

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Daniel Wilcock a prisoner at HMP Leeds on 3 April 2018

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 Daniel Wilcock was found hanged in his cell at HMP Leeds on 3 April 2018. He was 33 years old. I offer my condolences to Mr Wilcock's family and friends.

Although staff at Leeds had begun monitoring Mr Wilcock under Prison Service suicide and self-harm prevention procedures about three hours before he died, I consider that they underestimated his risk of suicide and so failed to put adequate measures in place to reduce his risk. Healthcare staff also failed to check him after he told a prison officer that he had swallowed razor blades. (Although this turned out to be untrue, staff did not know that at the time.)

Mr Wilcock had been diagnosed with a narcissistic and borderline personality disorder. I am concerned that the prison's mental health team discharged him without completing a mental health triage.

I am also concerned that the prison's control room did not immediately call for an ambulance when Mr Wilcock was discovered in his cell.

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

March 2019

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Summary

Events

1. On 22 February 2018, Mr Daniel Wilcock was sentenced to 20 weeks imprisonment for breaching a restraining order and was sent to HMP Leeds. He had been diagnosed with narcissistic and borderline personality disorder and had a history of depression.
2. On 12 March, a nurse saw Mr Wilcock for a mental health triage but ended the appointment because he would not answer any questions and was argumentative, abusive and threatening. The following day, a multidisciplinary team meeting discussed Mr Wilcock and noted that he did not have any mental health concerns so they discharged him from the mental health team.
3. At 10.45am on 29 March, a drug therapist began Prison Service suicide and self-harm monitoring (known as ACCT) after Mr Wilcock said that he had planned to kill himself with a ligature the previous night. At 9.30am on 31 March, a prison manager held the first ACCT case review. Mr Wilcock said that his thoughts of hurting himself had lessened, though he was struggling to cope with recent family bereavements and was worried about his housing situation on release. The manager decided that Mr Wilcock needed help with his housing and that he should continue working with the substance misuse team. As Mr Wilcock seemed calmer, the manager closed the ACCT.
4. At 5.20pm on 3 April, an officer reopened Mr Wilcock's ACCT after he said that he had swallowed four razor blades. The officer asked for healthcare assistance but a nurse did not see Mr Wilcock because she said he would digest the razor blades.
5. At 7.00pm, a prison manager held the second ACCT case review and Mr Wilcock said that he felt hopeless because he was being released shortly but had nowhere to live. He also said that he had mental health issues and agreed to see the mental health team after initially refusing help. The manager noted that Mr Wilcock engaged fully in the review so decided that he presented a low risk of suicide and self-harm (on a scale of low, raised, high and no change).
6. At 8.35pm, an operational support grade (OSG) checked on Mr Wilcock and found that he had covered his observation panel with a cabinet. The OSG asked for assistance and an officer responded. After moving the cabinet, they saw Mr Wilcock hanging from a ligature. At 8.42pm, the OSG called a code blue emergency (which indicates that a prisoner is unconscious or having difficulty breathing) and they entered the cell. They lowered Mr Wilcock to the floor and started cardiopulmonary resuscitation. Two nurses and a prison GP quickly responded to the code blue emergency and they assisted with the resuscitation.
7. The control room log noted that they called for an ambulance at 8.45pm, though Yorkshire Ambulance Service recorded it was requested at 8.48pm. Paramedics reached Mr Wilcock at 8.53pm but were unable to resuscitate him and at 9.23pm, the prison GP declared that Mr Wilcock had died.

Findings

Assessment of Mr Wilcock's risk of suicide and self-harm

8. Staff underestimated Mr Wilcock's risk of suicide and self-harm by not placing sufficient weight on his recent self-harm, unresolved concerns, and apparent mental health issues. We found no evidence that staff looked for a ligature after Mr Wilcock told a drug therapist that he had one in his cell. We are also concerned that healthcare staff did not assess Mr Wilcock after he told a prison officer that he had swallowed four razor blades.
9. We found a number of deficiencies with the ACCT process. The first ACCT case review was not held within 24 hours, caremap actions were inappropriately recorded as completed, and staff did not observe him hourly as specified – on one occasion he was not checked for 95 minutes.

Mental health

10. Despite being diagnosed with a narcissistic and borderline personality disorder, we are concerned that the mental health team did not assess Mr Wilcock for 18 days. We are also concerned that the mental health team discharged Mr Wilcock without completing his triage appointment.

Substance misuse

11. We agree with the clinical reviewer that, for the most part, Mr Wilcock received a good standard of substance misuse care that was equivalent to that which he could have expected to receive in the community. However, we are concerned that Mr Wilcock waited six days for his methadone dosage to be increased.

Emergency response

12. We are concerned that, after the OSG called a code blue emergency, the prison's control room did not call an ambulance for at least three minutes.

Family liaison

13. Following Mr Wilcock's death, West Yorkshire Police broke the news of his death to his mother but the prison's family liaison officer did not promptly visit her and instead chose to contact her by telephone.

Recommendations

- 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 a multidisciplinary case review within 24 hours of an ACCT being opened;
 - consider all risk factors, including suicidal statements, current self-harming behaviour and previous suicide attempts, when assessing a prisoner's risk;
 - do not record ACCT caremap actions as complete until they have been completed;
 - do not close ACCTs until the caremap actions have been completed; and

- adhere to the frequency of observations set out in the ACCT document.
- The Governor should ensure that when prisoners say they have ligatures, staff search them and their cells as soon as possible and remove any ligature.
- The Head of Healthcare should ensure that healthcare staff assess and treat all prisoners who have self-harmed, including those who report self harm.
- The Head of Healthcare should ensure that prisoners:
 - are seen within prescribed timescales; and
 - are not discharged from the mental health team without being assessed.
- The Governor should ensure that all prison staff are made aware of and understand their responsibilities during medical emergencies, including that control room staff call an ambulance as soon as an emergency code is called.
- The Governor should ensure, in line with PSI 64/2011, that where it has not been possible for someone from the prison to inform the family about a death in custody, prison staff should arrange a visit as soon as possible afterwards.

The Investigation Process

14. The investigator issued notices to staff and prisoners at HMP Leeds informing them of the investigation and asking anyone with relevant information to contact him. Three prisoners responded.
15. The investigator visited Leeds on 24 April 2018. He obtained copies of relevant extracts from Mr Wilcock's prison and medical records. He also spoke to the three prisoners who responded to notices about the investigation.
16. NHS England commissioned a clinical reviewer to review Mr Wilcock's clinical care at the prison.
17. The investigator interviewed 13 members of staff at Leeds on 7 and 8 June. The clinical reviewer took part in six of the interviews by telephone on 7 June.
18. We informed HM Coroner for West Yorkshire (Eastern) district of the investigation. He gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
19. One of the Ombudsman's family liaison officers, contacted Mr Wilcock's mother to explain the investigation and to ask if she had any matters she wanted the investigation to consider. Mr Wilcock's mother wanted to know:
 - What action did healthcare staff take after Mr Wilcock told them that he had swallowed razor blades?
 - What mental health input did he receive, particularly in treating his psychosis diagnosis, and what mental health medication was he prescribed?
 - What drug withdrawal medication did he receive?
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.
21. Mr Wilcock's mother received a copy of the initial report. The solicitor representing her wrote to us raising a number of comments that do not impact on the factual accuracy of this report. We have provided clarification by way of separate correspondence to the solicitor.

Background Information

HMP Leeds

22. HMP Leeds is a local prison holding a maximum of 1,218 men on remand, convicted or sentenced. The prison serves the courts of West Yorkshire. Care UK provides health services, including mental health services. The prison has 24-hour primary healthcare cover.
23. In August 2018, Leeds was selected to be part of the “10 Prisons Project”, which seeks to improve safety, security and decency in the prison. The project is focusing on reducing violence, improving living conditions, preventing drugs from entering the establishment and enhancing the leadership and training available to staff.

HM Inspectorate of Prisons

24. The most recent inspection of HMP Leeds was in October and November 2017. Inspectors reported that the number of self-harm incidents was higher than at similar establishments. They found that the quality of ACCT assessments was generally good and that mental health staff routinely attended ACCT reviews, though caremaps were often inadequate and observations did not demonstrate meaningful interactions.
25. Inspectors found that the demand for mental health services was high and a third of prisoners said that their mental health needs were not met. They found that mental health triage clinics were not used effectively.

Independent Monitoring Board

26. 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 December 2017, the IMB reported that the number of self-harm incidents had increased compared with 2016, though the new Safer Custody team had taken steps to reduce the incidences of self-harm and suicide.
27. The IMB reported that the mental health team was active throughout the prison and their attendance at ACCT reviews was good.

Previous deaths at HMP Leeds

28. Mr Wilcock was the 19th prisoner to die at Leeds since January 2015 and ninth person to take his own life. There have been five subsequent deaths. We have previously made recommendations about the management of suicide and self-harm monitoring, the provision of mental health care and staff responsibilities during medical emergencies.

Assessment, Care in Custody and Teamwork

29. Assessment, Care in Custody and Teamwork (ACCT) is the Prison Service care-planning system used to support prisoners at risk of suicide and 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.

30. After an initial assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. Checks should be irregular to prevent the prisoner anticipating when they will occur. There should be regular multidisciplinary review meetings involving the prisoner. As part of the process, a caremap (plan of care, support and intervention) is put in place. The ACCT plan should not be closed until all the actions of the caremap have been completed.
31. All decisions made as part of the ACCT process and any relevant observations about the prisoner should be written in the ACCT booklet, which accompanies the prisoner as they move around the prison. 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

32. On 22 February 2018, Mr Daniel Wilcock was sentenced to 20 weeks imprisonment for breaching a restraining order, harassment and theft offences. He was sent to HMP Leeds.
33. Mr Wilcock had been diagnosed with narcissistic and borderline personality disorder and had a history of depression, though there was nothing in his medical record to show that he had engaged with community mental health services. He also misused alcohol and drugs, including cocaine, opiates and cannabis.
34. When he arrived at Leeds, a nurse saw Mr Wilcock for an initial health assessment. Mr Wilcock said he had depression and narcissistic personality disorder, and that he was taking mirtazapine (used to treat depression) though he had recently stopped taking olanzapine (an antipsychotic drug used to support people with personality disorders). The nurse found that Mr Wilcock's urine tested positive for amphetamine, methadone and cocaine and he admitted to using psychoactive substances (PS). She referred Mr Wilcock to the mental health team, the substance misuse team and a prison GP.
35. The nurse assessed Mr Wilcock's risk of sharing a cell and decided that he presented an increased risk due to his personality disorder. A prison manager allocated him a single cell.
36. Later that day, a prison GP prescribed Mr Wilcock a 70ml dose of methadone (to treat opiate addiction), and diazepam and thiamine (to treat alcohol withdrawal).
37. On 23 February, a nurse saw Mr Wilcock for a secondary health assessment. She completed a mental health questionnaire and Mr Wilcock's responses showed he had anxiety and depression.
38. Between 23 February and 27 February, various substance misuse staff saw Mr Wilcock to assess his substance misuse needs and to assess his withdrawal from drugs and alcohol. On 27 February, a nurse noted that Mr Wilcock was no longer withdrawing from drugs or alcohol so planned for him to be seen on 27 March.
39. On 28 February, a healthcare administrator arranged for Mr Wilcock to attend the mental health triage on 13 March.
40. On 4 March, a nurse reviewed Mr Wilcock's community GP summary but did not identify any current concerns or risks. She noted that Mr Wilcock was due to attend a mental health triage on 12 March.
41. The following day, a clinical practitioner prescribed Mr Wilcock with mirtazapine.
42. On 12 March, a nurse saw Mr Wilcock for his mental health triage but ended the appointment because he would not answer any questions and was argumentative, abusive and threatening. She considered Mr Wilcock showed drug-seeking behaviour as he said he wanted olanzapine, and noted that she would discuss his behaviour at a multidisciplinary team meeting. The nurse recorded in Mr Wilcock's medical record that he did not have any thoughts of deliberate self-harm or suicidal thoughts.

43. The following day, a healthcare administrator recorded in Mr Wilcock's medical record that a multidisciplinary team meeting was held, involving seven nurses. The attendees concluded that Mr Wilcock did not have any mental health concerns so they discharged him from the mental health team.
44. That same day, a senior drug therapist saw Mr Wilcock during a substance misuse drop-in clinic. Mr Wilcock said he was not using any illicit substances and that he was struggling on his current dose of methadone. She planned to refer Mr Wilcock to a prison GP for a 10ml increase in his methadone dose. On 19 March, a pharmacist increased Mr Wilcock's methadone dose to 80ml.
45. At 10.27am on 29 March, a healthcare assistant, saw Mr Wilcock for a substance misuse review. Mr Wilcock said that he had had recent bereavements and was struggling with his mental health, though he had recently seen the mental health team and had been asked to leave the appointment.
46. At 10.45am, a senior drug therapist began Prison Service suicide and self-harm monitoring (known as ACCT) after Mr Wilcock said that he had planned to kill himself the previous night but that he had been unable to do so because he could not fix the ligature. He also said that he had stopped using illicit drugs, which had caused his emotions to return. She also recorded in Mr Wilcock's medical record that he was tearful when describing his current relationship with his family and the recent death of his grandfather.
47. At 11.15am, a Supervising Officer (SO) completed an Immediate Action Plan and instructed staff to observe Mr Wilcock every hour at irregular intervals.
48. At 7.30pm, an officer completed an ACCT Assessment Interview with Mr Wilcock, who said that he was struggling to control his emotions as he was detoxing and struggling to maintain family ties, though he was still close with his uncle and grandmother. He also said that he had no current intentions to take his own life and that he did not want to put his grandmother through it. The officer noted that Mr Wilcock had not committed any recent acts of self-harm though he had previously attempted suicide by taking an overdose. He decided that Mr Wilcock needed to continue to see the substance misuse team and needed to speak to Catch22 (the resettlement team) about getting accommodation when released.
49. At 9.30am on 31 March, a prison manager held the first ACCT case review with Mr Wilcock, an officer and a nurse. The prison manager noted that the case review was not held within 24 hours because it had not been picked up by an unspecified manager. Mr Wilcock said that his thoughts of hurting himself had lessened because he had stopped using illicit drugs. He said that he was struggling to cope with recent family bereavements and that he was worried about his housing situation on release. The attendees decided that as Mr Wilcock seemed calmer that the ACCT could be closed, though she did not assess his current level of risk. The post-closure interview was scheduled for 6 April.
50. The prison manager also completed Mr Wilcock's caremap (designed to identify the main areas of concern and the actions required to reduce risk) and added five actions. She decided that Catch22 needed to be contacted about his housing on release; that Mr Wilcock needed access to the Roman Catholic mass;

that Mr Wilcock needed to work with a senior drug therapist, and that Mr Wilcock should consider self-referring himself for counselling once released. The prison manager, also thought that Mr Wilcock needed a medication review but he declined this.

51. The prison manager also noted that Mr Wilcock was unwilling to provide details for his next of kin and that he had not provided them when he arrived at Leeds.
52. At 10.18am, the prison manager emailed a senior resettlement worker with Catch22 and explained that Mr Wilcock was anxious about housing on his release. She asked Catch22 to review Mr Wilcock as soon as possible.

3 April 2018

53. At 10.33am on 3 April, a senior resettlement worker emailed the prison manager and said that someone from Catch22 would see Mr Wilcock that week.
54. At 5.20pm on 3 April, an officer reopened Mr Wilcock's ACCT after he said that he had swallowed four razor blades. The officer recorded in Mr Wilcock's ongoing ACCT record that he spoke with Hotel 3 (a healthcare call sign, who was a nurse that day) and she said that Mr Wilcock did not need medical care because he would digest the razor blades in time.
55. At 7.00pm, a prison manager held the second ACCT case review with Mr Wilcock and a mental health nurse. Mr Wilcock said that he felt hopeless because he was being released in four weeks but had nowhere to live, and that he was frustrated at being unable to access his bank account. He was also unhappy with the cleanliness of his cell. He said that he did not want to take his life and that he wanted to engage with his family but could not. He also said that he had mental health issues and agreed to see the mental health team after initially refusing their help. The prison manager noted that Mr Wilcock engaged fully in the review and was goal-orientated throughout. The prison manager decided that Mr Wilcock presented a low risk of suicide and self-harm (on a scale of low, raised, high and no change) and that hourly observations should continue. The prison manager planned the next case review for 5 April.
56. The prison manager also added additional actions to Mr Wilcock's caremap. He decided that Mr Wilcock should engage with the mental health team and be referred to Catch22.
57. At 7.30pm, the prison manager emailed a manager with Catch22 and explained that Mr Wilcock did not have any housing when released. He asked Catch22 to review Mr Wilcock as soon as possible.
58. At 8.10pm, an officer recorded on Mr Wilcock's ACCT observation record that he was moving furniture around his cell and attempting to tidy up.
59. At 8.35pm, an operational support grade (OSG) checked on Mr Wilcock and found that he had covered his cell observation panel with a wooden cabinet. The OSG asked for assistance and an officer responded. The officer inserted a broom handle through a small hole in the observation panel and pushed the cabinet aside. They saw Mr Wilcock hanging from a ligature at the back of the cell. At 8.42pm, the OSG called a code blue emergency (which indicates that a

prisoner is unconscious or having difficulty breathing) and they entered the cell. The officer cut the ligature, which was made from a belt and had been attached to an electrical conduit on the ceiling, and they lowered Mr Wilcock to the floor. The officer and the OSG immediately started cardiopulmonary resuscitation (CPR).

60. Two nurses and a prison GP quickly responded to the code blue emergency. They inserted an airway, gave Mr Wilcock oxygen and sucked vomit from his throat and stomach. They also gave him adrenaline and naloxone (used to block or reverse the effects of opiate medication, especially during suspected overdoses) and attached a defibrillator but it did not detect a shockable heart rhythm and advised to continue CPR.
61. The control room log noted that they called for an ambulance at 8.45pm, though the Yorkshire Ambulance Service noted that an ambulance was requested at 8.48pm. Paramedics reached Mr Wilcock at 8.53pm. They took over the resuscitation attempt but they were unable to resuscitate him and at 9.23pm, the prison GP declared that Mr Wilcock had died.
62. Mr Wilcock left a note in his cell and said that he was “finally at peace”. He also said, “Just had another meeting with a condescending cunt from mental health. I cried out for help and didn’t get any. This prison service is toxic and people are suffering here needlessly.”

Contact with Mr Wilcock’s family

63. At 8.45pm on 3 April, the prison appointed, an offender supervisor as the family liaison officer (FLO). Mr Wilcock had not specified who he wanted as his next of kin so the FLO checked his prison documents and found an address for his aunt and uncle. Following a discussion with the Senior Investigating Officer for West Yorkshire Police, the police visited the home address of Mr Wilcock’s aunt and uncle and broke the news of his death. The police obtained an address for Mr Wilcock’s mother from them and visited her to break the news of his death.
64. On 4 April, Mr Wilcock’s mother briefly called the FLO but she did not allow him the time to offer her his condolences and support. That day, the FLO attempted to speak to Mr Wilcock’s mother on the telephone but she did not answer his calls.
65. The following day, the FLO spoke to Mr Wilcock’s mother to offer his condolences and support, and she decided that she wanted to be in charge of initiating any further contact. The FLO followed this up with a visit to the home address of Mr Wilcock’s mother on 20 April. He continued to support Mr Wilcock’s family until his funeral, which was held on 25 April. The prison paid for the costs of the funeral in line with national instructions.

Support for prisoners and staff

66. After Mr Wilcock’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.

67. The prison posted notices informing other prisoners of Mr Wilcock'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 Wilcock's death.
68. On 5 April, a member of the Safer Custody department, spoke with two prisoners who were close to Mr Wilcock and offered them personal support.

Post-mortem report

69. The post-mortem examination found that Mr Wilcock's death was caused by hanging. Analysis of Mr Wilcock's stomach found that it contained food but no razor blades or other objects.
70. The toxicology examination revealed medication within therapeutic ranges, which had no impact on Mr Wilcock's death. No other illicit substances were found in his blood or urine samples.

Findings

Assessment of Mr Wilcock's risk of suicide and self-harm

71. Prison Service Instruction (PSI) 64/2011 'Safer Custody' sets out the processes that should be followed when an ACCT has been opened. This includes that the first case review must be held within 24 hours of the ACCT being opened, that the case review team must review the level of risk that a prisoner presents taking into account all available information, and that staff must follow the planned frequency of observations. Guidance on these processes is also contained in the ACCT documentation which states that a prisoner should be regarded as a raised risk of suicide and self-harm when they present frequent but fleeting suicidal ideas, there is evidence of mental illness, there have been previous suicide attempts and there is current self-harming behaviour.
72. A senior drug therapist opened the ACCT document at 10.45am on 29 March and recorded that Mr Wilcock had planned to kill himself with a ligature but could not find a place to fix it. To comply with PSI 64/2011, the first ACCT case review should have taken place within 24 hours but actually took place nearly 48 hours later at 9.30am on 31 March.
73. A prison manager told the investigator that she realised that the review had not taken place when she started work on 31 March, though she did not know why, and she arranged for it to take place immediately. While we commend the prison manager for realising and rectifying this mistake, we are concerned that such a crucial requirement of the ACCT process was overlooked and that there was an unnecessary and significant delay in addressing Mr Wilcock's needs. We are also concerned that there is no record that officers searched for the ligature.
74. Following the first ACCT case review, the attendees decided to close the ACCT because Mr Wilcock knew that his issues were not being ignored. We are concerned about the speed of this decision because Mr Wilcock had planned to kill himself with a ligature two days earlier, and his issues, particularly his anxieties about his housing on release, had not been resolved. The prison manager added caremap actions for Mr Wilcock, which included contacting Catch22 about his housing on release and him continuing his substance misuse work with a senior drug therapist. These actions were marked as having been completed on 31 March, although Mr Wilcock's housing issue had not been resolved and he did not see the senior drug therapist for another substance misuse session before his death.
75. We are also concerned that, although a SO set hourly observations at irregular times when the ACCT was opened, there were nine instances when staff did not review Mr Wilcock within an hour, with the longest gap being 95 minutes. These nine failings also took place in less than 48 hours between the ACCT being opened at 10.45am on 29 March and closed at 9.45am on 31 March.
76. An officer reopened the ACCT document on 3 April, after Mr Wilcock said that he had swallowed four razor blades. A prison manager decided, during the ACCT case review, that Mr Wilcock only presented a low risk of suicide and self-harm. This was despite the fact that Mr Wilcock said he had swallowed razor blades less than two hours earlier; had talked of using a ligature a few days earlier; had

mental health concerns, as shown by a prison manager referring him to the mental health team; had continuing, unresolved anxieties about his housing issues; and had described his situation as 'hopeless'.

77. We are concerned that staff under-estimated Mr Wilcock's level of risk, particularly in the light of his recent self-harming behaviour and thoughts of creating and using a ligature, and that as a result the frequency of observations was not increased. We are also concerned that a nurse did not assess Mr Wilcock after he said he had swallowed razor blades, and that she did not record her decision in his medical record.
78. We make the following recommendations:

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 a multidisciplinary case review within 24 hours of an ACCT being opened;**
- **consider all risk factors, including suicidal statements, current self-harming behaviour and previous suicide attempts, when assessing a prisoner's risk;**
- **do not record ACCT caremap actions as complete until they have been completed;**
- **do not close ACCTs until the caremap actions have been completed; and**
- **adhere to the frequency of observations set out in the ACCT document.**

The Governor should ensure that when prisoners say they have ligatures, staff search them and their cells as soon as possible and remove any ligature.

The Head of Healthcare should ensure that healthcare staff assess and treat all prisoners who have self-harmed, including those who report self-harm.

Mental health

79. Prior to his arrival at Leeds, Mr Wilcock had been diagnosed with narcissistic and borderline personality disorder. Due to this diagnosis, a nurse promptly referred Mr Wilcock to the prison's mental health team. However, he was not seen by a nurse until 12 March, 18 days later. The Head of Healthcare, told the investigator the mental health team aimed to see non-urgent cases within five days. We agree with the clinical reviewer that an 18-day wait was inappropriate based on Mr Wilcock's mental health issues and the timescales set by the mental health team.
80. When a nurse saw Mr Wilcock, she quickly ended the appointment as she felt he was argumentative, abusive and threatening. While we appreciate that Mr Wilcock's behaviour was sufficient for the appointment to be cancelled, we are concerned that no one followed up the triage appointment and that they immediately discharged him without properly assessing his mental health needs.

We agree with the clinical reviewer that Mr Wilcock's mental health care was not equivalent to that which he could have expected to receive in the community. We make the following recommendation:

The Head of Healthcare should ensure that prisoners:

- **are seen within prescribed timescales, and**
- **are not discharged from the mental health team without being assessed.**

Substance misuse

81. Mr Wilcock had a history of drug and alcohol abuse so healthcare staff promptly referred him to the substance misuse team. We are satisfied that Mr Wilcock received regular monitoring of his withdrawal and could easily access substance misuse support. We agree with the clinical reviewer that, for the most part, Mr Wilcock received a good standard of substance misuse care that was equivalent to that which he could have expected to receive in the community.
82. However, we are concerned that Mr Wilcock told a senior drug therapist that he was struggling on his methadone dose on 13 March but that it was not increased until 19 March. We agree with the clinical reviewer that a six-day delay was too long based on his presentation. We refer the Governor and the Head of Healthcare to a recommendation made by the clinical reviewer.

Emergency response

83. PSI 03/2013, 'Medical Emergency Response Codes', contains a mandatory instruction that on hearing the code blue, control room staff must call an ambulance immediately.
84. An OSG called a code blue emergency at 8.42pm but the prison's control room log recorded that they did not call an ambulance for at least three minutes. According to the Yorkshire Ambulance Service, the prison's control room did not call for the ambulance until 8.48pm, a delay of six minutes. While we cannot be sure of the precise length of the delay, we are concerned that the control room ignored the requirement in PSI 03/2013 as they failed to immediately call for an ambulance. We make the following recommendation:

The Governor should ensure that all prison staff are made aware of and understand their responsibilities during medical emergencies, including that control room staff call an ambulance as soon as an emergency code is called.

Family liaison

85. PSI 64/2011 sets out the processes that should be followed when there has been a death in custody. This includes that, when the police have broken the news of the death to a family, a follow up visit by the prison's family liaison officer must be arranged as soon as possible.
86. Following Mr Wilcock's death, West Yorkshire Police broke the news of his death to his mother. The FLO spoke to Mr Wilcock's mother by telephone on 4 and 5 April but did not make any attempt to visit her in person. He did not visit her until

20 April. We are concerned that the FLO did not visit Mr Wilcock's mother soon enough, particularly in light of the questions that she had about his death, and so failed to comply with the provisions of PSI 64/2011. We make the following recommendation:

The Governor should ensure, in line with PSI 64/2011, that where it has not been possible for someone from the prison to inform the family about a death in custody, prison staff should arrange a visit as soon as possible afterwards.

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