Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr William Bissett, a prisoner at HMP Wymott, on 13 October 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 His Majesty's 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 William Bissett was found hanged in his cell on the morning of 13 October 2023. He was 88 years old. I offer my condolences to Mr Bissett's family and friends.

Up to the end of 2023, Mr Bissett was the second prisoner at Wymott to take his own life since October 2020. On the day of Mr Bissett's death, another prisoner was found hanging and he died the next day in hospital. The deaths were unconnected as he and Mr Bissett were in separate parts of the prison and did not know each other.

Mr Bissett died on the morning he was due to be released. He was not allowed to return to his marital home due to victim protection issues, but he knew that he would be housed by the local council. While he was unhappy about this, he gave no indication that he was at risk of suicide or self-harm.

I make no recommendations.

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 **August 2024**

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Summary

Events

1. On 21 January 2020, Mr William Bissett was sentenced to six years and six months in prison for historic sexual offences. He was moved to HMP Wymott on 6 March. In 2021, he was convicted of further offences and sentenced to another year in prison.

2. Mr Bissett was due to be released on 13 October 2023. In June 2023, he learned that he would not be able to return to his marital home as it was within a geographical exclusion zone for victim protection purposes. He was upset, and his family appealed against the decision but it was upheld. As his release date approached, staff told him that he would be given accommodation by his local council, outside the exclusion zone.

3. On 10 October, Mr Bissett's release paperwork was submitted to a prison manager. She asked if the exclusion zone could be revised. Mr Bissett's community offender manager raised the issue and it was referred to HMPPS headquarters. Once again, the decision was upheld. On 12 October, Mr Bissett had a video meeting with the council housing team, and confirmed his appointment to be allocated accommodation the following day.

4. During a routine check on the morning of 13 October, an officer found Mr Bissett hanging in his cell. He and a colleague started CPR which they continued until ambulance paramedics arrived. However, when paramedics arrived, they assessed that Mr Bissett had died.

Findings

5. When concerns were raised about Mr Bissett being unable to return to his marital home on release, both prison and probation staff explored with HMPPS policy teams whether there was any way he could return to his home. They were advised that it would not be permitted due to the victim protection measures in place. While Mr Bissett was unhappy about this, he did not give any indication that he was at risk of suicide or self-harm.

6. We make no recommendations.

The Investigation Process

7. HMPPS notified us of Mr Bissett's death on 13 October 2023.

8. The investigator issued notices to staff and prisoners at HMP Wymott informing them of the investigation and asking anyone with relevant information to contact him. No one responded.

9. The investigator visited Wymott on 24 October 2023. He obtained copies of relevant extracts from Mr Bissett's prison and medical records.

10. The investigator interviewed nine members of staff and two prisoners at Wymott. He also interviewed Mr Bissett's community offender manager.

11. NHS England commissioned two independent clinical reviewers to review Mr Bissett's clinical care at the prison. The investigator and a clinical reviewer jointly interviewed healthcare staff.

12. 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.

13. The Ombudsman's family liaison officer contacted Mr Bissett's wife to explain the investigation and to ask if she had any matters she wanted us to consider. She raised no issues but asked for a copy of our report. Mr Bissett's son and daughter subsequently contacted us with a number of questions about Mr Bissett's contact with the Probation Service and his pre-release planning, which we have addressed in this report.

14. We shared our initial report with HMPPS. They pointed out some factual inaccuracies which have been amended in this report.

15. We sent a copy of our initial report to Mr Bissett's son and daughter. They asked some further questions about their father's release planning, the exclusion zone and the proposed accommodation, which we have addressed in separate correspondence.

Background Information

HMP Wymott

16. HMP Wymott is a medium security prison in Lancashire holding adult men. Most prisoners are serving sentences of four years or longer. Specialist wings include two psychologically informed planned environment (PIPE) units for prisoners with personality disorders. Healthcare services are provided by Greater Manchester Mental Health NHS Trust. There is 24-hour nursing cover.

HM Inspectorate of Prisons

17. The most recent inspection of HMP Wymott was in December 2023. Inspectors reported that although the prison was not a resettlement prison, it was releasing around 20 prisoners a month due to population pressures elsewhere. Despite not having the funding, staff worked hard to support those who were leaving the prison through some good liaison with external services.

Independent Monitoring Board

18. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to 31 May 2023, the IMB reported that Wymott was generally a safe environment. Staff/prisoner relationships were generally good, but the prison was short of probation officers. The Board noted that some prisoners complained to them that they were due for release imminently without knowing where they would live, although almost all were found temporary accommodation.

Previous deaths at HMP Wymott

19. At the time of Mr Bissett's death, 23 prisoners had died at Wymott in the previous three years. Of the previous deaths, 22 were from natural causes and one was self-inflicted. On the day of Mr Bissett's death, another prisoner was found hanging and died the next day in hospital.

Key Events

20. On 16 January 2020, Mr William Bissett was remanded in prison charged with historic sexual offences. It was his first time in prison. On 21 January, Mr Bissett was convicted and sentenced to six years and six months imprisonment. He was moved to HMP Wymott on 5 March.

21. On 13 October 2021, Mr Bissett was convicted of further offences and was subsequently sentenced to a further year's imprisonment.

22. Mr Bissett's records show that he was polite and courteous, and enjoyed doing the work that he was allocated. He became the unit's health and safety representative. Aside from some medical issues, he did not report any problems. He maintained contact with his family, which included visits. He socialised with other prisoners on his unit, Haven Unit, which housed mainly elderly prisoners and those with disabilities.

23. In June 2023, Mr Bissett learned that, due to a geographical exclusion zone put in place for victim protection purposes, he would be unable to return to his marital home address on release and could not live there until the end of his sentence. He would not be allowed within the exclusion zone for any reason without special dispensation. He was upset at the news. Mr Bissett's community offender manager (COM, his allocated probation worker in the community) asked him to consider whether there were any alternative addresses where he could live, but he said that there was nowhere appropriate. She said they would therefore have to apply to the local council. Mr Bissett's daughter contacted Mr Bissett's COM to appeal against the exclusion zone. The COM discussed this with her managers and subsequently referred the issue back to the HMPPS Victims Team asking for them to assess the options further. They did so, and concluded that the exclusion zone was appropriate and should remain in place.

24. On 3 September, Mr Bissett's prison offender manager (POM) saw Mr Bissett for a key work session. Mr Bissett said that he was unhappy at not being able to return to his home on release. The POM told him that the decision had been made, and if he failed to comply Mr Bissett risked being recalled to prison. Mr Bissett said that he understood. He had no other concerns.

25. At the beginning of September, Mr Bissett found out that his brother had died. His record noted that he was coping well. He did not want to attend the funeral with prison officers so asked if he could watch a video stream. This was arranged and on 28 September, Mr Bissett went to the chapel and watched the funeral online. He raised no concerns. On 1 October, a member of the Chaplaincy Department spoke to Mr Bissett to ask how he was in light of his brother's funeral. Mr Bissett said that he was grateful to those in the Department who had helped him through what had been a difficult time.

26. On 5 October, Mr Bissett's COM visited Mr Bissett in Wymott to discuss his release. He remained upset at the exclusion zone. The COM said that she had asked for it to be reconsidered and been told that it would remain in place. She once again asked if he had any other addresses he could go to on release, but Mr Bissett said that there were no alternatives he wanted to consider. The COM told him that on

the day of his release, he should report to her office, and then he would need to go to the council offices who would allocate accommodation outside the exclusion zone.

27. A member of the Chaplaincy Department saw Mr Bissett on 6 October for a follow-up check. He said that he was still coming to terms with his brother's death, and appreciated the support he had received from staff in the Chaplaincy Department.

28. On 8 October, a nurse spoke to Mr Bissett to ensure that his medical needs would be covered in advance of his release, and to check whether he had any health concerns. Mr Bissett said that he was upset about not being able to return to his home. In interview, the nurse said that she had no concerns about Mr Bissett at that stage, and did not think that he required any additional support.

29. On 10 October, Mr Bissett's release paperwork was submitted to the Head of the Offender Management Unit. She asked if the exclusion zone could be revised so a member of her team emailed Mr Bissett's COM asking if it could be reconsidered. The COM again referred this to the Victims Team.

30. At approximately 8.00pm on 11 October, the nurse saw Mr Bissett. She gave him a discharge letter, outlining his medical history, for him to provide to his GP. He said that he had a meeting with the council the following morning about where he would live on release. Once again, in interview the nurse said that she did not have any concerns about Mr Bissett's safety.

31. The COM's manager contacted the Public Protection Operational Policy and Support team in HMPPS to ask if it would be possible for Mr Bissett to live in his home even though it was within the exclusion zone. They informed her that this would not be possible.

32. On 12 October, Mr Bissett had a video meeting with the council housing team. They confirmed his appointment for the day of his release and said that they would arrange hotel accommodation outside the exclusion zone.

33. After his meeting, Mr Bissett spoke to an officer and told her that he would be allocated accommodation at his appointment the next day. In interview, the officer said that he relayed the information to her in a matter-of-fact way, and gave her no indication that he presented a risk to himself. He also spoke to some prisoners. One of them said that Mr Bissett was distressed after his meeting, but that he did not report this to staff. Another prisoner said that Mr Bissett gave no indication that he was upset or a risk to himself.

34. That evening Mr Bissett telephoned his wife. They discussed his pending release the following day. He asked her to bring some identification for him, and some clothes.

13 October

35. Records show that Mr Bissett did not press his cell bell during the night and so staff had no reason to go to his cell. At around 5.10am, during a routine check, an officer was unable to see Mr Bissett through the observation panel. He opened the door and saw Mr Bissett hanging from a pipe by a ligature made from the drawstring of a

pair of jogging trousers. The officer cut the ligature and lowered Mr Bissett to the floor, and at 5.15am, used his radio to call a code blue (a medical emergency code used when a prisoner is unconscious or having breathing difficulties). This prompted the control room to call an ambulance and other staff to attend. Another officer arrived. They moved Mr Bissett out of his cell onto the landing and started CPR. A nurse responded to the emergency call and joined the officers. He said at interview that he thought Mr Bissett was dead and that CPR was futile but that the officers wanted to continue so he let them. They applied a defibrillator, but it found no electrical activity in the heart and told them to continue with CPR. They did so until paramedics arrived and took over. At 5.40am, paramedics declared that Mr Bissett had died.

Contact with Mr Bissett's family

36. Mr Bissett's family had made arrangements to come to the prison to collect him. The Acting Governor wanted to ensure that they were contacted before they set off on their journey. She therefore telephoned Mr Bissett's wife and informed her of what had happened. The Acting Governor and the prison's family liaison officer then travelled to Mr Bissett's wife's address and spoke to her in person. In line with guidance, Wymott offered a contribution to the costs of Mr Bissett's funeral.

Support for prisoners and staff

37. After Mr Bissett's death, the Head of Offender Management 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.

38. The prison held a meeting with prisoners on the Haven Unit to inform them of Mr Bissett's death, and offering support. Listeners (prisoners trained by the Samaritans to provide peer support) were available. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Bissett's death.

Post-mortem report

39. The post-mortem report concluded that Mr Bissett died from hanging.

Findings

Assessment of risk of suicide and self-harm

40. Mr Bissett gave no indication to staff that he was at risk of suicide or self-harm throughout his time at Wymott. He was found hanged the day of his release, which for reasons explored in more detail below was a source of understandable concern for him. However, he did not talk to staff about the extent of his anxiety or distress, and his interactions with others, including his last telephone call to his wife, gave no indication that he was at imminent risk of suicide. We are satisfied that staff could not have foreseen his actions.

Preparation for release

41. Mr Bissett was upset that he was not able to return to his family home on release. He had been aware that this would be the case for some months, and his family had made representations on his behalf. He did not know where he would be living, which he found unsettling.

42. Right up to his scheduled release date, prison and probation staff asked if his exclusion zone could be reconsidered. The request was relayed through senior managers but the exclusion zone remained in place. We found no evidence that correct procedures were not followed.

43. Some of the background work in relation to Mr Bissett's release preparation was not recorded on the case management computer system (DELIUS). This did not affect Mr Bissett's release preparation, but it did mean that not all staff in the prison and in the Probation Service were aware of all contacts that had been made about his release. We did not find anything to suggest that it would have affected the outcome.

Clinical care

44. Mr Bissett was not under the care of the mental health team at any time during his stay at Wymott. The clinical reviewers found that appropriate care planning was in place for the management of Mr Bissett's long term conditions and they concluded that the healthcare provided to Mr Bissett was equivalent to that which he could have expected to receive in the community. They commented that Mr Bissett was managed with compassion and cared for by competent, confident staff.

Head of Healthcare to note

45. When the nurse arrived at Mr Bissett's cell, he thought that Mr Bissett was already dead and that CPR was futile. However, he let the officers continue with CPR until paramedics arrived and assessed that Mr Bissett was dead.

46. European Resuscitation Council Guidelines (2015), which were shared with prison managers in September 2016, introduced new staff guidance about when not to perform CPR. The guidelines state, "Resuscitation is inappropriate and should not be provided when there is clear evidence that it will be futile."

47. Trying to resuscitate someone who is clearly dead is distressing for staff and undignified for the deceased. The nurse should have asked officers to stop CPR when he arrived. We bring this issue to the attention of the Head of Healthcare.

Inquest

48. The inquest, held from 13 to 22 January 2025, concluded that Mr Bissett died by suicide. The jury found that a failure of advance planning prior to 5 October 2023 for accommodation for Mr Bissett on release and insufficient engagement with Mr Bissett by prison offender management and the probation service may have contributed to his death.

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