

**Investigation into the circumstances surrounding
the death of a man
at HMP Wymott in April 2011**

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

April 2012

This is the report of the investigation into the circumstances surrounding the death of a man at HMP Wymott in April 2011. He was found hanging from the window bars in his single cell. I offer my sincere condolences to his family and friends.

The investigation was carried out on my behalf by one of our investigators. We are grateful to the Governor of Wymott and his staff for their co-operation with the investigation. I am sorry that the report has been slightly delayed.

NHS Central Lancashire commissioned a clinical reviewer to review the clinical care the man received at Wymott. I am grateful for her considered review.

The man was remanded into the custody of HMP Manchester in September 2007, having been charged with a serious offence. He had never been in prison before. His community medical record reveals that, even prior to this undoubtedly terrifying experience, he was an anxious man. He was originally from another country and had family there as well as in the United Kingdom. He worried about his responsibilities to both and this led to trouble sleeping as well as episodes of depression.

At several points during his sentence, he was monitored under the Prison Service's suicide prevention measures. However, he maintained that he would not kill himself because of his family and his religion.

Once at Wymott, he continued to experience times of anxiety. In February 2011, he began working with a mental health practitioner. In April, staff became concerned about him and began suicide prevention measures again. On 14 April, after a telephone conversation with his wife, he apparently took his own life.

The investigation has revealed a number of flaws and omissions in the clinical care the man received and a number of recommendations are made to address these. There were also weaknesses in aspects of Wymott's suicide and self-harm prevention arrangements. Indeed, it is troubling that some of these weaknesses are similar to those we have identified in a previous death in custody investigation at the prison. However, it seems that the man showed no particular signs that he posed a serious risk to himself in April, or in the days leading to it. On this basis, it does not appear that staff could reasonably have prevented his tragic death – but, clearly, lessons do need to be learned.

I am very grateful to his family for considering the report at the draft stage. His mother remains concerned that he was not being more regularly monitored. The report now includes the National Offender Management Service's (NOMS) response to the recommendations made.

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Prisons and Probation Ombudsman

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SUMMARY

1. The man, a foreign national prisoner, was remanded into custody in September 2007. He had been charged with a serious offence allegedly committed several years previously. He had never been in prison before.
2. On his reception at HMP Manchester, he denied any history of mental ill health, but told healthcare staff that he had a couple of physical health problems. In fact, he had seen his community doctor in the past complaining of anxiety, depression and trouble sleeping. Shortly before his arrest, he had been prescribed medication to help him sleep.
3. His anxiety and sleep problems resurfaced within weeks of being in prison. He was prescribed antidepressant medication which he remained on until his death. Staff became aware of his longstanding family concerns. The man made it clear that he wanted to be deported to his country as soon as possible. However, he was also worried about his wife and child, who lived in the United Kingdom (UK).
4. While at Manchester, he was monitored under suicide prevention measures on three separate occasions. On the first occasion, in January 2008, his friend and fellow prisoner hanged himself. Then in March of that year, he was found guilty of the offence and received a seven year prison sentence. On the third occasion, in January 2009, he apparently attempted to hang himself during the night. Each time, he said that he would not kill himself because of his family and because it was against his religion.
5. In May 2009, the man transferred to Wymott to be closer to his wife and child. He again denied any mental health problems and staff did not act upon entries in his medical record which suggested otherwise.
6. In July 2010, the Parole Board (which decides when prisoners are safe to be released) decided that he should not be released early because he denied having committed the offence. Staff began suicide prevention measures once more when he took the news badly. In August, he said he felt much happier and the measures were ended.
7. He was referred to the mental health team for assessment in February 2011 and the following month, he began working with a mental health practitioner on a regular basis. Later that month, the Parole Board deferred making a decision about his release until they had more information.
8. The mental health practitioner asked for the man's antidepressant medication dose to be raised on 30 March. However, due to administration issues, he did not receive the increased dose until 13 April. He continued to talk about his family worries and his desperation to be released and deported.
9. On 4 April, during a meeting with the mental health practitioner, the man showed him a ligature he had made some time earlier. Suicide monitoring procedures were put in place again. Staff thought that he was making progress and began to consider whether the suicide prevention measures could end. However, as he

was still upset about his family concerns, staff decided to keep the measures in place for the time being.

10. At about 11.30am on 14 April, he had a difficult telephone conversation with his wife, during which he said that he wanted a divorce and that the relationship was over. About an hour later, prisoners were locked up for the lunch time period. Friends of the man checked him regularly and at about 1.30pm, could not get a response when they knocked on his door. They alerted staff, who unlocked the cell and found him hanging from the window bars. Despite efforts by prison staff, nurses and paramedics who arrived shortly after, he could not be resuscitated.
11. This investigation has highlighted some omissions in the clinical care the man received and in the suicide monitoring procedures at Wymott. We make seven recommendations to either the Governor or head of healthcare as a result. However, there was no clear evidence to suggest that his risk of suicide had risen so dramatically that day. On that basis, we do not think that staff could reasonably have prevented his death.

THE INVESTIGATION PROCESS

12. The Ombudsman's office was notified of the man's death on 14 April and the investigation was allocated to a senior investigator. She visited the prison to open the investigation on 20 April. During her visit she met the prison Governor, the appointed family liaison officer, a member of the Independent Monitoring Board (IMB, described later) and the acting head of healthcare. She also visited the wing on which the man lived and met some members of staff who knew him. The investigator was provided with copies of relevant paperwork covering his time at Preston, including his prison file and medical record.
13. The investigator issued notices inviting staff and prisoners to contact her with any information they thought might be relevant to the investigation. There was no response to the notices.
14. NHS Central Lancashire appointed a clinical reviewer to undertake a review of the clinical care the man received at Wymott. The clinical reviewer had access to the man's medical record and other relevant documentation.
15. The investigator and the clinical reviewer carried out interviews with staff and prisoners at Wymott in June and July. Whilst at the prison, several prisoners asked to speak to the investigator and were also interviewed. The final staff interview was carried out in August. Verbal and written feedback was given to the Governor during the course of the investigation. The draft report is slightly overdue. The delay was caused by workload pressures.
16. The Coroner for Preston and the West Lancashire District was informed of the nature and scope of the investigation. Contact was also made with Lancashire Police and, through the Coroner, the investigator was given copies of statements gathered by the Police. We are grateful to the Coroner and his staff and Lancashire Police for their willingness to share information.
17. The Ombudsman's senior family liaison officer made contact with the man's wife and mother. His mother wanted to know the following:
 - How her son had died.
 - Why he was in prison.
 - Information about his life in prison.
 - Whether he had any problems that led him to act as he did.
 - How much of his sentence he had left to serve.

Some of the information has been provided already, but we hope that this report helps his family to understand the circumstances surrounding his death.

HMP WYMOTT

18. HMP Wymott is a category C training prison near Preston. (Each prison is categorised according to the levels of security in which it holds prisoners. Category A is the highest level of security. A category C prison holds prisoners who are not considered likely to try to escape but who still need to be held in secure conditions.) Wymott holds 1,077 adult male prisoners, around half of whom are vulnerable prisoners. (Prisoners may be deemed vulnerable due to the nature of their offences or because they are unable to cope on a normal wing for other reasons. Vulnerable prisoners are housed in separate wings from the rest of the population and undertake all activities, such as association, work, education and exercise separately.) In the last decade, Wymott has undergone significant expansion.

HM Chief Inspector of Prisons (HMCIP)

19. Wymott was last inspected by HMCIP in October 2008. The inspection report was positive, noting that despite recent expansion, the prison had sustained its performance, provided good quality activities and was “reasonably safe”.
20. The Inspectorate concluded that the prison’s suicide and self harm strategy was over long and complex. The formal process for supporting prisoners considered to be at risk of self harm or suicide was found to be generally good, although there was only limited evidence of multidisciplinary working. Links with healthcare staff, including mental healthcare, were limited.
21. Staff were generally found to be caring and knowledgeable about individual prisoners. Vulnerable prisoners were more positive than the general population about their relationships with staff. Vulnerable prisoners were also more positive about the personal officer scheme. (Most prisons in England and Wales operate a personal officer scheme. Staff are allocated to work with a number of prisoners and should act as those prisoners’ first port of call if they have any concerns or questions.) The Inspectorate found “particularly good” personal officer entries in wing files on the vulnerable prisoner wings.
22. The inspection report recorded the lack of an overarching diversity policy and many staff had not received any diversity training. Black and minority ethnic prisoners identified “some lack of staff cultural awareness and stereotypical assumptions”.

Independent Monitoring Board (IMB)

23. Each prison in England and Wales is monitored by an IMB, formed of unpaid members of the local community appointed by the Secretary of State for Justice. Members of the Board have access to all parts of the prison and all prisoners held there. The Board must satisfy itself that prisoners are held in humane conditions and treated fairly. It must report annually to the Secretary of State for Justice. The most recent available report for Wymott covers the period June 2009 to May 2010.

24. The Board judged that the prison provided a safe environment, where prisoners were treated “with decency and respect”. Prisoners at Wymott have access to an “extensive” programme of education and skills.
25. Healthcare provision (provided by NHS Central Lancashire) was judged to be “satisfactory”, but requiring improvements to bring it to the equivalent standard in the community. The Board also noted ongoing staff shortages which impacted on the provision of some services.
26. The Board concluded that safer custody was “taken very seriously” at Wymott. However it noted that, despite the HMCIP recommendations, healthcare was not routinely represented at safer custody meetings. (The investigator was provided with the minutes of the prison’s safer custody meetings which took place in March, April and May 2011. Mental health staff attended all three and primary healthcare staff attended two.) Following the most recent inspection, the Board also noted improvements in the suicide and self harm monitoring procedures.

Previous deaths at Wymott

27. The man was the fourth prisoner to apparently take his life at Wymott since the Ombudsman began investigating deaths in prisons in 2004. Given the prison’s relative inexperience in dealing with self inflicted deaths, it is very disappointing to find that we are repeating recommendations in this report that we made in relation to two previous such deaths. In 2005, we recommended that the head of healthcare carry out regular audits of clinical records. In 2008, we highlighted omissions in the ACCT processes at Wymott, specifically noting that case reviews and decisions made as part of the ACCT process should be multi-disciplinary.

Assessment, Care in Custody and Teamwork (ACCT)

28. ACCT, the Prison Service-wide process for supporting and monitoring those prisoners thought to be at risk of harming themselves, was introduced in 2007. An ACCT plan can be opened by anyone working in the prison if they have any concerns that a prisoner might have tried, or, in the future, might try to harm himself. The purpose of ACCT is to try to determine the level of risk posed, the steps that might be taken to reduce this and the extent to which staff need to monitor and supervise the prisoner. Levels of observations (where staff must check the prisoner) and interactions (where staff must have a conversation with the prisoner) are flexible and can be set according to the perceived risk of harm. If staff perceive the risk of harm to be very high, the prisoner may be constantly observed, with a member of staff positioned outside their cell at all times. Where the perceived risk is lower, the level of observations may be several times an hour or day. Observations also take place during the night. Prior to the introduction of the ACCT system, prisoners at risk of harming themselves were monitored under the F2052SH process.

KEY EVENTS

29. The man came to the UK and settled in the Manchester area with his wife and young child. In September 2007, he was remanded into the custody of HMP Manchester, charged with an offence of rape alleged to have occurred several years previously. He had never been in prison before. On his arrival at the prison, he told healthcare staff that he had no problems with alcohol or drugs and had no history of mental ill health. He said that he had never tried to harm himself and had no thoughts of suicide. Although he said that he was not prescribed any medication, he told staff that he was Hepatitis C positive. (Hepatitis C is a viral infection of the liver. It can cause inflammation and scarring of the liver tissue, but many sufferers do not know that they have the virus because they have no symptoms.) Staff established he had been diagnosed with this and was under the care of specialists at Manchester Royal Infirmary. He said that he was expecting to begin treatment for the virus (usually a course of injections and tablets).
30. Prison healthcare staff approached his community doctor for information about his medical history. It appears that this was never provided because his medical record contained information relating to another man, who had used the man's documentation to register at the surgery. Because of confusion about which entries related to which man and resulting data protection issues, the community surgery replied that they were unable to provide the information to the prison. After his death, the Coroner requested the information from the surgery and gave the investigator a copy of the record. This confirmed that he had first been diagnosed with Hepatitis C in 2004. He had not begun treatment at the time and had been retested for the virus in 2006. In 2005, He was assessed by the doctor having complained of anxiety and depression. He said that he had trouble sleeping, possibly because of his family responsibilities. However, he said that he had no thoughts of self harm. He again complained of anxiety and problems sleeping in May 2007 and was given advice by the doctor. According to the surgery records, he was prescribed temazepam (a medication prescribed for short periods to help resolve sleep problems) in August 2007.
31. At the end of October 2007, having been in Manchester prison for about a month, he complained of trouble sleeping. On 6 December, he had an appointment with the prison doctor and was tearful. He said that he was the victim of a miscarriage of justice and that he felt anxious. He was prescribed 15 milligrams (mg) of mirtazapine (a low dose of anti-depressant medication) and referred to the mental health in reach team (MHIT). Two weeks later, he had another appointment with the doctor. He was tearful again and said he felt "awful" about being in prison. While he admitted to feeling very low, he said that he was not thinking of harming himself.
32. On 11 January 2008, another prisoner (and a friend and former cell mate of the man) was found hanged in his cell. Later that day, the man had an appointment with the doctor. He was upset about his friend's death but said that he was not depressed or suicidal. He asked for sleeping tablets and was prescribed three nights' worth. He said he was missing his family, some of whom had health

- problems. The doctor noted that the man would receive support from the prison Imam.
33. Staff opened an ACCT plan for him on 11 January following the day's distressing events. He again admitted to feeling low, but said that he was not thinking of harming himself. He said that he had been praying and reading. He told staff that he thought about his wife, young child and mother all of the time.
 34. Following the other prisoner's death, the deputy governor asked the MHIT to assess the man. A mental health nurse did so on 28 January and recorded that the man did not speak very good English. The nurse noted that he was not coping very well since his friend's death but was receiving support from the Imam. The nurse concluded that there was nothing further the MHIT could offer.
 35. On 31 January, the man had another appointment with the doctor who noted that he was keen to start the Hepatitis C treatment. The treatment can cause side effects, including insomnia and depression and so the doctor wrote that staff would need to monitor his mental health while he completed the course of medication. He was given written information in his first language about the treatment.
 36. The ACCT plan was closed on 1 February after staff and he agreed that he was much happier.
 37. The man's criminal trial took place in March 2008. On 17 March, after a day in court, he told escort staff (responsible for managing prisoners while at court) that he would kill himself if "anything happens". They removed the lace that was tied around his waist (presumably for religious reasons, no further detail is given) as a precautionary measure. The following day, he was convicted of the offence and sentenced to seven years imprisonment. While in the court cells, awaiting transfer back to the prison, he banged his head against the cell wall. Escort staff opened a Suicide/Self Harm Warning Form recording that he was harming himself and rocking and crying. As a result, they monitored him constantly until he was passed to reception staff at the prison. Despite the concerns, an ACCT plan was not opened for him once back at the prison.
 38. On 19 March, a member of the chaplaincy team visited the man who admitted to having some thoughts of harming himself, because, he said, of his friend's death. He told the chaplain that his wife and child had moved from Manchester to Preston and that he would like to transfer to a prison closer to them.
 39. Staff decided that ACCT procedures should be commenced again on 25 March, because he seemed to be having trouble accepting his sentence. Other prisoners told staff that he had been making ligatures. During the opening of the ACCT plan, he continued to claim that he was innocent. He denied making any ligatures or having any plans to harm himself. When assessed by a mental health nurse, he admitted to feeling very low but said he had no suicidal thoughts. He had concerns about his Hepatitis C condition and so the nurse referred him to the specialist Hepatitis C nurse.

40. In early April, an entry in the ACCT plan revealed that he had not yet told his wife that he had been sentenced. Staff described him as tearful and asking for a transfer to a prison closer to his wife and son. On 15 April, the prison doctor increased the mirtazapine dose to 30mg a day. No reason for increasing the dose is recorded in the medical record. The ACCT plan was closed the following day, when he said that he was feeling more positive.
41. The man began his course of treatment for Hepatitis C on 24 April. The doctor explained to him that, for the duration of the treatment (about six months), he would not be able to transfer to another prison. He also explained that he might experience side effects during the treatment, including depression. Again, the doctor directed that staff from the MHIT should monitor his mental state throughout the course of treatment. (There is no evidence to suggest that his mental health was monitored during the treatment.)
42. In November, he was assessed by healthcare staff after complaining of feeling short of breath. He was prescribed salbutamol and ventolin medication (both commonly prescribed to people who suffer with asthma). During the appointment, he became upset and frustrated, saying that he had not seen his family for some time because of the distance from Preston to Manchester. Staff reminded him that he would not be able to transfer until he had completed his Hepatitis C treatment (which he did later that month).
43. On 8 December, the man received notification from the United Kingdom Border Agency (UKBA) that he was liable for deportation at the end of his sentence. (Under the Immigration Act 2007, foreign national prisoners from outside the European Economic Area and who have been sentenced to more than 12 months imprisonment can be automatically deported to their home country at the end of their sentence. To avoid this, such prisoners must show that deportation would breach their human rights.)
44. Shortly before Christmas, blood tests revealed that he suffered with hypothyroidism (also known as an underactive thyroid), a condition leading to problems with the production of the thyroid hormone. Patients with underactive thyroids may suffer with fatigue and depression. The condition is treatable with hormone replacement medication. Hypothyroidism is sometimes a side effect of Hepatitis C and in addition, can be caused by Hepatitis C treatment. He was prescribed medication to treat some of the symptoms of hypothyroidism (such as dry skin and eyes), however he was not prescribed a hormone replacement. (No further mention of his hypothyroidism is made in his medical record.)
45. On 19 January 2009, ACCT procedures were initiated for a third time, after he apparently attempted to hang himself during the night. Staff recorded that, on this occasion, his cell mate persuaded him not to. The man told staff that his main concerns still centred on his family, both in the UK and in his country. From entries in the ACCT plan, it seems that he gave staff an address in his country to which he wanted his body sent in the event of his death. Staff noted that he was depressed and worried about his family. He said that he had not harmed himself but had “seriously thought about it” during the night. He said that he did not want to kill himself and that his reason for living was to “receive the justice that he

believes he should" (he continued to claim that he was innocent of the offence). Staff noted that he needed telephone access to his solicitors because he did not fully understand the legal process. He was also referred for assessment by mental healthcare staff and staff recorded that he needed to remain in a shared cell.

46. The following day, he said that he was feeling better. Staff noted that they would pursue a transfer to Wymott, which would be closer to his wife and child. The MHIT referred him to the prison psychiatrist for a review of his medication. In the meantime, the doctor prescribed five days' worth of sleeping tablets. (It seems that he did not see a psychiatrist as directed.)
47. The ACCT plan remained open until 3 February. In the intervening period, he had an appointment with the doctor and said that his mood was much better since he had been prescribed a higher dose of mirtazepine. He said that he had been in regular contact with his family and his solicitor was going to appeal the sentence. He said that he was sleeping and feeling much better.
48. He had another appointment with the doctor on 30 March, complaining of shortness of breath at night. The doctor found no cause for concern but gave him a peak flow meter (which measures how quickly you can blow air out of your lungs and can help to diagnose conditions like asthma). He was prescribed inhalers to treat asthma, but there is no evidence to suggest that any follow up monitoring of the condition took place.
49. Despite having finished the Hepatitis C treatment in November 2008, he was still prevented from transferring to a prison closer to his wife. Staff looked into the reasons for the continued hold and discovered it was the result of the abnormal thyroid function tests. The doctor agreed for the transfer hold to be removed and on 1 May 2009, he moved to Wymott.
50. On his arrival, he was assessed by a nurse who noted that he had experienced breathing problems and was prescribed medication. The nurse also recorded that he was now Hepatitis C negative, having completed the treatment. The man denied any prior contact with mental health services or any history of self harm. The nurse recorded that his medical record contained no evidence of mental health contact. In fact, details of his prior contact with the MHIT were available in the record.
51. The nurse recorded that he was not currently on an ACCT plan (but made no mention of when he had last been subject to the procedures), was not anxious or depressed and had no current mental health problems. It seems that he told the nurse that he was prescribed mirtazapine because he had trouble sleeping. He was not referred for a mental health assessment on his arrival.
52. Later that day, a member of discipline staff completed the first night information sheet, recording that the man had no language difficulties, although his first language was not English. He said that he had no concerns about being in custody, had never harmed himself in the past and had no such thoughts currently. He denied any history of depression. (A prisoner's medical history is

confidential between them and healthcare staff. As such, discipline staff might only know that a prisoner has physical or mental health problems, or is prescribed any medication, if the prisoner tells them.)

53. On 28 May, he had an appointment with the doctor and discussed his worries about his family. The doctor told him that his antidepressant medication would help but was not a “cure” and suggested that he needed to keep busy. The doctor refused to prescribe any sleeping tablets.
54. Just under a month later, on 23 June, nursing staff were called to urgently examine the man after he complained of chest and abdominal pain. As a result, he was also examined by a doctor who referred him for an ECG (electrocardiogram – a test which measures the electrical rhythm of the heart and checks that it is beating effectively). However, the prison did not have the ECG products in stock and could not carry out the test until they had arrived. It is not clear when or if an ECG was performed. The following week, he saw the doctor again, complaining of “too much stress” and low blood pressure. He was referred to the gym to help improve his health.
55. In July, he met his personal officer. The officer made an entry in the man’s prison file following their meeting, noting that he became “very emotional” when talking about “issues”. The officer told him to speak to staff if he needed support.
56. The officer was interviewed as part of the investigation. She said that she was personal officer to between nine and 12 prisoners and usually met with them once a month. During the meetings, she encouraged prisoners to share any concerns or problems with her. She said that she had been the man’s personal officer since he moved to B wing in 2009. The officer explained that, although he could speak English he sometimes got anxious or uptight if he could not explain himself properly. All of the staff and prisoners interviewed were asked whether the man could speak and understand English. They agreed that he seemed to have no problems speaking English. However, none knew whether he was able to read or write in English.
57. In interview, the officer said that when the man first arrived on the wing he “had a lot of issues and ... seemed to be not coping well”. She described him as “crying a lot” but said that, despite knowing he had been monitored on an ACCT plan before, she had never had any concerns that he might harm himself.
58. He spoke to the officer in August about the possibility of his being released under the Early Removal Scheme. The Early Removal Scheme (ERS) was introduced in 2004 and applies to foreign national prisoners who are liable for deportation at the end of their sentence. Under the ERS, such prisoners can be released earlier than half way through their sentence in order to allow their deportation or removal from the UK. Their early removal must be agreed by the Parole Board, which assesses prisoners to decide when they are safe to be released. He had been told that his earliest possible date of release under the ERS was 24 June 2010.

59. The officer made a note of their conversation on the man's computer file. She wrote that he wanted to be released as soon as possible to return to his country where his mother was unwell. During the meeting with the officer he was emotional and said that he felt "very down" but would not harm himself because of his religion. The officer agreed to check the situation and found that although he was indeed eligible for ERS, it was by no means certain that he would be successful in achieving it. The officer recorded that the man "thinks he will be on a plane home" on 24 June and that he "could not comprehend" that he might not be released until 2012 (the half way point of his sentence when he would be automatically released). The officer wrote that staff needed to keep an eye on him.
60. On 10 November, he received confirmation of his deportation order, which confirmed that the earliest date on which he could be released was in June 2010. The following day, he complained of shortness of breath once more and was examined by a nurse. The nurse referred him for another ECG and for blood pressure checks. He was also referred to the well man clinic for routine screening because of a family history of heart disease. The ECG was carried out and showed no abnormalities.
61. In early December, he complained of being bullied by another prisoner and staff began Tackling Anti-Social Behaviour (TAB) procedures to monitor the situation. The TAB was closed seven days later when the other prisoner had been moved to a different wing and he said he had no further problems.
62. The man remained keen to be returned to his country as soon as possible and on 10 December, he wrote to UKBA volunteering to return there. UKBA acknowledged his letter on 16 December.
63. TAB procedures were started for a second time on 11 January 2010, after he and another prisoner fought and he complained of being threatened. The TAB was closed on 19 January with his agreement.
64. Healthcare staff were asked to examine the man again as a matter of urgency on 29 March, after he complained of chest tightness, sweating and shaking. The doctor who assessed him recorded that he might suffer with angina (a lack of blood to the heart, generally due to an obstruction or spasm of the blood vessels supplying the heart). He was treated with oxygen. He said that he had been thinking of his family and his possible release in June 2010 and thought he might have panicked, causing him to feel unwell. The doctor noted a history of heart disease in his family and ordered blood tests. The ECG machine was not working that day, and so the test was carried out the following day, again showing no abnormalities. He was prescribed two milligrams of diazepam (a sedative, anxiety relieving medication) to be taken three times a day.
65. During an appointment two weeks later, the man said that he had not experienced any more chest pain and that his inhalers were helping. He did complain of occasional tremors in his right hand and pain in one of his right fingers. He was prescribed 30mg tablets of nefopam (a pain relief medication) for 28 days.

66. On 17 April, the nurse was called to examine him on the wing because he had pains in his chest once more. He was anxious and tearful, but after ten minutes the chest pains had gone. He was assessed by a doctor, who thought he might have suffered a panic attack. A third ECG showed no problems and the results of a blood test were normal.
67. In the light of his upcoming Parole Board review, he met his offender manager (formerly known as probation officers) on 29 April to review his OASys. (OASys – Offender Assessment System – is a comprehensive risk assessment tool which can help to inform decisions about whether a prisoner is suitable for release.) The offender manager noted that, since his arrest, he had maintained his innocence. However, he was now prepared to discuss the offence for the first time and had admitted to certain aspects of it, while continuing to deny others. The offender manager wrote that, in his opinion, the man had changed his approach because he wanted to be granted early release and return to his country. In interview, his personal officer agreed that, in her view, the man had only begun to admit the offence when he realised it might speed his release.
68. The Parole Board refused his application for parole on 26 July. The decision was made because of his attitude towards the offence and the fact that he had not completed any offending behaviour related work and therefore still posed a high risk to the public. His personal officer said that, after the decision, the man seemed to accept that he would remain in prison until he had completed his sentence. The officer remarked that the man approached her less often with concerns or worries after the Parole Board's decision.
69. However, on 30 July, staff opened an ACCT plan once more. He said that "everything was finished" because he had not been granted parole. He repeated his wish to return to his country to be with his mother. He said that he had nothing to live for and wanted to be dead, but assured staff that he would not try to kill himself. Staff recorded that he had lost interest in exercise and mixing with other prisoners and was tired but unable to sleep. He said that he would kill himself if his mother died before he was released.
70. The ACCT plan remained in place until 13 August. The man was still upset about the parole refusal and was desperate to be deported so that he could see his mother. However, he said that he knew he was supported by staff and that he would continue to wait for deportation.
71. He was examined by the doctor on 7 September, once again complaining of chest tightness. He described feeling very stressed. The doctor questioned whether he suffered with asthma, or whether his symptoms were related to anxiety. As a result, he was prescribed another short course of diazepam and given information on relaxation techniques. He was not referred to the asthma clinic for further assessment or monitoring.
72. Clearly, he remained focused on being deported as soon as possible, and on 27 September, he wrote to the IMB reiterating this wish. A member of the Board replied, noting that his next Parole Board hearing was in March 2011 and that

nothing could be decided before then. His solicitors began gathering information ready for the March hearing.

73. On 20 October, he was examined by the doctor again, still complaining of difficulty breathing. He said that the inhalers he was prescribed were not helping very much and so the doctor referred him for a chest x-ray. This was carried out at the local hospital on 5 November and showed no problems with his heart or any signs of disease. (He was not told of the results until he put in an application for them in mid-December.)
74. In preparation for the next parole hearing, prison staff completed their assessment of whether he was suitable for parole. They advised that he was not suitable because he was still denying key aspects of the offence. (He was not informed of this because, ultimately, the decision rested with the Parole Board.) On 30 October, one of the prison governors replied to a complaint the man had submitted regarding ERS. The governor clarified that, if the Parole Board considered him suitable for parole following the review in March 2011, he would then be referred for the ERS.
75. In the early weeks of 2011, he remained focused on his parole review. On 17 January, he applied for an appointment with an immigration officer to discuss deportation.
76. Between January and 21 February, entries relating to another prisoner at a nearby prison were made on the man's electronic medical record in error. (On arrival in prison, prisoners are given a unique number which, in theory, avoids confusion if different prisoners share the same name or date of birth.) Staff realised the error on 21 February when they noted that entries in the record did not match his medical history. Staff were instructed to complete paper records until the problem had been rectified.
77. On 21 February, he was assessed by a nurse complaining of insomnia due to "family problems". He was tearful and said that he often thought of his mother, who was unwell. He described finding it hard to breathe when he thought about her, particularly at night. He told the nurse that the antidepressants were not helping, that he was still traumatised by the death of his friend at Manchester and that he had no one to talk about this with. He told the nurse that he was not thinking of harming himself. The nurse noted that the man wanted to get all the help he could and referred him for a mental health assessment.
78. Two days later, the man was discussed at the meeting between the MHIT and the primary care mental health team (PCMHT) and was placed on the waiting list for assessment by the primary mental health team. (The PCMHT generally work with prisoners suffering lower levels of mental ill health, such as depression and anxiety. The MHIT usually work with those suffering more severe mental illnesses, such as schizophrenia.) The PCMHT leader was interviewed during the investigation. She explained that practitioners discuss referrals during the meeting and decide who should conduct the assessment and how quickly. As a result of their discussions, the man was placed on the waiting list for a routine assessment by a mental health practitioner with the primary mental health team.

The PCMHT leader said that prisoners on the waiting list might wait for up to eight weeks for a routine assessment.

79. The man made an application to the prison Governor on 8 March, asking that he be released on parole in August 2011. The Governor replied that the Imam would talk to him about the issue. (There is no information in his file to confirm whether the Imam did in fact have such a conversation with him.)
80. The mental health practitioner arranged to carry out a mental health assessment with the man on 21 March. He was interviewed as part of the investigation and explained that he wrote to him to inform him of the appointment. He said that this is standard practice and gives the prisoner the opportunity to decline.
81. During the assessment, the mental health practitioner recorded that the man was tearful and emotional, was not eating or sleeping well and had “fleeting” suicidal thoughts. The mental health practitioner wrote that the man had no history of self harm and had not made any plans to harm himself. However, he described feeling “panicky and frightened” all of the time, as if “people were going to hurt him”. Once again, he protested his innocence, saying that the conviction had ruined his life. The mental health practitioner decided to discuss his medication with the doctor and use techniques to improve his mood and reduce his anxiety. He helped the man to complete the PHQ-9 (Patient Health Questionnaire, which helps to diagnose mental health problems such as depression) and the GAD-7 (the Generalised Anxiety Disorder assessment, which is a brief tool to help measure levels of anxiety.) He scored 22 out of 27 on the PHQ-9 and 15 out of 21 on the GAD-7 (both of which indicate high levels of depression and anxiety).
82. In interview, the mental health practitioner said that the man came across as a pleasant and communicative man, who seemed stressed and worried. He spent a lot of time alone in his cell and was somewhat “withdrawn”. The mental health practitioner considered the man to be a “compliant” prisoner, who did what was asked of him. He described him as often emotional, but “settling quickly” when he was given the chance to talk about his worries. The mental health practitioner said that the man could speak good English and was able to express himself without problems. The mental health practitioner said that the man’s primary concern was getting early release and returning to his country.
83. Following his initial assessment, the mental health practitioner said that he assessed the man as being “moderately severely depressed” with “fleeting suicidal thoughts”. He told the investigator that suicidal thoughts are fairly common amongst patients with depression. However, the man denied having made any plans to harm himself, which is a key indicator that the individual poses a serious risk to themselves. The mental health practitioner explained that the man was being prescribed 30mg of mirtazapine but, in his opinion, should have been on a higher dose. He said that a dose of 30mg will reduce feelings of anxiety, but that a higher dose of 45mg acts as a strong antidepressant. He explained that the PHQ-9 and GAD-7 scores helped him to build a picture of the man’s levels of distress and to plan what sort of intervention he needed.

84. The mental health practitioner said that he planned several cognitive behavioural therapies (CBT) interventions to use with the man. (CBT is a kind of therapy which aims to help the individual manage their problems by changing how they think and act.) As part of the process, he provided him with a diary in which to record his thoughts and feelings
85. On 29 March, the Parole Board informed the man that they were deferring their decision so that further information could be gathered. They concluded that an oral hearing (where the prisoner appears in person in front of the Board) was necessary to discuss the situation.
86. The mental health practitioner met a doctor to discuss the man's antidepressant medication on 30 March. The doctor agreed to increase the dose from 30mg to 45mg. However, due to an administration error, the dose was not increased that day. During interviews, the mental health practitioner, the PCMHT leader and the acting head of healthcare were asked about the process when a prescription is made. The mental health practitioner explained that the doctor wrote the new prescription during their meeting and he placed it in the file for delivery to the pharmacy department (which is based at HMP Garth, a few minutes walk away). He said that some days later, he found the original prescription in the man's file. When he realised that the prescription had not been completed, he spoke to another doctor who wrote a new prescription. (In fact, the man did not start receiving the correct dose of Mirtazepine – 45mg – until 13 April. The investigator and clinical reviewer were not able to establish exactly why or how the prescription process failed on this occasion.)
87. Five days later, on 4 April, the man and the mental health practitioner met again. The man was emotional and tearful. He described constantly thinking about his sentence and deportation, but said that his main concern was his mother. Once again, he threatened to kill himself if she died before he was released. The two men discussed techniques which might help him cope with his feelings.
88. The mental health practitioner explained that an important part of the meetings he has with prisoners is talking about managing risk. Part of that process involves asking the prisoner about their strategies for managing risk. Towards the end of their meeting, the mental health practitioner and the man began talking about this. He thanked the mental health practitioner for his continued support and mentioned that he had not been coping well recently. He told the mental health practitioner that he "had something to help him solve his problems". As the mental health practitioner probed further, the man said that he had something to show him. The man returned to his cell and came back to the meeting with a ligature, which appeared to have been made from prison sweatshirt material.
89. He asked the mental health practitioner not to tell anyone about the ligature. He said that he had had it in his cell for several weeks. The mental health practitioner said that the man became upset and was "adamant" that he would never use the ligature. The mental health practitioner told him that the purpose of telling other staff was so that they could offer support to him. The mental health practitioner explained the ACCT process and, in interview, said that the

man became less distressed and acknowledged the support he had received while on ACCT plans in the past. He assured the mental health practitioner that he had “no other means” to hurt himself and promised not to act on any negative thoughts.

90. The mental health practitioner opened an ACCT plan following the meeting. Fifteen minutes later, a senior officer (SO) and an officer completed the Immediate Action Plan (which records any actions that need to be taken straight away to safeguard the individual). Both members of staff were interviewed during the investigation.
91. The officer explained that he was generally based on B wing and knew the man reasonably well. He described him as “personable” and “positive”. He said that the man approached staff when he had worries and did not “seem the type to let things fester”. The officer said that he knew the man had been monitored on ACCT plans in the past.
92. The SO was on duty when the nurse finished his meeting with the man. He spoke to him and reminded him of the Listeners scheme and the Samaritans’ telephone. (Listeners are prisoners trained and supported by the Samaritans to offer a confidential listening service to other prisoners. The Samaritans’ telephone is normally a cordless telephone which can only be used to contact the Samaritans’. Prisoners are normally able to use the telephone in the privacy of their own cell and it should be available to them 24 hours a day.) The SO directed that staff should check on the man once in the morning, once in the afternoon, once during the evening and hourly during the night. The SO was interviewed in August, some four months after he was involved in opening the ACCT plan. He could not remember his meeting with the man on 4 April but did not think he had been overly concerned about his risk to himself. He acknowledged that he had made a ligature, but said that he had not “put it around his neck” or made any acts of self harm. The SO said that, sometimes, prisoners make ligatures as “threats” or to get something. He said that it is up to the senior officer to decide the level of observations necessary, according to the circumstances. The officer agreed that, while he and the SO discussed the man, it was up to the SO to set the level of observations. The SO did not ask the officer for his opinion on the level of observations to be set.
93. In interview, the officer was asked whether the man seemed the kind of man who “did things for effect” or to get attention from staff. The officer said that he did not appear to be that sort of prisoner. He agreed that he was not someone who often made ligatures and showed them to staff. Indeed, there is no evidence to suggest that he had ever shown staff at Wymott a ligature before (although there were concerns about him making ligatures at Manchester, he had never shown one to staff before). The officer said that staff took the concerns seriously because they related to the man. When he saw him on 4 April, he described him as seeming “down” but not showing any outward signs of distress.
94. The triggers section of the ACCT plan (which records specific issues or events that might increase the individual’s risk to self) was not completed by the SO on 4 April. In fact, no triggers were listed in the document prior to his death.

95. At around 10.00am on 5 April, an officer carried out the ACCT assessment interview. The officer was interviewed as part of the investigation. She said that she was told that the man needed to undergo an ACCT assessment interview on 4 April and so arranged a time to see him the following day. Prior to conducting the interview, she asked what the issues were and was told that he had made a ligature. She then reviewed his computer record to see if it contained any useful information. When she arrived on B wing on 5 April, she went to speak to the SO first, who told her that the man was worried about being deported and had family living in the UK. She then went to find the man, who was at the gym. He was brought back to the wing and the officer began the assessment.
96. His primary concerns continued to be his mother's ill health and whether his wife and child would accompany him to his country on his release. He said that he was worried he would lose both families. He explained that his worry and confusion led him to think about hanging himself. He described feeling depressed "all day every day", although he felt better when he was working. He said that he was not eating or sleeping, was suffering with asthma and angina because of the stress and heard voices telling him put a noose around his neck. He said that he wanted to be dead but worried about his family. He said that he would feel better if he knew the outcome of the parole hearing. The Officer recorded that he needed support to deal with his stress and anxiety.
97. In interview, the officer said that the man began to cry when he talked about his mother. She explained that he seemed very torn between wanting to return to his country to be with his mother and staying in the UK with his wife and child. She described him as being "in turmoil".
98. The officer said that she asked him if he was eating and sleeping and he said that he was not able to do either. She then asked him a series of direct questions about the ligature he had made. He told her that he had kept the ligature in the bin. She asked him if he intended to make another ligature, which he denied. He also denied having anything else in his cell which he could use to harm himself. He said that he did not think he could kill himself because of his son. The officer asked him if he heard voices and he said that he did, which told him to kill himself. They talked about his friends on B wing, his work in the tailor's workshop and his faith. The officer said that they discussed whether his problems sleeping might be making him feel more depressed and that if he could get a good night's sleep, he might feel better. She said that the two of them had talked for some time and she had tried to encourage him to think positively. By the end of the interview, she thought he seemed much "calmer" and he said he was "fine". When the officer returned the man to his cell, he showed her pictures of his family. He thanked the officer and said that he would pray for her.
99. The investigator asked whether the officer considered that he posed a risk to himself. She explained that the fact he mentioned hearing voices telling him to put the ligature around his neck caused her concern. She said "it did cross my mind that he was that low he could have [tried to kill himself] and he was in that much turmoil that he could have done". She hoped that his mental health

practitioner might be able to arrange for sleeping tablets to be prescribed as this might help “break the vicious circle”.

100. The officer explained that, if possible, she attends the first ACCT case review (held shortly after the assessment interview). On this occasion, she was not able to stay on the wing and so she discussed her thoughts the SO. While the officer was there, the SO rang the mental health team to ask them to see the man that day. The investigator asked whether the SO consulted with the officer about the appropriate level of observations to monitor the man. She said that she thought the SO had asked if the current level of observations was sufficient and she said that it was. (However, in interview, the officer recalled that he was being checked either every half an hour or every hour. As described earlier, he was being observed once during each of the morning, afternoon and evening duties and once an hour overnight.)
101. The SO and the man met for the first ACCT case review at about 11.00am. The SO wrote that he was “stressed out” by thinking about his situation and noted that he would contact the MHIT to see if they could help to relieve his stress. The SO also told him to speak to wing staff, a Listener or the mental health team if he was thinking of doing “anything silly”. He concluded that he posed a “raised” risk to himself (the other options being low and high). The level of observations remained the same. The SO made entries in the Caremap (every ACCT plan has a Caremap, which sets out the issues, sets goals and actions, and identifies who is responsible for carrying them out), noting that the man needed to speak to probation and the mental health team to see if they could help resolve any of his problems.
102. A nurse, a member of the PCMHT, spoke to the man at the SO request later that afternoon. (The mental health practitioner was not in the prison that day.) The nurse recorded details of their meeting in the ACCT On-going Record section (where staff record details of their interactions with and observations of the prisoner being monitored). The nurse wrote that, initially, the man seemed relaxed, but that he had become tearful. However, he denied any thoughts of harming himself and the nurse recorded that the importance of his family was a major “protective factor” (something which might help him to combat his negative thoughts and feelings). The nurse wrote that he would speak to the doctor about his medication and ask the nurse from the mental health to see the man the next day.
103. During the night of 5 April, staff checked the man once an hour, in line with the observation level set by the SO. The entries made in the ACCT On-going Record suggest that the checks took place on the hour, each hour. No members of night staff were interviewed during the course of the investigation so it is not known whether the written entries reflect the actual time of the check or not. However, it is accepted as good practice that ACCT observations should be carried out at varied intervals. This helps to avoid a situation where the prisoner being monitored knows when to expect the observation.
104. At 11.00am on 6 April, the mental health practitioner and the man met. The mental health practitioner described him as being low in mood, but

communicative and cooperative. He said that he “would be dead” if it was not for the support he was getting from the PCMHT. Again, he denied any thoughts of suicide but became emotional and “appeared overwhelmed” with worry. The mental health practitioner reiterated the importance of using the techniques he had been taught to manage his stress and anxiety. He agreed to “keep himself safe” until their next meeting on 8 April. He denied having any items in his cell with which he could harm himself. In interview, the mental health practitioner explained that the ligature the man showed him four days previously had been “manufactured”, probably while he was working in the tailor’s workshop. The mental health practitioner acknowledged that the man had a variety of other items that he could use to harm himself. However, he said that, at the time, he was satisfied that he was not likely to harm himself in the near future.

105. As arranged, the mental health practitioner and the man met at 11.00am on 8 April. The mental health practitioner assessed his mood as “low but stable”. The two men discussed his antidepressant medication and he said that he was still being prescribed 30mg, not 45mg. He then told the mental health practitioner that he had a month’s worth of his antidepressant medication “in possession”. (In prison, medication may be held “in possession”, meaning the prisoner is given a set amount of medication and is responsible for taking the correct dose as prescribed. Alternatively, if the medication has been assessed as a high risk medication – for example, because it can be traded with other prisoners – it is prescribed on a “not in possession” basis. Such medication is given by healthcare staff on a dose by dose basis and must be consumed in front of healthcare staff.)
106. The mental health practitioner told him that this was not normal procedure and that he should not have any in-possession medication while on an ACCT plan. In interview, the mental health practitioner explained that prisoners on ACCT plans may not hold medications such as antidepressants in possession, due to risks that they may try to overdose. He became upset and needed reassurance from the nurse. The mental health practitioner explained that it was normal protocol and that he should not take it personally. He said that a member of healthcare staff would come and take the excess medication away. The mental health practitioner told the investigator that the man appeared to be in much better spirits that day and staff told him that he was mixing more on the wing and coming out of his cell. On his way off the wing, the mental health practitioner talked to a nurse about the incorrect medication dose.
107. That day, another prisoner with a cell on the same landing as the man took an overdose of the pain relief medication nefopam, which had not been prescribed to him. As a result, the cells of other prisoners on the landing were searched. At midday, his cell was searched and staff found seven 30mg tablets of nefopam in his cell locker. He was placed on report for having an unauthorised item in his possession as a result, to await adjudication. (When a prisoner is accused of breaking a prison rule, they must appear in front of a governor who hears the evidence against them. This process is known as adjudication. If found guilty, they may face punishment, for example loss of earnings or a period of cellular confinement.)

108. The man was told that he would be moved to the Care and Separation Unit (CSU) prior to his adjudication first thing on 9 April, a Saturday. (The CSU is a small, separate unit within the prison where prisoners who cannot be managed on the main wings are held. They are held in single cells and have a restricted regime. Adjudications are held in the CSU.) Staff noted that he seemed upset when told this. At 9.25am, he was placed in a cell in the CSU which was monitored by closed circuit television (CCTV). Ten minutes later, healthcare staff carried out an assessment to ensure that he was mentally and physically well enough to be held in the CSU. The nurse judged that he was not suitable for segregation and that staff would need to consult with nurses if he was to be segregated for any lengthy period.
109. The adjudication began at 9.40am, in front of a governor. The man said that the tablets were left over from an earlier prescription (as noted earlier, he had been prescribed them for hand pain some months earlier) and that he did not know he was supposed to return unused medication to healthcare staff.
110. In interview, the adjudicating governor explained that all prisoners are told that they must return any unused medication to healthcare staff. In addition, on arrival at the prison all prisoners are asked to sign a medication compact, which sets out this rule. She said that the man told her that he was not aware of this. The adjudicating governor described him as being “not particularly cooperative” during the adjudication. She knew he was on an ACCT plan but said that he was not subdued. She described him as being “vocal” during the hearing.
111. The man admitted to having the medication and so the adjudicating governor found him guilty of having an unauthorised item in his possession. She noted that he had no previous adjudications against him and had only received one caution for breaking prison rules since his remand. The adjudicating governor decided that he should lose 25 percent of one week’s earnings and association privileges for one week. However, both punishments were suspended for three months (meaning that he would not be punished as long as he did not break the rules during the three month period). The adjudicating governor told the investigator that there are guidelines which set out the range of punishments appropriate for each charge. She took into account his history of good behaviour and the fact that he was on an ACCT plan when setting the punishment. The adjudicating governor described the punishment she gave to the man as “extremely lenient” and said that she had explained this to him.
112. By 2.45pm, the man was back on B wing. He told an officer that he was very upset about his family and worried about the adjudication. He said that the medication was his. He said that he did not want to speak to a Listener or the Samaritans, but would like to see the mental health nurse. The officer telephoned the healthcare unit but there was no reply so the officer agreed to call them again the following Monday morning. He denied any thoughts of suicide or self harm and agreed to speak to staff if he needed to. Later that evening, he said that he felt much better and more positive than on previous days.
113. At the request of wing staff, the mental health practitioner met the man in the afternoon of 11 April. He was anxious and emotional and said he was stressed

about the adjudication. In interview, the mental health practitioner explained that some prisoners had suggested that the adjudication might affect his parole hearing. Despite his distress at the adjudication, the practitioner described his mood as stable. In interview, the practitioner explained that he and wing staff felt that his mood was much improved. He was mixing well with other prisoners on the wing and seemed less withdrawn and upset. During their appointment, the two men discussed whether he was ready for the ACCT plan to be closed. The mental health practitioner said that he was much less emotionally unstable and said he was experiencing “reduced suicidal thoughts”. The mental health practitioner said that he would speak to wing staff about closing the ACCT.

114. At 3.30pm on 12 April, The SO on duty, the officer that completed the immediate action plan and the man met for the second ACCT case review. (There is no record of the mental health practitioner or any other member of the PCMHT having been invited to the review or contributing either by telephone or in writing.)
115. The SO was interviewed as part of the investigation. She explained that she is not normally based on B wing, but was covering the wing that day because of a shortage of staff. She did not know the man well and was carrying out the review because she was the SO on duty and it needed to be done that day. The SO said that, in the past, it had been hard to get staff from healthcare or the mental health teams to attend ACCT reviews because they were so busy. However, she said that more recently, mental health staff often came to ACCT reviews. She said that she normally invited mental health staff by ringing them on the day of the review. Because she was not familiar with the man, she said that she did not know that he was seeing the mental health practitioner. As a result, she did not invite him or anyone from the PCMHT to attend the review.
116. At the beginning of the review, he seemed “fine”. The SO described him as making good eye contact and having positive body language. The three present had a “laugh and a joke” and the SO and the officer thought that the ACCT could be closed. However, they continued to ask questions and when he began talking about his family, his demeanour changed. His body language became closed, he looked at the floor and became upset. He told the staff that he was worried that his wife was planning to leave him. He thought that her family was putting pressure on her to divorce him. He repeated that suicide was against his religion. The SO and the Officer decided that the ACCT should remain open because there were still issues that needed to be dealt with. The SO explained that, until that point, she had considered that he posed a very low risk to himself. She said that when he became upset, she still did not think that the risk he posed to himself was raised or high, just that it was not sensible to close the ACCT plan. The SO indicated on the ACCT form that he posed a low risk. The officer agreed, saying in interview that he never thought the man might harm himself.
117. The SO thought that she had asked the officer to contact the Imam and ask him to speak to him about his family concerns. However, this was not recorded on the Caremap. The SO did not change the level of observations, which remained at once in the morning, once in the afternoon, once in the evening and hourly during the night.

118. According to the ACCT On-going Record, he appeared to be in reasonable spirits on 13 April, certainly no concerns were raised. During the night, staff checking him recorded that he slept well.

14 April

119. During the morning of 14 April, he went to the gym. (Staff interviewed said that he went frequently as it helped him to feel less stressed.) The officer thought that he had returned to the wing at about 10.00am that morning.

120. His telephone records indicate that between 10.14am and 11.30am he tried telephoning his wife (using both her landline and mobile telephone numbers) 77 times. (When prisoners arrive in prison they must specify any telephone numbers they want permission to call. They are issued with a unique code which they must enter each time they make a telephone call. A computer system logs the details of any calls made by each prisoner. In addition, each call is recorded and may be listened to by staff, if there are grounds to do so.) On a number of occasions, there was no reply. However, at 11.30am, he spoke to his wife for six minutes. He and his wife spoke in Urdu and their conversation has since been translated at the request of the Coroner. The investigator was given a copy of the translation. During the conversation, he accused his wife of having been out with another man, which she denied. He told her that he wanted a divorce and that the relationship was finished.

121. During the investigation, several prisoners who lived on B3, the same landing as the man, and knew him were interviewed. One prisoner said he had known the man for over four years, having met him first at Manchester. He saw him shortly after he finished his telephone conversation with his wife. He described the man as "heated", but said that he was "okay" when asked. The prisoners agreed that staff were not aware that he had been using the telephone or that he and his wife had argued and no one passed any concerns to staff at the time. Staff told the investigator that the telephone he used is near to his cell and that staff were based in other parts of the wing during the morning.

122. The prisoners interviewed all knew that he had worries about his family and his deportation. They said that generally he was a positive man, who normally talked to others if he had a problem. Most also knew that he was on an ACCT plan, either because he had told them or because they had noticed staff checking on him. Most said that he had never talked about suicide or harming himself, even when he was having a "bad day" or feeling low. However, the prisoner said that the man had mentioned killing himself on a few occasions, either by taking an overdose of medication or by hanging himself. He said that he always encouraged him to think about his young son.

123. The officer who completed the immediate action plan noted in the ACCT plan that the man collected his lunch at about 12.30pm and "was in good spirits". In interview, the officer explained that he was monitoring the lunch queue that day and, as he passed, he asked how he was feeling. He said that he "gave the thumbs up gesture" and said that he was feeling "okay". The officer told the

investigator that he felt he knew the man quite well and said “I would like to think that I would pick up on some sort of change in his behaviour but I didn’t.”

124. Having collected their lunch, prisoners on B wing were locked onto their landings. (On B wing, prisoners have rooms rather than cells. They have a key to their own room and cannot be locked in the room, unlike in a traditional prison cell. Each landing has approximately 12 rooms on it. During the night and patrol states – when fewer staff are on duty, such as lunch time – prisoners are locked onto the landing by way of a gate. They are free to mix with other prisoners on their landing and also have access to the toilets, but cannot access other parts of the wing. If prisoners need staff urgently during these times, they can use the emergency bell situated in every room.)
125. Another prisoner living on the landing, told the investigator that on his return from collecting his lunch, he asked the man if he was alright. He said that he was. Because he knew he had had an upsetting telephone conversation, he returned about 15 minutes later and looked through the small window in his room door (known as the observation panel). He saw him sitting on his bed, crying. About 15 minutes later, he checked again. This time, he was lying on his bed.
126. Sometime around 1.30pm, the two prisoners went to check the man again. This time they found that he had covered his observation panel and they could not see into the room. All of his friends said that it was very unusual for him to do this because it is against prison rules. They said that he never covered his panel. They knocked on the door and called to him but got no response. They were immediately worried and at 1.35pm, one of the prisoners on the landing rang a cell bell.
127. Three officers including the man’s personal officer were in the B wing office and, on hearing the cell bell, made their way to B3. They were joined on the way by two other officers. There was a feeling amongst some of the prisoners interviewed that the staff response had been slow. Some also said that, when staff arrived at the locked gate, they appeared displeased that the cell bell had been used. However, the investigator interviewed one of the officers and the man’s personal officer, who described walking briskly to B3 landing. The officer estimated that it had taken the staff less than a minute to get from the wing office to B3. Unfortunately, there is no computerised emergency bell log at Wymott. (This system is in place in some other prisons and records the time a cell bell has been activated and when it is turned off by staff outside the cell).
128. The man’s personal officer explained that prisoners sometimes used the cell bell for non-urgent requests and that was what staff were expecting on this occasion. When they arrived at the locked gate, the group of prisoners who had collected there told them that the man was not responding and had covered his observation panel.
129. His personal officer was the first member of staff to reach his door and unlocked it. She and an Officer went in to the room and found the man hanging from the cell window bars, having used a piece of torn bed sheet to make a ligature.

130. The officers used anti-ligature knife (which is specially designed to safely cut ligatures) to cut the ligature, while his personal Officer supported the weight of the man's body. At 1.43pm, the other officer alerted the prison control room to a code blue emergency. (The term code blue is a standard emergency call used in many prisons. It alerts staff, including healthcare, of a medical emergency where someone is not breathing. Using such a code helps emergency response nurses to bring the right equipment to the incident.) The officer that alerted the prison control room is trained in first aid and she began cardiopulmonary resuscitation (CPR - normally a combination of chest compressions and rescue breaths), delivering 30 compressions to every two breaths. One of the two officers that joined the three officers to the wing and was also trained in first aid, assisted her.
131. Within a few minutes, two prison nurses arrived at the cell with oxygen and a defibrillator (a machine that reads the heart's electrical output and, in certain circumstances, can deliver an electric shock to re-establish a steady rhythm). One of the nurses told the investigator that the other nurse collected the emergency equipment from the treatment room on B wing on her way to the man's room. The nurses attached the defibrillator to his chest but it instructed that no shock be delivered and so staff continued to administer CPR. The nurse asked that the prison doctor be brought to help and asked staff in the communications room to call for an ambulance. The communications room log records that the request for an ambulance was made at 1.47pm.
132. A first response paramedic (who usually travel by motorbike or car) arrived at Wymott at 1.56pm. The prison doctor reached the man's cell at 2.01pm. An ambulance arrived at 2.05pm. The paramedics completed paperwork at the time of the incident which suggested that their entry into the prison had been delayed by unspecified "security" issues. The investigator telephoned the North West Ambulance Service (NWAS) NHS Trust for further information but they were unable to provide any more specific details about the nature of the delay.
133. Staff and paramedics' efforts to resuscitate the man were unsuccessful and the doctor pronounced that he had died at 2.07pm.
134. After his death, a prisoner, told staff that the man had asked him to pass on some tobacco to another prisoner at Friday prayers the following day. The prisoner was interviewed as part of the investigation. He said that at lunchtime on 14 April he saw him and thought he seemed a bit "down". He asked him if he would be at prayers the following day. He said that he told him that he would not be going as he was not very well. However, he asked him to return some tobacco to another prisoner. He had not give the prisoner the tobacco prior to his death. When speaking to staff, he said that he thought he should have alerted staff but had not done so.

Contact with the man's family

135. Shortly after his death, a governor was appointed as the prison family liaison officer. He and the governing Governor and the Imam travelled to the man's wife's address in Preston that afternoon to break the news of his death. In line

with Prison Service Order (PSO) 2710, Follow up to deaths in custody, the prison offered to assist with the cost of the funeral. The family was also offered the opportunity to visit Wymott.

136. Initially, the prison did not have contact details for his mother and family in his country. His wife agreed to break the news of his death to them. The prison was then contacted by his relatives from his country. His mother hoped to travel to the United Kingdom (UK) to visit Wymott, but was unable to.

Support for prisoners

137. When staff responded to the cell bell, they instructed the other prisoners on the landing to return to their rooms. Once the seriousness of the situation became clear, other members of staff moved them all to a communal room on the wing. They were given cups of tea and the governor who responded to the man's complaints came to tell them about the death. The prisoners were offered support from wing staff and members of the chaplaincy team. They were also reminded of the Listeners scheme and the Samaritans' telephone. Some of the man's friends did not want to continue to live on B3 landing and staff arranged for them to move to different wings.

138. Most of the prisoners interviewed said that they had received enough support from staff. One was placed on an ACCT plan shortly after the death. ACCT case reviews were carried out with prisoners on ACCT plans across the prison.

Support for staff

139. According to PSO 2710, a "hot debrief" should be held shortly after a death in custody. The purpose of the hot debrief is to bring together those staff involved in the emergency response, to give them the opportunity to talk about the events and provide reassurance. A hot debrief was held on B wing at that afternoon, chaired by a governor. Staff involved were contacted by the prison Care and Welfare Team. Those staff interviewed agreed that they had received sufficient support from the prison following the man's death.

ISSUES

140. As part of this investigation, NHS Central Lancashire commissioned a clinical reviewer to undertake a review of the clinical care the man received at Wymott. The clinical reviewer's review is lengthy and makes a number of recommendations. We include some of her discussion and recommendations in this report. However, we suggest that the healthcare providers and commissioners at Wymott read the review in its entirety and take the necessary steps.

The integrity of the man's medical record

141. The man's medical records (both that relating to the treatment he had received in the community and that relating to his time in prison) were beset with problems. On his arrival at HMP Manchester, staff requested a copy of his medical record from his community doctor. This is in line with guidance contained in PSO 3050, Continuity of healthcare for prisoners. Seeking information from the prisoner's community doctor helps to establish any existing physical or mental health problems and enables prison healthcare staff to continue to prescribe the correct medications. However, it seems that an acquaintance of the man had used his documentation to register at the surgery and so entries relating to the two different men were made on the same record. For this reason, the community surgery did not disclose the record to the prison.

142. Had staff at Manchester seen his community medical record, they would have been aware that he had complained of anxiety, depression and sleep problems at several times over the previous few years. They would also have known that he had been prescribed temazepam shortly before arriving in prison. When he arrived at Manchester, he told staff that he was Hepatitis C positive. However, despite being asked questions about his mental health, he chose not to tell staff about his mental health history. (On his arrival at Wymott, he again chose not to disclose his previous mental health problems.) It is not possible to say with certainty whether healthcare staff at Manchester would have acted differently had they known. However, they might have referred him to the MHIT on his arrival in prison.

143. The clinical reviewer notes that guidance relating to the treatment of anxiety and depression was updated by the National Institute for Health and Clinical Excellence (NICE) in 2009. The guidelines set out a four stage approach to the treatment. The first stage is diagnosing the problem, the second is treating it within the primary care setting. The clinical reviewer concludes that the man should have been at stage two on his arrival in prison but this was not identified. The fact that staff were not aware of his mental health history may have contributed to this.

144. At some point during his time in prison, his prison medical record apparently merged with that of another prisoner at nearby HMP Preston. The clinical reviewer notes that this caused problems for healthcare staff at Wymott, who for a short while had to complete paper records. (The clinical reviewer also finds that the standard of completion of the paper record falls below the level expected

and set out by the Nursing and Midwifery Council.) It undoubtedly complicated the review of his clinical care as part of this investigation.

145. As noted earlier, prisoners are issued with unique identifiers on their arrival in prison. The identifier is used on all of the prisoner's records, including their electronic clinical record. As such, it should be very difficult for prisoners' records to be confused.
146. The clinical reviewer writes that according to the Central Lancashire Records Policy, an audit of records should be carried out every year. She notes that it was "difficult to ascertain when one had been carried out". She concludes that such an audit might have identified some of the issues covered in her review, including staff training needs, and that an action plan could have been in place already to resolve them. We made a very similar recommendation in relation to an investigation carried out in 2005 and it is disappointing to find we must repeat it now:

The head of healthcare and the commissioning body should ensure that:

- **an annual audit of healthcare records takes place;**
- **the audit covers staff training needs;**
- **an appropriate action plan is developed and implemented.**

Treatment of the man's mental health needs

147. Within one month of being remanded into custody, his mental health problems surfaced. He was assessed by the doctor having complained of trouble sleeping and anxiety. He was prescribed a low dose of antidepressant medication, which was raised in April 2008. Although he was referred to the MHIT on several occasions, the clinical reviewer notes that he apparently never underwent a full mental health assessment at Manchester.
148. On his transfer to Wymott in 2009, a registered general nurse (not a nurse with specialist training to work with patients with mental health problems) carried out the reception mental healthscreen. (At Wymott the reception healthscreen is split into two, the first considers physical health and the second focuses on mental health.) The nurse recorded that there was no evidence that he had ever suffered mental health problems in the past or had contact with the MHIT. Information confirming both the man's contact with MHIT at Manchester and his mental health complaints was available in his medical record, which transferred with him. It is not clear why the nurse did not identify this. Although he was still being prescribed antidepressants, he was not referred to the MHIT at Wymott. The clinical reviewer makes the following recommendation, which we endorse:

The head of healthcare should ensure that staff conducting reception healthscreens have received appropriate training. The MHIT and PCMHT should have an input into the reception process to ensure that prisoners with mental health conditions are not missed.

149. In fact, the man was not referred for any mental health intervention at Wymott until February 2011. When assessed by mental health practitioner, he scored

highly for both depression and anxiety. Once referred, the mental health practitioner used cognitive behavioural therapy (CBT) alongside the prescribed antidepressants to help treat him. The clinical reviewer writes that the use of CBT with those suffering depression is in line with NICE guidance. The man himself praised the support he received from the mental health practitioner.

150. In interview, the mental health practitioner said that, in his opinion, the man should have been taking a higher dose of antidepressant for some time, given his mental health needs. The clinical reviewer concludes that, on the evidence available and according to NICE guidelines, the man's depression and anxiety could have been classed as "chronic" and that his medication needed to be reviewed.
151. The mental health practitioner discussed the prescription with the doctor and, on 30 March, arranged for the dose to be raised to 45mg. At this dose, mirtazapine acts as a strong antidepressant. However, the dose was not raised until the day before he died. The mental health practitioner explained that he put the prescription in the file for the pharmacist but later found it wrongly filed in the man's record (the original prescription has since gone missing and was not available to the investigator and reviewer). It is not clear exactly how the process for delivering prescriptions to the pharmacy failed on this occasion, but eventually a second doctor had to re-write the prescription. Interviews with a number of healthcare staff highlighted that the management of mental health prescribing is unclear. The clinical reviewer notes that such an error would be unlikely to occur if Wymott used electronic prescribing (available on SystmOne). She makes the following recommendation, which we endorse:

The head of healthcare should introduce electronic prescribing as soon as possible.

However, to ensure a smooth transition to this new way of working, staff will need to undergo sufficient training. This feeds in to our earlier recommendation about a general review of the electronic records and the use of SystmOne, and the identification of staff training needs.

152. The man was monitored under ACCT procedures from 4 April. The specific details of the ACCT and the risk he posed to himself are discussed in a later section. However, in interview, healthcare staff told us that prisoners on ACCT documents should not be given medication "in possession". The clinical reviewer notes that the Medication In Possession procedure in place in April confirms this. On 8 April, four days after the ACCT plan was opened, the man told the mental health practitioner that he had one month's supply of his antidepressant medication in his cell. The practitioner explained that the man should not have a supply of medication and arranged for a nurse to take it away.
153. Staff told us that, when a prisoner is placed on an ACCT plan, this information appears on their clinical record. They said that this is how nursing staff know not to give such prisoners in possession medication, or that it needs to be removed if it has already been dispensed. It is not clear why the man's possession

medication was not removed when the ACCT plan was opened. We make the following recommendation:

The head of healthcare should improve the processes by which healthcare staff are made aware of prisoners on ACCT plans and ensure that such processes are compatible with the Medication In Possession procedure.

Treatment of the man's physical health needs

154. When the man was remanded into custody, he told healthcare staff that he was Hepatitis C positive. He had been for some time and his care was being managed by a consultant at the local hospital. However, he had not yet begun the treatment for the condition. While at Manchester, he successfully completed the treatment and, by the time he arrived at Wymott, his blood tests revealed that he no longer had the virus. The clinical reviewer concludes that Manchester's treatment of his Hepatitis C was an example of good practice.
155. While still at Manchester, the man began complaining of chest pain and feeling short of breath. In March 2009, he was prescribed medication normally given to those suffering with asthma. He continued to be prescribed the medication at Wymott, despite apparently never having been formally diagnosed with asthma. There was also no evidence of regular reviews of his condition, either at Manchester or Wymott. In September 2010, a doctor assessed him after he complained again of chest tightness. The doctor questioned whether he did suffer with asthma, but no further action was taken.
156. Staff at Wymott said that, at the time of interviewing, there was no established asthma clinic at the prison. They explained that prisoners with chronic conditions (such as asthma) should be referred to the nurse led clinic for an assessment. However, they said that such referrals do not always occur with asthmatic prisoners. The clinical reviewer notes that this area of healthcare is currently under review. She makes the following recommendation:

The head of healthcare should establish an asthma clinic in accordance with the British Thoracic Society guidelines.

157. At times, when the man complained of chest tightness or pain, healthcare staff suggested that this might be a physical response to his anxiety and stress. On several occasions, he underwent an ECG examination, which showed no problems or abnormalities. Entries in his medical record suggest that some staff who assessed him thought he might be suffering from panic attacks. However, there is little evidence that any specific link was made between this and his existing mental health problems. Nor was any link made with any of his specific areas of concern, such as his desire for deportation, his proclaimed innocence or his family relationships. No treatment pathway or care plan was ever established to treat anxiety, although he was twice prescribed short courses of diazepam. He was not referred to either of the mental health teams for further exploration of his anxiety and there was no evidence of medical staff discussing their concerns with the mental health practitioner. We do not think that there is any recommendation that we could usefully make that would avoid this happening in

future. However, we are sure that the head of healthcare will wish to give the matter some consideration.

The ACCT process

158. The man was clearly an anxious man with a number of longstanding worries. He made no secret of the fact that he wanted to be deported to his country as soon as possible to be near to his mother. Both staff and prisoners knew that he was worried about his mother's ill health and that he was not there to support the family. He said that he was anxious that she might die before he was released from prison. He was also concerned about his wife and child who lived in the UK.
159. While at Manchester, he was monitored under ACCT procedures on three occasions. In January 2008, his friend and former cell mate hanged himself. He was placed on an ACCT plan to support him. In March 2008, shortly after he was sentenced, fellow prisoners told staff that he had been making ligatures, which he denied. He also denied having any thoughts of suicide. In January 2009, ACCT procedures were put in place again after he apparently tried to hang himself. He denied this but admitted to having "seriously thought about" suicide.
160. Once at Wymott, staff were aware of his anxieties but there was apparently no need to commence ACCT procedures until 4 April 2011. That day, he showed the mental health practitioner a ligature he had made some days earlier. He correctly opened an ACCT plan straight away. This is in line with PSO 2700, Suicide prevention and self harm management, and the prison's local Suicide Prevention Strategy, dated December 2010.
161. The SO who was on duty when the ACCT plan was opened, an officer and the man completed the Immediate Action Plan. However, both members of staff told the investigator that it was the SO who set the observation level at one observation in the morning, one in the afternoon and one in the evening, with hourly observations overnight.
162. PSO 2700 contains some guidance about the setting of observations and conversations. The policy directs that the observations be "appropriate to the individual's assessed level of risk, including their perceived intent and individual need". It continues that one conversation each shift (the level set by the SO) may be suitable for individuals who are not considered to be at high risk of suicide but where there is concern because of current stressors and/or depression.
163. The process of setting conversation and observation levels is clearly dependent on staff making reasoned judgements about what is necessary to support the prisoner and keep them safe. The SO could not remember his involvement in the man's ACCT plan and he did not know him very well. However, the officer thought he knew him quite well. He said that he was a compliant and not overly demanding prisoner. The officer said that he knew he had been monitored under ACCT procedures before. He did not think that he had ever showed staff a

ligature before and told the investigator that staff took seriously the concerns about him for that reason.

164. During the investigation, a principal officer (PO), who is part of the prison's Safer Custody Team, was interviewed. She was asked about the level of observations set by the SO. She emphasised that it is a matter for staff judgement, taking into account all of the information available. The PO said that it should be a multi-disciplinary decision, reached with the agreement of all of the staff present.
165. The PO also explained that the level of contact between staff and prisoners on the vulnerable prisoner wings at Wymott is quite substantial, largely because prisoners on those wings spend much less time locked in their cells. She said that this level of contact allows staff to monitor and interact with prisoners on ACCT plans much more regularly than the set level of observations and conversations recorded on the front of the document. We accept that to be the case, and found wing staff generally to be sensitive to and aware of the needs of prisoners on B wing. We acknowledge that the man did not apparently take his life until some ten days after the opening of the ACCT plan and the level of observations had not been altered since then. It is, of course, possible that, even had the SO set a higher level of initial observations, staff present at subsequent case reviews could have decided to lower the level. However, it is our view that the initial level of observations set by the SO did not reflect the severity of the risk the man posed on 4 April. The officer who completed the immediate action plan said that he did not contribute to the decision about the level of observations and described this aspect of the ACCT process as the decision of the senior officer involved.
166. Consideration of the man's ACCT document during the investigation revealed that the Triggers section of the booklet had not been completed prior to his death. Triggers can include events like anniversaries of the death of loved ones or upcoming court appearances, as well as more general concerns such as boredom. The triggers listed should be specific to the prisoner in question and can help other staff working with the prisoner to identify when the risk of suicide or self harm rises.
167. The PO explained that it can be difficult for staff to identify triggers and we accept this to be the case. However, from interviews with staff and from reading entries in the ACCT plan, it seems clear that the man had a number of significant triggers that could have been listed, including his mother's health, the state of his marriage and his parole application.
168. During the course of the investigation, the investigator considered ten ACCT plans which had been recently closed by staff. She found that in five of them, the staff were required to make an entry in the document once during each of the morning, afternoon and evening shifts. In five cases, no triggers had been listed. The review of the ten ACCT plans highlighted some other omissions, which we do not detail here but which were discussed with the PO.
169. Between 4 and 14 April, the man attended two ACCT case reviews, the first chaired by the SO who completed the Immediate Action Plan and the second by

another SO on duty . During the first case review, only the SO and the man were present (only having one member of staff present is not considered good practice). Although the SO noted that the officer who carried out the ACCT assessment was also there, she told the investigator that she had verbally debriefed the SO before the ACCT case review and had then left the wing. The officer who completed the immediate action plan attended the second case review, which was useful as the SO did not know the man well. However, neither the mental health practitioner nor any other member of mental healthcare staff was present at either case review, nor was there any indication that they had been asked to contribute in writing or by telephone. The Imam might also usefully have contributed but there is no evidence to suggest that he was ever approached. The review of other ACCT plans showed that mental healthcare staff were present at the reviews for six of the ten prisoners and so it seems that it was unusual, but unfortunate, that no mental health staff had an input into the man's case reviews.

170. In 2008, as a result of a previous investigation into a self inflicted death at Wymott, this office made a recommendation to the Governor that the ACCT process be reviewed. We made particular mention of the fact that case reviews and the decisions made as part of the ACCT process should be multi-disciplinary.

171. Wymott last had a safer custody audit in October 2010. This process assesses whether there are any weaknesses in the policies and practices in place. Following the audit, the prison is given a colour coded rating: green (indicating no problems), amber/green, amber/red and red (indicating serious problems). Wymott was given a green rating. Nevertheless, as a result of the discussions above, we make the following recommendation:

The Governor, with assistance from the Standards Audit and the area National Safer Custody Manager, should ensure that a full audit of the ACCT process at Wymott is conducted, and in particular, assure himself that:

- **observation levels set are appropriate to the circumstances and show that staff are clear about the range of options available to them;**
- **the process is multi-disciplinary and decisions are made by the group, rather than the individual;**
- **the Triggers section of the ACCT document is completed, or it is noted that there are no known triggers;**
- **any staff training needs are identified.**

The emergency response

172. On 14 April, the man went to the gym in the morning, returning to B wing at about 10.00am. Unbeknown to staff, he then made in excess of 70 attempts to telephone his wife, speaking to her at about 11.30am. He and his wife had what appears to be a difficult and emotional conversation. They spoke to each other in Urdu, so even those prisoners who could tell that it was not an easy conversation did not know what had been said. His friends said that they knew

he was upset, but when he collected his lunch that day, the officer who had been involved in the ACCT process thought he seemed fine.

173. Shortly after 12.30pm, the prisoners on B wing were locked on to their landings. Some of the prisoners on B3 landing checked the man regularly, because they knew he was upset. At about 1.30pm, they found he had covered his observation panel and was not answering them. They pressed the emergency cell bell to alert staff. Some of the prisoners interviewed were concerned that staff had not responded quickly enough, however, staff said that they walked briskly to the landing, arriving within about one minute. Given that both the prisoners and the staff were not able to provide exact timings, we are not able to comment on the speed of the staff response. We do know that, having found him hanging, an officer appropriately used her radio to alert the prison to the emergency at 1.43pm. As both she and another officer who responded were trained in first aid, they commenced CPR immediately, with two nurses arriving shortly after.
174. The clinical reviewer concludes that the staff response (both by nursing and discipline staff) was effective and in line with guidance issued by the Resuscitation Council UK. Emergency first aid equipment was easily accessible on the wing and the nursing staff were properly trained in its use, including the defibrillator.
175. The communications room log indicates that an emergency ambulance was requested at 1.47pm. The first response paramedic arrived at Wymott within ten minutes and the ambulance arrived within 20 minutes. On the documentation completed immediately after his death, the paramedics wrote that their entry into the prison had been delayed by eight minutes because of “security” reasons. The investigator was not able to gain any further information about this from the local ambulance service or from the prison’s documentation.
176. The investigator was provided with a local policy titled HM Prison Service and the North West Ambulance Service NHS Trust, Attendance of an emergency ambulance protocol. The front cover of the policy document records that it was issued on 1 June 2011, although the investigator was told that it was in place in April. The front cover also details three prisons which have signed up to the policy. Wymott is not one of the signatories although the Governor’s details are listed at the back of the document. The policy details the process for calling an ambulance and providing sufficient detail about the nature of the emergency as well as the security measures that will apply to the paramedics and the vehicles when they arrive. The purpose of the document is to “ensure that both NWS and HM Prison Service staff are working to agreed standards”.

The Governor should ensure that all relevant staff are familiar with and act on the Attendance of an emergency ambulance protocol.

Conclusion

177. Throughout his time in prison and, indeed, at times prior to this, the man presented as an anxious man with a number of longstanding worries. For some time he had protested his innocence; he wanted to be deported to his country as soon as possible to be with his family there; he was worried about his mother's health and that she might die before his release and he was, at times, anxious about his relationship with his wife. None of these issues was easily resolved and most were outside of his control. It is easy to understand that he must have found his time in prison frustrating and upsetting. Despite causing staff to be concerned about his risk to self on several occasions, he had always maintained that he would not take his life.
178. At the time of his death, he was working with a mental health practitioner, who thought that he was making good progress. A couple of weeks before his death, staff had identified that he posed a risk to himself and he was being monitored under ACCT procedures. Our investigation has highlighted that aspects of the care provided to him at Wymott were flawed and we make seven recommendations to reflect our concerns. However, on the evidence available, we conclude that staff had no reason to think his risk of suicide had increased so dramatically on 14 April that any further measures were necessary to keep him safe. On that basis, we do not think that staff could reasonably have prevented his death.

RECOMMENDATIONS

The NOMS response is noted in italics below each recommendation.

1. The head of healthcare and the commissioning body should ensure that:
 - an annual audit of healthcare records takes place;
 - the audit covers staff training needs;
 - an appropriate action plan is developed and implemented.

This recommendation was accepted. An audit of the clinical records took place in November 2011 and training for clinical and non-clinical staff is planned for 2012.

2. The head of healthcare should ensure that staff conducting reception healthscreens have received appropriate training. The MHIT and PCMHT should have an input into the reception process to ensure that prisoners with mental health conditions are not missed.

This recommendation was accepted. NOMS reported that all new staff working in reception at Wymott are mentored. The prison is also developing a reception/discharge policy with identified pathways. The process involves the mental health team.

3. The head of healthcare should introduce electronic prescribing as soon as possible.

This recommendation was accepted. Electronic prescribing is being trialled at the neighbouring prison and will be implemented at Wymott once an audit has taken place.

4. The head of healthcare should improve the processes by which healthcare staff are made aware of prisoners on ACCT plans and ensure that such processes are compatible with the Medication In Possession procedure.

This recommendation has been accepted. Each day, a list of all open ACCT plans is sent to a senior nurse who checks that the medication in possession risk assessment supports the ACCT. Medication is returned to healthcare and staff are made aware.

5. The head of healthcare should establish an asthma clinic in accordance with the British Thoracic Society guidelines.

This recommendation was not accepted because Wymott already has an asthma register and clinic.

6. The Governor, with assistance from the Standards Audit and the area National Safer Custody Manager, should ensure that a full audit of the ACCT process at Wymott is conducted and, in particular, assure himself that:
 - observation levels set are appropriate to the circumstances and show that staff are clear about the range of options available to them;

- the process is multi-disciplinary and decisions are made by the group, rather than the individual;
- the Triggers section of the ACCT document is completed, or it is noted that there are no known triggers;
- any staff training needs are identified.

This recommendation has been accepted. A quality check process on all open and closed ACCT plans has been implemented. Training will be provided to meet shortfalls. This process will be ongoing throughout 2012.

7. The Governor should ensure that all relevant staff are familiar with and act on the Attendance of an emergency ambulance protocol.

This recommendation was accepted. The emergency ambulance protocol is to be re-published and staff familiarised with its contents.