

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Andrew Fenn a prisoner at HMP Lowdham Grange on 4 October 2018

A report by the Prisons and Probation Ombudsman

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*



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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 Andrew Fenn died in hospital on 4 October 2018, after being found hanging in his cell at HMP Lowdham Grange earlier that day. He was 29 years old. I offer my condolences to Mr Fenn's family and friends.

Mr Fenn's behaviour was often challenging and he frequently self-harmed. He was supported by Prison Service suicide and self-harm prevention measures (known as ACCT) on five occasions while at Lowdham Grange, and staff were in the process of starting them again when Mr Fenn was discovered hanging. Mr Fenn was also supported under violence reduction measures after telling staff he was under threat from other prisoners.

The investigation found that the ACCT procedures were managed poorly, an issue HM Inspectorate of Prisons identified when they inspected Lowdham Grange in August 2018. The investigation also found that the violence reduction measures used to support Mr Fenn were inadequate.

There was a delay in the emergency response because staff did not immediately enter Mr Fenn's cell when he covered his observation panel. I cannot say whether the delay made a difference to the eventual outcome.

I am not satisfied that the care Mr Fenn received for his mental health and substance misuse issues was equivalent to that which he could have expected to receive in the community.

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

Sue McAllister CB
Prisons and Probation Ombudsman

June 2019

Contents

Summary	1
The Investigation Process	3
Background Information	4
Key Events	7
Findings.....	15

Summary

Events

1. Mr Andrew Fenn was serving a sentence of eight years and six months for robbery and false imprisonment. He was moved to HMP Lowdham Grange on 3 April 2018.
2. Mr Fenn had a history of self-harm in custody and was managed under Prison Service suicide and self-harm prevention procedures (known as ACCT) on five occasions at Lowdham Grange. He was also supported under the prison's violence reduction measures after telling staff that he was under threat from other prisoners.
3. On 4 October 2018, Mr Fenn was allowed out of his cell after lunch to use the wing facilities. At around 1.30pm, he refused to return to his cell. Staff negotiated with Mr Fenn for around 15 minutes before using control and restraint measures to return him to his cell. Initially, Mr Fenn was shouting, swearing and making threats to staff. He then covered his observation panel and went quiet. When staff entered his cell, they found Mr Fenn hanging. Staff and paramedics resuscitated him and he was taken to hospital. However, he did not regain consciousness and at 11.30pm, he died.

Findings

4. Staff managed the ACCT procedures poorly. Case reviews were not multidisciplinary, with no input from mental health staff, caremaps were not properly completed or reviewed and ACCT reviews were often late. HM Inspectorate of Prisons found that ACCT procedures were poorly managed at Lowdham Grange during its last inspection in August 2018.
5. Staff were aware that Mr Fenn was under threat from other prisoners but violence reduction measures were ineffective. Although a concern file and action plan were completed, no specific objectives to manage or mitigate his risk were identified and the plan was never reviewed.
6. We found the spontaneous use of force to return Mr Fenn back to his cell was appropriate. However, despite it being a mandatory requirement, nobody switched on a body worn video camera to record the incident. HM Inspectorate of Prisons identified this as an issue during its last inspection.
7. There was a short delay in entering Mr Fenn's cell after he had covered his observation panel, which resulted in a short delay in the medical emergency response. It is not possible to say whether this affected the eventual outcome, although we note that it was possible to resuscitate him when he was found.
8. We found no evidence that mental health or substance misuse services proactively tried to engage Mr Fenn. The clinical reviewer concluded that the care Mr Fenn received was not equivalent to that which he could have expected to receive in the community.

Recommendations

- The Director and Head of Healthcare should ensure that staff manage prisoners at risk of suicide and self-harm in line with national guidelines, in particular that they:
 - complete the immediate action plan, assessment interview, first case review and post-closure review within the set timescales;
 - hold multidisciplinary case reviews where possible, to include mental health staff where appropriate;
 - set caremap actions that are specific, time bound and meaningful, tailored to the individual to reduce their risks and update them at each case review;
 - hold case reviews when scheduled, and additional case reviews as necessary;
 - complete all ACCT paperwork fully and accurately; and
 - update a prisoner's record promptly with important information and significant events.
- The Director should review the effectiveness of HMP Lowdham Grange's violence reduction policy and its delivery, specifically ensuring:
 - effective identification and management of victims and alleged perpetrators;
 - effective support and protection for apparent victims with meaningful objectives and long-term solutions, which address their individual situations;
 - the risk of suicide or self-harm to victims of bullying and intimidation is considered; and
 - accurate and timely record keeping.
- The Director should ensure that sufficient numbers of staff are assigned to wear Body Worn Video cameras and that they activate them at the earliest opportunity during any reportable incident.
- The Director should remind staff that when an observation panel is covered and a prisoner fails to respond, arrangements should be made to enter the cell as quickly as possible, particularly in the case of prisoners being monitored under ACCT arrangements.
- The Head of Healthcare should review the use of telephone consultations to ensure assessment and ongoing support is provided in line with best practice, as set out in NICE Guidance (NG66) Mental Health of Adults in contact with the Criminal Justice System.
- The Director and Head of Healthcare should ensure substance misuse services are effective and:
 - attend ACCT reviews when appropriate to do so;
 - provide swift access to appropriate support;
 - assessments which consider all relevant information, including drug tests; and
 - communicate with the mental health team and prison staff about individuals' presentation and specific needs.

The Investigation Process

9. The investigator issued notices to staff and prisoners at HMP Lowdham Grange, informing them of the investigation and asking anyone with relevant information to contact her. One prisoner responded.
10. The investigator visited Lowdham Grange on 11 October, and obtained copies of relevant extracts from Mr Fenn's prison and medical records.
11. NHS England commissioned a clinical reviewer to review Mr Fenn's clinical care at the prison.
12. The investigator and clinical reviewer interviewed six members of staff and one prisoner at Lowdham Grange on 27 November. In addition, the investigator interviewed two members of staff by telephone in January 2019.
13. We informed HM Coroner for Nottinghamshire and Nottingham City of the investigation. The coroner gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

The Ombudsman's family liaison officer, contacted Mr Fenn's family to explain the investigation and ask if the family had any issues they wanted the investigation to consider. Mr Fenn's family wanted to know what medication he was prescribed and what support he received. We have addressed these question in this report.

14. We shared a copy of our initial report with Mr Fenn's family. They did not identify any factual inaccuracies.
15. The prison also received a copy of the report and did not identify any factual inaccuracies. An action plan for the recommendations is annexed to the report.

Background Information

HMP Lowdham Grange

16. HMP Lowdham Grange is a medium secure prison, managed by Serco, which holds around 920 men, many of whom are serving life sentences or indeterminate sentences. There are five houseblocks, two of which hold approximately 250 men and the other three houseblocks typically hold up to 130 men. Nottinghamshire Healthcare NHS Foundation Trust provides general healthcare, which includes 24-hour nursing cover.

HM Inspectorate of Prisons

17. The most recent inspection of HMP Lowdham Grange was in August 2018. Inspectors reported that levels of violence remained high, but the prison's new violence reduction strategy was encouraging. Inspectors found perpetrators and victims of violence were engaged and there was some good practice in the prison's actions to explore the links between violence and drug misuse. Concern files were adequate, but lacked individual planning and reviews were often perfunctory with generic targets. The introduction of a prisoners' violence hotline was identified as good practice, but it was too early to say if the approach was working.
18. The amount of self-harm in the prison had increased significantly and ACCT case management for those in crisis was inadequate. Inspectors found immediate action plans and some assessments were frequently completed late. Case reviews were often not multidisciplinary and care maps were frequently not updated. Some documents did not record meaningful interactions with prisoners, although prisoners reported feeling well supported. Inspectors found Lowdham Grange was progressing well with meeting the recommendations made by the PPO following their investigation into two previous deaths.
19. Inspectors noted the use of force had doubled since their last inspection. Oversight and accountability for the use of force (and segregation) required significant improvement. Body worn video cameras were not routinely used during spontaneous incidents.

Independent Monitoring Board

20. 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 most recently published annual report for the year ending January 2018, the Board noted that use of psychoactive substances remained high and caused unpredictable and at times violent behaviour.
21. The Board found low staffing levels made management of prisoners difficult and inexperienced staff contributed to challenging atmospheres on some wings. The Board had received complaints from prisoners that healthcare staff did not attend ACCT reviews.

Previous deaths at HMP Lowdham Grange

22. Mr Fenn was the seventh prisoner to die at Lowdham Grange since October 2015. Of the previous deaths, two took their own lives, one died from natural causes and three were drug related. There have been two deaths since, one self-inflicted and one drug related. There were no similarities between Mr Fenn's death and previous deaths at the prison.

Assessment, Care in Custody and Teamwork

23. ACCT is the Prison Service care-planning system used to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk, how to reduce the risk and how best to monitor and supervise the prisoner.
24. After an initial assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. Checks should be irregular to prevent the prisoner anticipating when they will occur. There should be regular, multi-disciplinary review meetings involving the prisoner. As part of the process, a caremap (a plan of care, support and intervention) is put in place. The ACCT plan should not be closed until all the actions of the caremap have been completed.
25. All decisions made as part of the ACCT process and any relevant observations about the prisoner should be written in the ACCT booklet, which accompanies the prisoner as they move around the prison. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011, *Safer Custody*.

Incentives and Earned Privileges Scheme (IEP)

26. Each prison has an incentives and earned privileges (IEP) scheme which aims to encourage and reward responsible behaviour, encourage sentenced prisoners to engage in activities designed to reduce the risk of re-offending and to help create a disciplined and safer environment for prisoners and staff. Under the scheme, prisoners can earn additional privileges such as extra visits, more time out of cell, the ability to earn more money in prison jobs and wear their own clothes. There are four levels, entry, basic, standard and enhanced.

Psychoactive Substances (PS)

27. Psychoactive substances (formerly known as 'new psychoactive substances' or 'legal highs') are a serious problem across the prison estate. They are difficult to detect and can affect people in a number of ways including increasing heart rate, raising blood pressure, reducing blood supply to the heart and vomiting. Prisoners under the influence of PS can present with marked levels of disinhibition, heightened energy levels, a high tolerance of pain and a potential for violence. Besides emerging evidence of such dangers to physical health, there is potential for precipitating or exacerbating the deterioration of mental health with links to suicide or self-harm.
28. In July 2015, we published a Learning Lessons Bulletin about the use of PS (still at that time NPS) and its dangers, including its close association with debt, bullying and violence. The bulletin identified the need for better awareness

among staff and prisoners of the dangers of PS; the need for more effective drug supply reduction strategies; better monitoring by drug treatment services; and effective violence reduction strategies.

29. HM Prison and Probation Service (HMPPS) now has in place provisions that enable prisoners to be tested for specified non-controlled psychoactive substances as part of established mandatory drugs testing arrangements. Testing has begun, and HMPPS continue to analyse data about drug use in prison to ensure new versions of PS are included in the testing process.

Key Events

30. On 14 July 2014, Mr Andrew Fenn was remanded in prison custody, charged with robbery and false imprisonment, and sent to HMP Dovegate. On 1 December, he was sentenced to eight years and six months in prison with an extended licence period of three years and six months. This was not his first time in prison.
31. Mr Fenn had a history of depression and anxiety and had regular contact with mental health services while in prison. Mr Fenn also had issues with alcohol and illicit substances dating back to when he was a teenager.
32. Mr Fenn was at Dovegate until 20 September 2017, when he was moved to HMP Altcourse. During this time, Mr Fenn achieved enhanced status, worked as a wing cleaner and attended offending behaviour programmes where he received good reports for his contribution.
33. There were several reported incidents of Mr Fenn self-harming by cutting to relieve his emotional distress including when his younger sister died, when he stopped taking his medication and when he felt frustrated or worried other prisoners knew about his offence. He was supported under Prison Service suicide and self-harm prevention measures (known as ACCT) on each occasion.
34. There were also several recorded incidents in Mr Fenn's prison record that he was found under the influence of illicit substances, had failed a mandatory drug test (MDT) and downgraded to the basic regime on the IEP scheme.

HMP Lowdham Grange

35. On 3 April 2018, Mr Fenn was moved to HMP Lowdham Grange. Nurse A completed Mr Fenn's initial healthcare screen and noted his medical history. The nurse wanted to refer Mr Fenn to the mental health and substance misuse teams, but he declined. Mr Fenn continued to be prescribed an antidepressant (trazadone). There is no evidence in Mr Fenn's prison record that he received an induction to Lowdham Grange.
36. On 11 May, Mr Fenn fought with another prisoner in the gym. (Officer A noted this in Mr Fenn's prison record on 15 June.)
37. Staff opened a concern file on 21 May, part of Lowdham Grange's violence reduction measures, to support Mr Fenn. An investigation found that the prisoner who fought with Mr Fenn on 11 May started the fight. There was one action recorded to support Mr Fenn which was for him to 'refrain from violence and anti-social behaviour'. Staff held reviews on 5 and 19 June. They decided to continue monitoring and made entries on most days as part of the ongoing record.
38. On 2 July, although there is no entry in his prison record, Mr Fenn was placed on report for going over the railings on C Wing. Mr Fenn's in-possession antidepressant medication was taken from him and he was required to collect it each day instead. Staff started ACCT procedures after Mr Fenn cut his arm with

- a razor blade. Neither the immediate action plan nor ACCT assessment were completed.
39. Staff reviewed Mr Fenn's concern file on 3 July. They noted that Mr Fenn had gone onto the railings the previous day and that the violence reduction team would see him regularly. There is nothing specific recorded on the action plan about how he would be supported.
 40. On 6 July, Custodial Operations Manager (COM) A chaired the first ACCT review which was attended by COM B and Mr Fenn. COM A recorded that Mr Fenn was in 'good spirits', that he had spoken to his grandmother and had been employed as a wing cleaner but was concerned about his progression and being under threat. Mr Fenn said that he did not feel like self-harming, but that he could be impulsive. Two issues were noted on the caremap: for Mr Fenn to get a job and to be on a safe location.
 41. On 10 July, Mr Fenn was discussed at the weekly intervention meeting (WIM) attended by safer custody and violence reduction staff. Staff noted that Mr Fenn had no further concerns and closed the concern file. The next ACCT review was scheduled for 13 July, but there is no evidence it took place.
 42. On 17 July, COM C chaired the ACCT review which was attended by Officer B, Officer C, COM C and Mr Fenn. The attendees assessed Mr Fenn's risk of suicide and self-harm as low and noted that the two issues on the caremap had been completed. Mr Fenn said he felt safer and would ask for help if he needed it. Despite noting that Mr Fenn was to be referred to the mental health team, staff closed the ACCT. A post-closure review was scheduled for 24 July.
 43. On 25 July, Mr Fenn was placed on report for possession of five litres of illicit alcohol (hooch). The next day, COM C noted that Mr Fenn said he was too tired to attend his post-closure review but said, 'Honestly miss I am fine.'
 44. On 27 July at 5.00pm, Officer D started ACCT procedures after Mr Fenn cut his arm. Mr Fenn said he had self-harmed because he felt vulnerable on the wing and was too anxious to leave his cell as he was being bullied. He also had some bedding tied as a ligature. Nurse A examined Mr Fenn and recorded in the medical record that no further treatment was required and that Mr Fenn had no thoughts of suicide or further self-harm. The officer completed an immediate action plan at 8.25pm.
 45. Officer E completed the ACCT assessment at 12.15pm on 30 July. The officer noted that Mr Fenn said he was under a lot of stress, was being made to hold illicit alcohol for other prisoners as he was an easy target and that he wanted to move wings or transfer to another prison as he believed he would get 'slashed up' if he left his cell. Mr Fenn told the officer that another prisoner had given him three new razor blades with a message to 'do us a favour'. He said he had tried to hang himself but felt dizzy so removed the ligature. He said he frequently thought about self-harm and that it provided some emotional release, but he did not often contemplate hanging himself. He said that he had not taken his antipsychotic medication since 25 July [he was not prescribed antipsychotic medication], as he was afraid to leave his cell.

46. On 30 July at 12.14pm, Mr Fenn telephoned the Violence Reduction Helpline. He told Officer F that he was being bullied through his door by three prisoners, that they were posting razor blades through his window and encouraging him to kill himself. Mr Fenn said he did not think a move to another wing would help, as he thought the issue would follow him. At 3.30pm, COM D chaired the first ACCT review attended by Officer F and Mr Fenn. Mr Fenn said that he was under threat and desperate to transfer back to Altcourse. He said that he self-harmed to release tension, but had no current thoughts of suicide and that he felt he could talk to staff if he needed further support. Staff assessed Mr Fenn's risk of suicide and self-harm as low and scheduled a review for 6 August. The caremap was not completed.
47. On 2 August, Officer G recorded that she had issued Mr Fenn with a warning for refusing to work and that he was self-isolating on the wing. The mental health team manager, noted in Mr Fenn's medical record that he was discussed at their multidisciplinary meeting. The mental health team manager recorded, 'Self-harm notification. Superficial. Not known to MH services currently. NPS use in December 2017. No self-referral.'
48. On 3 August, Mr Fenn told Officer B that he was self-isolating due to the problems on the wing and had self-harmed. The next day, the officer spoke to Mr Fenn again to check how he was and Mr Fenn said he was still low in mood and not happy at Lowdham Grange. On 5 August, the officer advised Mr Fenn to contact the Observation, Classification and Allocation (OCA) Team about getting a transfer to another prison. These three entries were made on Mr Fenn's prison record retrospectively by the officer on 10 August. Nurse B recorded in Mr Fenn's medical record that Mr Fenn had deliberately self-harmed over the past few days by cutting his arm, and advised him on how to keep his wounds clean.
49. On 7 August, COM D chaired an ACCT review attended by COM E and Mr Fenn. The review assessed Mr Fenn's risk of suicide and self-harm as low. Mr Fenn told the COM that he had made the decision to self-isolate, that he made superficial cuts to release tension, but that he did not want to end his life. COM D closed the ACCT and scheduled a post-closure review for 14 August.
50. Staff reopened Mr Fenn's ACCT on 10 August. COM F recorded on the ongoing record that Mr Fenn had cut his arm, felt stressed and suicidal, and had not been taking his medication as he was self-isolating. It was noted that Mr Fenn was seen by healthcare and that an ACCT review was scheduled for 11 August. No caremap was completed.
51. On 14 August, Mr Fenn was moved to M Wing. The next day, he told Officer F he had been assaulted in his cell by two prisoners who told him he had five minutes to get off the wing. Closed circuit television (CCTV) confirmed that two prisoners had entered Mr Fenn's cell for around two minutes. COM G, violence reduction and safer custody manager, said that officers from the violence reduction team who reviewed the CCTV footage spoke to Mr Fenn and he was offered a move to a different wing, but declined saying the problems followed him and made his situation worse. Officers reported Mr Fenn had no visible injuries, although Nurse B recorded in Mr Fenn's medical record at 9.58pm, he had a slight swelling near his right eye. The officer contacted OCA with a view to

moving Mr Fenn to Dovegate. There is no evidence a concern file was considered to support Mr Fenn.

52. On 16 August, Mr Fenn was discussed at the mental health team multidisciplinary meeting. Nurse C noted 'recent notification of self-harm, not requesting contact with ourselves. Continue to monitor situation'. There is no detail recorded about how healthcare staff would monitor Mr Fenn.
53. On 17 August, COM G chaired the ACCT review (which had been scheduled for 11 August). It was attended by Officer H and Mr Fenn. The review was held in Mr Fenn's cell as he continued to self-isolate and did not want to leave after being assaulted earlier in the week. Mr Fenn said he had not self-harmed and would continue to self-isolate until he was moved to another prison. COM G recorded that a possible transfer to Altcourse or Dovegate was being considered. The next ACCT review was scheduled for 21 August.
54. On 22 August at 12.00pm, Officer I started a concern file. He recorded in Mr Fenn's prison record that he was assessed as being vulnerable while he was on M Wing, but he gave no specific details. The officer asked Mr Fenn if he wanted to move wings, but he declined. Mr Fenn told the officer that he would self-isolate and only leave his cell when he needed to. At 6.00pm, COM H chaired the ACCT review, attended by Officer J and Mr Fenn. Staff considered that Mr Fenn's risk of suicide and self-harm remained low. Mr Fenn said he felt settled since his move to M Wing and staff agreed to close the ACCT. They scheduled a post-closure review for 29 August.
55. On 28 August, although there is no entry on Mr Fenn's prison record, he was placed on report for a failed mandatory drug test (MDT) which showed that he had used PS. The ACCT post-closure review was completed the next day, but the person completing the review did not record their name. Mr Fenn said he felt 'in a better place' but still got stressed.
56. On 6 September at 1.00pm, Officer K started ACCT procedures after Mr Fenn cut himself, because he said he was in debt on his wing and had forgotten to order his canteen (purchases from the prison shop). Nurse D treated his wounds, but Mr Fenn declined a referral to the mental health team. Officer L completed the ACCT assessment at 2.50pm, and noted Mr Fenn said he did not care if he died and showed the officer a readymade ligature, said that he would cut himself again and would continue to self-isolate. The officer assessed Mr Fenn was suicidal. COM E chaired the ACCT review shortly afterwards (although 2.30pm is the time recorded on the form), attended by the officer and Mr Fenn. Staff assessed Mr Fenn's risk as low. A caremap was not completed.
57. COM E reviewed Mr Fenn's ACCT the next day, attended by Officer M and Mr Fenn. The COM recorded that Mr Fenn was 'in a much better place' and had been socialising on the wing. He considered Mr Fenn's risk of suicide and self-harm remained low and closed the ACCT. He scheduled a post-closure review for 14 September.
58. On 13 September at 1.56pm, Nurse E contacted Mr Fenn on his in-cell telephone to conduct a brief mental health assessment, in response to his recent self-harm. Mr Fenn told the nurse that he did not have any mental health issues and did not

want to engage with mental health services. Mr Fenn was discussed at a mental health multidisciplinary meeting later the same day and was discharged.

59. On 14 September, COM E completed the ACCT post-closure review. He noted that Mr Fenn had received his canteen order and that he felt supported on the wing. At 12.00pm, an unnamed member of staff reviewed Mr Fenn's concern file. They noted that intelligence suggested Mr Fenn was being bullied because he was in debt on every wing and that he would continue to be monitored by the violence reduction team.
60. On 18 September, Mr Fenn cut his shoulder, neck and arm, and damaged his hand punching the wall. Officer N started ACCT procedures at 8.30am. Nurse F cleaned and dressed the wounds and noted Mr Fenn had movement in his hand, although it was swollen, and that it should be checked again the next day. The nurse also referred Mr Fenn to the mental health team. Mr Fenn was placed on report as he smashed his television and threatened to go onto the netting on the wing, because he was bored not having a job.
61. On 19 September, Nurse G examined Mr Fenn's hand, which was swollen and painful, and referred him for an X-ray. Officer N completed Mr Fenn's ACCT assessment at 9.00am. He recorded Mr Fenn told him that he had thoughts of self-harm every day, was very stressed and that 'he wouldn't be here if the blade was sharper yesterday'. Mr Fenn told the officer he hoped to get a job and was happy on M Wing. Staff reviewed Mr Fenn's concern file at 12.00pm, and made an entry that Mr Fenn was being bullied for a PS debt and that he was in debt on every wing.
62. COM F chaired the first ACCT review at 1.15pm, attended by Officer O and Mr Fenn. The COM recorded Mr Fenn had no thoughts of suicide or self-harm, was going to hospital for an X-ray and was only concerned about getting a television to keep him calm. Staff considered Mr Fenn's risk of harm to himself was low, but that the likelihood of further risky behaviours was raised. The caremap was not completed. The COM scheduled an ACCT review for 24 September.
63. On 20 September, Mr Fenn was treated at hospital for a fractured hand and a plaster cast was fitted. Officer P recorded in Mr Fenn's prison record that he completed an intelligence-led search of his cell. Mr Fenn fully complied and a small weapon was found in the bottom of a bag full of paperwork under his bed. Mr Fenn told the officer that he had not realised it was there and was most likely left over from when he was having trouble on his previous wing.
64. On 23 September, Nurse E conducted another telephone mental health assessment. The nurse recorded Mr Fenn had no thoughts of suicide or further self-harm, but wanted assistance to get a new television. The nurse told Mr Fenn he would need to speak to wing staff about his television, but told him she would send him some leaflets on anger management and self-harm.
65. The next day at 9.20am, COM H chaired an ACCT review attended by Officer M, COM J and Mr Fenn. Staff noted Mr Fenn had no thoughts of self-harm and that, as he was not on basic IEP, he should have a television. They closed the ACCT and scheduled a post-closure review for 1 October. After the review, the officer provided Mr Fenn with a television.

66. Nurse E discussed Mr Fenn at the mental health multidisciplinary meeting on 27 September, and Nurse C documented that no further contact from the team was required and that Mr Fenn's recent self-harm was 'reactive to no TV'. Mr Fenn had no further contact with the mental health team before he died.
67. On 1 October, COM I completed Mr Fenn's post closure review (this is recorded on the wrong form without a time). Mr Fenn told the COM he was happy that his ACCT was closed, that he was still waiting to get a job, but was happy that he had been given a television. Although there is no entry in his prison record, Mr Fenn was found in possession of approximately seven and a half litres of illicit alcohol and a homemade weapon that day.
68. On 2 October, at 2.30pm, staff reviewed Mr Fenn's concern file. They noted that Mr Fenn's offender supervisor would meet with him and the violence reduction team. At 3.13pm, COM E reviewed Mr Fenn's IEP status. He told Mr Fenn he was prepared to allow him to remain on standard, despite his recent poor behaviour, as he wanted to give him another chance. The COM told Mr Fenn that any further issues with his conduct in the next two months would result in him being downgraded to basic. This was the last entry in Mr Fenn's prison record.
69. On 3 October, at 6.00pm, Officer Q noted in Mr Fenn's concern file that he wanted to get out of Lowdham Grange as he keeps 'being stitched up' and felt in a rubbish mood.

4 October

70. On 4 October, at 12.35pm, Officer M recorded in Mr Fenn's concern file that he had been socialising with other prisoners on the wing, had spoken to staff and had raised no concerns.
71. Later that day, Mr Fenn asked Officer R if he could be allowed out of his cell to use the wing computer (which prisoners can use to make applications and contact internal services). The officer said that there was nothing unusual about Mr Fenn's request or demeanour, so he agreed. The officer said that he subsequently cleared the wing and locked up those prisoners who were not due to leave, when he realised at around 1.30pm that Mr Fenn had refused to lock up. CCTV shows Mr Fenn talking to Officer M, before he quickly ran to his cell and came back out again. Mr Fenn was outside another prisoner's cell, a few doors down from his own, and appeared to be talking to him through the door. The investigator asked to interview this prisoner, but got no response.
72. CCTV shows Mr Fenn then spoke to various prison officers, including Officer R, Officer M, Officer J, Officer I, Officer S and Officer T for around 12-14 minutes (CCTV does not have a time stamp). There is no audio on the CCTV, but the situation appeared calm, and for much of the time Mr Fenn was sitting casually on a table. After about 15 minutes, Officer J gave Mr Fenn a direct order to return to his cell and Mr Fenn made threats towards staff or to self-harm. Officers then grabbed Mr Fenn's arms and held his head. After a very short struggle, Mr Fenn was walked back to his cell, while being restrained by his arms.
73. Officer R said that Mr Fenn did not particularly struggle and thought his actions were probably a means of getting taken off the wing. After Mr Fenn was placed

in his cell he sat on his bed swearing and told officers to leave him alone. The reports completed by all the officers state that Mr Fenn continued to shout, make threats towards staff and kick his cell door. Officer S asked healthcare staff to examine Mr Fenn, as they had used force to locate him back into his cell.

74. At around 1.40pm, Nurse H arrived on M Wing and recorded that she was unable to assess Mr Fenn as officers had told her it was unsafe to see him due to the threats he was making. The nurse asked officers to inform her when Mr Fenn was calmer, but she remained on the wing as she had to see another prisoner.
75. At 2.00pm, Officer I started ACCT procedures. He recorded on the concern and keep safe form that Mr Fenn had 'had enough at LG [Lowdham Grange] citing he always got nothing. He said if we put him in the cell he would self-harm to get to hospital and cause staff issues. Force was used to locate him into cell when he stated he would throw excrement and urine at staff'.
76. CCTV shows that officers were outside or near Mr Fenn's cell, for around the next 20 minutes. During this time officers can be seen in conversation outside Mr Fenn's cell. After approximately 7-8 minutes, Officer S and Nurse H looked through the observation panel. Officer M also went to the door, kicked it, then stood on a chair trying to look through the gaps around the door. The officer said that although Mr Fenn was not answering her, she could hear him moving around inside his cell. The officers and nurse had a discussion and then walked away from Mr Fenn's cell.
77. Officer R and Officer S returned to Mr Fenn's cell less than a minute later and CCTV shows Officer R banged on the door with his hand, while also looking through the gaps at the side of the door. Officer R said Mr Fenn had covered his observation panel with toilet paper, and was no longer shouting or making a noise. Officer S said she warned Officer R to be careful being near the gaps in the door, as Mr Fenn had made threats to staff including throwing excrement at them.
78. Officer R collected the key from the wing office and removed the inundation bung from Mr Fenn's cell door (a removable bung that allows a hose to be used to spray water into a cell without opening the door in the event of a fire). The hole had also been covered by toilet paper, and after Officer M had used plastic cutlery to sweep the paper to one side, he saw Mr Fenn hanging. Officer K immediately radioed a code blue medical emergency (used to indicate that a prisoner is unconscious or having difficulty breathing) and unlocked the cell door at around 2.18pm, as other colleagues arrived to assist.
79. Mr Fenn was found hanging by a shoelace attached to his bed. Officer K supported Mr Fenn as Officer M removed the ligature. Nurse H responded to the code blue and started cardiopulmonary resuscitation (CPR) with the assistance of officers, and she was joined by Nurses E and Nurse A, a few minutes later. Nurses attached the defibrillator to Mr Fenn and they continued CPR until paramedics arrived.
80. East Midlands Ambulance Service records show they received a request for an ambulance at 2.20pm. When paramedics arrived at 2.31pm, they took over Mr Fenn's care and were able to resuscitate him. Mr Fenn was taken to hospital

and treated in intensive care. He did not regain consciousness and died at 11.30pm.

81. Mr Fenn made 89 telephone calls between 10 July and 28 September, but the audio download of these calls was not clear enough to hear both sides of the conversations. However, during a telephone call to his grandmother on 17 September, Mr Fenn told her that he was behind his door and wanted a transfer as he had 'had enough'. Mr Fenn spoke at being upset by his mother's actions and that he had waited around 6-9 months for a job. In the last telephone call he made on 28 September, Mr Fenn told his grandmother he had hurt his hand punching a wall in frustration, had smashed his television and had been placed on report for not following the prison regime, but that he did not want to 'stress her out'. Mr Fenn did not sound as though he was in crisis during these calls.
82. Prisoner A, a prisoner who lived on the same wing as Mr Fenn, said he knew him from when they were both at Altcourse. He said that Mr Fenn often appeared down and he knew that he self-harmed. He said that he had never known Mr Fenn to take drugs, and while he owed a small sum of money for vapes, he never witnessed him being bullied. He said Mr Fenn had spoken several times of taking his own life as 'he couldn't handle this place no more'.

Contact with Mr Fenn's family

83. The duty director, contacted Mr Fenn's family to inform them he had been taken to hospital. Lowdham Grange arranged for a taxi to collect Mr Fenn's family and the Director, met them at the hospital. The prison arranged for transport to take Mr Fenn's family home.
84. Lowdham Grange's family liaison officer, was on leave when Mr Fenn was taken to hospital. The prison appointed an officer from HMP Doncaster as the family liaison officer and an officer (from Lowdham Grange) as her deputy. They offered condolences and support to Mr Fenn's family. When the Lowdham Grange's family liaison officer returned from leave she provided ongoing support to family members. The prison contributed towards the costs of Mr Fenn's funeral, in line with national policy.

Support for prisoners and staff

85. The duty director held a debrief for all staff involved in the emergency response, and with staff who were with Mr Fenn when he died. Staff said they felt well supported.
86. The prison posted notices informing other prisoners of Mr Fenn's death, and offering support. Staff reviewed all prisoners considered to be at risk of suicide and self-harm, in case they had been adversely affected by Mr Fenn's death. The prison held a memorial service for Mr Fenn on 30 January 2019.

Post-mortem report

87. A pathologist concluded that Mr Fenn died from hanging. Toxicology results showed Mr Fenn had used PS before he died.

Findings

Management of Mr Fenn's risk of suicide and self-harm

88. Prison Service Instruction (PSI) 64/2011 – *Management of prisoners at risk from self, from others and to others (Safer Custody)*, sets out the procedures (known as ACCT) that staff must follow when managing prisoners at risk of suicide and self-harm. It says that an immediate action plan should be completed within one hour of the ACCT being opened, that an ACCT assessment interview and first case review should be held within 24 hours of the ACCT being opened, and that a post-closure review should be held within seven days of the ACCT being closed. Case reviews should be multidisciplinary and in addition to planned case reviews, a review should be held whenever a prisoner has self-harmed or where there are any other concerns about them. A caremap should be completed at the first case review and give detailed and time-bound actions aimed at reducing the risk posed by the prisoner.
89. Mr Fenn was supported by ACCT procedures on five occasions at Lowdham Grange up to 4 October: 2 to 17 July; 27 July to 17 August; 10 to 22 August; 6 to 7 September; and 18 to 24 September. ACCT processes were frequently carried out late and some were not carried out at all.
90. When the first ACCT was opened on 2 July, neither the immediate action plan nor the ACCT assessment interview were carried out. The second case review scheduled for 13 July, did not take place until 17 July, and the post-closure review was two days late.
91. The immediate action plan for the second ACCT, opened on 27 July, was completed over two hours late, and the ACCT assessment interview and first case review were almost two days late. The second case review, scheduled for 6 August, was held a day late. When the ACCT was reopened on 10 August, a case review should have been held on 11 August but did not take place until 17 August, and the case review scheduled for 21 August took place a day late.
92. The first case review for the fifth ACCT, opened on 18 September, was almost five hours late.
93. PSI 64/2011, and the ACCT document itself, is very clear about exactly when the various tasks involved in opening an ACCT should be carried out. It is unacceptable that on so many occasions in Mr Fenn's case, staff failed to complete these tasks on time.
94. Staff held a total of nine ACCT case reviews, yet nobody from the mental health team attended a single one. We consider that given Mr Fenn's mental health issues and his self-harming behaviour, it was crucial to have input from mental health staff on how best to manage his risk and their non-attendance was a significant failing.
95. We also consider there were times when additional case reviews should have been held. For example, staff should have held a case review on 3 August after Mr Fenn told Officer B that he had self-harmed, but a review was not held until

four days later. There was also no case review after Mr Fenn was assaulted on 14 August. The review was not held until three days later.

96. We also found that issues relevant to managing Mr Fenn's risk were sometimes added to his prison record belatedly. For example, despite Mr Fenn telling Officer B on 3 August that he had self-harmed, the officer did not update Mr Fenn's prison record with this information until 10 August. Mr Fenn also told the officer on 4 August that he was feeling low and was not happy at Lowdham Grange, but the officer did not update Mr Fenn's prison record until 10 August.
97. The care map, which sets out the actions to be taken to reduce a prisoner's risk to himself, is a key part of ACCT procedures. Staff should have completed a caremap each time they managed Mr Fenn under ACCT procedures. They managed him under ACCT procedures five times, but completed a caremap only once. This meant that on four occasions, staff stopped ACCT monitoring without ever having set any caremap action to reduce Mr Fenn's risk. The caremap that was completed lacked specific, tailored actions. In the absence of good quality care maps no actions were taken to reduce Mr Fenn's risk.
98. COM G told the investigator that since Mr Fenn's death a single point of contact has been established to ensure the ACCT process is better managed. The COM said within 24 hours of an ACCT being opened, they are now quality checked, and in addition there is a newly introduced senior management check which includes ensuring ACCT reviews are multidisciplinary. The COM said that coordination between prison and healthcare staff had been an issue, but the new checks should greatly improve delivery.
99. The mental health team manager, told the investigator that attendance at ACCT reviews had been identified as an issue, and a meeting to discuss the problems had been arranged with Serco, but the meeting was cancelled and had not yet been rearranged at the time of speaking (November 2018).
100. Mr Fenn's risk of suicide and self-harm should have been managed better. The poor management of ACCT procedures was an issue that HMIP inspectors identified during their inspection of Lowdham Grange in August 2018. While we acknowledge that Lowdham Grange has already taken some steps to improve the ACCT process, we make the following recommendation:

The Director and Head of Healthcare should ensure that staff manage prisoners at risk of suicide and self-harm in line with national guidelines, in particular that they:

- **complete the immediate action plan, assessment interview, first case review and post-closure review within the set timescales;**
- **hold multidisciplinary case reviews where possible, to include mental health staff where appropriate;**
- **set caremap actions that are specific, time bound and meaningful, tailored to the individual to reduce their risks and update them at each case review;**
- **hold case reviews when scheduled, and additional case reviews as necessary;**
- **complete all ACCT paperwork fully and accurately; and**

- **update a prisoner's record promptly with important information and significant events.**

Violence Reduction

101. A PPO publication in October 2011, *Violence reduction, bullying and safety*, noted the links between bullying and violence and self-inflicted deaths of prisoners of all ages. In our PPO thematic report into self-inflicted deaths in 2013 - 2014, we found that reports or suspicions that a prisoner is being threatened or bullied need to be recorded, investigated and responded to robustly.
102. Lowdham Grange has a violence reduction strategy (undated), which sets out the process for raising and investigating any identified or suspected acts of aggression, bullying, intimidation or violence. The policy says: 'In all cases where violence has occurred details of the incident must be entered on case notes on PNOMIS [prison record], wing observation books and the Managers handover book. In instances where bullying or non-associations are identified then alerts must be put in place via PNOMIS. In addition, PNOMIS, through case note entries, will be used for the monitoring of those on concern files to review progress and support.'
103. Mr Fenn regularly found himself in debt, told staff that he was being bullied and self-isolated. The concern file opened in May 2018, had no specific details on what was going to be done to support Mr Fenn when he felt under threat. The one action listed was never reviewed and there is no evidence of what action was taken against the alleged perpetrator. The concern file was closed on 10 July, after Mr Fenn was discussed at the WIM, but the closing interview was not completed.
104. The concern file started on 22 August lacked detail. The action plan was not specific and although Mr Fenn had reported being assaulted when he moved to M Wing, the action plan was not completed, but just noted Mr Fenn's intention to self-isolate until he could move to a different wing. Although the expectation is that staff make at least two entries per day on the ongoing record, there were significant gaps: no entries were made between 28 August and 3 September, 7 and 8 September, 12 to 17 September (which was flagged on the concern file by the violence reduction team during a management check) and 23 to 25 September (also flagged during a management check on 28 September).
105. Lowdham Grange has a safer custody strategy, dated 2017, which says that prisoners who self-isolate should be provided with a reintegration plan and be discussed at the WIM to identify the support available. The investigator did not find any evidence of a reintegration plan for Mr Fenn.
106. We consider that Lowdham Grange made inadequate attempts to resolve Mr Fenn's concerns about his safety and did not follow their own violence reduction and safer custody strategies. Staff failed to put in place sufficient measures to protect Mr Fenn, particularly when it was clear that he was fearful about living on M Wing and had been self-isolating in the months before he died.

107. COM G told the investigator that violence reduction and the ACCT process should not be mutually exclusive and all flags and risk factors should be considered. Although we were told Lowdham Grange had introduced new guidance for the violence reduction process, that staff have been given clearer information and that there has been a renewed approach to try and engage those prisoners who self-isolate, we were not provided with any evidence. We make the following recommendation:

The Director should review the effectiveness of HMP Lowdham Grange's violence reduction policy and its delivery, specifically ensuring:

- **effective identification and management of victims and alleged perpetrators;**
- **effective support and protection for apparent victims with meaningful objectives and long-term solutions, which address their individual situations;**
- **the risk of suicide or self-harm to victims of bullying and intimidation is considered; and**
- **accurate and timely record keeping.**

Use of Force

108. When Mr Fenn refused to return to his cell on 4 October, despite repeated instructions to do so, spontaneous force was used. Prison Service Order (PSO) 1600 sets out the policy on use of force. Paragraph 2.2 states that the use of force is “justified, and therefore lawful, only:

- If it is reasonable in the circumstances
- If it is necessary
- If no more force than is necessary is used
- If it is proportionate to the seriousness of the circumstances”.

109. PSO 1600 says that staff should always try to prevent a conflict wherever possible and that the “best defensive weapon that staff have is their verbal and non-verbal communication skills”. However, the PSO also recognises that sometimes staff may “have no other option than to use force” and says that “when force has become necessary C&R techniques [control and restraint] are always the preferred option”.

110. We are satisfied that all officers involved used appropriate de-escalation techniques and approved C&R techniques. CCTV footage shows they attempted to negotiate with Mr Fenn for over 15 minutes, before force was used to move him back to his cell. We found that the use force was appropriate.

111. However, none of the officers' present used a body worn video camera (BWVC). PSI 04/2017, *Body Worn Video Cameras*, states it is mandatory for staff to use BWVCs at any reportable incident (as outlined in PSI 11/2012, *Management and Security of the Incident Reporting System*) and that staff should start recording at the earliest opportunity to maximise the material captured by the camera.

112. In the recent HMIP inspection of Lowdham Grange in August 2018, inspectors identified issues about the use of force and using BWVC. COM Tom Foster, security manager, told the investigator that there was an expectation BWVC were used for incidents such as the one involving Mr Fenn on 4 October, and that C&R advisors and managers now review every incident when force is used. COM Foster said Lowdham Grange is working hard to raise staff awareness of the importance of activating the camera at the first opportunity and, in response to the findings of the HMIP inspection in August 2018, managers have started meeting staff at the gate to raise awareness and remind them to use BWVC.
113. In this case, it appears that none of the officers were wearing a BWVC. We make the following recommendation:

The Director should ensure that sufficient numbers of staff are assigned to wear BWVCs and that they activate them at the earliest opportunity during any reportable incident.

Delay entering Mr Fenn's cell

114. Initially, after force was used to move Mr Fenn back to his cell, he was shouting, kicking his cell door and continued to make threats. However, after around 26 minutes Mr Fenn covered his observation panel and stopped responding to staff. Officer M said she could hear him moving around in his cell, and staff were cautious as Mr Fenn had threatened them with violence and that he would throw excrement and urine over them.
115. As Mr Fenn was assessed as being at heightened risk of suicide and self-harm and had threatened to self-harm during the negotiations when he refused to return to his cell, we consider that once officers had failed to get any response from him, they should have considered wearing personal protection equipment, which is held on the wing, and unlocked the cell to check on his wellbeing.
116. The emergency response carried out by prison and healthcare staff once they discovered Mr Fenn was well delivered, resulting in him being resuscitated. Although we cannot say whether earlier intervention would have prevented Mr Fenn's death, it is critical that staff act quickly in situations such as this. We make the following recommendation:

The Director should remind staff that when an observation panel is covered and a prisoner fails to respond, arrangements should be made to enter the cell as quickly as possible, particularly in the case of prisoners being monitored under ACCT arrangements.

Clinical care

117. The clinical reviewer concluded that the care that Mr Fenn received from healthcare staff at Lowdham Grange was of mixed quality, with some elements of care not wholly equivalent to the care he would have received in the community.

Physical health

118. Mr Fenn had limited involvement with physical healthcare services while at Lowdham Grange. However, following the incidents of self-harm his wounds were treated effectively and care was equivalent.

Mental health

119. The clinical reviewer concluded that mental health services at Lowdham Grange were not of an equivalent standard to the services in the community, and there were several missed opportunities to engage Mr Fenn.
120. There was no mental health team representative at ACCT reviews and no face-to-face assessment took place following referrals to the mental health team after Mr Fenn had self-harmed. Telephone assessments were deemed to be an 'opt in' consultation, despite Mr Fenn having repeated incidents of self-harm and a history of self-harm at other establishments. There was no evidence of the mental health team proactively trying to engage Mr Fenn. The investigation found there was an over reliance on telephone consultations and we make the following recommendation:

The Head of Healthcare should review the use of telephone consultations to ensure assessment and ongoing support is provided in line with best practice, as set out in NICE Guidance (NG66) Mental Health of Adults in contact with the Criminal Justice System.

Substance Misuse

121. Lowdham Grange has a comprehensive Drug and Alcohol Strategy dated March 2018-2019, which is reviewed and updated annually. The strategy sets out the objectives to prevent supply and reduce the demand for illicit substances. A drug supply reduction action plan is completed and reviewed each month and sets out the targets for cell searches, visitor and staff searching and the process for referring those found under the influence of illicit substances to substance misuse services.
122. Mr Fenn declined to be referred to substance misuse services when he arrived at Lowdham Grange. There was no documented use of illicit substances in Mr Fenn's medical record while he was at Lowdham Grange, although his self-harm behaviour was recorded in the ACCT documents as being linked to being bullied or in debt, often related to illicit drug use. The absence of healthcare staff or other services at ACCT reviews where he might have been encouraged to engage was a missed opportunity.
123. Prison staff tried to protect and support Mr Fenn with violence reduction plans and ACCT procedures. However, he continued to use PS and despite failing an MDT on 28 August, there is no evidence there was any proactive attempt by substance misuse services to engage him. We therefore make the following recommendation:

The Director and Head of Healthcare should ensure substance misuse services are effective and:

- **attend ACCT reviews when appropriate to do so;**
- **provide swift access to appropriate support;**
- **assessments consider all relevant information, including drug tests;
and**
- **communicate with the mental health team and prison staff about
individuals' presentation and specific needs.**

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