

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Clive Cocking, a prisoner at HMP Wymott, on 22 October 2024

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



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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.

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 Clive Cocking was found hanged in his cell at HMP Wymott on 22 October 2024. He was 63 years old. I offer my condolences to Mr Cocking's family and friends.

His was the fourth self-inflicted death at Wymott in the past three years and there has been one self-inflicted death since.

Mr Cocking was recalled to prison around seven weeks before he died, and shortly after he had attempted to take his life in the community. Despite clear indicators of heightened risk, staff at HMP Preston did not initially start suicide and self-harm prevention procedures (known as ACCT) following his arrival. When they did start ACCT procedures, they were poorly managed, and some key aspects of national instructions were not followed.

Following his transfer to Wymott, staff managed Mr Cocking's ACCT procedures reasonably well.

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

June 2025

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Summary

Events

1. On 4 September 2024, Mr Clive Cocking was recalled to prison having breached the conditions of his release licence and was taken to HMP Preston. On 2 October, Mr Cocking transferred to HMP Wymott.
2. Mr Cocking had a history of mental health issues, self-harm and suicidal ideation. He had only been released from prison for a week when he lapsed into drinking and attempted to take his own life. Members of the public found him collapsed and Mr Cocking was taken to A&E before being returned to prison.
3. Staff began suicide and self-harm prevention procedures (known as ACCT) the day after Mr Cocking arrived at Preston, which were closed at Wymott on 16 October. Following the closure of ACCT procedures, staff encouraged Mr Cocking to engage with the regime and he told staff that his cellmate supported him. On 21 October, his cellmate transferred to another prison.
4. At around 2.07pm on 22 October, an officer unlocked Mr Cocking's cell and discovered him hanged from the bedframe. Staff started CPR and paramedics continued resuscitation efforts. However, at 2.33pm paramedics confirmed life extinct.

Findings

HMP Preston

5. Although Mr Cocking's Person Escort Record (PER, to highlight risks including of suicide and self-harm) highlighted his recent suicide attempt and a clear intent to end his life, staff did not start ACCT procedures when Mr Cocking first arrived at Preston. When ACCT procedures were started, they were not always managed in line with policy or best practice. There was no oversight by a consistent case co-ordinator, no support actions were identified to reduce or mitigate Mr Cocking's risk of suicide or self-harm and daily entries, when made, lacked meaningful content.

HMP Wymott

6. Staff at Wymott managed Mr Cocking's ACCT procedures reasonably well. Although his cellmate was listed as Mr Cocking's only source of support, no one checked on his welfare when his cellmate was transferred, and staff did not consider whether this meant that his risk of suicide and self-harm had increased.
7. The clinical reviewer found that an assessment completed before Mr Cocking was discharged from the mental health team caseload was not sufficiently detailed and that Mr Cocking should have had a full mental health assessment.
8. There is a significant overuse of medical emergency codes in non-emergency situations at Wymott. This leads to increased workload for emergency responders and potentially dilutes the urgency of emergency codes.

Recommendations

- The Governor and Head of Healthcare of HMP Preston should introduce a robust quality assurance process to ensure that staff consider all available information in reception, including the PER, when considering whether ACCT procedures should be started, and evidence their decision.
- The Governor of HMP Preston should satisfy himself that robust procedures are in place to assess the quality of ACCT procedures, including identifying and correcting practice that is not in line with the Prison Safety Policy Framework.
- The Head of Healthcare of HMP Wymott should ensure that all prisoners subject to ACCT procedures receive a comprehensive mental health and risk assessment to inform future care needs.

The Investigation Process

9. HMPPS notified us of Mr Cocking's death on 22 October 2024.
10. The investigator issued notices to staff and prisoners at HMP Wymott informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
11. The investigator visited Wymott on 29 October. She obtained copies of relevant extracts from Mr Cocking's prison and medical records and spoke to two prisoners who lived in the cell next door.
12. NHS England commissioned a clinical reviewer to review Mr Cocking's clinical care at the prison. The investigator and clinical reviewer jointly interviewed three prison staff and ten members of healthcare staff. In addition, the investigator interviewed a custodial manager and two prison officers from HMP Preston, and Mr Cocking's former cellmate.
13. 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.
14. The Ombudsman's office contacted Mr Cocking's solicitor, his nominated next of kin, and explained the remit of our investigation. Mr Cocking's solicitor confirmed that he had informed Mr Cocking's family of his death and asked if they had any questions for the investigation to consider. They did not ask any specific questions.
15. The prison received a copy of the report. In response to their feedback, we have amended the name of the healthcare provider.

Background Information

HMP Wymott

16. HMP Wymott is a medium security prison in Lancashire for 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 Practice Plus Group. There is 24-hour nursing cover.

HMP Preston

17. HMP Preston is a men's reception prison serving courts in Lancashire.

HM Inspectorate of Prisons

HMP Wymott

18. The most recent inspection of Wymott was in December 2023. Inspectors reported that healthcare services were not good enough, particularly the provision of mental health support for the many vulnerable prisoners at Wymott. At the time of the inspection, there were excessive waits of up to 39 weeks for psychological therapies and over a year to get counselling. Inspectors found that neither the health trust nor commissioners were addressing the level of need within the prison.
19. Inspectors reported that the reception process was comprehensive.
20. Inspectors found the quality of completed ACCT documentation was reasonable, but case reviews often lacked multidisciplinary input. Care plans were limited, which meant that an individual's triggers were not always addressed. Inspectors reported that it was positive that findings from the quality assurance of ACCTs was fed back to the safety meetings, where good practice was highlighted, and the consistency of case management reviewed. However, in the inspector's survey, less than half (42%) of prisoners who had been on an ACCT felt well cared for and those prisoners who inspectors spoke to were also very mixed in their views about the quality of care provided.

HMP Preston

21. The most recent inspection of Preston was in March 2023. Inspectors were positive about the quality of ACCT documents, where quality assurance by leaders meant that the standard was consistently good. However, inspectors identified there was scope for improvements, as some support plans were not as comprehensive as they could be and did not include targets to address all the issues that had been identified.
22. Inspectors reported that the Head of Healthcare was doing an outstanding job and standards had improved markedly since their last inspection, with a strong and proactive staff team working to improve outcomes for a population that had many difficulties with mental health and substance misuse.

Independent Monitoring Board

HMP Wymott

23. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to May 2024, the IMB reported that Wymott continued to suffer the effects of staffing shortages and this had impacted significantly upon prisoners' experiences. The rate of absences among uniformed staff remained one of the highest in the region, putting a strain on the prison's ability to maintain a decent regime.
24. The IMB noted that they routinely monitor ACCT documents and have generally been satisfied that these are being completed appropriately.

HMP Preston

25. In its latest annual report for the year to March 2024, the Board reported that self-harm rates were quite high in comparison with previous years. They found in every case where concerns had been raised about the wellbeing of a prisoner, ACCT procedures were initiated, and quality assured by managers.

Previous deaths at HMP Wymott

26. Mr Cocking was the 32nd prisoner to die at Wymott since October 2021. Of the previous deaths, 26 were due to natural causes, three were self-inflicted, one drug related, and one is awaiting classification. To the end of March 2025, there have been three more natural cause deaths, one self-inflicted death and one where the cause is currently unascertained.

Assessment, Care in Custody and Teamwork

27. Assessment, Care in Custody and Teamwork (ACCT) is the care planning system the Prison Service uses to support prisoners at risk of suicide or self-harm. The purpose of the ACCT is to try to determine the level of risk posed, the steps that staff might take to reduce this and the extent to which staff need to monitor and supervise the prisoner. Checks should be made at irregular intervals to prevent the prisoner anticipating when they will occur.
28. Part of the ACCT process involves assessing immediate needs and drawing up support actions to identify the prisoner's most urgent issues and how they will be met. Staff should hold regular multidisciplinary reviews and should not close the ACCT plan until all support actions are completed. Guidance on ACCT procedures is set out in the Prison Safety Policy Framework (from January 2025, and prior to that Prison Service Instruction (PSI) 64/2011 on safer custody).

Imprisonment for Public Protection (IPP)

29. IPP sentences were introduced in 2005 and abolished in 2012. They were intended to protect the public against offenders whose crimes were not serious enough to merit a normal life sentence, but who could only be released once they had served

their minimum tariff and had demonstrated to the satisfaction of the Parole Board that they had sufficiently reduced their risk.

Licence recall

30. When prisoners are released on licence, they are required to keep to certain conditions while serving the remainder of their sentence in the community. Released prisoners on licence are supervised by probation services.
31. When released, the prisoner is given a copy of their licence with all the conditions they must follow. If they do not keep to the conditions of their licence, are charged with another crime, or behave in a way that causes their probation officer concern, the licence can be revoked, and the offender recalled to prison. For those serving determinate sentences, the recall can be for 28 days (known as a fixed term recall) or to serve the remainder of the original sentence (known as a standard recall). However, those serving an IPP sentence are not given a release date and the Parole Board decides when they are deemed suitable for release. Prisoners are given the reasons for their recall and can make written appeals to the Parole Board.

Key Events

Background

32. On 4 March 2011, Mr Clive Cocking was sentenced to an Imprisonment for Public Protection (IPP) sentence and required to serve at least seven years for attempted murder and child cruelty. He had been to prison before. Mr Cocking spent time at HMP Preston, HMP Leicester and HMP Rye Hill before he was transferred to HMP Grendon in December 2012.
33. Mr Cocking had several physical health conditions for which he was prescribed medication and received treatment, including having a pacemaker fitted.
34. In April 2003, a doctor diagnosed that Mr Cocking had mixed anxiety and depressive disorder. He was prescribed an antidepressant (sertraline). Before he went to prison, Mr Cocking had been admitted to hospital under the Mental Health Act on several occasions, which he said was linked to his alcohol use and depression.
35. Mr Cocking also had a long history of self-harm and suicidal behaviour in prison, dating back to 2012. In total, between January 2012 and February 2019, Mr Cocking was supported by ACCT procedures on at least seven occasions, following statements of intent to take his own life, low mood, an overdose and being found with tied ligatures (on one occasion he was taken to hospital for treatment). His prison record detailed that Mr Cocking's self-harming behaviour coincided with him being unable to appropriately manage his emotions.
36. On 27 August 2024, Mr Cocking was released on licence from Grendon and required to reside at Bradshaw House Approved Premises (AP). Mr Cocking was recalled to prison on 1 September, for failing to return to Bradshaw House AP and breaching his licence conditions.

Recall to custody

37. On 1 September, Mr Cocking failed to return to Bradshaw House AP. On 2 September, he travelled to a remote local beauty spot (Darwen Tower) with the intention of taking his own life, having consumed a large amount of alcohol. Members of the public found Mr Cocking collapsed, after he had overexerted himself walking, and alerted the emergency services, who took him to A&E. On 4 September, Lancashire Police took Mr Cocking to HMP Preston as his licence had been revoked.

HMP Preston

38. On his Person Escort Record (PER - a document that accompanies all prisoners when they move between police stations, courts and prisons which sets out the risks they pose), police recorded:

"They [Mr Cocking] have said they will self-harm or commit suicide – Daily thoughts of suicide. Tried to hang self 02.09.24 but grass below and failed. Today took a noose up Darwen Tower, was seen by mounted division who took

rope off him. States will rip pacemaker out of heart if left in cell. Sectioned five times in the past. Constant watch.”

39. Reception staff processed Mr Cocking when he arrived, but there are no entries on his prison record and no evidence that they considered the information in the PER. The desk officer in reception recorded that an officer in the first night centre had completed Mr Cocking’s first night interview and had no issues or concerns about Mr Cocking and that he had no thoughts of suicide or self-harm. (The officer did not make a record of the first night interview.) There is no evidence that anyone considered the information contained in the PER, or other risk factors, or considered starting ACCT procedures.
40. A nurse completed a reception health screen which identified that Mr Cocking had some withdrawal symptoms from alcohol. A doctor prescribed Mr Cocking’s sertraline medication and a course of medication to alleviate alcohol withdrawal symptoms. Mr Cocking was referred to both the mental health team and substance misuse services at Preston. There is no evidence that the nurse considered the information from the PER.
41. On 5 September, Mr Cocking complained of chest pains. While healthcare staff assessed him, he handed them a ligature and said that he wanted to die by any means. Staff started ACCT procedures, with observations set at three an hour.
42. An officer completed Mr Cocking’s ACCT assessment. Mr Cocking disclosed that he had not eaten since 1 September, had not slept properly and shared his experience of being sexually abused in prison some years earlier. Mr Cocking said that he wanted to move to the vulnerable prisoners’ unit (VPU – where prisoners who have committed sexual offences or who are at threat from others live).
43. On 6 September, prison staff found Mr Cocking unresponsive on his cell floor and radioed a code blue medical emergency (used to indicate when someone is unresponsive or not breathing). Mr Cocking went to hospital, where he was assessed. All his clinical observations were normal, and he returned to Preston the following day. He was monitored by healthcare staff on his return and his physical observations were all within normal range. Healthcare staff noted that Mr Cocking disclosed he had pulled at his pacemaker as he wanted a move to the VPU. Staff increased the frequency of ACCT observations to four an hour.
44. On 7 September, Mr Cocking attended his first ACCT review, chaired by a Custodial Manager (CM). A mental health nurse also attended. Mr Cocking told the ACCT review panel that his main concern was a move to the VPU. The CM made immediate arrangements for this to be authorised, and Mr Cocking moved straight to the VPU. The ACCT case review continued in the VPU and Mr Cocking thanked staff for facilitating his move. He said that he had no ongoing thoughts of suicide or self-harm. Mr Cocking told the review he would start eating and taking his prescribed medications. Observations remained at four an hour, with three meaningful conversations per day. No support actions to mitigate or reduce Mr Cocking’s risk were recorded.
45. Over the next two weeks, staff twice reviewed Mr Cocking’s ACCT. Mr Cocking reported feeling calmer since his move to the VPU and took his medications as prescribed. On 9 September, observations were reduced to twice an hour and, on

16 September, observations were reduced to hourly. No support actions were recorded.

46. On 21 September, an officer met Mr Cocking for a key work session. She recorded that Mr Cocking attended education in the mornings, but typically stayed in his cell watching television or played dominoes with a select few prisoners in the afternoons. Mr Cocking told her that he had stopped taking his medications but gave no reason why. She informed healthcare staff.
47. A nurse then assessed Mr Cocking and concluded that he had the capacity to refuse his medications and that he was aware of the associated risks in doing so. The next day, the mental health team discussed Mr Cocking's refusal, noted that he had the capacity to make the decision and referred him for a mental health review.
48. On 23 September, a CM chaired an ACCT case review attended by an officer and Mr Cocking; nobody from the mental health team attended. The CM noted that Mr Cocking did not fully engage with the review, appeared despondent and said that he believed refusing his medications would be enough to end his life. He increased observations to three an hour, but no support actions were recorded.
49. On 27 September, a CM chaired an ACCT case review with Mr Cocking; nobody else attended. She noted that Mr Cocking wanted to end his life and he believed this would be achieved by refusing his heart medications. Observations remained three times an hour and no support actions were recorded.
50. On 29 September, a mental health nurse assessed Mr Cocking. He recorded that Mr Cocking appeared very low in mood and at times tearful. Mr Cocking said he had had enough and did not want any help. He had ongoing thoughts of ending his life, but no specific plans or intent. Mr Cocking said that he got on well with staff and his cellmate, who provided support. He agreed to a referral for counselling but continued to refuse his medication.
51. On 1 October, a counsellor working within the mental health team saw Mr Cocking to discuss the referral for counselling. Mr Cocking told her that he did not feel like speaking and that counselling had not previously worked. Mr Cocking said he felt down about his recall and would engage with an assessment on another day. She agreed to visit him again within the next week.
52. The Prison Service Population Management Team identified that Mr Cocking fitted the criteria for a move to Wymott, to free up spaces at Preston. On 2 October, healthcare staff assessed Mr Cocking as fit to be transferred. Before he left Preston, a CM completed an ACCT case review. He noted that Mr Cocking was unhappy moving as he felt settled at Preston and continued to feel aggrieved that he had been recalled. Preston completed an ACCT Annex Q form, which staff emailed to Wymott before Mr Cocking arrived, detailing his ACCT history. Escort staff were given a supply of Mr Cocking's medication.

HMP Wymott

53. When Mr Cocking arrived at Wymott, a CM completed an ACCT case review, which two nurses from the mental health team attended. The ACCT panel noted that Mr Cocking stated his intent to continue refusing his heart and antidepressant

medication and that he had active thoughts of suicide. Observations remained at three an hour with a review scheduled for the following day.

54. A nurse completed Mr Cocking's initial health screen. She noted Mr Cocking's history of self-harm and recent suicide attempt. Mr Cocking told her that he felt anxious about his transfer and that he would continue to refuse medication. She noted that all of Mr Cocking's clinical observations were within normal range, and she referred him to the mental health team for assessment. She completed a medication in-possession risk assessment, which identified that Mr Cocking should not hold any medications in possession (meaning he would need to collect them each day from the medications hatch on his wing).
55. On 3 October, Mr Cocking attended an ACCT case review chaired by a CM, which a mental health nurse attended. Mr Cocking spoke at length about the events leading up to his recall and said that refusing his medication was a rebellious act against the Probation Service. Mr Cocking told the review panel that he had spent the night thinking about this, had slept well and that he wanted to take responsibility for his actions.
56. Mr Cocking reported that he had taken his prescribed medications that morning and now planned to continue to take them. He said that his cellmate was supportive and he felt able to speak freely to him when needed. Mr Cocking said he had no current thoughts or plans of suicide or self-harm. He asked for a move to the older prisoner unit (I Wing) as this would enable him to attend less strenuous jobs. The CM said he would make enquiries about a move. The CM confirmed that Mr Cocking was on the Wellman Assessment waiting list (a screening assessment for mental health conditions). He referred Mr Cocking to the drug and alcohol recovery service (DARS). The ACCT review panel agreed that observations should be reduced to a minimum of once an hour. Three support actions were recorded: Mr Cocking to engage with the mental health team during his Wellman Assessment; continue taking his critical medications for depression and heart problems; and that he should engage with DARS. The CM listed Mr Cocking's cellmate as his only source of support (Mr Cocking was not in contact with any family or friends while in prison).
57. On 5 October, a recovery practitioner from DARS completed an initial assessment with Mr Cocking. She completed a history of Mr Cocking's alcohol use, left him information to work through and did not identify any issues. She told Mr Cocking that a further assessment would be completed by 5 November.
58. On 8 October, a mental health nurse met Mr Cocking and completed his Wellman Assessment. As part of this assessment, she obtained a brief history of Mr Cocking's mental health and previous suicide and self-harm attempts. Mr Cocking denied any current thoughts and said he felt low being back in prison. Mr Cocking gave a brief personal history and talked about traumatic experiences from his past. She suggested to Mr Cocking that he could have therapy related to past trauma, but he declined as he had not found it helpful in the past. She concluded that Mr Cocking did not require any further input from the mental health team.
59. On 9 October, a DARS recovery practitioner met Mr Cocking as part of his induction to Wymott. She noted that he appeared well, had already signed up to work with DARS and that someone had been allocated as his recovery practitioner. Mr Cocking said he struggled with alcohol and, although he did not drink while in

prison, he was aware that he had relapsed soon after release. She had no concerns about his mental health and provided Mr Cocking with harm reduction advice.

60. Later, Mr Cocking attended an ACCT case review, chaired by a CM in the first CM's absence. Nobody else attended. Mr Cocking said that he wanted to move to I Wing as he did not like being around younger prisoners, but had no other issues. The CM noted that she would send an email regarding a wing move and that Mr Cocking had no current thoughts of suicide or self-harm. Observations were reduced to one each morning, afternoon and evening.
61. The next day, during a mental health team multi-disciplinary meeting, Mr Cocking's discharge from their service was confirmed. They sent him a letter advising him of the decision and how to get in contact with the service again should he need to.
62. On 12 October, an officer met Mr Cocking for a key work session. He noted that Mr Cocking worked in the laundry, appeared much more settled and got on very well with his cell mate. Mr Cocking said he felt happier at Wymott than when at Preston and had no issues.
63. On 16 October, the original CM chaired an ACCT review, which Mr Cocking and a wing officer attended. Prior to the review, the CM contacted the mental health team to invite them to attend but, because of the outcome of the Wellman Assessment and Mr Cocking having been discharged from their service, they declined. The review panel noted that Mr Cocking appeared more positive, that he was sleeping well and had support from his cell mate and DARS. Mr Cocking reported that he took his medications and had no thoughts of suicide or self-harm. The panel noted all support actions had been completed, agreed to close the ACCT procedures and scheduled a post closure review for 23 October.
64. On 18 October, Mr Cocking refused to attend work in the laundry, but there is no explanation recorded. This is the last entry in Mr Cocking's prison record.
65. At around 11.20am on 21 October, Mr Cocking's cell mate left the wing and went to Reception, as he was transferring to another prison. The cell mate told us that he had never seen Mr Cocking in a low mood or in crisis and that he had no concerns about him. They shook hands and Mr Cocking wished him well. There is no evidence that staff spoke to Mr Cocking about or otherwise considered the potential impact of his cellmate transferring. Mr Cocking remained the sole occupant of the cell.

Events of 22 October

66. The investigator watched closed circuit television (CCTV), body worn video camera footage (BWVC) and listened to staff radio communications from 22 October. She also obtained information from North West Ambulance Service. The following account has been taken from all sources.
67. At 11.57am, Officer A unlocked Mr Cocking's cell so he could collect his lunch. A minute later, Mr Cocking left his cell, collected his lunch and, at 12.01pm, she locked him back into his cell.

68. At around 2.00pm, Officer A started to unlock prisoners and, three minutes later, arrived at Mr Cocking's cell. She looked through the observation panel and saw Mr Cocking sitting on the floor. When she unlocked the door, she found Mr Cocking hanging from his bedframe and cut the ligature. She radioed a code blue medical emergency stating "ligature" and confirmed that Mr Cocking was unresponsive and not breathing. The communications room operator called an ambulance immediately.
69. The emergency response nurse responded to the code blue and asked over the radio if Mr Cocking was breathing. The control room operator responded, "That's a negative". The nurse incorrectly interpreted this as the control room not providing further information on the situation.
70. Officer B went to the cell and assisted Officer A. They checked for a pulse and Officer A began CPR. A mental health nurse on the wing and other officers also responded and staff took it in turns to deliver CPR.
71. At around 2.09pm, the emergency response nurse arrived at Mr Cocking's cell. She asked someone to fetch the wing defibrillator, which was then attached to Mr Cocking and indicated there was no shockable rhythm. At 2.20pm, paramedics arrived at Mr Cocking's cell. They moved him to the landing where there was more space and they continued CPR. At 2.33pm, paramedics confirmed life extinct.

Contact with Mr Cocking's family

72. Mr Cocking did not have a nominated next of kin. Lancashire Police and the Coroner were informed and later a family solicitor confirmed that he had informed Mr Cocking's family of his death. In line with Prison Service instructions, the prison contributed towards the costs of Mr Cocking's funeral, which was held on 13 November.

Support for prisoners and staff

73. Postvention is a joint HMPPS and Samaritans initiative that aims to ensure a consistent approach to providing staff and prisoners support following all deaths in custody. Postvention procedures should be initiated immediately after every self-inflicted death and on a case-by-case basis after all other types of death. Key elements of postvention care include a hot debrief for staff involved in the emergency response and engaging Listeners (prisoners trained by the Samaritans to provide confidential peer-support) to identify prisoners most affected by the death.
74. After Mr Cocking's death, the acting Governor and duty governor debriefed the prison 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. Healthcare staff attended a separate debrief with their manager. At the time of Mr Cocking's death Wymott did not have TRiM trained staff (trauma informed management), but 12 staff were trained to deliver this support on 4 & 5 December 2024.

75. Wymott contacted the Cumbria & Lancashire Group Safety Team who, together with the North West Wellbeing Team, visited the prison on 19 December. They undertook a floor walking exercise with staff, offering further support and advice.
76. The prison posted notices informing other prisoners of Mr Cocking'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. Samaritans and Listeners were quickly notified of the death and provided support to prisoners.
77. HMP Risley were notified of Mr Cocking's death, and they broke the news to the former cell mate. He said he felt well supported.

Post-mortem report

78. The pathologist concluded that the cause of Mr Cocking's death was hanging.

Findings

Identifying the risk of suicide or self-harm

79. At the time of Mr Cocking's death, Prison Service Instruction (PSI) 64/2011 governed ACCT suicide and self-harm prevention procedures, which required all staff who have contact with prisoners to be aware of the risk factors and triggers that might increase the risk of suicide and self-harm and take appropriate action. (This has now been superseded by the Prison Safety Policy Framework implemented on 1 January 2025 – the principles of how an ACCT is managed remain largely unchanged.) Any prisoner identified as at risk of suicide or self-harm must be managed under ACCT procedures. We have considered whether staff at Preston and Wymott appropriately managed the ACCT and if staff at Wymott should have re-started ACCT procedures to support Mr Cocking in the time before his death.
80. Mr Cocking had some important risk factors for suicide and self-harm. He had a history of self-harm and suicide attempts, including a suicide attempt in the time shortly before his recall to prison, and he did not know when he would be released again. He had a mental health diagnosis, albeit relatively low-level, and was prescribed medication for this. A potential trigger emerged the day before Mr Cocking died when his cell mate, who he had often described as supportive, in the absence of other sources of support, transferred to another prison. (This happened while Mr Cocking was in the ACCT post closure phase.)

HMP Preston

81. Mr Cocking arrived at Preston with a PER detailing a recent suicide attempt and that he had daily thoughts of suicide. Neither the reception officer nor the reception nurse started ACCT procedures and did not make an entry in Mr Cocking's prison or healthcare record to justify their decision. Although ACCT procedures were started the next day, when Mr Cocking handed staff a ligature, we are concerned that reception staff did not do so despite such clear evidence of high risk.
82. Mr Cocking told staff that he had no thoughts to harm himself, but there were other obvious risk factors. A prisoner's presentation reveals something of their level of risk, but it is only one piece of evidence in assessing overall risk. Staff should make a considered, objective evaluation of all risk factors when assessing the risk of suicide and self-harm. We make the following recommendation:

The Governor and Head of Healthcare of HMP Preston should introduce a robust quality assurance process to ensure that staff consider all available information in reception, including the PER, when considering whether ACCT procedures should be started, and evidence their decision.

83. PSI 64/2011 and accompanying user guidance says that a consistent case co-ordinator is responsible for chairing ACCT case reviews. The Prison Safety Policy Framework says that a case co-ordinator must be allocated to a prisoner for the duration of their ACCT support to conduct all ACCT case reviews (unless in exceptional circumstances when they are not available).

84. PSI 64/2011 and the Prison Safety Policy Framework also say that the case review team must set and review support actions, to mitigate and lower risk.
85. During their inspection in March 2023, HMIP inspectors were positive about the quality of ACCT documents at Preston and found the standard consistently good. However, they also reflected there was scope for improvement and support plans were not as comprehensive as they should be. We identified issues with ACCT management. ACCT procedures were not managed by a single case co-ordinator to ensure consistency. Mr Cocking's ACCT was reviewed six times at Preston, by five different case co-ordinators. Significantly, there were no support actions identified at Preston to help reduce Mr Cocking's risk. (Support actions might have been set to consider factors such as Mr Cocking's decision to stop taking his medication.)
86. We also found that records of meaningful conversations lacked detail or were not completed at all. Not all summaries or supervisor checks were completed, making it harder to identify any issues with the day-to-day management of the ACCT procedures. We make the following recommendation:

The Governor of HMP Preston should satisfy himself that robust procedures are in place to assess the quality of ACCT procedures, including identifying and correcting practice that is not in line with the Prison Safety Policy Framework.

HMP Wymott

87. At Wymott, Mr Cocking's ACCT was broadly well managed. Staff closed the ACCT procedures on 16 October, which we found reasonable. Support actions (which were appropriately set at the first case review after Mr Cocking's arrival) had all been completed, and although the mental health team did not attend the case review, a CM contacted them for their input beforehand. It was noted that Mr Cocking's main source of support was his cellmate.
88. When Mr Cocking's cellmate transferred, staff said that they had planned to find him a new one. However, there was no evidence that anyone considered whether this might indicate an increase in Mr Cocking's risk of suicide and self-harm, and there is no evidence that anyone considered whether the ACCT should be reopened, in the interim to finding him a new cell mate. There is also no evidence that a member of staff spoke to Mr Cocking about his cellmate's move, checked his welfare, or spoke to him about what would happen next. The only source of support listed for Mr Cocking was having a cellmate and so this should have been prioritised.

Mental Health

89. Mr Cocking had a long history of low mood, self-harm incidents and before his recall had intended to take his own life.
90. On 8 October, a nurse completed the Wellman Assessment, which is a brief overview of mental health and not a comprehensive assessment. As a result of this brief assessment, Mr Cocking was discharged from the mental health team caseload. The clinical reviewer found that a more comprehensive mental health assessment should have been undertaken by the mental health team. He found that the Wellman Assessment was not sufficient to base a decision on Mr Cocking's

ongoing mental health need, and that a more comprehensive assessment should have been undertaken, involving a risk assessment as recommended in NICE Guidance NG66 (Mental Health of Adults in Contact with the Criminal Justice System). We make the following recommendation:

The Head of Healthcare of HMP Wymott should ensure that all prisoners subject to ACCT procedures receive a comprehensive mental health and risk assessment to inform future care needs.

Governor and Head of Healthcare to Note

Emergency response

91. PSI 03/2013, *Medical Emergency Response Codes*, sets out the actions staff should take in a medical emergency. It requires all prisons to have a medical emergency response code protocol in place to ensure a timely, appropriate, and effective response to medical emergencies. When a medical emergency is discovered, staff should call the appropriate medical emergency code straightaway so that relevant staff are alerted, the correct equipment is brought, and an ambulance is called immediately.
92. While Wymott have their own protocol that largely reflects national guidance, (re-issued as a Notice to Staff 254/2024 on 13 September 2024), the wording and information contained is overly complicated and does not give clear advice or instructions. The policy says that the person discovering someone in a potentially life-threatening situation is responsible for requesting an ambulance, although then goes on to say that this will be done by the control room. The policy does not mention code red or code blue emergency codes until the bottom of the first page and says:

“You should also request that Hotel 2 attend, this time indicating Code Blue for breathing difficulties or collapses or Code Red for blood loss or burns. Where it is thought that the situation is critical or the individual is not breathing then start your transmission with ‘Urgent Message’.”
93. The emergency codes are meant to be radioed in any potentially life-threatening situation and the transmission of urgent message should be unnecessary if the emergency medical codes are used correctly.
94. When staff found Mr Cocking, the correct procedure with calling an appropriate code and requesting an ambulance was followed. The emergency nurse responded to the emergency code, but it took her around six minutes to arrive.
95. During interview all healthcare staff said that the routine and overuse of medical emergency codes led to increased workload, diluted the urgency of code blues specifically and potentially diverted resources away from those genuine emergencies. Healthcare staff said prison staff radioed code blues for prisoners under the influence of illicit substances, but who clearly were not in a potentially life-threatening situation. The Head of Healthcare confirmed that on the day Mr Cocking died, 16 code blues had been radioed, when only two met the criteria for requesting an ambulance. It is possible that the overuse of emergency radio codes influenced the emergency nurse’s interpretation of the advice she was given about whether Mr

Cocking was breathing. The Governor and Head of Healthcare will wish to ensure that staff properly understand the circumstances in which emergency codes should be used.

ACCT training

96. We identified that only around one third of healthcare staff had received mandatory Suicide and Self-harm Awareness training (commonly referred to as ACCT training). While we know that both the Governor and Head of Healthcare are aware of this issue, they should ensure all staff are trained as soon as possible.

Person Escort Record (PER)

97. During our investigation we were told that healthcare staff do not routinely have access to PERs when prisoners arrive in reception at Wymott. PERs contain vital information that should be considered when a prisoner first arrives, including information about their medical history and if there are any markers for suicide or self-harm.

Emergency response bag

98. We identified that the emergency response bag the nurse carries does not contain all emergency medical equipment, but contains a range of medical equipment (bandages, plasters, dressings). The emergency bags are kept in the treatment rooms on each wing and because they contain medications, can only be accessed by healthcare staff. (The defibrillators are kept in the wing office and accessible to all staff.) The clinical reviewer noted that this presents a risk, particularly overnight when there is only one nurse on duty.

Immediate debrief

99. There was no collective debrief with all the staff involved after Mr Cocking's death. The Governor and duty governor debriefed the prison staff involved in the emergency response and healthcare staff were invited to attend. During interview we were told healthcare staff were encouraged to return to the healthcare centre for a separate debrief. The Head of Healthcare said that if staff had wanted to attend the prison-led debrief they could have. Giving staff the opportunity to collectively discuss an incident and reflect on all aspects of how it was managed is fundamental to providing the prison with feedback on any issues that need to be addressed.

Inquest

100. The inquest into Mr Cocking's death concluded on 21 September 2026 and recorded a verdict of suicide by hanging.



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