

A Report by the
Prisons and
Probation
Ombudsman
Nigel Newcomen CBE

**Investigation into the death of a man while in the
custody of HMP Wakefield in May 2014**

Our Vision

*'To be a leading, independent investigatory body,
a model to others, that makes a significant contribution to
safer, fairer custody and offender supervision'*

This is the investigation report into the death of a man, who died in hospital in May 2014, after an officer had found him hanging at HMP Wakefield ten days earlier. He was 31 years old. I offer my condolences to his family and friends.

A clinical review of the care the man received at Wakefield was undertaken. The prison cooperated fully.

The man was serving a life sentence and had been at Wakefield since 2008. He had a diagnosed personality disorder and the prison mental health team gave him frequent support. In January 2012, he attempted to hang himself but prison officers found him, cut the ligature and saved him. He suffered physical health complications and stayed in hospital for two months. When he returned to Wakefield, staff supervised him constantly in the prison's healthcare centre for several months. He went back to live on a standard prison wing in September 2012.

In February 2014, the man returned to the healthcare centre, for respite, at his request. On 6 April, he cut himself because he was anxious about moving back to a prison wing and remained as an inpatient. The staff managed him using Prison Service suicide and self-harm prevention procedures.

On the evening of 6 May, healthcare staff told the man that he would have to return to a wing, as they needed his bed in the healthcare centre. Although unhappy, he appeared to accept this and recognised he could not stay there indefinitely. The next morning, a prison officer discovered him hanging from a shower rail in the bathroom. Staff and paramedics attempted to resuscitate him and he was taken to hospital. He remained unconscious and several days later, after consulting his family, the hospital withdrew his life support. He died that day.

The clinical reviewer concluded that the mental and physical healthcare the man received was exemplary and comparable to that he could have expected in the community. I agree. He was a complex person to manage. Prison and healthcare staff adopted a multidisciplinary approach to his care, supported him well and conducted frequent case reviews. Staff had recognised that moving back to a wing would cause him anxiety and had begun to put in place plans to mitigate this risk before they moved him. I am satisfied that although, sadly, he succeeded in taking his own life, staff had worked hard to address his mental health needs and keep him safe.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman

January 2015

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SUMMARY

1. The man had been in prison since 2006, and was serving a life sentence for murder, rape and wounding. He transferred to Wakefield in 2008. He had a diagnosed personality disorder and, throughout his time at Wakefield, he was under the care of the prison's healthcare and mental health teams and a psychiatrist. Doctors prescribed antidepressants and antipsychotic medication and frequently reviewed it. Prison intelligence suggested that he also took other prisoners' medication.
2. In January 2012, the man tried to kill himself by hanging. Officers rescued him, but he suffered severe physical complications and stayed in hospital for two months. When he returned to the prison in March, he lived in the prison's healthcare centre because of his health problems. A multidisciplinary team managed him under the Prison Service suicide and self-harm prevention procedures, known as ACCT. Staff supervised him constantly for several months.
3. In September 2012, the man moved back to a prison wing. In October, staff closed the ACCT. He found it difficult to settle on the wing and had paranoid thoughts about staff and other prisoners. His mental health deteriorated and he went back to the healthcare centre in February 2014, for respite care. He was anxious about returning to a wing and healthcare staff tried to explore the reasons with him, he was unable to explain this and threatened to harm himself. On 6 April 2014, he cut himself and staff again began ACCT procedures again. (These remained in place until his death.) He said he had constant suicidal thoughts and wanted to die.
4. On the evening of 6 May 2014, healthcare staff told the man that he would have to return to a wing, as they needed his healthcare bed. The next morning, an officer found him hanging from a shower rail in the communal bathroom. Staff carried out cardiopulmonary resuscitation and an emergency ambulance took him to hospital. Several days later, the hospital turned off his life support machine and he died that afternoon.
5. Throughout his time at Wakefield, the man received comparable healthcare. The healthcare and mental health teams consistently managed his physical and mental health problems and medication. A psychiatrist reviewed him regularly. The clinical reviewer concludes that the standard of care was equal to that he could have expected in the community.
6. We are satisfied that the man was well managed and supported by a multidisciplinary team under ACCT procedures. The staff held regular case reviews, with consistent case managers and staff involved in his care who knew him. ACCT documents were completed to a good standard. We consider that it would have been very difficult for staff at Wakefield to have prevented his death. We make no recommendations as a result of this investigation.

THE INVESTIGATION PROCESS

7. The investigator issued notices to staff and prisoners at HMP Wakefield, informing them of the investigation and inviting anyone with relevant information to contact her. No one responded directly, but she contacted two prisoners after receiving information from solicitors acting for the man's family.
8. The investigator obtained copies of the man's prison and medical records. She interviewed ten members of staff and a prisoner at Wakefield on 16 July. She also spoke informally to another prisoner and two prison family liaison officers. She gave the Governor initial feedback about the preliminary findings of the investigation.
9. NHS England commissioned a clinical reviewer to review the man's clinical and mental health care at the prison.
10. We informed the Coroner for West Yorkshire of the investigation. We have sent a copy of our investigation report to the Coroner.
11. One of the Ombudsman's family liaison officers contacted the man's next of kin and explained the investigation process. Solicitors acting for them subsequently gave the investigator more information about the man. They asked that the investigation take account of his attempt to hang himself in 2012 and assess whether he was monitored and managed appropriately when he returned to Wakefield from hospital. His family received a copy of the draft report. They did not make any comment.

HMP WAKEFIELD

12. HMP Wakefield is one of eight high security prisons in England and Wales. It holds up to 750 men. There are four main residential wings, a healthcare centre, a segregation unit and a close supervision centre.
13. Spectrum CIC (Community Interest Company) provides primary healthcare services during normal working hours. Humber NHS Foundation Trust (intermediate care) employ the nurses in the inpatient unit, who also provide overnight and weekend care for prisoners with physical health problems. Nottinghamshire Healthcare NHS Trust provides Mental Health Services.

HM Inspectorate of Prisons

14. The most recent inspection of Wakefield was in July 2014. Inspectors found that levels of self-harm among prisoners were not high and support for those at risk of self-harm was generally well managed, with good care for prisoners who were vulnerable. They also considered that health services were very good.

Independent Monitoring Board

15. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help ensure that prisoners are treated fairly and decently. In its most recent report for the year to May 2013, the IMB noted that the healthcare unit continued to improve and provided a comprehensive healthcare service that met prisoners' needs. They also noted that safer custody meetings with prison staff, prisoner representatives, Samaritans and Listeners were well attended.

Previous deaths at Wakefield

16. The man's death was the eighth of eleven deaths at Wakefield since 2013. The other deaths were from natural causes and there are no similarities between those deaths and that of his.

Assessment, Care in Custody and Teamwork

17. Assessment, Care in Custody and Teamwork (ACCT) is the care planning system the Prison Service uses to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk posed, the steps that staff might take to reduce this and the extent to which staff need to monitor and supervise the prisoner. Checks should be at irregular intervals to prevent the prisoner anticipating when they will occur. Part of the ACCT process involves assessing immediate needs and drawing up a care-map to identify the prisoner's most urgent issues and how they will be met. Regular multi-disciplinary reviews should be held. Staff should hold regular multidisciplinary reviews and should not close the ACCT plan until all the actions of the caremap are completed. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

KEY EVENTS

18. The man was remanded to prison in 2006 charged with murder, rape and unlawful wounding. On 16 February 2007, he was sentenced to life imprisonment, with a minimum period to serve of 29 years before he could be considered for release. Later in 2007, he was diagnosed with a personality disorder with anti-social traits.

2008 – 2010

19. The man transferred from HMP Chelmsford to Wakefield on 18 March 2008. On 1 July a mental health nurse assessed him as wing staff were concerned he had been isolating himself. He told her he suffered from anxiety, low mood and anger towards others. He said that he used to cut his arms as a teenager but had no current thoughts of suicide or harming himself. She referred him for an anger management course and made an appointment for him to see the prison doctor. A week later, the doctor prescribed chlorpromazine (an antipsychotic drug) and he remained under the care of the mental health team. He asked to move to the segregation unit in September, as he felt threatened and anxious on A Wing and he went there on 10 September.
20. During 2009, the mental health team became concerned that the man's mental health had deteriorated. He described increasing feelings of anxiety and paranoia and refused to leave the segregation unit. He also felt that his chlorpromazine was no longer effective.
21. In April, a psychiatrist assessed the man. He diagnosed anti-social personality disorder (a lack of empathy or remorse) and replaced the chlorpromazine with citalopram 20mg, an antidepressant. He did not attend the anger management classes or follow-up appointments with the psychiatrist. He continued to refuse to leave the segregation unit or attend work. Throughout the year, he continued to take citalopram and painkillers for a shoulder injury sustained in 2008. His record shows he did not attend a number of medical appointments.
22. In August 2009, the man was moved to Belmarsh prison to allow his family to visit him. (When a prisoner is a long distance from his home and not receiving visits, he can apply to be moved to a prison nearer to his family for 28 days.) In December, he told a nurse that he had mental health problems and that no one had reviewed him since he had got back from Belmarsh in September. She referred him to the mental health nurse. Throughout 2010, doctors and healthcare staff saw him frequently, but he did not have a mental health review.

2011

23. At the beginning of May 2011, a nurse assessed the man, at the request of wing staff. He told her that his paranoia and anxiety had returned but he had no thoughts of harming himself. She noted in his medical record that she

would discuss him with the mental health team to determine whether he should see a doctor. There is no record that this was followed up.

24. On 20 June, the man told staff that he had taken an overdose of his prescribed citalopram and co-codamol (painkillers). He was taken to hospital, but the level of painkillers in his system was below risk levels and he returned to the prison that day. Prison staff began the ACCT procedures and admitted him to the healthcare centre as an inpatient. During an ACCT review and a medical assessment the next day, he told staff that he was fed up and anxious but had no thoughts of self-harm. As he insisted he no longer wanted to take any medication or stay in the inpatient unit, healthcare staff stopped the prescription of citalopram and painkillers and discharged him from the healthcare centre. Staff closed the ACCT on 5 July.
25. On 15 August, the man told an officer that he had a drug habit and was in debt. As he walked away from the conversation, he threatened to cut his throat. Staff opened ACCT procedures again and referred him to the drug treatment team. He subsequently said he no longer wanted to proceed with the referral but did not give a reason. Staff closed the ACCT on 24 August. Prison intelligence suggested that he had bought medication from other prisoners and a drugs test proved positive for codeine, which he had not been prescribed.
26. In September, the man asked for antidepressants and a doctor prescribed citalopram again. Staff opened an ACCT plan on 21 November, and set hourly observations, as he had appeared agitated and withdrawn. He refused to take part in any ACCT assessments. In December, his mental health appeared to have improved. Staff considered he was no longer at risk of suicide or self-harm and closed the ACCT on 9 December. That day, he told healthcare staff that he was addicted to prescribed medication he obtained from other prisoners, but wanted to become drug-free.

2012

27. An entry in the man's case notes on 2 January 2012 stated that he had settled well on A Wing since the end of the ACCT monitoring in December. However, on the afternoon of 19 January 2012, officers discovered him hanging from the window bars in his cell. They cut the ligature and began cardiopulmonary resuscitation. After about ten minutes, they detected breathing and a pulse and an ambulance took him to hospital.
28. An internal investigation concluded that the man had made a determined attempt to end his life, but it was not clear what the trigger for this was. Staff were aware he had substance abuse and associated debt problems, but there was no evidence to suggest that these had escalated in the preceding days. He had not sought any help for problems.
29. Prisoners who knew the man said that he had lost his job as a wing cleaner because of misusing drugs. They said he had been unhappy about being unemployed and felt that this incident had prevented him from getting a job as

a wing painter. He had refused to attend education classes. However, the last prisoner to see him before staff found him hanging said he had given no indication of his intended actions.

30. The man suffered physical health complications from the hanging incident. A lack of blood supply to his intestine had caused gangrene, so doctors performed an ileostomy (where the small bowel is diverted through an opening in the abdomen). The ligature had caused damage to his tongue and larynx, so he could not speak. Although his speech slowly returned, his swallow reflex was inadequate and he was unable to swallow food or drink. As a result, doctors inserted a feeding tube through his abdominal wall. Before he left hospital, prison healthcare staff met staff at the hospital to discuss and plan his discharge needs.
31. On 19 March, the man returned to Wakefield's healthcare centre as an inpatient. Staff managed him under ACCT procedures and constantly supervised him in a gated cell. Staff assessed his level of risk of suicide and self-harm as high. His ACCT caremap objectives included referring him to a psychiatrist, increasing his family contact and improving his health and feeds, which took place through a feeding tube.
32. Healthcare staff contacted the Speech Therapy Service and the hospital as they had had conflicting advice about whether he should sip small amounts of fluid. This remained unresolved, but the man chose to drink. Staff alerted him to the health implications and asked him to sign a disclaimer.
33. On 21 March, a psychiatrist assessed the man. He found no symptoms of mental illness at that time and noted that his attempt to hang himself had not followed a period of depression. He said he had problems with opioid drugs and felt stressed but could not describe his triggers. Although he said that he had no thoughts of suicide, the psychiatrist considered him at risk of suicide and suggested that he might need a named nurse to review his mental state. He was prescribed oral solutions of citalopram and trazadone (another antidepressant), as well as paracetamol and tramadol. (The trazadone prescription ended in April.)
34. At an ACCT review on 3 May 2012, staff planned to adjust the man's observations. He was to remain in the gated cell, but his standard cell door would be closed during the day and staff would watch him using a camera, rather than through the bars of the gate. He was angry about this and walked out of the review. The staff agreed to continue the existing arrangements and review them a week later.
35. On 17 May, staff at an ACCT review decided that the man's cell door would be closed during the night, and he would be monitored by a camera. He accepted this.
36. On 10 June, the man told healthcare staff that he wanted to return to a residential wing, as he was not happy in the healthcare centre. They agreed to plan a structured re-integration back to a wing, once he no longer needed

to be constantly supervised. Over the next few days, he was admitted to hospital twice because of stomach pains and had further surgery.

37. On 24 July, staff at an ACCT review, reduced the man's level of ACCT observations from constant to hourly throughout the day and night and assessed his risk of suicide or self-harm as low. Two days later, he appeared to be in a lot of pain and hospital admitted him for assessment. Doctors diagnosed a blockage in the ileostomy, which had become infected. After treatment, hospital staff advised him to stay in hospital, but he discharged himself and returned to the prison on 27 July. (During his stay in hospital, a nurse became his mental health care coordinator in the prison.)
38. From 5 September, the man no longer needed a feeding tube and, on 12 September, he transferred to A Wing. At an ACCT review on 17 October, he said that he felt he no longer needed to be managed under ACCT arrangements. He discussed the possibility of getting a wing-based job and seemed eager to make progress. The caremap objectives were complete and the review team closed the ACCT. A post-closure review took place the next week.

2013

39. In the first few months of 2013, the man's mental health care co-ordinator frequently reviewed his mental health. On 15 August, he told her that he had experienced anxiety for the previous four or five months. He could not identify the causes or triggers but said that he was coping by keeping busy. He had a job as a wing cleaner and liked to do puzzles when he was in his cell. He was expecting an operation to reverse the ileostomy and, although he felt nervous, he was looking forward to getting it done. He said he had no thoughts of suicide or self-harm at the time.
40. On 28 September, the man told his mental health care co-ordinator he wanted a transfer to Belmarsh, as it would be easier for his mother to visit him. A few days later, on 3 October, he told a nurse, another member of the mental health team, that he felt anxious but could not say what caused him to be anxious. He said that he had no suicidal thoughts and said, "I would never do that again".
41. The man did not discuss the circumstances of his suicide attempt with the mental health team until 13 October 2013, when he told his mental health care co-ordinator he could not remember what he had done or why, but other prisoners had told him that he had seemed to be in good spirits that day. He said that after his forthcoming ileostomy operation he wanted to move on.
42. On 4 November, the man told a nurse that his anxiety had recently increased. She gave him information on overcoming negative thinking and made an appointment to see him a week later. The next day, 5 November, his mental health care co-ordinator reviewed his mental health care plan. She noted that he had seemed more withdrawn recently and appeared to be avoiding social

interactions, so she referred him to the doctor. She also spoke to senior staff on the wing and asked them to keep a close eye on him.

43. On 25 November, the man was angry and frustrated during a meeting with a nurse. He said that he had been unable to contact his mother for three weeks and was concerned that something might have happened to her. He said he had no thoughts of suicide or self-harm at the time, particularly because of the affect it had had on his mother when he had last tried to take his life. After his conversation with the nurse, his mental health care co-ordinator referred him to the interventions team in the prison's Offender Management Unit. The next day a member of the interventions team telephoned and spoke to the man's mother to ensure she was all right and asked wing staff to pass this message to him.
44. On 2 December, a member of the safer custody team noted that the man did not receive visits. She gave him information about pen pals and the prison visitors' scheme. On 4 December, he told his mental health care co-ordinator that he had received a letter to say he could not transfer to Belmarsh because of building work at Belmarsh. He appeared angry about this decision and she advised him to discuss it with an officer.

2014

45. The man's mental health care co-ordinator reviewed him on 7 January. He was hopeful that he would be able to have accumulated visits with his family at Belmarsh again soon, and that he would shortly hear about his ileostomy reversal. She considered that he seemed quite positive during the meeting. He had not been able to discuss his permanent transfer to Belmarsh with a member of staff, so she agreed to send an email on his behalf, about this.
46. On 30 January, the man told his mental health care co-ordinator that his anxiety had increased and certain people on the wing were provoking him. He said he did not want to confront them as he was waiting for his operation and accumulated visits at Belmarsh. He said he had fleeting thoughts of ending his life, although he immediately stressed that he would not do so because of the effect it would have on his family. She gave him some literature about coping with anxiety and spoke to a doctor about reviewing his medication. The doctor prescribed him trazadone and quetiapine (an antipsychotic drug).
47. The next day, the man told an officer that he thought officers were getting at him, but he could not identify anyone in particular. Although he felt low, he said he did not feel comfortable talking to the officers or supervising officers. However, he said that he spoke to someone from the mental health team every month. He said he did not think he would harm himself as he had too many things coming up, such as his operation and seeing his mother.
48. The man's mental health care co-ordinator and a nurse saw him at his request on 17 February. He thought the medication was helping him, but he felt very tired. He said that his tolerance levels were very low and he felt at breaking

point. He reported having had suicidal thoughts but said he would not act on them. His application to go to Belmarsh for accumulated visits with his family had been delayed because of building work. He told the nurses that he needed additional support and coping strategies and asked if he could return to the healthcare centre for some respite. Healthcare centre staff agreed he could go for a week and admitted him later that day.

49. Two days later, on 19 February, the mental health care co-ordinator and the man discussed how he felt about returning to A Wing once the week was up. He said that he did not want to go back to A Wing, or any other wing, as he was concerned about possible confrontation with other prisoners. He spoke about various difficulties he had experienced on the wing, such as the time he had been unable to contact his mother. He felt that he was being “fobbed off” about a transfer to Belmarsh and doubted that there was any building work there. She considered that he appeared very low in mood.
50. A psychiatrist reviewed the man on 26 February. He said he had no thoughts of suicide or self-harm, but recounted paranoid ideas that others were trying to antagonise him. The psychiatrist considered this was a symptom of his personality disorder. He stopped his quetiapine and prescribed him chlorpromazine, 25mg. He continued to take trazadone each night.
58. On 5 March, the mental health care co-ordinator, a nurse and a custodial manager held a mental health care planning meeting with the man to discuss his discharge from the healthcare centre. He said others were still winding him up to get a reaction. The staff advised him that it would be better to return to a wing, as staying in the healthcare centre might affect his applications for accumulated visits and a permanent transfer. However, he said that he was likely to attack someone on a wing. The staff agreed that he should remain in the healthcare centre for another two weeks. Over the next few days, he appeared to integrate and communicate well and seemed much happier.
59. At a review with a psychiatrist on 12 March, the man still presented as low in mood. However, he said he felt a little better in the healthcare centre and his mood had improved. The psychiatrist increased the chlorpromazine dosage and considered changing trazadone to sertraline (another antidepressant), to be reviewed three weeks later. He concluded that, although his risk of suicide or self-harm was “chronically raised”, he was in no immediate danger and advised that he should remain as an inpatient for respite and to monitor the change in his medication.
60. On 19 March, the prison’s offender management unit advised the man that they had reviewed his security category and decided that he should remain as category A. Staff had recorded in the review papers (in entries dated August 2013) that in the preceding year, there had been no evidence of inappropriate behaviour or any disciplinary action taken against him and no positive mandatory drug tests. They had also noted that the substance misuse team had assessed him and he had recently agreed to one to one sessions with the team.

61. For the next two weeks, the man's mood was bright and he interacted well with staff and other prisoners. However, on 26 March, when a psychiatrist saw him again, he appeared irritable and hostile. He was annoyed that he was still waiting for his operation and frustrated that his application for a transfer to another prison had not been approved. The psychiatrist increased his chlorpromazine again.
62. The next day, an officer gave the man a warning for verbal aggression. In the afternoon, a chaplain went to see him as he had said he wanted to donate his guitar to the chapel. The chaplain persuaded him not to, as playing his guitar helped him cope. He said he would arrange for him to have some guitar lessons. Immediately afterwards, he told an officer that he felt stressed, but did not know why and thought that officers were stressing him out on purpose. He assured her he did not feel like harming himself. He did not attend his appointment with the psychiatrist on 2 April. (He had attended counselling and support meetings earlier that day.) The mental health care co-ordinator and psychiatrist discussed him and the nurse agreed to speak to him later.
63. On 3 April, the man attended the colorectal clinic at hospital. The hospital put him on the waiting list to have his ileostomy reversed and he seemed happy about this.
64. The next day, the man told his mental health care co-ordinator about his hospital visit. She asked whether he had thought about returning to a wing. He said he would refuse to move to A Wing or B Wing, but accepted that he could not stay in the healthcare centre indefinitely. She then spoke to a nurse about a move to either C Wing or D Wing. Later that day, staff told him that he would be moving to C Wing. He became very anxious, so they agreed he should stay in the healthcare centre a few days longer. His medical record shows that throughout his time in the healthcare centre, he received frequent counselling, advice and support from healthcare staff and had frequent mental health reviews.
65. On 6 April, the man smashed his CD player and his guitar. His mental health care co-ordinator went to see him the next day and he explained that this had been triggered by an argument with his mother about his unwillingness to go back to a wing. He showed her superficial cuts to both his forearms. He said that he had intended to bleed to death, but he had not gone deep enough. She began ACCT procedures.
66. An immediate action plan stated the man should remain in the healthcare centre, staff should conduct hourly observations, he should be referred to the mental health team and given full access to the Samaritans' telephone (a cordless phone to allow prisoners to call the Samaritans from their cells) and Listeners (prisoners trained by the Samaritans to support others in distress).
67. On 8 April, at an ACCT assessment interview with an officer, the man said that he was so wound up that he felt he might take his life.

He repeated that the cuts to his arms had not been deep enough and he had, and still wanted, to die. He said he had felt very low for a couple of weeks with constant thoughts of suicide and ways he could take his life. He said he did not want to be in Wakefield and would like to be in a prison nearer his family.

68. A nurse held the first ACCT case review at 2.30pm with the mental health care co-ordinator and a chaplain. The man said that he wanted a transfer to another prison and would harm himself if staff forced him to move out of the healthcare centre. He thought that everyone was against him. He said that his CD player had been bugged and that he had seen an officer putting the bug in his pocket.
69. The nurse noted that the man's risk of self-harm was raised and his likelihood of further risk behaviours high. It was agreed that he would have another mental health review and that staff should continue to observe him hourly. The next ACCT review was scheduled for 11 April (although one was held the next day). She completed the caremap with the following actions:
- To help him try and build a better relationship with wing staff and return to a wing, with the assistance of the mental health team and chaplaincy.
 - Staff to ensure he attended a pre-existing appointment the next day with the prison's psychiatrist.
 - For him to remain in regular contact with the mental health team and attend weekly meetings to address his paranoia and mental health.
 - A healthcare officer would take the lead in encouraging him to relax and eat his meals, as there was concern that he was malnourished.
 - The same healthcare officer would encourage him to participate in small groups.
 - He should apply to an operational manager for a transfer to Long Lartin.
70. Just after 10.00pm that evening, a member of staff (signature illegible) carrying out the nightly observations saw the man standing in his cell, with his back to the door, holding what appeared to be a strip of a bed sheet. The officer persuaded him to hand it to him and they spoke for about ten minutes about how he was feeling. A little later, the same officer went back to his cell with a nurse who was dispensing medication. He said there was nothing he needed and would not discuss his concerns with the nurse. An hour later, the officer observed him tying a length of bed sheet to his bed frame. He handed it to the officer, who contacted a custodial manager, who was the night orderly officer in charge of the prison that night.
71. The night orderly officer went to the man's cell and spoke to him for over half an hour. After the night orderly officer had a discussion with the duty governor, they agreed that he should remain in the cell with observations increased to three an hour. He assured staff that he would not attempt "anything stupid" and a member of the intermediate care team spoke to him.

72. The Head of Safer Custody held the second case review the next day, 9 April, with a Healthcare Officer, a residential officer, a chaplain and the mental health care co-ordinator. A psychiatrist and a member of the mental health team joined them for part of the meeting. They now assessed him risk as low and agreed that he needed to remain in the healthcare centre as he had complex needs. Staff were required to have one quality social interaction with him each morning, afternoon and evening and observe him at least once every two hours. They discussed the short-term aims of getting him to relax and take meals and long term aims of resolving the reasons for his reluctance to return to a wing and getting him back to a wing. They agreed that he was not in acute crisis and planned a review for 19 April.
73. After the meeting, the psychiatrist noted in the man's medical record that decisions about his placement should be taken by a multidisciplinary team, including mental health staff, as his risk of suicide was high given his history.
74. A supervising officer (SO) chaired the third case review on 19 April, with a Healthcare Officer (HCO). They agreed that the man had appeared more settled and his mood seemed stable. They moved him to a safer cell (with reduced ligature points) in the healthcare centre. As a number of key staff were not available for this review, another was planned for 23 April. The front of the ACCT plan noted that observations should be once every two hours during the night.
75. On 20 April, the man telephoned a friend and said that he was on a waiting list for an operation to reverse his ileostomy, which could take place in three months. He said that this was good news. He also said that he had lost his enhanced privileges as he had "smashed up" some items in his cell. He explained it was because he had felt stressed, but that staff did not believe that he suffered from stress and anxiety.
76. In a telephone conversation with another friend on 23 April, the man said that he had hung himself a while ago, but he was getting through it. He said that he was worried that none of his friends would want to talk to him because of his offence.
77. That afternoon, 23 April, the man attended a fourth case review chaired by the SO. A chaplain, an officer and a member of the mental health team also attended and they reviewed the caremap. He said he felt all right and had had a good few days. He felt he was getting the support he needed, although he sometimes found it hard to speak to staff. He said he had no thoughts of harming himself at that time. The review team continued to assess his risk as low and kept the same level of observations.
78. On 25 April, the man telephoned a friend. He said he was in "a bad way" and lived in the prison's healthcare centre, as he could not cope on a wing. His friend was supportive.
79. The next day, 26 April, the man telephoned another friend and said that he had tried to hang himself and his bowel "had stopped working". However, he

had found out he could have an operation to reverse this. He added that people in the prison thought he was a “nutcase”.

80. At a mental health review on 28 April, the man was animated about his conversation with his friend and told the mental health care co-ordinator that he was looking forward to visits from him and other friends. He also spoke in detail and at length about his disagreement with his mother and said they had not spoken since their argument. He thought he ought to telephone her to tell her about his forthcoming operation.
81. The mental health care co-ordinator reminded the man that he had been an inpatient for ten weeks and offered him the opportunity to go to the wing for association. He said that he would prefer to be transferred back to the wing than have a gradual reintegration, but kept talking himself out of it. He said he was concerned that returning to the wing would delay his operation. She assured him that it would not affect his admission date.
82. A SO and a member from the mental health team and the chaplain held a fifth ACCT case review on 30 April. The man said that he felt settled but he became agitated easily. He said he wanted to transfer to Long Lartin prison, which was closer to his mother (although this was not correct). He mentioned that he had had some problems on the wing, issues that prevented him from returning, but would not go into detail about them. The case review continued to assess his level of risk as low. His observations remained the same during the day but were reduced to five each night. The case review record showed the next review as 13 April. (Which we assume should have been 13 May.)
83. The same day, a psychiatrist reviewed the man. He noted that he presented as calm at first, but later became irritable and walked out of the consultation. He said that he had thoughts of self-harm but did not intend to act on them. He also said that he hated Wakefield and would do something to himself in future if he did not transfer. He felt that no one was listening to his requests for a transfer. He blamed the prison for his condition and said he should not have been sent back to Wakefield after he had tried to hang himself. The psychiatrist recorded that his risk of suicide or self-harm was chronic. (This referred to the fact that he had an ongoing likelihood of a further attempt at suicide because of his history, not that his risk was acute or high at the time.)
84. On 1 May, the man left a telephone message to say that his operation could be reversed, but it is not clear who the message was for. His last call was to a friend on 3 May. They spoke about mutual friends and his friend agreed to visit him. Over the next few days, he engaged well with staff and associated more with other prisoners.

6 May

85. At 5.00pm on 6 May, a nurse held a mental health review with the man, at the request of healthcare inpatient staff. They thought he was doing well and wanted to discuss the possibility of him moving back to a residential wing. He said that he was unhappy about this, but that, he would move if he had to.

The nurse told him that the mental health team would offer him increased support, including daily contact, on the wing if he needed it. After their meeting, the nurse discussed with inpatient staff the increased risks of him returning to a wing against his will, including the risk of suicide or self-harm. They agreed to complete a discharge review for his move and develop a risk management plan.

86. Half an hour later, an officer noted in the on-going ACCT record that the man had become confrontational and felt that staff were singling him out. He was unhappy about the suggestion that he would have to move back to a wing.
87. Later that evening, a nurse told the man that he would have to move, as they needed the bed. She recorded that he was unhappy at the prospect. He raised no further concerns during the night.

7 May

88. On 7 May, prisoners in the healthcare centre were unlocked between 8.00am and 8.30am for medications and breakfast. HCO 1 recalled unlocking the man that morning and saw him go into the day room to speak to other prisoners. A prisoner remembered that he had chatted to him that morning. He said that he gave no indication that he was intending to harm himself.
89. Another prisoner said that the man sat in the day room with him and other prisoners, and they had walked to the kitchen together after breakfast. He had asked the prisoner to get a general application form for him, which he did. He then said he was going to have a shower.
90. The man asked the HCO if he could take a shower. (The bathroom is usually locked in the mornings and prisoners have to ask staff to unlock it for them.) While walking to the bathroom, he said that he needed clean clothes and they went to the clothing cupboard. The HCO recalled that the T-shirt he handed to him had a cigarette burn. He offered to change it, but he replied that it did not matter. He unlocked the bathroom and he went inside. The HCO said he did not seem any different from usual, or give him any cause for concern. He did not go back to his cell at any stage after he was unlocked.
91. At approximately 9.00am, HCO 2 was passing the shower and noticed the man looking out of the observation window. He said he then went to the day room and sat with some of the prisoners. Sometime later, a prisoner asked him if he could have a shower. He went to the bathroom and knocked on door. There was no reply. He looked through the observation panel but could not see anyone, although he noticed a pile of clothes on the floor. The door was still unlocked, so he opened it and shouted the man's name twice as he had seen him in the shower earlier. He pulled back the shower curtain and found him hanging from a ligature made from a bed sheet, tied to the shower rail. He immediately called for assistance, but did not use an emergency medical code. He lifted him to try to release the pressure of the ligature. He told the investigator that he did not use an emergency code, as healthcare staff were immediately available.

92. Officer A had been watching a prisoner on an ACCT who was being constantly supervised. He said he heard the man's name being called followed by a call for staff but, at the time, he did not know it was from HCO 2. He went to the shower room, where the HCO was holding the man's weight to release the tension on the ligature. He cut the ligature to release it from the rail and both officers lowered him onto the floor. He cut the ligature from his neck. As he left the shower room to alert other staff, he checked the prisoner he was meant to be watching constantly and a nurse arrived.
93. The nurse asked Officer B to call an emergency code blue and ask the control room to call an ambulance. (A code blue call indicates a medical emergency such as where the prisoner is unresponsive or has difficulty breathing.) Control room staff noted in the log that they received the code blue call at 9.29am and called an ambulance immediately. She checked the man but found no signs of life. She asked another nurse to bring an emergency bag and a defibrillator. Two more nurses arrived and Officer A returned to the prisoner he was supervising.
94. The staff started cardiopulmonary resuscitation (CPR). An officer carried out chest compressions while the nurse administered breaths using an ambu-bag. They attached the defibrillator, which did not advise a shock and continued CPR. Paramedics arrived at the prison at 9.35am and reached the healthcare centre at 9.41am. They continued CPR and eventually felt a pulse. At 10.04am, the ambulance crew transferred the man to the ambulance and took him to hospital.

Transfer to hospital

95. Staff completed a risk assessment for the man's journey to hospital. This noted that there were medical objections to the use of restraints and he should not be handcuffed. Although staff assessed his risk as 'medium' and he was a category A prisoner, he was unconscious and therefore was not a threat to staff, the public or an escape risk. The Governor agreed that he should not be restrained and the Deputy Director of Custody for high secure prisons approved this. A supervising officer and a prison officer would escort him and keep a discreet presence in the hospital.
96. The man arrived at hospital resuscitation room at 10.19am and hospital staff later moved him to the intensive care unit and placed him on a ventilator. A scan showed that he had significant brain damage. He remained unconscious throughout. Healthcare staff at Wakefield contacted the hospital frequently for updates on his condition.

Informing the man's family

97. A prison chaplain telephoned the man's mother at 10.35am to tell her what had happened. As there was no response, he left a message asking her to call him back. He managed to speak to the man's stepfather at 10.45am and explained that his stepson was in hospital after an attempt to take his life.

Prison family liaison officers then kept in close and frequent telephone contact with the family. They arranged transport and accommodation for his family to visit the hospital on 10 May. A family member remained at the hospital with him.

Debrief and support immediately after the incident

98. Prison managers debriefed the staff involved in the emergency and reminded them of the support available. Healthcare staff monitored a prisoner and offered him the support of Listeners and the Samaritans. They reviewed other prisoners subject to the suicide and self-harm procedures in case they had been affected by the man's actions.
99. The next day, the Governor reissued a notice to staff about the emergency response procedures. Managers began an application for early release on compassionate grounds. They obtained medical information to support the application, but the man died before it could be fully considered.

11 May

100. The Duty Governor held an ACCT review on 11 May, with one of the escort staff, another officer and a family liaison officer. They noted that the man remained unconscious, in a critical condition and was unlikely to survive. With the agreement of his family, they closed the ACCT procedures.

Events leading up to the man's death

101. Two escort officers were on duty. The man remained on a ventilator in the intensive care unit. At 9.30am, a hospital consultant told them that a decision had been made to withdraw his life support as his condition was deteriorating further. An officer telephoned the prison and passed on this information. The consultant telephoned the family. They agreed to travel to the hospital and estimated that they would arrive at 4.00pm. An operational manager at the prison arrived at the hospital at 2.15pm for a management check of the escort and to meet the family.
102. At 5.30pm, with the consent of the family, hospital staff removed his breathing tube. A doctor recorded time of death as 5.50pm.

Post-mortem

103. The provisional post-mortem report concluded that the man died from bronchopneumonia, global cerebral hypoxia (lack of oxygen to the brain) caused by hanging.

Support for staff and prisoners

104. After the man's death, the operational manager debriefed the two escort officers and one of the family liaison officers and offered support.

105. The Governor issued a notice to staff and prisoners, informing them of the man's death and outlining support available for anyone who was affected by his death.

Information received after the man's death

106. Two prisoners wrote to the investigator. Prisoner A had worked with the man as a painter. He said that the man had been prone to mood swings, but he seemed to have made progress and felt better. He had been unhappy about wearing a colostomy bag, but had hoped to have it reversed.
107. Prisoner B said he had been concerned about the man's mental health, particularly in the weeks before he died. He said that, after his first suicide attempt in 2012, he had started to take medication prescribed to other prisoners to help him cope with the stress of prison. He had got into debt for this and had been bullied to repay it. After he moved to A Wing in September 2012, he had problems with his medication and his colostomy bag frequently leaked. He felt they were being sabotaged and this had increased his anxiety.

ISSUES

Clinical care

108. The man had been diagnosed with a personality disorder and, for most of his time at Wakefield, was under the care of the mental health team and a psychiatrist, who prescribed antidepressants and antipsychotic medication.
109. The clinical reviewer considered that the healthcare the man received after his self-harm attempt in 2012 was exemplary. He commented that the man received excellent care after his major operation in 2012 and there was evidence of good liaison between the services and patient-centred care. He was appropriately admitted to the healthcare centre as an inpatient and the care he received was consistent with his diagnosis. Staff handled his reluctance to live in a residential wing sensitively and made plans to ensure that he reintegrated gradually, with continuing daily support from healthcare staff.
110. In the week before his death, the man did not display the signs of stress or anxiety that he had demonstrated previously and had preceded his mental health deterioration in the past.
111. The clinical reviewer commented that it does not appear that the shower rail in the healthcare centre was a collapsible type, which would have been the requirement in a NHS in-patient mental health facility. His clinical review therefore recommends that this issue should be addressed. We agree, but do not make a formal recommendation about specific types of shower rails, as the Head of Healthcare will need to ensure a wider risk assessment that takes into account security implications. More broadly, we also think it important to recognise that it is not possible to eliminate all ligature points. Prisoners who have made a determined decision to kill themselves will be able to find other opportunities, including in their cells, and the challenge facing staff is to manage those risks in the prison context.
112. The clinical reviewer acknowledged that the resuscitation attempt was in accordance with the guidance of the European Resuscitation Guidance 2010. He concluded that the care the man received at Wakefield was comparable to that he would have expected in the community. We agree that he received a high standard of physical and mental healthcare throughout his time at Wakefield.

Suicide and self-harm monitoring

113. Prison Service Instruction (PSI) 64/2011 sets out the Prison Service framework for delivering safer custody procedures and practice. It states that ACCT reviews should be multi-disciplinary, held at the appointed dates, set appropriate levels of frequency of observations and staff should complete ACCT documents fully and accurately.

114. Staff managed the man under the ACCT provision several times. After he tried to kill himself by hanging in January 2012, they continuously monitored him under the ACCT process until October, and he remained on constant supervision for the first few months. Staff reviewed his level of observations frequently and adjusted them as necessary. The ACCT documents were fully completed. Case reviews were multidisciplinary, with healthcare and mental health representatives, members of the chaplaincy and others, such as a psychologist and his psychiatrist. It is noteworthy that over a nine-month period, apart from three or four occasions, the same two staff acted as case managers at ACCT case reviews and the mental health representatives were those directly involved in his care. This provided excellent continuity of care.
115. We consider that throughout his time at Wakefield, the man's risk of suicide and self-harm was acknowledged and managed effectively over a long period. The staff involved complied with the requirements set out in national instructions and provided good support through the ACCT process and in their day-to-day care.
116. The man's history meant that he was always at increased risk of suicide, which is why the psychiatrist assessed his risk as 'chronic' rather than immediate. The staff had recognised that the possibility of a move back to the wing would cause him anxiety and, on 6 May, had discussed what needed to be done to reduce the risk before that was done. This included providing extra mental health support and developing a risk management plan. However, at that time, they had made no firm decision about a discharge date and he did not present as at imminent risk of suicide. We are satisfied that the staff understood the risk and were making appropriate plans to mitigate it. It would have been very difficult to have anticipated his actions on 7 May. Ultimately, it is very difficult to prevent a person who makes a determined decision to kill themselves from doing so, especially when they indicate otherwise.

Emergency response

117. The HCO who found the man shouted out for staff. He told the investigator that he did not use an emergency code as they were in the healthcare centre and there were several healthcare staff nearby. We understand that his first priority was to support the man's weight. A nurse arrived immediately and asked an officer to call an emergency code blue. We are satisfied that there was no delay in getting assistance and the control room called an ambulance as soon as they received the emergency code. We also note that the Governor reissued guidance on emergency response codes the day after the incident as a reminder to staff.

Allegations of debt and bullying

118. The man was anxious about living on a residential wing, but would not disclose to staff or his psychiatrist the reasons for his anxiety. One of his friends said that, in the past, he had got into debt because of using illicit drugs and had been bullied for repayment. We have found no evidence that he

reported that he had been bullied and, although some staff were aware that he had taken medication that had not been prescribed to him, there is no record that they suspected other prisoners of bullying him. A security category review in 2013 indicated that there had been no evidence of substance misuse during the year. There are no security incident reports that indicate any concerns that he was being bullied.

119. Although it is possible that previous bullying was one of the causes of the man's anxiety about living on the wing, he never spoke about it to staff and we cannot know whether this was the case, or whether it was related to his general feelings of anxiety and paranoia.