

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# Independent investigation into the death of Mr Orlando Santos a prisoner at HMP Gartree on 4 November 2016

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

## Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

## Our Values

**We are:**

**Impartial:** *we do not take sides*

**Respectful:** *we are considerate and courteous*

**Inclusive:** *we value diversity*

**Dedicated:** *we are determined and focused*

**Fair:** *we are honest and act with integrity*



© Crown copyright 2015

This publication is licensed under the terms of the Open Government Licence v3.0 except where otherwise stated. To view this licence, visit [nationalarchives.gov.uk/doc/open-government-licence/version/3](http://nationalarchives.gov.uk/doc/open-government-licence/version/3) or write to the Information Policy Team, The National Archives, Kew, London TW9 4DU, or email: [psi@nationalarchives.gsi.gov.uk](mailto:psi@nationalarchives.gsi.gov.uk).

Where we have identified any third party copyright information you will need to obtain permission from the copyright holders concerned.

The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out **independent** investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

My office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Santos was found hanged in his cell at HMP Gartree on 4 November 2016. Mr Santos was 52 years old. I offer my condolences to Mr Santos' family and friends.

Mr Santos transferred to Gartree in 2016, and lived on a specialist unit, designed to provide prisoners with support following a period of high intensity treatment. While Mr Santos had depression and was finding it difficult to settle at Gartree, there was no indication that he intended to take his life and I do not consider that staff could have predicted or prevented his death.

Nevertheless, I am concerned that, in spite of Mr Santos making two self-referrals for mental health assessment and staff making an urgent mental health referral when Mr Santos was found in a distressed state three days before he died, he was never seen. Staff need to ensure that mental health referrals are assessed for urgency and prioritised accordingly.

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

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

**July 2017**

**Contents**

Summary ..... 1  
The Investigation Process ..... 3  
Background Information ..... 4  
Key Events ..... 6  
Findings..... 11

# Summary

## Events

1. Mr Orlando Santos was a life sentence prisoner who had been in custody for ten years. He applied to be transferred to a specialist Psychologically Informed Planned Environment (PIPE) unit at Gartree and was moved there in August 2016.
2. Mr Santos found the transition difficult. He was not used to the more relaxed regime in the unit and did not mix with other prisoners, preferring to spend time alone. He also missed therapeutic sessions on the unit because he was unclear about whether he would be penalised for not attending work. This was only clarified shortly before he died. He was also worried about the possibility of being deported when he was released, although staff had arranged for him to discuss this and had managed to temporarily allay his fears.
3. On 1 November, Mr Santos became very distressed and was found squatting on the floor of his cell because he said he felt unsteady. He told officers that he was very depressed and experiencing vertigo. Staff considered starting suicide and self-harm prevention (ACCT) monitoring but Mr Santos said he felt okay and did not want to be subject to ACCT procedures. Staff telephoned the mental health team for an urgent appointment and were told that Mr Santos would be seen later that afternoon or the next morning. Despite this, Mr Santos was not seen by the mental health team before he died.
4. Staff found Mr Santos hanging in his cell during the afternoon of 4 November. Staff attempted to resuscitate him but he was pronounced dead at 2.32pm.

## Findings

5. This investigation found that Mr Santos' decision to take his life appeared sudden and it would have been difficult for staff to have predicted or prevented his death. We are concerned that despite staff making an urgent mental health referral three days before he died, he was not seen by mental health staff before his death. The Head of Healthcare told the investigator that urgent referrals should be seen within 24 hours but could provide no explanation as to why this had not happened in Mr Santos' case. Mr Santos had also made two self-referrals around one month and one week before he died, in the latter saying he felt hopeless and helpless. On both occasions, Mr Santos was added to the waiting list and there was no evidence that his referrals were assessed for urgency. We found that the system for assessing and prioritising mental health referrals was ineffective.
6. We also found that, despite being in a PIPE unit, staff were unaware that Mr Santos had not attended scheduled therapeutic sessions. This non-attendance should have been identified and discussed with him. We are particularly concerned that given the emphasis placed on a strong prisoner and personal officer relationship in the unit, Mr Santos was unaware of the regime, felt very unsettled on the unit and struggled with the freedom and space it afforded him.

## Recommendations

- The Governor should ensure that staff working on the PIPE Unit work closely with prisoners new to the unit, ensure they are settled and that they understand the unit's regime and expectations.
- The Head of Healthcare should ensure there is an effective mental health referral system in place, that all referrals are assessed for urgency, and prisoners are seen within prescribed timescales.

## The Investigation Process

7. The investigator issued notices to staff and prisoners at HMP Gartree informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
8. The investigator visited Gartree on 7 November 2016. She obtained copies of relevant extracts from Mr Santos's prison and medical records.
9. The investigator interviewed 11 members of staff and two prisoners at Gartree on 7 and 8 December 2016.
10. NHS England commissioned a clinical reviewer to review Mr Santos' clinical care at the prison. He jointly interviewed healthcare staff and spoke to three by telephone.
11. We informed HM Coroner for Leicester City and South District of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
12. One of the Ombudsman's family liaison officers contacted Mr Santos' wife to explain the investigation and to ask if she had any matters she wanted the investigation to consider. She asked whether her husband had been on any medication when he died and whether he was receiving mental health treatment. She received a copy of the initial report. The solicitor representing her wrote to us raising a number of questions that do not affect the factual accuracy of the report. We have written to the solicitor separately.

# Background Information

## HMP Gartree

13. HMP Gartree is a category B prison, near Market Harborough in Leicestershire, which holds up to 708 men sentenced to life imprisonment and other indeterminate sentences. Leicestershire Partnership Trust is responsible for delivering primary physical and mental healthcare services in the prison and Northamptonshire Healthcare NHS Foundation Trust runs secondary mental health in-reach services.

## HM Inspectorate of Prisons

14. The most recent inspection of Gartree was in March 2014. Inspectors reported that the PIPE Unit offered an extremely positive environment for prisoners who had, in most cases, struggled to make progress through the mainstream prison system. Prisoners were generally positive about their experiences, what they had learned, and the support from staff.
15. Inspectors found that relationships between staff and prisoners were good and the personal officer scheme was effective.

## Independent Monitoring Board

16. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to 30 November 2015, the IMB reported that the PIPE Unit had been running for four years and had gained a reputation for delivering results. However, staff felt they could be better supported by managers and were frustrated that they were sometimes asked to work elsewhere because of shortages in other areas.

## Previous deaths at HMP Gartree

17. Mr Santos was the second prisoner to take his life at Gartree since 2015. There were three deaths from natural causes over the same period. The cases have no similarities.

## Psychologically Informed Planned Environment Unit (PIPE Unit)

18. Gartree's PIPE Unit opened in 2011 and has 60 spaces. The PIPE Unit accommodates prisoners who have completed an intensive period of offending behaviour work or therapy and is part of the pathway for offenders with personality disorders.
19. Prisoners in the PIPE Unit should have more time with their personal officers, because there are more officers than on a standard wing. Each prisoner will be part of a small group of 10 prisoners to attend a structured group and explore issues relevant to their progression. Prisoners will also be given the opportunity to attend voluntary creative sessions, including reading, art, music and gardening.

## Assessment, Care in Custody and Teamwork

20. Assessment, Care in Custody and Teamwork (ACCT) is the care planning system the Prison Service uses to support prisoners at risk of suicide or self-harm. The purpose of the ACCT is to try to determine the level of risk posed, the steps that staff might take 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. Part of the ACCT involves assessing immediate needs and drawing up a caremap to identify the prisoner's most urgent issues and how they will be met. Staff should hold regular multidisciplinary reviews and should not close the ACCT until all the actions are completed.

## Key Events

21. Mr Orlando Santos, who was a Filipino national, was remanded into custody for murder on 5 December 2005. Due to the nature of his offence, he was monitored under suicide and self-harm procedures (ACCT) as a precaution. Mr Santos said he had no thoughts of harming himself and the monitoring was stopped after a few days.
22. On 16 October 2006, Mr Santos received a life sentence at Crown Court, with a minimum of 24 years to serve. Mr Santos was recommended for deportation once he had served his sentence, which would have been 2029 at the earliest. He was initially held at HMP Wakefield. During his early days in custody, staff were concerned he was at risk of suicide and self-harm, so monitored him briefly through ACCT again.
23. Around June 2015, Mr Santos' offender supervisor at Wakefield noted that he had completed all the offending behaviour courses available to him there (Thinking Skills Programme (TSP) and Controlling Anger and Learning to Manage It (CALM)) and recommended he apply to move to the PIPE Unit at Gartree as a next step. Mr Santos applied to the PIPE Unit in May 2015 and was assessed as suitable in December 2015.
24. Mr Santos was transferred to Gartree on 22 August 2016. In reception, a nurse noted that he had in-possession medication from Wakefield, which he was allowed to keep, and she added his name to the prison's mental health team's list for assessment within 24 hours. Mr Santos said he had no thoughts of suicide or self-harm. A prison GP saw Mr Santos the next day and re-prescribed antidepressants, Lansoprazole for gastric problems and naproxen for pain relief.
25. A cell sharing risk assessment (CSRA) completed on 22 August highlighted no concerns and Mr Santos was allocated a single cell on the PIPE Unit. Mr Santos was allocated to a group on the unit, which had weekly therapeutic sessions on Mondays. An officer was assigned as his personal officer.
26. A nurse reviewed Mr Santos' mental health on 30 August. Mr Santos said he had post traumatic stress disorder (PTSD) due to his offence, and took antidepressants which he found helpful. Mr Santos spoke to his family on the telephone but they did not visit him because of the distance to the prison. Mr Santos told the nurse that he was trying to cope with prison life and trying to make friends. He struggled with the freedom he had on the unit as he was not used to it. He asked for a follow up assessment in a month, but she advised him to contact healthcare staff whenever he felt he needed to instead.
27. The personal officer met Mr Santos for the first time on 6 September. Mr Santos explained that his purpose for joining the PIPE Unit was to progress through his sentence and secure release to be with his wife and daughter. Mr Santos was upset about the possibility of deportation and was determined to stay in the UK with his family. He said that he needed to clarify his position before he made any plans to progress through his sentence, with a view to his release. The officer said he would contact the Foreign Nationals Officer. He

noted that Mr Santos had not integrated with prisoners and spent most of the time alone in his cell.

28. The Foreign Nationals Officer met Mr Santos on the same day. He explained to Mr Santos that he would serve his sentence in the UK and would not be deported until this was completed. He offered to assist with the paperwork for an appeal against deportation. He arranged an interview with an Immigration Enforcement officer to explain the deportation process in more detail. This was subsequently cancelled but he told Mr Santos that he would put his name down for the next immigration surgery and he was happy with this.
29. Mr Santos completed a self-referral form to speak to a mental health nurse on 26 September. He wrote that he had been feeling very low and struggling to settle at Gartree. The referral was processed in the healthcare department on 28 September, and Mr Santos was added to the waiting list, but was not seen by a mental health nurse.
30. On 28 September, Mr Santos told his personal officer that he felt very low and was struggling to settle in at Gartree. He said he had trouble sleeping, which made him feel worse. Mr Santos said he wanted to return to Wakefield, as he was happy there. The officer tried to persuade him to give Gartree a chance and they agreed to keep talking about it.
31. The personal officer noted that between 28 September and 10 October, he had struggled to find time to have quality conversations with Mr Santos, and had just had brief discussions with him over the previous week. When they met on 10 October, Mr Santos said he was still finding it difficult to settle on the PIPE Unit and still had not integrated. They spoke again the next day, when Mr Santos said he felt a little better. He still had not attended any creative sessions, because he mistakenly thought he would lose pay for not attending work. The officer assured him this was not the case.
32. On 14 October, Mr Santos told his personal officer that he was still struggling to settle on the PIPE Unit and was again questioning whether he had done the right thing. The officer explained that it might not be possible to return to Wakefield and if Mr Santos applied to move from the PIPE Unit, he might have to relocate to another wing at Gartree, but Mr Santos seemed untroubled by this. Mr Santos told him that he would go to the Philippines at the end of his sentence whether he was deported or not. The officer noted that last time he had spoken to Mr Santos he was intent on staying in the UK with his family and had no idea what had prompted this change. Throughout their conversation, Mr Santos seemed distant and preoccupied. He advised Mr Santos not to make any rash decisions.
33. Mr Santos completed another self-referral to see a mental health nurse on 7 October. He wanted to know why his antidepressants had been suddenly stopped. This referral was processed on 9 October and he was seen on 13 October. He was assured that his medication had not been stopped and it had been a misunderstanding. The clinical reviewer confirmed there was no break in Mr Santos' medication.

34. Mr Santos asked to meet a trainee psychologist on 12 October. He said he was struggling with the open spaces on the unit and the freedom he had, compared to Wakefield. They discussed how he could manage this, and Mr Santos said he attended the gym, exercise, the chapel and worked, which helped him. They discussed whether Mr Santos should remain on the unit, and he decided he should stay.
35. Mr Santos asked to see the trainee psychologist again on 21 October. He was anxious because another prisoner on the unit had left to move to a lower category prison. He was concerned that if he stayed on the unit he would move quickly, and did not want this. He said he thought it would be better to leave the unit and completed an application form to do so. They agreed to meet again on 24 October to see if Mr Santos still wanted to move. On 23 October, an officer passed a message to the trainee psychologist, saying that Mr Santos wanted to withdraw his application to move off the unit. She spoke to him, as planned, the next day. Mr Santos apologised and said he had spoken to his wife and she thought he should stay. Mr Santos explained that he had struggled with depression for many years and became anxious about small things. She asked if he was in touch with the mental health team and Mr Santos said he had submitted an application to see them. On 27 October, Mr Santos told her again that he was unsure whether he wanted to stay on the unit but he agreed to think it over.
36. Mr Santos attended his first structured group session on 24 October, and two days later applied to leave the PIPE Unit, but then withdrew the application again. His personal officer asked why, and Mr Santos said he did not want to move to a lower category prison, but wanted to stay on the PIPE Unit for a full two years. They spoke again on 30 October, when Mr Santos again explained that he was reluctant to move to a lower category prison too soon and that was why he had applied to move off the unit.
37. On 31 October, Mr Santos attended a creative reading session. A prisoner and mentor on the PIPE Unit, who was at the same session, told the investigator that Mr Santos had told him that he had not attended the sessions before because he was worried he would get into trouble for not attending work and would not get paid, which would mean he would have no money for telephone calls. Someone had mentioned to him that he would still get paid, albeit a lesser amount, which is why he had started attending. He recalled that Mr Santos said he wanted to leave the unit, but did not say why. He said that Mr Santos engaged well and there was no indication that anything was wrong.
38. On the same day, Mr Santos picked up a month's worth of antidepressants. Mr Santos spoke to the trainee psychologist, told her he wanted to stay on the unit, that he had started to enjoy the group sessions, and was feeling brighter. He said he was still waiting to see someone from the mental health team.
39. Also on 31 October, Mr Santos telephoned his wife and they discussed his depression and medication. Mr Santos said there was a therapeutic community at Gartree, but he would not be eligible unless he no longer took antidepressants and asked for her advice.

40. The personal officer told the investigator that he had been unaware that Mr Santos had not been attending his therapeutic sessions. A senior psychologist on the PIPE Unit was also unaware that Mr Santos had not attended any structured or creative sessions until 24 and 31 October respectively. She said she was surprised, as she thought he had been, but his attendance had not been recorded. She said that, in any case, prisoners would not be rushed and they would be given time to settle into their new environment. She said it was not unusual for prisoners not to attend in their first few weeks.
41. The personal officer went to see Mr Santos in his cell on 1 November. Mr Santos was speaking to an officer and was very distressed. The officer left and the personal officer asked what was wrong. Mr Santos explained that he felt very depressed and was experiencing vertigo. He squatted on the floor, as he felt unsteady on his feet, and was wringing his clothes. The officer said he considered starting ACCT monitoring. He explained to Mr Santos that if he opened an ACCT he would see a member of the mental health team straightaway, but Mr Santos said he was reluctant to do that because he felt he was forcing them to see him. He telephoned the mental health team to ask for an urgent assessment. They later left a message that Mr Santos would be seen at 5.30pm that afternoon or, failing that, the next morning. He told Mr Santos this, and he seemed relieved. He said he felt okay and did not want to be subject to ACCT monitoring. Officer Evans spoke to the trainee psychologist, who agreed that this was the best course of action.
42. On 3 November, the personal officer discovered that Mr Santos had not been seen by a member of the mental health team. As he was going off duty, he asked an officer to telephone them. He was told that a nurse would see him the next day.

#### **4 November 2016**

43. An operational support grade carried out the morning roll check at 5.30am to ensure that all prisoners were safely in their cells. He said he checked every cell and noted nothing out of the ordinary. He did not recall any observation panels covered that morning.
44. All cells on the PIPE Unit were unlocked at 8.00am so that prisoners could collect their breakfast. They returned to their cells at 8.45am. The prison was having a training day, so all work, association and activities were cancelled. One prison officer remained on the unit, although the prison is unable to say who this was. The cells were unlocked again at 11.30am, so prisoners could collect their lunch. Nobody can remember unlocking Mr Santos's cell.
45. A prisoner who worked on the servery on the PIPE Unit noticed that Mr Santos had not picked up his lunch. He offered to take it to his cell and arrived there just after midday. He saw the observation panel was covered with toilet paper. He explained that prisoners understood that they should not go into a cell if the panel is obscured, nor tell a member of staff. He knocked on the door, but got no response. He shouted that he would leave the tray of food outside the door.
46. Officer A started his shift on the PIPE Unit at midday. At approximately 1.45pm, he started cell security checks. He arrived at Mr Santos's cell at 1.55pm. He

saw that his observation was obscured with toilet paper, so knocked on the door before going in, in case he had been using the toilet. He got no reply so went in and saw Mr Santos hanging from the hinge of his locker, with a ligature made from a bedsheet. He remembered that the courtesy lock was on. He shouted for help, and Officer B who was nearby responded immediately.

47. Officer A supported Mr Santos while Officer B cut the ligature and they laid him on the floor. The personal officer went into the cell, saw what had happened and radioed an emergency code blue (which is a medical emergency code used when a prisoner is unconscious and alerts the control room to call an ambulance immediately). Officer A checked for a pulse, but did not find one. Mr Santos felt cold and clammy. He started chest compressions, assisted by the personal officer, until nurses arrived.
48. Two nurses responded to the emergency call. Mr Santos did not have a pulse, so one nurse administered oxygen and the other applied defibrillator pads. The defibrillator advised no shock and to continue resuscitation. Another nurse took over chest compressions and two other nurses tried to insert an airway, but Mr Santos' jaw was too rigid.
49. Paramedics arrived at 2.05pm and continued CPR with staff. The defibrillator was used throughout and repeatedly advised that no shock was required. More paramedics arrived at 2.25pm and took over CPR. They pronounced Mr Santos dead at 2.32pm.

#### **Contact with Mr Santos' family**

50. Two members of staff travelled to Chester to visit Mr Santos' wife, where they broke the news of his death. The prison contributed to Mr Santos' funeral, in line with national instructions.

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

51. After Mr Santos' death, the deputy governor debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.
52. The prison posted notices informing other prisoners of Mr Santos' death, and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Santos' death.

#### **Post-mortem report**

53. The post-mortem report concluded that Mr Santos died from hanging. A toxicology report showed Mr Santos had taken only his prescribed medication.

# Findings

## Assessing Mr Santos's risk of suicide and self-harm

54. Prison Service Instruction (PSI) 64/2011 on safer custody lists a number of risk factors and potential triggers for suicide and self-harm. Mr Santos had mild depression but seemed to respond well to antidepressants, which he had been taking for 10 years. He had no history of self-harm or attempted suicide, and had only been subject to suicide prevention monitoring procedures briefly, 11 years earlier when he first arrived in prison and again when he was sentenced.
55. Mr Santos had found it difficult to settle into the PIPE Unit and had spoken about applying to move on several occasions, although he had always changed his mind. He had also expressed concern about the prospect of being deported at the end of his sentence. Staff had engaged with Mr Santos on both issues to try to alleviate his concerns. There was no indication that either issue was causing him distress to the extent that he was intending to take his life or harm himself.
56. When Mr Santos was found in a very distressed state on 1 November, staff did consider starting ACCT procedures but decided not to after they had arranged for Mr Santos to be seen by the mental health team. It is regrettable that Mr Santos was never seen and, had staff opened an ACCT, this would have ensured an assessment. Nevertheless, Mr Santos' actions appear to have been sudden and unexpected, we consider that staff could not have predicted or prevented his death and we consider his personal officer's decision not to start ACCT procedures reasonable given his conversations with the mental health team.
57. We are concerned that Mr Santos was insufficiently aware of the regime on the PIPE Unit and consequently felt unsettled. He told staff he was struggling with the freedom and space on the unit, something he had not been used to previously. Staff were initially unaware that Mr Santos had not been attending his therapeutic sessions, which is surprising given the additional resources on the PIPE Unit, and their personal officer scheme, which allows staff to spend more time and develop a more meaningful relationship with prisoners. It should also have been made clear to Mr Santos that he would get paid for attending the sessions and not be penalised for not attending work, an issue he was clearly concerned about and which was not clarified with him until after almost two months on the unit. We make the following recommendation:

**The Governor should ensure that staff working on the PIPE Unit work closely with prisoners new to the unit ensure they are settled and that they understand the unit's regime and expectations.**

## Mental health referrals

58. The Head of Healthcare explained that if a referral was assessed as urgent, staff would see the prisoner within 24 hours, a routine referral would be seen within four weeks and a non-urgent referral could take up to 12 weeks. The mental health manager explained that a member of the healthcare department

would assess the referral, look at the prisoner's medical notes and decide on a course of action. The Head of Healthcare could not explain why nobody had seen Mr Santos on 1, 2 or 3 November, despite his personal officer having made an urgent referral on 1 November and having been told that Mr Santos would be seen later that afternoon or failing that, the next morning. She said that a nurse was due to see Mr Santos on 4 November, the day he died. While it is difficult to predict whether the outcome for Mr Santos would have been different had he been seen by mental health staff in the days before his death, it is likely that staff could have made a better informed decision about Mr Santos' likely risk of suicide and self-harm had a mental health assessment taken place.

59. The senior psychologist on the PIPE Unit said that staff had difficulty contacting healthcare staff and that the only way to guarantee their input was to open an ACCT. It is not acceptable that staff are having to start ACCT procedures in order to secure engagement from healthcare staff.
60. In terms of Mr Santos' own referrals to mental health on 26 September and 28 October, there was no evidence that they had been assessed for urgency. The clinical reviewer agreed that there was no evidence of a risk assessment, or rationale, to determine the urgency of Mr Santos' referrals.
61. The clinical reviewer concluded that, although Mr Santos' clinical care was equivalent to that which he could have expected to receive in the community, it was disheartening that nobody saw him in the days before he died, especially as he had been assured that he would be seen. We make the following recommendation:

**The Head of Healthcare should ensure there is an effective mental health referral system in place, that all referrals are assessed for urgency, and prisoners are seen within prescribed timescales.**

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations