

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Karl Saunders, a prisoner at HMP Wymott, on 28 September 2025

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 Karl Saunders was found hanged in his cell at HMP Wymott on 28 September 2025. Staff and paramedics tried to resuscitate him but were unsuccessful. He was 51 years old. I offer my condolences to Mr Saunders' family and friends.

Mr Saunders had regular meetings with the mental health team and frequently told them he was having suicidal thoughts, but that he had no plans to act on them. Around two weeks before he died, he told his mental health nurse that his suicidal thoughts had increased. However, the nurse did not start suicide and self-harm procedures (known as ACCT).

Although the nurse said she was aware of ACCT from colleagues, she had not received formal ACCT awareness training. Nor had other mental health staff that worked with Mr Saunders. More needs to be done to ensure that everyone who works at the prison is aware of their responsibilities to start ACCT procedures when a prisoner is at risk of suicide or self-harm.

The clinical reviewer found that the mental healthcare Mr Saunders received was only partially equivalent to that which he could have expected to receive in the community.

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

Adrian Usher
Prisons and Probation Ombudsman

May 2026

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Summary

Events

1. On 19 June 2024, Mr Karl Saunders was sentenced to 11 years imprisonment for sexual offences, false imprisonment and assault. On 12 July, he was moved to HMP Wymott.
2. Mr Saunders had a personality disorder, PTSD and mixed anxiety and depressive disorder. He had a history of self-harm and suicide attempts. He was prescribed antidepressant and antipsychotic medication.
3. The mental health team saw Mr Saunders regularly and during several meetings, he told staff he was having suicidal thoughts but would never act on them. He said his partner was a strong protective factor.
4. On 15 May 2025, Mr Saunders told his psychological wellbeing practitioner (PWP) that his relationship had ended. He said he and his former partner would remain in touch and that she was still a source of support.
5. Over the next few months, during meetings with his PWP and mental health nurse, Mr Saunders continued to say that he was having suicidal thoughts but that he had no plans to act on them.
6. On 12 September, in a meeting with his mental health nurse, Mr Saunders said he had been feeling low since the breakdown of his relationship and that his suicidal thoughts had increased. The mental health nurse discussed with Mr Saunders whether he needed the support of suicide and self-harm procedures (known as ACCT) but he said he would find this disruptive and unhelpful. He told the nurse he could manage his thoughts and had no plans to act on them. The nurse did not start ACCT procedures.
7. At around 9.22pm on 28 September, during a routine check of all prisoners, an officer found Mr Saunders hanged from the bars of his cell window. The officer radioed a medical emergency code, cut the ligature and started CPR which was continued by nurses when they arrived.
8. At around 9.41pm, paramedics arrived and continued CPR. However, at 9.48pm, they pronounced life extinct.

Findings

9. Despite Mr Saunders reporting an increase in his suicidal thoughts on 12 September, the nurse decided that ACCT monitoring was not necessary. She made the decision without consulting senior healthcare staff or prison staff. The clinical reviewer considered that a multidisciplinary approach would have resulted in a better informed decision.
10. Although the nurse was aware of ACCT from shadowing colleagues, she had not received ACCT awareness training. Nor had Mr Saunders' PWP.

11. The clinical reviewer concluded that the mental healthcare Mr Saunders received was not of the required standard and only partially equivalent to that which he could have expected to receive in the community. He found no evidence of a safety plan or appropriate escalation of risk when Mr Saunders' suicidal thoughts increased.

Recommendations

- The Governor and Head of Healthcare should ensure that all staff working at Wymott (both directly and non-directly employed) receive ACCT awareness training so they understand their role and responsibility should they have concerns about a prisoner's risk of suicide and self-harm.
- The Head of Healthcare should ensure that all members of the mental health team receive adequate training in safety planning, and that patients presenting with suicidal ideation are provided with a comprehensive safety plan at an early stage.

The Investigation Process

12. HMPPS notified us of Mr Saunders' death on 29 September 2025.
13. 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.
14. The investigator visited Wymott on 9 October. She obtained copies of relevant extracts from Mr Saunders' prison and medical records. She also watched CCTV and obtained body worn video camera (BWVC) footage of the emergency response, the HMPPS Early Learning Review and Ambulance Service records.
15. NHS England commissioned an independent clinical reviewer to review Mr Saunders' clinical care at the prison.
16. The investigator interviewed two members of staff by video call on 9 December. The clinical reviewer joined her for one of the interviews.
17. We informed HM Coroner for Preston and West Lancashire of the investigation. We have sent the Coroner a copy of this report.
18. The Ombudsman's office contacted Mr Saunders' next of kin to explain the investigation and to ask if she had any matters she wanted us to consider. She did not raise any concerns but said she would like a copy of the report.
19. We shared our initial report with HMPPS and the prison's healthcare provider, Practice Plus Group. They found no factual inaccuracies and their action plan is an additional annex to this report.
20. We also shared the initial report with Mr Saunders' next of kin. She did not make any comments.

Background Information

HMP Wymott

21. HMP Wymott is a category C training prison for adult men. 60% of the population is prisoners convicted of a sexual offence. Most of the prisoners are serving sentences of four or more years. Practice Plus Group provides healthcare services. There is 24-hour nursing cover.

HM Inspectorate of Prisons

22. 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.
23. Inspectors found that a recommendation made following the last full inspection, that all staff should be appropriately trained in ACCT processes, so that they could support prisoners at risk effectively and address underlying issues, had not been achieved.

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 ending 31 May 2025, the IMB reported that referrals to the mental health team increased during 2024-2025 and that approximately 100 prisoners were case loaded across five mental health nurses in February 2025, with another 20 receiving psychological services. They found that the main issues that concerned prisoners were delays in getting to see a mental health nurse, wanting to be recommended for a single cell, and access to medication for ADHD.

Previous deaths at HMP Wymott

25. Mr Saunders was the 34th prisoner to die at Wymott since September 2022. Of the previous deaths, 27 were from natural causes, four were self-inflicted and two were drug related. Up to the end of February 2026, there have been four further deaths, one self-inflicted, two from natural causes and one that is still awaiting classification.

Assessment, Care in Custody and Teamwork (ACCT)

26. 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.

27. 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).

Key Events

28. On 11 June 2024, Mr Karl Saunders was remanded in prison, charged with sexual offences, false imprisonment and assault. On 19 June, he was sentenced to 11 years in prison. He was sent to HMP Altcourse. It was not his first time in prison.
29. Mr Saunders had a history of mental health issues and was diagnosed with a personality disorder, PTSD and mixed anxiety and depressive disorder. He was prescribed olanzapine (an antipsychotic), mirtazapine (an antidepressant) and propranolol (a beta blocker that can be used to treat anxiety as well as heart problems) to manage his mental health.
30. On 21 June, staff started suicide and self-harm prevention procedures (known as ACCT) for Mr Saunders after he said he was having suicidal thoughts due to the shock about the length of his sentence. During his ACCT review he told staff about his history of mental health issues including previous suicide attempts, self-harm and an admission to a psychiatric unit in 2020.
31. On 28 June, during his next ACCT review, Mr Saunders said he had the support of his partner and was coming to terms with his sentence. Staff stopped ACCT monitoring on 2 July.

HMP Wymott

32. On 12 July, Mr Saunders was moved to HMP Wymott.
33. On 29 July, a mental health nurse saw Mr Saunders to complete a well man mental health screen.
34. On 1 August, staff discussed Mr Saunders at the mental health multidisciplinary team meeting (MDT) and agreed he would be referred to the psychiatrist.
35. On 29 August, a psychiatrist saw Mr Saunders for a mental health and medication review. During the meeting Mr Saunders talked about his PTSD after an accident at work in 2009 and said he suffered frequent nightmares and panic when he heard loud banging. Mr Saunders told the psychiatrist that he was detained under the Mental Health Act in 2020 for around six months after an attempt to hang himself as well as other admissions previously. The psychiatrist increased Mr Saunders' propranolol dose and recommended that he was placed on the mental health team's caseload for therapy options to be considered.
36. A nurse saw Mr Saunders on 14 October, 4 November and 11 November.
37. On 20 February 2025, the psychiatrist saw Mr Saunders for a review. Mr Saunders said he had been "up and down" and that he had occasional thoughts of suicide but said he had no plans to act on them. He described his partner as a strong protective factor and said they were in daily phone contact. The psychiatrist recorded that talking therapy should be explored as an option for Mr Saunders to address his emotional dysregulation and distress tolerance.

38. In a mental health MDT meeting on 27 February, staff agreed that Mr Saunders would be referred to the psychology team for an initial assessment.
39. On 19 March, Mr Saunders attended a meeting with an assistant psychologist. Mr Saunders said his main concern was his low mood and anxiety which he said he experienced most days. The assistant psychologist noted a plan to discuss his case with the single point of access (SPOA) (a centralised system that coordinates and simplifies the process of accessing healthcare services) to decide who would be best placed to support Mr Saunders.
40. On 20 March, healthcare staff discussed Mr Saunders again at the mental health MDT. A plan was agreed for him to be added to the psychological wellbeing practitioner's (PWP) waiting list.
41. On 1 May, the PWP met with Mr Saunders. Mr Saunders said he was taking one day at a time but that this was a struggle for him at times. He said various factors led him to feel overwhelmed and sometimes battling to come out of his cell. Mr Saunders talked about his mental health issues and PTSD. He told the PWP that he attended a cognitive behavioural therapy (CBT) course for trauma in 2013 but said that further support and treatment would be helpful. Mr Saunders said that he had thoughts around suicide and self-harm but said he would not act on them due to his partner being a huge protective factor.
42. On 8 May, Mr Saunders attended another meeting with the PWP. He told her that he had had a difficult weekend with strong suicidal thoughts but had managed by talking to his partner. Mr Saunders told the PWP that his partner was a good source of support. The PWP gave Mr Saunders some strategies and techniques to help with overthinking.
43. On 15 May, the PWP saw Mr Saunders again and during their meeting he told her that his relationship had broken down. The PWP noted that his relationship had been a protective factor and she asked Mr Saunders about any thoughts of suicide or self-harm. Mr Saunders told her that he did have thoughts but said he would not act on them. He said he would remain in contact with his former partner as a friend and said she was still a source of support.
44. On 16 May, a mental health nurse went to the wing to introduce herself to Mr Saunders as his allocated mental health worker. Mr Saunders told the mental health nurse that his mood had been up and down and that his partner had ended their relationship the previous week. They discussed his medication and Mr Saunders asked for an increase in his propranolol to manage his anxiety symptoms. Mr Saunders told the mental health nurse that he was not willing to attend the healthcare unit due to his anxiety so she agreed to ask the GP to increase the propranolol dose (which she did that day). The mental health nurse noted that Mr Saunders appeared low in mood.
45. On 21 May, the mental health nurse created a care plan for Mr Saunders which said that she would see him at regular intervals to continually assess, monitor and review his mental health and risk. It also said that Mr Saunders should report any early warning signs of a deterioration in his mental health to staff.

46. On 22 May, the PWP met with Mr Saunders and he said his thoughts of suicide and self-harm remained but he had no intention to act on them.
47. On 29 May, the PWP met with Mr Saunders. He told her he had had some positive days and had increased the time he spent mixing with other prisoners (association time). He told the PWP that he was still in touch with his former partner and that she remained supportive. Mr Saunders reported a decrease in thoughts of suicide and self-harm.
48. On 5 June, the PWP met with Mr Saunders. She noted no concerns about suicide or self-harm. Mr Saunders said he had not yet received the increased dose of propranolol. The PWP said she would raise this.
49. On 17 June, a member of staff from the chaplaincy team was asked to go and see Mr Saunders due to news that his brother had been killed in a car accident. He told the chaplain that he was estranged from his brother and most of his family, but they agreed he would visit the chapel on 26 June to light a candle for his brother.
50. On 19 June, the PWP met with Mr Saunders. He told her about his brother's death. He said in the meeting that he was starting to notice more positives instead of negatives and was more aware when he was feeling low.
51. On 21 June, the mental health nurse saw Mr Saunders for a mental health review. Mr Saunders told the mental health nurse that he was feeling brighter than he had done previously. The mental health nurse noted that Mr Saunders continued to express longstanding fleeting thoughts of self-harm but had no plans to act on them. She also noted that he named his family as strong protective factors and that he had daily phone contact. (He must have been referring to his former partner as he was not in regular contact with his family.)
52. On 28 June, Mr Saunders' key worker (an officer) saw him for his first key work session. Mr Saunders told the officer that he was fine and had no concerns.
53. On 10 July, the PWP met with Mr Saunders for a final session. He told her he was feeling much better and that his thoughts of suicide and self-harm were much less and that his former partner remained a support.
54. On 16 July, the mental health nurse met with Mr Saunders for a care plan review. She recorded in the care plan that Mr Saunders should report any thoughts of suicide or self-harm to staff and engage with the psychiatrist on a needs-led basis. She scheduled a review for 16 August. (This did not take place. No reason was recorded.)
55. On 26 August, a prison offender manager (POM) visited Mr Saunders to introduce himself. Mr Saunders said he was settled at work and on his wing and that he did not have any issues.
56. On 12 September, the mental health nurse saw Mr Saunders for a mental health review meeting. He told her that he had been feeling low due to the breakdown of his relationship but that he still spoke to his former partner regularly. He said he was worried about where he would live on release. He told the mental health nurse that he continued to have suicidal thoughts and that these had been more frequent recently but that he had no plans to act on them. The mental health nurse noted

that they discussed whether an ACCT was needed to support Mr Saunders, but that he told her that he found this process disruptive and unhelpful. The mental health nurse did not tell wing staff about Mr Saunders' suicidal thoughts. In interview, the mental health nurse said that as this was not a new presentation for Mr Saunders and he did not express any plan or intention to harm himself, she considered that ACCT monitoring was not necessary.

57. On 17 September, Mr Saunders' key worker saw him for a key work session. Mr Saunders told the officer that he was all right and had no concerns. In interview, the officer said there was no indication that Mr Saunders was struggling with his mental health.
58. Mr Saunders made several calls to his former partner in September. During one of the calls he said his head had been "swimming" for the last few days and mentioned his concern about the change in his mental health worker (from the PWP to the mental health nurse, with whom he seemed to have less rapport). In another call he said it was his deceased sister's birthday and that he "just had to get through it".
59. The investigator spoke to a prisoner who spent time with Mr Saunders. He said that during a conversation with him that weekend Mr Saunders talked about his former partner and said, "If she doesn't talk to me, I've got nobody at all."

Events of 28 September

60. The investigator watched CCTV footage and body worn video camera (BWVC) footage from 28 September. She also obtained information from North West Ambulance Service NHS Trust. The following account has been taken from all sources.
61. At around 1.30pm, Mr Saunders tried to ring his former partner but the call diverted to answerphone.
62. At around 4.35pm, an officer completed the afternoon roll check (a routine check that all prisoners are present in their cells and are alive and well). He raised no concerns.
63. At around 9.22pm, during the evening roll check, an officer saw through the observation panel in Mr Saunders' cell door that Mr Saunders was slumped at the back of his cell. The officer entered the cell and found Mr Saunders hanging from the bars of the cell window using material from prison bedding. The officer radioed a code blue (a medical emergency code used when a prisoner is unconscious or having breathing difficulties that alerts healthcare staff and tells the control room to call an ambulance immediately) and told the control room that Mr Saunders had ligatured, lost colour and had blue lips. He cut the ligature using his anti-ligature knife and started CPR. Other officers responded quickly and supported with CPR. Nurses arrived around four minutes later and continued with CPR. They applied a defibrillator which advised no shock.
64. A member of staff in the control room called for an ambulance in response to the code blue and provided information about Mr Saunders' condition.

65. At around 9.41pm, paramedics arrived and continued CPR. However, at 9.48pm, they pronounced life extinct.

Contact with Mr Saunders' family

66. On 29 September, the prison appointed two officers as family liaison officers. They and the Governor visited Mr Saunders' next of kin's address but she was not at home. One of the family liaison officers informed her of Mr Saunders' death by phone and offered support.
67. Wymott contributed to the cost of Mr Saunders' funeral, in line with national guidelines.

Support for prisoners and staff

68. Postvention is a joint HMPPS and Samaritans initiative that aims to ensure a consistent approach to providing staff and prisoner 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.
69. After Mr Saunders' death, the Head of Residence debriefed the prison and healthcare 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.
70. The prison posted notices informing other prisoners of Mr Saunders' death and offering support. The prison also deployed Listeners to the wing to offer support. Staff reviewed all prisoners assessed at being of risk of suicide or self-harm in case they had been adversely affected by Mr Saunders' death.

Post-mortem report

71. The post-mortem report concluded that Mr Saunders died from compression of blood vessels in the neck (hanging).

Findings

Assessment of Mr Saunders' risk of suicide and self-harm

72. The Prison Safety Policy Framework, implemented on 1 January 2025, which superseded Prison Service Instruction (PSI) 64/2011, Management of prisoners at risk of harm to self, to others and from others (Safer Custody), requires 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. Any prisoner identified as at risk of suicide or self-harm must be managed under ACCT procedures.
73. Mr Saunders had a history of mental health issues, including suicide attempts and self-harm. While at Altcourse, he was subject to ACCT monitoring on one occasion from 21 June to 2 July 2024, but he was not subject to ACCT monitoring at Wymott. He had frequent contact with the mental health team and often told them he was having suicidal thoughts but said he would never act on them. Wing staff, including Mr Saunders' key worker, were not aware of Mr Saunders' suicidal thoughts.
74. On 12 September, just over two weeks before his death, Mr Saunders told the mental health nurse that he was having more frequent suicidal thoughts but had no plans to act on them. The mental health nurse discussed ACCT monitoring with Mr Saunders but he said he found this process disruptive and unhelpful. At interview, the mental health nurse said that as this (having frequent suicidal thoughts) was not a new presentation for Mr Saunders and as he said he had no plans to harm himself, she decided an ACCT was not necessary. She said that she had not received ACCT awareness training at Wymott but was aware of ACCT from shadowing colleagues.
75. The clinical reviewer found that although the mental health nurse recognised the importance of discussing ACCT monitoring with Mr Saunders, there was no opportunity for senior or multidisciplinary discussion, which may have supported more informed decision making.
76. The Prison Safety Policy Framework says, "Governors must ensure that all staff are aware of the ACCT process and know how to act on concerns they become aware of from any source."
77. The Head of Safety told us that ACCT awareness training is delivered to all new staff, both directly and non-directly employed, during induction. He said that specific ACCT awareness training is delivered to those who have face-to-face meetings with prisoners, which tends to be healthcare and mental health staff. The awareness session is delivered by the Safety Custodial Manager and is made available once the manager has identified a need and requested sessions. However, neither the mental health nurse nor the PWP had had ACCT awareness training. We recommend:

The Governor and Head of Healthcare should ensure that all staff working at Wymott (both directly and non-directly employed) receive ACCT awareness training so they understand their role and responsibility should they have concerns about a prisoner's risk of suicide and self-harm.

Clinical care

78. The clinical reviewer found that the mental healthcare Mr Saunders received was not of the required standard and was only partially equivalent to that which he could have expected to receive in the community. The clinical reviewer found that while there was responsive mental healthcare, there was no indication of the presence of a safety plan or appropriate escalation of risk when Mr Saunders' suicidal thoughts increased. We recommend:

The Head of Healthcare should ensure that all members of the mental health team receive adequate training in safety planning, and that patients presenting with suicidal ideation are provided with a comprehensive safety plan at an early stage.

Inquest

79. At the inquest, held from 14 to 16 September 2026, the jury concluded that Mr Saunders died by suicide.

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