

**Investigation into the death of a man at HMP Whitemoor
in July 2007**

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

July 2009

This is the report of an investigation into the circumstances surrounding the death by hanging of the man at HMP Whitemoor. Late that evening, the man was found in his cell, sitting on the floor between the window and his table. He had wound a piece of material around his neck and attached it to a bracket on his pin board. The man had suffered some years of psychological and behavioural difficulties, and had a history of regular self harming.

I offer sincere condolences to the man's family and those affected by his death. As with so many of my investigations, this report tells a sad story.

The investigation was undertaken by my investigators. In addition, a clinical reviewer from Cambridgeshire PCT carried out by an independent clinical reviewer of the care received by the man at Whitemoor and I thank her for her assistance. My senior family liaison officer, was my office's principal contact with the man's family. I am grateful for the cooperation the investigators received from the Governor and staff at Whitemoor.

The man had been resident in the Close Supervision Centre (CSC) at Whitemoor since February 2007. CSCs are designed to remove the most seriously disturbed and disruptive prisoners from main prison wings and locate them in small, highly supervised units. Prisoners located in CSCs may have a range of complex psychological and security needs. The management of someone who regularly self harms, as the man did, presents an enormous challenge. Difficult decisions have to be made about the level of risk posed by each prisoner to themselves and to others. On the whole, I judge that staff did their utmost to meet those challenges in a rigorous and caring fashion. I make five recommendations and endorse a recommendation made by the clinical reviewer.

During the investigation it became clear that the man had been close to some of Whitemoor's staff members who worked with him. My investigator noted that all but one of those staff were away from work at the time of his death, and she conveyed that information to the Governor as part of her initial findings. Within this report, I report and commend the actions of one member of staff who tried to minimise the effect on the man's state of mind of the absence of those staff.

I must apologise to the man's family in particular for the delay in issuing this report. This was largely due to circumstances beyond my control in connection with staff illness.

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

Stephen Shaw CBE
Prisons and Probation Ombudsman

July 2009

CONTENTS

Summary	4
The investigation process	7
HMP Whitemoor	9
Key events	11
Events prior to the man's death	15
Issues considered during the investigation:	22
- Self harm and risk	
- The management of ACCT	
- Unlocking the cell	
- Administering first aid	
- Summoning emergency services	
- Clinical care	
- The return of Jonathan's property after his death	
Clinical care	27
Conclusion	28
Recommendations	30

SUMMARY

The man died at HMP Whitemoor, apparently by his own hand, July 2007. He had a history of instability and psychological problems, and had self harmed on numerous occasions during his sentence. He was awaiting the result of an assessment of his suitability for transfer to Rampton Special Hospital, and had become concerned about the length of time that this was taking.

In 1999, he had been charged and remanded in custody. During his time on remand he was referred to Rampton but he was thought to be too young for an adult high security psychiatric hospital. He was sent to HMYOI Glen Parva but assaulted a nurse in the healthcare centre and further charged with wounding with intent to cause serious harm. These offences resulted in him receiving two life sentences.

The man did not find it easy to settle to prison life and several instances of self harming by cutting and using ligatures were recorded. He provided various reasons for his self harm but gave staff no serious cause to be concerned that he would take his life. He was assessed as having mental health difficulties and posing a risk to himself and others. He was sent to HMP Long Lartin in July 2002. Some weeks later, he and an accomplice took another prisoner hostage in a violent incident lasting several hours. He was subsequently to receive a third life sentence for this offence.

Following the hostage-taking, he was assessed as being suitable for location in a Close Supervision Centre (CSC) when a place became available. He was thus transferred to HMP Full Sutton where there were further instances of self harm through cutting and use of ligatures. He was seen regularly and treated by psychiatrists and staff in the mental health team (MHT), and on several occasions was managed under the prison's self harm and suicide monitoring procedures. Towards the end of 2003, he said he wished to address his problems by being transferred to one of the Special Hospitals at either Rampton or Broadmoor, and the following February he was accepted for the Dangerous and Severe Personality Disorder (DSPD) unit at Rampton. He was transferred to Rampton in April 2004.

The man failed to participate fully in Rampton's regime, and he was returned to prison in October 2004 following an act of violence against a member of staff. He was said to be unhappy about returning to the prison system but was resigned to it. Nevertheless, almost immediately after arriving at the CSC in HMP Woodhill, he expressed an interest in being returned to Rampton. Psychiatric assessments from Rampton indicated he fitted the criteria for borderline paranoid and anti-social personality disorders, and placed him above the national threshold for psychopathy. Although psychiatrists thought he would benefit from therapeutic intervention, at that time he was considered to be unsafe in a hospital setting.

During the man's time at Woodhill, he self harmed several times by various means and on occasion refused food. It was also noted that self harm increased in response to anxiety, and in particular his concern that he might not be able to return to Rampton. In June 2006, he was refused a place at Rampton and expressed a wish to go to HMP Belmarsh. He was transferred there in July 2006. In February

2007, in what was seen as a progressive move, He was moved to the CSC unit at Whitemoor.

The unit at Whitemoor is the last stage of the CSC system. It is small, with a high staff to prisoner ratio, and has a more therapeutic regime. Prisoners leaving Whitemoor typically move to a mainstream prison setting or to a DSPD unit. However, it appears that the man did not view the move to Whitemoor as a progression. On the contrary, he was said to be frustrated at remaining in the CSC system and to feel he was stagnating. Although he was seen to settle well and participated in a number of activities, he was determined to regain a place at Rampton and a further referral was made. However, his threats to self harm and refuse food continued. In April 2007, he self harmed by cutting himself and the injuries were serious enough for an Assessment, Care in Custody and Teamwork (ACCT) plan to be opened. He threatened to go on hunger strike as he wanted the ACCT closed, but reported minor incidents and thoughts of self harm to staff, and spoke freely to them about his feelings. Consequently the ACCT document was not closed.

The man told a member of staff he had cut his arm and handed over a razor blade. A little later he cut his wrist although the injury was not serious. It was noted that he had not been taking his medication and was not cooperating with the regime. It was also noted that he had asked to go to his cell, and this was seen as a trigger factor for self harm. Consequently, another ACCT plan was opened. When he spoke with staff, he said he was anxious about the Rampton assessment, and over the following days his mood was low and he was abusive.

In July, the man again asked to go to his cell but later emerged and spent the afternoon outdoors with other prisoners. During the afternoon, he was unlocked to attend an ACCT review but he refused. The review went ahead without him and noted that he appeared unhappy. The man was aware that the Rampton admissions panel was due to sit that week and he expected to hear imminently about his future. He appears to have invested a lot of hope in returning to Rampton. He spent the evening with two other prisoners and was said to be in a jovial mood.

At the time when a check was made, an officer saw the man sitting on the floor between the window and the table. He had a piece of material around his neck attached to a lower bracket of the pin board. The officer immediately alerted colleagues who cut the ligature and attempted CPR until paramedics arrived. Paramedics pronounced that death had occurred.

The man's parents have told my office that they had last seen him ten days before he died, and had spoken to him on the telephone the day before his death. They said that the presence of prison staff during visits made conversation difficult. Nevertheless, they had detected nothing different in his attitude, and said his death came as a complete shock to them. His parents are convinced that he would have left a note if he had intended to kill himself.

It is clear that the man was both vulnerable and difficult to manage. Nevertheless, those charged with his care were required to do their utmost to ensure his safety. On the whole, I find that they discharged their responsibilities with rigour and

compassion. I note that the man found it easier to talk to female staff, and that all but one of the staff to whom he felt closest were on leave during the week he died.

I have some concerns about the management of the ACCT process and the procedure for summoning an ambulance. I have also considered the parents' concerns about their son's property.

I make five recommendations and endorse a recommendation made by the clinical reviewer.

THE INVESTIGATION PROCESS

1. When I was notified of the man's death I allocated the investigation to my investigators in July 2007. My investigator visited Whitemoor to begin her work. She met the Governor, a representative from the Independent Monitoring Board (IMB), and a representative from the Prison Officers' Association (POA). She visited F wing where the man had been located and issued notices of the investigation. My investigator was provided with copies of his prison record, Inmate Medical Record (IMR), various other significant documents, and the incident reports prepared after his death.
2. The notices issued to staff and prisoners invited anyone who considered they had relevant information to make themselves known. My investigators interviewed staff at Whitemoor in September. They spoke to a number of prison officers, two members of the Mental Health In-Reach team, and to a consultant clinical and forensic psychologist and a visiting consultant forensic psychiatrist who had assessed the man and been involved in his care. In November 2007, the investigators visited Woodhill where they interviewed a prisoner who had been at Whitemoor with the man until a few days before he died. While at Woodhill they also interviewed, the chair of the Close Supervision Centre Selection Committee (CSCSC).
3. My investigators visited Rampton in December and interviewed, consultant forensic psychiatrist. One of my investigators' interviewed two more people by telephone.
4. A clinical review of the man's care was commissioned from Cambridgeshire PCT and was undertaken by the clinical reviewer. A copy of her review is annexed to this report.
5. My senior family liaison officer, contacted the man's parents and visited them with my investigator to explain the investigation process and offer them the opportunity to be involved. The man's parents were concerned that they had not received all of his property from Whitemoor. They also had concerns about his treatment in prison, and his access to courses and treatment that would have enabled him to progress through the system. The man's parents said that their liaison with the prison since the man's death had been good on the whole. However, they were unhappy about one occasion when they telephoned with a query about his property. They had asked to speak to a person, whose name they had been given as a contact, only to be told that he no longer worked at the prison. The man's parents felt they should have been informed of his move and given the name of a replacement contact. However, the Prison Service has confirmed that he remained at the prison and is still there. It is not known how or why the man's parents were misinformed. Nevertheless, when the man's parents visited Whitemoor, they felt there was a good atmosphere and that staff had a good attitude.
6. I have said in my foreword that this report was unavoidably delayed by staff sickness and other circumstances beyond my control. To avoid further delay, I asked one of my former Assistant Ombudsmen to prepare the draft report on

my behalf. She is an experienced investigator who previously managed one of my investigation teams, and was given confidential access to all the information obtained by the investigators.

HMP WHITEMOOR

7. Whitemoor is one of eight high security prisons for category A and B male prisoners. The man was classified as Category A, the highest risk. Whitemoor holds some of the most serious offenders in the prison system. It has an operational capacity of 500 prisoners, most of them held in four main residential wings with individual cells.
8. The last full announced inspection by the HM Chief Inspector of Prisons, took place in February 2006. At that time the Chief Inspector found that management of the specialist units in the prison was extremely good. She found that the atmosphere in those units was relaxed, and there was a great deal of staff-prisoner interaction. An unannounced full follow-up inspection in April 2008 found that interactions with prisoners in specialist areas and the CSC remained generally good. This was in contrast with other areas of the prison where prisoner-staff relationships were found to have deteriorated and were said to be “mostly distant and distrustful”.
9. The death of the man was one of three apparently self-inflicted deaths at Whitemoor in 2007. I have not identified any shared themes or concerns.

The Close Supervision Centre

10. The Prison Service’s system of CSCs for the management of disruptive prisoners was introduced in 1998 to replace a former network of Special Units. The original statement of purpose in the Operating Standards for CSCs stated that the units would operate as part of a “national management strategy which aims to secure the return of problematic or disruptive prisoners to a settled and acceptable pattern of institutional behaviour.” The CSC system has four main functions:
 - to remove the most seriously disruptive prisoners from mainstream prisons
 - to contain highly dangerous or disruptive individuals in small, highly supervised units with safety for staff and prisoners
 - to provide opportunity for individuals to address their antisocial, disruptive behaviour in a controlled environment
 - to stabilise behaviour and prepare individuals for a successful return to the mainstream or long-term containment in designated units.
11. CSCs differ from DSPD Units in that they are designed to manage prisoners who are considered to present a danger to themselves or others but do not necessarily have a personality disorder. Nevertheless, CSC prisoners usually have a range of complex psychological, psychiatric and security needs. Prisoners referred to CSCs have displayed a variety of disruptive behaviours and are likely to have exhibited violence to others within the prison system. They are also likely to have had several transfers around the prison estate.
12. The CSC at Whitemoor opened in 2004 to house prisoners thought to be disruptive and violent. Staff in the unit are experienced, and all volunteered for their posts. Many of them have worked previously in DSPDs or

segregation units. A forensic psychologist takes part in the selection process to ensure that those who staff the unit have the necessary skills and emotional capacity to do so. A community psychiatric nurse (CPN) is based on the unit full time, and a psychologist attends twice weekly. Prisoners on the unit are seen by the psychologist either weekly or fortnightly according to need, and the unit functions as a multi-disciplinary team.

13. There are members of prison staff on duty during the day and early evening. Prisoners are engaged in activities and games until 7.00pm when they are locked up. The night officer, a regular member of CSC staff, begins duty at 9.00pm and is joined by an Operational Support Grade (OSG). These two staff remain on duty throughout the night.
14. Each prisoner in the CSC has two allocated personal officers with the aim that one of them will usually be on duty. Personal officers are expected to get to know the prisoners as well as they can. They attempt to familiarise themselves with body language, facial expressions and other behaviours in order to understand “what makes them tick”. Staff must complete history sheets three times each day and there are daily briefing sessions.
15. A key feature of the unit’s work is the process of fortnightly review meetings for each prisoner housed there. The meetings are attended by representatives of all key areas such as discipline, education and psychology. Each prisoner receives an assessment from one of his personal officers before the meeting and is invited to comment. Objectives are reviewed and may be amended as necessary. A record is made of each meeting.

KEY EVENTS

16. The man was sentenced to life imprisonment. The victim had not been known to him previously and appeared to have been chosen at random. While on remand for that offence, the man assaulted a healthcare worker with a weapon, apparently in an escape attempt. This resulted in a second life sentence. Although he had been referred to Rampton Special Hospital, the man was considered to be too young for placement there and was kept in the prison system.
17. There were four recorded instances of the man self harming with nooses and, on one occasion, by swallowing a battery. At HMP Long Lartin in September 2002, the man and another prisoner took a third prisoner hostage. Over a period of some eight hours, the man inflicted a number of knife wounds to the victim's face. He subsequently wrote a letter describing what he would do if he could take a member of staff hostage. The man gave different accounts of the reason for his actions. He told some staff his behaviour had been designed to force a move to Rampton, but subsequently he talked about the feelings of power and control that hostage taking gave him. His behaviour resulted in him being assessed as suitable for placement within the CSC system.
18. He was thus transferred to Full Sutton where, during 2003, his medical records recorded eight attempts at self harm by cutting, making a noose and attempting an overdose. The man was seen regularly by psychiatrists and staff in the Mental Health In-Reach Team (MHIRT), and managed under the Prison Service's self harm and suicide procedures. In March 2003, a self harm form F2052SH (the forerunner of ACCT) was opened. The man told doctors and staff variously that he did not want to kill himself but did these things for fun or sexual gratification, and from a desire to see blood. On occasions he claimed to be the son of Satan and said he could not die. However, he clearly recognised that he had problems and told staff he wanted to address them by being transferred to Rampton or Broadmoor.
19. The man was referred to Rampton, and in 2004 the hospital agreed to accept him when a bed became available in the DSPD. He was impatient for a place, and the following month he told the prison psychiatrist that he was going to hang himself. He said he was not suicidal but thought staff were lying to him about going to Rampton. In 2004, he was transferred to the DSPD unit at Rampton under section 47/49 of the Mental Health Act 1983 (the section which covers transfer from prison to a secure hospital).
20. Unfortunately, despite his expressed desire to address his difficulties, the man became disruptive at Rampton. There was concern about his commitment to engage with treatment programmes and, in particular, his interaction with another patient. There were several disruptive incidents that culminated in a violent attack on a nurse who was injured when he threw a chair. The nursing team dealing with the man at Rampton broadly felt that they could continue to manage him. However, the operational manager believed that it was not proper for nursing staff to deal with his violence. As a consequence, the man

was returned to the prison system and transferred to the CSC at HMP Woodhill in 2004.

21. Staff at Woodhill contacted Rampton to ascertain what medication the man had been prescribed to ensure that the correct medicines would be immediately available to him. The man was variously prescribed diazepam to relieve anxiety, clomipramine to treat depression and phobias, and lorazepam to help produce calmness and relaxation. From time to time he was also given chlorpromazine. This is a drug often used to deal with episodes of sudden dangerous behaviour although it is not clear in what context it was prescribed for him.
22. At the time of the transfer, the forensic nurse specialist in the mental health team at Woodhill, recorded that Rampton had said the man's presentation would benefit from therapeutic intervention but that he was not considered to be safe in a hospital setting. Although Rampton agreed to maintain contact to reassess whether he could return there at a later date, they said he would need to demonstrate that he could control some of his behaviour before treatment would be possible.
23. The man was charged with attempted murder for the attack on the nurse at Rampton but it was more than a year before the case went to court. During that time it was clear that the man had great difficulty in coping with the pressures of waiting for assessments and court appearances. The forensic nurse specialist recorded that he reacted by engaging in disruptive behaviour such as self harming and threatening to take hostages. The man's prison clinical record indicated that over the next few months he refused food, swallowed batteries, and used ligatures. In January 2005, a consultant forensic psychiatrist suggested that the man's behaviour was linked to his desire to return to Rampton. He believed that the man thought Rampton would see no reason to take him back if he behaved himself.
24. In 2005, Woodhill again referred the man to Rampton as there were concerns about a possible psychotic illness. Rampton said he represented a "grave and immediate danger" to others and should be contained in a high security establishment. They gave no indication of when or indeed if they would re-admit him and it was decided he should remain in a CSC. In July of the same year, when he was seen by a doctor from Rampton, it was noted that he had increased his self harm to emphasise that he should return there. The man said the system would "have a body on its hands" if he was not returned. Shortly after this meeting, he cut himself and threatened to hang himself.
25. An ACCT plan (Assessment, Care in Custody and Teamwork – the Prison Service's process for monitoring and supporting those who are thought to be at risk of suicide or self-harm) was opened on July, and the man was more closely monitored. In July, he told an officer that, if his application to return to Rampton was turned down, he would refuse food and liquids. Later that day the man was told that he would not yet be returning to Rampton. Shortly afterwards, he called a member of staff having cut his face. The same evening he threatened to hang himself and spoke of his long term plan to

starve himself to death. He said he was looking forward to his parents' visit the following day as it would be the last time he saw them. The man was observed at short, regular intervals throughout the night.

26. The man continued to refuse food until the morning of 15 August although he took fluids and his medication. He made no further attempts to self harm and his mood appeared to improve. In August, he accepted breakfast, had good interaction with staff, and was in good spirits. As a consequence, the ACCT was closed.
27. Thereafter, a pattern emerged of the man self harming or threatening self harm when things were not going well for him and, in particular, when he was running out of tobacco. In the following months no fewer than nine ACCT plans were opened, although most were closed after a few days when he became calmer. He variously told staff that he cut himself either to manipulate the system, to relieve tension, or when he was bored. He said he was frustrated at remaining in the CSC and wanted to be de-selected and returned to Rampton. Staff noted that he tended to inform them "straight away" after he had harmed himself.
28. In May 2006, an ACCT plan was opened after the man told staff he had taken an overdose of olanzapine (an anti-psychotic drug used to help overcome feelings of wanting to be alone) and eaten 16 nicotine patches. He said he could not sleep, and had been thinking about taking his life for about an hour before ingesting the tablets and patches. He told staff it had been a genuine attempt to take his life but he also said he was happy to be alive. Over the following days he was observed constantly and appeared in good spirits. He was eating, taking exercise and interacting normally. In May, he told staff he was feeling fine and the ACCT was closed.
29. Also in May 2006, the senior forensic nurse specialist in the MHT asked Rampton to reconsider the man for re-admission for treatment. Unfortunately, the unit where he had been placed previously was closed to residents following a number of incidents. In June, Rampton declined to accept him at that time. His disappointment was characterised by further incidents of self harm.
30. On 29 June, the man told staff he had forgotten to order any tobacco and had run out. He felt that staff were unhelpful and later said he had swallowed a razor blade. He described the act as a "gesture" to demonstrate his frustration and prompt the acquisition of tobacco. An ACCT plan was opened. He felt he was suffering nicotine withdrawal. He threatened to regurgitate the razor blade and use it to cut himself if he remained without tobacco. Later that evening he cut his arm and leg.
31. Over the next few days, the man regained his good spirits, and by July he was asking for the ACCT to be closed. His request was refused as the consensus was that he continued to pose a risk to himself and needed ongoing intensive support. The following day, he widened the cut on his leg to the extent that it required stitches. His mood continued to fluctuate from good to bad, and on 9

July he again aggravated the leg wound by removing the stitches. There were no further incidents and his mood continued to improve until the ACCT was closed on 17 July.

32. During this period, the man became more insistent that he should be deselected from the CSC system. He asked to be transferred to HMP Belmarsh for this to happen. Towards the end of July, he began refusing his medication and continued to do so until he was transferred to Belmarsh at the beginning of August to facilitate visits and allow him a respite from CSC. The man was located in the segregation unit at Belmarsh.
33. The man continued to refuse medication and, in August 2006, a member of the MHT at Belmarsh noted in the man's prison clinical record that he was reluctant to accept responsibility for himself and believed it was the system that needed to change. The man was said to be unable to accept that he should "switch focus to challenging self". Nevertheless, he initially appeared more relaxed at Belmarsh although he was said to be negative about the possibility of ever leaving the CSC system. Subsequently, he returned to Woodhill and, after a period of more positive behaviour, was transferred to Whitemoor's CSC unit in February 2007.

EVENTS PRIOR TO THE MAN'S DEATH

34. The man was received into the CSC unit at Whitemoor in February 2007. He had five days supply of medication. He was to remain in the CSC unit until his death. His last months were characterised by rapid mood swings and periods of stability interspersed with episodes of anxiety and self harm. Weekly progress reports indicate that he initially engaged well with staff and in particular with officers, who were his assigned personal officers. He would approach one of them when he wanted to talk and they got to know him quite well. On the whole, he appeared to relate better to female officers with one male officer being the exception.
35. The man participated in activities including education, and met all his targets. He also met with a psychologist and arranged to have further sessions. The man also had regular contact with various members of the MHIRT including daily contact with the senior nurse practitioner (SNP). There was a problem over some of the man's property that had not arrived at Whitemoor with him but at first he coped with his frustration well. However, as the problem persisted, he became more agitated and threatened to refuse food if the property was not returned.
36. In March, the man was recorded as having had an "outburst" in his cell over his property. He smashed a cup against his cell wall and told staff that he wanted to go to the segregation unit to "chill out". Although an officer talked through the situation and helped him calm down, he remained negative in his view of staff on the unit. The following day, staff found a broken glass saucepan lid on the floor of the man's cell. He said he had intended to use it to cut himself but it was "the wrong type of glass". He explained to staff that smashing his things was a coping mechanism he had learned in Rampton.
37. The man's demeanour and behaviour continued to fluctuate rapidly. In March, he had his first meeting with a consultant clinical and forensic psychologist, and agreed initial goals to work on. Two days later, he met a forensic psychiatrist, for a review meeting. The man told the forensic psychiatrist about keeping razors and cutting himself. The forensic psychiatrist noted that the man had not been prescribed antidepressant medication since November 2006 but he wanted to resume. The man left the interview after being refused the medication that he requested. He was abusive and swore at the forensic psychiatrist. In contrast, the daily wing monitoring reports indicate that on the same day the man participated positively in a craft group and interacted well with staff. The SNP recorded that the man threatened to harm himself when he did not get what he wanted. Subsequently, the forensic psychiatrist re-referred him to Rampton for further assessment.
38. Records indicate that by 2 April the man was refusing medication, saying it was useless. He had also refused food on occasion and was seen to be losing weight. After lock up on the evening of 4 April, he self harmed by cutting his left arm and immediately called staff to see what he had done. The injuries were considered to be more serious than on the previous occasion of

self harm and an ACCT plan was opened. He again said that cutting was a mechanism to cope with stress. Despite this, on 10 April in his weekly written submissions, he said he was settled, relaxed in his environment and eager to start positive steps towards progressing to a normal location.

39. The ACCT remained open, and during April the man appeared more settled. He engaged well with staff despite making some disparaging comments when he thought he was out of earshot. The man discussed problems with staff during his exercise periods, and had several long conversations with one of the personal officer in which he shared feelings and frustrations appropriately. In interview, the personal officer said the man had told her that he was afraid of the future as he did not know why he did what he did to other people.
40. During the day on 7 May, the man appeared to be in good spirits, talking with staff and other prisoners. In the afternoon he played chess with an officer and seemed cheerful. However, that evening he refused his evening meal, and handed a razor to a Senior Officer, indicating he felt unhappy. Although he later talked with staff, he declined to give details of what was troubling him but said he was not going to “do anything”. The man’s mood subsequently improved but, at a review on 9 May, it was decided that the ACCT should remain open. The man said he agreed with this decision as he was struggling with several issues to do with his past.
41. On 3 May, consultant clinical and forensic psychologist, had introduced the man to the ‘Keeping Safe Package’ and he agreed to work with her on it. The work began on 10 May when the consultant clinical and forensic psychologist noted that the man engaged well. She also noted that he found it difficult to identify that he had coped with anything positively, although he acknowledged that he had avoided any serious self harm.
42. When the man met with the forensic psychologist, in May, he was tearful and angry that he remained in the CSC. The man had a good visit from his parents on 13 May, but two days later he became angry after a visit to the doctor and smashed a cup when he returned to his cell. Later that day, he was involved in an incident with another prisoner that led to him being placed on a disciplinary report. Later still, he told staff that he had swallowed glass from his watch face and the staff consulted a doctor. The doctor did not consider that the incident was life threatening and advised what action should be taken. In the evening, when he asked to speak with the Samaritans, an officer noticed that he had cuts to his face and leg. Before using the Samaritans telephone, he handed in a blade.
43. The man spoke with the Samaritans again the following day and had sessions in the quiet room with officers whom he trusted. The daily record sheet noted that he remained negative to staff and the CSC system as his aim was to be deselected and placed in a DSPD unit. On 17 May, he attended an adjudication for disobeying a lawful order two days earlier. (Adjudications are disciplinary hearings conducted by governors or independent adjudicators, according to the seriousness of the alleged offences.) The man appeared before a governor who put the charge to him and heard evidence from an

officer about the circumstances in which the alleged offence occurred. He pleaded guilty and said he recognised he had been stupid. The man's was six days loss of association and 50 per cent loss of earnings. It was noted that he took the punishment well and seemed in good spirits. However, when he was seen later in the day by the MHIR team, he was said to be very negative about himself and the future.

44. The man remained negative over the next two days. He was uncommunicative and described by an officer as "surly". On the morning of 20 May, he handed a towelling ligature to one of the officers and later handed the officer a blade. He was reported to be depressed and lonely, and the frequency of observations was increased. He also showed the officer poetry he had written describing pain and loneliness. Later in the week, the man was angry when he discovered that what he thought were confidences had been shared and recorded in the weekly review. He said he felt he could not trust staff.
45. The daily monitoring sheet for 24 May indicates that the man was settled and he was said to have had a very good day. However, in his session with the consultant clinical and forensic psychiatrist that day, he said he was feeling less than okay. He said he was always in a "bad phase" although at times this became a "very bad phase". He said he had self harmed and decided to kill himself by ingesting the glass from his watch. He told the consultant clinical and forensic psychiatrist that he had not disclosed his intention to her as she would be obliged to report it. He believed the officers were laughing at him and saw him as worthless. The man said his thoughts and feelings raced around in his head and he self harmed to control them. On 25 May, the SNP, noted that she had discussed the man with a doctor who had advised that the man prescribed risperidone (an anti-psychotic drug) could be a partial cause of his low mood. The SNP said the doctor advised changing the risperidone if she thought the man was depressed. Although the SNP did not consider that he was showing any symptoms of depression, the risperidone was reduced and an SSRI started. (SSRIs - selective serotonin re-uptake inhibitors - are a group of medicines used sometimes to treat symptoms of depression or obsessive compulsive disorders.)
46. A consultant forensic psychiatrist, a psychologist and a clinical nurse specialist from Rampton arranged to visit the man on 1 June as part of their ongoing assessment for his return. Each of the assessors was required to write a report to be considered by members of the admissions panel whose responsibility it would have been to make the final decision about the man's return. A day earlier (31 May), he refused his medication and made a superficial cut to his hand. He said he had done it "for a laugh". However, later he confided to one of the personal officer how anxious he was about the following day's interview and asked her to accompany him. There was further indication of the extent of the man's anxiety later when he threatened to cut himself again if he was not given the medication he had earlier refused.

47. The daily record sheets indicate that the interview with Rampton staff was difficult for the man. He was said to have been very honest, but distressed when speaking about his childhood experiences and offending behaviour. His anxiety continued after the interview when he was quite negative. My investigators spoke to the three members of the assessment team from Rampton. They discovered that the consultant forensic psychiatrist had told him that his chances of being readmitted to Rampton were "slim". The psychologist and the clinical nurse specialist had decided to recommend the man for readmittance to Rampton. They did not tell him because the admissions panel does not have to accept recommendations. At lunchtime on the same day, he handed a ligature to staff. This anxiety went on over the next few days, and on 4 June he than cut himself superficially. On the same day, in a session with the mental health in-reach nurse, he said that he had attempted suicide but the wire had snapped as it was not strong enough. When the nurse tried to ascertain if he still felt suicidal, he refused to answer and walked out of the session. The nurse told officers and arranged for his cell to be searched. A thin strand of wire was found in his rubbish bag but the nurse said she could not tell if it had been used as a noose. Later, he said that he did not feel suicidal but was unsettled after the Rampton assessment. His ACCT was reviewed and the frequency of his observations was increased.
48. The man's scheduled session with the consultant clinical forensic psychiatrist on 7 June did not go well. The consultant clinical forensic psychiatrist, recorded that he did not engage with her and had destroyed his homework. She said he was angry but had told her that he had been feeling "on top of his game" since tying a ligature a few days earlier. In her opinion, he was rejecting her in anticipation of the rejection he expected from Rampton. The SNP also recorded that the man's mood had changed and he did not participate in the group on the wing. After a second interview with staff from Rampton the following day, he was said to be upbeat and positive, thinking he would soon be transferred. On that basis, he decided to stop smoking as Rampton had a no smoking policy.
49. His positive mood did not last, and by 19 June he was refusing food and threatening to go on hunger strike. When he talked to staff he raised concerns about Rampton and about wanting the ACCT closed. He was told that Rampton staff would visit him once more on 29 June, and he asked one of the personal officers to accompany him again. Three days later, he asked to be placed in the segregation unit as he was anxious. He spent time in private with staff and appeared calmer. Again his anxiety increased as the Rampton visit drew nearer and was exhibited in negative and abusive behaviour to staff.
50. On 21 June, the forensic psychiatrist saw him. She noted that he had seen doctors from Rampton and expected to hear the result of the assessment in a few weeks. The forensic psychiatrist recorded that the man had been fine apart from one or two flashes of temper. She noted it appeared that the doctor had changed the man's medication but had not recorded any consultation with him. Consequently, she did not know if the man had seen

the doctor or whether the change had come about after the conversation between the SNP and the doctor.

51. The man was positive after the Rampton interview, feeling it had gone well, but he soon became anxious and emphasised to staff how important the move was to him. The wing daily record sheet indicates that one of the personal officers informed him that a meeting would be held on 24 July to decide if Rampton would accept him. The man's good mood did not last, and over the next three days he made cuts to his arms and shoulders. An unscheduled review meeting was held and the personal officer discussed various coping mechanisms with him. He said he felt that his mood and self harming stemmed from his anxiety over Rampton. The man spoke with other officers about his worries.
52. On 3 July, SNP recorded that the man had told her that he was unhappy and wanted to change his body. She commented that he had something new to explore each time she saw him, and that it was difficult to pinpoint just what was making him unhappy. The SNP wrote that the man was willing to engage with staff although there was not "much depth" to the contact as he then became dissatisfied if he was not told exactly what he wanted to hear. On 5 July, he told the SNP that he no longer wished to engage with clinical psychology as he needed to concentrate on his move to Rampton. This decision appears to have lifted his mood, and over the next few days he remained positive. At the monthly CSC review meeting on 11 July, it was noted that he felt the CSC system had nothing to offer him. Staff explained that, even if Rampton accepted him, he would have to work on improving his behaviour in the CSC before any move could take place. The ACCT plan was closed.
53. However, by 15 July the man's mood and behaviour had deteriorated and he made negative comments at every opportunity. The Senior Officer opened a separate log to record how the man's behaviour was affecting other prisoners. When his parents visited him that day, the man told them of a bad atmosphere on the unit although it appears that he was thought at least partially responsible for it. Later in the afternoon, one of the personal officers found that he had cut his arm and he handed her a blade. However, within a few minutes he made further cuts to his wrist and the officer asked for another ACCT plan to be opened.
54. When an ACCT plan was opened the following day (16 July), trigger points were noted as being when the man was not participating with the regime, not taking his medication, and asking to be locked up. The man said he had cut himself because of his anxiety about Rampton, and that he had used self harm as a coping mechanism for many years. However, he also said that self harm no longer helped him, and he needed to learn new strategies. He had a session with the forensic psychologist, in which he told her there was nothing left for him and he wanted to die. The forensic psychologist said in interview that it was not unusual for the man to make such statements, and so it is perhaps not surprising that she gave it no more weight on this occasion. The forensic psychologist also said the man's mood fluctuated but, in her opinion it

became more negative the longer he was on the unit. With hindsight, she thought he could have been at a slightly lower level in the days before his death.

55. On Friday 20 July, the man reported being very distressed and feeling no hope. He agreed to speak with SNP, and said he felt he might self harm over the weekend. He was prescribed medication to help him sleep over the weekend, and told that if he self harmed his observations would have to be increased. In her account of their meeting, the SNP noted that he had been clear he did not want to kill himself and said he would find any increase of observations intrusive. He agreed to speak to staff if he felt distressed.
56. On 24 July, the man asked to be locked in his cell. The daily record indicates he spoke with the forensic psychologist although my investigation found no record of the conversation. The forensic psychologist recalled him asking to see her on that day and made notes of the meeting. She said he told her he was feeling “very low and quite desperate”. But she also said he had been like this in previous meetings. They talked about the things he could do to manage his time and his mood until their scheduled meeting the following week. The forensic psychologist felt it was not unusual for him to make such statements. Nevertheless, at the afternoon briefing, the forensic psychologist told officers that although the man often said he was feeling pretty desperate, they needed to be sure they did not “desensitise” his distress. The record states that he spent the afternoon outside with other prisoners but remained uncommunicative and did not speak with staff. The following afternoon, he was unlocked to attend an ACCT review as part of the quarterly CSC review but he refused to attend. The review noted that he felt low and had spoken with the forensic psychologist about his feelings. It was also recorded that his negativity had decreased, and the review commended his participation in wing and garden activities. The daily monitoring record notes that he appeared to be “in a jovial mood this evening” and was associating with other prisoners.
57. The man was subject to hourly observations. When one of the officers first checked on him that evening, he was watching television and said he was okay. The officer checked again at 9.27pm. The man was lying on his bed and looked at her, although neither of them spoke. The man would have been aware that the officer would return at some time within the hour. At 10.16pm, the officer checked him again and saw him sitting on the floor between the window and his table with a piece of material around his neck. The officer told my investigators that, although she called it a noose, the material was just “a very very loose piece” (she thought it was probably three times the size of the man’s head) that had been tied to the picture board and went under his neck. She thought that he had leaned forward and “was really just resting his chin on it”. The officer was certain that the noose was not tied round his neck, “it was just a loose piece of material”. She was certain it was not a towel, but she could not identify what material had been used.
58. In interview, the officer said that for the first few seconds as she tried to get a response from the man she wondered if he was pretending. But when he did not respond she immediately used the red telephone to contact the control

room. The Night Orderly Officer arrived a minute or so later, having sent the Assist Orderly Officer to collect a nurse. The Night Orderly Officer and the officer entered the cell together and the Night Orderly Officer supported the man while the officer used her 'fish' knife to cut the material from the man's neck. (These knives are specially designed for use in such circumstances and, following recommendations in some of my earlier reports, are now standard issue to all frontline staff. It is standard practice to cut 'nooses' however loose they are, rather than try to remove them) Night Orderly Officer and the officer moved the table to make more room to place him on the floor. In interview, both said that, as the tension was released from the material, the man made a moaning noise that made them think he was alive.

59. The nurse on scene recorded that he received a call from the Control Room at approximately 10.15pm and was escorted to the cell where the man was on the floor. In interview, he said there were no signs of life and that the noise heard could have been the release of air. He said the man's skin was cold and clammy, his pupils fixed and dilated. The nurse informed the Night Orderly Officer that paramedics were required and immediately started cardio pulmonary resuscitation (CPR), continuing until the paramedics arrived. The officer said that the nurse was very efficient. He used oxygen, and told her exactly where various instruments were located in his bag. The officer said she handed him what he needed but the nurse continued CPR alone until the paramedics arrived. Although the officer offered to take over compressions if the nurse was tired, he did not take up her offer and she thought he knew exactly what he was doing.
60. According to the control room log sheet, an ambulance was called at 10.22pm and arrived at 10.34pm, reaching the wing by 10.37pm. The paramedics pronounced the man dead at 10.41pm. The prison's contingency plans were activated and liaison officers were appointed to call on the man's parents to inform them in person of his passing.

ISSUES CONSIDERED DURING THE INVESTIGATION

Self harm and risk

61. The man had a history of self harm and behavioural difficulties from an early age. There were numerous incidents of self harm recorded throughout his time in custody and on occasions he threatened to kill himself. He also assaulted staff, took another prisoner hostage, and threatened to take other hostages on other occasions. It is clear that he remained unhappy and unsettled within the prison estate and focussed all his attention upon returning to a DSPD unit, with a preference for Rampton. Sometimes it was thought that he could have exaggerated his behaviour to make his condition seem worse as he worried that Rampton would not consider him if he was stable.
62. The man had several psychiatric assessments but was not diagnosed as suffering with a treatable mental illness. The most recent psychiatric report I have seen was prepared by a consultant forensic psychiatrist from Rampton, in May 2005. The psychiatrist found that the man had a severe personality disturbance but was not suffering from a mental illness or from a depressive disorder. This diagnosis was repeated in the psychiatric progress report dated 8 June 2007 that stated the man suffered from “a many faceted personality disorder which is well documented in all of his assessments”.
63. The Offender Assessment System (OASys) forms seen by my investigators indicate that the man was considered to present a high risk of harm to himself and some risk to others. The most recent form, completed in April 2007, suggested that self harm was a risk that needed to be taken very seriously. The report also suggested that the risks could be reduced if the man continued to work with the psychologist and the MHIR team. ACCT care plans indicate that the team did their utmost to identify risk reducing strategies, and made themselves available to him. The team encouraged him to address his concerns, but their efforts could only be successful when he was willing to work with them. Towards the end of his life, he became completely focussed on achieving a move to Rampton, and was less and less willing to work with staff at Whitemoor.
64. From all of the available information, it is clear that staff were alert to the risk he posed to himself. The Senior Officer, who spoke with the man on a number of occasions, told my investigators that many of the incidents of self harm appeared to be minor – more like scratches than cuts. However, he also said that, if he had them in his cell, the man would readily hand over blades or nooses when asked. Two other officers also said that many of his self inflicted injuries were minor and seen as a means of gaining attention. Despite this, prison staff and those in the MHIRT who had daily contact with him ensured the correct procedures were followed by opening ACCT plans. Staff were aware that the increased observations triggered by such plans in themselves caused further stress for him. They ensured that observation levels encroached upon his privacy as little as possible.

65. All those who had close contact with him agreed that the man's mood would fluctuate rapidly, making him more difficult to manage. They were alert to the necessity of managing his risk without exacerbating it. Records and information obtained by my investigators in interview indicate that the multi-disciplinary staff group did what they could to help him utilise other coping mechanisms, although he was not always able to take their advice. None of the staff interviewed thought he was an overt risk of suicide, but many acknowledged that he was capable of behaving impulsively. The clinical nurse specialist from Rampton believed that he had acted impulsively on the night of his death and had not intended the outcome. Likewise, the psychologist from Rampton was aware that the man had slept with nooses for relief in the past and thought he could have done so on the night he died.

The management of ACCT

66. The version of Prison Service Order (PSO) 2700 – Suicide and Self Harm Prevention that was in force at the time of the man's death said that for the purposes of the Order, self harm is any act where a prisoner deliberately harms themselves irrespective of the method, intent or severity of any injury. The PSO went on to state that an act of self harm should always be taken seriously:
- “Even if a prisoner appears to be using self harm as a means of gaining something, it is still a desperate act and the prisoner should be helped to find constructive ways to meet the underlying need.”
67. The PSO required that a Form 2052SH (the forerunner of an ACCT plan) should be opened, where there was not one already, following any act of self harm. I am satisfied that staff met the requirements of the PSO by opening an ACCT on 4 April 2007 when the man showed one of the officers he had made cuts to his arm and leg. The plan was closed on 11 July after the man had been assessed as stable over a period of nine days. I am also satisfied that this was appropriate.
68. A second ACCT plan was opened on 16 July after the man cut himself twice in the space of less than half an hour. The front cover of the plan provides space for staff to state the frequency of observations, conversations and the required frequency of recording those contacts in the on-going log. The plan said that the man was to be observed hourly and that there should be two “quality entries” per shift. Inside the front cover of the document there is space for staff to record what triggers or warning signs should prompt an immediate review. These were listed as:
- “Not participating with regime, not taking his medication and asking to be locked up.”
69. On 24 July, the day before the man's death, the on-going log recorded that at 7.15am he was up and dressed, and appeared to be okay. The next entry was at 12.00 noon and recorded that he had asked to be put in his cell – one of the trigger factors. There was then a gap of more than three hours

until the next entry recorded that he was on the wing and reacting positively. It is not possible to decipher the signatures for those entries.

70. I accept that the ACCT plan required “two quality entries per shift”. However, given that asking to be locked up was one of the identified trigger factors for risk, I would have expected extra vigilance and recording after the man made this request. It may well be that observations continued as required and that the man was spoken to about his request. However, without the evidence of recording on the log, I cannot say what took place.

I recommend that the Governor of Whitemoor should issue a reminder to all staff about the importance of maintaining detailed, clearly signed on- going records in ACCT plans.

I further recommend that the Governor considers whether staff should be provided with refresher training at regular intervals to keep them up to date with the requirements of ACCT plans.

71. As required by the PSO, there was an immediate review on 16 July that noted the man’s risk remained raised and was connected to his anxiety over whether he would be allowed to move to Rampton. The next review was conducted on 25 July and the record noted that it was carried out during his quarterly CSC review. At the meeting, the man still appeared low and so the review panel decided to keep the ACCT document open with a further review when Rampton’s decision was known. I recognise that it is incumbent upon the prison to utilise time and human resources as effectively as possible. Nevertheless, I am concerned that a crucial decision about keeping a prisoner subject to a procedure that he found intrusive, albeit one designed to keep him safe, should have been taken in conjunction with a decision about his placement in the CSC. I accept that the issues may have been closely related but, in my view, consideration of a prisoner’s risk to himself is of such significance that it should be considered separately to the suitability of his placement in the light of his disruptive and violent behaviour.

I recommend that all ACCT review meetings should be conducted separately to any other reviews that may be necessary, albeit taking into account all relevant information that may arise from such other meetings.

Unlocking the cell

72. One of the officers was acutely aware that she was the only one of the man’s favoured officers who was on duty during the week of his death, and she was on night shift. In interview, she said she knew that he was awaiting information from Rampton and that this was very much on his mind. She said she had discussed the staffing situation with him a lot” before she went on night duty. She needed to make sure that he was comfortable with the fact that the support usually available to him would be absent for a time. The officer said that she reminded him he could talk to her through the door if he felt low, and he agreed to do so. I am impressed by the officer’s actions, and I

would be grateful if the Governor could draw my commendation to her attention.

73. Night duty officers carry a cell key in a sealed pouch and the officer agreed in interview that she had one on her. She said staff were instructed not to enter cells on their own and she had never had cause to use her key. In the few seconds after she saw the man, she thought about opening the cell door but recalled the danger and risk that he had previously posed and decided against it. The officer assessed that the risk was not only to her but could also have endangered the Operational Support Grade (OSG) on night patrol. Consequently, she waited for her colleague from the control centre, knowing he had only about 400 yards to travel and would arrive quickly. This cannot have been an easy decision for the officer to make. On the one hand she needed to get to the man as quickly as possible, on the other she knew of his history of hostage taking and could not be completely certain that he was unconscious. In my view, she made an informed, reasonable and correct decision by waiting for her colleague before unlocking and entering his cell.

Administering first aid

74. Annex C of PSO 2700 that was in force at the time of the man's death provided guidance about the emergency procedures to be followed after an incident of self harm. It stated that after a hanging staff should:

“Check for signs of life, i.e. breathing, pulse and any movement of the body.

“If not breathing and /or no pulse is present, clear airway and attempt resuscitation ...unless rigor mortis has set in.”

It then goes on to describe rigor mortis. The guidance is repeated exactly in Whitemoor's contingency plans in the First on Scene Action Sheet.

75. The officer told my investigators that when she and the Night Orderly Officer opened his cell door, they could tell he was “not very well” as he was grey. She said that, after she had cut the material round his neck, and she and the Night Orderly Officer had laid him down, the first nurse on the scene arrived in what seemed like seconds. The officer said that she did not attempt first aid as she is not trained to administer CPR, and because there was no need to do so as the nurse arrived so quickly. In the man's case there was virtually no delay before the nurse arrived, but this would not necessarily be so in every case when the swift administration of CPR could mean the difference between life and death.

I recommend that the Governor of Whitemoor reviews the prison's programme of CPR training, and considers if it is effectively targeted at staff who are most likely to need it. I have in mind particularly those who are on duty at night when there are far fewer staff in the prison.

Although I acknowledge that there would be a cost in extending the programme, this would be justified if it helps save lives.

Summoning emergency services

76. Whitemoor's First on Scene Action Sheet instructs that the first person on the scene should:

“Raise the alarm and request emergency medical assistance and first aid equipment.”

I am concerned that the instruction as it stands is open to misinterpretation. It does not make it clear if the medical assistance requested should be from within the prison, from outside emergency services, or from both.

77. The officer told my investigators that, when she used the red emergency phone to inform the control room that she had discovered the man, she did not specifically request an ambulance. The officer believed it was in the contingency plan that an ambulance would be called automatically, but she accepted that she was not absolutely sure. Given the ambiguity of the instruction, I make no criticism of the officer. The nurse's account of his attendance did not indicate that he called an ambulance, nor was it his responsibility to do so.
78. The Night Orderly Officer reported on his Incident Report Form that it was the nurse who, while attending to the man, said that paramedics were required urgently and that the Night Orderly Officer informed the control room. The control room log sheet confirms that an emergency 999 call was made at 10.22pm to request an ambulance, six minutes after the man was found. The ambulance arrived at the prison 12 minutes later at 10.34pm. Paramedics reached the man at 10.37pm, 21 minutes after he was discovered. I accept that there was absolutely no delay once the ambulance reached the prison. I further accept that a delay of six minutes between the man being found and an ambulance being called may not have affected the outcome for him. Given that he was cold and clammy with fixed and dilated pupils when the paramedics arrived, it is unlikely that they would have been able to resuscitate him if they had arrived a little earlier. However, in different circumstances, six minutes could make a crucial difference.

I recommend that the Governor of Whitemoor takes action to ensure that Whitemoor's contingency plans are written in plain language that leaves staff in no doubt of what action they are required to take. The Governor should also remind staff to familiarise themselves with these plans.

Clinical care

79. As noted earlier, the clinical reviewer from the Cambridgeshire PCT prepared a clinical review. (Her review is dated 17 April 2008.) She confirms that throughout his time at Whitemoor the man had daily contact with mental health staff, and regular interviews with both a clinical psychologist and a psychiatrist. However, she is concerned that there was no record of the man's consultation with the doctor and that she was unable to confirm if such a consultation had taken place (and, as a consequence, on what basis his medication was changed). The clinical reviewer recommends that all interactions regarding the medical care of prisoners should be recorded. I endorse her recommendation and suggest it should also cover any decisions made about treatment.

All interactions and decisions regarding the medical care of a prisoner should be recorded, even if the prisoner has not been present.

The return of the man's property after his death

80. PSO 1250 requires that all in-possession and stored property is recorded. Any bags in which property is stored must be sealed with security seals unique to the establishment, and numbered. The numbers should be recorded on property cards. The PSO also says that, when a prisoner has died, all property should be returned to the next of kin. The man's parents were concerned that not all of his property was returned to them after his death.
81. My investigators ascertained that when the man's parents visited Whitemoor on 29 July 2007 they took away with them a number of items that had belonged to their son. Four days later, on 2 August, the man's cell was cleared and the remainder of his property was placed into five sealed bags. The cell clearance record indicates that two officers started the clearance at 2.10pm and concluded at 3.25pm. The two officers signed the forms confirming that the bags were sealed in line with the PSO. The list of property is attached and I understand that the bags were returned to the man's parents. They were concerned at the lack of personal letters and a book that the man's father had given him. They said that they had seen a large crate containing papers under the man's bed but had not received the contents. Consequently, my investigator, made a number of inquiries of the Prison Service's property storage facility to no avail. When she visited Woodhill, my investigator asked staff whether any of the man's property remained there but none could be found. I appreciate the man's parents' concerns about what they believe to be missing papers. Nevertheless I am confident that my investigator was vigorous in her efforts to ascertain if items belonging to the man remained at the prison. Unfortunately, she could find no trace of any more of the man's property.

CONCLUSION

82. During this investigation it quickly became apparent that the man was a deeply troubled young man who had struggled with behavioural problems for much of his life. He was unhappy in the prison system and his dearest wish was to return to a special hospital. This was notwithstanding that his violent behaviour had led to his removal from an earlier placement at Rampton. Staff at Rampton told my investigator that the man was fearful of rejection and often acted to make people reject him first. They viewed his attack on the member of staff at Rampton in this light. They described him as a very bright and very funny man who had insight into his problems. He has also been described as a loner whose only way of coping with stress and self loathing was self harm. He had often told staff he was feeling hopeless and had used nooses. Cutting himself and using nooses had become a regular pattern of behaviour and he described the feeling of nooses as comforting. Despite this, there was little evidence that he had a serious intention to take his life. Both the staff who knew him best in prison and his family were convinced that he would have written a note if he had intended to kill himself.
83. The man believed he was misplaced in the CSC system but, despite regular counselling from psychiatrists and staff in the MHIRT, he was unable to see that the biggest obstacle to acceptance on a DSPD was his own erratic behaviour and tendency to self harm. He variously told people that he self harmed because it made him feel good and that it helped him cope with stress. It was also the opinion of those who knew him well that he would use the self harm as a means of obtaining attention and status. I have found evidence of ongoing efforts by staff in Whitemoor to cope with the man's behaviour and to try to help him to progress. He received what was by any standards significant and quality intervention from mental health professionals in Whitemoor.
84. Although the very nature of a CSC unit meant that the man was more closely observed and received more attention from staff than he would have had on normal location, his self-harming led to him being subject to even greater intervention when ACCTs were opened. He found this intrusive rather than helpful, believing that it made him stand out among his fellow prisoners. Nevertheless, I am entirely satisfied that staff acted correctly in opening the final ACCT and in keeping it open - even though it did not prevent the man's death.
85. I am also in no doubt that the man's personal officers, and other staff who had regular contact with him, tried their utmost to provide him with alternative coping mechanisms, and persevered in their efforts to divert him from self harm.
86. I have not seen evidence to suggest that the man's mood at the time of his death was significantly worse than it had been on numerous previous occasions as he had often expressed feeling of hopelessness. However, it is a matter of record that he was anxious about the outcome of his referral to

Rampton and was imminently expecting news of a decision in which he had invested heavily. There are accounts of him being in a good mood during the evening of his death, giving no indication of any immediate intention to harm himself. While there is a body of research to suggest that for some people, the decision to take their own lives has the effect of lifting their spirits in the time immediately preceding the act, I have found no specific indication that this was the case for the man.

87. My investigators ascertained that, apart from in-confidence disclosures to medical and psychiatric staff, information about prisoners on the CSC is recorded and shared by the multi-disciplinary team via daily records, weekly and monthly reviews, and shared entries in the prison clinical record. My investigation found some instances where records were insufficiently detailed or omitted altogether and I have reflected this in my recommendations. The man was encouraged to attend review meetings to ensure he was aware of and understood assessments and treatment plans. When he chose not to attend, various members of staff ensured that he knew what had taken place.
88. I conclude that the man received a high standard of care in the CSC, and that his personal officers and mental health professionals in particular did their utmost to improve his situation and frame of mind. Sadly, the man's untimely death prevented him from making further progress and fulfilling his ambition of returning to Rampton.

RECOMMENDATIONS

National recommendations

1. I recommend that all ACCT review meetings should be conducted separately to any other reviews that may be necessary, albeit taking into account all relevant information that may arise from such other meetings.
2. All interactions and decisions regarding the medical care of a prisoner should be recorded, even if the prisoner has not been present.

Local recommendations

1. I recommend that the Governor of Whitemoor should issue a reminder to all staff about the importance of maintaining detailed, clearly signed on-going records in ACCT plans.
2. I further recommend that the Governor considers whether staff should be provided with refresher training at regular intervals to keep them up to date with the requirements of ACCT plans.
3. I recommend that the Governor of Whitemoor reviews the prison's programme of CPR training, and considers if it is effectively targeted at staff who are most likely to need it. I have in mind particularly those who are on duty at night when there are far fewer staff in the prison.
4. I recommend that the Governor of Whitemoor takes action to ensure that Whitemoor's contingency plans are written in plain language that leaves staff in no doubt of what action they are required to take. The Governor should also remind staff to familiarise themselves with these plans.