

A Report by the
Prisons and
Probation
Ombudsman
Nigel Newcomen CBE

**Investigation into the death of a man in December
2013 at HMP Wymott**

Our Vision

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

This is the investigation report into the death of a man, who was found hanged in his cell at HMP Wymott in December 2013. I offer my condolences to his family and friends.

The investigation was carried out by one of my investigators. A clinical reviewer was appointed to review the man's clinical care at Wymott. The prison cooperated fully with the investigation. The investigation was suspended between December 2013 and January 2015, for the outcome of police enquires and a decision by the Director of Public Prosecution. I am sorry for the consequent delay to this report.

The man had been in prison since October 2010 and at Wymott since March 2012. He suffered from depression and was under the care of a mental health nurse and a visiting psychiatrist. However, the man presented positively and officers regarded him as a cheerful person. Prison staff managed him under suicide and self-harm prevention procedures, between September and November 2013, after a psychiatrist was concerned about him. The monitoring ended on 28 November, although a nurse was concerned that a proposed wing move might cause him anxiety. No one reviewed the man within seven days, as should happen.

On Friday 6 December, the man was due to move to a different wing but he objected. The move did not go ahead that day, and it was planned he would move on Monday 9 December. He wrote a note setting out his objections to the move, in which he indicated he would be at risk from two other named prisoners. He referred to the possibility of hanging himself as a solution to his problems. It is not clear who he gave the note to, but an officer read his representations against the move and, later on 6 December, recorded this in his prison record and submitted a security report. The officer believed the man was trying to avoid an unwelcome wing move and did not consider that he was at risk of suicide and self-harm, as the move had not yet taken place, but he did nothing to prevent the move going ahead or seek to reassure the man about this. On the morning of Monday 9 December, an officer found the man hanged in his cell. He radioed a medical emergency, but it was another seven minutes before anyone called an ambulance. Staff began cardiopulmonary resuscitation and paramedics took over his emergency care when they arrived. Emergency treatment was unsuccessful and paramedics confirmed that the man had died.

While I consider the man received some good support at the prison, the investigation identified some areas for improvement in suicide and self-harm prevention procedures. If it was necessary to move him, I consider that monitoring procedures should have continued until the man was settled on a new wing. Staff should have begun monitoring him again when they received his note explaining his reasons against the move, with a threat that he would hang himself. The man received swift emergency treatment from prison and healthcare staff, but I am concerned that it took too long to call an ambulance.

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

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SUMMARY

1. On October 2010, the man was remanded to HMP Manchester. While the man was on remand he was twice managed under Prison Service suicide and self-harm prevention procedures, known as ACCT; once when he tried to hang himself, and later when he was low in mood. On 27 January 2012, he was sentenced to 7 years 6 months in prison. . He transferred to HMP Wymott on 2 March 2012.
2. On 12 September 2013, the mental health team manager at Wymott began ACCT procedures after she and a psychiatrist assessed the man as at raised risk of suicide and self-harm. Prison staff closed the ACCT on 28 November when they considered that the man's risk had reduced, although a nurse had been concerned about the effect of a proposed wing move. No one reviewed the man in the week after the ACCT was closed, as should have happened. The review was set for 9 December.
3. The man was due to move from A Wing to G Wing on Friday 6 December, but he objected and the move was postponed until Monday. At some time that day, he submitted a note with representations against the move. He feared for his safety and said that a relative of one of his victims lived on G Wing and he was in debt to another prisoner who had threatened him. He referred to the possibility of hanging himself and that he might kill someone on the wing. An officer read the note, recorded this on the man's prison record and submitted an intelligence report. He did not consider that the man was at imminent risk of suicide and self-harm and did not open an ACCT, because the wing move had not taken place. He did not suggest that the move should be put on hold until the man's concerns were investigated. There was no indication over the weekend that the man appeared distressed or at increased risk of suicide and self-harm. However, a prisoner later said he had given away some of his possessions on Sunday night, which was out of character.
4. At 8.38am on Monday 9 December, an officer found the man hanged in his cell and radioed a medical emergency. Nurses arrived quickly and began cardiopulmonary resuscitation. Control room staff did not call an ambulance until seven minutes later. Nurses continued to attempt resuscitation until paramedics arrived and took over his care. At 9.36pm, the paramedics confirmed that the man had died.
5. We consider that staff generally supported the man well through the ACCT process and he had good mental health support. However, a nurse had identified concerns about a proposed wing move and we consider it would have prudent to have kept the ACCT open until the man settled on his new wing. The ACCT was closed ten days before the man died and no one reviewed him in the week after the ACCT was closed, to check how he was feeling. We consider that staff should have considered opening an ACCT when the man identified his fears about moving wings and reassured him that the move would not take place until his concerns had been investigated. Although it would not have affected the outcome for the man, we are concerned that control room staff did not call an ambulance immediately the emergency call was received, as they should have done. We make two recommendations.

THE INVESTIGATION PROCESS

6. The investigator issued notices to staff and prisoners informing them of the investigation and inviting anyone with relevant information to contact him. No one responded. He visited Wymott on 23 December 2013 and obtained relevant records about the man.
7. Lancashire Police asked us to suspend our investigation on 24 December 2013, as they were enquiring into aspects of staff actions related to the circumstances of the man's death. The investigator liaised with Acting Superintendent about the police investigation. On 18 January 2015, the Director of Public Prosecutions decided there was insufficient evidence to bring any criminal charges. We re-opened our investigation the next day, 19 January 2015. We regret the delay this has caused.
8. NHS England appointed a clinical reviewer to review the man's clinical care at the prison.
9. The investigator and clinical reviewer interviewed six members of staff and one prisoner at Wymott on 18 and 24 February 2015. The investigator interviewed another member of staff at the prison on 19 March.
10. The investigator contacted Her Majesty's Coroner for Preston and West Lancashire to inform him of the investigation and to obtain a copy of the post-mortem report. We have sent a copy of this investigation report to the coroner.
11. One of our family liaison officers contacted the man's sister to inform them of the investigation and to invite them to identify relevant matters they wanted the investigation to consider. The man's sister had the following questions, which we have addressed in the report:
 - Why was the man not on an ACCT at the time of his death?
 - Why had the man been taken off an ACCT two days before he died?
 - Did the man receive support from the mental health team?
 - Were there plans for the man to move wings, and if so why?

The man's family received a copy of the draft report. The solicitor representing the family wrote to us raising a number of questions that do not impact on the factual accuracy of this report. We have provided clarification by way of separate correspondence to the solicitor.

HMP WYMOTT

12. HMP Wymott is a medium security prison holding over 1,100 sentenced men. About half of the prison is for prisoners who are regarded as vulnerable to attack from the mainstream population, principally because of the nature of their offence.
13. Lancashire Care NHS Foundation Trust provides healthcare services at the prison. A private company provides GP services and out of hours medical cover. There are no inpatient beds, but there is 24 hour nursing cover.

HM Inspectorate of Prisons

14. The most recent inspection of HMP Wymott was in July 2014. Inspectors found that the prison did not have a local self-harm and suicide prevention policy tailored to the circumstances of the establishment. There had been an increase in self-inflicted deaths and inspectors considered that was a need to keep action plans in response to recommendations from Prison and Probation Ombudsman's investigations under review. Inspectors found some serious deficits in ACCT procedures. Although there were some good assessments and interactions recorded, the quality of care planning was often poor and did not address the identified issues. A third of staff required refresher training in ACCT suicide and self-harm prevention procedures.

Independent Monitoring Board

15. Each prison in England and Wales has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community, who help ensure that prisoners are treated fairly and decently. In its most recently published report, for the year to May 2014, the IMB noted that vulnerable prisoners lived in separate accommodation with its own workshops, education and training facilities. They commented that management and staff had worked hard to maintain Wymott as a prison that held prisoners with safety, decency, respect and security.

ACCT - Assessment Care in Custody and Teamwork

16. ACCT is the care planning system the Prison Service uses to support prisoners at risk of suicide or self-harm. Once a prisoner has been identified as at risk, the purpose of the ACCT process is to try to determine the level of risk, the steps that might be taken to reduce this and the extent to which staff need to monitor and supervise the prisoner. Part of the ACCT process involves assessing immediate needs and drawing up a caremap to identify the prisoner's most urgent issues and how they will be met. Regular multi-disciplinary reviews should be held. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

Previous self-inflicted deaths at Wymott

17. The man's death was the sixth self-inflicted death that the Ombudsman has investigated at Wymott since 2004. There were no significant similarities with the circumstances of the other deaths. However, since 2013, we have made a number of recommendations about the need to call an ambulance immediately in an emergency.

KEY EVENTS

18. On 6 October 2010, the man was remanded to HMP Manchester. In May 2011, prison staff opened an ACCT, after the man tried to hang himself. He said he had taken part in a Tarot card reading and it had upset him, but said he had not planned to kill himself. The ACCT was closed on 16 June. Prison staff opened an ACCT again on 21 November, when the man said he was in low mood due to his court appearance. He was convicted on 28 November. The ACCT was closed on 3 January 2012. On 20 January 2012, he was moved to HMP Forest Bank and on 27 January, was sentenced to 7 years 6 months in prison.
19. On 2 March 2012, the man transferred to Wymott. At Wymott, he worked in the tailor's workshop and had a single cell on A Wing. The wing is divided into spurs with 11 or 13 cells on each spur, with communal facilities including toilets and showers on each spur. Each spur is locked off during the night but prisoners have access to the spur facilities at all times, which allows them more freedom than on most other wings. Cells on A Wing are allocated only to prisoners who work in the tailor's workshop and the laundry, who work longer hours than other prisoners.
20. The man had a lot of contact with healthcare staff. Between 2 March 2012 and 11 September 2013, he saw a member of the mental health team 21 times, had six general nurse appointments and three appointments with a doctor. He was diagnosed with depression, for which doctors prescribed mirtazapine.
21. On 12 September 2013, Dr A, a visiting consultant forensic psychiatrist, and the mental health team manager, saw the man for a mental health review. The doctor recorded that the man found it difficult to come to terms with his offences and the impact on his family. He noted that the man had previously attempted to kill himself on the birthday of one of his victims.
22. The man said that he saw no way out of his situation. He said he sometimes had thoughts of ending his life, but he did not have any plans to carry this out. Dr A recommended that the mental health team manager open an ACCT, as he thought that the man was at risk of suicide and self-harm at the time, and needed additional support. The doctor also changed the man's prescribed antidepressant to fluoxetine and prescribed zopiclone for seven days to help him sleep.
23. The mental health team manager began ACCT procedures and recorded that the man had increased thoughts of harming himself but had no plans. The man said that he had become more irritable, found it difficult to sleep, had lost his appetite, and found it difficult to concentrate and mix with others. As a result, he had lost his job in the tailor's workshop.
24. Custodial manager, A, completed an ACCT immediate action plan. He recorded that the man should stay on A Wing, so he could receive support from his friends, and that he should continue to work with the mental health team, as his medication had changed. The custodial manager recorded the man's level of risk of suicide and self-harm as raised and set the level of observations at three times during the day and four times at night.

25. That evening, Officer A interviewed the man for an ACCT assessment. The man said he had massive feelings of guilt about the impact his offences had on his family. He said that he found that time of year particularly difficult as two of his daughters had birthdays and he was not allowed to have any contact with them. He said that he did not keep in contact with anyone and had tried to hang himself in 2011, as a way out. He said he wanted to be dead but had no plans to kill himself and could not go through with it again.
26. On 13 September, Supervising Officer (SO) A held the first ACCT case review, with Nurse A and Nurse B, from the mental health team. SO A identified two actions for the ACCT caremap. Firstly, that staff should not allow the man to keep medication in his possession and secondly, that officers should find him alternative employment. The review assessed that his level of risk as raised and maintained the level of observations remained at three times during the day and four times during the night. They scheduled the next case review for 16 September.
27. Between 16 September and 22 November, staff held 11 ACCT case reviews with the man. A member of the mental health team attended each review, and Nurse A was present at nine. Each time, staff reviewed the man's level of risk and the caremap. By 22 November, the man had a new job as a dining room cleaner. A review assessed his risk of suicide and self-harm as low. Observations were still three times during the day, but reduced to three times during the night.
28. While the man was being managed under ACCT procedures, Nurse A saw him seven times to review his mental health and he had one appointment with Dr A. The nurse told the investigator that the man presented very differently to different people and often gave the impression that he was a very happy-go-lucky type of person. The nurse said she worked closely with Dr A and they assessed that the man had a reactive depressive illness related to his offences. They did not consider he had a severe and enduring mental illness.
29. At an ACCT review on 22 November, a move to G Wing had been suggested and Nurse A had been concerned that the environment was not suitable for him. Prison staff considered it was necessary as it would be easier to supervise him there. On 28 November, SO B and Nurse A held a further ACCT review. The man said that he was happy with his new job, which gave him a degree of flexibility. He said that he understood that he would have to move from A Wing, as he no longer met the criteria for the wing, because he did not work extended hours, although he was slightly apprehensive about moving. The man said that he had no thoughts of suicide or self-harm and was "in an all right place".
30. SO B and Nurse A agreed that because the man was at low risk of suicide and self-harm and the caremap actions had been completed, they could close the ACCT. The SO scheduled a post-closure review for 9 December, although the national instructions require the review to be held within seven days of an ACCT being closed. A first post-closure review should therefore have been held on or before 5 December.

31. After the ACCT review, Nurse A recorded in the man's medical record that Officer B and Officer C had told her that now that the man's ACCT had been closed, he would have to move to G Wing because he did not have a longer hours job. The nurse recorded that, from a mental health perspective, the man would be better moving to B Wing, as that was the same layout as A Wing and would provide the social interaction that the man needed.
32. Nurse A told the investigator that she had raised this with the wing staff but she felt that they did not take her seriously. (Nurse A had also recorded in the medical record that she had discussed her concerns about a possible move for the man to G Wing with a custodial manager at an ACCT review on 22 November.) She considered that because of the man's apparently positive demeanour, prison staff did not recognise his underlying anxieties. She said that had she been aware at the ACCT review, that staff planned to move the man imminently, she would have recommended that the ACCT should remain open, with a raised level of observations, so that he received additional support until he settled on a new wing.
33. Officer B told the investigator that he knew the man very well. He described him as a "Jack the Lad", sociable character who had a good relationship with staff and other prisoners. The officer was aware that the man saw Nurse A frequently and that Nurse A had concerns about his wellbeing.
34. Officer B said that staff knew that the man pestered other prisoners to try to get some of their prescribed medication, particularly tramadol (an opioid pain relief medication). Officers did not think that the man bullied other prisoners, but "chanced his arm" to see what he could get away with. There were no security intelligence reports about this.
35. Prisoner A, a prisoner on A Wing, who was a close friend of the man, told the investigator that he had known the man for 25 years. He described the man as a "loveable rogue", but he was volatile and lost his temper easily. Prisoner A knew that the man had tried to hang himself at Manchester and that he saw someone from the mental health team frequently. He said the man relied on drugs, both prescribed and illicitly obtained, and would take whatever he could get to help him get through the day.
36. On 4 December, Nurse, A, saw the man for a mental health review. The man said that he felt better and was OK at work. He said he felt anxious that he might have to move wings, but would deal with it when it happened. Nurse A recorded that she would see the man again in seven to 10 days.

Friday 6 December

37. On the morning of 6 December, Officer D was working in A Wing office as the collator, responsible for organising and arranging prisoner moves as instructed by managers. He said he had a list of 10 prisoners, including the man to be moved. The officer said that at about 8.30am, he called the man to the office and told him that he was moving to G Wing. The man said that he had issues on G Wing and the officer told him that he would speak to the orderly officer, the manager responsible for the routine operation of the prison that day. This was about 8.30am.

38. Custodial manager, B, was the orderly officer on 6 December. He said that Officer D had phoned him about the move and he had asked him to check the man's prison records to see if there was anything recorded that would prevent a move to G Wing. If there was nothing noted in his record, then he should go ahead with the move. Custodial manager B said that Officer D did not contact him again and he assumed that there was no problem.
39. Officer D said that he checked the man's prison records and found nothing to indicate that it would be inappropriate to move him. He told the man that he would move to G Wing at some point, but not that day, as they had missed the time for G Wing moves. Officer D said that he did not speak to the man again that day.
40. Officer B was working the late shift, from 12.30pm to 9.00pm. He came onto A Wing at 1.30pm and said there were two "letters" in the wing observation book from prisoners, one from the man. The man had written that he did not want a move to G Wing because a prisoner on G Wing was a relative of one of his victims. He also said he was in debt to another prisoner there, who had made death threats against him. He feared for his safety on the wing. He said he had not been well for months and the stress of this move might make him lose control and kill someone. At the end, he wrote, "I could just hang myself and that would put a stop to all this shit".
41. As Officer D was the collator for that day, Officer B assumed that he had already dealt with the man's note. He checked the wing observation book, saw that the man's move to G Wing had been postponed and thought that this had been in response to the issues the man had raised.
42. Officer D told the investigator that he had not seen the man's note. He said the first time he had seen it was after the man's death, when the police interviewed him.
43. Officer B said he went back to the wing office at approximately 6.30pm. The two notes were still in the wing observation book and there was no record that anyone had done anything about them. He read them, made entries in each prisoner's prison record, submitted intelligence reports and sealed each note separately in an evidence bag. The officer noted in the record that the man had said that he feared for his safety if he was moved to G Wing, as he was in debt for drugs, and named two prisoners. He did not refer to the man's concern about an association with one of his victims. The officer wrote that he believed a move to G Wing would be a benefit for the man as the camera cover and wing layout might prevent him using other prisoners' prescribed medication. This would also provide some respite for prisoners who were prescribed medication on A Wing.
44. Officer B gave the notes to custodial manager, C, who was the night orderly officer. Officer B told the custodial manager what he had done and said that there was nothing to worry about. The custodial manager told the police that he did not read what the man had written, as Officer B had said he had no concerns about him. He left the notes in the security department office, where no one would be on duty until Monday morning.

45. The investigator asked Officer B whether, based on the content of the man's letter, and his knowledge that the man had recently been on an ACCT, he considered opening an ACCT. Officer B said that he did not think there were any immediate reasons to open an ACCT, as the man had not moved to G Wing. The man had spoken to him briefly at dinnertime that day and gave him no reason for concern. The officer saw the man on the wing over the next two days and said that he seemed fine, did not raise any problems and there was nothing to indicate he was at risk of suicide and self-harm.
46. Prisoner A told the investigator that over the weekend of 7 and 8 December, the man's whole demeanour changed. He wore his Islamic hat, which he had never done before. He had been very calm and collected and spent a lot of time with the people he was close to. He played snooker, which he had not done for a long time, and won. He said the man seemed happy in himself and had not even asked anyone for a smoke, which was very unusual. He said the last time he saw the man was between 4.30pm and 5.00pm on the Sunday evening, when he had said, "come and see me in the morning, I need to see you, and I need to speak to you". They shook hands, hugged, and the man walked off to his cell.
47. Prisoner A said that he had heard later that the man had been giving some of his possessions away to other prisoners on his spur that evening. He told them he was being transferred the next morning and these items were not on his property card. The prisoner said that if he had known this at the time, this would have alarmed him, as the man was the type of person who took things off people, not gave them away.

Monday 9 December

48. Night patrol officer, A, was on duty on A Wing on the night of 8/9 December. She told the investigator that the wing had been quiet all night, with no problems. At approximately 6.20am, Officer E did an early morning roll check to ensure that all prisoners were present in their cells. She did not raise any concerns.
49. At 7.45am, the spurs were unlocked and prisoners were free to move to work and collect medication. Officer F was organising the movement of 48 prisoners who lived on the man's side of the wing. The officer had a list of prisoners and checked it as they left the wing to go to their activities. Just after 8.35am, he noted that two prisoners on the list, including the man, had not left the wing.
50. Officer F went to the man's cell and when he opened the door observation panel, he found it was covered with toilet paper from inside, blocking the view into the cell. He opened the door and found that the man had hanged himself using bedding attached to the window bars. The officer supported the man's body while he cut the bedding. He placed the man flat on the floor and, at 8.38am, radioed a code blue emergency.
51. Prisoner A said that he had gone to the man's cell that morning but the observation flap was covered. He went to join the medication queue and expected to see the man there. While he was waiting, he heard the emergency code blue over the staff radio network.

52. Nurse C reached the cell within two minutes of the code blue being called. She and Officer G started cardiopulmonary resuscitation and attached an automated external defibrillator. The defibrillator did not detect a shockable rhythm. Other nurses joined them.
53. The control room log shows that the code blue was called over the radio at 8.38am. However, the control room did not call an ambulance until 8.45am, when Nurse G checked whether one had been called. Paramedics arrived at 9.05am and took over the man's care. At 9.36am, they confirmed that the man had died.

Contact with the man's family

54. At 10.30am, the deputy governor, the Head of Safer Custody, and a prison chaplain, visited the man's sister, informed of her brother's death and offered condolences and support. The prison kept in contact with the man's family for ongoing support and offered a contribution towards the funeral expenses, in line with national guidance.

Support for prisoners and staff

55. A manager held a debrief on the morning of the man's death for the staff involved in the emergency response to discuss what had happened and to offer the services of the prison's care team. Officers and members of the chaplaincy team supported prisoners affected by the man's death. Staff reviewed prisoners assessed as at risk of suicide or self-harm in case they had been adversely affected by the man's death.

Post-mortem

56. A post-mortem examination gave the cause of the man's death as hanging. A routine toxicology examination had shown the presence of lansoprazole, fluoxetine and tramadol. Each medication was below the level associated with fatalities, and the man has been prescribed all of these at some point in the months before his death.

ISSUES

Management of risk of suicide and self-harm

57. Staff at Wymott appropriately opened an ACCT on 12 September 2013, when they assessed the man as at raised risk of suicide and self-harm. We consider the initial level of observations of three times during the day and four times at night appears relatively low for someone considered at raised risk of suicide. There were two issues on the caremap about his medication and for officers to find him alternative employment. Staff held 13 multidisciplinary reviews with the man and closed the ACCT on 28 November, when they considered he was no longer needed monitoring. Both caremap actions had been completed.
58. We are satisfied that the man was appropriately supported while being managed under ACCT procedures during this period. However, we note that at an ACCT review on 22 November, Nurse A raised concerns about a proposed move to G Wing. In his medical record she indicated that he might need additional support if the move went ahead. We consider that the ACCT review should have identified this as an additional caremap action. This should have ensured that the ACCT was not closed until the suitability of a new wing had been agreed and he had settled there. As the concern had been raised, it would have been prudent to keep the ACCT open until the man's location had been agreed.
59. Nurse A told us that she did not think that wing staff took her concerns seriously when she questioned the man's proposed move to G Wing. Prison staff had told her there were security reasons which they could not tell her about. She said that had she known the move was imminent on 28 November, she would have recommended that the ACCT remained open to ensure that the man was supported after the move. We are concerned that prison staff did not recognise that a wing move might prove difficult for the man and that he might need further support. It is also a concern that Nurse A did not feel empowered to raise her concerns at a senior level.
60. Prison Service Instruction (PSI) 64/2011, covering safer custody states that ACCT post-closure interviews should be conducted within seven days of the closure of the ACCT. We are concerned that SO B scheduled the post-closure interview for 9 December, when it should have been conducted on or before 5 December. This was a further missed opportunity to identify the man's concerns about moving and consider whether to re-open the ACCT to support him. However, we note that Nurse A saw the man on 4 December for a mental health review on 4 December and did not identify him as at risk or suicide and self-harm at the time.
61. On 6 December, the man gave staff a note setting out his concerns about the proposed move to G Wing. He concluded by saying he "could just hang myself and that would put and end to all this shit." Lancashire Police, as part of their investigation, were unable to establish which member of staff received the note from the man, and how many staff had handled it before Officer B read it. We consider that some action should have been taken when it was received. A manager should have been alerted and the move postponed until someone could consider whether the man's concerns about the move were justified.

62. Prison Service Instruction 64/2011 states the following mandatory action:

“Any member of staff who receives information, including that from family members or external agencies, or observes behaviour which may indicate a risk of suicide/self-harm must open an ACCT by completing the Concern and Keep Safe form”

63. The man’s note gave a clear indication that he might try to hang himself. We consider that this information should have led staff to re-open the ACCT. In a thematic report about risk factors in self-inflicted deaths published in April 2014, we identified that assessments of risk too often placed insufficient weight on known risk factors and too much on staff perceptions of the prisoner’s behaviour and demeanour. The man had a number of factors known to increase the risk of suicide and self-harm which are identified in our thematic report and in Prison Service instructions: he had told staff that he would kill himself, his offence was against family members, he had mental health problems and he had made previous suicide attempts.
64. Officer B believed he knew the man well and did not consider that he was at risk of suicide or self-harm. He thought he was manipulating staff to try to prevent a move and indicated to the orderly officer that there was no immediate problem. Although the officer appropriately referred the note to the security department, this would have been too late to prevent a move on Monday. He, or other staff on duty, should have reassured the man that his concerns would be taken into account before a move was agreed. We cannot know whether the decision not to re-open the ACCT would have altered the outcome, but it meant that the man did not receive structured, ongoing support or a further assessment of his risk of suicide and self-harm.
65. Although much of the ACCT process was handled well, we do not consider the level of observations initially set was sufficient to reflect raised risk of suicide and self-harm. The post-closure review was set outside the time limits stipulated in the national instruction. We consider that an additional caremap action should have been set to reflect the man’s anxieties about the move and the ACCT should not have been closed until he was settled on a new wing. We recognise that the man’s threat that he might hang himself could have been interpreted as a throwaway comment reflecting frustration about his position, but in the context of his recent management under ACCT procedures and his risk factors, we consider that staff should have opened an ACCT when they first received the man’s written reasons for objecting to the move. We make the following recommendation:

The Governor should produce clear guidance about procedures for identifying prisoners at risk of suicide and self-harm and for managing and supporting them. In particular staff should:

- **Have a clear understanding of their responsibilities and the need to share all relevant information about risk;**
- **Consider and record all the known risk factors of a prisoner when determining their risk of suicide or self-harm, including information from all sources and open an ACCT whenever a prisoner has expressed suicidal intent;**

- **Set appropriate levels of observations which are adjusted as the perceived level of risk changes;**
- **Agree effective ACCT caremap objectives which are specific and meaningful, aimed at reducing a prisoner's risk, and that the ACCT is not closed until all objectives have been completed;**
- **Holding post-closure interviews in line with PSI 64/2011.**

Clinical Care

66. The clinical reviewer noted that the man received a high standard of care from both primary and secondary mental health services at Wymott. The man developed a good therapeutic relationship with Nurse A and Dr A, and the nurse was actively involved in the ACCT process. The clinical reviewer noted that it appeared that the man did not always present as being depressed to custodial staff and the confidentiality of the relationship with healthcare meant that officers did not fully understand the stressors that the man experienced. As a consequence, prison staff did not always accept the views and recommendations of healthcare staff. However, as noted above, we consider that information sharing within the ACCT process could have been better.
67. The clinical reviewer was satisfied that that the man received a very good standard of healthcare at Wymott, which was equivalent to the care he could have received in the community.

Emergency Response

68. PSI 03/2013 *Medical Emergency Response Codes*, issued in February 2013, contains mandatory instructions for efficiently communicating the nature of a medical emergency, ensuring staff take the relevant equipment to the incident and that there are no delays in calling an ambulance. It explicitly states that all prison staff must be made aware of and understand this instruction and their responsibilities during medical emergencies. It directs that when a medical emergency code is called the control room must call an ambulance immediately and should not wait for a decision from healthcare staff or a duty manager.
69. Officer F correctly called a code blue emergency at 8.38am, when he found the man hanged in his cell. However, the control room did not call an emergency ambulance until 8.45am - a delay of seven minutes, which is unacceptably long. There is no evidence that this delay affected the outcome for the man but in other emergencies, such a delay could be crucial. Since the man's death, we have made a number of recommendations about this issue to Wymott. We make the following recommendation:

The Governor should ensure that control room staff call an ambulance as soon as a medical emergency code is called.

RECOMMENDATIONS

1. The Governor should produce clear local guidance about procedures for identifying prisoners at risk of suicide and self-harm and for managing and supporting them. In particular staff should:
 - Have a clear understanding of their responsibilities and the need to share all relevant information about risk;
 - Consider and record all the known risk factors of a prisoner when determining their risk of suicide or self-harm, including information from all sources and open an ACCT whenever a prisoner has expressed suicidal intent;
 - Set appropriate levels of observations which are adjusted as the perceived level of risk changes;
 - Agree effective ACCT caremap objectives which are specific and meaningful, aimed at reducing a prisoner's risk, and that the ACCT is not closed until all objectives have been completed;
 - Holding post-closure interviews in line with PSI 64/2011.

2. The Governor should ensure that control room staff call an ambulance as soon as a medical emergency code is called.

Action Plan: The man (Wymott)

Action Plan

No	Recommendation	Accepted/Not Accepted	Response	Target date for completion and function responsible	Progress (to be updated after 6 months)
1	<p>The Governor should produce clear local guidance about procedures for identifying prisoners at risk of suicide and self-harm and for managing and supporting them. In particular staff should:</p> <ul style="list-style-type: none"> • Have a clear understanding of their responsibilities and the need to share all relevant information about risk; • Consider and record all the known risk factors of a prisoner when determining their risk of suicide or self-harm, including information from all sources and open an ACCT whenever a prisoner has expressed suicidal intent; • Set appropriate levels of observations which are adjusted as the perceived level of risk changes; • Agree effective ACCT caremap objectives which are specific and meaningful, aimed at reducing a prisoner's risk, and that the ACCT is not closed until all objectives have been completed; • Holding post-closure interviews in line with PSI 64/2011. 	Accepted	<p>A notice to staff has been published outlining the responsibilities of staff in line with PPO recommendations and PSI 64/2011. Included in this is reference to an ACCT procedure chart which has been produced by the safer prison team and is displayed around the prison for all staff to see.</p> <p>A programme of ACCT refresher training is being delivered to operational staff who are due to be trained every three years. The programme is ongoing. All case managers have attended case manager training.</p> <p>ACCT awareness events have been held with all staff with input from the Samaritans.</p> <p>ACCT is included in the safer prisons induction input with all new operational staff.</p> <p>Quality checks are carried out on ACCTs by the Safer Prisons department to ensure all relevant information is included in the ACCT document and follow up actions are taken when necessary. This is for post closures and open documents.</p> <p>A daily register of all ACCT documents is now produced and circulated to all staff involved in the ACCT process to ensure that reviews are carried out on time and that post</p>	Safer Prisons Completed	

Action Plan: The man (Wymott)

Action Plan

No	Recommendation	Accepted/Not Accepted	Response	Target date for completion and function responsible	Progress (to be updated after 6 months)
			closure reviews are completed as per PSI 64/2011.		
2	The Governor should ensure that control room staff call an ambulance as soon as a medical emergency code is called.	Accepted	<p>A notice to staff has been issued advising all staff members of the protocol for summoning medical assistance and calling an ambulance immediately when an emergency medical code is used.</p> <p>All communications room staff have now signed to say that they understand and will comply with the instruction.</p>	Safer Custody Completed	