Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Michael Tucker, a prisoner at HMP Wayland, on 22 March 2023

A report by the Prisons and Probation Ombudsman

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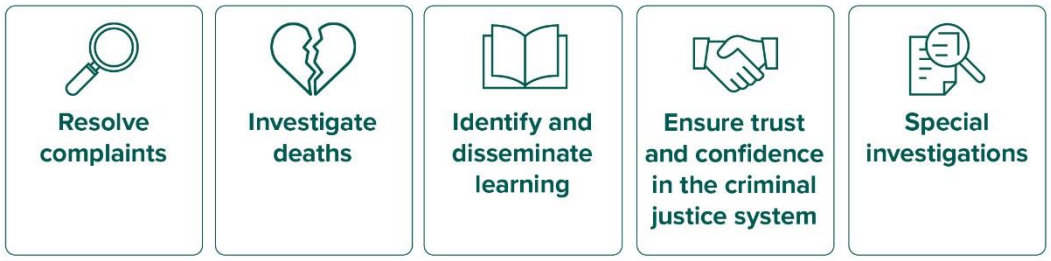
OUR VISION

To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.

WHAT WE DO



WHAT WE VALUE

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.

If my office is to best assist HM Prison and Probation Service (HMPPS) in ensuring the standard of care received by those within service remit is appropriate, our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.

Mr Michael Tucker was found hanged in his cell on 22 March 2023 at HMP Wayland. He was 40 years old. I offer my condolences to Mr Tucker's family and friends.

Prison staff started suicide and self-harm prevention procedures (known as ACCT) six days before Mr Tucker died. During ACCT case reviews, he expressed frustrations with his dose of benzodiazepine medication and, on several occasions, threatened to take his life if changes were not made to the prescription.

Although the correlation between Mr Tucker's perception of his healthcare treatment and his increased risk of suicide was acknowledged, there were missed opportunities to increase the level of support and monitoring shortly before his death, when he was clearly angry about medication decisions.

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

Adrian Usher
Prisons and Probation Ombudsman **December 2023**

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Summary

Events

1. On 17 August 2022, Mr Michael Tucker was recalled to HMP Chelmsford. He had been in prison several times previously and had been managed under Prison Service suicide and self-harm prevention procedures (known as ACCT). At Chelmsford, Mr Tucker was prescribed medication for anxiety, depression and emotional dysregulation.

2. On 3 February 2023, Mr Tucker was transferred to HMP Wayland. Three days later, a psychiatrist reviewed his medication and recommended a reduction in diazepam (which Mr Tucker took for anxiety). His other medications (clonazepam and olanzapine) remained unchanged.

3. On 16 March, a mental health support worker started ACCT procedures as Mr Tucker said that he was struggling with thoughts of harming himself. The next day, Mr Tucker said that he had expected his clonazepam dose to be increased to counter the reduction in diazepam (both are benzodiazepines) and suggested that he would end his life if this did not happen. Healthcare staff told Mr Tucker that they would discuss this further with the psychiatrist (on 20 March). They recorded that Mr Tucker's risk of suicide and self-harm might increase if the outcome was not what he hoped for.

4. On 20 March, healthcare staff told Mr Tucker that they had not yet spoken to the psychiatrist. He said that he would "end it" if his medication was not amended to his satisfaction. The ACCT case co-ordinator recorded that the frequency of ACCT observations should be reconsidered if Mr Tucker was given any news about medication that he did not agree with. In the evening, Mr Tucker cut his wrist and said that he had done so due to frustrations with his medication. The duty manager increased the frequency of ACCT observations.

5. On 21 March, a mental health worker told Mr Tucker that the psychiatrist would not increase his clonazepam dose. Mr Tucker indicated that he intended to end his life and walked out of the review. Staff persuaded him to return, and he continued to complain about his medication and said that he had previously harmed himself due to a need for benzodiazepines. Mr Tucker left the case review again, stating that he would "tie a rope and kill himself". The panel increased the frequency of ACCT observations to a minimum of three per hour.

6. In the evening, a nurse recorded that Mr Tucker was "clearly attempting" to divert his clonazepam at the medication hatch.

7. The following day, healthcare staff decided to withhold his evening dose of clonazepam. When Mr Tucker was told this later in the day, he argued with healthcare staff at the medication hatch and punched a hole in the Perspex screen. Wing staff locked Mr Tucker in his cell to calm down and returned in the next half an hour to give advice about what he could do the following day to find out more. They last spoke to Mr Tucker at 5.21pm.

8. At 5.33pm, an officer completed a very brief ACCT observation at which he looked in the cell observation panel for a fraction of a second. At 5.48pm, another officer recorded an ACCT observation which CCTV footage shows was not completed.

9. At 6.01pm, a third officer found Mr Tucker hanging from a ligature. He opened the cell and started cardiopulmonary resuscitation. At 6.58pm, paramedics confirmed that Mr Tucker had died.

Findings

10. ACCT procedures were initially managed well, with multidisciplinary case reviews and appropriate decisions made about risk and the frequency of observations. When healthcare staff chose to stop clonazepam, little consideration was given to how best to inform Mr Tucker of this decision. There was no thought to holding an urgent case review, as national policy instructs for events that are likely to increase the risk of suicide and self-harm, and the ACCT case co-ordinator was not informed.

11. The actions of staff tasked with carrying out Mr Tucker's ACCT observations once he was locked in his cell fell below the expected standard.

Recommendations

- The Governor and Head of Healthcare should ensure that staff hold an urgent ACCT case review whenever information is received that a prisoner's risk might have increased, in line with the requirements of PSI 64/2011.

- The Governor should commission a disciplinary investigation into Officer C's and Officer A's actions on the evening of 22 March 2023.

The Investigation Process

12. The PPO was notified of Mr Tucker's death on 23 March 2023. 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 wrote to him as a result.

13. The investigator visited Wayland on 29 March. He obtained copies of relevant extracts from Mr Tucker's prison and medical records and interviewed two additional prisoners.

14. Another investigator interviewed ten members of staff at Wayland, and an additional five, via Microsoft Teams, in June.

15. NHS England commissioned a clinical reviewer to review Mr Tucker's clinical care at the prison. She joined the investigator for staff interviews at Wayland and for Teams interviews with clinical staff.

16. We informed HM Coroner for Norfolk of the investigation. The Coroner gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

17. The Ombudsman's family liaison officer contacted Mr Tucker's father and sister to explain the investigation and to ask if they had any matters they wanted us to consider. Mr Tucker's sister asked the following questions:

    - What information about Mr Tucker's history was available to staff at Wayland when he transferred to the prison?
    - Why and how was the decision made to stop Mr Tucker's evening clonazepam (on 22 March 2023), and was the decision proportionate?
    - When and how was Mr Tucker told of the decision to stop his evening clonazepam and was this appropriate?
    - What information was shared with the supervising officer on Mr Tucker's wing about this decision and was there a change to the frequency of his observations as a result?

18. We shared the initial report with HM Prison and Probation Service. They did not identify any factual inaccuracies.

19. We also shared the initial report with Mr Tucker's family, who did not respond.

Background Information

HMP Wayland

20. HMP Wayland is a training and resettlement prison in Norfolk, holding 890 prisoners. Practice Plus Group provides mental and physical healthcare.

HM Inspectorate of Prisons

21. The most recent full inspection of HMP Wayland was in April 2022. Inspectors reported poor outcomes in several areas, including in safety. They found that the number of self-harm incidents was higher than at comparator prisons and there was no overarching strategy to reduce self-harm and support vulnerable people. Inspectors found that care planning for prisoners being monitored under ACCT procedures was not used well, and several such prisoners told inspectors that they did not feel well supported.

22. Inspectors found that mental health services provided a comprehensive range of support.

23. In March 2023, inspectors conducted a review of progress at Wayland. Inspectors followed up on priority recommendations from their previous visit (none of which related directly to suicide and self-harm prevention) and identified evidence of progress against nearly all of their priorities.

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 2022, the IMB reported that levels of self-harm were high but had fallen significantly during the reporting year. They also reported that the comments and recommended actions in many ACCT documents were poor and sometimes very poor.

Previous deaths at HMP Wayland

25. Mr Tucker was the eighth prisoner to die at Wayland since March 2020, and the third to take his own life in that time. Our investigation into the death of a man in April 2020, who was managed under ACCT procedures, found that some indicators of heightened risk were not recognised.

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. 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.

27. As part of the process, support actions are put in place. The ACCT plan should not be closed until all the support actions have been completed. 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.

Key Events

28. Mr Michael Tucker had been to prison several times in his adult life. During some of his previous times in prison, Mr Tucker had undergone alcohol, benzodiazepine and opiate detoxification programmes. In March 2022, prison staff managed Mr Tucker under ACCT procedures when he cut his arm and said that he did not expect to be alive afterwards. At around the same time, a psychiatrist prescribed medication for paranoia, anxiety and depression. Mr Tucker was released from prison in June 2022.

29. On 17 August, Mr Tucker was recalled to HMP Chelmsford. He began a short course of methadone for opiate (heroin) misuse and was prescribed diazepam and sertraline for anxiety and depression. Following triage, Mr Tucker was added to the mental health team's caseload. (Benzodiazepines, including diazepam, are highly addictive medications and doctors usually advise their use in the short-term only. In prisons, benzodiazepines are also highly tradable.)

30. In the autumn, Mr Tucker saw the mental health team and GP regularly to discuss his medication needs. Various changes to dosage and type of medication were trialled before professionals and Mr Tucker settled on continuing with diazepam and sertraline, with an additional prescription of olanzapine (an antipsychotic medication that was prescribed to Mr Tucker for emotional dysregulation). Mr Tucker also began a series of counselling sessions, which he completed in December.

31. In December, healthcare staff identified that Mr Tucker was trying to obtain extra medication by pretending that he had not received his full allocation. On review, he said that he was not happy that the GP had reduced his dose of diazepam.

32. On 29 December, a psychiatrist reviewed Mr Tucker. The psychiatrist identified no psychotic symptoms but noted that Mr Tucker reported some features of emotionally unstable personality disorder (a condition that affects how people think, feel and interact with other people). The psychiatrist recorded a plan to reduce diazepam and introduce clonazepam (an alternative benzodiazepine medication that is prescribed for various conditions, including anxiety).

33. On 28 January 2023, prison staff started ACCT procedures as Mr Tucker said he would harm himself due to noise on the wing and because his television was not working.

34. That day, Mr Tucker told a substance misuse worker that he had been using methadone illicitly and asked for this to be prescribed to help with "stress". The substance misuse worker told him that this was not appropriate and gave him harm minimisation advice.

35. On 29 January, prison staff stopped the ACCT monitoring.

HMP Wayland

36. On 3 February, Mr Tucker was transferred to HMP Wayland. A nurse assessed him on arrival and recorded that Mr Tucker spoke about a history of self-harm and attempted suicide both inside and outside prison. He said that he had no current

thoughts of harming himself. Mr Tucker spoke about depression and anxiety, and she referred him to the mental health team. (The nurse, along with all healthcare staff at Wayland, had access to Mr Tucker's medical history through his electronic medical record. Operational staff had access to Mr Tucker's prison history, including details of previous self-harm and periods under ACCT management, through his electronic prison record.)

37. Later that day, the mental health clinical lead assessed Mr Tucker. She recorded his current medication (which was olanzapine, clonazepam and diazepam). She noted that Mr Tucker did not have a diagnosis of an acute or enduring mental illness and did not present with symptoms of such. She referred Mr Tucker for a medication review.

38. That day, the healthcare multidisciplinary team meeting discussed Mr Tucker. The meeting record identified that the psychiatrist at Wayland had reviewed Mr Tucker's notes and agreed that diazepam should be reduced every week to a stop, as benzodiazepines are usually prescribed for short-term use due to their potential for addiction. Mr Tucker's prescriptions for clonazepam and olanzapine would be reviewed when he had completed his diazepam reduction.

39. On 27 February, the psychiatrist assessed Mr Tucker. He recorded that Mr Tucker said that he was not tolerating the reduction in diazepam very well. He noted that the whole appointment was about Mr Tucker wanting his clonazepam dose increased to compensate for this, despite the psychiatrist's advice against long-term use of benzodiazepines and the benefits of reducing off them. Mr Tucker said that he had fleeting thoughts of suicide that he did not intend to act on. He also said that since moving to Wayland, he was "constantly looking over his shoulder" for fear of attack. (There was no recorded intelligence that Mr Tucker was under threat or being bullied and wing staff who knew him told us that they were unaware of him having any related issues in prison life.) The psychiatrist increased Mr Tucker's dose of olanzapine and recorded that the reduction in diazepam would continue.

ACCT procedures

40. On 16 March, a mental health support worker recorded that Mr Tucker spoke to her about concerns relating to his mental health. She recorded that Mr Tucker had expected his medication to be adjusted (a colleague who was also present recorded that Mr Tucker said that he had expected clonazepam to be increased) and that he was struggling with increased thoughts of harming himself, which he was close to acting on. She started ACCT procedures.

41. On 17 March, a Supervising Officer (SO) assessed Mr Tucker for the ACCT procedures. He recorded that Mr Tucker's issues were that he was "detoxing" from his medication and felt isolated from his family. Mr Tucker also said that he felt depressed due to pain in his hands and heels which meant that he could not attend the gym. (Mr Tucker had long-standing arthritic pain due to historic injuries.) He said that he had constant, daily thoughts of harming himself.

42. The ACCT case co-ordinator then chaired the first ACCT case review, with a SO, a mental health support worker and a mental health practitioner. The practitioner recorded that Mr Tucker said that he was struggling with reducing diazepam and that he had been told that his clonazepam would be increased alongside this. (She

reminded Mr Tucker that it was his olanzapine prescription that the psychiatrist had increased, not clonazepam.) She recorded that Mr Tucker said that he had no current intent to end his life but that "if my meds don't get sorted, this will change". She noted that the mental health team would discuss his medication with the psychiatrist the following Monday (20 March), which Mr Tucker was happy with. Mr Tucker also accepted a referral to the IAPT wellbeing service for his anxiety. The case co-ordinator recorded these as support actions in the ACCT document. He set ACCT observations at a minimum of one per hour, plus three quality conversations per day.

43. The mental health practitioner recorded that staff present thought that Mr Tucker's risk of harming himself might increase if the outcome of the discussion with the psychiatrist was not what he hoped for. She told us that this was because he said at the review that he had seriously harmed himself in the past when healthcare professionals had made decisions about his medication that he did not agree with. She said that Mr Tucker showed scars from what he said were previous self-inflicted wounds to support this. As a result, the next ACCT case review was scheduled for 20 March.

44. On 18 March, a SO spoke to Mr Tucker about his "negative behaviour". He recorded that Mr Tucker had been vaping on the landing (against prison rules) and arguing with staff. (The SO is now a custodial manager at Wayland. At the time that Mr Tucker lived on D Wing, he was an SO wing manager.)

20 March 2023

45. In the morning, the case co-ordinator chaired the scheduled ACCT case review, with the mental health practitioner and mental health support worker also present. Mr Tucker said that he had started work in one of the prison workshops, although he found it boring. He said that his medication was still an issue and that he wanted it resolved as it was affecting his mental health. The case co-ordinator recorded that the practitioner said that she would speak to the psychiatrist about his medication and would hopefully have an answer for him later that day. The mental health support worker, who wrote up the case review in the medical record, recorded that she and the practitioner advised Mr Tucker that they would discuss with the psychiatrist later that day or the next day and inform him of the plan.

46. The case co-ordinator recorded that Mr Tucker ended the case review by saying that he would "end it" if his medication was not sorted. He noted that Mr Tucker's observations should "be looked at if [he] is given any news that he does not agree with". He told us that he meant that an ad hoc case review should take place were Mr Tucker to be told that he could not have the medication he wanted. The panel agreed to keep Mr Tucker's observations at the same frequency and set the next case review for 27 March.

47. There is no record that anyone spoke to the psychiatrist about Mr Tucker's medication on 20 March. He told us that he did not recollect anyone discussing Mr Tucker with him at the time, although he said that staff in the mental health team did sometimes discuss patients with him informally. The mental health practitioner told us that she spoke to the psychiatrist at a clinical team meeting about Mr Tucker's prescription but could not remember the outcome.

48. At around 9.00pm, Mr Tucker told the night officer that he had cut his wrist. The night manager held an ad hoc ACCT case review, and recorded that Mr Tucker said that he had harmed himself because of frustrations with his medication and dosage. He increased the ACCT observations to a minimum of two per hour and set an additional case review for 21 March.

21 March 2023

49. In the morning, Mr Tucker saw a GP at Wayland to discuss the pain in his fingers and heel. He said that this meant that he could not attend the gym and that this affected his mental health. Mr Tucker asked him to prescribe tramadol (a strong opioid painkiller). The GP recorded that he declined the request and explained the reasons why. They discussed amitriptyline (an antidepressant, also used to treat pain) which Mr Tucker agreed to trial.

50. The case co-ordinator was not scheduled to work on 21 March, so in the late morning a SO chaired an ACCT case review, with the mental health practitioner. She recorded that Mr Tucker was angry and said that the review was "pointless" until his medication was sorted. She recorded that the practitioner tried to explain to Mr Tucker the reasons for his prescription, but that he did not accept this and left saying that he was going to "string up in his cell".

51. The mental health practitioner recorded that she told Mr Tucker that she had spoken to the psychiatrist the previous day, who deemed an increase in clonazepam to be inappropriate. She recorded that Mr Tucker said that they would "find a body later today" on leaving the case review.

52. The Head of Reducing Reoffending was on the unit and Mr Tucker approached him on leaving the case review to show him his bandages from his self-harm the previous evening. The SO and the mental health practitioner persuaded Mr Tucker to return to the case review, and he agreed that the Head could also sit in.

53. On resuming the case review, the SO recorded that Mr Tucker continued to speak vocally about his medication and dosage. The mental health practitioner recorded that Mr Tucker linked his history of self-harm to a need for benzodiazepine medication. She noted that they discussed alternative support, such as talking therapies, but that Mr Tucker was unwilling to engage. She recorded that Mr Tucker continued to state that he would harm himself if he was not given the medication he wanted. She told him that she would book an appointment for him to discuss his medication needs with the psychiatrist. (An appointment was subsequently booked with the psychiatrist for 28 March.)

54. The SO recorded that Mr Tucker chose not to continue the case review and left stating that he was going to "tie a rope and kill himself". The panel agreed to increase the frequency of ACCT observations to a minimum of three per hour.

55. In the evening, a nurse recorded that when Mr Tucker collected his medication, he "threw them on the floor and clearly attempted to divert his clonazepam". He recorded that Mr Tucker picked up all his medication but claimed to have lost the clonazepam and asked multiple times for another tablet.

22 March 2023

56. In the afternoon, healthcare staff held a weekly multidisciplinary meeting to discuss patients with complex needs. The panel included the Head of Healthcare, the mental health practitioner, a nurse and a GP. The panel considered Mr Tucker's behaviour the previous evening and concluded that they should stop his evening clonazepam. (Mr Tucker's morning dose would continue.) The nurse told us that the report of the diversion was that it had been "blatant" and that they chose to stop the evening prescription due to the risk to other prisoners if it was traded or sold.

57. The nurse emailed the psychiatrist to obtain his view on the events. He replied to confirm that he agreed with the panel's view and actions.

58. The panel agreed that Mr Tucker would be informed of the decision when he collected his evening medication and that he would later receive written notice of the full reasons.

59. Following the meeting, the mental health practitioner telephoned M Wing and spoke to the SO about the panel's decision. She said that she told the SO about the news Mr Tucker would receive at the medication hatch and said that he might react adversely to this. She said that she told him that an ACCT case review would be scheduled for the following morning but that he should consider increasing the frequency of observations depending on how Mr Tucker reacted to the news that evening.

60. The SO told us that the mental health practitioner telephoned and told him that Mr Tucker was going to have his medication stopped. He said that she said that an ACCT case review would be held, but he could not remember when that would take place. He said that he was not asked to hold a case review and that no one considered holding a case review that afternoon.

61. The case co-ordinator told us that he was working on 22 March (on a different unit) but was not told about any of the events or decisions surrounding Mr Tucker's diversion and stoppage of evening medication.

62. At around 4.05pm, Mr Tucker went to collect his evening medication. A pharmacy technician recorded that Mr Tucker was "very verbally aggressive" when he told him that his clonazepam prescription had been stopped. Officer A intervened and walked away with Mr Tucker to speak to him separately.

63. Shortly after they finished speaking, Mr Tucker returned to the medication hatch and again spoke aggressively to the pharmacy technician. He then punched a hole in the Perspex screen of the medication hatch, resulting in a cut to his hand. An officer walked Mr Tucker away from the medication hatch, after which he went into the wing office to speak to the SO.

64. The SO recorded the conversation on his body-worn video camera. He told Mr Tucker that because he had damaged prison property, he would have to go into his cell to calm down. He said that he would then investigate the medication issue and come back to speak to Mr Tucker when he knew more.

65. The SO then walked Mr Tucker to his cell, with three officers. At the cell, he reiterated that he would try to find some answers for Mr Tucker. He told Mr Tucker that it was unlikely that he would get the medication that night as the healthcare decision had been made but he might be able to see a doctor in the morning to talk it over. At 4.40pm, the officers left Mr Tucker's cell and locked the door.

66. At 4.54pm, Officer A unlocked the cell and spoke to Mr Tucker at the door for around a minute. He told us that they discussed Mr Tucker's medication and reiterated that Mr Tucker could speak to healthcare staff about it the next day.

67. At 5.04pm, Officer B spoke to Mr Tucker at his cell door for around four minutes. He told us that Mr Tucker's aggression had now gone. He said that he told Mr Tucker that the officers would find out any information they could that evening, and again reiterated that he could see healthcare staff in the morning.

68. At 5.12pm, a nurse went to Mr Tucker's cell to treat the wound he had sustained to his hand (when punching the Perspex screen), accompanied by Officer B. The nurse told us that Mr Tucker only wanted to speak about his medication. When she explained that she was there to treat his hand, Mr Tucker said that he did not need anything. She then left the cell.

69. At 5.21pm, Officer B and Officer C went to the cell and spoke to Mr Tucker for around three minutes. Officer B said that he explained to Mr Tucker that the SO had spoken to healthcare staff, who had confirmed that he would not get his medication that night. He added that he had been told that Mr Tucker's medication would be raised with a healthcare manager in the morning. He said that Mr Tucker thanked him and appeared to be fine when given this news. He said that Mr Tucker apologised and fist-bumped him before he left the cell.

70. At 5.33pm, Officer C went to Mr Tucker's cell for an ACCT observation. He looked through the cell observation panel very quickly, for a fraction of a second. He told us that this was sufficient to see in clearly and that Mr Tucker was sitting on his bed, gave a thumbs up and said "goodnight". He told Officer A that he had completed the observation, and Officer A recorded this in the ACCT record.

71. Officer A recorded an ACCT observation at 5.48pm. CCTV footage shows that no one went to Mr Tucker's cell at or around this time. Officer A said that Officer C told him that he had completed this observation. Officer C said that he only told Officer A about the earlier observation (at 5.33pm).

72. At 6.01pm, Officer B went to Mr Tucker's cell for the next ACCT observation. He saw Mr Tucker hanging from a ligature that he had attached to the light fitting. He pressed an alarm button and shouted to the SO, who was nearby. They went into the cell immediately and cut the ligature. The SO radioed a medical emergency code blue, indicating a life-threatening situation, and the officer began cardiopulmonary resuscitation.

73. At 6.04pm, a nurse arrived and took over the resuscitation. At 6.27pm, paramedics arrived. At 6.58pm, they confirmed that Mr Tucker had died.

Contact with Mr Tucker's family

74. Mr Tucker did not name a next of kin in prison. Prison staff obtained a telephone number (but not an address) for his mother from local police. On the night of 22 March, a prison family liaison officer telephoned Mr Tucker's mother and informed her of his death. He remained in contact with other members of Mr Tucker's family, and Wayland contributed to funeral costs in line with national policy.

Support for prisoners and staff

75. After Mr Tucker's death, an operational 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.

76. The prison posted notices informing other prisoners of Mr Tucker'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 death. Prisoners who lived close to Mr Tucker told us that they received good support from prison and chaplaincy staff.

Post-mortem report

77. A post-mortem examination identified the cause of death as hanging.

Findings

Managing the risk of suicide and self-harm

78. Prison Service Instruction (PSI) 64/2011 contains guidance and mandatory instructions on managing prisoners at risk of suicide and self-harm. The mental health support worker appropriately started ACCT procedures when Mr Tucker said that he was struggling with thoughts of self-harm. The case reviews that followed were multidisciplinary with consistent attendance from appropriate staff. Decisions about risk and observations made at the case reviews were reasonable, and appropriate adjustments were made when Mr Tucker harmed himself and threatened to take his life.

79. PSI 64/2011 instructs that an urgent case review must take place as soon as possible if risk is likely to have increased between planned case reviews, including when an ACCT trigger occurs that is not currently mitigated against through the Care Plan.

80. In both the ACCT document and records of the case reviews in the medical record, prison and healthcare staff recorded that Mr Tucker's risk of suicide and self-harm might increase if he received news about his medication with which he did not agree. The case co-ordinator explicitly recorded that a change to ACCT observations should be considered if Mr Tucker received such news. Mr Tucker stated at case reviews that he would harm himself if he was not given the medication he wanted.

81. On 22 March, healthcare staff chose to stop Mr Tucker's evening medication. The clinical reviewer found that this was a reasonable decision.

82. The multidisciplinary panel decided that Mr Tucker would be told when he collected his medication. Both the Head of Healthcare and the mental health clinical lead said that the panel did not consider informing Mr Tucker in another way, such as by a person he knew or at an ACCT case review. Both agreed that this was a learning point. The clinical reviewer found that Mr Tucker should have been informed of the decision by a member of the healthcare team rather than at the medication hatch.

83. The mental health practitioner telephoned the SO and both agreed that they discussed a future case review. However, neither appeared to have considered holding an urgent case review either before or immediately after Mr Tucker was given the news about his medication. The case co-ordinator was working on 22 March but was not informed of any of the events and was not therefore able to contribute to any consideration of Mr Tucker's risk or observations. We make the following recommendation:

    The Governor and Head of Healthcare should ensure that staff hold an urgent ACCT case review whenever information is received that a prisoner's risk might have increased, in line with the requirements of PSI 64/2011.

Conducting ACCT observations

84. PSI 64/2011 instructs that ACCT observations must be carried out in line with levels set by case review teams. It states that the ongoing record must be completed immediately after observations take place and not retrospectively. At the time of his death, Mr Tucker's ACCT required him to be observed a minimum of three times per hour.

85. In the 40 minutes after he was locked in his cell on the late afternoon of 22 March, prison staff visited Mr Tucker's cell four times and held good quality conversations with him.

86. However, in the following 40 minutes the ACCT observations were poorly completed. At 5.33pm, Officer C looked through the cell observation panel for a fraction of a second. He told us that this was sufficient time to see Mr Tucker sitting on his bed, give a thumbs up and say "goodnight". On balance, given how briefly he looked into the cell, we consider it is unlikely that he was able to complete this observation to the degree he suggested.

87. At 5.48pm, Officer A recorded an ACCT observation that CCTV footage shows was not completed. He and Officer C gave different accounts of a conversation they had about the completion of this observation.

88. The SO told us that conducting ACCT observations on D Wing is the responsibility of the officer assigned the Delta 2 radio call sign. He said that the responsibility would be shared among staff if there were a number of prisoners requiring ACCT observations.

89. Officer A held the Delta 2 radio on 22 March. He told us that it is not always feasible for one officer to conduct all the ACCT observations on the wing, given workload pressures. He said that the responsibility can be shared between staff, especially if there are multiple prisoners being monitored under ACCT procedures on the wing. On 22 March, there were two prisoners (including Mr Tucker) being monitored under ACCT procedures, and all of the prisoners on the wing were locked in their cells at the time of the poorly completed and missed observations. While prison staff are undoubtedly busy, completing ACCT observations should be an operational priority.

90. We are not satisfied that Mr Tucker was properly observed in the 40 minutes before he died, and not in line with the expectations set by the case review team. We make the following recommendation:

    The Governor should commission a disciplinary investigation into Officer C's and Officer A's actions on the evening of 22 March 2023.

Inquest

91. The inquest into Mr Tucker's death concluded on 14 May 2024, and recorded a verdict of misadventure.

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Independent Investigations

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