



A Report by the
Prisons and
Probation
Ombudsman
Nigel Newcomen CBE

**Investigation into the death of a man at HMP Wymott
in June 2008**

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 report considers the circumstances surrounding the death of a man, a prisoner at HMP Wymott, in June 2008. He was found hanging in his cell. He was 27 years old. I offer my sincere sympathy and condolences to the man's family for their loss.

I apologise for the considerable delay in publishing this report and any distress this may have caused the man's family and staff at Wymott.

The prisoner was a troubled young man whose difficulties stemmed from issues arising both within and outside prison. He had a history of substance misuse that continued for a time in prison, which he eventually appeared to overcome in the last few months of his life. He engaged with both the drug counselling services and mental health teams and was also supported by staff as part of their anti-bullying strategies. In the last six months of his life, he was monitored under the self-harm and suicide monitoring procedures over three separate periods, citing longstanding family issues as the source of his unhappiness. He had a pattern of short periods of stability and a positive outlook, followed by bouts of despair regarding his family difficulties and relationship problems. This prompted three serious attempts at harming himself, the last resulting in his death.

The investigation was carried out by an Assistant Ombudsman. I would like to thank the Governors of both HMP Wymott and HMP Risley for the cooperation of their staff during the investigation. Particular thanks go to two members of liaison staff for their efficiency in facilitating visits and sharing documents. I am also grateful to the clinical reviewer for conducting the review of the man's clinical care, on behalf of Central Lancashire Primary Care Trust.

The self-harm monitoring of the man at HMP Risley complied with policy requirements in its level of detail and multidisciplinary reviews. I am pleased to note an example of good practice on the part of a principal officer, who had the foresight to email staff at HMP Wymott to alert them to an outstanding post-closure ACCT case review the day before the man transferred there. I have copied this report to the Governor of HMP Risley. Support was less effective at HMP Wymott. I therefore make a recommendation about reminding staff of the key elements of the Assessment, Care in Custody and Teamwork (ACCT) process. The handling of family liaison also fell short of expectations, owing to the absence of trained family liaison officers. Although some of the shortcomings have been addressed as a result of previous recommendations, and there has been a change of Governor since the man's death, I recommend that staff are reminded of the need for equal treatment in the event of the deceased having more than one branch of the family. I also recommend that the Governor makes a retrospective offer of a contribution towards the man's funeral expenses. It is disappointing that during a period of such distress his family were not dealt with in a more considerate manner.

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.

Jane Webb
Acting Prisons and Probation Ombudsman

July 2011

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SUMMARY

The man was remanded to HMP Forest Bank on 13 June 2007. This was not his first time in prison. He had served previous sentences at both Forest Bank and HMP Wymott. He was 27 years old.

During a health assessment in his first few days at Forest Bank, the man admitted to unresolved bereavement issues, feeling depressed and previous thoughts of harming himself and ending his life. A subsequent mental health assessment concluded that he displayed no signs of biological depression but the assessor gave him advice on ways to naturally lift his mood. He was convicted on 13 August and remained at Forest Bank until December. He then completed a 20 week substance misuse course in which he identified arguments with his partner as a high risk situation. Between August and November, he was subject to disciplinary action on several occasions and was also reported for allegedly bullying other prisoners.

The man transferred to HMP Risley on 10 December. At his reception healthscreen, he told staff that he had taken heroin the previous day and had previously suffered from low mood. Later that day, the prison community health team assessed him and he denied any thoughts of self-harm or suicide, or feeling highly distressed. He agreed to drug detoxification the following day, but was recorded to be uncooperative.

Towards the end of January, the man told staff that he feared for his safety. His brother also telephoned prison staff to alert them to his brother's concerns that he would be assaulted. Staff agreed to treat him as a victim under the prison's anti-bullying strategy and reassured both the man and his brother that they would support and monitor him. The man asked to be segregated in the Care and Separation Unit, but staff resisted this and advised him they would prefer to put alternative solutions in place. They explained the various options to him. Nevertheless, he was taken to the Care and Separation Unit on 27 January after staff found a mobile telephone in his possession. Two hours later, staff placed him on self-harm and suicide prevention monitoring (which remained in place until 27 February) as he had written to his partner to say that he intended to end his life. In an assessment the following day, he cited family problems and the threat of assault by other prisoners as the cause of his stress and inability to cope. He admitted that he had been close to hanging himself the previous evening. He also mentioned a previous suicide attempt in 2003.

Prison staff responsible for supporting the man explored his concerns and the actions necessary to address them and held regular multidisciplinary case reviews. In spite of this, on the evening of 3 February 2008, while carrying out a monitoring check, staff found him in his cell lying in a pool of blood, caused by deep cuts to his forearms. He was taken to hospital where he underwent surgery under general anaesthetic. On his return to Risley, he continued to be monitored under the prevention of self-harm and suicide provisions until 27 February. A post-closure review was set for 26 March.

The man transferred to HMP Wymott on 4 March. The day before he moved, a principal officer at Risley notified Wymott of the details of the outstanding review.

During the reception healthscreen at Wymott, the man said that he was depressed and had been using drugs in prison. He spoke of the episode of self-harm in February but said he was no longer feeling suicidal and asked to be placed on one of the wings for vulnerable prisoners rather than a standard residential wing.

The man continued to have family difficulties. On 15 April, staff again placed him on suicide prevention monitoring when he told an officer that he had nothing to live for and felt like ending his life. The document relating to this period could not be found by the prison, but there are references to some of the actions in his personal, medical and wing records. It is not known when this period of monitoring ended, but anecdotal evidence suggests that it was still in place in early May.

The man made another attempt to take his life on 7 May. He tried to hang himself and then cut deep wounds to both inner elbows. Suicide prevention measures were again put in place and he was taken to hospital, where he had an operation to repair the wounds. A psychiatrist at the hospital also assessed him. He returned to prison two days later and remained subject to monitoring. A post-closure review was held on 28 May, in which he was said to be positive about the future and confident about seeking staff support if he needed it.

The day before the man died, he had an interview with his personal officer in which he was said to be calm and positive. They discussed his wish to work positively towards release and spoke about the support he had received from other prisoners with whom he felt able to share his problems. However, it seems that during that day, he also had acrimonious telephone conversations surrounding his family issues.

The man was found hanging in his cell just after 6.00am the following day and staff attempts to resuscitate him were unsuccessful. A hot debrief was held a little later and staff were also advised of the sources of support. (A hot debrief is a meeting for staff to discuss emotive issues and lessons learned after serious events such as a death in custody.) Staff moved prisoners to an association room and offered them support. The man's partner, who he nominated as his next of kin, was told of his death by the police. The news was broken to his parents by other relatives.

The clinical reviewer identified no serious failings in the management of the man, but he has made several in respect of clinical processes, which I endorse. I am satisfied that staff managed the man appropriately throughout his sentence. However, I make three recommendations asking the Governor of Wymott to consider improvements to suicide prevention procedures and family liaison. I also identify an instance of good practice at Risley.

THE INVESTIGATION PROCESS

1. The investigator visited HMP Wymott on 12 June 2008 to open the investigation. She had meetings with the then Governor, the Chair and Board Development Officer of the Independent Monitoring Board (IMB) and representatives of the Prison Officers' Association.
2. Invitations were extended to staff and prisoners, inviting anyone who might have information relating to the man to contact the investigator. In response to the notices, the investigator had a discussion with a prisoner during her initial visit and conducted an interview with him on a subsequent visit.
3. The prison provided copies of the man's prison and medical records. The Clinical Services Coordinator of North Lancashire Primary Care Trust (PCT), conducted a clinical review of the care the man received prior to his death on behalf of Central Lancashire PCT.
4. The investigator carried out interviews with a number of staff and prisoners in October 2008, assisted by a colleague. The investigator returned to conduct further interviews in February 2009 and two telephone interviews were carried out thereafter. All interviews were either recorded or notes taken.
5. The investigator also visited HMP Risley on 18 June 2009. She talked to staff about specific aspects of the man's management, as well as the policy and procedures relating to suicide and self-harm prevention monitoring, segregation, anti-bullying and other key issues. She was also given a tour of specialist facilities such as the reintegration unit.
6. One of the family liaison team telephoned the man's partner to tell her about this investigation and to offer the opportunity to raise any concerns or questions that she wish to be addressed. She raised no concerns at that time but mentioned that she found it difficult to speak to people she did not know over the telephone. His partner subsequently contacted the family liaison team to say that she would like to know the outcome of the investigation.
7. The family liaison officer also wrote to the man's parents and she and the investigator subsequently visited them and the man's wife at their home on 19 August 2008. The family solicitor was also present at the meeting. The family raised a number of issues, summarised below:
 - Concerns regarding bullying.
 - Why they were not allowed to visit the man in hospital after the incidents of self-harm.
 - Whether there was any CCTV footage covering the man's cell.
 - The handling of family liaison and breaking the news of his death.
 - Clearance of the cell before the family visited.
 - Confiscation of photographs taken during the family visit to the prison.
 - Why the man was not being monitored under the suicide prevention measures at the time of his death.

- Whether the length and quality of any assessments before removing the man from suicide prevention monitoring were appropriate.
- Why the man was not checked overnight.
- How the man was found and what he had used as a ligature.

I hope the findings of my investigation help the man's family better understand the events leading to his death.

HMP WYMOTT AND HMP RISLEY

HMP Risley

8. HMP Risley, where the man was located before he went to Wymott, is the largest category C prison in the country. It has an operational capacity of 1,085. In an inspection by HM Chief Inspector of Prisons from 14 to 18 July 2008, it was judged that, “staff struggled to cope with the pervasive influence of readily available drugs and gang activity”.
9. In addition to general wings, Risley has specialist wings for substance misuse support, sex offenders and a reintegration unit, run as a ‘halfway house’ for prisoners with behavioural problems. The protocol is that prisoners are only selected to live on that wing from the CSU. The prisoners are interviewed before gaining a place and are given more attention because of a higher staff to prisoner ratio (2:12). Prisoners in the unit are able to deal with various agencies in jail and there is more scope for dealing with punishments. The man spent some time in the reintegration unit and, as he had built up a drug debt, this was considered to be the safest place for him.
10. HMP Wymott is a male category C training prison near Preston. (On arrival into prison, prisoners are risk assessed and given a category based on their offence and the risk that they pose to the public should they escape. There are four categories: A, B, C and D, with category A prisoners being the most dangerous. Category C is for prisoners who cannot be trusted in open prison conditions but who would not have the ability or resources to make a determined escape.) The prison has an operational capacity (maximum crowded capacity) of 1,144, with facilities for vulnerable prisoners, who make up over half the total population. (Vulnerable prisoners are those who request segregation under Prison Rule 45. This can be for a number of reasons, for example, if they have committed an offence of which other prisoners disapprove, if they have debts to other prisoners that they are unable to pay, or if they are at risk of bullying.)
11. The prison consists of a number of accommodation blocks, some built just before the prison opened in 1979 and others, in the 1990s and 2000s. There are 11 wings, as well as a Care and Separation Unit (CSU). (The CSU is a unit where prisoners are held if they are removed from association with other prisoners, for example, if it is thought that their behaviour might lead to a disruption in the good order of the prison. An operational manager is required to record the reasons for the prisoner’s removal.) The blocks provide different types of cellular accommodation, ranging from very secure to dormitory style. ‘A’ wing, where the man mainly lived, is not secure and has no integral sanitation. Prisoners on that wing have a key to enable them to lock their own cell and they have communal toilet facilities. There are no CCTV cameras on that wing.
12. The healthcare centre provides primary care. It does not have inpatient facilities and prisoners with these needs are referred to a nearby prison or local hospital. There is a general practitioner (GP) surgery five days a week.

Overnight and weekend services are covered by a local GP as part of an on-call service. The prison has 24 hour nursing cover, with nurses employed by the Primary Care Trust.

13. An inspection by HM Chief Inspector of Prisons was conducted in November 2006. As a result of this inspection, she concluded:

“The inspection confirmed that Wymott continued to perform reasonably well and managers and staff deserve credit for the improvements achieved since our last inspection, and for putting in hand further improvements. There remain some difficult issues to grapple with, above all how to ensure the safety of vulnerable prisoners when they are not separated from other prisoners, but, overall this is a generally positive report on an improving prison.”

14. A further inspection was carried in October 2008, a few months after the man’s death. The resulting report identified that, “some aspects of care were good, but many written care plans did not reflect assessments”. ACCT documents (explained later in this report) were opened appropriately, with some good quality and detailed immediate action plans:

“However, care and support planning were poor and it was not unusual for care maps to contain only one vague entry, often not reflecting the assessed risk. They were rarely updated after reviews. Case managers at reviews regularly changed, so there was little continuity in care and support and attendance by anyone other than wing-based or primary care health staff at reviews was extremely rare.

“There were restrictions in staff observing and gaining access to prisoners on the spurs on A and B wings during patrol state because they were locked off to allow prisoners access to sanitation and night staff could not go in alone.”

HM Chief Inspector of Prisons’ comments about ACCT documents reflect the findings of this investigation.

Independent Monitoring Board (IMB)

15. Every prison in England and Wales has an Independent Monitoring Board (IMB). The members are volunteers who monitor the day-to-day life in their local prison and ensure that proper standards of care and decency are maintained. Prisoners can complain using confidential access. Board members visit the prison regularly and require responses from Governors on any points raised by prisoners. The Board is required to produce an annual report on the prison to the Secretary of State, highlighting good practice and flagging up areas of concern. The IMB report covering the period June 2008 to May 2009, noted the following:

- Healthcare had improved since the Primary Care Trust had taken over its management.
- Wymott takes the issue of safer custody very seriously and has a strategy and a number of policies in place to ensure this. However, continuity in taking forward improvements following from the quarterly Violence Reduction, Suicide and Self-Harm meeting had been affected by frequent changes of governors chairing the meetings.
- ACCT is not applied consistently across the prison. The initial assessments could be more thorough and searching, staff and instructors in workshops and education are often not aware of prisoners' state of mind and conversational and observational entries in the ACCT documents are not always meaningful. Care plans sometimes lack focus and decisions are deferred because the same staff do not attend the review.

Overall, the Board considered that Wymott was providing a safe environment in which prisoners are treated with decency and respect and that senior managers have set out to address areas requiring improvement. The Chair of the IMB told my investigator that the prison was well run and he was satisfied that the handling of the man's death had been professional and the staff involved were well trained.

16. The man's death was the first that had been self-inflicted since 2005. The circumstances were not similar to those of the previous self-inflicted death. However, there have since been several deaths from natural causes in which I have made recommendations about the need for more family liaison officers and for staff to break the news to bereaved families rather than asking the police to do so. Wymott accepted these recommendations and put in place an action plan, so I do not repeat them in this report.

KEY FINDINGS

HMP Forest Bank

17. The man was remanded into custody by a magistrates' court on 13 June 2007 and taken to HMP Forest Bank. This was not his first time in prison and he had served a sentence at Forest Bank a few months before. The Greater Manchester Police detained person's medical form indicated that the previous day, the man had been in police custody where he had asked to see a doctor to get some medication to help him to sleep. The doctor considered that he was upset and agitated by the use of crack cocaine, but found no evidence of withdrawal or medical problems and concluded that he had no serious drug problem and no medical or psychiatric conditions. He decided that no treatment was required and that there was a standard risk of self-harm.
18. When he arrived at Forest Bank, the man said that he was physically well and gave his consent for the prison to obtain his previous medical records. He did not have an immediate medical check.
19. The following day, 14 June, the man had a first reception health screen. (This is an initial medical assessment of a newly-arrived prisoner's physical and mental health.) The health screen indicated that he was not registered with a general practitioner (GP), had no illnesses or health concerns, no longer drank alcohol and, contrary to the observations of the police doctor, had not used crack/cocaine for two years. It was also recorded that he was not prescribed medication for any mental health condition and had no history of self-harm. The assessor decided that no immediate action was required and the man was fit for normal location, work and any type of cell occupancy.
20. During the second health screen assessment, conducted on 19 June by a nurse, a number of health matters were revealed. The man again said he was a heavy smoker and smoked crack cocaine. He told the nurse that he had a history of depression and said that, in the last month, he had felt depressed. He asked to speak to someone about his problems and also admitted that, in the past, he had thought of harming himself and ending his life. The outcome of the review was that the nurse referred the man to the mental health in-reach team. She also referred him for bereavement counselling, to the smoking cessation and hepatitis B vaccination clinics and to the optician.
21. The mental health record shows that following the referral, a mental health assessment was conducted on 26 June. The man said that he had felt unhappy since he was eight years old as a result of the death of his brother and had unresolved issues. He had no previous contact with mental health services and no history of mental illness, but he had received counselling for a short period at HMP Wymott which he had found beneficial. The assessor considered he displayed no biological signs of depression such as loss of appetite or disturbed sleep and expressed no thoughts of self-harm or suicide. During the review, the man listed his drug and alcohol consumption and said he had never had treatment.

22. The assessor gave the man advice on ways to naturally lift his mood by way of exercise and meaningful activity, which he said he had found helpful in the past. She considered no further contact was required from the in-reach team, but referred him to the counselling services and the Counselling, Assessment, Referral, Advice and Throughcare service (CARATs) team, with a view to addressing his substance misuse. (Organisations specialising in the treatment of substance abuse have drugs workers based in most prisons. CARATs workers can run programmes, offer counselling, support and referral to rehabilitation centres to prisoners and on release. Access to CARATs is voluntary, by application.) An unsigned entry in the man's main record says the in-reach team found no evidence of substance misuse. This is at odds with the confirmatory note of the assessment but could not be resolved without the identity of the author.
23. The man was committed to a crown court on 26 July where he was convicted on 13 August. On 15 August, a comprehensive substance misuse assessment was conducted by the CARAT team. This indicated that he had started misusing drugs at the age of 22, mainly crack cocaine and alcohol, on a daily basis in the community. He had never had any drug free periods. He had started smoking heroin in prison owing to boredom, had last used it the previous weekend and found it helped him to deal with stressful situations such as relationship problems. His parents were unaware of his drug use. The assessment concluded that he had a high dependence on drugs but was motivated to address his problem. He had seen all the dangers and problems caused by drug use and wanted to get away from this and lead a normal life. He was referred to the Short Duration Programme (SDP) and signed up for the voluntary drug testing (VDT) scheme. (The SDP is a four week, structured and interactive drug intervention programme carried out over 20 sessions. The VDT is a commitment to remain drug-free while living in a unit with other prisoners on the scheme.)
24. The report completed at the end of the man's SDP course confirmed:
- “...attended 19 of 20 sessions, but completed catch up work. Began course with an open mind and with a clear view of what he hoped to achieve. From first session, showed a willingness to engage and was receptive to the ideas of the course. Participated well in all of the sessions, was always willing to feed back his diary assignments and these reflected the learning points of the sessions and his thoughts and feelings. Positive impact on other members. Engaged in many subgroup exercises. Made excellent contributions during brainstorming and several of his ideas generated excellent discussion within the group. Overall, maintained mature approach. Looked back on past mistakes and set positive goals for the future. Contributions were valuable and gained the respect of group members and facilitators and this resulted in the group voting him group member of week three for his positive attitude and contributions. TM has identified that using the counselling service at Forest Bank has been beneficial. He may benefit

from continuing to attend these sessions so as to continue to deal with anxiety.”

25. During the course, the man identified arguments with his girlfriend as a high risk situation. He became drug free after completing the course and his four week follow-up indicated that he had remained so.
26. Prison records show that between August and November, the man received a number of disciplinary warnings and was subject to several adjudications. (An adjudication is an internal hearing into a breach of discipline by a prisoner, conducted by a governor or an independent adjudicator.) He also attended the medical centre for minor ailments and on two occasions for injuries sustained following fights and assaults by other prisoners. Following the discovery of banned articles, he was subject to closed visits from 1 November and this continued when he subsequently transferred to HMP Risley. (A closed visit is when the prisoner and visitor are separated by a glass screen to prevent physical contact between them. Prisoners might be subject to a period of closed visits because of suspected, attempted or actual smuggling of banned items.) Between 20 and 24 November, he was subject to a bullying information report (BIR) for bullying other prisoners. He was sentenced to four years imprisonment on 27 November.

Transfer to HMP Risley on 10 December 2007

27. The man transferred to HMP Risley on 10 December. He went through the usual reception procedures and was located on D wing. It is recorded in the continuous clinical record that at his reception health screen, he told staff that he had taken heroin the previous day and a note was made that he needed immediate medical help for this. He added that he did not want methadone or subutex and was advised that the prison could only offer Britlofex. (Britlofex is also known as lofexidine and is used to ease the symptoms for people withdrawing from drug addiction.) He also mentioned that he had previously suffered from a low mood and was undergoing counselling but felt alright at that time. Following a further reception health check later that day, a referral was made to the doctor and mental health team.
28. The prison community mental health team assessed the man the same day. He told them that he had not self-harmed, had no thoughts of self-harm or suicide and did not feel highly distressed. It was noted that depression and low mood had been diagnosed and treated by a GP and psychiatrist, but no other information was given as to where and when this had occurred.
29. An entry in the continuous clinical record the following day, 11 December, confirms that the man agreed to lofexidine and symptomatic relief. It also says he was undergoing drug detoxification and had been prescribed other drugs to relieve diarrhoea, stomach pain and help him sleep. The detoxification form shows on 12 December that he did not cooperate. He moved to C wing on 13 December. A few days later, on 17 December, his CARATs file arrived, indicating that he wished to continue with the programme.

30. The man moved to B wing on 25 January 2008. It is recorded in his personal record that he had no issues when he arrived. However, on the same day, a subsequent entry in his record shows that he approached an officer and wrote to staff about fears for his safety. He said that he had been told by another prisoner that there was a “hit out on him” for someone to stab him. He felt that the threat might have been related to a previous offence two years before, for which he had been attacked and admitted to hospital for ten days. He did not want to take any chances and asked for a move to E wing or the segregation unit as he was unwilling to go on normal location. Staff opened a victim BIR and explained that they would support him and manage the situation on the unit, but he was to speak to staff if anything changed. (A note was made to review the matter on 29 January.)
31. The day after the man initially expressed his concerns, his brother telephoned the prison to say that he had received telephone messages that his brother was scared he was going to be assaulted. His brother telephoned again the following day, 27 January, to say that he was considering taking the matter up with his Member of Parliament (MP) and possibly the press. Staff assured him that they took the matter very seriously and were supporting and monitoring his brother.
32. A Senior Officer (SO) spoke to the man that morning. Although he had slept well, he still had serious concerns about his safety. They discussed the possibility of moving wings. He did not want to go to A wing as he considered it too close, but was prepared to try G wing. The SO said that he would be given support and help but advised that they should try other alternatives rather than going straight to the segregation unit. At 1.30pm that day, the man rang his cell bell to ask what was happening and asked again to go to the Care and Separation Unit (CSU). He considered the prison was doing nothing about the threats. The SO assured him that they were doing everything reasonably practicable to help in the situation. The SO made a further entry in the man’s record indicating that he was “constantly on cell bell”. He again explained the options to him which included the possibility of an application to transfer to another prison.
33. The man was taken to the CSU at 5.05pm, after being found with a mobile telephone and resisting B wing staff. At 7.15pm, staff opened the Assessment, Care in Custody and Teamwork (ACCT) procedures. (This is a process to support and monitor prisoners at risk of self-harm or suicide.) The man had told them that he had big family problems that were making him suicidal. The action plan was for him to stay in his existing location, with hourly observations and telephone access was to be arranged. He had explicitly indicated his intention to take his life in an undated letter to his partner, which had been placed in his ACCT file.
34. The ACCT file shows that an assessment interview took place on 28 January. Potential triggers of self-harm were identified as family problems, particularly concerns about the health of his newborn son. During the interview, the man explained the two main causes of his current state as the potential friction

between him and his partner as a result of their baby son's possible blindness. He also claimed to have been approached by various prisoners who said that he was going to be assaulted. He said that he was feeling stressed and unable to cope and admitted that he was close to hanging himself on the evening of 27 January, but had calmed down sufficiently without doing anything drastic.

35. The man mentioned a previous attempt at suicide in 2003. His feelings at that time were related to issues with a previous partner and their two children and he considered the only way out would be suicide. He told the ACCT assessor he would have nothing to live for if he lost his current partner and contact with his baby. He said he was thinking more clearly. He viewed his forthcoming adjudication for possession of a mobile telephone and being moved from B wing as a chance to get his life together. He described having his first good night's sleep the previous night. He added that he had been taking a great deal of heroin since June 2007 and wanted help via CARATs.
36. The assessor found the man to be open and coherent and considered that talking helped him a great deal. His thoughts centred on his partner and child and moving to a safer environment on another wing. The assessor suggested that these areas be monitored as any sudden change could trigger further thoughts of suicide and helplessness. When asked if he wanted to die, the man replied a straight 'no' and said he had not thought of how he would carry out such an act. Visits from his partner, child and brother were of great importance and a major stabilising factor in his life and he was worried about moving to a prison too far away for them to visit. Although he remained in contact with his mother and father, their relationship had deteriorated.
37. The ACCT record shows that a senior officer and officer held a case review shortly after the assessment interview. It was agreed to ask the CARATs worker to visit the man in the CSU as soon as possible. He would remain there until after his adjudication when staff would arrange to relocate him safely to another wing. The officers acknowledged that he still had the opportunity to maintain his relationship with his family via telephone calls, letters and visits. He was assessed as low risk but a routine referral was made to the healthcare centre. The next review was scheduled for 4 February and representatives from the healthcare centre and IMB would be invited.
38. The ACCT procedure requires a CAREMAP to be completed outlining all the actions to be taken to keep a prisoner safe. The man's CAREMAP listed the following:

“Worried about loss of contact with family – maintain ties. Gov looking into him coming off closed visits.

Drug abuse – estab relationship with CARATS group, appl'n to visit him on CSU – awaiting appt.

Worried about relocation in the prison – decide which wing he would feel safe on – interact with staff. Located on R1 as this is where TM feels safest.

Following the act of self-harm on 3/2/08 TM has asked if we can look at a move to Buckley Hall – move closer to home to make contact easier- R1 staff to contact OCA [observation, classification and allocation department] to see about move. PO looking into this.”

39. The segregation file shows that on the same day, a Principal Officer (PO) spoke to the man at length about the reason for being located in the CSU. He reiterated that he would not feel safe on normal location. The PO said that this and the options would be discussed at a CSU case review on 30 January. As the man claimed to have been threatened on B wing, the senior officer for that wing was to be invited to the meeting. He was to be observed hourly under the ACCT procedures.
40. The adjudication record for the following day, 29 January, shows that following a hearing, a penalty of forfeiture of both canteen and association for 35 days was imposed. (Canteen is the prison shop where prisoners can buy or order goods each week to a limited value, mostly foodstuffs, confectionery, stationery, toiletries and tobacco products. Association is the period of time when prisoners are unlocked from their cells and are able to associate with each other and engage in activities such as playing table games and making telephone calls.)
41. It is recorded in the ACCT ongoing record that at 3.00pm that day, the man had refused to go back to B wing. At 6.00pm, he was placed on a disciplinary report for refusing a direct order as staff considered there was no problem about him returning to the wing. After the evening meal, he protested about being reported and asked to speak with the security department.
42. An entry dated 30 January, in the continuous clinical record, noted that the man had been using heroin regularly on the wing, had been experiencing some withdrawal symptoms, muscle pain and insomnia. However, his mood was considered to be alright, he was not anxious and had no thoughts of self-harm. He agreed to take medication to relieve his symptoms. His prescription chart showed that he had been prescribed loperamide (for diarrhoea), Buscopan (for irritable bowel syndrome), ibuprofen (an anti-inflammatory painkiller), Maxalon (anti-sickness) and zopiclone (for insomnia). On the same day, a CARATs worker recorded in the CARATs file that she went to see the man that morning but he was already in the CSU.
43. The ACCT ongoing record shows that the man attended an adjudication hearing the following day but the outcome was not recorded. A CSU risk assessment for prisoner segregation notes that he had been alright while located in the CSU.
44. Staff held a CSU review with the man on 1 February. No problems had occurred in the unit and they decided that no intervention with mental health services was necessary at that time as he had no thoughts of self-harm or suicide. However, he still felt at risk of harm from gang members. After the review, his segregation ended and he transferred to R1 wing. He was content with this move. He had asked for the ACCT to be closed but staff advised him

to wait until he had settled on R1. The day after his move to R1, an entry in his ACCT record shows that he seemed to be happy, “chatty and laughing with fellow prisoners”.

45. The man had a closed domestic visit at 2.50pm on 3 February. It was noted in the ACCT record that an operational manager was due to review the man’s closed visit status on 25 February. An hour and a half later, he had a discussion with a principal officer about closed visits but the detail of the discussion was not recorded.
46. The man’s ACCT and continuous clinical record shows that at 6.55pm, while carrying out a patrol/ACCT check, two officers discovered him face down in his cell. They attempted to go into the cell but were hindered by his head and arms which were directly behind the cell door. The officers forced the door to gain access just as the nursing staff arrived and found the man lying in a pool of blood, caused by numerous cuts to his forearms. An ambulance was called and medical attention given. A nurse wrote in the continuous clinical record that the man had deep lacerations to both forearms, a deep laceration around both brachial areas (the major blood vessels of the upper arms) and blood was still spurting. No other injuries were found. He was described as drowsy but responsive.
47. The ambulance arrived shortly afterwards. The man was initially taken to outside hospital and transferred to another hospital just after midnight, where his wounds were stitched under general anaesthetic. While in hospital, the man told officers that he had thought about suicide since he found out about his son and had left a note in his cell, although he had not shared his thoughts of self-harm with his partner during the visit the day before. He also spoke of the death of his brother in childhood and his difficulty in coming to terms with it. He explained that he had taken a razor from someone else’s cell and made the cuts at around 5.10pm, but had hidden them when he was checked earlier in the evening. In a discussion later that night with another officer, he attributed his actions to threats from gangs and feeling helpless about his son. He mentioned his previous sentence of four and a half years and said he wanted to transfer to HMP Haverigg or HMP Wymott where he could get a job and go to the gym.
48. On his return from hospital at 7.00pm on 4 February, staff sought the man’s agreement to being located in B wing as his previous cell had been sealed, but they ensured no other prisoners saw him. Mental health and risk assessments were conducted by an RMN, a registered mental nurse, in which the man gave a detailed account of his background and history and expressed feelings of helplessness and anger. He admitted to having contemplated self-harm for around a month. He was assessed as having a high risk of self-harm as there was evidence that he had continued thoughts of harming himself. He was also assessed as potentially having a medium to high risk of harm from others given the evidence of bullying.
49. An ACCT case review was also held immediately on the man’s return. His level of risk was raised and the frequency of observations reviewed and

raised to every ten minutes. During this meeting, he reiterated the reasons for his actions. A further review was scheduled for 3.00pm the following day, 5 February, and it was intended to invite a member of healthcare staff and the chaplain.

50. The ACCT record shows that the man moved back to his previous wing (reintegration unit) early on 5 February, before the main wing was unlocked. The Imam made an entry at 11.40am which indicated that the man looked worried and was feeling down. During the case review held later in the day, he said he felt fine back in his old cell and had been talking with other prisoners. He seemed settled and observations were changed to half hourly, with a further review to be held on 8 February. The RMN's notes of the review in the continuous clinical record indicated that he had been determined to take his life and was disappointed that he had been found. He had agreed to see her regularly and had an appointment with a doctor that afternoon. The doctor concluded that, in spite of the man's assertion that he would not harm himself again, there was still a moderate risk. He dressed the wounds and prescribed mirtazapine (an antidepressant).
51. Entries in both the ACCT and continuous clinical record on the morning of 7 February show that a principal officer became aware of two letters from the man's partner, ending their relationship. Staff were concerned about the impact of the letters and considered the possibility of constant supervision. They arranged to see him in the afternoon to tell him about the letters and discuss how they should be interpreted. During that meeting, he was relaxed and said he had been expecting the letters. He felt his partner was not ending the relationship but was asserting that she could not put up with his tantrums and abuse. He was permitted to telephone her when everything appeared to be alright. He repeated that he had no intentions of harming himself again. A principal officer undertook to try and get the man back onto open visits so that he could hold his son.
52. During the ACCT case review on 8 February, staff acknowledged the man's improvement and that he was a lot happier in spite of continuing worries about his young baby. He expressed a wish to go to HMP Buckley Hall to settle, undertake some courses and achieve category D status. (Category D are prisoners who can be reasonably trusted to serve their sentences in open conditions. There are no physical barriers preventing a prisoner from escaping if they wish to do so.)
53. The next ACCT review took place on 11 February. Staff considered it went well in spite of the fact that the man had been subject to an adjudication in which the penalty imposed had been loss of association and television. (This was in addition to the loss of canteen during the previous adjudication.) The man was said to be bright and alert, talkative and engaging well. He said that he was coping, liked the staff and prisoners on his landing and was happy so long as could keep regular family contact on which he relied heavily. Triggers remained loss of contact with his family. During the meeting, he commented that if he wanted to do it (meaning harm himself), "I'd do it and no one would know". He confirmed that he was aware of the availability of the Listener and

the Samaritans telephone and said he would ask for access to them if needed. (Listeners are prisoners who volunteer to be trained by the Samaritans to provide confidential emotional support to fellow prisoners in distress. Prisoners are also entitled to confidential access to a telephone with a direct line to the Samaritans.) A nurse who attended the review expressed concern about the loss of TV and was going to suggest that he should have a radio. Later that day, staff told the man that an operational manager had authorised an open visit for Wednesday with his partner, son and brother and that it would be reviewed on an ongoing basis. (The visit, which took place on 13 February was recorded in the ACCT document as having gone well and the man was able to hold his son.) The CARATs worker introduced herself to the man that day and also commented that he seemed settled.

54. A doctor reviewed the man on 15 February. He considered that his mood was improving with mirtazapine, although he was said to be “stagnating” in the reintegration unit and still wished to transfer to Buckley Hall. The doctor asked to review him again in a week and made a note to speak to a manager regarding the transfer.
55. The fifth ACCT case review was held on 18 February. The previous day, the man had told an officer that the night checks were preventing him sleeping and he was “desperate” for the ACCT monitoring to stop. At the review, staff assessed him as low risk. However, they were concerned as to how he would react and cope after his baby’s forthcoming hospital appointment, so they decided to keep the ACCT document open until the outcome was known.
56. At the next ACCT review on 22 February, this decision was reiterated, in spite of the man’s assertion that he had no thoughts of harming himself and his assessment as low risk. However, the following day, he again expressed thoughts of harming himself which he said was a direct result of another closed visit. Staff held lengthy discussions with him and, although he subsequently denied suicidal thoughts, his ACCT observations were increased from three per day (plus three at night) to four per hour.
57. The man received positive news regarding his baby son’s eyesight on 26 February. Staff reported that he took the news very well and was keen for the ACCT monitoring to stop so he could get a transfer and progress his sentence. The ACCT document was closed the next day, 27 February, following the seventh case review. He was said to be happier after the news the previous day. He was aware of the support available and agreed to approach staff about any concerns. A note was made to hold a post closure review on 26 March. (When an ACCT document is closed, a date should be set for staff to conduct a post closure interview with the prisoner. The timing of the interview can vary depending on the needs of the individual and there can be more than one follow-up interview. The purpose of the interview is to discuss how the person has been feeling since the end of the additional monitoring and support how they are managing with problems and whether they feel that they could cope with similar problems in the future.)

58. Plans were made for the man to transfer to HMP Wymott on 4 March. During the afternoon of 3 March, at 3.50pm, a principal officer at Risley sent an email to a member of staff at Wymott to alert staff that the man had been subject to an ACCT document that had recently been closed and that a post closure review was due on 26 March. He also gave contact details if any further information was required.

Transfer to HMP Wymott on 4 March 2008

59. The man transferred to HMP Wymott, where he had previously served a sentence, on 4 March. Prior to the move, a brief summary of his background was recorded in his personal record for the information of staff at Wymott.
60. At a reception health screen, carried out on the day of his transfer by a registered general nurse, the man said he was suffering from depression and had been using drugs in custody, having last taken heroin in December. He also spoke of his attempt to harm himself in February. He added he was not suicidal and he maintained good eye contact and conversation with the nurse. A referral was made to the mental health team and he was entered on the chronic disease register. He was also offered smoking cessation advice.
61. The RGN told my investigators that the man was “quite upbeat” during the assessment and “seemed quite elated”. He held a conversation with her, maintained good eye contact (and so the nurse thought that he was open with her). He assured her that he was not feeling suicidal and was getting over his recent attempt at self-harm. The man's medical records accompanied him and the nurse had access to them. She knew that an ACCT document had been closed before he transferred to Wymott, but did not see it during the reception interview. She was also aware that he was suffering from depression and referred him to the primary care mental health team. Although she acknowledged that depression is regarded as a chronic disease, she recorded that the man was not mentally ill. (In interview, the nurse was unable to explain the reason for this.)
62. A cell sharing risk assessment (CSRA) was also completed. (The CSRA is used to assess the risk a prisoner poses to a cellmate if they are required to share a cell.). Some of the information on this document does not accord with the man's history, for example it is claimed there was no history of alcohol or drug abuse.
63. The first night care and support document shows that the man was given an induction pack. He named his partner as his next of kin and mentioned that he was taking medication for depression. He expressed concerns about being on the category C side of the prison and said he would prefer to be on the vulnerable prisoner side. (Vulnerable prisoners are located away from the main prison population for their own safety. They might be considered vulnerable for reasons such as conviction for a crime of which other prisoners disapprove, being indebted to other prisoners, being seen as an informer or the subject of bullying.) He was located on G wing, for security reasons. He told the officer who completed the document that, since previously being at

Wymott, he had been at other category C prisons where rumours of his past had led to fights. Again, he denied having used drugs and said it was unlikely that he would harm himself. The CARATs worker at Risley completed a transfer plan on 10 March, which listed issues, key achievements and outstanding goals.

64. There were no other significant entries in the man's personal record until 23 March. An entry on that day by an officer recorded that he was having problems with his partner. As his pinphone numbers had not been entered on the system, staff allowed him to make a free telephone call. An undated entry which appears to have made at around that time indicated that, on two occasions, he had been given £10 of telephone credit.
65. A CARATs worker had a discussion with the man on 1 April. He told her that he wanted to maintain contact with CARATs. He was determined to change and wanted to get involved with the Therapeutic Community to build on the SDP he had recently completed. (The drug Therapeutic Community provides a long term, residential, offending behaviour intervention for prisoners who have a range of offending behaviour risk areas, including emotional and psychological needs.) The CARATs worker noted his recent attempt to harm himself and his explanation that it was linked to family issues, in particular the problems concerning his son's eyesight. A week later, on 8 April, the man was again seen by a CARATs worker, but the entry is unsigned. At that meeting, he said that he no longer wished to engage with the Therapeutic Community, for fear of being victimised. However, he planned to fully participate in education to help with his addiction problems. It was noted that a follow up session was required to set out his care plan objectives. A subsequent entry on 11 April confirmed that his case had been allocated to [initials of person] (assumed to be a CARATs' worker) and that a note had been sent to him to advise of the time and date of his first appointment.
66. An officer made entries in both the man's personal record and the A wing staff observation book on 15 April. He recorded that the man had approached him at 3.15pm and asked to talk. The man told him that he had "hit rock bottom" after constant arguments with his partner. He then started to cry and repeatedly told the officer that he had nothing left to live for and felt like ending his life. The officer reassured him that he could talk to officers as well as wing Listeners and offered him use of the Samaritans' telephone. The officer opened an ACCT document and observation book. (The ACCT document opened on 15 April was not provided for the investigator and following enquiries with the prison liaison officer, she was advised that it had been mislaid.)
67. At interview, the officer confirmed the sequence of events. He added that the man also mentioned difficulties with his parents as well as his partner. He told him that he felt helpless as he could not talk to them face to face. He spoke several times about ending his life and he appeared to be serious, but refused the offer of the Samaritans' telephone or the Listeners.

68. The day after the ACCT was opened, the chaplain met the man. He noted that the man was distressed about the relationship with his partner and that he was not dealing with his problems. He added that a senior officer had allowed the man a telephone call, but his partner was not available when he rang.
69. On the same day, a registered general nurse attended the man's wing to assess him. The nurse described the man's appearance as very depressed and said that he felt he wanted to end everything so that he would not have to face any problems. The nurse was aware that he was subject to ACCT monitoring and referred him to the mental health in-reach team. A short, unsigned entry on the same day by a member of the team, reiterated the man's depression and thoughts of suicide.
70. An unsigned and apparently incomplete entry in the medical record on 17 April indicates that the man was seen at 9.30am on the wing by the author of the entry. He was said to be initially guarded and unwilling to engage. He eventually settled, making good eye contact and rapport with the member of staff. He then related events from the past such as the death of his brother. The man's condition was said to have deteriorated recently because of the possibility that his relationship was coming to an end, but he appeared to have settled after a number of telephone calls with his partner. He admitted to steroid use and heroin addiction, but said he had not smoked it since June 2006. A further, undated entry by a registered mental nurse (signature indecipherable) around that time recorded that he worked in the laundry and education. He went to the gym regularly which he was encouraged to continue. He said he had been seen by a counsellor in the past and had found it moderately beneficial. His medication, Zispin (an antidepressant), was increased and the ACCT document remained open. The author recorded an intention to see him again early the following week with a view to referring him to counselling services. In the meantime, he was advised that if he wished to speak to the author of the entry or a team member, he should ask wing staff to contact the primary care team.
71. A registered mental health nurse (signature indecipherable) recorded in the medical record that an ACCT review took place on 21 April. The nurse said that the man looked well. He told the review team that he had resolved the problem with his partner and was positive about the relationship continuing. He agreed to a referral to a counsellor. A senior officer agreed to keep the ACCT document open for a further review the following week. My investigator interviewed the senior officer as part of the investigation, to find out whether he could shed any light on the missing ACCT document. He did not think that the ACCT was closed at the review meeting on 21 April. The senior officer transferred to Hindley at the beginning of May 2008 and recalled that the man was still subject to ACCT monitoring when his employment at Wymott ended. He could not think of any reason why the ACCT file would have gone missing.
72. During one of the investigator's visits to Wymott, she asked again about the document and was told that it had not been found. The investigator was concerned about this and asked staff to explain Wymott's process for filing

completed ACCT documents and show her where they were held. In addition, she also interviewed a senior officer who undertook one of the reviews during that period of monitoring.

73. The senior officer recalled that the opening of the ACCT had stemmed from problems in the man's relationship but could not be more specific as to the details. In relation to the storage of documents, the SO explained that the ACCT files are held on the wing during the monitoring and review process. After the post closure review takes place, the document is then sent to the safer custody office.
74. A document dated 22 April by a member of Chorley NHS Trust confirms that the man had been referred by a member of the mental health team for a number of underlying reasons such as the death of his brother, mixed-race relationship and a recent problem with his partner. He was again said to have benefited from counselling in the past, was well motivated and appeared willing to make contact with the various services. Two days later, on 24 April, the man advised a CARATs worker that he could not attend his planned CARATs meeting, so this was rescheduled.
75. A few days later on 29 April, following a voluntary drug test, the man tested positive for opiates. His explanation was that he had taken someone else's medication for a toothache. Two days later, on 1 May, another voluntary drug test was negative.
76. An entry (indecipherable signature) in the man's personal record on 5 May explains that staff allowed him to make another telephone call to his partner as he had told them that he felt stressed about not speaking to her for a while. The officer told the man it was "one off" and advised him to ensure that in future he bought enough telephone credit to last all week. (Prisoners have access to telephones on the wing. They are operated via a 'pinphone' system in which they can purchase credit. Each prisoner is given a unique PIN to access their account and they are only able to dial authorised numbers.)
77. At night, one of the duties undertaken by Operational Support Grade (OSG) staff is pegging. (Pegging is a form of patrol in which an electronic device is used to scan certain points in each unit, providing an auditable register of the patrol.) In the category C part of the prison, the OSG is able to patrol and check prisoners as they are in locked cells. However, in the areas for vulnerable prisoners, including A wing, OSGs can only access the landing and not the wing as prisoners are in self-locking cells.
78. An OSG was on duty in the early hours of 7 May. She explained that there are nine pegging points and pegging has to be carried out at 10.00pm, 10.25pm, 10.40pm, 10.55pm, 11.15pm, 11.40pm, 12.00am and then every half hour during the night. Two peggings can be missed for breaks, but not consecutively. That night, she was scheduled to start duty at 9.00pm, but had actually reported at 8.30pm. She said that nothing unusual occurred during the night.

79. At around 6.00am on 7 May, officers responded to a landing bell and found the man sitting in the cell of another prisoner. (Each landing has a bell which prisoners can use to call for urgent help.) The man had cut both his arms. An entry in the man's medical record by a nurse recorded that he had deep wounds to both inner elbows in which his tendons were visible. Prior to cutting his arms, he had tried to hang himself with the cord from his kettle and there was a slight reddening to his neck. He told staff about his previous attempt to take his life 12 weeks when he was at Risley. He insisted that he was serious about killing himself and that he could not take anymore. He had left letters to both his partner and children.
80. During an interview with my investigators, the nurse said she had been on night duty when she received a code red call over the radio at about 6.00am. (Most prisons operate a system of emergency codes. Code blue indicates that a person has breathing/respiratory problems and code red that the person is bleeding. The code allows medical staff to respond with appropriate equipment.) The nurse grabbed the emergency bag for code red incidents and went to the wing, where the man was sitting on a chair with his arms crossed over his chest. She asked him what he had done and, when he extended his arms she saw cuts to both his inner elbows, both wrists and a ligature mark around his neck. The wounds were still fresh and appeared to be a serious attempt at self-harm.
- “He just said he wanted to end it, he wanted to kill himself. He said he'd tried his hardest to hit the arteries but he hadn't been able to, because he'd tried his wrists and then he'd tried his elbows and he'd tried his best to hit the arteries. He said he had hit his arteries 12 weeks previously whilst in HMP Risley, he hadn't actually hit the arteries but it was sufficient enough to warrant surgery on his arms.”
81. The nurse put on pressure bandages on all the wounds and immediately asked for him to be sent to hospital. She could not remember whether restraints were used, but thought that he would have had some kind of restraint. (If a prisoner is admitted to outside hospital, depending on the risk assessment carried out by the prison, they may be handcuffed while they are in bed. This is usually done by means of an escort chain which allows the prisoner to be attached to a member of staff.) She then copied the two letters written by the man and left a message for a member of staff from the mental in-reach team to see him when he returned from hospital.
82. An officer opened an ACCT plan. She made an entry in the concern and keep safe form of the document in which she described very deep cuts, as well as ligature marks around the man's neck. She wrote that he told staff that he had made the cuts at approximately 3.00am. He was sent to the Accident and Emergency (A&E) Department at outside hospital for treatment, escorted by two officers, and subsequently transferred to another hospital. The officer explained at interview that, on hearing the landing bell, she and two other officers had gone to the prisoner's cell. There were already three other officers there at that point. The man was having a cigarette and a cup

of tea. He then took his jumper off and the officers saw that he had cut his arms. She opened the ACCT just as the two other officers were about to escort the man to hospital.

83. The prisoner said that he had been seen laughing and joking with the man until about 9.30pm to 10.00pm the previous night and he did not notice anything unusual about him. He said that the man had come to his cell at around 5.00am after cutting his arms. He told him that he had done so at about 3.30am. The prisoner pressed the landing bell and he estimated that it took 15 minutes for officers and healthcare to attend. (My investigator has been unable to confirm how long it took the officers to attend.)
84. A psychiatrist at the hospital assessed the man in A&E and wrote a discharge summary to the medical officer at Wymott. He had recounted some of his history to the psychiatrist. He told him that he had felt low for the past 12 weeks. He described previous traumatic events in his life as well as various family problems which had recently caused him stress. He had stopped drinking alcohol and until December 2007, had been abusing heroin. He was frustrated by his inability to support his partner in bringing up two young children as he was in prison and felt guilty about this. He also cited problems with his family concerning his mixed relationship. As a result of feeling helpless and wanting to end his life, he had cut himself with a razor blade. The psychiatrist noted that the man had told officers that he regretted doing it and felt better. He said his partner and children were his protective factors and he wanted to live for them. The psychiatrist found him to have good eye contact and good insight into his problems, but his mood was low and his appetite poor. He denied any plans or thoughts of harming himself or others. The psychiatrist concluded, "Impression: stress reaction".
85. The following afternoon, the man underwent an operation to repair the lacerations (cuts) to his arms. The Consultant recommended a review by the prison doctor in a week and prescribed augmentin (an antibiotic used to treat skin infections), paracetamol and mirtazapine.
86. On the man's return to the prison on 9 May, a registered general nurse (signature indecipherable) assessed him in reception. The man talked at length about the previous few days. He said that he had been very determined to kill himself and was concerned about talking to mental health staff as he was worried that he would be "sectioned" (meaning formally admitted to a psychiatric hospital). The nurse strongly advised him to discuss his concerns and worries with the mental health team and he agreed to do so. His dressings were renewed and he was to be seen daily by healthcare staff for medication and to check his dressings.
87. At some point during the day, the prison was faxed a safety profile risk assessment completed by the psychiatrist at the hospital:

"Expressing high levels of distress/recent traumatic events; hopelessness, guilt etc; failing to eat; history of aggression to others; lack of impulse control; evidence of rootlessness/ detachment; history of alcohol and poly

drug use. Wants to sort out his family and wants to live a good life once he comes out of prison.”

88. That afternoon, a registered mental health nurse from the mental health team assessed the man and made an entry in his medical record. He was said to be anxious about speaking to the team but was reassured. He felt embarrassed about harming himself and explained that numerous family problems had led to his actions. Although it was a serious attempt to end his life, he said he now felt a lot better. The nurse recommended that, due to his “unpredictability”, he should be placed in a camera cell with regular/intermittent observation by staff. A principal officer (PO) was contacted and agreed that the man could move to G wing, with a review on the following Monday, 12 May. Staff were told of the situation and asked to monitor him.
89. The man initially refused to move to G wing but eventually agreed after a discussion at 5.30pm with a registered mental health nurse and the duty governor. It was planned to provide two Listeners to sit with him. The duty governor confirmed to my investigators that the man had been very reluctant to go to G wing but, given his serious attempt at self-harm, he considered it would enable a better level of supervision than the open accommodation on A wing. The man said he was alright and wanted to go back to his friends. He swore that he would not harm himself again. In the light of his request to return to A wing, the duty governor held a meeting with mental health and nursing staff. He took their advice that he should be located in G wing.
90. A little later, at 7.00pm, while giving medication on the wing, a nurse wrote that she was unsure about the man and whether he was alright following a conversation they had earlier. Her entry in the medical record referred to the decision by the duty governor and the mental health nurse to place the man in a camera cell. However, as the cell could not accommodate the Listeners, she rang the mental health nurse to discuss this. The nurse suggested that the man would be better in a camera cell with observations five times an hour. In an earlier discussion with a member of the mental health team, his view was that five times an hour was the maximum number of ACCT observations which could be made in a secure mental health environment. The nurse told the duty governor, who was not happy about the situation as he had told the man that he could have the support of two Listeners.
91. During an ACCT assessment interview with an officer and senior officer on 10 May, the man gave a detailed account of his family situation, including the conflict between him and his blood family over his relationship with his partner. He attributed these pressures as his reason for wanting to “end it” which he saw as a way of escaping his problems. He mentioned his previous attempts and cited the same reasons. He told the officers that, because he was in a single cell and had hours to think and worry about what was happening, he still intended to kill himself. He felt he could not cope in a lock up cell and remaining in one would lead him to harm himself again. He said that returning to his friends on A wing would keep him occupied and he could talk to them during the night if he felt unhappy.

92. When discussing his reasons for living, the man said he had talked to his partner a lot in the last few days and she had pointed out what it would do to her and their children if he killed himself. He had also asked for a change of job to work in the gym but was content to work in the laundry as he knew he was unlikely to get a change at that time. He agreed with the assessment that he was still a very high risk of attempting to harm himself again.
93. The action to be taken after the ACCT assessment was that the man would remain on G wing until at least the following Monday and after he had seen the mental health team. The officers explained the agencies available to him, recommended that the same level of observations continue, referred him to the mental health team and kept the ACCT document open. An undated ACCT Care and Management Plan (CAREMAP) noted “family issues” as the man’s most pressing risk factor and “to maintain family links, phone letters” as the action required by him. No staff actions were identified. (The CAREMAP is the section in which the prisoner’s urgent problems are identified and an action plan drawn up to help them achieve their goals.)
94. An entry in the wing staff observation book that evening, apparently written by the officer who conducted the ACCT assessment interview on 10 May, records that the officer spoke to the duty governor about the requirement for five ACCT observations per hour. He considered that the night patrol officer could not make the observations as well as completing his normal duties and monitoring all the other prisoners subject to the ACCT procedures. The officer asked that either another night patrol officer be allocated to assist or that all the other night patrol duties be suspended. The duty governor, in turn, spoke to another operational manager colleague who said she would provide additional prison officers on G wing to do the ACCT monitoring.
95. An ACCT case review was held on the morning of 13 May, with a senior officer and a member from the mental health team. They recorded that the man was in high spirits, he sounded very positive and his body language was open and receptive. He was due to return to A wing the following day. He spoke very positively about his plans on release and his partner and children. He considered that his only issue was the relationship with his parents, who did not approve of his partner. He was assessed to be low risk of harming himself and the frequency of observations was reduced. The next review was scheduled for 20 May. He moved back to A wing on 14 May where he was located in cell A8-13.
96. At the ACCT review on 20 May, the man was said to be feeling much better and had sorted out a lot of his problems during a visit the previous Friday. He had no further thoughts of harming himself but agreed to talk to staff if he felt low. He was fully aware of the avenues of help available to him. He was judged to still be at low risk of harming himself and so the ACCT procedures were closed. A post closure review was to be held on 28 May. The case manager responsible for closing the ACCT told my investigators that he had taken account of the man’s mood as well as the previous review and staff observations during the previous week. The man agreed it was right for the

ACCT monitoring to come to an end.

97. The man had a personal officer. (A certain number of prisoners are allocated to a named officer as a point of contact. The officer completes reports on the prisoners for whom they are responsible, holds monthly meetings with them, ensures entries are made in their records and offers general advice as well as resolving complaints.) The officer told my investigators that he became the man's personal officer about six to eight weeks before his death. In addition to the monthly interview, they would talk in passing on the wing at various times every day. He said the man had a lot of personal issues, many of them seeming to arise from his inability to be in control of things outside prison and he missed his children.
98. The man's personal officer recorded the details of a conversation with him on 24 May in which he explained his circumstances. As well as his offending background and the various courses he had undertaken, he told the officer about his serious self-harm attempts. He explained that he was over this "phase", was looking forward positively to the future and intended to work towards category D status.
99. An officer conducted the post closure ACCT interview on 28 May. He wrote:

"Following closure of ACCT document, [the man] has resolved a number of issues that led to his self-harm. He now feels more confident in the staff and he is now looking forward. His feelings of self-harm have gone away and he is positive about the future. He also realised that he was putting pressure on his partner who has two children to support. He states that he now realises that help is available and if the need arises he will speak to staff and Listeners."
100. The Imam at Wymott had been working at the prison for two years at the time of the man's death. He knew the man as he made informal visits to him. Also, the man attended some of his classes as well as Friday prayers. On Wednesday 4 June, while attending the Imam's class, the man had told him that, out of frustration, he had ripped up his pinphone sheet and so he asked the Imam to facilitate a telephone call. The Imam took him to the chaplaincy office and tried to call his partner but there was no response. He therefore undertook to sort it out for him the following Friday. That Friday (6 June), as agreed, the Imam spoke to the pinphone clerk and arranged for the man to be given £10 pinphone credit, explaining that it was a "one off favour" and he should not rip his sheet again. He also encouraged the man to go to Friday prayers that day, but was subsequently told by the other Imam that he had not attended.
101. The man's personal officer held a monthly personal officer interview with the man at about 9.15am on 6 June. He recorded the details in his personal record and subsequently in a statement. The man told him that he had ended the relationship with his partner to give them both some space. He thought this would help him deal with the remainder of his sentence, but they had agreed to stay in limited contact for the sake of their children. The officer

thought that he was both calm and positive about the decision. They discussed working towards enhanced status under the Incentive and Earned Privileges (IEP) Scheme, category D security status and release from custody. (IEP is used as an incentive to reward good behaviour in prisons. There are three levels - basic, standard and enhanced. Incentives include access to in-cell television, more private cash to spend, wearing own clothes, more time out of cell and community visits. Each prison sets its own criteria to obtain each level.)

102. The man also mentioned to his personal officer that he was under consideration to become a painter. The officer said he would support the man's application for enhanced status if he had settled into the job by the time of their next monthly interview. He also offered to contact the pinphone clerk to resolve the problem of his personal identification number (pin) being "locked".
103. In his statement, the personal officer said that he next saw the man at about 2.30pm that day. He told the officer that his pin number had stopped working again, that he had argued with his partner on the telephone and wanted to ring her to apologise. On enquiry, the pinphone clerk told the officer that the man had already used his daily quota of ten calls. The man's personal officer negotiated a further five calls, advising the man to use them wisely and think how best to apologise to his partner without further argument. The man thanked him. When the officer asked if he was alright now, he replied that he was fine. The officer reminded him to approach staff if he had any further problems. The officer described the man as calm and content. Before going off duty, he told a senior officer and officer of the help and support he had given to the man.
104. The man's personal officer said that, in the period leading up to the day of the man's death, he saw no indications that he was considering taking his life. He was calm, relaxed and told the officer that he regarded his previous self-harm as a mistake. He expressed a wish to work positively towards release. The officer said that the man received support from other prisoners as he talked to them about his problems and sought their opinions.
105. Two officers came on duty at 9.00pm and 8.00pm respectively and carried out a visual roll check at about 10.00pm. (Prisoners are counted at various times of the day, usually at shift handovers, to check that they are all present.) One of the officers had worked at Wymott for 13 years and the other for eight years. One of the officers knew the man quite well. He had first met him when he was younger and serving previous sentences at Wymott. He last saw him at about 11.20pm that night while checking another prisoner being monitored under the ACCT procedures. The other officer said that they exchanged a few words and the man seemed fine.
106. On a night in June, an Operational Support Grade (OSG) was carrying out the pegging duties from around 10.00pm. At about 11.20pm, a wing bell sounded but when the OSG attended with an officer no one admitted to having pressed a bell. (Alarm bells are usually fitted inside cells to enable prisoners to call for

attention. However, on A wing at Wymott, as prisoners can lock their own cells, the bells are positioned at the end of the landing. This means that if a prisoner has a problem which prevents him from leaving his cell, there is no easy way of summoning help.) At that time, the staff saw the man socialising with the other prisoners. Another check was made at midnight, but this was a cursory check to ensure that prisoners were not causing a disturbance. The only prisoners who were checked after that time were those subject to self-harm monitoring. The OSG continued pegging throughout the night, apart from two one hour breaks, until 5.30am. There was no contact with the man during the night.

Events the following day

107. Two officers, who shall be referred to as Officer A and Officer B, found the man the following morning. The officers made statements describing events and were also interviewed by my investigators. At approximately 6.10am, the officers were conducting the morning roll check on A wing. Officer A found that the observation flap of cell A8-13 was covered and there was no response when he knocked on the door and shouted. He alerted Officer B and told him that he could not see "behind the door". Officer B opened the door and saw the man with his back to the window and the top half of his body covered by the curtain. Both officers went into the cell, calling to him, but got no response. They pulled the curtain aside and found him hanging by what Officer B thought to be bedlinen, tied to the top of the window bars. The officers said that until they lifted the curtain they were not absolutely sure what had happened.
108. Officer B used his radio to ask for urgent help. The officers then supported the man's body and Officer B cut the ligature with his anti-ligature knife. While Officer B was doing this, Officer A checked for any signs of breathing, but found none. He saw dried blood around the man's neck and the top of his chest. As they lowered his body to the floor, some air was expelled and his bowels emptied. Officer A rushed to the office telephone to alert the communications room that an ambulance was required immediately. As he finished making the telephone call, a senior officer and other staff arrived (according to Officer B within 30 seconds). A nurse followed, which Officer A estimated was about two minutes later. Officer A followed them back to the cell to show them where the man was located and the senior officer began cardio pulmonary resuscitation (CPR). Officer A was unsure whether a code was used to inform healthcare staff of the nature of the problem so that they could determine what equipment to bring. Also, he could not recall whether the man was cold to the touch and could not assess whether rigor mortis had set in.
109. The senior officer was Oscar 1, which means that he was in charge of the prison during the night. As part of this role, he had to ensure that all the keys were in place and ready for the staff coming on duty. In his statement and at interview, Oscar 1 said that at 6.05am, just after completing key and handcuff checks in the gate area (entrance of the prison), he heard a garbled message over the radio asking for urgent assistance on A wing. He and other staff ran

to the wing where the OSG beckoned them and pointed towards Officer B who he said was shocked, agitated and retching violently. Oscar 1 saw the man lying on the floor of the cell, face up with his head towards the cell door, with the remains of a brown prison sheet around his neck and some (mostly dry) blood on his upper chest. He appeared to be unconscious and, on checking, Oscar 1 could not find a pulse in either his neck or under his arm.

110. Oscar 1 instructed a member of staff to contact the control room to ask for an emergency ambulance. He asked other staff to find a medical box with a mask to be used for CPR, as white foam was coming from the man's mouth, and the mask arrived within seconds. Oscar 1 then began CPR with a colleague. A staff nurse arrived and attached the defibrillator (a portable electronic device which measures electrical activity in the body and advises on action to be taken). The defibrillator advised that an electric shock should not be administered and advised CPR. The officer who was conducting CPR with Oscar 1, and the staff nurse re-started CPR and continued until the ambulance crew arrived. The ambulance staff connected their equipment and began treatment, but "within moments" established that the man had died, recording the time as 6.36am.
111. Oscar 1 said that he instructed the control room to open the contingency plans for a death in custody and contact the duty governor. He took steps to preserve the area (keeping it untouched until the police could establish whether a crime had been committed), and dealt with the prisoners and staff. A principal officer arrived at around 7.00am and Oscar 1 told him what had happened. The duty governor instructed them to remove all prisoners from the area and locate them elsewhere. Oscar 1 handed over to the wing SO and the PO. The police had arrived and Oscar 1 showed them the man's cell, including the remains of the ligature behind the curtains, a small razor blade on the table and a toothbrush with a razor blade embedded in it (both razors had blood on them).
112. The staff nurse made a statement and an entry in the man's medical record. She explained that at 6.14am, she heard a radio call from the control room for all staff to attend A wing immediately. She was directed to cell 13 on landing 8 and was told that "there had been a hanging". When she reached the cell, she saw the man lying on the floor beside his bed and CPR being given by two officers. The nurse examined him and he appeared to have no signs of life and felt cold to the touch. She used the defibrillator and continued CPR until the ambulance staff arrived but, throughout her efforts, there remained no signs of life.
113. In his statement, an officer from E/F wing said that at 6.14am he responded to a radio call on A wing with three officers and a senior officer. They were directed to the landing and found the man on the floor of his cell. The officer went with two of his colleagues to get the medical box and when he returned, he assisted the senior officer with CPR until the staff nurse arrived. The nurse connected the defibrillator and he continued to assist her with CPR until the paramedics arrived.

114. At interview, the officer said that he was in the communications room when he heard the call for assistance. Although he could not be certain, he thought it was a code blue call. He initially stood outside the cell, but then went to the senior officer's office to find a resuscitation kit. When he returned, he assisted the CPR attempts by performing chest compressions. He said that the man was "stone cold" and he thought that he had been dead for several hours. Nevertheless they felt that attempting resuscitation was the right thing to do. He said that the defibrillator recommended "carry on CPR" at least four or five times in the period until the ambulance crew arrived. He also mentioned that there was a problem opening the seal on the self-harm kit.
115. Prison records completed by an OSG show that the ambulance arrived at 6.32am. The care team, IMB and the chaplain were contacted just before 7.00am and left a message for the Imam, shortly afterwards. The police arrived at 7.24am. The duty doctor arrived at around 9.00am and pronounced that the man had died at 9.30am. A little later, the Imam performed the necessary rites of the man's faith. At 11.40am, his body was taken away by the undertaker and the cell was secured shortly afterwards.
116. The duty governor said at interview that an OSG from the communications room called him at home at around 6.30am and he immediately went to the prison. He confirmed that the other prisoners on the landing were taken away from their cells and were initially placed in an association room where support was provided for them. They were later asked to go into different cells over the lunch period to allow the police and coroner to carry out their duties. A senior officer said that each prisoner was interviewed to check if they were alright and whether they had seen or heard anything.
117. A hot debrief was held at 8.15am. (A hot debrief is a meeting for staff to discuss emotive issues and any lessons learned following serious events such as deaths in custody.) The meeting confirmed that the man had been found suspended from the window bars with a bedsheet wound twice around his neck, which was removed with an anti-ligature knife. Night staff had seen him earlier in the night but he had not pressed his cell bell whilst they were on duty. The only matter identified for improvement was that the seal on the medical bag had to be cut open as it did not open up when pulled. The duty governor explained that the bag had a reception seal which was quite difficult to open, but this did not refer to the emergency response bag carried by the nurse. It was agreed that the Safer Custody Officer would review the seals on the bags. Staff were made aware of the support services available and offered taxis home, but they all felt fit to drive. Some days later, the staff were invited to another meeting to talk about their experiences. The care team and other staff also offered help.
118. Staff took statements from a number of prisoners on A wing. One of the prisoners said that he spoke to the man between 7.00pm and 7.30pm on the evening before his death. He asked him how he was doing and about his relationship as the man looked distressed and they had spoken about the subject previously. He replied that he had spoken to his partner earlier that day and she was refusing to let him see the children. He told his fellow

prisoner that he would be alright and would talk to him again if he needed to. The fellow prisoner thought that he appeared calm at this point.

119. Several other prisoners had contact with the man during the late evening before his death. As prisoners on that wing had keys to their own cells and were able to lock and unlock them whenever they wished to, there was no set time for them to return to their cells. Staff allowed them to associate and move around freely at night so long as they were quiet. He was said to have had a cup of tea and a chat with four of his fellow prisoners at about 10.30pm. Some of them continued talking until around 11.30pm. One of them recalled the man telling them that he had split up with his partner and he “felt a bit down because she would not let him see his children and that he would have to contact a solicitor”. He said the man returned to his own cell at about 11.45pm and he (the fellow prisoner) thought he would be able to cope.
120. Two of the prisoners from the group of four seem to have been the last people to see the man alive. The first to see him, Prisoner A, said that at 12.30am they had a conversation in which the man had focussed on his partner not allowing him to see his children. He gave no indication to them of any intention to harm himself. The second prisoner, Prisoner B, said that he went to the toilet in the early hours of the morning, at approximately 1.30am. He saw the man pacing up and down the landing and knocking on prisoner A’s cell. The man appeared anxious. On his return from the toilet, he heard voices in prisoner A’s cell and assumed that the two men were having a conversation. Another prisoner spoke of hearing a loud thud on the pipes in the early hours but attached no importance to it as he had heard similar noises the night before. A further prisoner heard a banging noise on the pipes between 5.30am and 6.00am.
121. The man left some undated letters to his partner. In one of them he specified his wishes and it appears that he intended to take his life. He also left a note confirming his next of kin as his partner and asking for all his personal belongings and a letter to be given to her.
122. The man made a number of telephone calls the day before he died to his partner, brother and father. Transcripts of the calls indicate that he was distressed that his relationship with his partner appeared to have foundered and he made comments which suggest that he was thinking about harming himself.

Family contact

123. At the time of the man's death, Wymott had two family liaison officers. However, one was on long term sick leave and the other was on holiday abroad and did not return to work until two days afterwards. It is unclear from the documents who decided how the news should be broken to the man’s partner and family. His partner was notified by the police. While the police were at her home, she telephoned the man’s younger brother, who in turn, called the family whilst they were travelling. His father said that they were told about the death at around midday, while they were travelling to visit relatives.

- 124.** The man's father was distressed and angry at the delay informing them and the manner in which it was handled, particularly as the prison was only about a 20 to 30 minute drive from their home. The duty governor said that the Governor, in consultation with the police, decided that the police would notify the family. In the absence of the prison's family liaison officers, the Imam was designated as their point of contact. The Governor retired during the course of the investigation and these matters could not be clarified because of her ill-health.
- 125.** At interview, the Imam told my investigators that just after 8.00am on the day of the man's death, he picked up a message on his mobile phone from the communications room. The message told him that there had been a death in custody and he was required in the prison. He returned the call to find out who had died and was told it was the man. He then went to the prison where he spoke to the prison chaplaincy and other staff. The paramedics and police were already there. Although he was not able to go inside the cell, the Imam was permitted to stand at the door of the cell to conduct prayers. The Imam was surprised at the man's actions, especially as he had seemed happy and content the day before when he had received the additional pinphone credit.
- 126.** The Imam did not know how the man's family were told of his death. He told other prison staff that he would not telephone the family. However, if the Governor agreed, he would speak to the family if they contacted him. That evening, a member of staff from the communications room telephoned the Imam to tell him that the family wished to speak to him. When the Imam returned their call, he paid his respects, gave his condolences and explained that the man had taken his own life. Over the next two days, the Imam had further telephone conversations with the man's father. During one of their calls, the man's father asked for clarification as to how his son had taken his life. It was unclear whether the police had given the family details of his actions. The Imam explained that he had not been formally appointed as the family liaison officer, the family having assumed that he was acting in an official capacity, and not just as a member of the chaplaincy team.
- 127.** The following day, at the request of the orderly officer, the duty governor telephoned the man's family. He spoke to someone he believed to be the man's brother who relayed the conversation to another family member. He told them where their relative had been taken and explained the visiting arrangements. The family member he spoke to asked how he had died and the duty governor was surprised by this given it was over 24 hours since he had died. The duty governor explained that he had been found in his cell with a ligature around his neck.
- 128.** My investigator spoke to an operational manager, who has been a family liaison officer for five of his ten years at Wymott. He was away at the time of the man's death and took on the family liaison role two days later on his return. In his absence, the then Governor had deployed the Imam to liaise with the man's family and she had explained to him that the Imam had been able to deal with some of the cultural matters. The Imam had been in contact

with the man's parents, not his partner.

- 129.** When he took on the family liaison role, the family liaison officer spoke to the man's partner on the telephone on several occasions. He invited her into the prison to see his cell and gave her personal photographs, letters and items relating to "her side of the relationship". The family liaison officer explained that, because of acrimony between the man's parents and his partner, it had been difficult to decide who would be given items of property. The man's father had objected to the prison liaising with his son's partner. The then Governor had explained that prison staff would deal with both parties.
- 130.** My investigator asked the family liaison officer why two of the photographs taken by the man's family had not been returned and why the cell had been cleared before their visit. He explained that the Deputy Governor had viewed the photographs to approve them for security purposes. He considered that photographs, in which the man's brother had posed in the cell, were inappropriate. He thought that they could have been misconstrued if they fell into the wrong hands and came to the attention of the press or public. The cell had been cleared but not completely emptied. The family liaison officer said that after his death the man's family had gone to Pakistan for about three and a half weeks. Staff felt it was not right to leave the cell untidy for an extended period, so his property was placed in a bag and placed in the reception area.
- 131.** The family liaison officer was unable to say whether funeral expenses were offered. He was also unable to shed any light on whether the man's wishes about being buried in the UK had been communicated to the family. He had passed to the man's partner all the letters he had left for her.

ISSUES

Clinical care

132. A clinical review was conducted by the Clinical Services Coordinator, North Lancashire PCT, on behalf of Central Lancashire PCT. The post mortem confirmed the cause of the man's death as hanging.
133. The clinical reviewer commented that other than his written record, there was no evidence of any contribution from the healthcare department into the man's transfer from Risley. He considered that, after a serious instance of self-harm and significant involvement with mental health services, good practice would have been for a letter summarising his condition to accompany him. It would appear that this did not happen as his contact with the mental health services stopped at the same time as his monitoring under ACCT ended. The clinical reviewer was concerned that the man's medical risk assessment contained a sweeping statement that he was not mentally ill. He questioned that greater priority was not given to a referral to the primary care mental health team given his history of serious self-harm.
134. At Wymott, the man had his first mental health review on 17 April 2008. The referral had been made the previous day by a nurse who thought he was depressed. The clinical reviewer considers that, with hindsight, a number of triggers were evident during the session. Greater familiarity with the man's history might have led to a more formal mental health assessment and/or referral to a psychiatrist.
135. The clinical reviewer also suggests that the transfer between prisons shortly after self-harm attempts and periods on ACCT monitoring might have increased the man's risk, and at the same time reduced the opportunities for staff to identify triggers and offer appropriate support. He found the recordkeeping disjointed and difficult to follow, partly because there had been more than one system of recording, and the standard of handwritten records was inadequate. He also considered that interventions were reactive and ad hoc, with little evidence that staff had thought about any therapeutic interventions such as anxiety management, family therapy or review by a psychiatrist.
136. The clinical reviewer concluded that there were no serious shortcomings in the care given to the man before his death and that the nurse on duty responded appropriately when he was found hanging. However, he highlighted several areas for improvement and makes nine recommendations on clinical matters relating to the three prisons in which the man spent time from 2007. I endorse his recommendations, particularly those relating to record keeping as there are a number of incidences of illegible or unsigned entries and signatures. This has impaired the quality of evidence in the investigation.

ACCT monitoring

137. ACCT is a tool for monitoring and providing support to prisoners identified as at risk of self-harm or suicide. All staff should receive basic ACCT training and be able to start the process, as well as make appropriate entries in the ongoing record. The basic training includes identifying signs of risk. Some staff receive more in-depth training to conduct assessment interviews and take part in case reviews. (At Risley, every principal officer and senior officer is a trained case manager.) A trained member of staff should undertake the first assessment interview. Subsequent case reviews should ideally be multidisciplinary, comprise no less than two members of staff and also include the prisoner. Once the staff who conduct the reviews determine that the risk is no longer evident, the ACCT document can be closed. A post-closure review should take place seven days later to confirm that the risk remains reduced.

Risley

138. The man was subject to ACCT monitoring at both Risley and Wymott prisons. At Risley, ACCT monitoring was started promptly on 27 January, following concerns raised by his brother as well as the man's explicit admission that he felt suicidal. He had asked to be moved to the CSU as he feared for his safety. Staff resisted this and considered other solutions, but coincidentally, he was then placed in the unit as a result of being found with a mobile telephone. He was subsequently penalised by withdrawal of his television and no association with other prisoners. The suicide prevention policy suggests that prisoners on ACCT should only be segregated in exceptional circumstances and punishments other than confining prisoners to their cells should be considered. Staff at Risley told the investigator that no one subject to ACCT monitoring is kept in the CSU unless it is absolutely necessary and there would always be mandatory case reviews. They also demonstrated the methods used to occupy and keep prisoners active within the CSU, such as activity packs and anxiety management classes.
139. The ACCT CAREMAP was detailed and, during the period of review listed several different actions, including compassionate decisions enabling him to have open rather than closed visits and careful consideration as to how to handle letters from his partner threatening to end their relationship. Staff managed the period of ACCT monitoring flexibly, taking account of future events that could impact on his condition. For example, on 18 February, the man was insistent that he wished the monitoring to end and he was assessed as low risk. However, staff did not take this at face value and decided to continue the ACCT monitoring as they were concerned as to how he would react to the outcome of his baby son's impending hospital appointment. A few days later they again decided to continue the ACCT support, in spite of the man's assertion that he did not intend to harm himself. The following day, they increased the frequency of observations from three per day to four per hour as he was unhappy after having a closed visit.

140. The ACCT was closed on 27 February. Given how flexibly staff had managed the process, it is rather surprising that it was closed only four days after the man had admitted feelings of harming himself. With hindsight, it might have been better to keep it open for a while longer. There is provision for it to remain open with a much reduced level of contact of around one to two conversations a day. A post closure review date was set for 26 March, but by then the man had transferred to Wymott. Staff there overlooked the completion of the review in spite of an email being sent to warn them it was outstanding. I am pleased to note that all the reviews at Risley complied with policy guidelines in respect of being multidisciplinary, with good quality entries.

I commend the principal officer for taking the additional step of sending an email to Risley to alert staff to the recent ACCT monitoring, the outstanding post closure review and contact details for any further information required.

Wymott

141. At Wymott, ACCT monitoring was put in place on 15 April. There are references to it in personal and medical records, as well as the wing observation book. Regrettably, the prison could not find the ACCT document so I have been unable to assess the quality of management or determine when it was closed. It is not known whether the document was lost while it was current or sometime thereafter. Although there is no indication that losing ACCT documents was a common occurrence at Wymott, a missing ACCT document could impact gravely on the well being and life of a prisoner. The Governor will wish to ensure that the procedures for handling and filing ACCT documents is clear to staff.
142. A further ACCT plan was opened on 7 May after the man made another serious attempt to take his life. He spent two days in hospital and returned to the prison on 9 May. The immediate action plan section of the document was not completed. He was in hospital for the first two days of monitoring and, during this time, staff made regular descriptive entries regarding observations, events and key decisions. Staff conducted an assessment interview the day after his return (10 May) and his risk of repeating self-harm was judged to be very high. During a case review later the same day, although he asserted that he was no longer suicidal and was not considering harming himself, staff considered his risk to remain high and his observations were continued at the same frequency.
143. Further ACCT case reviews were held on 13 and 20 May. On 13 May, the review was attended by a senior officer and a member of the mental health in-reach team, together with the man, and he was considered to be very positive. The level of risk was recorded as low and observations at night were reduced from five to three per hour. The ACCT was closed during the review on 20 May and a post-closure review set for 28 May. The meeting was attended by the man and two discipline staff.

144. Although most sections of the ACCT were completed adequately, the CAREMAP was poor. This is an important part of the document. Its purpose is to identify key issues and the steps necessary to address them to help keep a prisoner safe. Only one goal (to maintain family links) was identified and the action was for the man to write and make telephone calls, with no staff input identified. The assessor explained at interview that a number of options put forward were rejected by the man. Nevertheless, I am concerned that the onus was entirely only on the man to achieve this and no other goals were identified which engaged staff. I am also concerned that the decision to close the ACCT was taken solely by discipline staff, although best practice is for review meetings to be multidisciplinary. In particular, I consider that it would have been beneficial to have input from the mental health team. Knowing that the man's history of serious self-harm arose from ongoing family issues followed by a pattern of initial resolve not to harm himself again, I judge that it would have been better for him to have remained on ACCT monitoring until it was possible to convene a multidisciplinary meeting with mental health representation.

The Governor should remind staff of the key requirements of the ACCT process. Notably, that it is good practice for ACCT case reviews and decisions on closure to be multidisciplinary and include key people who know the person at risk or are involved in his care, such as staff from the mental health team. Post-closure reviews must take place when ACCT documents are closed, including those outstanding from previous prisons. Attention should also be given to the safe storage of ACCT files.

Bullying

145. The man's family asked if he had been bullied and whether the issues that had been problematic for him at Risley had followed him to Wymott. He had asked to be segregated there for his own protection and his family had also raised concerns for his safety via his brother. The family said that for the first few days in Wymott he seemed happy and settled, but then seemed to become "stressed out" before his two suicide attempts there. Documents from all three prisons where he served his sentence show that he was subject to anti-bullying measures, both as an alleged bully and also as a victim. It is clear that from time to time he was fearful of being bullied and the support given to him by staff, such as consideration of his location, is documented. However, I am satisfied that there is no evidence that the episodes of bullying had any impact on him deciding to end his life.

Emergency response

146. Wymott operates a code system for staff to communicate the nature of medical emergencies. Code blue is used for emergencies involving breathing difficulties and code red for bleeding. The man's actions in harming himself resulted in both. Staff used both radio and telephone contact to summon initial help and ask for an ambulance to be called. However, there are conflicting accounts as to whether a code was used to indicate what response

was required and if so, what colour code was given. The staff nurse speculates that a code was not used over the radio as it would have been inappropriate over an open network. Fortunately, the emergency bag holds equipment to cover both types of emergency so, in spite of the confusion about codes, there does not appear to have been any delay in giving the correct treatment or getting an ambulance. In light of this, I make no formal recommendation, but the Governor may wish to satisfy himself that staff are aware of the correct use of the coding system.

Family liaison

147. The man's family asked a number of questions when the investigator visited them. These have been addressed throughout the report. The family's questions regarding hospital visits were put to the family liaison officer. He explained that given the nature of the offences committed by most of the prisoners at Wymott, public protection is a key issue and the prison policy is robustly adhered to. The policy is that if a prisoner is taken to hospital, for security reasons his family is not told for 72 hours unless his condition is life threatening. My investigator pointed out that although the man's condition was not life threatening, he had made a serious attempt at taking his life and queried whether there was any flexibility in the policy. The family liaison officer said there was room for discretion and such decisions would probably be taken by the security department or deputy governor.
148. Wymott is not used to dealing with self-inflicted deaths. When the man died, neither of the trained family liaison officers were available. Handling of matters such as breaking the news is unclear as it was not documented and the Governor, who had overseen the initial arrangements, was not interviewed after the opening visit as she had a period of ill health and subsequently retired.
149. The man had complex family relationships. Before he went to prison he lived with his partner, but he also had a wife and was in contact with his parents and brother. The police broke the news to the man's partner, who he nominated as his next of kin. There were conflicting accounts as to whether this was by telephone or face to face and there is no indication as to why the police rather than the prison undertook this task. It might well have been because of the absence of a trained family liaison officer. The man's parents were told a few hours after his death by other relatives who had taken calls from his partner. They immediately returned to their home to find that other people, unrelated to the family, were already aware.
150. Supplementary guidance to Prison Service Order (PSO) 2710 states in section 3.2, "every family is different and has its own dynamics. A family liaison officer needs to be flexible and open-minded and should approach the family in accordance with its individual needs". The guidelines also set out, in section 3.4, that at times families will be divided, but all have equal rights to information. When it is not possible to liaise with one single point of contact in the family, the liaison officer should be prepared to communicate with different sections of the family. As each branch of next of kin is entitled to equal

information, they should also be treated equally. The man's parents were unhappy with the initial handling of communication with them and considered that their needs were not met, for example, not being told of the cause of death. They certainly do not appear to have been treated equitably regarding how the news was broken and their access to prison staff, but when the family liaison officer returned from leave things seemed to improve. There are often instances of divided families and, in these circumstances, prisons should consider appointing more than one liaison officer to ensure that the needs of all parties are addressed.

151. There was clearly a lack of contingency planning for handling family liaison during the absence of both family liaison officers. The Imam did his best in respect of dealing with the man's blood relatives, but he had no family liaison training and could not have been expected to fulfil that function in its entirety or to be aware of the processes or requirements. The investigator was told that steps have been taken to recruit more family liaison officers. Also, Wymott accepted two previous recommendations relating to training more family liaison officers and asking prison staff to break the news of deaths to families, so I make no formal recommendations on these particular aspects. However, I do consider that the Governor should ensure the family liaison team are fully aware of the guidelines about communicating with families so that they are taken into full consideration in any future cases to prevent further upset to families.

The Governor should remind the prison's family liaison officers of the National Offender Management Service (NOMS) guidance regarding dealing with more than one branch of family or next of kin, particularly drawing attention to the right of equal access to information.

152. The prison did not make a contribution to the man's funeral expenses. Anecdotally, this was said to be because his father had been out of the country, having taken his son's body to Pakistan for burial. In spite of the funeral taking place abroad, the family should be treated in the same way as other bereaved prisoners' families. I consider that the Governor should offer a payment retrospectively.

The Governor should retrospectively offer a contribution towards the man's funeral expenses.

CONCLUSION

153. The man spent just under a year in prison. At each of the three prisons where he served his sentence, he went through cycles of feeling low and vulnerable to harming himself, followed by periods of positive outlook and a resolve to address his problems. He was not always the easiest of prisoners to manage, having been subject to disciplinary action on a number of occasions. His difficulties and the staff responses to supporting him were well documented.
154. Prison staff put in place appropriate formal and informal measures to support the man through substance misuse, anxieties about bullying as well as his thoughts of harming himself. He responded positively to some of these interventions, such as drug counselling. In spite of this, he made three serious attempts to take his life and died on the last occasion. The man's episodes of harming himself were consistently triggered by difficult family issues which he felt unable to control or deal with while he was in prison.
155. I judge that, on the whole, the man was managed flexibly and appropriately at each prison. However, the investigation has identified scope for improvement in the administration of the ACCT procedures and family liaison and I make recommendations on these matters. In addition, the clinical reviewer has identified the need for enhancing clinical procedures and I concur with his recommendations on these matters.

RECOMMENDATIONS AND GOOD PRACTICE

Recommendations

1. The Governor should remind staff of the key requirements of the ACCT process. Notably, that it is good practice for ACCT case reviews and decisions on closure to be multidisciplinary and include key people who know the person at risk or are involved in his care, such as staff from the mental health team. Post-closure reviews must take place when ACCT documents are closed, including those outstanding from previous prisons. Attention should also be given to the safe storage of ACCT files.

The National Offender Management Service accepted the recommendation and made the following comments:

“ACCT foundation training and refresher training highlights the importance of a multi-disciplinary approach when conducting ACCT case reviews, refresher training is ongoing for all staff. It also covers the issue of relevant parties being present and a multi-disciplinary decision being made to close an ACCT document.”

“Post closure interviews are completed 7 days after the ACCT document has been closed, including post closure interviews necessary from transferred in prisoners from other establishments. The above issue forms part of the quality check process that is undertaken on all ACCT documents.”

“All ACCT documents are securely stored in the offender’s core record.”

2. The Governor should remind the prison’s family liaison officers of the National Offender Management Service (NOMS) guidance regarding dealing with more than one branch of family or next of kin, particularly drawing attention to the right of equal access to information.

The National Offender Management Service accepted the recommendation and made the following comments:

“There are now four trained FLOs at HMP Wymott who operate in line with PSO 2710 follow up to Death in Custody.”

“Equal access to information sharing has been raised and the FLO’s are aware of this requirement.”

3. The Governor should retrospectively offer a contribution towards the man’s funeral expenses.

The National Offender Management Service accepted the recommendation and made the following comment:

“A letter outlining a retrospective offer to contribute £2,000 towards funeral costs was made to [the family] by the Governor on 04 August 2010. [The family]”

replied 24 August 2010 accepting this offer. A cheque for the sum of £2,000 was mailed to [them] 02 September 2010.”

Good practice

I commend the principal officer for taking the additional step of sending an email to Wymott to alert staff to the recent ACCT monitoring, the outstanding post closure review and contact details for any further information required.