

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# Independent investigation into the death of Mr Scott Wilgos a prisoner at HMP Wayland on 14 March 2016

**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*



© Crown copyright 2015

This publication is licensed under the terms of the Open Government Licence v3.0 except where otherwise stated. To view this licence, visit [nationalarchives.gov.uk/doc/open-government-licence/version/3](http://nationalarchives.gov.uk/doc/open-government-licence/version/3) or write to the Information Policy Team, The National Archives, Kew, London TW9 4DU, or email: [psi@nationalarchives.gsi.gov.uk](mailto:psi@nationalarchives.gsi.gov.uk).

Where we have identified any third party copyright information you will need to obtain permission from the copyright holders concerned.

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 Scott Wilgos was found hanging in his cell at HMP Wayland on 14 March 2016. He was 28 years old. I offer my condolences to Mr Wilgos' family and friends.

Mr Wilgos had been in prison before but had no history of self-harming in custody, but had twice previously, been subject to suicide and self-harm monitoring, because of comments he made while at court. He had depression, for which he was receiving treatment in custody.

While the investigation found deficiencies in the management of suicide and self-harm procedures and in the emergency response, I am satisfied that prison staff could not have identified he was imminent risk of suicide or prevented his actions. Similarly, while the clinical review has identified some procedural weaknesses in healthcare, the care Mr Wilgos received was equivalent to that he could have expected in the community.

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

**Nigel Newcomen CBE**  
**Prisons and Probation Ombudsman**

**November 2016**

**Contents**

Summary ..... 1  
The Investigation Process ..... 3  
Background Information ..... 4  
Key Events ..... 6  
Findings..... 18

# Summary

## Events

1. Mr Scott Wilgos was recalled to Norwich prison in October 2014, after he breached the terms of his licence. He had been subject to suicide and self-harm monitoring (ACCT) on two previous occasions in 2010 and 2011 but had no history of self-harm while in custody. On 25 March 2015, he was transferred to HMP Wayland where he was well known to staff from previous sentences.
2. On 9 July 2015, while at work, Mr Wilgos told the instructor that he no longer wished to be there and that he had been 'feeling strange' for a few days, and had thought about hurting himself. The officer began ACCT procedures. Mr Wilgos later punched his television, resulting in a laceration to his hand, which required hospital treatment. He told staff that he done this out of frustration, not with any intention to harm himself. Mr Wilgos was prone to outbursts of anger when things did not go as he wished.
3. Following the opening of the ACCT, Mr Wilgos was referred to the prison mental health team who concluded that, although there were no signs of any mental health disorder, they should continue to review and support Mr Wilgos. The ACCT document was closed on 10 July.
4. Mr Wilgos was prescribed anti-depressant medication (fluoxetine) in August and later admitted to buying another anti-depressant from other prisoners. He often did not collect his prescribed medication but healthcare staff did not follow this up.
5. In March, Mr Wilgos was involved in a sequence of incidents with staff and damaging of cells. He refused to answer when asked about thoughts of self-harm, but staff had no real concerns about his well-being.
6. During conversations with Mr Wilgos, a fellow prisoner said that he told him that he was worried about his mother who was unwell and spoke about his release from custody, which was imminent. Mr Wilgos also disclosed to him details of a phone call he had with his ex-partner and mother of his children a couple of weeks earlier. During this call, his ex-partner had allegedly told him that she would not allow him to see his children. The prisoner said that it was clear that Mr Wilgos was angry about this, although Mr Wilgos did not mention harming himself or disclose that he was having such thoughts.
7. On the morning of 14 March, a night operational support grade (OSG) checked on prisoners in their cells believed Mr Wilgos was either reading or watching television. Later, an officer unlocked the cells but did not check the cell using the observation panel or did not look into the cells as she moved along from one to another. At around 8.08am a prisoner found Mr Wilgos hanging from the light fitting. He ran to alert an officer who called a medical emergency.
8. Staff quickly responded, entering the cell and cutting the ligature from around Mr Wilgos' neck. Staff described Mr Wilgos as showing clear signs of rigor mortis and did not immediately start cardiopulmonary resuscitation (CPR). However nursing staff began CPR and this continued until the arrival of the healthcare

manager who assessed Mr Wilgos and informed her team that to continue CPR would be futile. Paramedics arrived shortly after and confirmed death at 8.48am.

## Findings

9. There were deficiencies in the management of ACCT processes. In particular, healthcare staff did not attend the initial ACCT case review, although mental health had seen Mr Wilgos the previous day. The attendance of healthcare staff at initial reviews is a mandatory requirement of ACCT procedures.
10. The clinical reviewer was satisfied that the care Mr Wilgos received was equivalent to that he could have expected to receive in the community but noted that there was inadequate follow up when Mr Wilgos failed to collect his prescribed medication. A doctor did not inform security staff that Mr Wilgos had disclosed using illicitly obtained prescription drugs.
11. When unlocking prisoners on 14 March, the officer failed to check inside the cell. This meant that Mr Wilgos went undiscovered until found by a fellow prisoner some eight minutes later. While earlier intervention would not have changed the outcome for Mr Wilgos, failure to check the well-being of a prisoner could lead to an ill, dying or injured prisoner going undiscovered in other cases.
12. The emergency response was expeditious but, despite the presence of rigor mortis, nursing staff still attempted to resuscitate Mr Wilgos.
13. While the investigation identified concerns about the management of ACCT procedures, we do not consider that, at the time of Mr Wilgos' death, prison staff could have identified he was at imminent risk of suicide or done anything to prevent his death.

## Recommendations

- The Governor should ensure that prison staff manage prisoners at risk of suicide or self-harm, in line with national guidance, including:
  - A multi-disciplinary approach for all case reviews.
  - Healthcare staff attending all first case reviews.
- The Governor of HMP Wayland should review the procedures for unlocking prisoners and ensure that, when a cell door is unlocked, staff satisfy themselves of the safety of the prisoner and that there are no immediate issues that require attention
- The Governor and Head of Healthcare should ensure that prison and healthcare staff are given clear guidance and training, in line with established professional guidelines, about the circumstances in which resuscitation is inappropriate.
- Healthcare staff and the Mental Health Team should ensure that a follow up appointment is arranged and recorded when a prisoner stops taking prescribed medication prematurely. Prisoners who fail to collect prescribed medication should also be contacted and the risks of stopping their medication explained.

## The Investigation Process

14. The investigator issued notices to staff and prisoners at HMP Wayland informing them of the investigation and asking anyone with relevant information to contact him. Two prisoners responded but had no relevant information about Mr Wilgos.
15. NHS England commissioned a clinical reviewer to review Mr Wilgos' clinical care at the prison.
16. The investigator visited Wayland and obtained copies of relevant extracts from Mr Wilgos' prison and medical records. He interviewed 12 members of staff and one prisoner at Wayland.
17. We informed HM Coroner for Norfolk of the investigation and he provided the results of the post-mortem examination. We have sent the coroner a copy of this report.
18. One of the Ombudsman's family liaison officers contacted Mr Wilgos' family to explain the investigation and to ask if they had any matters they wanted the investigation to consider. Mr Wilgos' family raised the following questions:
  - The family said that they understood that Mr Wilgos had recently wrecked his cell on two occasions. Prior to this, there had also been an incident in July 2015 when he had damaged his television. They asked for any information that was noted in regards to any reasons he might have for damaging his cell and asked for confirmation on whether he was placed in a single cell.
  - After the incident in July 2015, Mr Wilgos was placed on an ACCT. The family asked whether any consideration was given to placing him on an ACCT after the recent incidents.
  - The family understood that Mr Wilgos was taking anti-depressants and asked for confirmation of the medication he was being prescribed while in custody. The family also enquired whether the mental health team had assessed him.
19. The initial report was shared with the Prison Service. The Prison Service identified no factual inaccuracies and accepted the recommendations made.
20. Mr Wilgos' family received a copy of the initial report. The solicitor representing them wrote to us pointing out some factual inaccuracies. The report has been amended accordingly. They also raised a number of questions that we do not feel impact on the factual accuracy of this report. We have provided clarification by way of separate correspondence to the solicitor.

# Background Information

## HMP Wayland

21. HMP Wayland is a medium security prison, near Thetford in Norfolk, holding over 1,000 men in thirteen residential units. Virgin Care provides healthcare services.

## HM Inspectorate of Prisons

22. The most recent inspection of HMP Wayland was published in January 2014. Inspectors reported that healthcare had improved since the last inspection. Prisoners had access to a range of well-run clinics. Good progress had been made on recommendations of the Prisons and Probation Ombudsman following investigations into two self-inflicted deaths. Recorded levels of self-harm were low and the number of assessment, care in custody and teamwork (ACCT) documents opened were slightly lower than at similar prisons. There was good support from the mental health in-reach team but other areas of the prison needed to be more involved with the process.

## Independent Monitoring Board

23. 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 Virgin Care delivered a sustainable, reliable service, although the IMB was concerned about the high numbers of temporary healthcare staff.
24. The safer custody team meet monthly with a mix of uniformed staff, Samaritans, healthcare, psychology, drug and alcohol caseworkers, chaplaincy, offenders representative and the IMB, chaired by the Deputy Governor. The Safer Custody team has complete ownership of ACCT plans, and at each meeting examples of good and poor reporting are shared. The Safer Custody team is responsible for highlighting any inadequacies and feeding these back to the individual(s) responsible.

## Previous deaths at HMP Wayland

25. Mr Wilgos' death is the first self-inflicted death at Wayland since December 2014. There were no significant similarities with the circumstances of the previous deaths and those recommendations made after that investigation are not repeated.

## Assessment, Care in Custody and Teamwork

26. ACCT is the care planning system the Prison Service uses to support prisoners at risk of suicide or self-harm. The purpose of the ACCT is to try to determine the level of risk posed, the steps that staff might take to reduce this and the extent to which staff need to monitor and supervise the prisoner. Checks made on prisoners should be at irregular intervals to prevent the prisoner anticipating when they will occur. Part of the ACCT process involves assessing immediate needs and drawing up a caremap to identify the prisoner's most urgent issues and how they will be met. Staff should hold regular multidisciplinary reviews and should not close the ACCT plan until all the actions set out in the caremap are

completed. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011 (Management of prisoners at risk of harm to self, to others and from others (Safer Custody)).

## Key Events

27. Mr Scott Wilgos was released from custody at HMP Wayland in July 2014, subject to conditional licence. Mr Wilgos was returned to custody at HMP Norwich in October 2014 after he breached the terms of his licence. Mr Wilgos had been at Norwich on previous occasions and was known to staff. Prison records indicate that during previous periods at Norwich, Mr Wilgos was considered to have behavioural issues but was also felt by staff to be a hard and reliable worker. Mr Wilgos had been subject to suicide and self harm monitoring procedures (ACCT) on two previous occasions in 2010 and 2011. However, these periods of monitoring followed comments he had made while at court and were not the result of actual self-harm. Mr Wilgos had no history of self-harm while in custody, but disclosed during a healthscreen that he had overdosed on prescribed medication in 2010. It is not clear whether this was in custody or the community, but it is not recorded in his prison record.
28. Mr Wilgos' offender supervisor informed him in January 2015 that the Parole Board had reviewed his recall and made no direction for him to be released on licence. This meant that he would remain in custody until his sentence expiry date of 23 July 2016. No additional action was taken in respect of the offences that had led to his recall. Mr Wilgos was transferred to HMP Wayland on 25 March as part of his sentence progression. As he had been at Wayland during earlier periods of custody, staff knew him well.
29. On arrival at Wayland, a nurse completed a full initial health screen, with another nurse completing a secondary review the following day. The healthscreen indicated that Mr Wilgos was not taking any prescribed medication, had no thoughts of self-harm, smoked (for which the nurse referred him to the smoking cessation clinic) and he was given a Hepatitis B vaccination. Mr Wilgos raised no concerns about his physical or mental health.
30. On 8 May, a nurse was asked to attend the exercise yard, because a prisoner appeared to be having a seizure. When she arrived, she found Mr Wilgos lying on the ground, and recorded that he was conscious but drowsy. On examination, nothing indicated that Mr Wilgos had suffered a seizure. She recorded that Mr Wilgos' presentation was more likely a result of illicit drug use, which he denied. Mr Wilgos was walked back to the wing and required no further treatment.
31. Mr Wilgos was employed in one of the prison workshops. On 9 July 2015, the workshop instructor recorded that he was in a 'low mood'. Mr Wilgos told him that he no longer wished to work in the workshop and that he had been 'feeling strange' for a few days, and had thought about hurting himself. As a result, the officer opened an ACCT document.
32. ACCT observations were set at every 15 minutes, prior to staff completing a full ACCT assessment. An officer was on duty on the wing that afternoon and recorded that at 2.06pm he heard a loud noise in Mr Wilgos' cell. When he went to the cell, he found that Mr Wilgos had punched his television, which had led to a wound to his hand. Nursing staff initially treated the wound and it was decided that he would need to attend outside hospital for further investigation.

33. A Supervising Officer (SO) carried out an ACCT assessment, during which Mr Wilgos spoke about the concerns he had regarding the health of both his mother and girlfriend. Mr Wilgos had received news while at Norwich that his mother was unwell, and staff recorded at the time that this had caused him some upset. When asked about the injury to his hand, Mr Wilgos said that it was anger and frustration, rather than any intent to self-harm. He said that, although he had previously self-harmed by overdose, he had no current thoughts or intentions of doing so. The observations remained at four per hour. A brief case review took place, chaired by a Supervising Officer (SO), prior to Mr Wilgos being taken to hospital. The SO recorded that the document should remain open, with another review the following day and attendance by the mental health team.
34. Shortly after the case review, a mental health nurse also assessed Mr Wilgos as staff had made a referral when they opened the ACCT. During the assessment, Mr Wilgos denied that any current sources of stress had triggered his actions, but the nurse recorded that he contradicted this by saying 'things had built up to a point where he was struggling'. When questioned further, Mr Wilgos refused to say what had triggered his distress, despite having already mentioned the concerns about his mother during the ACCT assessment and case review. The nurse recorded that there were no signs of any thought disorder and Mr Wilgos denied having any concerns about his mental health or any plans or intent to self-harm.
35. Staff escorted Mr Wilgos to hospital late that afternoon for an initial assessment and he then returned the following morning, 10 July, to undergo treatment. The officer knew Mr Wilgos well and escorted him to hospital on both occasions. The officer told the investigator that Mr Wilgos had a minor operation to repair tendons in his hand. She said that throughout this excursion he was laughing, joking, and was polite to both prison and hospital staff. The investigator asked the officer whether Mr Wilgos spoke about the issues, which had caused him to damage his television.
36. The officer said that she could not recall the run up to Mr Wilgos punching his television, but said that he had been angry about something. The officer said that Mr Wilgos could get angry about things, and described him as 'blowing hot and cold'. She said that as soon as they were on their way to hospital, Mr Wilgos was back to his normal self. He told her that he had taken his frustration out by punching the television but that he now felt fine.
37. When Mr Wilgos returned from hospital, an ACCT case review was held, chaired by a Custodial Manager (CM). Two wing officers also attended the review, but no healthcare or mental health staff attended. The CM recorded that 'it was clear from the review that Mr Wilgos struggled to talk and as a result anger builds up inside him, and he lets this out by punching things'. The CM also recorded that Mr Wilgos was currently in a good mood, and that it seemed clear he would not self-harm. The review concluded that there was no further risk of self-harm and the decision was taken to close the ACCT.
38. When interviewed, the CM was unable to confirm whether he had spoken to any healthcare staff prior to the review, but accepted that the record of the review indicated that he had not. The CM was also unable to recall much of what he had

discussed during the review, but said that the decision to close the document would have been a joint decision by all those present because it was felt that Mr Wilgos was at no further risk of self-harm.

39. On 16 July, a nurse visited Mr Wilgos on the wing to follow up on his earlier assessment. The nurse recorded that there was some evidence of mood changes over a period of time, which had never been explored. There was also evidence of emotional instability and Mr Wilgos displayed limited ways of coping with pressure. The nurse recorded that Mr Wilgos would benefit from some form of emotional regulation and distress tolerance and further assessment of his mood would be beneficial. The nurse made a referral to the Well-Being service. He also recorded that the Mental Health team would continue to monitor Mr Wilgos' mental state, mood, risk and behaviour once he was stable.
40. During the assessment, Mr Wilgos denied any use of illicit drugs, any previous contact with mental health services in the community and any thoughts or intent to self-harm.
41. Staff should conduct a post closure interview at least seven days after an ACCT has been closed. This is intended to check on the well-being of the individual and ensure no reoccurrence of the issues that had led to the initial monitoring. The Supervising Officer (SO) completed an ACCT post-closure interview with Mr Wilgos on 17 July. She recorded that the problems that had led to the opening of the ACCT had not been resolved, as Mr Wilgos' mother was still unwell. However, he said that he was working in the workshops, had contact with his family and was associating with his peers. She concluded that there was no need for a follow up interview or for the ACCT to be re-opened.
42. The SO was asked whether she had given any thought to planning a further follow up or the re-opening of the ACCT because Mr Wilgos had stated that the issues were still present. She said that she did not consider it necessary as Mr Wilgos had a good rapport with staff and he was talking to them constantly about his mother's ill health and was very open about discussing those issues. Although initially staff had considered the injury sustained by Mr Wilgos an act of self-harm, he stated that he had not intended to hurt himself and that it had been an act of frustration.
43. On 5 August, a nurse spoke with Mr Wilgos again, as part of his ongoing mental health support. The nurse recorded that Mr Wilgos spoke at length about his current situation and events that had led to his stress. The nurse discussed with Mr Wilgos about how he coped with stress. Mr Wilgos told the nurse that he felt medication would help him cope and asked to see the GP to discuss this.
44. Mr Wilgos attended an appointment with a prison GP on 13 August. The GP recorded that Mr Wilgos complained of symptoms of depression, which he said that he had always had, and that his mood was 'up and down.' Mr Wilgos said that he had not previously received any treatment for mental illness, but had been prescribed both mirtazapine and citalopram (both antidepressants) in the past. Another GP prescribed 20mg daily of fluoxetine, an antidepressant medication.
45. Following a referral by a nurse, Mr Wilgos attended an appointment with a member of the Wellbeing service. The NHS and Voluntary services provide the Wellbeing

service for prisoners in Norfolk. It aims to help prisoners who are low in mood and who are experiencing anxiety. It helps prisoners cope with prison life through self-care groups, guided self-help sessions and one-to-one sessions.

46. The worker completed a Patient Health Questionnaire 9 (PHQ9) with Mr Wilgos on which he scored one. The PHQ9 is a multipurpose instrument for screening, diagnosing, monitoring and measuring the severity of depression. A series of questions are asked, the answers to which are scored. The higher the score, the more severe the depression. During the assessment, Mr Wilgos told her that he had asked himself 'what's the point?' but these were not thoughts of ending his life or self-harming and he had no plans to do so. She planned to see Mr Wilgos again to provide further support.
47. A nurse visited Mr Wilgos on 2 September on the wing as part of the ongoing support by the mental health team. The nurse recorded that when he arrived onto the wing he saw Mr Wilgos interacting and socialising with other prisoners. Mr Wilgos described his mood to the nurse as being 5 out of 10. The following day, a prison GP assessed Mr Wilgos and recorded that he had now been taking medication for two weeks and was tolerating it well with no side effects. Mr Wilgos told the GP that he had been working with the Wellbeing service on a one-to-one basis.
48. Mr Wilgos attended further appointments with the worker from the Wellbeing service on 11 September and again on 22 September. During both appointments, he denied having any thoughts or intentions of self-harm. Mr Wilgos failed to attend for an appointment on 28 September. Wing staff spoke with him and he said that he no longer wished to attend but he gave no reason for his decision. On 29 September, he was discharged from the care of the Wellbeing service.
49. On 13 October, a nurse reviewed Mr Wilgos. He recorded that Mr Wilgos expressed no suicidal thoughts, was pleasant in his manner and displayed no agitation or anxiety. The nurse reminded Mr Wilgos of the support available to him should he require it. The nurse's last contact with Mr Wilgos was on 10 November. He recorded that Mr Wilgos denied having any thoughts of suicide or feelings of self-harm. Mr Wilgos spoke about feeling that he was being stitched up by Social Services and Probation, probably relating to contact with his children. However, the nurse recorded that Mr Wilgos spoke positively about the future. Mr Wilgos' care was discussed during a mental health trust (MHT) meeting on 16 November, and it was agreed that he could be discharged from MHT support.
50. Staff had employed Mr Wilgos as a wing cleaner, a role, in which, according to all staff interviewed, he took great pride. However, during November and December 2015, Mr Wilgos received a number of negative entries for his behaviour and attitude toward staff, mostly related to his work. An officer had known Mr Wilgos from previous periods of custody at Wayland and recorded that she had always had a good relationship with him. She recorded on 8 December that lately he had been prone to outbursts and appeared moody, which she considered was out of character.
51. The officer told the investigator that Mr Wilgos was a 'really nice lad'. She said that he would help whenever he could and often offer to help without staff having to ask. She said that if Mr Wilgos was upset by anything at any time he did used

to 'blow a little bit' and staff would leave him to allow himself to calm down and then speak to him. She subsequently said that Mr Wilgos' outbursts were in her opinion not common, but when they did happen, they could be 'quite severe'.

52. The investigator asked the officer whether Mr Wilgos appeared any different during this period of custody to the periods she had previously had contact with him. She said Mr Wilgos had become upset a few times and she had gone to his cell and asked him if he was all right. Mr Wilgos had spoken about his mother being unwell, and she said that she had the impression that this was difficult for him to deal with while in custody, and being unable to help her.
53. Another officer also had reason to record negative entries about Mr Wilgos' behaviour during December. The officer explained that in December there were occasions when, staffing shortages meant the prison regime had to be curtailed. This meant that some wings were placed on what is referred to as a 'red regime.' This meant that, apart from unlocking prisoners for meals, medication and exercise, prisoners were obliged to remain in their cells.
54. On 15 December, because of the wing being on the 'red regime', Mr Wilgos made threats to 'smash up' staff with a metal pole. Staff allowed him time to calm down, but when they went back to speak with him, he was still angry and continued to make threats. Mr Wilgos was unlocked to collect his lunch, but was still angry about the regime. A SO went onto the wing and witnessed Mr Wilgos sitting on the stairs, refusing to return to his cell. She recorded that he was angry about the regime and was trying to incite other prisoners not to go back to their cells. Staff attempted to reason with Mr Wilgos but he stated that he would 'get out of Wayland' and made threats to kill members of staff. He told staff that he did not care if he was charged with further offences as it would be worth it.
55. The SO said that this was a serious outburst, and although Mr Wilgos did eventually return to his cell, an officer placed him on report and submitted paperwork for a review of his Incentives and Earned Privilege (IEP) level. The IEP scheme has three levels, Basic, Standard and Enhanced. Each level is dependent on a prisoner's behaviour, the higher the level the more privileges a prisoner is permitted. Mr Wilgos was at Enhanced level but, after his behaviour on 15 December, paperwork was submitted for this to be reviewed and possibly downgraded to Basic level.
56. The SO said that if something upset Mr Wilgos he would have a little outburst but staff would leave him alone and knew that he would come through it and apologise for his behaviour. She said that all prisoners were becoming frustrated with the restricted regime, and the prison was having difficulties with prisoners refusing to lock up, raising barricades and other disruption arising from this. On 15 December, staff viewed Mr Wilgos' behaviour as being in this vein and she said that she had no concerns regarding his risk of self-harm or suicide.
57. Following his outburst on 15 December, the officer had placed Mr Wilgos on report. She told the investigator that because she had done so, Mr Wilgos refused to speak with her when she next saw him, stating that she had 'stitched him up.' She said that this continued for a day and then he was speaking with her again and back to his normal self.

58. On 22 January 2016, Mr Wilgos' attended an appointment with a prison GP. Mr Wilgos stated that he had last taken his prescribed medication (fluoxetine) three weeks earlier, and had been buying 25mg tablets of amitriptyline from other prisoners, which he had been taking every night. During the appointment, Mr Wilgos spoke about his mood lowering, his inability to sleep and depression.
59. When interviewed, a prison GP said that she could not remember Mr Wilgos or the consultation on 22 January and had to rely on the records of her consultation. She said she had not been clear why Mr Wilgos had been taking the amitriptyline as it was only a relatively small dose and she considered whether he had been using it for sedation. When she reviewed Mr Wilgos, she said that she had been under the impression that he was still under the care of the MHT. She said that she assumed this as she had thought that all prisoners taking antidepressant medication were automatically under the care of the MHT. However, she has since found out that this is not the case.
60. During the consultation, the GP did not repeat the PHQ9 test and again said that she assumed the MHT would have completed this. The investigator asked her if she had reported the fact that Mr Wilgos was buying amitriptyline to wing staff or the security department. She said that she did not have direct access to the prison's computer system (known as NOMIS) from her computer. She explained that, if she needed to access the prison system, she had to ask a member of the prison staff to open NOMIS and then enter the details. She confirmed that she had not done so following the consultation with Mr Wilgos.
61. In concluding the consultation, the GP prescribed another course of fluoxetine for Mr Wilgos, as he said this had helped in the past. However, she said that as Mr Wilgos had indicated he had bought medication on the wing, she ensured that the fluoxetine was not to be held in possession and instead Mr Wilgos would need to attend daily and take the medication within sight of a nurse. She said that this would also allow nursing staff to assess his presentation. She did not plan any follow up appointments with Mr Wilgos.
62. Despite the GP prescribing the medication to be collected daily, Mr Wilgos failed to attend for his medication after this appointment. Entries made on the medical record state that he did not attend between 27 January and 16 February. Officers interviewed said that they were not aware that he had not been collecting his medication and nursing staff did not alert them to this fact.
63. On 30 January, Mr Wilgos moved cells at his own request. An officer said that the cellmate of another prisoner on the wing, with whom Mr Wilgos got on well, had been released and he had asked to move into the cell. She also recorded again that while Mr Wilgos was a good worker, he was prone to aggressive outbursts and might benefit from anger management classes, which she intended to discuss with him.
64. On 23 February, healthcare admin staff recorded on Mr Wilgos' medical record 'patient has DNA'd (did not attend) for 28 days for his fluoxetine. This script has not been reauthorized now'. No further follow up or GP appointment was mentioned.

65. In the light of Mr Wilgos' recent behaviour, a SO completed an IEP review on 1 March. The review was for a downgrade from the Enhanced to the Basic regime. The SO recorded that the majority of the negative entries for Mr Wilgos had been made during December, and in view of his recent more positive behaviour, he was downgraded to Standard rather than Basic. The investigator asked the SO why there had not been a review of Mr Wilgos' IEP level in December following his threats to assault staff. The SO said that although, in his opinion, there should have been, he was unable to explain why this had not happened. However, he said that when he completed his review, as there had been improvements in Mr Wilgos' behaviour, he had decided that there was no need to reduce him to the Basic regime.
66. On 10 March, an officer was working on L wing when Mr Wilgos approached him and asked if he had removed shelves from his cell. The officer told Mr Wilgos that he and another officer had removed them, as they were unauthorised. Mr Wilgos then stated to him 'the next time you come into my cell I will knock you out.' He then placed Mr Wilgos on report.
67. The officer told the investigator that it had been a difficult day and managers had instructed staff to remove all the excess furniture from the cells. Prior to this, he said that prisoners were given a notice that if they have any extra furniture in their cells or anything attached to their wall that was unauthorised, it should be removed otherwise staff would do so. He said that he and another officer went around the wing and asked prisoners politely to remove items. Some did so voluntarily, and others said 'no, you just take it off'.
68. Later that afternoon, the officer was assaulted when he had a bucket of unknown liquid thrown over him by another prisoner. He explained to the investigator that he had seen the prisoner approaching him, carrying the bucket, and just before he threw the contents, he apologised to him.
69. The officer told the investigator that, following the assault, managers asked him whether he had any issues with other prisoners on the wing who may have been involved in the incident. He said that he mentioned his contact with Mr Wilgos earlier that day, although there was no evidence to suggest that Mr Wilgos had been involved in the events that afternoon.
70. The officer said that as Mr Wilgos had made threats towards him earlier that day he thought that he could have been involved.
71. On the morning of 11 March, while most prisoners on L wing were unlocked for work, Mr Wilgos and three other prisoners, including his cellmate, were kept locked in their cells. An officer told the investigator that a manager was planning to speak to each prisoner about the assault on her colleague.
72. The officer said that she began unlocking the landing but had left three cells locked up, including that of Mr Wilgos, as managers had instructed her to do. She said that, when she had finished, Mr Wilgos had pressed his cell bell, she answered his call and he asked her what was happening. She said that she explained that she understood managers wanted to speak with certain individuals before they were unlocked. She said that Mr Wilgos then began destroying his cell. She said that he was 'shouting and going mad'.

73. The officer said that, before returning to Mr Wilgos' cell, she spoke with the other prisoners who remained locked up and explained what was happening, as they too were getting angry. She said that Mr Wilgos' cellmate was standing by the door, and was passive, not shouting or angry. He told her that Mr Wilgos had hurt himself and that she should get healthcare to see him. She said that she looked into the cell through the observation panel, which had been smashed and Mr Wilgos was lying on his bed holding a mop handle, and was clearly still very angry. She said that she asked Mr Wilgos what he had done, to which he replied 'nothing'.
74. Due to the damage caused to the cell, Mr Wilgos was moved to B wing and escorted there by staff. Staff said that Mr Wilgos was compliant during the move, although staff applied ratchet handcuffs for both control and safety reasons following his violent outburst. Once located on B wing, Mr Wilgos noticed a cut to his hand caused during the damage to the cell, but refused to allow healthcare staff to assess him. Mr Wilgos then requested to see healthcare, but when they attended, refused to speak with them. When asked about thoughts of self-harm, Mr Wilgos would not respond. He then proceeded to try to damage the new cell.
75. A nurse recorded that he attempted to examine Mr Wilgos at 11.10am, 11.30am and again at 1.10pm, but on each occasion, Mr Wilgos refused treatment.
76. A SO told the investigator that she had not been involved in the initial incident that morning but was asked to attend B wing that afternoon to film staff while they removed Mr Wilgos from the cell on B wing that he had also damaged while staff cleaned it. (When a prisoner is volatile and an intervention is planned that may result in staff needing to restrain the prisoner, it is normal practice for the process to be filmed. This is to protect both staff and the prisoner and to ensure compliance with procedure.)
77. The SO said that when staff removed Mr Wilgos from the cell he was compliant and they stood him to one side as they cleared his cell out. However, as the staff were doing this, she said that Mr Wilgos became verbally threatening towards the staff. She said that the staff gave Mr Wilgos every opportunity to calm himself and were trying to reason with him but he continued to get agitated. When his cell was clear the staff walked him back, but he became non-compliant and shoved a member of staff. As a result, he was physically restrained.
78. The SO said that once back in his cell, Mr Wilgos calmed down. About ten minutes later pressed his cell bell. When she answered, Mr Wilgos asked her for his training shoes, which had been removed as a precaution. She told him that she did not know where they were, but would find out. Mr Wilgos began threatening her. She said that she considered Mr Wilgos' behaviour to have been an escalation of his earlier outbursts. She explained that, although Mr Wilgos had in the past made 'half-hearted' threats toward staff, those he made on 11 March were directed at her and serious. He had stated that he knew where she lived and intended to kill her.
79. The SO confirmed that Mr Wilgos had refused to be seen by any nursing staff and told the investigator that it was not uncommon for a prisoner to refuse to see healthcare following a restraint. She said that she had no immediate concerns about Mr Wilgos' well-being or his risk to himself. She said that, after his outburst toward her, staff on B wing had spoken with him and he had calmed down. She

said that by the time she left the wing, Mr Wilgos was interacting with staff and he appeared to be his usual jovial self. She said she had no serious concerns about Mr Wilgos.

80. Prisoner A, who lived on B wing, told the investigator that prior to Mr Wilgos' arrival on the wing on 11 March he had no knowledge of him. A regular wing officer had asked him and his friend to keep an eye on Mr Wilgos.
81. Prisoner A was living in the cell opposite that occupied by Mr Wilgos and said that he approached him shortly after he had arrived on the wing to introduce himself. He said that Mr Wilgos was at that time still quite angry about what had happened, but he calmed down and appeared to settle quickly onto B wing.
82. Over the weekend of 12-13 March, Prisoner A said that Mr Wilgos appeared well and spent time out of his cell and had joined him for a cup of tea. He said that in conversation Mr Wilgos had told him that he was worried about his mother, who was unwell, and spoke about his release from custody, which he believed was imminent. He told the investigator that Mr Wilgos had also mentioned to him a phone call he had had with his ex-partner and mother of his children a couple of weeks earlier. Mr Wilgos had apparently contacted her using an illicit mobile phone, and his ex-partner had told him that she would no longer allow him to see his children. He said that it was clear that Mr Wilgos was angry about this. However, he said that Mr Wilgos did not mention harming himself or disclose that he was having such thoughts.
83. Officer A was on duty on Friday 12 March and over the following weekend. As a regular B wing officer, he had worked closely with Mr Wilgos after he arrived onto the wing. He told the investigator that he had known Mr Wilgos previously and described him as a 'decent lad and a generally nice fellow'.
84. Officer A said that Mr Wilgos felt that he had been moved for something he had not done, and as a result was quite frustrated. He explained that he spoke with Mr Wilgos, who said that he had 'got things off his chest' but had caused further damage to his cell. He said that he worked with Mr Wilgos to replace furniture in his cell and when he asked him whether he was going to cause further damage, Mr Wilgos replied 'I wont, I have got it out of my system now'.
85. Because of the damage he had done, Mr Wilgos was reduced to the Basic regime, and would remain locked in his cell until he attended for an adjudication. He was also in a single cell as he had been volatile. Despite this, Officer A said that he had spoken with the duty manager and reassured him that he could work with Mr Wilgos. The duty manager agreed that Mr Wilgos could be unlocked.
86. Officer A said that Mr Wilgos had everything in his cell apart from a television, as he was on Basic regime. Over the weekend he seemed 'fine' and he also became friendly with some other prisoners on the wing and attended the library on Saturday morning. Mr Wilgos asked about a job on the wing and he told him that they needed to get through the weekend, and then start afresh once he was settled.
87. On Sunday 13 March, Prisoner A associated with Mr Wilgos during the afternoon and Mr Wilgos sat in his cell drinking tea and playing cards prior to being locked in

his own cell at around 5.30pm. The prisoner said that as Mr Wilgos did not have a television in his cell, another prisoner had given him the loan of a radio. He said that in his opinion Mr Wilgos was in a 'normal mental state' when he last saw him, and he had no concerns regarding his well-being. He said that, during the evenings, some prisoners will call to one another on the landing, but after staff had locked Mr Wilgos in his cell, he had no further contact with him.

88. An Operational Support Grade (OSG) was on duty on B wing overnight on 13-14 March. He said that he carried out a full count of all prisoners on A wing and B wing at around 8.20pm. He said that could not recall checking on Mr Wilgos specifically, but would have done so and there were no issues at this time. He said that during the night he had no cause to go to Mr Wilgos' cell and the night passed without incident.
89. At 5.00am on 14 March, the OSG began the morning count of all prisoners, on A and B wing, beginning on B wing. The investigator viewed CCTV, showing the OSG checking cells on B wing and particularly that occupied by Mr Wilgos at around 5.10am. The OSG said that he recalled checking Mr Wilgos, as he was one of the few prisoners who was awake at that time. He said that Mr Wilgos was sitting on his bed, dressed in prison clothing and the cell light was on, providing a good view of him. He said that he believed Mr Wilgos was either reading or watching television. However, the investigation has confirmed that Mr Wilgos did not have a television in his cell.
90. The OSG said that he would probably have said 'good morning' but could not be certain and he was unable to recall whether Mr Wilgos responded.
91. Officer B was working on B wing on the morning of 14 March. Shortly after 8.00am, she began unlocking prisoners. She explained that she went along the landing unlocking each cell, and saying 'good morning' to prisoners as they came out. CCTV viewed by the investigator shows her completing this task. However, as she unlocked the cells she did not check inside each cell using the observation panel, nor did she look into the cells as she moved along from one to another. She said that as she finished unlocking, a prisoner approached her and asked the whereabouts of Officer A, and she left the spur to try to find him.
92. Prisoner A told the investigator that he was unlocked just after 8.00am and went to collect some cleaning materials, before returning to his cell. He said that his friend had gone with him and when they returned he went across to Mr Wilgos' cell. As he pushed the cell door open, he said that his friend immediately saw Mr Wilgos hanging from the fitting. He shouted to Prisoner A as he ran to alert an officer. These events were also viewed on CCTV.
93. Officer B told the investigator that she was making her way back to the spur when the prisoner approached and told her that Mr Wilgos was 'hanging'. She ran to the cell. CCTV shows her looking into the cell before making a medical emergency 'code blue' call via her radio. A code blue is a medical emergency code used to alert staff to a prisoner who is having breathing difficulties or is unconscious. She did not enter the cell.

94. The communication room relayed a code blue call over the radio at 8.10am, and contacted East of England Ambulance Service at 8.11am requesting an ambulance.
95. Officer A told the investigator that he had been unlocking on the opposite side of the wing when he heard the 'code blue' call over the radio. He said that he and two other officers, along with other staff, responded immediately. He said that when he arrived at Mr Wilgos' cell he was unaware of the nature of the incident but Officer B was standing outside the cell and was visibly distressed. He said that the door was pushed open and Mr Wilgos could be seen suspended from the light fitting. He said that he and his colleagues entered the cell. One officer supported Mr Wilgos, while the other cut the bed sheet, which had been used as a ligature, and lowered Mr Wilgos down to the bed.
96. Officer A said that as other staff arrived, he was moved away from the cell, as he was quite upset. However, he said that it was clear to him that Mr Wilgos had died and he described there being clear signs of rigor mortis. He said that, as Mr Wilgos was cut down and lowered to the bed, he was both stiff and cold to the touch.
97. Nursing staff attended Mr Wilgos' cell immediately upon hearing the code blue call. When they arrived, staff had not begun cardiopulmonary resuscitation (CPR). After assessing Mr Wilgos, a nurse instructed staff to begin CPR.
98. The healthcare manager was about to attend her morning meeting when she was told of the incident on B wing. She said that when she arrived there were several officers outside the cell and a nurse was carrying out CPR. Other nursing staff were attempting to manage Mr Wilgos' airway. She said that she did an initial assessment and Mr Wilgos showed clear signs of rigor mortis in both his face and limbs. Due to the extent of the rigor mortis, nursing staff were unable to insert an airway, so were relying on a facemask and oxygen.
99. While in the cell, the healthcare manager said that she received an update that the Air Ambulance and paramedics were en route. She told her team that Mr Wilgos was clearly in a state of rigor mortis and had, in her opinion, been dead several hours. She told them that to continue CPR was futile. She then agreed with her team that resuscitation should cease. Paramedics arrived at the cell about eight minutes after staff had ceased CPR and after carrying out their own assessment confirmed death at 8.48am. The Air Ambulance, which had also arrived at the prison, was stood down.

### **Contact with Mr Wilgos' family**

100. Wayland appointed an officer as the family liaison officer. Along with a governor they visited the home of Mr Wilgos' parents at 10.30am on 14 March.
101. The officer informed Mr Wilgos' parents of his death. Mr Wilgos' sister and partner also attended the home and were informed of his death. The family requested that the officer contact the funeral director on their behalf to begin funeral arrangements. Mr Wilgos' brother also attended later and was informed by the officer of his brother's death. She told the family that the prison would contribute towards funeral costs in line with national guidance. The prison confirmed to the

investigator on 21 November, that they were awaiting an invoice from the funeral directors and still intended to pay the agreed amount.

### **Support for prisoners and staff**

102. Following Mr Wilgos' death, the staff care team supported those staff who had been directly involved. Prisoners on B wing were offered support from the chaplaincy team. All prisoners who were subject to suicide and self-harm monitoring were reviewed and offered additional support where required.
103. A 'hot' de-brief was completed immediately after Mr Wilgos' death chaired by security governor.

### **Post-mortem report**

104. The Coroner has confirmed that the cause of Mr Wilgos' death was hanging. Toxicology tests performed indicated that Mr Wilgos had not taken any illicit drugs or medication prior to his death. The toxicological tests performed also covered new psychoactive substances (NPS) the results of which were also negative.

# Findings

## Assessment, care in custody and teamwork (ACCT)

105. Mr Wilgos had a long custodial history, during which time he had been subject to ACCT monitoring twice prior to 9 July 2015. However, he had never self-harmed while in custody. He had overdosed on prescribed medication in 2009. On 9 July 2015, Mr Wilgos told staff that he was struggling and had thought of hurting himself, because of which an ACCT was opened. At lunchtime that day, he punched his television, causing a cut to his hand, requiring hospital treatment. However, Mr Wilgos was adamant that he had not intended to injure himself and denied that the cut was a deliberate act of self-harm.
106. When staff opened the ACCT, the immediate action plan indicated that Mr Wilgos would benefit from assessment by the mental health team, and a nurse saw him later that day to assess him. On 10 July, a CM chaired an ACCT review with Mr Wilgos, during which Mr Wilgos spoke about concerns he had regarding his mother's health, which had led to his frustration the previous day. Again, he denied any thoughts or intentions to self-harm. The ACCT review concluded that Mr Wilgos presented no further risk of self-harm and took the decision to close the document. However, apart from a wing officer, no one else had attended the review. The CM was unable to recall whether he had sought advice or input from either mental health team (MHT) or primary care nursing staff prior to the review, but, as he had not recorded this, it seems likely that he had not. The only action on the caremap was for the MHT to see and assess Mr Wilgos. This had taken place the previous day, and the MHT was to contact and follow up with Mr Wilgos over the coming weeks.
107. On 17 July, a SO completed a post closure review with Mr Wilgos. He said that he was still concerned about his mother's ill health, but was coping with this better. He reiterated that the injury to his hand was not an act of self-harm, and had resulted from being frustrated and punching his television. He denied any thoughts or intentions to self-harm, and she concluded that there were no reasons for the ACCT to be re-opened.
108. Mr Wilgos was only subject to ACCT monitoring for a relatively short period. The MHT saw him quickly once concerns had been raised and he was able to discuss the issues that had led to his frustration. As the MHT had seen him on 9 July, prior to the first ACCT case review, it would have been advisable for the CM to seek some input from either MH or primary care nurses at that review. PSI 64/2011 (Management of prisoners at risk of harm to self, to others and from others), instructs that it is a mandatory action for a nurse to attend the initial case review. In relation to the management of ACCT at Wayland, we make the following recommendation:

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

- **A multi-disciplinary approach for all case reviews.**
- **Healthcare staff attending all first case reviews.**

## Unlocking procedures

109. Officer B unlocked cells on the morning of 14 March, including that of Mr Wilgos. She said that she had been trained to look into the cell before unlocking the door. However, on the morning of 14 March she did not check inside Mr Wilgos' cell. The CCTV also showed that as she passed along the landing, she did not check into any of the other cells before unlocking the door. The guidance set out in The Prison Officer Entry Level Training (POELT) manual says, "Prior to unlock, staff should physically check the presence of the occupants in every cell. You must ensure that you receive a positive response from them by knocking on the door and await a gesture of acknowledgement. If you fail to get a response, you may need to open the cell to check. The purpose of this check is to confirm that the prisoner has not escaped, is ill or dead". Although this relates to conducting a roll check, the reasons for checking remain the same when opening the cell door.
110. Officer B did not check on the welfare of those prisoners she was unlocking, by way of conversing with them or obtaining a response and, as a result, Mr Wilgos went unnoticed until discovered by another prisoner. The investigation has heard that earlier intervention would not have prevented Mr Wilgos' death, but in other cases, such routine safety precautions may prevent an ill or dying prisoner going unnoticed in the future. We therefore make the following recommendation:

**The Governor of HMP Wayland should review the procedures for unlocking prisoners and ensure that, when a cell door is unlocked, staff satisfy themselves of the safety of the prisoner and that there are no immediate issues that require attention**

## Emergency response

111. Prison Service Instruction (PSI) 03/2013 (Medical Emergency Response Codes) requires governors to have a medical emergency response code protocol, which ensures an ambulance is called automatically in a life-threatening emergency. The protocol should give guidance on efficiently communicating the nature of a medical emergency, ensuring that staff take the correct 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, the protocol and their responsibilities during medical emergencies.
112. When Officer B was called to Mr Wilgos' cell and realised what had happened she immediately called an emergency code blue on her radio. According to the control room log, the initial call was received at 8.10am and a call was made to the ambulance service at 8.11am. Prison staff and nurses responded quickly to the code blue and there were no apparent delays in obtaining emergency equipment or with the ambulance service gaining entry to the prison. We make no recommendations.

## Resuscitation

113. The first prison staff to attend Mr Wilgos' cell described him as stiff and cold, and displaying clear signs of rigor mortis. These staff did not immediately attempt CPR but medical staff, who despite stating themselves that Mr Wilgos showed signs of rigor mortis, took the decision to begin CPR when they arrived a few

minutes later. The nursing staff had been unable to insert an airway into Mr Wilgos, due to the severity of the rigor mortis. The healthcare manager said that in her opinion Mr Wilgos had been dead for several hours.

114. We consider that it was not necessary to attempt to resuscitate Mr Wilgos. European Resuscitation Council Guidelines 2010 state, “Resuscitation is inappropriate and should not be provided when there is clear evidence that it will be futile ...” The guidelines define examples of futility as including the presence of rigor mortis. More recently, the British Medical Association (BMA), the Royal College of Nursing (RCN) and the Resuscitation Council (UK) issued guidance in October 2014 about making appropriate decisions in respect of resuscitation. The guidance says that every decision should be made on the basis of a careful assessment of each individual’s situation. Decisions should never be dictated by ‘blanket’ policies.
115. We understand that the natural inclination of prison and healthcare staff is to begin emergency first aid by giving life support. However, attempting resuscitation when someone is clearly dead is distressing for staff and undignified for the deceased. We make the following recommendation:
- **The Governor and Head of Healthcare should ensure that prison and healthcare staff are given clear guidance and training, in line with established professional guidelines, about the circumstances in which resuscitation is inappropriate.**

#### Clinical care

116. The clinical reviewer concludes that Mr Wilgos’ death was not foreseeable and that the medical care he received was equivalent to that he might expect to have received in the community. However, he was concerned that Mr Wilgos often failed to collect his prescribed anti-depressant medication and that there was a lack of process to follow up such events. We make the following recommendation:
- **Healthcare staff and the Mental Health Team should ensure that a follow up appointment is arranged and recorded when a prisoner stops taking prescribed medication prematurely. Prisoners who fail to collect prescribed medication should also be contacted and the risks of stopping their medication explained.**
117. He also makes recommendations to improve information sharing in healthcare and the appointments process for the Wellbeing service which the Head of Healthcare will need to address

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations