cells away on the same landing.
79. The other officer told the investigator that he went straight to the man's cell when the officer shouted. He said that because the officer was upset, he radioed for urgent medical assistance but did not use an emergency code. The control room log shows that the call for urgent medical assistance was made at 2.47pm.
80. The officer went into the cell, supported the man's body and cut the ligature. The officer had arrived and helped him move the man onto the bed. The SO, two officers and another SO then arrived, moved the man to the floor and immediately began cardiopulmonary resuscitation (CPR). The SO called the communications room to request an ambulance. Ambulance service records show that the 999 call was received at 2.48pm. (Although a emergency medical code should have been used to alert the control room to call an ambulance immediately, we are satisfied that there was no significant delay in the emergency response).
81. Healthcare staff, including a Sister and nurse, responded quickly and assisted with the resuscitation attempt when they arrived. They moved the man to the landing where there was more space. The nurse recorded in the medical record that the man had vomited. They used an automated external defibrillator (which monitors the heart rhythm and administers electrical shocks to restore the normal rhythm when necessary). The defibrillator advised that there was no shockable rhythm. Paramedics arrived at the cell at 2.55pm and took over the man's care. At 3.55pm, they confirmed that the man had died.

### **Contact with the man's family**

82. After the man's death, the Governor asked HMP Wakefield to send one of their family liaison officers to visit the man's nominated next of kin, his grandparents, to break the news of his death. A prison family liaison officer and a chaplain visited the man's grandparents that evening and offered condolences and support. The clinical lead for the mental health team and the safer custody manager also visited the man's grandparents on Sunday 26 January to offer further condolences. Lancaster Farms maintained contact with the man's family to provide ongoing support and offered financial assistance towards the funeral expenses, in line with national guidance.

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

83. A debrief was held on the afternoon of the man's death for staff involved in the emergency to discuss what had happened and to offer support. Not all staff attended the debrief, but all were offered the services of the prison's care team.
84. Officers and members of the chaplaincy supported prisoners affected by the man's death. Prisoners assessed as at risk of suicide or self-harm were reviewed in case they had been adversely affected by the man's death.

#### **Post-mortem**

85. A post-mortem examination found that the cause of death was hanging. A toxicology report revealed traces of the man's prescribed drugs at levels in line with his prescriptions. There was no evidence of any other drug use.

## ISSUES

### Assessment of risk and ACCT procedures

86. Assessment, Care in Custody and Teamwork (ACCT) is the Prison Service process for supporting and monitoring prisoners assessed as being at risk of harming themselves. The purpose of ACCT 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.
87. The man was diagnosed with depression, had frequently self-harmed and had thoughts of suicide while he was in custody. Between January 2012 and January 2014, the man had a total of 13 ACCT documents opened. The investigation has identified some concerns about the operation of ACCT procedures.
88. We are satisfied that prison staff at Lancaster Farms appropriately took into account the self-harm suicide prevention measures that were already in place when the man transferred from Deerbolt. ACCTs were also opened appropriately when the man harmed himself.
89. However, we are concerned that not all case reviews were multidisciplinary. In particular, there was no healthcare representative at either of the initial case reviews for the ACCTs opened at Lancaster Farms, which is a mandatory requirement. As the man had a lot of interaction with the mental health team, this meant that an important perspective on his care was missed.
90. We do not consider that the level of observation set were always appropriate to the man's assessed level of risk of suicide and self-harm. For example, the man cut himself on 17 January. At the review the next day, the SO assessed the man's risk of further self-harm as raised. Despite the man's history of self-harm and him being at raised levels of risk, the SO set the level of observation as three recorded observations during the day and hourly at night. We do not consider that this level of observation is commensurate with a raised level of risk. There was no mental health team input at this review.
91. The caremap objectives in the ACCT opened on 17 January amounted to no more than referrals to services. These actions were insufficient in themselves to ensure that the man's risk of self-harm had abated, that he received the support he needed or that the underlying issues that led to his self-harm had been successfully addressed. The caremap actions, a referral for bereavement counselling, a referral to the mental health team and a referral to the healthcare team, were closed before there was any meaningful intervention and were signed off as closed by the SO at the review on 18 January.
92. Prison Service Instruction 64/2011, which sets out the Prison Service's framework for delivering safer custody procedures and practices, states that caremap actions should be aimed at reducing the risk the prisoner poses to themselves. While an essential first step, it is difficult to see how a caremap action simply to refer someone for an assessment will reduce their risk. In our

view, the caremap should have had more specific actions clearly aimed in themselves at reducing the man's risk and should not have been closed until the outcomes of the referrals were known and discussed fully at an ACCT case review.

93. On the morning of his death, the man had received a punishment for hitting another prisoner with a pool cue the previous evening. We are concerned that the head of security and operations, the adjudicator, was not aware that the man was being managed on an ACCT and that the ACCT document was not available for the head of security and operations to consider and complete. This meant that the decision to reduce the man's earnings, loss of association, use of a television and use of the gym, was not made with the knowledge that the man had been assessed as being at raised risk of self-harm. It is likely that such sanctions would have a negative impact on a prisoner's state of mind, and this might have increased his risk of suicide or self-harm. The head of security and operations says that had he known that the man was on an ACCT this would not have affected the punishment he gave. However, it should have been considered. Prison Service Instruction 47/2011, which governs the conduct of disciplinary hearings, requires the adjudicators to take account of the likely impact of punishments on the prisoner, including their health and welfare. This could not have been done properly if the head of security and operations was unaware that the man was on an ACCT.
94. Overall, we consider that the operation of the ACCT procedures at Lancaster Farms did not give the man sufficient active support or help manage and reduce his level of risk of suicide and self-harm. We accept that the man could be difficult to manage and had been monitored under ACCT procedures many times during his sentence. However, during the final period of ACCT monitoring the ACCT procedures were not managed as effectively as they could have been to support the man and help reduce his risk.
95. We make the following recommendation:

**The Governor should ensure that prison staff manage prisoners at risk of suicide or self-harm in line with national guidelines, including:**

- **A multidisciplinary approach for all case reviews;**
- **Assessing the level of risk and recording the reasons for decisions;**
- **Setting appropriate frequency of reviews and levels of observations which are adjusted as the perceived risk changes;**
- **Completing ACCT documents fully and accurately so that all incidents of self-harm and suicidal ideation are discussed and recorded at reviews with caremaps revised and updated;**
- **Setting ACCT caremap actions which are specific and meaningful and which are aimed at reducing prisoners' risks to themselves;**
- **Continuing ACCT monitoring until the risk posed by the prisoner has reduced and all caremap actions have been completed.**

## Clinical Care

96. The clinical reviewer noted that the man received frequent support from health care team following his incidents of self-harm. The man also received support from the mental health team, which offered monitoring of symptoms and medication along with some psychological therapy.
97. The man was assessed by a psychiatrist only once, when he was at Deerbolt. The psychiatrist confirmed that the man suffered from depression. However, no further opinion was sought or referral made at Lancaster Farms, even though the man had been identified as having depression, ongoing self-harming behaviour and being at medium to high risk of suicide.
98. The clinical reviewer noted that a consultant psychiatrist was available three times a week at Lancaster Farms. He considered that the man's level of risk was sufficient that, when taken into account with his depression, he should have been referred to the psychiatrist for a formal diagnosis and to enable a robust care plan to be generated. The clinical reviewer also commented that guidance on self-harm provided by the National Institute for Clinical Excellence states that access to psychological therapy should form part of a wider treatment approach.
99. We agree with the clinical reviewer that a further psychiatric assessment and opinion should have been sought for the man. We make the following recommendation:

**The Head of Healthcare should ensure that prisoners with high levels of self-harm and with a diagnosed mental illness are assessed for appropriate treatment including psychological therapy.**

100. The clinical reviewer also commented on the interaction between the substance misuse and mental health teams at Lancaster Farms. He established that there was no joint screening tool for dual diagnosis and there was no evidence of regular meetings between the two services to discuss and review prisoners under the care of both services, as set out in guidance issued by the Department of Health ('Dual Diagnosis: Good Practice Guide, Mental Health Policy Implementation'). Although there was no evidence that the man exhibited signs of a dual diagnosis involving substance misuse and psychosis, the substance misuse service maintained their own separate records and did not input any detail into the prison health record. This practice prevented a shared understanding and a coherent approach of the man's health needs and associated risks. We make the following recommendation:

**The Head of the Healthcare Team should ensure that the mental health team and substance misuse team manage prisoners identified at medium to high risk of suicide or self-harm by:**

- **Having a joint understanding of clinical risk of suicide and self-harm;**
- **Using an agreed dual diagnosis tool;**

- **Holding regular multidisciplinary meetings to co-ordinate a prisoner's care management; and**
- **Fully and accurately completing medical records to ensure that all interventions are recorded to provide a comprehensive record of a prisoner's care.**

## RECOMMENDATIONS

1. The Governor should ensure that prison staff manage prisoners at risk of suicide or self-harm in line with national guidelines, including:
  - A multidisciplinary approach for all case reviews;
  - Assessing the level of risk and recording the reasons for decisions;
  - Setting appropriate frequency of reviews and levels of observations which are adjusted as the perceived risk changes;
  - Completing ACCT documents fully and accurately so that all incidents of self-harm and suicidal ideation are discussed and recorded at reviews with caremaps revised and updated;
  - Setting ACCT caremap actions which are specific and meaningful and which are aimed at reducing prisoners' risks to themselves;
  - Continuing ACCT monitoring until the risk posed by the prisoner has reduced and all caremap actions have been completed.
2. The Head of Healthcare should ensure that prisoners with high levels of self-harm and with a diagnosed mental illness are assessed for appropriate treatment including psychological therapy.
3. The Head of the Healthcare Team should ensure that the mental health team and substance misuse team manage prisoners identified at medium to high risk of suicide or self-harm by including:
  - Having a joint understanding of clinical risk of suicide and self-harm;
  - Using an agreed dual diagnosis tool;
  - Holding regular multidisciplinary meetings to co-ordinate a prisoner's care management; and
  - Fully and accurately completing medical records to ensure that all interventions are recorded to provide a comprehensive record of a prisoner's 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 should ensure that prison staff manage prisoners at risk of suicide or self-harm in line with national guidelines, including:</p> <p>A multidisciplinary approach for all case reviews;</p> <p>Assessing the level of risk and recording the reasons for decisions;</p> <p>Setting appropriate frequency of reviews and levels of observations which are adjusted as the perceived risk changes;</p> <p>Completing ACCT documents fully and accurately so that all incidents of self-harm and suicidal ideation are discussed and recorded at reviews with caremaps revised and updated;</p> <p>Setting ACCT caremap actions which are specific and meaningful and which are aimed at reducing prisoners' risks to themselves;</p> <p>Continuing ACCT monitoring until the risk</p>	Accepted	<p>Lancaster farms will continue to encourage the use of our partner agencies to participate in all case reviews and stress the importance of everyone's roles. This will be highlighted in our annual <b>staff refresher training for managers who will be chairing ACCT case reviews</b>. ACCT arrangements will be quality checked by the Safer Custody team both daily and 10% during our Safer Custody meeting. Managers will be reminded of the need for multi-disciplinary attendance at all ACCT case reviews, in particular Mental Health In reach colleagues will be expected to attend, and must be advised of planned reviews.</p> <p>The Safer Custody department are committed to ensuring ACCT documents are discussed, monitored and quality checked to ensure we comply with national instructions. Moreover, the ACCT document has to be meaningful to the prisoner with the care map being achievable and relevant as this is the most important part to the individual. Through staff training and ongoing coaching, the Safer Custody team will support managers and staff in ensuring Lancaster Farms adheres to National Standards and follows best practice in managing and caring for prisoners</p>	Head of Safer Custody and Equalities 31/08/14	

Action Plan					
No	Recommendation	Accepted/Not Accepted	Response	Target date for completion and function responsible	Progress (to be updated after 6 months)
	posed by the prisoner has reduced and all caremap actions have been completed.		vulnerable to self harm and/or suicide. Lancaster Farms is committed to continuously learning and staff training will be integral to ensuring staff knowledge is updated as well as refreshed. The Safer Custody team will communicate to staff regularly via Notices and briefings such as the updated information which is continually available for staff to view on the Quantum Z Drive under Quick Time Learning Bulletins; this can also be found externally on the intranet.		
2	The Head of Healthcare should ensure that prisoners with high levels of self-harm and with a diagnosed mental illness are assessed for appropriate treatment including psychological therapy.	Accepted	The current Health Care Workforce Development model includes a psychological well being practitioner role within the integrated mental health team. Mental Health In Reach (IMHT) Staff are currently undertaking training to deliver Cognitive Behavioural therapy and other psychological therapies/Interventions. A consultation process is due to be launched for an aspirational workforce development model in which will include provision of a dedicated psychological role, subject to agreement by the Health Care Provider.	Head of Health Care December 2014	
3	The Head of the Healthcare Team should ensure	Accepted	An agreed and existing assessment tool concept	Head of Health Care	

Action Plan					
No	Recommendation	Accepted/Not Accepted	Response	Target date for completion and function responsible	Progress (to be updated after 6 months)
	<p>that the mental health team and substance misuse team manage prisoners identified at medium to high risk of suicide or self-harm by including:</p> <p>Having a joint understanding of clinical risk of suicide and self-harm;</p> <p>Using an agreed dual diagnosis tool;</p> <p>Holding regular multidisciplinary meetings to co-ordinate a prisoner's care management; and</p> <p>Fully and accurately completing medical records to ensure that all interventions are recorded to provide a comprehensive record of a prisoner's care.</p>		<p>will be enhanced by the prospect of the Substance Misuse Service (SMS). Provider (CRI) gaining access to the System One clinical records system. The current In Reach assessment tool includes a section on Substance misuse for dual diagnosis issues.</p> <p>CRI (SMS provider) and IMHT will meet weekly at a referral and allocation meeting to discuss new/emerging and existing cases. SMS and IMHT meet monthly at a Substance Misuse Health Operational meeting.</p> <p>Currently IMHT have full access to System One (as well as use of electronic patient care records (eCPR). In order to facilitate the development of a comprehensive and integrated record the SMS provider will require access to System One. These arrangements will be introduced following agreement with Commissioners and healthcare and SMS providers.</p>	<p>October 2014 (Alongside CRI establishment lead)</p> <p>Head of Health Care/SMS provider August 2015</p>	