

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Raymond Mills a prisoner at HMP Wandsworth on 8 June 2015

**A report by the Prisons and Probation Ombudsman
Nigel Newcomen CBE**

Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

Our Values

We are:

Impartial: *we do not take sides*

Respectful: *we are considerate and courteous*

Inclusive: *we value diversity*

Dedicated: *we are determined and focused*

Fair: *we are honest and act with integrity*



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The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out independent investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

My office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Mills was found hanged in his cell at HMP Wandsworth on 8 June 2015. He was 66 years old. I offer my condolences to Mr Mills' family and friends.

Mr Mills had been charged with the murder of his wife and remanded to Wandsworth in February 2015. When he arrived at the prison, staff appropriately identified that he was at risk of suicide and self-harm and he received appropriate support in the prison's mental health unit.

However, when he later moved to the vulnerable prisoner unit, the management of his risk was poor. There was inadequate communication from mental health staff about Mr Mills' risk and Prison Service suicide and self-harm prevention procedures were not used well to support Mr Mills. There was also little evidence of meaningful staff interaction with Mr Mills. Similar issues have arisen in previous investigations into deaths at Wandsworth and the Governor needs to make sure that improvements are made and sustained.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman

March 2016

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Summary

Events

1. On 11 February 2015, Mr Raymond Mills was remanded to HMP Wandsworth, charged with the murder of his wife. At an initial health screen, a nurse noted his charges and that Mr Mills had taken an overdose the week before. He told her he felt like killing himself. The nurse began suicide and self-harm prevention procedures (known as ACCT). A doctor prescribed sleeping tablets and referred Mr Mills for a mental health assessment.
2. The next day, a psychiatrist assessed Mr Mills and recommended that he should go to the specialist mental health unit in the prison for further assessment. He moved there on 16 February. The mental health team concluded that Mr Mills was depressed and felt hopeless, but he did not have an acute mental illness.
3. On 11 March, Mr Mills moved to the prison's vulnerable prisoners unit. Between 17 and 27 March, a mental health nurse saw Mr Mills every day but did not record anything in the ACCT record, did not speak to unit staff about Mr Mills' risk and did not attend ACCT case reviews.
4. Staff did not update Mr Mills ACCT caremap to reflect any changes in the support he needed. Without holding a case review, they reduced his level of observations to three quality interactions a day and hourly checks overnight. After he moved to the vulnerable prisoners unit, no one from the mental health team ever attended case reviews. On 30 March, a supervising officer, who did not know Mr Mills, and had not been trained in ACCT case management, ended monitoring, without any input from the healthcare team. On 18 April, an officer began ACCT procedures again, as Mr Mills appeared upset.
5. On 22 April, a psychiatrist reviewed Mr Mills' mental health and noted he was better than previously, but still at elevated risk of suicide. On 14 May, another psychiatrist saw Mr Mills and noted he was very stressed about his forthcoming court appearance and worried about his safety from other prisoners. He said he wished his suicide attempts at home had worked, as it was not possible in prison. The psychiatrist considered Mr Mills remained a long-term significant risk of suicide. The psychiatrists did not make any entries in Mr Mills' ACCT record about their assessments and there is no evidence that prison staff were aware of them.
6. On 1 June, at the last ACCT case review before Mr Mills died, a supervising officer considered that Mr Mills' mood had improved, as he was interested in taking an art class. The review assessed Mr Mills as at low risk of suicide or self-harm, but agreed to continue to support him using ACCT procedures. Staff were to continue to speak to him at least three times a day and check him hourly at night.
7. On 8 June, a night patrol officer went to check Mr Mills at 1.15am, but could not see him in the cell. His cellmate found Mr Mills hanging in the toilet and shouted to be let out of the cell, but did not tell the officer what he had seen. The officer radioed for help. The night manager and other staff attended and radioed an emergency code. The control room then called an ambulance. Staff and

paramedics were unable to resuscitate Mr Mills and at 2.27am, the paramedics recorded that he had died.

Findings

8. The prison appropriately began ACCT procedures when Mr Mills arrived at Wandsworth but we are concerned about the operation of ACCT procedures, which were not in line with national policy. There was a disjunction between healthcare and prison staff and a lack of multidisciplinary teamwork, which is the basis of effective ACCT management. Healthcare staff did not record important information about Mr Mills' risk in the ACCT records and prison staff did not invite relevant healthcare staff to attend all case reviews. ACCT case reviews significantly underestimated Mr Mills' risk of suicide. We found little evidence of supportive interaction with Mr Mills and the personal officer scheme did not operate effectively.

Recommendations

- The Head of Healthcare should ensure that there are appropriate records in ACCT documents of all clinicians' contact with prisoners identified as at risk of suicide and self-harm, particularly assessments of risk. Where possible a member of healthcare staff who is involved in the prisoner's care should attend ACCT case reviews.
- The Governor and Head of Healthcare should ensure that prison staff manage prisoners at risk of suicide or self-harm in line with national guidance, including in particular:
 - All staff, including healthcare staff, should record relevant information about risk, observations and interactions with prisoners in ACCT records and any action taken.
 - Triggers for suicide and self-harm should be identified and recorded
 - All case reviews should be multidisciplinary with continuity of case management. A member of healthcare staff should attend all first case reviews.
 - Caremap actions should be specific and meaningful, aimed at reducing prisoners' risks and reviewed and updated as necessary.
 - Assessment of risk should take into account all available information. The level of observations should reflect the prisoner's risk, which should be discussed at each case reviews.
 - Checks should be completed at the required frequency.
 - All staff, particularly case managers, should have relevant ACCT training.
- The Governor should ensure that officers have meaningful contact with every prisoner, through an effective personal officer scheme, which ensures that officers get to know prisoners and identify their needs.

The Investigation Process

9. The investigator issued notices to staff and prisoners at HMP Wandsworth informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
10. NHS England commissioned a clinical reviewer to review Mr Mills' clinical care at the prison.
11. Ms Watkins visited Wandsworth on 9 June. She obtained copies of relevant extracts from Mr Mills' prison and medical records.
12. Ms Watkins interviewed nine members of staff at Wandsworth on 3 and 10 August. The clinical reviewer joined Ms Watkins for two of the interviews.
13. We informed HM Coroner for Westminster of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
14. One of the Ombudsman's family liaison officers contacted a friend of Mr Mills, who he had named as his next of kin, to explain the investigation. His friend asked the investigation to consider how Mr Mills was able to kill himself and what checks staff had made on him, as he had understood Mr Mills was on a 24-hour 'suicide watch'.
15. Mr Mills' friend received a copy of the initial report. He made a number of comments, which did not impact on the factual accuracy of this report.

Background Information

HM Prison Wandsworth

16. HMP Wandsworth is a local prison in southwest London that holds over 1,250 men and primarily serves the courts in south London. St George's University Hospitals NHS Foundation Trust provides healthcare services at the prison. The prison has a two inpatient healthcare units. The Addison Unit is an acute psychiatric assessment unit run by South London and Maudsley NHS trust and the Jones unit is for prisoners with physical health problems.

HM Inspectorate of Prisons

17. The most recent inspection of HMP Wandsworth was in March 2015. The report noted that outcomes for prisoners were not as good as at the last inspection and the prison was facing severe problems. The quality of ACCT documents was variable and many of those inspected were poor. Reviews were often conducted late, with minimal attendance. Caremaps failed to identify issues and set actions to mitigate risk. Inspectors noted that overcrowding meant that almost every service in the prison was insufficient to meet the needs of the population.

Independent Monitoring Board

18. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to May 2015, the IMB reported that staff reductions had resulted in a detrimental effect across the prison. This limited the time officers had to interact with prisoners at times when suicide or self-harm might be more likely.

Previous deaths at HMP Wandsworth

19. There have been seven self-inflicted deaths at Wandsworth since 2014. We have previously identified concerns about how well the prison managed prisoners assessed as at risk of suicide and self-harm and the lack of supportive interaction with prisoners through an effective personal officer scheme. Similar issues arose in this investigation.

Assessment, Care in Custody and Teamwork (ACCT)

20. Assessment, Care in Custody and Teamwork (ACCT) is the care planning system the Prison Service uses for supporting and monitoring prisoners assessed as at risk of suicide and self-harm. The purpose of the ACCT process is to try to determine the level of risk posed, the steps that might be taken to reduce this and the extent to which staff need to monitor and supervise the prisoner. Levels of supervision and interactions are set according to the perceived risk of harm. There should be regular multi-disciplinary case reviews involving the prisoner. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

Key Events

21. On 11 February 2015, Mr Raymond Mills was remanded to HMP Wandsworth charged with the murder of his wife. It was his first time in prison.
22. At an initial health screen, Nurse A noted that Mr Mills had been charged with a grave offence of violence against his wife. He said that he was anxious about being in prison and felt like killing himself. She recorded that Mr Mills suffered from depression and had taken an overdose of paracetamol the previous week. The nurse told Mr Mills how he could get support in prison from the mental health team, the chaplaincy and the Samaritans. She began ACCT suicide and self-harm procedures and referred Mr Mills to a doctor.
23. That evening, Dr A noted that Mr Mills said he had killed his wife on 2 February. Mr Mills told the doctor he had taken an overdose and had tried to kill himself several times when he was in police custody. He said he felt suicidal. The doctor noted that Mr Mills was tearful, anxious and unable to make eye contact. He referred him for an urgent mental health assessment and prescribed sleeping tablets.
24. The next day, 12 February, Dr B, a psychiatrist, and Nurse B, a mental health nurse, assessed Mr Mills. The doctor concluded that Mr Mills' risk of self-harm was significantly high because of the nature of his alleged offence and because he had a long history of depression and suicide attempts. She recommended that Mr Mills should be moved to the Addison Unit, the prison's mental health unit. Later that day, the doctor and Nurse B discussed their assessment of Mr Mills with another psychiatrist, Dr C. They agreed that, as the Addison Unit was quite "disturbed" at that time, it would be better to manage Mr Mills on his wing, with the support of the ACCT process.
25. Supervising Officer (SO) A assessed Mr Mills as part of ACCT procedures, that afternoon. Before the assessment, the SO contacted Nurse C from the mental health team and she briefed him about the team's contact with Mr Mills. Mr Mills told the SO that he did not know why he was in prison and that he had not self-harmed before. The SO noted that this was different from what he had told the mental health team. The SO said Mr Mills was guarded in his replies and said he had no thoughts of suicide.
26. SO A then held Mr Mills' first ACCT case review. There was no other member of staff present, although there should be a healthcare representative at first ACCT case reviews. The SO assessed Mr Mills as at raised risk of suicide and self-harm and recorded that staff should check him hourly. The SO noted that someone from the mental health team should be invited to the next ACCT case review. He did not complete an ACCT caremap, a plan of care, support and intervention.
27. On the afternoon of 16 February, Mr Mills was moved to the Addison Unit. Nurse D explained the unit's routines to him. The nurse told Mr Mills that he would be staying in the unit to allow staff to assess his mental health.
28. SO B was Mr Mills' ACCT case manager while he was in the Addison Unit and completed his caremap. He noted that the mental health team needed to assess

Mr Mills and that all staff should monitor his behaviour and report any concerns to the clinical team. The SO told the investigator that prisoners' care in the Addison Unit is determined by psychiatrists during a weekly ward round and the ACCT process is secondary to the nursing care plan.

29. On 18 February, Dr B and Nurse D spoke to Mr Mills in his cell. The doctor noted that Mr Mills talked a lot more than at their previous meeting and became tearful when he talked about his wife. The doctor decided that he should stay in the Addison Unit.
30. Later that day, Dr D, a psychiatrist, led a ward round and discussed Mr Mills' care. The team agreed that Mr Mills should remain in the Addison Unit for a period of assessment. Dr E, who specialised in the mental health assessment of older adults, would assess him and he should have blood tests and a physical examination. SO B recorded the ward round as an ACCT case review and assessed Mr Mills as at high risk of suicide or self-harm.
31. On 24 February, Nurse E wrote a care plan for Mr Mills. This included that Mr Mills should continue with activities outside his cell, that he should continue to eat and drink well and take his medication, and that ACCT monitoring should continue.
32. On 25 February, SO B held an ACCT case review, after he had spoken to Dr D and Nurse D about Mr Mills. No other member of staff was present. The SO recorded that Mr Mills broke down from time to time, but when staff had spoken to him about this, he did not say he wanted to die and talked about the future. The SO assessed that Mr Mills was still at high risk of suicide or self-harm and that staff should continue to observe him hourly.
33. On 26 February, Dr D reviewed Mr Mills during a ward round and noted that the team had not found a clear mental disorder and he did not consider he was depressed. The doctor recommended that Mr Mills should stay in the Addison Unit while the mental health team continued to assess him.
34. On 2 March, SO B chaired an ACCT case review with Nurse D and a recovery support worker. Mr Mills had been tearful that morning. Mr Mills explained that he was distressed about a prisoner next door to him shouting his name and making a lot of noise. Later that day, staff moved Mr Mills to a different cell.
35. On 4 March, Dr E saw Mr Mills for an old age psychiatric assessment. He recorded that, although there were no biological symptoms of depression, Mr Mills presented as depressed and hopeless. He found no signs of any cognitive difficulties. The doctor's impression was that Mr Mills presented a long-term elevated suicide risk due to his previous suicide attempts, depressed mood and the circumstances of his charge. He made no entry in the ACCT record about the consultation and neither did anyone else.
36. At another ward round on 4 March, Dr D noted that Mr Mills had had some difficulty with another prisoner in the unit and had been complaining about the noise. The team agreed to make plans to move Mr Mills to the prison's vulnerable prisoners unit. On 6 March, the doctor agreed with Mr Mills that he

would move to the vulnerable prisoner unit the next week. Mr Mills said that did not want to be prescribed antidepressant medication.

37. On 10 March, although Mr Mills was still low in mood, he was discharged from the care of the Addison Unit. SO B and the mental health team agreed that he should move to the vulnerable prisoners unit, and be on the list of complex cases overseen by the safer custody team. He would remain under the care of the mental health in-reach team. As he had been discharged as an inpatient, the SO chaired an ACCT case review with Dr D, two psychiatric nurses and two other psychiatrists but no one from the vulnerable prisoners unit attended. The review reduced his level of assessed risk from high to raised, but staff were still required to check him at least once an hour. The SO told the investigator that Mr Mills was prepared for the move and wanted to go.
38. The next day, 11 March, Mr Mills moved to the vulnerable prisoners unit. There is no record of any handover of care from the Addison Unit to the vulnerable prisoners unit. On 13 March, the ACCT document indicated that Mr Mills' level of observations was reduced from hourly to three quality interactions each day and hourly at night. There is no record of a case review or who made this decision and why.
39. On 17 March, Nurse F from the mental health in-reach team first saw Mr Mills, who told him he was having problems getting his medication. The nurse explained that the routine was very different from that in the Addison Unit. The nurse did not record anything in Mr Mills' ACCT record. She told the investigator that all her contact with Mr Mills was recorded in his medical record. She said that she had never made any entries in his ACCT record and attended only one ACCT case review.
40. On 18 March, an officer asked Nurse F to see Mr Mills because he thought that his mental health was deteriorating. The nurse told the investigator that the officer was new and did not know Mr Mills. She said that she did not think Mr Mills was any worse than usual, but he was in a low mood, as previously. She referred him for help with housing issues and to the chaplaincy. She told him that he could speak to a Listener if he needed additional support. (Listeners are prisoners trained by the Samaritans to offer confidential support to other prisoners.)
41. On 23 March, SO C and Officer A held an ACCT case review and agreed that Mr Mills' observations should remain the same, but that his level of risk was now low. The SO recorded that Mr Mills had said that he felt depressed and his trial was due to start on 1 May. He said he had no outside support. There was no healthcare presence or input into the case review and the SO did not review or update Mr Mills' caremap.
42. That afternoon, Mr Mills told Nurse F that he was thinking about his wife and feeling low and very tearful. The nurse saw Mr Mills each day until 27 March. She referred him for psychological counselling and to the chaplain. The nurse told the investigator that Mr Mills was stressed and worried about housing matters and paying bills. She referred him to relevant agencies for help.

43. Nurse F told the investigator that she had asked Mr Mills if he had any thoughts of suicide or self-harm every time she saw him. He had said that he would not attempt suicide in prison because he would not succeed. The nurse did not record this in Mr Mills' medical record or in his ACCT record, but noted in his medical record that Mr Mills had no thoughts or plans to harm himself.
44. On 30 March, SO D and a custodial manager, held an ACCT case review. The SO told the investigator that he could not remember the case review and he did not know Mr Mills. During the review, he noted that Mr Mills should be referred to the mental health in-reach team, even though Mr Mills already had extensive contact with the team. He did not review or update the caremap, where he would have seen that the mental health team had already assessed Mr Mills. The SO and the custodial manager decided to end ACCT monitoring. There is no evidence of a post-closure review, which should take place within a week, to check that Mr Mills was okay. The SO told the investigator that he had not received any training as an ACCT case manager.
45. On 15 April, Mr Mills told Nurse F that he was feeling tired and drowsy most of the time. They agreed that they should reduce his sleeping medication.
46. On 18 April, Officer B found Mr Mills very low and tearful. She began ACCT procedures again and recommended that Mr Mills should be checked hourly until he was assessed. SO B agreed the immediate action plan. Officer C assessed Mr Mills on 20 April. (Although PSI 64/2011 requires assessments to take place within 24 hours.) She described Mr Mills as very low in mood and worried about personal matters and his property. He was not sleeping well and was anxious about his upcoming trial. Officer C concluded that staff needed to contact the prison's reception to confirm Mr Mills' bank details, contact the bank about his outstanding bills and his solicitor about his trial. She recommended that staff should contact the mental health in-reach team to review Mr Mills' medication. Officer C wrote actions in Mr Mills' caremap about these issues.
47. The custodial manager asked Nurse F attend a case review on 20 April. There is no record of a case review that day in the ACCT documents, but the nurse recorded discussion of a review in Mr Mills' medical record. Mr Mills' observations were set at three observations daily and hourly at night. Mr Mills' remained subject to this level of observation until he died.
48. SO E was named as Mr Mills' case manager in the ACCT document. The SO told the investigator that he had not had ACCT case manager training and he did not consider himself to be Mr Mills' case manager. He said that all ACCT plans for prisoners in the vulnerable prisoner unit wing were reviewed every Monday morning by whichever SO was on duty on the wing at the time. He said he just happened to be on duty that day.
49. On 21 April, Nurse F discussed Mr Mills' fluctuating mood during a care-planning meeting with mental health colleagues. They agreed that a psychiatrist should review Mr Mills' mental state. On 22 April, Dr E, who had previously assessed Mr Mills on 4 March, assessed him again. The doctor found Mr Mills to be better, but considered that he was still an elevated risk of suicide. Mr Mills did not want to take antidepressant medication because he was worried about side effects. He said he did not want counselling, but found it helpful to speak to a chaplain.

- The doctor recommended that the mental health in-reach team should continue to see Mr Mills. Nothing about this assessment was noted in the ACCT record.
50. On 27 April, the custodial manager and Officer B held an ACCT case review. The custodial manager had not seen the psychiatrist's assessment and recorded that Mr Mills was at low risk of suicide and self-harm. Mr Mills said he was worried about his court appearance and she noted that he was finding it difficult to come to terms with being in prison. She suggested that Mr Mills should get a job or go to education classes, if he came back to Wandsworth after his court appearance, which was scheduled for 1 May. The custodial manager added actions to Mr Mills' caremap that he should spend more time out of cell and that he should contact his solicitor about his court appearance. (Mr Mills' court appearance on 1 May was subsequently postponed to 9 June.)
 51. On 28 April, Officer D introduced himself to Mr Mills as his personal officer. He described Mr Mills as very insular and noted in his prison record that he did not engage with staff or prisoners.
 52. On 5 May, Mr Mills told Nurse F that he was finding it difficult to get to sleep, although he did not want to change his medication. On 13 May, the nurse suggested that he should consider taking antidepressants, but Mr Mills did not want to.
 53. On 14 May, Dr B and Nurse F saw Mr Mills to review his mental health and his medication. The doctor noted that Mr Mills was very stressed about his forthcoming court appearance and was worried about his safety and the threat from prisoners if his case was reported in the news. Mr Mills said that there would be no point in attempting suicide in prison because it was not possible and he wished that previous attempts at suicide at home had worked. The doctor considered that Mr Mills remained a long-term significant risk of suicide. She recommended that Mr Mills should continue to take his sleeping tablets and his medication should not be changed at such a stressful time. This was his last recorded contact with the mental health in-reach team.
 54. On 29 May, another officer, Officer E, introduced himself to Mr Mills as his personal officer. (His previous personal officer had moved to another landing.) The officer told the investigator that Mr Mills kept to himself. He knew that Mr Mills had some support from the mental health team but he did not have any particular concerns about him.
 55. SO E chaired the last three ACCT reviews for Mr Mills on 18 May, 26 May and 1 June. At each review, The SO recorded that Mr Mills at low risk of suicide or self-harm. (Again the SO was unaware that Dr B had assessed Mr Mills as a long-term significant risk of suicide.) The mental health team did not contribute to any of the reviews, but a substance misuse nurse, who had not had any contact with Mr Mills, attended two of the reviews. The last review was held on 1 June. The SO told the investigator that Mr Mills seemed to be improving slightly and had shown an interest in taking an art class. There was no record of any discussion about his planned court appearance on 9 June, although Mr Mills had said he was concerned about other prisoners knowing about his crime if it was on the news. The SO reassured him that other prisoners in the vulnerable prisoner unit were in a similar situation. He recorded that Mr Mills' mood lightened. Mr

Mills' level of observations remained at three conversations daily and hourly checks overnight. His next case review was scheduled for 15 June.

56. Despite his imminent court appearance on 9 June, there is no record that staff considered any additional support measures or that his court appearance was identified as a potential trigger for suicide or self-harm. No one from the mental health in-reach team saw Mr Mills during that time.

Monday 8 June

57. An operational support grade, who was the night patrol officer on Mr Mills' wing, recorded in the ACCT document that Mr Mills was watching television at 12.05am. Although checks were expected to be at least hourly, he next went back to check him at 1.15am. Mr Mills was not in his bed and he assumed he was in the toilet, which was ensuite to the cell. The operational support grade shook the cell door handle to get Mr Mills' attention but did not get a response. Mr Mills' cellmate woke up and the operational support grade asked him to check that Mr Mills was all right. Mr Mills' cellmate opened the toilet door and shouted to the operational support grade to open the cell door to let him out. He did not say what was wrong or that Mr Mills had hanged himself. The operational support grade radioed the night manager and asked him to come to the cell. He did not radio a medical emergency code, which would have alerted the control room to call an ambulance immediately. With hindsight, it appears that the operational support grade should have radioed an emergency code as soon as he discovered something was wrong, but we understand that he could not see Mr Mills and was not sure it was a medical emergency.
58. The night manager told the investigator that he went straight to the cell when he heard the operational support grade's message. Officer F, Officer G and Officer H went to the wing as well. The night manager went into the cell and found Mr Mills suspended by a shoelace around his neck, attached to the bars of the toilet window. The night manager supported Mr Mills' weight and Officer F cut the lace from Mr Mills' neck. After they had lowered him to the floor, Officer F radioed an emergency code one at 1.21am. (An emergency code one indicates situations such as when a prisoner is unconscious, not breathing or is having breathing difficulties.) The control room called an ambulance at 1.22am.
59. The night manager (who told the investigator that he had been first aid trained about six weeks before) started cardiopulmonary resuscitation (CPR). Nurse G heard the operational support grade's call for the night manager and went to the wing. When she got there, she administered oxygen and asked Officer F to bring emergency equipment. The night manager continued chest compressions until the nurse attached a defibrillator. The defibrillator found no shockable heart rhythm and the nurse and Officer I took over CPR until paramedics arrived at the cell at 1.34am. Paramedics continued emergency treatment until at 2.27am, they recorded that Mr Mills had died.

Contact with Mr Mills' family

60. Mr Mills had named a friend as his next of kin, when he arrived at the prison. The prison's family liaison officer broke the news of Mr Mills' death to his friend on the morning of 8 June in person. The prison offered to contribute to Mr Mills' funeral expenses in line with national instructions.

Support for prisoners and staff

61. The night manager and another prison manager debriefed the staff involved in the emergency response and offered their support. The staff care team attended the debrief and reminded the staff of the support available.
62. On the night Mr Mills died, Mr Mills' cellmate was taken to a cell where Listeners supported him. The prison posted notices informing other prisoners of Mr Mills' death and offering support. Staff reviewed all prisoners assessed as at risk of suicide and self-harm in case they had been adversely affected by Mr Mills' death.

Post-mortem report

63. The results of the post-mortem examination were not available at the time of issuing this initial report. The coroner gave Mr Mills' preliminary cause of death as hanging.

Findings

Management of risk of suicide and self-harm

64. Mr Mills was appropriately identified as at risk of self-harm and suicide when he arrived at Wandsworth and was managed under ACCT procedures for almost all his time at the prison. However, we have a number of concerns about the management of ACCT procedures, which we do not consider operated effectively to support and protect Mr Mills.

Healthcare involvement in the ACCT process

65. Mr Mills was assessed for just over three weeks in the prison's mental health unit, the Addison Unit. While he was in the Addison Unit, mental health nurses wrote entries in his ACCT record, but ACCT case reviews were replaced by ward rounds. SO B attended the ward rounds and recorded the outcome in the ACCT document. When Mr Mills was moved from the Addison Unit to the vulnerable prisoners unit on 11 March, there was no handover between the Addison Unit and officers in the receiving unit.
66. Mr Mills' psychiatric assessments were not recorded in his ACCT record and the ACCT process was described as secondary to Mr Mills' mental health care plan. Psychiatrists concluded that Mr Mills would be at high and long-term risk of suicide but this was not noted in his ACCT document or otherwise shared with prison staff responsible for Mr Mills' day-to-day care. This meant that prison staff at ACCT case reviews tended to underestimate Mr Mills' risk of suicide. On 14 May, Dr B described Mr Mills as a long-term significant risk of suicide when, at the same time, ACCT case reviews had assessed him as low risk.
67. A mental health nurse saw Mr Mills frequently while he was living in the vulnerable prisoner unit, but made no entries in his ACCT record and apparently attended only one case review, which was not recorded. The clinical reviewer, noted that, when Mr Mills moved from the Addison Unit to the vulnerable prisoners unit, the mental health team had little involvement and engagement in the ACCT process and did not contribute to the management of Mr Mills' risk of suicide or self-harm.
68. The ACCT document should be used by healthcare staff as a means of communication with prison staff and vice versa. Prison Service Instruction 64/2011, notes that information sharing between agencies is key to enabling continuity of care to prisoners at risk and it is concerning that there was such disjunction between prison and healthcare processes in Mr Mills' case. Disclosure of information that would normally be regarded as medical in confidence should take place if it is considered necessary to protect the individual from risk of death or serious harm. The PSI notes, "All healthcare staff have a duty to pass on information that involves issues of patient safety, vulnerability or immediate risk to self or others to relevant staff." We make the following recommendation:

The Head of Healthcare should ensure that there are appropriate records in ACCT documents of all clinicians' contact with prisoners identified as at risk of suicide and self-harm, particularly assessments of risk. Where

possible a member of healthcare staff who is involved in the prisoner's care should attend ACCT case reviews.

ACCT procedures

69. We found a number of deficiencies in the prison's management of ACCT procedures, which were not in line with national instructions and guidance.
- The first ACCT case review was held without a member of healthcare staff present, which is a mandatory requirement of PSI 64/2011.
 - On 30 March, a supervising officer who had no knowledge of Mr Mills, who had evidently not read the ACCT document and said he had not received any case manager training, ended Mr Mills ACCT monitoring without an appropriate assessment of his risk. There was no post-closure review to check Mr Mills' progress.
 - There was little continuity of case managers and ACCT reviews were attended by officers and other staff who did not know Mr Mills.
 - ACCT reviews were rarely multidisciplinary and mental health staff involved in Mr Mills' care did not attend or contribute to the reviews.
 - Some ACCT reviews were held by just one member of staff acting alone, which is inappropriate. Even when multidisciplinary attendance is not possible, it is implicit that ACCT reviews, which are based on teamwork, involve more than one member of staff.
 - Caremaps were not used effectively to identify actions that might have helped reduce Mr Mills' risk of suicide. They were not reviewed at each case review.
 - Mr Mills had said a number of times that he was very anxious about attending court, yet no one identified this as a potential trigger for suicide so that extra support could be considered at the time.
 - Mr Mills' level of observations were reduced on 13 March without holding a case review. Three quality conversations were expected each day but records indicate these were mainly observational checks, rather than positive interaction.
 - Mr Mills' first case review after leaving the Addison Unit took place on 23 March. His level of risk was reduced to low risk without explanation or evidence to support the decision.
 - Mr Mills' last ACCT observation was more than an hour after the previous one, which meant he was not checked as required.
70. In general, the ACCT procedures were poorly managed. Communication, recording of information and assessments of Mr Mills' risk were poor. We consider that this meant that Mr Mills was not effectively supported at Wandsworth. We make the following recommendation:

The Governor and Head of Healthcare should ensure that prison staff manage prisoners at risk of suicide or self-harm in line with national guidance, including in particular:

- **All staff, including healthcare staff, should record relevant information about risk, observations and interactions with prisoners in ACCT records and any action taken.**
- **Triggers for suicide and self-harm should be identified and recorded**
- **All case reviews should be multidisciplinary with continuity of case management. A member of healthcare staff should attend all first case reviews.**
- **Caremap actions should be specific and meaningful, aimed at reducing prisoners' risks and reviewed and updated as necessary.**
- **Assessment of risk should take into account all available information. The level of observations should reflect the prisoner's risk, which should be discussed at each case reviews.**
- **Checks should be completed at the required frequency.**
- **All staff, particularly case managers, should have relevant ACCT training.**

Personal officer support

71. On 28 April 2015, Officer D introduced himself to Mr Mills as his personal officer and wrote an entry in Mr Mills' prison record. He made no further entries and there were no entries from other officers on the wing. A month later, on 29 May, Officer E introduced himself as Mr Mills' new personal officer. The officer's entry suggested that he had interacted positively with Mr Mills but there were no further entries in Mr Mills' record. Wandsworth's personal officer policy states that personal officers should make a minimum of two personal officer entries each month. The officer said that he became Mr Mills' personal officer because personal officers were frequently reallocated from the wing, which prevented them getting to know prisoners well.
72. Mr Mills was an older prisoner who had never been in prison before and was assessed as at risk of suicide and self-harm. We consider that he would have benefited from having a positive relationship with his personal officer. Although staff were supposed to record three quality conversations with him each day, as part of ACCT procedures, the records of these show that they were simply observational checks. Mr Mills had received intense support from staff in the Addison Unit, but there is little recorded evidence of meaningful interaction with him after he transferred to the vulnerable prisoner unit. This is a particular concern in the days leading up to his court appearance as it is evident that this was a potential trigger for suicide and Mr Mills needed staff support at that time. We make the following recommendation:

The Governor should ensure that officers have meaningful contact with every prisoner, through an effective personal officer scheme, which ensures that officers get to know prisoners and identify their needs.

Clinical care

73. The clinical reviewer reviewed the clinical care that Mr Mills received in Wandsworth and concluded that the care was equivalent to that Mr Mills would have expected to receive in the community. Despite the disjunction between healthcare and prison staff in the management of the ACCT process, he was satisfied that Mr Mills had comprehensive assessments by a range of mental health staff, including psychiatrists. He noted that Mr Mills declined treatment options for depression, including antidepressant medication and counselling.

**Prisons &
Probation**

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Independent Investigations