

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Joshua Hunter a prisoner at HMP Wymott on 29 June 2017

A report by the Prisons and Probation Ombudsman

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 Joshua Hunter died in hospital on 29 June 2017 of peritonitis and a perforated stomach, while he was a prisoner at HMP Wymott. He was 27 years old. I offer my condolences to Mr Hunter's family and friends.

Mr Hunter, who had a personality disorder and was a prolific self-harmer, had a long history of swallowing small metal objects, such as paperclips, and inserting wire and other objects into his penis. He had severe abdominal problems as a result and underwent surgery on several occasions.

Prison staff monitored Mr Hunter under suicide and self-harm prevention procedures (known as ACCT) on 61 occasions while he was in prison and I am satisfied that they did what they reasonably could to prevent him self-harming. When Mr Hunter died, paperclips and wire were found in his abdominal cavity, bowel and bladder. These appear to have accumulated over many years, rather than as the result of a recent act of self-harm.

The investigation found that Mr Hunter received an appropriate standard of physical healthcare at the prison, equivalent to that which he could have expected to receive in the community.

However, there were deficiencies in the management of Mr Hunter's complex mental health needs. I am not satisfied that his mental health care was equivalent to that which he could have expected to receive 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.

Sue McAllister CB
Prisons and Probation Ombudsman

May 2019

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Summary

Events

1. Mr Joshua Hunter was serving an indeterminate sentence for public protection and had been in prison since 2006. In September 2012, he was moved to HMP Wymott. He was moved to the Beacon Unit (for prisoners with a personality disorder) at HMP Garth in February 2014, before being returned to Wymott in October 2014.
2. Mr Hunter had a personality disorder and was a prolific self-harmer. He had a long history of swallowing small metal objects, as well as inserting them into his body. Prison staff monitored him under suicide and self-harm prevention procedures (known as ACCT) on 61 occasions while he was in prison.
3. Mr Hunter was regularly admitted to hospital with abdominal pain caused by swallowing objects. He underwent surgery on several occasions. In October 2015, a hospital doctor decided he could not have further abdominal surgery because it had become too risky due to the number of previous operations.
4. In April 2016, the mental health team reviewed Mr Hunter's care plan under the NHS Care Programme Approach (CPA - used to coordinate the care of patients with mental health disorders) and allocated two mental nurses as his care coordinators.
5. In August 2016, the mental health team manager reviewed the CPA care plan and arranged a further review for February 2017. There is no evidence that the review took place.
6. Between 25 March and 11 April, prison staff monitored Mr Hunter under the ACCT process for the final time. Mr Hunter said he was concerned about his prescribed medication and social care. Healthcare staff provided a carer to help Mr Hunter with his personal care.
7. On 27 June, Mr Hunter complained of severe abdominal pain and a nurse arranged for an emergency ambulance to take him to hospital. Hospital doctors diagnosed liver failure and a liver abscess. Mr Hunter continued to deteriorate and he died in hospital at 12.28pm on 29 June.
8. The post-mortem showed that Mr Hunter died from peritonitis (inflammation of the thin layer of tissue that lines the inside of the abdomen) and stomach perforation (a hole in the stomach lining) following ingestion of foreign bodies.

Findings

9. I am satisfied that prison staff did what they reasonably could to prevent Mr Hunter self-harming. When he died, paperclips and wire were found in his abdominal cavity, bowel and bladder. These appear to have accumulated over many years, rather than as the result of a recent act of self-harm.
10. The clinical reviewer concluded that Mr Hunter received an appropriate standard of physical health care at Wymott, equivalent to that which he could have expected to receive in the community.

11. The clinical reviewer concluded that the standard of mental health care provided to Mr Hunter was not equivalent to that which he could have expected to receive in the community. We are concerned that it was not until April 2016 that staff at Wymott reviewed Mr Hunter's CPA care plan, and then they did not review this as they should have done. We are also concerned that mental health staff at Wymott do not receive appropriate training in the management of prisoners with personality disorders.
12. We identified some deficiencies in the management of Mr Hunter's final ACCT. The first assessment interview and the first case review were not held within 24 hours as they should have been. We do not consider, however, that this contributed to Mr Hunter's death.

Recommendations

- The Head of Healthcare should ensure that all mental health staff are up to date with Care Programme Approach (CPA) training and that staff ensure prisoners subject to the CPA:
 - have a documented therapeutic plan with clear objectives; and
 - their care coordinator in the prison meets them regularly to update the plan and records all contact and concerns.
- The Head of Healthcare should ensure that mental health nurses receive training in the management and treatment of prisoners with personality disorders.
- The Governor should ensure that staff manage prisoners at risk of suicide and self-harm in line with national guidelines, including ensuring that they:
 - hold an assessment interview within 24 hours of an ACCT being opened; and
 - hold a multidisciplinary case review within 24 hours of an ACCT being opened.

The Investigation Process

13. The investigator issued notices to staff and prisoners at HMP Wymott informing them of the investigation and asking anyone with relevant information to her. No one responded.
14. The investigator obtained copies of relevant extracts from Mr Hunter's prison and medical records. Our investigation was suspended between 11 July 2017 and 17 September 2018 while we awaited the cause of death and the appointment of a suitable clinical reviewer.
15. The investigator interviewed three members of staff at HMP Wymott on 12 October 2018.
16. NHS England commissioned a clinical reviewer to review Mr Hunter's clinical care at the prison. They conducted joint interviews.
17. We informed HM Coroner for Lancashire and Blackburn with Darwen of the investigation. The coroner gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
18. The investigator wrote to the solicitor acting on behalf of Mr Hunter's family to explain the investigation and to ask if they had matters they wanted the investigation to consider. They did not raise any issues.
19. Mr Hunter's family received a copy of the initial report. The solicitor representing Mr Hunter's family wrote to us pointing out some factual inaccuracies. They also forwarded us a copy of a letter dated 13 November 2017. The report has been amended accordingly. The solicitor also raised a number of questions that do not impact on the factual accuracy of this report. We have provided clarification by way of separate correspondence to the solicitor.
20. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out some factual inaccuracies and this report has been amended accordingly.

Background Information

HMP Wymott

21. HMP Wymott is a medium secure prison which holds over 1,100 adult men. Bridgewater Community NHS Trust and Greater Manchester Mental Health Trust provide healthcare services and Geometric Results International provides locum GP services, including 24-hour nursing cover, and the out of hours GP is via the local provider. There are no inpatient beds.

HM Inspectorate of Prisons

22. The most recent inspection of HMP Wymott was in October 2016. Inspectors reported that staffing levels in the integrated mental health team were too low to provide a satisfactory service. The team prioritised prisoners with severe health problems and contributed to ACCT reviews and regular multidisciplinary complex case meetings. The team also provided comprehensive mental health awareness training for prison officers.
23. Inspectors found that the prison had a detailed local self-harm and suicide prevention policy. A weekly complex case review meeting discussed the most prolific self-harmers. A large proportion of ACCT case reviews were multidisciplinary. However, self-harm triggers were not identified well enough and caremaps were often insufficiently focused on need.

Independent Monitoring Board

24. 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 2018, the IMB reported that the standard of healthcare was poor and frequently fell below that which could be expected in the community. The Board found that safeguarding of vulnerable prisoners who were subject to ACCT procedures was good, and prisoners mostly engaged with the process. Recommended schedules for observations and case reviews were followed but the associated care plans were not always completed.

Previous deaths at HMP Wymott

25. Mr Hunter was the 16th prisoner at Wymott to die since June 2014. All were from natural causes. There have been ten deaths since. Six of these deaths were from natural causes, three were drugs related and one is awaiting classification.

Assessment, Care in Custody and Teamwork

26. ACCT is the Prison Service care-planning system used to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk, how to reduce the risk and how best to monitor and supervise the prisoner. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011, Managing prisoners at risk of harm from self, from others and to others (Safer Custody).

Care Programme Approach

27. The Care Programme Approach (CPA) is an NHS system of delivering community mental health services to individuals diagnosed with a severe mental illness or other vulnerabilities such as a history of violence or self-harm. Someone who needs CPA support should have a formal written plan that outlines any risks and a CPA care coordinator to organise and review the plan.

Key Events

28. On 4 August 2006, Mr Joshua Hunter received an indeterminate sentence for public protection (IPP) for robbery and sexual offences with a minimum term of 3 years 8 months. (Offenders sentenced to an IPP are set a minimum term (tariff) which they must spend in prison. After they have completed their tariff they can apply to the Parole Board for release.) On 26 September 2012, he was moved to HMP Wymott. On 6 February 2014, he was moved to HMP Garth before being returned to Wymott on 16 October 2014.

Mr Hunter's history of self-harm

29. Mr Hunter had a long history of self-harm, which Mr Hunter said started when he was aged 10. He cut his arms as a young adult in custody, which escalated to swallowing and inserting objects into his body from 2009. On two occasions in 2012 and 2013, he took an overdose of paracetamol. He placed a ligature round his neck on two occasions in 2014 and 2016. Prison staff monitored him under suicide and self-harm prevention procedures (known as Assessment, Care in Custody and Teamwork (ACCT)) on 61 occasions between June 2008 and April 2017.
30. Mr Hunter frequently swallowed various items, including batteries, cleaning products, shower gels, arms of spectacles, paperclips, razors, plastic knives and pieces of plastic. He also inserted pens and metal wire into his penis.
31. Prison staff managed Mr Hunter under the ACCT process for the final time between 25 March and 11 April 2017.

Mr Hunter's mental healthcare

32. Mr Hunter was managed by the prison's mental health team for most of his time in custody and a mental health nurse attended his ACCT case reviews. A mental health nurse attended weekly complex case meetings to discuss Mr Hunter's needs.
33. From 6 July 2012, while Mr Hunter was located at HMP Channings Wood, the mental health team managed him under the NHS Care Programme Approach (CPA - used to coordinate the care of patients with mental health disorders). Nurses created a CPA care plan which was reviewed every six months.
34. In May 2013, a clinical director at the forensic personality disorder assessment clinic in Merseyside (a medium secure psychiatric unit), assessed Mr Hunter and diagnosed him with a personality disorder (a complex psychiatric condition characterised by emotional changeability and difficulty relating to other people). He concluded that Mr Hunter's primary motivation for his self-harm was not to take his own life and he self-harmed to control and manipulate prison staff.
35. On 6 February 2014, Mr Hunter was moved from Wymott to the Beacon Unit (a prison-based assessment and treatment service for prisoners with a personality disorder) at HMP Garth. Despite receiving specialist support and therapy in the unit, Mr Hunter continued to self-harm.

36. On 15 October, a prisoner made an allegation of sexual assault against Mr Hunter. Prison and healthcare staff decided that due to his behaviour, Mr Hunter was unsuitable for the Beacon Unit. He was returned to Wymott on 16 October.
37. Between April and November 2015, there is no evidence that Mr Hunter self-harmed. On 26 November, he was discharged from the mental health service and advised to contact the team if he needed support. On 6 January 2016, Mr Hunter self-harmed and was monitored under ACCT. A mental health nurse attended his ACCT case review.
38. On 24 April 2016, the mental health team reviewed Mr Hunter's CPA care plan. Mr Hunter was allocated to the caseloads of two nurses, both mental health nurses.
39. On 2 August 2016, the mental health team manager, reviewed Mr Hunter's CPA care plan and set a review date of 2 February 2017. There is no evidence in Mr Hunter's medical record that the review took place.
40. Both mental health nurse did not see Mr Hunter until 27 March when he self-harmed and one of them attended his ACCT case review.
41. On 19 April, both mental health nurses saw Mr Hunter in his cell. Mr Hunter discussed his ongoing concerns about his physical health and one of them noted that he engaged well.
42. On 23 June, Mr Hunter contacted healthcare and asked to see both mental health nurses. Mr Hunter said his mental health had deteriorated due to difficulties with his physical healthcare. Mr Hunter did not see them again before he died.
43. On 28 June, one of the mental health nurses created a personality disorder care plan. An appointment was made with a prison psychiatrist for 20 July. Mr Hunter died before this took place.

Mr Hunter's physical healthcare

44. Mr Hunter regularly experienced abdominal pain caused by his history of swallowing and inserting small metal objects. Prison GPs prescribed pain relief medication. In April 2012, hospital specialists at a hospital diagnosed Mr Hunter with a perforated duodenum (a hole in the small intestine) and a liver abscess caused by swallowing paperclips.
45. In March 2013, hospital doctors diagnosed recurrent urethral stricture (narrowing of the urethra) caused by Mr Hunter inserting objects into his penis. Mr Hunter often needed to insert a catheter to enable him to pass urine. In April, Mr Hunter inserted a metal aerial and a pen cartridge into an abdominal wound. Hospital doctors treated him with intravenous antibiotics.
46. During 2014, Mr Hunter was admitted to hospital on four occasions with severe abdominal pain and was treated with intravenous antibiotics. In March 2014, hospital specialists surgically removed a pen which he had inserted into his

penis. In June 2014, the results of a CT scan showed small metal objects in his abdomen and pelvis.

47. In October 2015, Mr Hunter was admitted to hospital suffering from abdominal pain. Investigations showed that Mr Hunter had a cyst on his liver and he had his ninth laparotomy (a surgical incision into the abdominal cavity) to remove it. A hospital consultant decided Mr Hunter was unsuitable for further surgery due to the risk of developing complications. Mr Hunter regularly experienced chronic pain caused by the objects which remained in his abdomen. The pain management clinic at a hospital prescribed fentanyl patches (for chronic pain) and provided a transcutaneous electrical nerve stimulation machine (TENS - the use of a mild electrical current to manage pain).
48. In July 2016, Mr Hunter told a prison GP, he had swallowed approximately 50 paperclips three weeks earlier. He refused to attend hospital for further investigation and signed a disclaimer to that effect. In September, Mr Hunter was admitted to hospital with abdominal pain. The results of an endoscopy (an examination of the gullet, stomach and intestine) revealed a perforated stomach caused by swallowing metal objects. Mr Hunter refused further investigation and discharged himself from hospital.
49. On 24 February 2017, a prison GP saw Mr Hunter who complained of severe abdominal pain. Mr Hunter refused to attend hospital and signed a disclaimer to that effect. He was satisfied that Mr Hunter understood the risks to his health if he refused to attend hospital.
50. On 27 February, blood tests showed a low haemoglobin level which required further investigation. Mr Hunter refused to attend hospital for further investigation and signed a disclaimer to that effect. On 28 February, Mr Hunter complained of severe abdominal pain. A prison GP arranged for an emergency ambulance to take Mr Hunter to hospital. Hospital doctors told Mr Hunter that his low haemoglobin level was caused by a poor diet. Mr Hunter was returned to Wymott on 1 March.
51. At 1.30pm on 25 March, an officer began ACCT monitoring after Mr Hunter said he would self-harm because he had not received his anti-sickness medication. An officer contacted healthcare staff who advised that Mr Hunter had received his medication as prescribed. A Custodial Manager (CM) completed an immediate action plan and noted that Mr Hunter did not intend to self-harm and wanted healthcare to investigate the problems with his medication. The CM instructed staff to observe Mr Hunter every three hours.
52. At 3.40pm on 26 March, the prison chaplain completed an ACCT assessment interview with Mr Hunter, who said that he had difficulties with healthcare about his medication and felt he was being forced to self-harm. Mr Hunter said he had no intention to take his own life.
53. At 1.30pm on 27 March, a Senior Officer (SO) held the first ACCT case review with Mr Hunter's offender manager, and with one of his mental health nurses. The SO did not record why the case review was not held within 24 hours. Mr Hunter said he had no thoughts of self-harming and wanted healthcare staff to address the problems with his medication and social care. The SO assessed

Mr Hunter as a low risk of suicide and self-harm (on a scale of low, raised and high) but decided to keep the ACCT open to ensure his medical needs were addressed and documented.

54. An SO also completed Mr Hunter's caremap (designed to identify the main areas of concern and the actions required to reduce risk) and added three actions. The SO said that healthcare staff needed to look at Mr Hunter's care package and his medication, and hold a meeting to discuss his complex care needs.
55. On 29 March, a multidisciplinary team meeting involving a healthcare manager, a social worker, and Mr Hunter's offender manager, discussed Mr Hunter's deteriorating physical health. The healthcare manager noted that Mr Hunter was refusing to get out of bed because of his abdominal pain. The social worker said she had completed a social care needs assessment and a carer would support Mr Hunter with his personal care. The healthcare manager referred Mr Hunter to a GP for a medication review. Nurses provided Mr Hunter with a pressure relieving mattress and a commode.
56. On 3 April, an SO held an ACCT case review with two nurses in attendance. The SO assessed Mr Hunter as at low risk of suicide and self-harm. Mr Hunter said his concerns were related to his medication and he did not intend to self-harm.
57. On 6 April, a prison GP reviewed Mr Hunter's prescribed medication.
58. On 11 April, an SO held an ACCT case review with a nurse. The SO assessed Mr Hunter as at low risk of suicide and self-harm. Mr Hunter said he did not intend to self-harm and his issues with medication were resolved. The SO decided that as Mr Hunter no longer had issues with his medication, the ACCT could be closed. On 18 April, a CM held a post-closure interview which did not identify any issues.
59. On 5 May, a prison GP examined Mr Hunter and noted he may have an abdominal abscess. Mr Hunter refused to attend hospital and signed a disclaimer to that effect.
60. On 10 May, Mr Hunter agreed to attend hospital and a prison GP arranged for an ambulance to take him to hospital. Investigations showed no abnormalities and hospital doctors gave Mr Hunter a blood transfusion and prescribed antibiotics. Mr Hunter was returned to Wymott on 11 May.
61. On 19 May, a prison GP prescribed Mr Hunter mirtazapine (antidepressant). Nurses saw Mr Hunter daily to administer his prescribed medication.
62. On 27 June, Mr Hunter complained of severe abdominal pain. A nurse arranged for an emergency ambulance to take Mr Hunter to hospital. Two officers accompanied Mr Hunter and restrained him using an escort chain (one hand is handcuffed to an officer using a chain). A prison manager, informed Mr Hunter's family that he was in hospital.
63. When Mr Hunter's condition deteriorated on 28 June, a prison manager authorised the removal of restraints. Hospital doctors admitted Mr Hunter to the

intensive care unit. Mr Hunter was diagnosed with liver failure and a liver abscess. The results of a CT scan showed multiple objects in his bowel, pelvis and bladder. Mr Hunter continued to deteriorate and he died at 12.28pm on 29 June.

Contact with Mr Hunter's family

64. The prison chaplain, was appointed as the family liaison officer (FLO) when Mr Hunter was admitted to hospital. Mr Hunter's father was listed as his next of kin.
65. On 28 June, the FLO met with Mr Hunter's parents in hospital to offer support. Mr Hunter's parents were present when he died on 29 June.
66. The FLO remained in contact with Mr Hunter's parents until Mr Hunter's funeral on 7 July. The prison contributed to the funeral costs in line with national instructions.

Support for prisoners and staff

67. After Mr Hunter's death, a prison manager debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.
68. The prison posted notices informing other prisoners of Mr Hunter's death, and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Hunter's death.

Post-mortem report

69. The post-mortem report found that Mr Hunter died from peritonitis (inflammation of the thin layer of tissue that lines the inside of the abdomen) and stomach perforation (a hole in the stomach lining). The post-mortem examination found paperclips throughout the upper abdominal cavity, within the loops of bowel and one perforating the small intestine. Copper wire was also found next to the small bowel and in the bladder (inserted via the penis).
70. The toxicology examination showed prescribed medication within therapeutic ranges. Paracetamol was above the normal therapeutic range (129mg/L). The report said that fatalities attributable to chronic paracetamol poisoning are typically in the range 160-387 mg/L.

Findings

Clinical care

Physical healthcare

71. Mr Hunter had complex physical healthcare needs as a result of a long history of swallowing and inserting small metal objects into his body. After nine laparotomies, hospital doctors decided in October 2015 that Mr Hunter was unsuitable for further surgery due to the risk of developing complications. The clinical reviewer noted that prison healthcare staff and hospital doctors ensured Mr Hunter was aware of the consequences of swallowing metal objects and he understood the risks to his health if he continued to do so.
72. The clinical reviewer noted that while Mr Hunter did not have a formal care plan to manage his physical healthcare needs, nurses appropriately considered his needs and prison GPs referred him to hospital when his condition deteriorated.
73. When Mr Hunter experienced mobility problems, healthcare staff completed a social care assessment and provided him with a carer who provided support with his personal care.
74. The clinical reviewer concluded that Mr Hunter's physical healthcare was of an acceptable standard and equivalent to that he could have expected to receive in the community.

Mental healthcare

75. The clinical reviewer commented that healthcare and prison staff discussed Mr Hunter at weekly complex care meetings which demonstrated a collaborative approach towards managing Mr Hunter's physical and mental health. The two mental health nurses told the investigator that their role was primarily to provide Mr Hunter with emotional support and they did not consider that Mr Hunter was experiencing an acute mental illness. A nurse said that Mr Hunter's concerns were related to his physical healthcare.
76. The clinical reviewer commented that there was no evidence that Mr Hunter had a formal mental health assessment at Wymott until April 2016 when he was managed under the CPA approach. The mental health team did not review Mr Hunter's CPA care plan until August 2016 and the planned review in February 2017 did not take place. In the months leading up to Mr Hunter's death, both mental health nurses appeared to have had little contact with Mr Hunter. We note that the mental health provider at Wymott changed in April 2017, which led to increased pressure on mental health nurses.
77. We agree with the clinical reviewer that Mr Hunter's mental healthcare was not equivalent to that he could have expected to receive in the community. We make the following recommendation:

The Head of Healthcare should ensure that all mental health staff are up to date with Care Programme Approach (CPA) training and that staff ensure prisoners subject to the CPA:

- **have a documented therapeutic plan with clear objectives; and**
 - **their care coordinator in the prison meets them regularly to update the plan and records all contact and concerns.**
78. Prior to being moved to the Beacon Unit for further assessment, Mr Hunter had been diagnosed with a personality disorder. Mr Hunter was returned to Wymott in October 2014 when allegations of inappropriate behaviour meant he was considered unsuitable for the unit.
79. The mental health team manager, told the investigator that Wymott does not have a specific pathway to manage prisoners who are diagnosed with a personality disorder. Mr Hunter's conviction for sexual offences meant he was unable to move to the prison's Psychologically Informed Planned Environment (PIPE - a unit for prisoners with complex offending behaviour) and he was managed by the mental health team. At interview, a nurse said that mental health nurses did not receive formal training in managing prisoners with personality disorders and we note that he did not create a personality disorder care plan until the day before Mr Hunter died.
80. Mr Hunter had complex needs and we are concerned that healthcare staff at Wymott do not receive appropriate training to enable them to manage prisoners with personality disorders effectively. We make the following recommendation:

The Head of Healthcare should ensure that mental health nurses receive training in the management and treatment of prisoners with personality disorders.

Managing Mr Hunter's risk of self-harm

81. Prison Service Instruction (PSI) 64/2011 'Management of prisoners at risk of harm from self, from others and to others (Safer Custody)' sets out the processes that should be followed when an ACCT has been opened. This includes that a trained ACCT assessor must interview the at-risk prisoner within 24 hours of the ACCT being opened. The first case review must also be held within 24 hours of the ACCT being opened.
82. Mr Hunter was frequently monitored under the ACCT process during his time in custody and during his time at Wymott. He was last subject to ACCT monitoring between 25 March and 11 April 2017. An officer opened the ACCT document at 1.30pm on 25 March. To comply with PSI 64/2011, the assessment interview should have taken place by 1.30pm on 26 March but took place at 3.40pm. The first ACCT case review should also have taken place by 1.30pm on 26 March but was over 24 hours late when it was held at 1.30pm on 27 March.
83. The Head of Safety and Equality, told the investigator that during week days, the prison's Safer Living team closely monitor prisoners who are subject to ACCT monitoring to ensure that assessments and reviews are completed within the mandatory time frames. At weekends, it is the responsibility of prison staff to ensure that the first assessment and case review take place within 24 hours.

84. An officer began ACCT monitoring on 25 March, which was a Saturday. The FLO completed the assessment interview with Mr Hunter at 3.30pm on 26 March after the Sunday church service. The Head of Safety and Equality said that mental health nurses finish duty at 1.00pm during the weekend and, because it was important for them to attend Mr Hunter's first case review, this was held on 27 March. He could not explain why the assessment review did not take place on Saturday to enable the mental health nurses to attend the first case review before they went off duty.

85. While we appreciate that the levels of staff are reduced at weekends, we are concerned that such a crucial requirement of the ACCT process was overlooked and that there was an unnecessary and significant delay in assessing Mr Hunter's needs. We make the following recommendation:

The Governor should ensure that staff manage prisoners at risk of suicide and self-harm in line with national guidelines, including ensuring that they:

- **hold an assessment interview within 24 hours of an ACCT being opened;**
- **hold a multidisciplinary case review within 24 hours of an ACCT being opened.**

86. The Head of Safety and Equality told the investigator that prisoners are not authorised to have paper clips in possession and they are unable to purchase them. While staff use paper clips in the wing offices and in the education department, prisoners are unable to access these areas without supervision. After Mr Hunter died, the police did not find any evidence that Mr Hunter had paper clips or other small metal objects in his possession. Mr Hunter's death was caused by the cumulative effect of swallowing and inserting small metal objects over a number of years. We are satisfied that the prison had taken reasonable actions to prevent Mr Hunter obtaining paper clips and small metal objects.

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