

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Stephen Harper a prisoner at HMP Frankland on 26 March 2018

A report by the Prisons and Probation Ombudsman

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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 Harper was found hanged in his cell at HMP Frankland on 26 March 2018. He was 56 years old. I offer my condolences to Mr Harper's family and friends.

Mr Harper had a history of depression, suicidal thoughts and self-harm by cutting. His complex mental health needs required and received considerable input from staff and he was often managed using Prison Service suicide and self-harm monitoring procedures (known as ACCT). Although we identified some deficiencies in the way staff operated ACCT procedures from which the prison can learn, we consider that, overall, Mr Harper received very good care at Frankland.

However, I consider that the search of his room and the removal of his tapestry easel on the day he died was inappropriately heavy-handed. Although information that Mr Harper intended to hang himself using a piece of wood in his cell prompted that decision, no one assessed his risk of suicide and self-harm, as they should have done. Some 90 minutes after the search and the removal of the easel, Mr Harper was found hanged.

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

Sue McAllister CB
Prisons and Probation Ombudsman

January 2019

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Summary

Events

1. Mr Stephen Harper was sentenced to life imprisonment in 2003 for rape. In 2008 he was treated in Broadmoor Secure Mental Hospital but returned to the prison system at his own request. He was diagnosed as having anti-social and borderline personality disorders with paranoid traits. Between 2011 and 2014 he was treated on the Fens Personality Disorder Treatment Unit at HMP Whitemoor. He was deselected after disengaging from treatment. On 24 March 2015, he transferred to HMP Frankland in order to undertake the Sex Offender Treatment Programme (SOTP).
2. Mr Harper did not comply with the conditions necessary to begin SOTP at Frankland and also refused to work with the mental health team to explore his non-compliance. He had a history of depression, suicidal thoughts and self-harm by cutting. His complex mental health needs required and received considerable input from staff and he was often managed using Prison Service suicide and self-harm monitoring procedures (known as ACCT).
3. On the morning of 26 March, a custodial manager received information that Mr Harper intended to hang himself using a piece of wood (his tapestry easel) in his cell. No one assessed Mr Harper's risk of suicide and self-harm and whether ACCT monitoring was appropriate. At 10.18am on 26 March, the Dedicated Search Team (DST) searched Mr Harper's cell and removed his tapestry easel.
4. At 11.49am, two officers discovered Mr Harper hanging when they unlocked his cell for lunch. The officers raised the alarm and a nurse who was already on the wing started cardio-pulmonary resuscitation. Paramedics checked Mr Harper but he was pronounced dead at 12.37pm.

Findings

5. We consider that using the DST to search and remove property from Mr Harper's cell in response to information that he might be at risk of suicide was an inappropriately blunt instrument. The significant information was not that Mr Harper had threatened to hang himself using wood in his cell, but that he had threatened to hang himself. We consider that staff should have spoken to Mr Harper, assessed his risk of suicide and decided whether ACCT monitoring was appropriate before action to remove items from his cell was considered.
6. None of the four officers who discovered Mr Harper hanging or responded first called a code blue as they should have done. This resulted in a ten minute delay before the control room called an emergency ambulance. No one checked whether Mr Harper was breathing or started basic life support before the first nurse arrived.
7. We identified several areas of learning in the way in which the ACCT process was used with Mr Harper: no one from healthcare was present at the first review; case reviews were not sufficiently multi-disciplinary; there was a lack of focus on caremap actions needed to reduce his risk; and his ACCT was closed before caremap actions had been completed.

Recommendations

- **The Governor and Head of Healthcare should ensure that all staff are aware of their responsibilities to keep prisoners safe and begin ACCT procedures when they receive information or observe behaviour that may indicate a risk of suicide or self-harm.**
- **The Governor should ensure that there are sufficient first aid trained staff on duty at all times and that staff administer basic life support as needed until healthcare staff arrive.**
- **The Governor should ensure that staff manage prisoners identified as at risk of suicide or self-harm in line with national guidelines, including:**
 - **Holding multi-disciplinary case reviews attended by all relevant people involved in a prisoner's care. A member of healthcare staff should attend all first case reviews.**
 - **Setting effective ACCT caremap objectives which are specific and meaningful, aimed at reducing a prisoner's risk and which identify who is responsible for them. Progress should be considered at each review and the caremaps updated if additional needs are identified.**
 - **Ensuring that all caremap actions have been completed before ACCT monitoring is stopped.**

The Investigation Process

8. The investigator issued notices to staff and prisoners at HMP Frankland informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
9. The investigator visited Frankland on 30 and 31 May 2018. She obtained copies of relevant extracts from Mr Harper's prison and medical records, watched CCTV from 26 March and interviewed eight members of staff. The investigator spoke to six staff and one prisoner by telephone. Further information was obtained from North East Ambulance Service.
10. NHS England commissioned a clinical reviewer to review Mr Harper's clinical care at the prison. The clinical reviewer joined Ms Mulinder for interviews on 30 and 31 May.
11. We informed HM Coroner for Durham and Darlington 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 Harper's sister, to explain the investigation and to ask if she had any matters she wanted the investigation to consider. Mr Harper's sister did not have any specific questions at that time. We contacted her again to tell her our initial report was ready but Mr Harper's sister did not ask for a copy. We have sent her a copy of this report.

Background Information

HMP Frankland

13. HMP Frankland is a high security prison holding over 800 adult men. Over 100 vulnerable prisoners are held on the original wings, A, B, C and D. Healthcare is 24 hours and there is an inpatient unit with 13 beds. Primary care services are provided by G4S and Spectrum Community Healthcare. Tees, Esk and Wear Valleys NHS Foundation Trust provide mental healthcare.

HM Inspectorate of Prisons

14. The most recent inspection of HMP Frankland was in February and March 2016. Inspectors reported that levels of self-harm were low overall, with most incidents due to a small number of prisoners on the vulnerable prisoner wings. Most ACCT documents were of a reasonable standard and the care provided was usually good. Assessments were prompt and reviews were multi-disciplinary including mental health staff, the chaplaincy and offender supervisors.

Independent Monitoring Board

15. 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 November 2017, the IMB reported that Frankland had retained an inherent stability with a generally settled population enjoying progression and risk reduction through education, work and purposeful activity. The separation of prisoners into vulnerable and standard wings had reduced violence and bullying.

Previous deaths at HMP Frankland

16. Mr Harper's is the first self-inflicted death at Frankland since December 2014. There were eleven deaths by natural causes between then and Mr Harper's. In our investigations into the death in December 2014 and one in January 2016 we found that no emergency code was called, which led to delays in calling an ambulance. In our investigation into the death before Mr Harper's, in February 2018, we found that the officers who found the prisoner did not perform basic checks required to establish whether he was still breathing.

Assessment, Care in Custody and Teamwork

17. 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.
18. 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 (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.

19. 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.

Key Events

20. On 12 April 2003, Mr Stephen Harper was sentenced to life imprisonment for rape. He was given a tariff (minimum time to serve) of seven years. In 2007, he was assessed as meeting the criteria for personality disorder services and in 2008 he spent six months in Broadmoor secure mental hospital. Mr Harper was returned to prison at his own request. Mr Harper's medical records showed a diagnosis of anti-social and borderline personality disorders with paranoid traits.
21. In 2011 and 2012, Mr Harper was assessed in the Fens Personality Disorder Treatment Unit at HMP Whitemoor and offered a place on their five-year treatment programme. In June 2014, Mr Harper was deselected from the Fens Unit after a lengthy period of disengagement from treatment. The Fens Unit prisoner management meeting decided that he should complete the Sex Offender Treatment Programme (SOTP) before being considered for readmission.
22. Mr Harper had a history of depression and suicidal feelings in the community. He was regularly managed using Prison Service suicide and self-harm monitoring, known as ACCT, during his time in prison. He also self-harmed by cutting.

HMP Frankland

23. On 24 March 2015, Mr Harper moved to HMP Frankland to be assessed for SOTP. He declined to engage with assessment and then with one to one work with the mental health team to address his motivation. Mr Harper maintained his innocence and said he did not want to engage with offending behaviour programmes. Mr Harper was managed under Prison Service suicide and self-harm procedures on several occasions at Frankland.
24. Mr Harper made cuts to his arms seven times at Frankland between 18 August 2016 and 3 September 2017. A Supervising Officer (SO) said most of Mr Harper's self-harm was superficial scratches to his arms. He thought Mr Harper had a pattern of self-harming when he wanted to make a point to staff about decisions they had made.
25. On four occasions between 15 April 2015 and 13 February 2018, Mr Harper either told staff he had made a ligature or said he felt like hanging himself. The SO said Mr Harper would usually put ligatures round his neck or leave them in plain sight. He handed the ligatures to staff and told them that he had been going to use them, but the SO said Mr Harper had never made a serious attempt to kill himself. Mr Harper told him on numerous occasions that he had "had enough" but always allowed himself to be talked round.
26. The SO said Mr Harper sometimes needed the comfort of being on an ACCT because he liked the attention of staff checking him. He did not like participating in reviews and it was difficult to find caremap actions to work on with him because he always wanted to do things his way.
27. Mr Harper was referred to the Westgate Personality Disorder Treatment Unit at Frankland by his Offender Supervisor in August 2017. The referrals panel

discussed him on 5 September and again on 3 October 2017. The panel noted the reasons for his discharge from the Fens Unit and the recommendation that Mr Harper undertake SOTP. They rejected his referral and said that Mr Harper should do SOTP before being considered for re-referral to them.

ACCT monitoring 14 September 2017 – 16 March 2018

28. On 14 September 2017, staff began Prison Service suicide and self-harm monitoring, known as ACCT, after Mr Harper told them he had slept with a ligature around his neck and had tried to kill himself in the night. A SO set observations at twice an hour and referred Mr Harper to the mental health team. A mental health nurse visited him the same day but Mr Harper declined to speak to them. Mr Harper told an officer in his ACCT assessment that he felt bullied at Be Active (a work group designed to encourage older prisoners to leave their cells and socialise) and felt stressed when he was there. The officer noted Mr Harper had a history of self-harm when he became stressed. Mr Harper said he liked Be Active but wanted to move to the Westgate Unit.
29. Mr Harper did not attend his first ACCT review. A SO completed the caremap and entered three actions: to offer Mr Harper victim support under violence reduction procedures, for staff to investigate Mr Harper's allegations of bullying in Be Active, and for Mr Harper to be seen by the mental health team. Mr Harper refused to speak to the mental health team leader, the following day. The first two actions were marked complete on the day the ACCT was opened and the third was marked complete the following day. Staff investigated and found no evidence that Mr Harper had been bullied at Be Active, but did find that he and other prisoners there had disagreed about having the radio on during a session.
30. Mr Harper was reviewed weekly from 19 September and attended all his reviews until 10 October. A nurse also attended these reviews because Mr Harper wanted to have his support. Mr Harper did not otherwise want to work with the mental health team. On 10 October, he said he did not think it was fair that he was no longer in Be Active (Mr Harper decided he no longer wanted to go to the sessions) but acknowledged that he was unable to be in places that played music and had too many people in them. He said he did not get anything from the ACCT process but was happy for it to continue.
31. On 17 October, Mr Harper walked out of an appointment with a nurse and refused to attend his ACCT review. The nurse said Mr Harper told him he no longer wanted him to take part in the ACCT process. The nurse did not attend any further reviews. Mr Harper resumed attending his reviews the following week. The ACCT was closed on 31 October after Mr Harper said he no longer needed to be supported by it.
32. On 31 October, the Westgate Unit referral team wrote to Mr Harper confirming that he had not been accepted for assessment. On 1 November, Mr Harper told a SO that he wanted to hang himself because he could see no positives in his life. The SO re-opened the ACCT.
33. Mr Harper attended weekly ACCT reviews throughout November but less regularly thereafter. The review records indicate that he believed his referral to the Westgate Unit was an ongoing matter. We do not know why. The review

records also indicate that the SO was trying to get permission for Mr Harper to do education on a paid basis in his cell. (All sentenced prisoners passed fit for work are required to attend work or education classes. Prisoners who attend education earn a small amount of money as an incentive. Prisoners passed fit who do not attend education or work are locked in their cells during those periods and might face sanction for not going.)

34. The SO said that Mr Harper's personality traits meant that he was unable to work in a workshop with other prisoners. Be Active was the smallest group available and Mr Harper had not been able to cope with it. The SO said he asked permission for Mr Harper to be able to do paid education in-cell to give him something to do and allow him to earn some money. This was ultimately refused by the prison activities hub. The SO said Mr Harper enjoyed in-cell hobbies, in particular using his tapestry easel, but this did not count as employment and he was not allowed to use it during the core day.
35. On 29 December, Mr Harper said he was unhappy about the slow progress of his in-cell work application and felt that he had been lied to about his application to the Westgate Unit. He reiterated that he had on-going thoughts of suicide and self-harm but was not planning to act on them.
36. On 29 January, Mr Harper refused to attend his ACCT review. Observations were reduced to three conversations a day. Later the same day he handed staff a noose and said he was unhappy that staff who did not know him well had reduced his observations. Observations were returned to one an hour.
37. On 2 February, Mr Harper said that he was being considered for medical retirement and was pleased because this would mean that he could be unlocked when other prisoners were at work or education. On 9 February, he asked if he could have access to his in-cell hobbies during the day. He walked out of the review when he was told Safer Custody would have to consider the issue. On 13 February, Mr Harper told staff he had made a ligature. They removed it from his cell. Mr Harper denied current intent to harm himself.
38. Mr Harper refused to attend his review on 23 February but told a member of staff that he did not need to be observed as everything was fine. The review took place without him and it was decided to reduce observation to written entries only. Mr Harper attended only one more weekly ACCT review on 9 March. On 16 March, a SO and Custodial Manager (CM) decided to close the ACCT in Mr Harper's absence because he did not appear to have any outstanding issues.
39. The SO said she telephoned Safer Custody and the mental health team to check whether they knew of any reason why the ACCT should stay open and neither raised any issues. She said she spoke to other wing staff in the wing office but had not written their names on the record. Everyone she spoke to told her that Mr Harper appeared fine. The SO said that Mr Harper was on the minimum number of observations and she knew that wing staff interacted with him regularly whether he was being monitored under ACCT or not. With hindsight the SO said she should have told Mr Harper that she was going to close the ACCT and asked him how he felt about that.

40. On 23 March, Mr Harper refused to speak to the duty C Wing senior officer (SO), who wanted to conduct an ACCT post-closure review. He changed his mind when a wing officer, said he would go along as well. Mr Harper told an officer that he was unaware that his ACCT had been closed and was unhappy about the decision. On 24 March, Mr Harper walked out of the post-closure review with two officers. An officer said Mr Harper did not want to listen to anything he or the other officer had to say.
41. A prisoner said he was a good friend of Mr Harper's and had known him for about two and a half years. He said Mr Harper trusted and confided in him. He thought Mr Harper was locking himself away in his cell more often in the period leading up to his death and his moods were more up and down than usual. He said that Mr Harper got on well with staff although he thought some ignored him. He said he had seen Mr Harper the day before he died and thought that he was in a good mood.

26 March 2018

42. At about 8.00am, a volunteer member of the Samaritans who support Frankland's Listeners (prisoners trained by the Samaritans to offer confidential peer support) told a Custodial Manager (CM) that one of the Listeners had told her that, roughly a week before, Mr Harper had shown him part of his tapestry easel wedged into the pipes in the corner of his cell above his door. Mr Harper told him that he was going to use the wood to hang himself because it could take his weight. The Listener said he had tested the wood and found this to be true. Mr Harper gave him permission to tell staff and he said he had witnessed Mr Harper telling staff himself.
43. The CM told another Custodial Manager at the morning custodial manager meeting. The CM, who was in charge of the Dedicated Search Team (DST), completed an information report and asked two DST Officer's to complete a targeted search of Mr Harper's cell and remove any wood they found. (Both have since become wing Supervising Officers.) A CM said she did not consider starting ACCT procedures because the information had not been presented to her as an imminent threat of self-harm.
44. Two SO's said Mr Harper complied with the search but he was not happy about it. They explained why they were searching, cautioned him, searched him and took him to wait in the wing TV room while they searched his room. They identified Mr Harper's tapestry easel as the wood they were looking for and removed it from the cell.
45. An officer said he was asked to remind Mr Harper that he had an appointment for a blood test that morning. Mr Harper was lying down in the TV room. He raised his head and said, "Not interested."
46. A SO said Mr Harper was grumpy that his easel was being removed and told them it was on his property card. The SO, who knew Mr Harper quite well, said Mr Harper did not become irate or distressed as he had known him to in the past. He told Mr Harper he could apply to get his easel back. The SO said Mr Harper had self-harmed after a previous search when he had removed some glue from

his cell so he stopped at the wing office on his way out and told the wing staff to keep an eye on Mr Harper.

47. CCTV showed the two SO's opened Mr Harper's cell at 10.18am. Mr Harper went to the TV room at 10.21am. At 10.29am both SO's came out of Mr Harper's cell with Mr Harper's tapestry easel. Mr Harper returned from the TV room at 10.30am. He talked and gesticulated to the two SO's before he was locked back in his cell at 10.31am.

Emergency response

48. At about 11.45am two officers began unlocking the cells on Mr Harper's landing for lunch. CCTV showed that an officer got to Mr Harper's door at 11.49am. The officer said he noticed a note on the floor outside that said, "Do not unlock for lunch". He looked through Mr Harper's observation panel and saw him hanging from his window bars. He told the other officer, who opened the cell immediately, grabbed Mr Harper by the waist and tried to lift him to relieve pressure on his neck. He heard Mr Harper exhale as he lifted him and so thought he was still breathing.
49. An officer said he was not carrying a radio so he shouted along the landing to alert other staff and ask for healthcare, and followed the other officer into Mr Harper's cell. An officer cut the ligature from Mr Harper's neck and they put Mr Harper on the floor in the recovery position because an officer had said he felt Mr Harper breathe on him when he moved him. An officer said Mr Harper was wet and at the time he thought it was sweat. He realised afterwards that Mr Harper had been incontinent.
50. Both officers said they tried to find a pulse but neither checked whether Mr Harper's airway was clear and whether he was breathing. Mr Harper was very pale, his eyes were shut and he was not moving. An officer radioed for immediate healthcare assistance. He said he was aware of the emergency code system in operation at Frankland and could not explain why he did not call a code blue. CCTV showed two more staff arrive at 11.51am
51. A nurse said she was on duty in the C Wing treatment room when she heard a radio call for the emergency response nurse to go to the wing. She was not the dedicated emergency response nurse that day but radioed that she would attend. She was not aware it was an emergency but locked the treatment room and went directly to Mr Harper's cell. CCTV showed the nurse go into Mr Harper's cell at 11.52am.
52. The nurse turned Mr Harper on to his back and checked for breathing and pulse. Mr Harper was grey and his pupils were fixed and dilated. He had no pulse and was not breathing so she began cardio-pulmonary resuscitation (CPR). She gave her treatment room keys to a SO, told him to collect the emergency equipment and shouted for someone to radio a code blue emergency and ask for an ambulance and further assistance from healthcare.
53. The SO returned to the cell with the emergency bag at 11.55am at the same time as, the emergency response nurse. A nurse gave Mr Harper oxygen therapy using a bag and mask and staff attached a defibrillator (a life-saving device that

gives the heart an electric shock in some cases of cardiac arrest). The defibrillator did not advise an electric shock so the nurse continued CPR with the emergency response nurse until ambulance paramedics arrived. CCTV showed paramedics arrived at 12.23pm and prison logs record they pronounced Mr Harper dead at 12.37pm.

54. Call logs and telephone recordings of the 999 calls showed that the prison first called for an ambulance at 11.59am. At 12.02pm, after triage, the ambulance service allocated a response time of 18 minutes or sooner. The prison called back at 12.04pm to confirm Mr Harper was not breathing and the response was upgraded. The first ambulance reached the prison at 12.19pm.

Contact with Mr Harper's family

55. A Custodial Manager (CM) was appointed as the prison's family liaison officer. Mr Harper's next of kin was his mother who lived a considerable distance from Frankland. The FLO contacted the prison nearest to Mr Harper's mother and the Governor drove to break the news of Mr Harper's death in person. The prison contributed to Mr Harper's funeral costs in line with national guidance.

Support for prisoners and staff

56. After Mr Harper's death, an operational manager 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.
57. The prison posted notices informing other prisoners of Mr Harper's 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 Harper's death.

Post-mortem report

58. The pathologist concluded that Mr Harper died from pressure on the neck due to hanging. Toxicology showed the presence of three medications prescribed to Mr Harper at therapeutic doses, none of which contributed to his death.

Findings

Information received via the Samaritans on 26 March

59. Prison Service Instruction (PSI) 64/2011 provides guidance on ACCT procedures. Chapter five states:

“Any member of staff who receives information, including that from family members or external agencies, or observes behaviour which may indicate a risk of suicide/self-harm must open an ACCT by completing the Concern and Keep Safe form.”

The italics indicate that this is a mandatory action.

60. A volunteer member of the Samaritans reported that Mr Harper had said, more than once, that he intended to hang himself using the wood of his tapestry easel. We consider that using the DST to search and remove property was an inappropriate response. The significant information was not that Mr Harper had threatened to hang himself using wood in his cell, but that he had threatened to hang himself.
61. We consider that staff should have spoken to Mr Harper, assessed his risk of suicide and decided whether ACCT monitoring was appropriate before action to remove items from his cell was considered. Mr Harper had a history of threatening suicide and making ligatures but he also had a history of handing ligatures to staff when they asked for them.
62. These particular characteristics of his risk and the importance to Mr Harper of his tapestry easel and in-cell work to him were well known to staff. In these circumstances the decision to remove the easel without considering its impact and the possible reaction appear particularly ill-considered. Mr Harper did not need to have wood in his cell to attempt suicide or self-harm, as was very sadly demonstrated less than 90 minutes later. We make the following recommendation:

The Governor and Head of Healthcare should ensure that all staff are aware of their responsibilities to keep prisoners safe and begin ACCT procedures when they receive information or observe behaviour that may indicate a risk of suicide or self-harm.

Emergency response

63. Prison Service Instruction 03/2013 requires governors to have a two code medical emergency response system based on the instruction. As is usual, Frankland use code blue to indicate an emergency when a prisoner is unconscious, or having breathing difficulties, and code red when a prisoner is bleeding. Calling an emergency code should automatically trigger the control room to call an ambulance.
64. An officer said he was aware of the emergency code system but acknowledged he did not use it when he discovered Mr Harper hanging at 11.49am. We understand that he was in shock. Nevertheless, prompt action in an emergency can save lives. Other staff were quickly on scene but they did not radio an

emergency code either. An emergency code would have alerted staff throughout the prison, including the emergency response nurse, and signalled the control room to call an ambulance immediately.

65. A nurse arrived at 11.52am and realised immediately that Mr Harper was not breathing. The control room did not call an ambulance until 11.59am, some ten minutes after Mr Harper was discovered and seven minutes after the nurse had asked for a code blue to be called. Frankland were unable to provide us with the emergency radio traffic so we do not know exactly who called the code blue and when. The 999 call recording indicated the control room were aware that it was a code blue and called an ambulance at 11.59am in response.
66. Although Mr Harper received reasonably prompt emergency aid from a nurse, any delay can be crucial to the outcome in cases of hanging and paramedics offer a higher level of airway management and advanced life support. Since Mr Harper's death, the prison has issued a new emergency protocol, including wallet size cards with the different codes. In light of this we make no recommendation.
67. Prison Service Instruction 29/2015 requires the Governor to ensure that suitably trained first aiders are always available to provide first aid if someone becomes ill or injured. The officers who found Mr Harper believed he was breathing without making proper checks and none of the staff who arrived before a nurse began basic life support. It is important that staff begin cardiopulmonary resuscitation as soon as possible to improve the chances of survival unless there are clear signs of death, which would indicate that resuscitation would be futile. We highlighted a similar situation in our report into the death immediately before Mr Harper's in February 2018. We make the following recommendation:

The Governor should ensure that there are sufficient first aid trained staff on duty at all times and that staff administer basic life support as needed until healthcare staff arrive.

ACCT procedures

68. Prison Service Instruction (PSI) 64/2011 sets out a number of mandatory actions, including:
 - Each caremap action must reflect the prisoner's needs and aim to address identified issues to reduce the prisoner's risk.
 - The actions must be time bound and must be reviewed at every ACCT case review.
 - Reviews must be multi-disciplinary where possible and a member of healthcare must be present at the first review.
 - ACCTs should only be closed once caremap actions are completed.
69. Mr Harper had complex personality disorder issues and limited coping mechanisms. He had a number of factors that indicated he was at risk of suicide and self-harm and his mental health issues meant that this risk fluctuated according to context but was never absent. We consider that overall Mr Harper

was well supported by staff. However, we have identified a number of weaknesses in the ACCT process from which the prison can learn. We understand and accept that Mr Harper was a challenging man to manage and many of the issues identified are procedural ones which would not necessarily have impacted significantly on his care. They are, nevertheless, relevant to delivery of ACCT within the prison more broadly.

70. There was no one from healthcare at Mr Harper's first case review as there should have been. Case reviews were not sufficiently multi-disciplinary and were sometimes held by one member of staff and Mr Harper. Of the three caremap actions identified at the first review, two were marked as complete the same day and the third the following day. No new actions were added at the next seven reviews. The ACCT was closed on 31 October even though the reviewers noted that Mr Harper was still waiting for a decision on whether he was going to the Westgate Unit and this was known to be an issue for him.
71. The ACCT was re-opened on 1 November, but a caremap action was only added on 3 January 2018. During this period the ACCT was reviewed 14 times without any apparent consideration of what was needed to reduce Mr Harper's risk. We understand that a lot of work was done at this time to find Mr Harper employment but none of this is reflected on the caremap or elsewhere on Mr Harper's prison record. We are concerned that Mr Harper appears to have been under the impression that his referral to the Westgate Unit was ongoing for some two months after the referral panel wrote to him rejecting his application.
72. The ACCT remained open for another three and a half months and only one further action was added. This was not marked as completed when a SO closed Mr Harper's ACCT on 16 March. The ACCT was closed in Mr Harper's absence. It was known that Mr Harper refused to attend reviews when a SO was present and he was also known to self-harm in response to decisions he did not like. For both reasons we consider that someone should have spoken to him to explain the decision to stop monitoring. We recommend:

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

- **Holding multi-disciplinary case reviews attended by all relevant people involved in a prisoner's care. A member of healthcare staff should attend all first case reviews.**
- **Setting effective ACCT caremap objectives which are specific and meaningful, aimed at reducing a prisoner's risk and which identify who is responsible for them. Progress should be considered at each review and the caremaps updated if additional needs are identified.**
- **Ensuring that all caremap actions have been completed before ACCT monitoring is stopped.**

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