

**Investigation into the circumstances surrounding the
death of a man at HMYOI Aylesbury
In December 2008**

**Report by the Prisons and Probation Ombudsman
for England and Wales**

June 2010

This is a report following the death of a man in December 2008 at Her Majesty's Young Offender Institution (HMYOI) Aylesbury. He was found hanging in his cell in the early hours during a routine check. Despite staff's efforts to resuscitate him, he was pronounced dead by the paramedics 20 minutes after he was found. He had been in custody for just six months and had already been moved between four different establishments, with little more than a week at Aylesbury. The man was 18 years old.

I pass on my sincere condolences to the man's friends and family for their loss. I trust that this report addresses the questions that they have about his care in prison. I must apologise for the delay in issuing the draft and final reports and the additional distress this has caused.

The investigation was carried out by my colleague. I would like to thank the local Primary Care Trust (PCT), and the appointed clinical reviewer, for their contribution to the investigation process. The clinical review is the first annex to this report. I am also grateful to the Governor of Aylesbury and the investigation liaison officer for their help throughout the investigation.

The man was only 17 years old when he committed the offence that attracted much media coverage. He had been transferred from a prison for those under 18 to the young offender institution for 18 to 21 year olds less than a month before his death. During those few weeks, he was apparently the victim of bullying.

As well, the prescription for the man's mental health medication had expired. He arrived at Aylesbury without a prescription and received no further medication before he died. On the day before his death he told his family he was worried that other young offenders had found out the nature of his offence and that he would become the target of bullying. Suicide prevention measures were started the day he arrived at the YOI, but was closed the next day.

I have examined the procedures for transferring medication, investigating bullying and the assessment of risk in Woodhill and Aylesbury. I make seven recommendations.

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

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June 2010

CONTENTS

Summary

The Investigation Process

HMYOI Aylesbury

Key Events

Issues

Conclusion

Recommendations

SUMMARY

At the time of his death the man was 18 years old and serving a seven and half year sentence at HMYOI Aylesbury. He was first sent to HMYOI Feltham on 6 June 2008 when he was remanded into custody. Both Luton Youth Offending Team and the prisoner custody officer sent suicide and self harm and vulnerability warnings to Feltham. During his first reception healthscreen and reception assessment, he told staff he was not at risk of harming himself. The following day, however, he was identified as being particularly low in mood and Assessment Care in Custody and Teamwork (ACCT) self harm risk management procedures were initiated. They were closed following a full assessment the next day, on 8 June.

During the rest of June and July, the man settled at Feltham. He earned himself enhanced status under the Incentives and Earned Privileges Scheme. (The Incentives and Earned Privilege (IEP) scheme is designed to encourage and reward positive behaviour. The scheme has three levels: standard, basic and enhanced.) On 18 August, he appeared at Crown Court and pleaded guilty. He was remanded following the judge's request for psychiatric reports before sentencing.

Following a further court appearance, the man was transferred to HMYOI Glen Parva on 8 September. He initially continued to progress well. However, on 10 November, he told staff he felt depressed. At the suggestion of a mental health worker, he was assessed on 17 November by a consultant psychiatrist who prescribed an antidepressant. He continued treatment with a mental health worker and responded well. On 3 December, he was assessed by a different psychiatrist for the court report, who concluded that he was not mentally ill.

The man was sentenced at Crown Court on 11 December. After his court appearance he was transferred to HMP Woodhill with his friend. Healthcare staff at Woodhill noted that he was prescribed an antidepressant. Whilst at Woodhill both he and his friend were subject to bullying and intimidation over their offence. After some wing moves, it was agreed to transfer them both to HMYOI Aylesbury on 18 December.

Neither his drug chart, the ACCT document from Woodhill, nor a supply of his medication, were transferred with the man. Healthcare staff on reception started suicide prevention measures for a second time. They were closed the following day. He was in a positive mood when he was assessed by the prison doctor on 22 December. The doctor noticed his prescription, but agreed to his request to stop taking his antidepressant. He reported his fears to staff that other prisoners had found out about his offence, although staff recorded that he mixed well on the induction unit for the rest of the week.

During a routine observation check in the early hours of 26 December 2008, an officer found the man hanging by a ligature in his cell. Officers and healthcare staff responded quickly to his emergency call for assistance. Despite efforts to resuscitate him, his death was confirmed by paramedics. A doctor pronounced that he had died at 4.55am.

THE INVESTIGATION PROCESS

1. I appointed a senior investigator to conduct the investigation into the circumstances surrounding the man's death. Another of my colleagues visited Aylesbury on 4 January to collect the paperwork and meet the man's friend to explain the investigation process. The second investigator also met a representative from the Prison Officers' Association and Independent Monitoring Board (IMB).
2. Notices were sent to the prison to invite prisoners and staff to contact the investigator with any information that thought was relevant to the investigation. There was no response to these notices.
3. The prison liaison officer organised for the man's prison records to be copied in time for the investigator's visit on 16 January. As well as looking round the prison and reviewing his files, she introduced herself to the Governor. That afternoon, she met the Clinical Governance Manager from the local PCT.
4. Accompanied by a colleague, the investigator conducted interviews with staff and prisoners at Aylesbury on 9, 10 and 11 February. She also interviewed the man's close friend at HMP Wellingborough as part of the investigation process. The clinical reviewer was not present at these interviews, but he was sent copies of the interview transcripts for his consideration as part of the clinical review process. He accompanied the investigator to Aylesbury on 1 July to carry out some follow-up interviews. I am grateful to the local PCT for appointing the clinical reviewer and commend his clinical review, which is the first annex of this report.
5. The investigator wrote to HMP Woodhill requesting copies of the prescription charts and the Assessment, Care in Custody and Teamwork document recorded to have been opened and closed at Woodhill. The ACCT document was sent, but the prescription chart was not. She also spoke to the Head of Healthcare at Glen Parva during the course of the investigation.
6. The Ombudsman's senior family liaison officer arranged to meet the man's mother, with the investigator. The man's mother explained that her main concern was that he was not taking his medication at the time that he died. She was worried that he had been moved to Woodhill, despite telling her that he was happy at Glen Parva and needed to return there for the continuation of his medical care. She also expressed her concern about the content and quality of the entries made in his clinical record.
7. The man's mother and close friend both raised concerns about the man being bullied at Woodhill and Aylesbury. She told my investigator that he had spoken to his grandmother on the afternoon before his death seemed fine, so she was worried that he had been bullied later that day. She was also surprised by the media attention that his death received and felt that the prison could have done more to prepare her. I am grateful to the family for their valuable contribution to my investigation. I trust that the concerns they raised have been addressed in this report.

8. The family liaison officer also wrote to the man's sister at HMP Peterborough to offer her the opportunity to contribute to the investigation process.

HMYOI AYLESBURY

9. HMYOI Aylesbury is a young offender institution holding long term sentenced young adult males between 18 and 21 years of age serving from two years to life imprisonment. Up to 444 young adult prisoners live on eight wings in accommodation which is certified to hold 437 prisoners. Four additional wings, built in 1902 and 1997, were added to the original Victorian wings. 'D' Wing is the induction unit, holding up to 55 prisoners.
10. There have been no self-inflicted deaths at Aylesbury since the Ombudsman took over responsibility for undertaking death in custody investigations in 2004. The last self-inflicted death occurred in 2003. Following this death, staff introduced routine observations of young adults at two hour intervals throughout the night, a practice that is still in place today. In fact, it was during such a check that the man was found in the early hours.

Her Majesty's Chief Inspector of Prisons (HMCIP)

11. Her Majesty's Chief Inspector of Prisons carried out an unannounced inspection in June 2005. The inspectors found "impressive arrangements to prevent suicide and self harm". The team also noted that "there had also been significant progress in the management of bullying".
12. The Chief Inspector has since carried out a full announced inspection after the man's death in March 2009. The Chief Inspector found that ACCT procedures were "satisfactory" and found "clear evidence of a multidisciplinary approach to the care of those at risk", a matter which I will examine further later in this report. The inspection team were concerned about the number of people attending case reviews, or providing a written contribution and the quality of ACCT entries. The team also noted that there were no Listeners on the induction unit, where the man was located. (A Listener is a prisoner who has been trained by the Samaritans to support prisoners through periods of crisis.)
13. As part of their inspection, the team examined violence reduction procedures and was concerned at an apparent "under-reporting" of violent incidents, although found that they were "generally good". The inspectors observed that young adults were shouting out of their windows, both during the day and at night, but prisoners mostly felt that the prison was quiet enough to sleep in at night.
14. Each prison in England and Wales has an Independent Monitoring Board responsible for monitoring day-to-day life in the prison and to ensure that proper standards of care and decency are maintained. In his annual report, the Chair of the IMB found that the YOI "takes a strong and well managed approach to Safer Custody" and the policy for violence reduction was "long standing and effective".

Assessment, Care in Custody and Teamwork (ACCT)

15. ACCT is a set of procedures designed to reduce incidences of self inflicted death and self harm. It provides prisoner centred assessment and care planning, offering personalised care and support before, during and after crisis.

Youth Offending Team (YOT)

16. A Youth Offending Team is run by every local authority and combines representatives from all of the local services required to care for young people involved in the criminal justice system.

HMYOI Feltham, HMYOI Glen Parva, HMPYOI Woodhill

17. HMPYOI Feltham takes both offenders from 15 to 18 years deemed unsuitable for secure local authority accommodation, and also offenders between the ages of 18 to 21 years sent into custody by the adult courts. Due to the population pressure in the London area, young adults who are not scheduled to have a court appearance in London within three months are often moved to other establishments.
18. HMYOI Glen Parva holds both remand and sentenced young people and young adults. Like Feltham, it is a split site prison, with one part dedicated to young people under 18 and the other to prisoners between 18 and 21 years of age. Glen Parva is one of three prisons to which Feltham routinely transfers prisoners.
19. HMPYOI Woodhill is a local prison serving both Crown and Magistrates Courts. It takes sentenced prisoners with a view to allocation to other establishments. These include a small number of young adult offenders between 18 and 21 years of age.

KEY EVENTS

HMYOI Feltham

20. The man was remanded to HMYOI Feltham following a court appearance on 6 June 2008. A suicide and self harm warning form was completed by a prisoner custody officer (PCO), and sent with him from court to Feltham. It identified that the man was depressed, had not been in prison before and that he “states that he will harm himself if he is beaten up while in custody”. It recorded he had a history of self harm by an overdose in the past one to five years. Similarly, the Youth Justice Board sent a ‘placement alert form’ indicating “vulnerability” with its placement confirmation form. The alert form specified mental health concerns, a history of abuse or trauma, and his eligibility for support under leaving care legislation.
21. According to the reception nurse, who carried out his first reception healthscreen, the man was “very tearful, frightened”. (A first reception healthscreen is an interview by healthcare staff which takes place when a prisoner arrives at the prison. It should determine any physical or mental health conditions that require treatment, and any risk that the prisoner may pose of harming himself or attempting suicide.) During the healthscreen, he told the nurse that he had attempted suicide by overdose on New Year’s Eve 2007. Following his overdose, he explained that he received psychiatric treatment as an outpatient at hospital. He also told the nurse that his uncle had died in the previous year.
22. When asked whether he was thinking of harming himself at the time, the man replied, “I won’t do anything, I don’t want to upset my mum”. The reception nurse did not consider him at risk of harming himself and therefore did not start ACCT procedures. As the man had received mental health treatment in the community and had previously self harmed, he was referred to the mental health inreach team.
23. Any young person under the age of 18 has to undergo an initial custody reception assessment (T1:V) which focuses on the assessment of their vulnerability and risk. When asked whether he had any concerns about being in prison, the man told an officer that he was worried about “trouble with his peers”. The officer reassured him that staff would be around at all times. The officer went on to note that the man’s “first night nervousness [was] to be expected”. The officer did not think that the man was at risk of harming himself so he did not start an ACCT document either.
24. A member of the mental health inreach team saw the man that evening at 7.40pm following the reception nurse’s request. During the conversation, he again discussed his anxiety about other young people and the nurse “reassured him he won’t be alone”. After their conversation, the nurse found “there appeared to be no obvious mental health issues at this time”.
25. The next evening, the officer noticed that the man was “quite tearful” when he was collecting his evening meal. The man said that he was feeling “very low

and missing his mum". The officer arranged for him to use the unit telephone to call his mother and for the inreach team to visit him the next morning. After her telephone call with him, his mother told staff that she was "very worried about him". A Senior Officer (SO) raised a Concern and Keep Safe form, the first stage of the ACCT process. She recorded that he was "very upset at being in prison" and he "has stated he has had enough of life". She suggested that he would "need watching during the settling in period at Feltham".

26. During the ACCT assessment on 8 June, the man was "tearful from time to time" but assured staff that he was "very motivated to make his situation better". When asked whether he had ongoing thoughts of harming himself, he said "none, he would not want to hurt his family and doesn't want to die". After the ACCT assessment had taken place, a senior officer from the wing and the nurse from the inreach team held an ACCT case review. At the meeting, she recorded about him, that "he has no intention to hurt himself and is happy with life. He misses his family and hopes to overcome this with visits". Together with him, they decided to close the ACCT document and a date was set for a post-closure interview with the nurse.
27. On 9 June, a second officer from the Offender Management Unit completed the man's "Remand Information" form, which summarised his personal details, including those of his legal representatives. The officer also noted the reason that bail was refused on 6 June and the man was remanded, as follows: "Witness intimidation/failure to surrender."
28. The man moved off the induction wing on to another residential wing on 11 June. At his initial remand planning meeting, the second officer recorded that a bail application was going to be made. A member of the Youth Offending Team (YOT) attended the meeting and agreed with the planned course of action. Despite the application, the second officer set a date for the next remand planning meeting as 2 July.
29. The man earned a basic weight training award on 16 June and settled into life on the wing. The same day, a post-closure ACCT interview was held with the nurse from the inreach team and he reported "doing fine, waiting for phone credit". He told her that he had "no thoughts of self harm". The document remained closed. The following day he was moved to another unit, where he remained for less than two weeks.
30. At the remand care plan meeting on 2 July, the man was encouraged to attend the Prisons Information and Communications Technology Academy (PICTA), use the gym and maintain contact with his family on a regular basis. In accordance with national requirements, his mother was invited to attend the meeting and did so. He told those present that he had no thoughts of self harm or suicide and he had no problems with other trainees. His next court date was recorded as 18 August.
31. The man moved to F wing on 4 July. During his first night on the new unit, an officer observed that he was "tearful on association". He said he had no

thoughts of harming himself but that another young person had been verbally abusive towards him. Although he would not identify the young person, he was advised to report any similar behaviour to staff in future. After this incident, he appeared to adjust to the routine of the prison and earned himself enhanced status on 27 July. (The Incentives and Earned Privilege, or IEP, scheme is a system to encourage behaviour by rewarding good behaviour with benefits. There are three standards that prisoners can achieve, that is basic, standard and enhanced.)

32. The second officer chaired a review of the man's remand plan on 31 July, and recognised: "The man has maintained an excellent standard of good behaviour and positive attitude." Again, he reassured those present that he was not thinking of harming himself and had no trouble with other young people. He continued to maintain regular contact with his family and achieved those objectives set out in his remand plan.
33. On 18 August, the man was assessed as fit to appear at Crown Court and pleaded guilty. As his date of birth was 31 August, he had turned 18 and could be sentenced as an adult. The judge adjourned the case to wait for psychiatric reports, before sentencing him.

HMYOI Glen Parva

34. Instead of returning to Feltham after a further appearance at Crown Court, the man went to Glen Parva on 8 September. The Prisoner Escort Record (PER) is a record of all escorted journeys made by a prisoner. It also includes a section highlighting any known risks involved in moving that prisoner, including potential medical issues. The PER, dated 8 September, for his journeys from Feltham to Crown Court and then to Glen Parva. It noted that he had a closed ACCT document because of the previous risk that he would harm himself.
35. At the first reception healthscreen at Glen Parva, the man told the nurse about his overdose on New Year's Eve 2007. The nurse noted that he was an "occasional drinker" and that he had received treatment from a psychiatrist outside prison. He said he had no "thoughts of deliberate self harm". She recorded that she had received his clinical record from Feltham. The nurse made no referrals following the healthscreen. The third officer, who completed the Cell Sharing Risk Assessment (CSRA) undertaken in order to determine whether it is safe for a prisoner to share a cell, noted "previous threats of self harm but [no] thoughts of s/h [self harm] at present. Will share with a decent lad." The man was assessed as a medium risk and therefore would be allowed to share a cell. The wing history opened for him on reception at Glen Parva records that he had suffered a recent bereavement, specifically of a "close friend last year, uncle and nan's sisters".
36. The man adjusted well to life at Glen Parva and his "good conduct" was frequently remarked upon in his wing history. He applied himself in education, with one teacher noting, "an excellent student. Works really hard. Completed two courses in a very short period of time." In just over a month, he had not

only earned enhanced status, (such status is not automatically awarded after a transfer between prisons), but found himself on the enhanced landing. He was employed as the unit cleaner, which is a position given to the most trusted prisoners because it allows more freedom of movement around the wing.

37. During an appointment with CARATS (the Counselling, Assessment, Referral, Advice and Throughcare Service which is a non-clinical treatment programme for prisoners who misuse drugs or alcohol) on 10 November, the man told staff that he “was feeling a bit depressed but is generally ok and says he won’t hurt himself”. Nevertheless he was referred to the mental health team. Three days later, he had a long conversation with a worker from the team. She noted that he felt “remorseful” and that “had he not been under the influence of alcohol then he may not be in prison now”. She discussed the possibility of him taking anti-depressants and he agreed that it might help him.
38. A prison doctor assessed the man on 17 November. He found that the man was suffering from “poor sleep, lack of drive, feels let family down, etc”. He told the doctor that he had no thoughts of harming himself. The doctor prescribed 20 mg fluoxetine (an anti-depressant) to be taken daily. (The recommended dose is 20 mg for someone who is starting to take anti-depressants for the first time. The dose is usually reviewed after four to six weeks.) The doctor specified that the man could hold one week’s worth of his prescription in his possession at a time and that the prescription should be reviewed in four weeks. He also noted that the man needed “mental health support”. In their response to the draft report, the family told my investigator that they were concerned that he was allowed to hold medication in possession, despite his history of attempting an overdose. I understand the family’s concern; however, as he was not considered to be at risk of self harm at this time and the decision was made by an appropriately qualified professional, I do not think that it was unreasonable to prescribe him in-possession medication.
39. The next day the man had another appointment with CARATS and this time no issues were reported. However, over the following days, staff noticed that his “attitude to work was slipping”. Although employed to clean the third floor landing, he would often be found in the kitchens. An officer challenged his behaviour on 25 November. Despite this warning, on 29 November, the officer recommended that the man’s IEP status be downgraded from enhanced to standard due to being “complacent in his attitude”.
40. That same day, the man asked to see the mental health inreach worker. He admitted that he was “struggling with [his] mood at the moment”. When asked what was bothering him, he said that he could not get a visiting order for his brother who had flown from Ireland to visit his family. (Every convicted prisoner is allowed two hour-long visits every four weeks and is given visiting orders accordingly. A visitor must have a visiting order before they are permitted to see the prisoner.) He told her that he intended to move to Ireland when he was released and become a chef in his brother’s business. She spoke to the officer who agreed to help him get a visiting order.

41. Two days later, on 1 December, the man became angry when he asked to make a telephone call and was told to wait. The officer wrote a lengthy entry in his wing history record, regarding his “extremely poor attitude”. As a result of this exchange and his worsening behaviour, the officer told him that he would no longer be employed as a unit orderly and he would have to move to another landing that was not exclusively for enhanced prisoners.
42. The following day, the man appeared at Crown Court. He was not sentenced because the forensic psychiatric assessment had yet to take place. The hearing was adjourned to 11 December. A psychiatrist completed a psychiatric assessment on 3 December at the request of the court. Unfortunately, the Ombudsman’s investigator did not have a copy of this report for the purposes of the investigation. However, the psychiatrist made a lengthy entry in the man’s medical record with his findings, which was available for my investigation.
43. In his entry, the psychiatrist noted the man’s family history of abuse, although he had always been supported by his mother and grandmother. He was about six years old when he was first taken into care and endured nine foster placements over just a few years. It was while he was in foster care that he first drank alcohol and took drugs. By the time of his arrest, he described himself as a regular drinker who would use cocaine once or twice a week. He eventually returned to the custody of his family. He explained that he took the overdose on New Year’s Eve 2007 because he was “hammered” and saw “no point in being around anymore”. He assured the psychiatrist that he would not consider taking an overdose again because he “had his whole life ahead of him”. He told the psychiatrist that his meetings with the inreach team worker were the first opportunity he had to “get things off his chest” and he appreciated that. He said that he had been prescribed anti-depressants because of his lack of appetite. He described in some detail the circumstances of his offence and concluded that he was “disgusted” with himself. He said “I want to get punished for it” and “I’m disgusted with what I’ve done”. The psychiatrist concluded that the man did not have a mental illness.

HMPYOI Woodhill

44. On 11 December, the man was sentenced to seven and a half years at Crown Court. Rather than returning to Glen Parva, he was transferred to HMPYOI Woodhill. During the course of the investigation, the investigator met the man’s friend, and had since been moved to Wellingborough. He was remanded to Woodhill for a short time before the court appearance. He explained to the investigator that the man wanted to stay with him because they were “as close as brothers”. The man was not returned to Glen Parva, but was taken to Woodhill. When the investigator met the man’s mother, she thought that he wanted to return to Glen Parva. She was concerned that he should have returned to Glen Parva to continue the treatment for depression. The investigator spoke to the Head of Healthcare at Glen Parva who explained that, given the routine nature of his prescription, it was unlikely that

he would have been put on clinical hold. (Clinical hold means that the man would have been specifically held at Glen Parva for a medical reason.) There is no record of whether he was expecting to return to Glen Parva or not.

45. The PER dated 11 December covering the man's journeys from Glen Parva to Crown Court, and his transfer to Woodhill recorded the closed ACCT for self harm risk.
46. The first reception healthscreen process at Woodhill differs for prisoners who have transferred from another establishment. The man's "Transfer-in Reception Screening document" noted that he had been diagnosed with depression and was taking 20mg fluoxetine. No immediate health concerns were identified and no subsequent referrals were made. The CSRA undertaken on reception at Woodhill identified him as 'low risk' and, recording no open ACCT and no concerns, assesses him as suitable to share a cell.
47. The day after the man's arrival, an Initial Classification and Allocation (ICA) form was completed. This form is completed for any young offender aged 18 to 21 years to determine their security category and the most appropriate prison to transfer them to. According to this assessment, he was "currently on an open ACCT" but with a "review just completed with view to closure". This ACCT document was made available to the investigator after his death. He told the officer that he would like to remain near to his friend, who was also at Woodhill. The ICA form records the decision to transfer him to Aylesbury.
48. During his interview for this investigation, the man's friend recalled the seven days that the two young men spent at Woodhill. He said that when the man arrived, he was honest about the nature of his offence. Despite the non-sexual nature of the conviction, other prisoners at Woodhill misunderstood him and thought he was a sex offender. The friend said that he experienced no physical aggression personally, but he noticed that prisoners were intimidating the man. On one occasion, the man was followed into the shower area by four other prisoners. The friend said that there was no physical violence during the exchange but the man was shaken by it. He and the man were moved to another wing where they shared a cell. The friend told the investigator that the man was much happier after the move. However, he thought it would be better for the man if he moved to another prison. He explained to him that he was 20 years old but could still spend nearly another year in a YOI with him. The man and his friend approached staff who agreed to transfer them to the nearest YOI, which is HMYOI Aylesbury.
49. The man's medical record was reviewed on 16 December. He was judged fit to transfer to another prison. This was also the date that his fluoxetine prescription was due to be reviewed. There is no evidence that the review took place. The investigator has not seen any prescription charts for the seven days he spent at Woodhill, despite several requests for these records.

HMYOI Aylesbury

50. The man was transferred to Aylesbury on 18 December. The PER document covering his transfer from Woodhill to Aylesbury records that an ACCT document had been closed on 12 December, that is the day after his arrival at Woodhill. A nurse told the investigator that the prescription chart, ACCT document and a supply of fluoxetine did not accompany the man from Woodhill.
51. During his first reception healthscreen at Aylesbury, he told the nurse that he was “having thoughts of self harm”. He said that he “was worried about people finding out about his offence”. He told the nurse that he was bullied while he was at Woodhill. The nurse said that she was aware that he had been on an ACCT document while he was at Woodhill and that she “did look for it” but could not see it in his records. The nurse did not contact Woodhill or try to obtain a copy of the ACCT document. During interview, she remembered he said that he was not thinking of killing himself because he “did not want to die”.
52. Despite the man’s denial, the nurse spoke with the Senior Officer (SO) and they agreed to open an ACCT document due to his “low mood”. Whilst she did not refer him initially as part of the healthscreen, a referral was made as part of the ACCT immediate actions. The other immediate actions included locating him close to his friend, hourly observations and four conversations a day, access to the Samaritans telephone, which he declined, and to a Listener.
53. As a matter of routine, all prisoners are told about the Listener scheme when they arrive at Aylesbury. He asked to speak to a Listener that first night. The Listener saw him in his cell that evening. During interview with the investigator, he said that the Listener scheme is well supported at Aylesbury, however for security reasons, contact with prisoners at night must be conducted over a telephone system.
54. The man had a secondary healthscreen on 19 December and was then returned to the wing for his ACCT assessment. A second SO was the reserve ACCT assessor that day. In order to become an assessor, he had undertaken a five day training course, including a short introduction to mental health awareness. During interview, the SO described the role of ACCT Assessor as “to see if they can help identify what problems they have at the time and what has caused them to self harm”. A third SO tried to contact the duty ACCT Assessor to carry out the man’s assessment, but he was unavailable. As the second SO was working on the neighbouring wing, the third SO asked him to carry out the assessment.
55. The second SO explained to the investigation team that the ACCT assessment took place in a private room on the wing. He spoke to the man about what was bothering him and whether he had any thoughts of self harm at that time. He recorded that the man had only been recently sentenced and that his main concern was about other prisoners finding out about his offence as he had been bullied at Woodhill. He told the investigator that the man was worried that others might find out about his offence, not that they had or that

he felt currently at risk from other prisoners. He explained the support which was available at Aylesbury for dealing with this, including the Listener scheme and Samaritans, the possibility of moving to the vulnerable prisoners unit, and support from staff. The man indicated that his 'brother', his friend, was a good source of support and if he had problems he would go and speak with him.

56. The man did not discuss his offence in any great detail during the assessment; however he did tell the second SO that he had been having "flashbacks" about it for some five months. The SO recorded this and believed that he had the flashbacks at night. In the assessment the SO specifically recorded that the man was not "hearing voices telling him to do anything" and that he had told him he "feels ok". The man did not mention anything to do with medication, nor did the SO know whether he was receiving any support regarding these flashbacks.
57. Following this interview the second SO assessed that the man was not at risk. He recorded him as saying that he had "no thoughts of killing himself, feels not worth it as he has his life ahead of him ... don't want to be dead". The senior officer told the investigator that the man was quite positive about the future. Discussing his previous suicide attempt, he said he did not want to die as he had a lot to live for and would still have his life ahead of him. He would only be 22 when released, and he had a lot of support from his family, mother and step-father.
58. The ACCT review was undertaken immediately following this assessment, attended by the third SO (who as unit manager chaired the meeting), the second SO, the man's personal officer and the man. There is no evidence that healthcare was invited to the review meeting, or made any written contribution. Neither the second SO nor the personal officer knew there had been an ACCT opened and closed at Woodhill the previous week. The man is described as coming "across shy but then had good eye contact and contributed well". The third SO recorded systematically that the man was able to describe what support was available to him, said he was not likely to harm himself, agreed that his risk was now low, and wanted the ACCT plan to be closed. The man said he had had a "good think last night and would not do anything like harming himself", and that he wanted to be at Aylesbury and felt better since the transfer. Despite not consulting anyone involved when the ACCT was opened, those present agreed to close it, with the expectation that the man would use support and speak to staff if needed. The third SO set a date for the routine post-closure ACCT interview with the man on 26 December.
59. On 22 December, the man had an appointment with the doctor working at Aylesbury. He told the investigation team that he was unaware that the man ACCT had been closed when he saw him. He had not participated in the decision to close the ACCT. He believed he was referred to him due to the need for medication and because he was being monitored on the ACCT procedures. He confirmed to the investigator that he had access to the man's continuous clinical record, but neither his previous prescription chart nor the psychiatric report, and had written requesting a copy.

60. In assessing the man, the doctor said that in contrast to descriptions in the notes of a very unhappy person "I thought this man was positive ... I came across a very positive looking person". The doctor did not assess him as a high risk of self harm. He told the investigator that he was struck by how positive the man was during his assessment. For example, the doctor noticed good body language and eye contact, the man told him about having family support, clear future plans (his ambition to become a chef in his brother's planned restaurant), fluid conversation, and a pattern of mood variation which gave little cause for concern. The man asked to stop taking fluoxetine, and the doctor agreed that he could. However, he continued to prescribe the antidepressant indicating that the man could resume it if he needed, and also allowing time for a fuller healthcare assessment as he settled at Aylesbury.
61. There is no record that the man took any fluoxetine whilst at Aylesbury. His wing history between 19 and 26 December is sparsely completed. Most, but not all, the first week's induction modules had been completed by 23 December. A fourth SO, who undertook the diversity induction as a group, told the investigator that the man seemed relaxed with other prisoners and she had no cause for concern about him.
62. On 20 December, the wing occurrence book records that the man and his friend approached staff about concerns that other prisoners knew about the man's offence and were shouting about it through the windows. The man's personal officer told the investigator that he remembered that the man had expressed this concern on one occasion. He said that the man could not identify who had shouted to him. He advised him that if any physical threats were made, staff would be able to challenge them but there was little they could do about an unidentified person shouting. A fifth SO recorded that staff checked whether there were any self harm thoughts and found none, and that the man was advised to speak to staff if any threats were made to him.
63. The man's personal officer said that staff were considering locating him on the vulnerable prisoners unit due to the profile of his offence. He had not discussed this with the man and he was not aware if other staff had. The third SO told the investigator that he believed he had discussed this incident with the man who perceived that the shouting was about him. He had discussed with both the man and his friend their previous experience of bullying at Woodhill. He remembered that the man was happy to be at Aylesbury, "I perceived a real change in his demeanour, I think he was quite relieved to be removed from that environment".
64. The chaplain interviewed the man on 22 December. He recalled that he expressed concerns about other prisoners finding out about his offence and discussed what happened at Woodhill, said that he wanted to share a cell with his friend, and expressed remorse over his offence. The chaplain reassured him about Aylesbury's non-tolerance of bullying policy. He indicated that, because of the Christmas period, the cell sharing request would take time to process. He suggested that the man should come on the chaplaincy's victim empathy programme to work through his remorse, which he agreed to do.

The chaplain found him positive about his plans to work as a chef with his brother on release. As there were no thoughts about self harm nor allegations he had been bullied, he saw no need to raise an ACCT or complete a security information report. Nevertheless, he made a point of seeing the man again on 24 December, when he found him in a good mood and saying “I have no problems at all”.

65. The man’s other personal officer told the investigator he met the man and his friend for the first, and only, time on the evening of 23 December. He recalled that the man said he was generally alright, but both he and his friend seemed a little agitated. The man’s main concern was to share a cell with his friend. He advised them both to make an application, and explained the risk assessment takes time to complete, even though they were friends.
66. The man attended the healthcare centre again on 24 December. He gave consent and received a routine Hepatitis B vaccination. There is no record of any other health concerns being raised.

Events of 25 December and 26 December

67. The fourth SO was the senior officer on duty on D wing on 25 December. She told the investigator that as it was Christmas Day prisoners were on association all day. (Association is when prisoners leave their cells and mix with each other on the wing.) After breakfast, prisoners were unlocked from about 9.00am until midday, and then from 1.30pm until about 4.30pm. She recalled that both the man and his friend stayed around the tables in the middle of the wing, playing games all day. In the morning, an officer played chess with them, and she described them as “very jolly” with no sign of depression or anxiety. She remembered they went to use the telephone several times, and seemed quite relaxed. She saw them mixing with other prisoners, and no concerns were expressed about other prisoners knowing about their offence.
68. The first personal officer was on duty in the afternoon, and he played draughts with the man. He recalled the man making a telephone call. He described him as neither being “upbeat” nor “down” but just “normal”. The man did not appear anxious, and there had been no discussion about other prisoners knowing or talking about his offence. Later in the day, the nurse happened to meet him on the wing. She had a brief chat with him and described him as seeming “much brighter” than when she had seen him on reception. In response to her asking how he was, “he said ok because I have got my friend and he wasn’t too bad”. Despite the man’s mother’s concern that he was subject to bullying that afternoon, there is no evidence to support this.
69. The night officer for D wing arrived on the wing about 8.30pm and no issues of concern were reported to him at handover. In ‘night state’ the officer makes a routine observation check, through the cell door observation panel, on all prisoners at intervals of between two to three hours. He told the investigator that he checked all the prisoners just before 9.00pm and again at 11.00pm. He did not recall specifically whether the man was either sitting on his bed or

watching television during these first two checks. He said that he had no cause to speak to him. He said there had been some shouting out of the windows earlier in the night, but he did not hear anyone calling the man's name, nor anything about offences or anything that could have been considered bullying. He remembered that it quietened down quite quickly between 9.30pm to 10.00pm, and remained so. He said he had no cause to warn anyone to be quiet.

70. The man's friend, who was located in a cell next door but one to the man's, told the investigator that he and the man had given each other Christmas cards just before lock up and that he had replied "yes I'll see you in the morning" to him. He said he had later called out through the window to him at about 1.00am and, having received no reply, asked one of the officers to go and check on him, which they did.
71. At 1.48am, during his round of observational checks, the night officer opened the observational panel on the man's door and turned on the night dimmed light. He saw him hanging and immediately used his radio to issue a Code Red alert. (A Code Red alert is used when there is a serious self harm incident that requires emergency and medical assistance.) The officer then opened his sealed key pouch in readiness to open the door once assistance arrived. (The prison policy is that a single officer on a wing may not enter a cell alone.)
72. The night orderly officer's role meant that he was the senior officer operationally managing the prison during the night. He had just left the healthcare centre when the call came through. He returned to the centre to collect the nurse and help her carry the emergency equipment. A senior staff nurse followed the orderly officer, along with two assistant orderly officers, to D wing. During interview for this investigation, the night orderly officer guessed that it had taken the four members of staff "less than a minute" to get to the man's cell after hearing the Code Red alarm.
73. The senior officer went into the cell, accompanied by the night officer. The officer cut the ligature while the night orderly officer supported the man. The night orderly officer noticed that the man was in such a position that his arm was caught under and around a hot pipe running along the wall. When he freed the arm, he noticed red marks and a further mark on the man's side, which explains the marks that his mother noticed after his death. Once on the floor, the staff nurse asked for him to be moved from the cell to the landing to provide sufficient room for the attempts to resuscitate him.
74. Though she found no pulse and the man was not breathing, the staff nurse noticed that he was still warm. On checking his airway, she found no obstructions, so she began cardio-pulmonary resuscitation (CPR). The night orderly officer gave cardiac massage while the nurse used an ambubag (a self-inflating device used instead of mouth to mouth). At the same time, she asked for an ambulance to be called. The first assistant orderly officer called for an ambulance. The staff nurse attached the defibrillator (a machine that applies electrical impulses to the heart and advises whether there is any

rhythm which might be stimulated) which indicated there was no rhythm, so the man should not be shocked.

75. The ambulance arrived at Aylesbury at 1.56am. The night orderly officer was carrying out chest compressions at the time that he received a radio call to inform him that the ambulance had arrived at the prison. As the orderly officer he was the only member of staff to keys that enabled him to move between wings, so he was required to go to the prison gate and escort the paramedics to the cell. The first assistant orderly officer took over chest compressions. The night orderly officer arrived back at the cell. The nurse explained that staff continued chest compressions and administering oxygen until the paramedics had set up their equipment. She remembered that the paramedics changed the defibrillator leads to those of an electrocardiogram (a device used to test the electrical activity in the heart). She thought that they checked for activity three times. Having undertaken necessary tests, the paramedics they confirmed that the man had died at 2.05am.
76. After he had been confirmed dead by the paramedics, the night orderly officer asked whether the man could be moved back into his cell. The senior officer told the investigation team that the paramedics said that he had to remain on the landing until both police and the duty doctor had arrived. Conscious of other prisoners being able to see the scene and as a mark of respect, the night orderly officer instructed the lights to be put out, and a blanket placed over the man.
77. The Governor, Deputy Governor and Duty Governor that night, arrived at 2.37am. The police then arrived at 2.55am and the duty doctor at 4.35am. The police undertook their necessary investigation, including informing the coroner, and called the undertakers at 5.05am. The duty doctor confirmed the man's death at about 4.55am and she and the ambulance then left the prison. The man remained on the landing until 6.05am when he was taken away in an ambulance.
78. The police made two written documents available to the investigator which had been removed from the man's cell during their investigation. The first was an undated letter he had written to his sister apparently on Christmas Day, but which was unsent. The second document was an application form to see the chaplain which was dated 25 December, which had not been handed in. In this letter he expresses being "upset" about his sister, one of his co-defendants, being sentenced to such a long sentence and "also it is nearly a year since [the mans close friend who died following an overdose] died and I wish I could just go up to his grave and have a chat with him". The letter also requests she send him a stamped envelope and looks forward to their release. The application reads "I need to have a chat with someone from the chaplain as soon as possible".

Support for prisoners

79. After she stopped her resuscitation efforts, the staff nurse heard the man's friend calling in a distressed state from his cell, asking if the man was all right. The nurse spoke to him through his cell door. She recalled telling him that she was very sorry but they believed the man had died and there was nothing more they could do for him. She told the investigation team that, "due to security restrictions", she could not open his door at night. (During the night, the prison is in patrol state which means that the night orderly officer must give permission before a cell is unlocked.) Nevertheless, she said she spoke to him for some time and asked him if he smoked. When he said that he did, she rolled a cigarette and slid it under this door. After talking to him, she talked to some other prisoners who had been calling through their doors.
80. Individual support was organised for the man's friend from 26 December onwards. An ACCT document was opened, but he told the investigation team that he was uncomfortable with so much attention from staff. The ACCT was closed shortly afterwards. Other prisoners were offered support during the day with wing visits from chaplaincy staff, and time to associate and discuss any issues with the staff.
81. A second chaplain arrived at about 3.15am. She prayed over the man and for his family and friends. She told the investigators that she then spoke to the man's friend a number of times, as did the night officer. After the police and doctor left, she and the officer ensured that the man was covered more fully with another blanket until the undertakers arrived.

Family liaison

82. A Detective Inspector spoke with the duty governor and offered that the police could inform the man's next of kin. The duty governor accepted the offer. In the morning, the duty governor learned that a member of his staff had been trained in family liaison and appointed him as the Family Liaison Officer, with the second chaplain as deputy.
83. The man's mother was informed of his death by the police at her home at 10.15am on 26 December. The prison Family Liaison Officer had decided to inform his mother personally but was unable to do so before the police had arrived. He checked with the undertakers and the mortuary to establish when the man's mother could visit her son, before contacting her by telephone at 2.30pm. The Governor had already telephoned the man's mother in the morning to offer his condolences. Unfortunately, the news of his death was reported in the local press. His mother was not aware that this could happen and was surprised that the prison had not warned her. Although there is no requirement for a Prison Service family liaison officer to mention the possibility of media coverage, I hope some consideration will be given to doing so in the future.
84. The Family Liaison Officer liaised with the coroner's office, the funeral directors, and the police, and maintained regular contact with the man's

mother. She instructed that she wanted the funeral arrangements to be made through the funeral directors who organised the funeral for her other son. She asked to see the cell where he died and the visit took place on 31 December. The man's mother was accompanied by her brother, and the man's friend was allowed to join them. The Family Liaison Officer sought to answer her immediate concerns about events, and undertook to investigate some of these concerns. He subsequently explained the purpose of the coroner's inquest and the Prisons and Probation Ombudsman's investigation. Regrettably, due to the time taken for the post-mortem, but particularly delays by the funeral directors, the man's mother was unable to visit him until after 7 January. The Family Liaison Officer had liaised with the funeral directors seeking to resolve this issue. He represented the Governor and staff of Aylesbury at the man's funeral which was held on 13 January.

Support for staff

85. A 'hot debrief' was convened by the duty governor, at 8.10am on 26 December. The meeting was intended to enable staff involved with the man during the night to express immediate feelings and identify any learning issues. All staff interviewed told the investigation team that it was a helpful meeting. The duty governor requested that a representative of the prison's Care Team attend the following night to speak with staff individually. A few weeks later, a critical incident debrief was held and any staff who had come into contact with the man were invited. Again, the purpose of this meeting was to allow staff to find support and also to distil lessons to be learned.

ISSUES

Clinical care

86. As noted above, a clinical review was undertaken on behalf of the local Primary Care Trust. The panel appointed a clinical reviewer as the Chair. I note the clinical review panel's opinion that neither the absence of the prescription for the antidepressants nor its abrupt cessation following his transfer to Aylesbury contributed to the man's risk of suicide.
87. The review panel makes 14 recommendations which I endorse, and do not repeat here. The recommendations concern the man's medical records, the assessment of risk of self harm and the ACCT process, continuity of medical care, emergency response, debriefing and training. I hope that the review sufficiently addresses the man's family's concern about the quality and content of his medical record. I commend the recommendations to the attention of the Head of Healthcare and the Governor.
88. I agree with the panel findings in respect of the medical records and continuity of care. Furthermore, it is clear that in addition to failing to send a prescription chart, with what can only be described as inadequately completed medical records, on the man's transfer to Aylesbury, no arrangements were made to provide his antidepressant. It is not clear that his prescription of fluoxetine had been reviewed prior to his transfer to Aylesbury, although he had been deemed fit for transfer at Woodhill. I am concerned that neither the doctor nor the first reception healthscreen nurse followed up the missing prescription chart, medication review or lack of medication at reception.
89. In the event, the man arrived at Aylesbury without his prescription or medication. Medication for young adult prisoners at Aylesbury is ordered from the pharmacy at Woodhill. During interview, the prison doctor told the investigation team that it can take two or three days for medication to arrive from Woodhill. Had the man's medication been appropriately reviewed and that review effectively recorded, the prescription may not have lapsed as it did. This is an unacceptable interruption in continuity of his care. I therefore make the following additional recommendation:

The Head of Healthcare at HMPYOI Woodhill should review the system of assessing medical fitness for transfer to ensure that all outstanding medication reviews have been carried out and that there is no interruption to the supply of prescribed medication.

ACCT processes and practice

90. The man's ACCT document from Woodhill did not accompany him on his transfer either. The Suicide Prevention Co-ordinator from Woodhill explained to the investigator that the office who managed the man's transfer, noted only that he had a closed ACCT document. The system in place at that time at Woodhill meant that the ACCT document was not flagged as necessary for transfer. As the man's wing file also did not accompany him either,

communication between Woodhill and Aylesbury about his level of risk failed completely.

91. Prison Service Order (PSO) 2700 – Suicide Prevention and Self Harm Management sets out the requirements for prisons to manage suicide or self harm. When discussing prisoners transferring between establishments who are on an ACCT document or in the post-closure phase of an ACCT document, the PSO requires that “the closed ACCT Plan must accompany them”. There is no evidence that a post-closure review took place while the man was at Woodhill. Therefore, he was still in the post-closure phase of ACCT when he was transferred to Aylesbury.
92. Since the man’s death, the Suicide Prevention Co-ordinator confirmed that “remedial action” has been taken to correct the systems at Woodhill. However, I am concerned that such important information was not effectively transferred with him when he moved from one prison to another. The information about the experience he had in Woodhill, and his consequent anxiety about other prisoners discovering the nature of his offence, was never formally communicated to staff at Aylesbury.

The Governor of HMPYOI Woodhill should check that robust arrangements are in place to ensure that all ACCT documents, whether open or closed, are transferred with prisoners to their receiving establishment in line with PSO 2700.

93. The staff nurse, who completed the first reception healthscreen, said that she understood that the man was on an ACCT at Woodhill, and she noticed that she could not find the document in his records. Nevertheless, she did not contact Woodhill to ask for it. The PSO makes it clear that the responsibility for transferring documents lies with the originating prison. However, the nurse understood the importance of ACCT documents. She told the investigation team that she was concerned about his presentation during the healthscreen and opened an ACCT document herself. I am surprised that she did not contact Woodhill to ask about the missing document.
94. Neither the second SO, who completed the ACCT assessment at Aylesbury, nor his personal officer, were aware that the man was recorded as having been on an ACCT at Woodhill. The SO told the investigation team that he would have contacted Woodhill to ask for the missing ACCT document, had he been aware of its absence.
95. The first SO explained that neither the second SO nor the man’s personal officer would have been aware of the missing ACCT document. At the time that the man was at Aylesbury, a closed ACCT document was filed with a prisoner’s custody records, and was not on the wing but in a central administrative block. During his interview for this investigation, he explained that the system is now under review, but at the time, there is no reason that the staff would know to request the previous establishment for any ACCT documentation.

The Safer Custody Manager and the Governor at HMYOI Aylesbury should ensure that a system is introduced so that any missing ACCT documentation is identified as soon as a prisoner arrives at the YOI and followed up with the relevant establishment without delay.

96. On the man's reception at Aylesbury, the nurse opened an ACCT document, in consultation with the SO. PSO 2700 requires: "An ACCT Plan must be opened in every case where the [reception] screen is positive for current thoughts of self-harm, wherever the prisoner is located in the prison". The nurse recorded that she was concerned about his low mood and that he presented a 'raised risk', or 'medium risk', of self harm. The immediate action plan contained appropriate actions to manage this risk, and the ongoing record shows that ensuring he was located as near as possible to his friend, giving him access to a Listener, and implementing hourly observations with at least four meaningful conversations a day. There was a further immediate action, namely the referral to the mental health inreach team. There is no record of his being interviewed by the mental health team, either before or after the ACCT was closed the following day.
97. During the ACCT assessment and review on 19 December, the man presented well to staff. He requested to be taken off the ACCT plan. The review was chaired by the induction wing's senior officer, who had not previously met him. Also present was the second SO, the ACCT assessor, who met him that morning. Neither the first SO nor the nurse was invited to the review or to make a contribution, despite having been instrumental in opening the ACCT document. (In their response to the draft, the family expressed concern about staff at the review's understanding of the purpose of the ACCT document. This could have been avoided by inviting those involved in opening the ACCT document to participate in the subsequent review.) There is no evidence that anyone from the healthcare team were invited to attend the review. One of the actions identified in the man's immediate action plan was to undergo a mental health assessment. It was still outstanding at the time of the case review. The personal officer and the third SO told the investigator that healthcare would have been invited to attend the review, but there is no evidence to support this. In their response to the draft report, the family expressed concern that his ACCT plan was closed without the mental health assessment, specified in his immediate action plan, having taken place.
98. The man did not mention during the ACCT assessment or review that he had been prescribed and was taking antidepressant medication at Glen Parva and Woodhill. There was no obligation on him to share confidential healthcare information. However, given that healthcare were aware that his antidepressant medication had been interrupted on his transfer to Aylesbury, ensuring their advice was given to the review meeting was particularly important. The prison doctor subsequently agreed with the man that he could stop taking his antidepressant medication if he wished.

99. Whilst I understand the competing demands on healthcare staff in prison, the importance of a multi disciplinary approach to those subject to ACCT cannot be underestimated.

The Safer Custody Manager and the Head of Healthcare at HMYOI Aylesbury should enable healthcare to contribute into all ACCT reviews, where relevant.

100. That the man had a brother who had committed suicide by overdose was not known to Aylesbury, or any of the institutions he had been in, until after his death. Both at Feltham and at Glen Parva, questions were asked which had elicited from him that he had suffered bereavements in the past year. However, on neither of these occasions had he talked about his own brother's death. Whilst the second SO talked to him about his own previous suicide attempt during the ACCT assessment, there is no evidence that he was asked whether there was a family history of suicide. Undoubtedly a difficult question to ask, nevertheless it might have been important in establishing any patterns of risk. In his last letter to his sister, he mentions that the anniversary of his brother's death was approaching, and he wished he could go to his grave. A family history of suicide is a significant risk factor. Young people under the age of 18 who are in prison are often asked about any experiences of self harm within their family. There is no evidence that he had discussed his feelings about this with anyone, and it is sadly not possible to establish with any certainty how this affected him.
101. Only the ACCT assessor had met the man before the ACCT case review when the document was closed. He had arrived at the YOI in a "tearful" state and felt better the following morning. He had never been to Aylesbury before and knew none of the staff there. Whilst he presented well both in the ACCT review meeting and generally on the wing in the week up to his death, I am concerned how quickly the ACCT was closed. The flexibility of the ACCT process means it can be used simply to record interactions at flexible intervals according to the assessed level of risk, such as twice a day. The third SO told the investigator that he had considered reducing observations and significant conversations as ACCT actions rather than full closure. I am concerned that the man's ACCT document was closed so quickly after it was opened, and after he had only been at Aylesbury for such a short time. I understand that the third SO intended him to be monitored as part of the post-closure review process, but I do not accept this to be an adequate substitute for the structured support of an open ACCT document.

The Safer Custody Manager at HMYOI Aylesbury should review all ACCT documents closed within one week of opening, with the expectation that such quick closures should only happen in exceptional cases.

102. PSO 2700 advises that an ACCT should not be closed if there are outstanding actions in the prisoner's caremap. The third SO said that he had the action plan on his desk during the week after he closed the man's ACCT document. The man's mental health had not been assessed. This was identified as an action in the caremap drafted when his ACCT was opened.

The Governor of HMYOI Aylesbury should remind staff that an ACCT must not be closed while there remain outstanding actions in the immediate action plan or caremap, in line with PSO 2700.

Cell sharing

103. The man was located in a single cell. PSO 2700 advises that “doubling-up of an at-risk prisoner with a cellmate can help to reduce feelings of loneliness and provide both with someone to talk to”. It was not possible to locate the man and his friend together on the induction unit at Aylesbury, as they had requested, as there is only one shared cell which is used by the cleaners. They both had been risk assessed for cell sharing; however the prison policy is to undertake a full assessment after prisoners have settled into the prison. Therefore, officers at Aylesbury do not undertake such a review until a prisoner has completed his induction.
104. Staff on the induction unit were considering the possible location of the man on the vulnerable prisoners unit following induction, but had not discussed this with him directly. While I acknowledge that he would have found support in sharing a cell with his close friend, I do not think it was unreasonable of staff to wait until they were satisfied that they could make a full assessment of the risk that each prisoner presented.

Violence reduction and vulnerability

105. The man and his friend both said that the man had been subject to bullying at Woodhill. There is little evidence of these allegations and the subsequent investigation, but it seems that the problem was solved by moving both to other wings within that prison. Officers then agreed to move them together to Aylesbury. The man expressed his anxiety on a number of occasions that other prisoners at Aylesbury had found out about his offence. He was worried that it might be similarly misinterpreted as a sexual offence. From the moment of his first remand into custody he had, in any case, expressed serious remorse over his offence, which he discussed with the chaplain at Aylesbury. His remorse, coupled with other prisoners’ misunderstanding of the nature of his offence, is likely to have contributed to his vulnerability.
106. The man had alerted staff at Aylesbury to shouting out of the windows which he perceived as being directed toward him and about his offence. He approached his personal officer on 20 December in this regard. As he could not pinpoint who had shouted at him, no violence reduction measures could be taken. The personal officer reassured him they would consider moving him for his own safety, if necessary. The exchange was recorded in the wing observation book and the officer checked whether the man had any thoughts of self harm, which he denied.
107. The man’s family told my investigator that he had spoken to his grandmother on the afternoon of 25 December and he seemed well. They were concerned

that his mood had deteriorated so dramatically in so short a time and were worried that he may have been bullied that afternoon. In fact, there is no evidence that there was a repeat of this behaviour on 25 December, although the night officer recalled there was some shouting early in his night shift. The officer did not recall anything specific to the man and heard nothing that he needed to challenge. The man had been observed to be mixing well both with staff and other prisoners that day, and had told the nurse at teatime that he had no problems.

108. This is not the first Ombudsman's report involving young adults feeling targeted by shouting of other prisoners out of windows. The then, NOMS Violence Reduction lead advised the investigator that such behaviour should be considered as bullying and dealt with using violence reduction measures. I make no separate recommendation here, but reinforce the recommendation of the Chief Inspector that "all incidents of violence and assault should be accurately recorded through the incident reporting system". It should include incidents related to shouting out of windows perceived to be intimidating. These measures should enable the institution to plan appropriate actions to reduce the incidence of intimidating shouting from windows. In respect of any potential impact on the man it would also have been good practice to have discussed with him directly that consideration was being made to move him to the vulnerable prisoner's unit so that he had a sense of planned response to his concerns.

Emergency response

109. The response to the night officer's discovery of the man and his call for emergency assistance on 26 December was prompt and professional. There was no significant delay caused by the policy that a single officer could not open a cell door alone at night. Both the nurse and all necessary emergency equipment arrived speedily at the cell. Due to the size of the cell, it was appropriate that the man was moved out to the landing to enable staff to do their best to resuscitate him. Both the nurse and uniformed staff made considerable and careful efforts at resuscitation before the paramedics arrived.
110. Once the paramedics had confirmed that the man had died, staff were advised that he could not be moved until both the police and the doctor had seen him. The night orderly officer took action out of respect for the man and out of concern for other prisoners to dim the lights and cover him. However, it was some two hours before the police and doctor were able to complete their examination. The delay may have increased the distress for the man's friend, whose cell was nearby, and other prisoners. Dependant on the police instructions, the man might have been moved back into his cell once the doctor had finished. I make the following recommendation in order to increase the mark of respect and decrease the potential for other prisoners' and staff distress in similar circumstances.

The Governor of HMYOI Aylesbury should make suitable provision for a screen to be used in the event of a young prisoner's death on the landing at night and further promote dignity and respect.

111. There is evidence that substantial efforts were made by the nurse, officers and the chaplain to speak with, comfort and reassure the man's friend during the night, despite his own recollection that he did not find out about his friend's death for several days. I am satisfied that specific assistance and support was provided for him in the following days. I make no recommendation here. However, after he was moved, opening his friend's cell and talking face to face might well have given him additional comfort for the loss of his friend.

Family liaison

112. The duty governor arranged with the police during the night to visit the man's mother to inform her face to face of his death as soon as possible. PSO 2710 and the accompanying Family Liaison Officer guidance states that breaking the news of a prisoner's death should be undertaken wherever possible in person by the prison family liaison officer. During interview with the investigator, the duty governor acknowledged this as a learning point for himself. I suggest therefore that the senior management team familiarise themselves with National Offender Management Service family liaison guidance.

113. The morning after the man's death, the duty governor appointed a governor the family liaison officer. He, and Aylesbury's Governor, contacted the man's mother as soon as possible after the police had informed her of her son's death. His mother and family were given support and assistance following his death. The family liaison officer liaised closely both with the coroner's office and the funeral directors to assist the man's mother as much as possible. It is regrettable that so much time passed before she was able to visit her son, but I am satisfied that the family liaison officer did all he could to reduce the delay, which lay outside of his control. One learning point, however, is to consider, in conjunction with the coroner's office and the funeral directors, how to prepare a family member for seeing injuries on their loved one.

114. The man's mother expressed her thanks for the considerate way in which the family liaison officer facilitated her visit to her son's cell.

CONCLUSION

115. The man's custody was transferred from Woodhill to Aylesbury on 18 December. Staff at the receiving prison did not have all of the information or medication they needed to exercise their duty of care for him. His full medical history, prescription and previous ACCT document did not transfer with him.
116. Nevertheless, reception staff immediately identified that he was at risk of self harm and required a mental health assessment. Those staff were not involved in the decision to close the ACCT the next day. Support for prisoners in the post-closure phase of ACCT is not a substitute for the fully flexible, multidisciplinary support provided by ACCT monitoring. I hope the Governor and the Safer Custody Manager work together to strengthen the processes in place to safeguard young adults.
117. There is no evidence to suggest that the man was being bullied the afternoon before his death. He was remorseful about his offence and feared that other prisoners would misunderstand its nature. While it is not possible to determine what was on his mind in the early hours of 26 December, he was open to staff about the difficulty he had coming to terms with the offence he committed and his time in prison.

RECOMMENDATIONS

1. The Head of Healthcare at HMPYOI Woodhill should review the system of assessing medical fitness for transfer to ensure that all outstanding medication reviews have been carried out and that there is no interruption to the supply of prescribed medication.

This recommendation was accepted. The response was:

“The Head of Healthcare will review the pre transfer assessment, and include a section to confirm that all outstanding medication reviews have been carried out and that the prisoners’ current medication is suitable.”

2. The Governor of HMPYOI Woodhill should check that robust arrangements are in place to ensure that all ACCT documents, whether open or closed, are transferred with prisoners to their receiving establishment in line with PSO 2700.

The Governor accepted this recommendation with the following response:

“All closed ACCT documents will be stored in the prisoners 2050 file in the discipline office immediately following the post closure review and transferred with the prisoner to the new establishment. All open documents will be taken to reception by the staff member escorting the prisoner to reception and handed over to reception staff ready for transfer.

In addition the safer custody team on a daily basis will check the discharge list the day before and inform reception if any prisoners due for transfer have been on an ACCT document within the last 30 days in accordance with PSO 2700. Reception staff will then ensure that the ACCT document is present prior to transfer.”

3. The Safer Custody Manager and the Governor at HMYOI Aylesbury should ensure that a system is introduced so that any missing ACCT documentation is identified as soon as a prisoner arrives at the YOI and followed up with the relevant establishment without delay.

This recommendation was accepted with the following response:

“All young prisoners are interviewed by reception staff when they arrive at the establishment. This interview is mandatory and is an integral part of the Reception protocol. A system will be put in place for the specific question of “have you been on an ACCT Plan?” as part of the Reception interview. Reception Officers will check all documents to ensure the previous ACCT Plan is available. If not available the Safer Custody Coordinator will be informed as a matter of urgency to contact the previous establishment to retrieve the ACCT Plan. Reception Staff

will have the responsibility for ensuring that past ACCT Plans are available. The same question will also be asked as part of the Reception Board Interview and any deficiencies will be reported to the Safer Custody Coordinator as a matter of urgency. At weekends or Friday evenings, the orderly Officer will be notified to take action.”

4. The Safer Custody Manager and the Head of Healthcare at HMYOI Aylesbury should enable healthcare to contribute into all ACCT reviews, where relevant.

Again, the prison accepted this recommendation and responded as follows:

“A discussion has taken place between the Safer Custody Manager and the Head of Healthcare act on this recommendation. Where relevant, Residential Case Managers will ensure that Healthcare are invited to attend the reviews and record any apologies or failure of attendance in the ACCT Plan (on the Record of Case Review). In the circumstances of non attendance a written report will be requested for the Case Review team to consider during the review.”

5. The Safer Custody Manager at HMYOI Aylesbury should review all ACCT documents closed within one week of opening, with the expectation that such quick closures should only happen in exceptional cases.

The Safer Custody Manager accepted this recommendation and responded as follows:

“All ACCT Plans will be thoroughly checked post closure by the Safer Custody Manager as part of the assurance process. Any that are closed within one week of being opened will be brought to the Safer Custody Meeting for discussion to establish and validate if there was justification for an exceptional reason why closure occurred within seven days.

The Local Suicide Prevention and Self Harm Management policy will be reviewed to include the statement that *“ACCT Plans should not be closed within seven days of opening, except in exceptional cases”* and *publicised by a notice to staff.*”

6. The Governor of HMYOI Aylesbury should remind staff that an ACCT must not be closed while there remain outstanding actions in the immediate action plan or caremap, in line with PSO 2700.

The Governor has accepted this recommendation and responded accordingly:

“A notice to staff will be issued to inform staff of the need to ensure that all actions on CAREMAPs are completed prior to closure of the ACCT Plan. This will also be highlighted at the Safer Custody Meeting every month during the feedback on closed ACCT plans.

All ACCT Plans are checked by the Safer Custody Manager and any deficiencies will be discussed at the monthly Safer Custody Meeting and the weekly Residential managers meetings.”

7. The Governor of HMYOI Aylesbury should make suitable provision for a screen to be used in the event of a young prisoner’s death on the landing at night and further promote dignity and respect.

The Governor has agreed to this recommendation and set out the following action:

“Screens are available in the establishment and will form part of the contingency plan as an aide to use these if the need arises.”