

**Investigation into the circumstances surrounding the
death of a man at HMP Whatton in April 2007**

**Report by the Prisons and Probation Ombudsman
for England and Wales**

December 2007

The man who is the subject of this report was 26 years old when he died on in April 2007 after hanging himself in his cell at HMP Whatton. My investigator and I offer our sincere condolences to the man's family and friends for their said loss.

I wish to thank the Governor of Whatton for making the necessary facilities and information available to my investigator, and for the invaluable assistance of the Liaison Officer. In the course of the investigation, I also asked for a clinical review to be carried out into the care and treatment the man received in custody. I am therefore grateful to the PCT for its assistance too.

I have been concerned to learn that a wing manager at Whatton did not implement the prison's suicide prevention and violence reduction strategy correctly, and it appears that the man was not monitored appropriately and so was vulnerable to bullying. Additionally, I have discovered that the emergency services took 35 minutes to arrive at the prison after the man was found, by which time it was too late to save him. I conclude that he was not given the level of support and protection to which he was entitled.

This investigation report makes three recommendations for the prison, and one for the Prison Service. One recommendation is in recognition of the actions of an officer who, realising the man had died, sat with him until it was time for him to be taken to the mortuary so that he would not be alone.

This report has been anonymised for publication on the website of the Prisons and Probation Ombudsman.

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SUMMARY

The man was serving a five year prison sentence imposed at Crown Court in January 2006. Prison was a new experience for him and something he did not easily settle into. The Prison Service suicide prevention procedures, Assessment, Care in Custody and Teamwork (ACCT), were initiated at least five times during his time in custody.

In September 2006, as part of his sentence plan, the man was transferred to HMP Whatton and later joined an offender treatment programme. He completed the course in 2007 and then joined a smoking cessation group. Whilst attending the third session of the group, the man told the tutor he was being bullied and felt like ending his life. The tutor opened an ACCT document and took it to the B wing manager. She also asked a mental health nurse to assess the man.

The wing manager wrote the instructions about the ACCT monitoring on the front of the document, but did not complete the remainder until the following day. His instructions were ambiguous and he also changed the front cover. He spoke to the man and, believing that he had identified the bully, opened a violence reduction document with the intention of monitoring the bully's behaviour. However, as with the ACCT document, the manager did not complete it correctly or follow the Governor's policy on violence reduction, and the prisoner was not monitored. (The manager's inadequate completion of both documents was the subject of an internal disciplinary investigation. I understand that the manager in question has now resigned from the Prison Service and that, for this reason, the internal disciplinary investigation will not proceed further.)

At about 7.30pm on Saturday 28 April 2007, as part of the ACCT procedures, an officer went to check the man. He looked into the cell and saw him fully suspended off the ground, hanging by a ligature attached to an electrical pipe running along the ceiling. The officer returned to the wing office to summon assistance and to collect a pair of anti-ligature scissors. He returned and went into the cell and supported the man until his colleagues arrived soon afterwards. Cardio Pulmonary Resuscitation (CPR) was attempted for 35 minutes until the paramedics arrived. Sadly, it was too late and the man had died.

Following disclosure of my draft report to the Prison Service my investigator received the following response from the Prison Service. "There were two investigations. A simple enquiry was held immediately after the man's death. The results of this were disclosed to the PPO investigator. The investigator then kindly disclosed to the Governor the emerging findings of his investigation into the man's death. In light of these the Governor initiated a full disciplinary investigation. This was completed and he accepted its findings. The senior officer was suspended pending a hearing under the disciplinary code. The senior officer, who was over retirement age, retired from the service before the hearing could take place"

THE INVESTIGATION PROCESS

1. My office was informed of the man's death by the Prison Service National Operations Unit on 28 April 2007. The investigation was allocated to a member of my staff, who in turn organised a meeting with members of management at HMP Whatton.
2. On 2 May, my investigator went to the prison to open the investigation. He met the Deputy Governor, the Prison Liaison Officer, the Chair of the local Independent Monitoring Board, the Prison Officers' Association representative, the Healthcare Manager and the Head of Residence. The Deputy Governor gave an overview of the circumstances surrounding the man's death.
3. As part of the normal procedure following any death in custody, the police were notified and initially dealt with the man's cell as a potential scene of crime. My investigator met the police officers concerned. My investigator agreed the scope of the investigation and confirmed that the police were not treating the man's death as suspicious. My investigator supplied the officers with a copy of the Memorandum of Understanding between my office and the Association of Chief Police Officers. The police agreed that my investigator would be provided with copies of the police interview statements. I am very grateful for the close working relationship developed between my investigator and the police.
4. In order to familiarise himself with the layout, my investigator went to the cell where the man had died but it had not yet been released by the police and remained sealed. He therefore looked at a cell in the same wing, similar to that occupied by the man.
5. Later that same day, my investigator met the Area Safer Custody Manager for the Prison Service, East Midlands who had been asked to consider the circumstances of the man's death.
6. My investigator identified which staff he wanted to interview and arranged to return on 4 June to begin the interviews.
7. Additionally, my office sent the Governor a copy of the investigation terms of reference and two notices telling staff and prisoners about the investigation. As with every death in custody, I ask the Governor to display the notices around the prison and make them available for staff and prisoners to read, and if appropriate, contribute towards my investigation.
8. On 3 May, my investigator contacted the local Primary Care Trust (PCT) and asked them to carry out a clinical review of the healthcare and treatment received by the man. I am grateful to the PCT for its assistance.
9. On 4 June, my investigator returned to Whatton to begin his investigation. As part of my normal office's management checks, the investigator's line manager, an Assistant Ombudsman, accompanied the investigator on 5 June and assisted with a number of interviews.

10. The Assistant Ombudsman met three prisoners who had asked to see the investigator, but it was not clear whether they were responding to my notices of investigation. Two prisoners did not know the man and so their limited contribution has not been included in this report. The other prisoner gave a statement to the Assistant Ombudsman which I have referred to.
11. Two days later, the investigator met the Governor and Deputy Governor to feedback his findings at that point. They both welcomed and accepted the feedback.
12. My investigator completed the majority of interviews at the prison, but unfortunately not all those identified were available during the week. He therefore returned on 9 July to complete the remainder. Before leaving the establishment, the investigator met the Governor and gave him further feedback and likely recommendations. The Governor accepted the findings and thanked the investigator for the feedback.
13. One of my Family Liaison Officers (FLOs) made an appointment for my investigator and herself to meet the man's mother and her family. The aim was to give them the opportunity to raise any concerns about the man's care and treatment by the prison. The meeting was scheduled for 24 June but unfortunately, due to severe weather conditions, my investigator could not attend. He briefed the FLO with the salient information. The man's mother's questions are listed later in my report. I trust that the disruption caused by the weather did not prevent her from asking questions, and that my report has answered them for her.
14. On 9 July, my investigator returned to complete his interviews and give further feedback to the Governor. He drew the Governor's attention to the conduct of two members of staff, and confirmed the findings in writing the following day. Subsequently, the Governor commissioned his own internal disciplinary investigation into the actions of the manager and agreed to inform my investigator of his findings.

HMP WHATTON

15. HMP Whatton is a category C adult male establishment situated close to the village of Whatton, Nottinghamshire. All the men held there have been convicted of sex offences. They are serving a variety of sentences, including life.
16. The prison was originally built in 1966 as a detention centre for boys and changed in 1989 to a young offender institution. One year later, it became an adult male category C prison and later developed into its current role as a sex offender prison. In 2006, new accommodation was built on the site alongside the existing buildings, more than doubling the spaces to a maximum of 761.

Her Majesty's Chief Inspector of Prisons (HMCIP)

17. In January 2007, HM Chief Inspector of Prisons (HMCIP), Ms Anne Owers, carried out an announced inspection of the prison. The report of the inspection and its recommendations were published on 20 June 2007. As part of the normal processes following an inspection, the Governor and his team produced an action plan to implement the report findings.
18. The introduction to Ms Owers' report said that Whatton remained a reasonably safe prison. Ms Owers recognised improved facilities for new arrivals. She went on to say that prisoner discipline arrangements were good with use of force being rarely used. Her report added that safer custody policies set out appropriate strategies, but the procedures were not fully implemented. Incidents of bullying were going unreported and Ms Owers found weaknesses in suicide prevention arrangements.
19. The HMCIP report commented that Whatton's new accommodation was excellent, but B wing was identified as a fire hazard requiring immediate attention. The report described B wing as not being fit for purpose unless work already identified by the prison was carried out immediately. The report added that B wing was cramped, with small cells, and little in the way of natural light. Problems were also identified with sanitation.
20. The final paragraph of the introduction acknowledged that the rapid changes that had taken place at the prison had restricted managers from achieving the standards expected. Ms Owers acknowledged the work done so far, but recognised the need to do a lot more.

Safer Cells

21. Safer cells are designed to have no obvious ligature points. The furniture is built into the fabric of the cell, with no moveable furniture allowed. Whatton prison has 50 safe cells, all on A wing (A3), with a further eight in the Care and Separation Unit, making 58 in total. If necessary, and subject to a case review, the normal bedding can be replaced with anti ligature bedding, which is bedding made from strong cloth material designed not to be torn.

New Leaf

22. New Leaf is a smoking cessation course facilitated at Whatton by a healthcare assistant from the National Health Service. Prisoners attend the weekly course on a voluntary basis, with each course having a maximum capacity of 15 prisoners. Interested prisoners submit a written request to join the course and, due to its popularity, their names are placed on a waiting list. When their name comes to the top of the list, a place is given and the prisoner informed of the start date.

Prison Service Orders (PSOs)

23. Prison Service Orders are long term instructions to prison Governors or Directors of contracted out prisons. Each instruction has a title and unique reference number, with any mandatory instructions written in italics.

Prison Service Instructions (PSIs)

24. Prison Service Instructions are mandatory instructions that have a definite expiry date. They are also used to introduce amendments to Prison Service Orders. Each PSI is given a title and unique reference number.

PSO 2700, Assessment, Care in Custody and Teamwork (ACCT)

25. ACCT requires staff to identify any concerns, take action, and document those actions for prisoners identified as at risk of suicide or self-harm. The ACCT document should be available to all the staff where the prisoner is located. Within 24 hours of the document being opened, the at-risk prisoner will be seen by an assessor and have a case review meeting. The meeting draws up a care and management plan, known as a CAREMAP, and a member of staff is nominated as the case manager. Wing managers take on the role of case manager, oversee the management of the ACCT document and attend case reviews.
26. As well as the CAREMAP, the document includes an on-going record of significant events, conversations and observations. There is an assessment section which covers eight specific questions designed to remind the assessor of the areas to be covered. Following the assessment, the case review will determine what action should be taken and by whom. The PSO says that the person carrying out the assessment should have been trained to do so. There are three training courses for staff, the first being Foundation training which is a half day course to show attendees how to open and complete the basic requirements of the document. There is also one day course for case managers to learn how to complete the Immediate Action Plan. The plan includes decisions about support for the prisoner, including the frequency of monitoring. The third course is for ACCT assessors. It lasts four days, including three days examining mental health issues and one day on the completion of the documentation. Assessors are trained to restrict their recording to what has actually been said by the prisoner.

27. The ACCT document is divided into four sections. Once the document has been opened, the person opening it is required to complete section one, "Concern and keep safe form". Additionally, within section one, a member of staff (usually the wing manager) will complete the "Immediate action plan". The immediate action plan is meant to last no longer than 24 hours from the risk being identified.
28. Section two, "Assessment Interview", should be completed within 24 hours of when the document was first opened. It is divided into eight sections and asks the assessor to record their observations and conversations with the prisoner. After completing the assessment interview, a summary of the meeting is recorded on the "Action following interview" page. Additionally, following the first review, section two records the time and date of the next review.
29. Section three records the CAREMAP decisions and subsequent case reviews.
30. Section four is an on-going record of significant events, conversations and observations. The on-going record allows anyone to make an entry of their contact or observations, but as a minimum the entries should be made at the times specified on the front page of the document.

Listeners

31. Like almost all prisons, Whatton has a "Listener Scheme" under which the Samaritans train and support selected prisoners to offer confidential, emotional support, to fellow prisoners in distress. The scheme is confidential and any prisoner can ask to speak to a Listener at any time of the day or night. Prisoners can easily access a Listener by speaking to a member of staff who will then arrange for the Listener to speak to the prisoner concerned. During the hours that prisoners are locked in their cells, anyone wishing to speak to a Listener can ask the staff on duty.

Night State 10.00pm – 6.00am

32. Night state is when the prison is fully locked up for the night and staffing levels are at the minimum. There is often just one night patrol officer per wing, or on occasions, between two wings, and their role is to monitor the security of the wing and prisoners.
33. In night state, no one can gain entry to the prison or leave it without the night manager's permission. The night manager would have to override the security systems, which automatically engage from 10.00pm until 6.00am when they disengage. It is only in exceptional circumstances, such as an emergency, or when the Duty Governor requires entry, that night state would be broken.

Night Patrol

34. Cells are not usually unlocked during night state, unless the night manager has sufficient staff resources in place to deal with the situation. Night patrol staff do not carry security keys and are therefore unable to move freely around the prison. However, they do carry a cell door key in a sealed pouch which is secured to their uniform belt. If in the event of a life threatening situation, and if it is felt necessary to enter a cell, the night patrol officer has first to break the pouch seal to obtain the key. However, the officer must summon assistance and should only enter a cell alone if safe to do so.
35. Unlike the night patrol staff, the night manager does carry security keys and is able to move freely about the prison. The manager will usually visit the wings during the night and check on the welfare of the staff and ensure they are carrying out their duties correctly

Patrol State

36. Patrol state refers to the other times when prisoners are locked into their cells, for example during staff meal times. In patrol state, it is only the cells that are locked, and other parts of the prison may be functioning normally. At least one officer is required to patrol the wing, but occasionally two. The patrol officers deal with any cell call bells, check those prisoners on ACCT documents and monitor the security of the wing. They continue to carry the normal security keys and can if necessary access most parts of the prison, including individual cells.

Whatton unlock times

37. During the week, the prison is unlocked from 8.00am to 8.00pm. The unlock hours at weekends and Bank Holidays are from 8.00am to 5.00pm.

Roll checks

38. Roll checks are carried out in order to confirm that the number of prisoners on each wing corresponds to the total number in the prison. When the roll is checked the officer must physically see that the prisoner is in the cell. However, they are not required to confirm the prisoner is alive. Some roll checks are carried out very early in the morning when it would be inappropriate to wake the prisoner to check if he is alive. However, if the prisoner is subject to ACCT monitoring, the officer must confirm that the prisoner is alive. During routine roll checks, if the officer has any doubt about the condition of the prisoner, or is unable to see the occupant, they must seek assistance immediately and if necessary, enter the cell.

PSO 2750 Violence Reduction

39. The PSO was introduced to help Governors produce their own strategy to reduce violence, promote a safe and healthy prison environment and foster a culture of non-violence amongst all staff and prisoners.
40. In November 2006, the Governor at Whatton issued his own Violence Reduction Strategy (VRS) in line with the mandatory instructions contained in PSO 2750. At chapter 11, the strategy explains "The Three Stage System". It says, "HMP Whatton will operate a three stage system aimed at identifying the perpetrators of violence and bullying, challenging this behaviour and addressing persistent perpetrators." As an aide memoir, the Governor has issued all staff with an "Easy Reference Guide" explaining the three stage system.

Stage one

41. The alleged perpetrator is monitored for a minimum of 14 days and reviewed after this time every 14 days until the file is closed, or the prisoner moved to stage two. The wing manager (Senior Officer) will decide whether the prisoner is told that he is being monitored.

Stage two

42. The alleged perpetrator is monitored for a minimum of 14 days and reviewed after this time every 14 days or until the file is closed, or the prisoner is moved to stage three. The Group Manager authorises stage two monitoring.
43. Unlike stage one, the prisoner is told that he is being monitored and his movement is restricted, including where he works and the use of the gymnasium. The prisoner is allowed to associate with other prisoners on the wing.

Stage three

44. The prisoner is monitored for a minimum of 28 days and reviewed every seven days. Authorisation to monitor at stage three is agreed by the head of the unit.
45. The movement is further restricted, with no access to work, education or gymnasium.

Monitoring

46. Once it has been decided to place a prisoner on monitoring, a VRS assessment book is opened. The person opening the document informs a member of staff in the prison control room and they in turn record the details in a register and issue a reference number. The reference number is then transferred to the front cover of the open booklet.
47. In addition, the person opening the document makes an entry in the wing observation book in red, noting the name of the alleged bully and the victim. There is also a requirement to raise a Security Information Report (SIR) and pass

the SIR to the security department. Additionally, an entry is made in the wing observation book (also in red), noting that the information has been passed to the security department via an SIR.

48. During the night, a member of the night staff completes a 'Daily Briefing Sheet', listing the names of prisoners on ACCT or VRS, as well as operational details. The sheet is passed to wing managers and the Duty Governor of the day the following morning when they arrive for duty. The Duty Governor briefs the Governor and other managers at the morning meeting, which takes place about 8.45am Monday to Friday. The wing managers in turn brief their own staff.
49. The daily briefing sheet is used by wing managers and Duty Governor to identify who is subject to VRS. It is the wing manager's responsibility to ensure that monitoring is carried out by staff and that they make a quality entry in the VRS document at least daily. Wing managers are required to check any open VRS documents on their wing daily, whilst the Duty Governor is required to check the VRS document at least twice a week. Once open, the VRS booklet is held in the wing office and kept separate in an identifiable folder to which all wing staff have access.

B wing cells

50. The cell doors have an observation panel built in where staff can look into the cell and check on the prisoner. On B1, the observation panels are covered over by a small curtain which the officer simply lifts to see into the cell. Cell B1 207 is 1.75 metres wide and 2.75 metres long.

Adapted Sex Offender Treatment Programme (SOTP)

51. The adapted sex offender treatment programme is a primary treatment programme for offenders who have learning difficulties and an IQ of 80 or below. Prisoners must have committed a sexual offence or have committed an offence that was sexually motivated. Attendance on the course is not mandatory and prisoners must apply to do it.
52. The course, comprising eight prisoners and a minimum of two facilitators, lasts for up to six months. The course is divided into 14 blocks and every week there are four sessions, each lasting two and a half hours. The participants must take responsibility for their offence, or at least part of it, and be classified as at medium, high or very high risk of re-offending. Additionally, they agree not to discuss the content of the sessions outside the group.

Prison Officer Grades

53. There are three levels of uniformed prison officer grades. Prison officers are the front line supervisory staff and, in the majority of cases, prisoners have first and most contact with them.
54. Senior officers (SOs) are the first grade of managers and act as a reference point for prison officers. SOs are responsible for the day to day management of their area, supervising staff and dealing with issues raised by prisoners.
55. Principal officers (POs) are the highest rank of the uniformed staff. They supervise the uniformed staff and have operational responsibility for the prison.
56. The orderly officer is the duty manager and is often referred to by the radio call sign "Oscar". During the day, the duty manager is a principal officer, but at the weekends in the evening, and every night, Oscar is a senior officer. Due to the physical layout of HMP Whatton, there are two senior officers on duty in the evenings and both carry a prison radio. One has radio call sign Oscar 1 and the other has Oscar 2.
57. Operational Support Grades (OSGs) wear prison uniform and carry keys, but do not carry out the same function as prison officers. Their role is to support the areas of the prison that have little or no prisoner contact, for example the gate. However, they do regularly support the officers by carrying out wing patrols when the prison is in patrol or night state.

PSI 2700, Personal Issue Cut-Down Tools

58. PSO 2700 contains mandatory instructions relating to the procurement, issue and use of cut-down tools. The tools are designed to allow the user to get underneath a ligature, without cutting the person. Once underneath, the user can safely cut the ligature from around the neck.

Radio Communication System

59. The prison radio system has a facility where all radio transmissions are recorded. If necessary, the transmissions can be downloaded and or replayed.

Healthcare

60. Healthcare at Whatton is provided between 7.30am and 6.45pm, Monday to Friday. At the weekends, it is available between 7.30am and noon. The prison doctor attends from 7.30am to 6.00pm, Monday to Friday. Outside of these times, healthcare is not available and the prison must either contact an on call doctor or the emergency services.

Previous deaths in custody

61. Since my office took over the responsibility for investigating all deaths in custody on 1 April 2004, there have been ten deaths at HMP Whatton, including that of the man who is the subject of this report, eight of which were due to natural causes. My investigator has not identified any similarities to between the investigations into these other deaths and the circumstances surrounding the death of the man.

KEY FINDINGS

62. On 8 December 2005, the man was remanded into custody and taken to HMP Winchester. He was assessed by a member of the mental health team and, due to his mood and self harm history, was located in healthcare. I understand from the clinical review that his medical record notes an ACCT document was opened. Unfortunately, the prison records given to my investigator do not show any evidence of an ACCT at that point.
63. On 6 January 2006, the man was sentenced to five years imprisonment at Crown Court and returned back Winchester. Just over three weeks later (30 January 2006), an ACCT document was opened after his mother telephoned the Governor raising concern about the man's mental health. His mother told the Governor that the man was in distress due to his imminent transfer from Winchester. As a result, the man was temporarily taken off the transfer list. After two further ACCT reviews, the document was finally closed on 20 February.
64. Through February and March, the man was on normal location and his mood was stable. There were reports of bullying, but no further self harm. On 1 March, he transferred to HMP Usk but he stayed for only two days. The reason for his short stay was due to his history of taking a drug overdose. Prisoners at Usk hold their own medication and the risk to the man was considered to be too great.
65. As a result, the man was transferred to HMP Littlehey. On 27 April, he told an officer that he had nothing to live for and said he had previously harmed himself. The officer opened an ACCT document, which was closed on 3 May.
66. The following month, another ACCT document was opened after the man became angry and upset towards healthcare. He wrote a letter saying that he did not think healthcare were dealing with a medical problem. At the case review, the man said he should not be on ACCT as he had written the letter whilst he was angry. After reviewing the case, the file was closed the following day.
67. On 13 July, the man was transferred to HMP Wayland, where he remained until being transferred to Whatton on 22 September. He was seen in the prison reception by a Senior Practice Nurse and later by a prison doctor.
68. The PCT in its clinical review reports that the medical examination was thorough and the doctor accurately summarised the man's past medical history. He said that he weighed 58 kilos (which is underweight), and was 1.78 metres tall. The doctor identified an overdose of propranolol in January 2006 and eight instances where the man had self harmed by cutting his abdomen. The doctor also noted a history of depression and of bullying. The man's mood was noted as low, but there was no evidence of suicidal thoughts.
69. The following month (16 October), a primary mental health assessment was carried out. The PCT says this assessment was also thorough and accurately identified the man's impulsivity and learning difficulties and noted that he was not

psychotic. The man was impulsive and liked to be occupied, which helped distract him from worrying about his problems.

70. The man began the Sex Offender Treatment Programme (SOTP) course on 17 October. He was one of eight prisoners on the programme, with three facilitators and a supervisor. The course was the "Adapted" programme, which had 89 sessions and was scheduled to run between five and six months.
71. One of the tutors (an officer) on the man's course told the my investigator that at the beginning of the course the man appeared not to want to be there. He went on to say that the man's behaviour was not unusual and he settled down and joined in. During the first few sessions, the man told the officer that his motivation for being on the course was to help him gain parole and so he would tell the tutors what they wanted to hear.
72. After a few sessions, the man asked the officer if he could tell if he was lying. The officer told him that, as time went on, it would be evident whether what he said was consistent. If he was inconsistent, it would suggest that he was being untruthful. A few days later, the man spoke to the officer and told him that he had been thinking about the course and about being honest with himself. The man told the officer that he had written to his family and girlfriend to tell them that he had been lying about his offence, and that he had carried out the offence for which he was imprisoned. Although the man had written to his family, the prison were unaware of what he had said because there was no requirement to monitor his correspondence.
73. Part of the prisoner's SOTP coursework is to produce a "spider web map". The purpose of the map is to identify the people in the prisoner's life who can help and support. The man originally included his family and girlfriend on the map, but after sending the letters he removed their names. When asked why he had removed the names, the man told the officer that his family would not support him as he had confessed to the crime. Some time later, the officer noticed that the man had reinstated the names and, when he asked the reason, the man said that his family and girlfriend were supporting him.
74. The officer told my investigator that, after the man decided to be honest with himself, it was noticeable that his motivation increased. However, there were occasions when he would apparently look uninterested. The officer described the man as helpful, caring, sometimes immature, someone who at times tried to be "jack the lad". As an example, the officer said the man would give the impression to others in the group that he could sort out any problems they had with other prisoners. The officer said that the man responded well to praise and reassurance.
75. An important part of the SOTP course is the requirement that prisoners discuss their offences with the rest of the group. Although worried about doing so, the man did talk about the offence which the tutors noted he appeared to cope with well. The officer told my investigator that, after discussing his offence, it was noticeable that the man did not see the remaining sessions of the course as important.

76. Up to the mid-point part of the course the man progressed well but after this time he began to miss a number of sessions. Normally, the maximum number of sessions a prisoner is allowed to miss before being removed from the programme is ten. The man exceeded this figure, but the course tutors felt that he had progressed well enough to be allowed to continue. The tutors spoke to him about the absences, after which his attendance improved and he participated well and continued to make progress.
77. The clinical review notes that, in February 2007, the man's mother wrote to the Governor telling him that her son was losing weight and was being ignored by healthcare. The PCT says that the man's mother was incorrect and his weight remained stable at between 54 and 58kg.
78. The final part of the SOTP programme is for the prisoner to look at the "old me" and compare with the "new me". The man spoke positively about treating people better and planning for the future. However, in an unexpected development, the man became de-motivated, leaving tutors feeling that as he had opened up about his offence he did not wish to participate any longer.
79. At the end of each course, the tutors complete a report which is then shared with the prisoner. The prisoner is asked to sign the report to show they have had the opportunity to see and read it. In keeping with this procedure, the man was given a copy of his report. He was unhappy with it, picking out one particular reference to him looking at times uninterested and yawning. The officer told my investigator that the man felt this would be viewed negatively by the Parole Board. The officer tried to explain that this would be a small area of the report, and the man should remember how much he had progressed since being on the programme. He said the man could not see that the positive comments were far greater than anything negative. On 5 April, when asked to sign the report, the man refused to do so. Although I cannot say with any certainty, I have no reason to believe that the man's actions were anything to do with the report.
80. On 10 April, the man joined the New Leaf smoking cessation course. A Healthcare Assistant was the course tutor. The course tutor told my investigator that the man attended the course from the beginning and went to three sessions. She had not met the man before he started the course. She described him as quiet, adding that he preferred to sit at the rear of the group rather than the front.
81. At 6.53pm the following day (11 April), the man used one of the wing public telephones to telephone his mother. As well as being able to record the call, the system records the duration of the call and number called. The prison records show the telephone call lasted 14 minutes and 32 seconds.
82. Following the man's death, my investigator downloaded the telephone conversation from the prison telephone system. The transcription of the telephone conversation showed that the man told his mother he had completed the SOTP course. He went on to say he had applied to go to C wing, but recognised that only those prisoners who had less than 12 months to serve were allowed onto the wing. He told his mother that C wing cells had showers in them

and that the accommodation was better than where he was. He then told his mother that he was in trouble. When she asked why, he said, "Just leather boots has been bothering me all the time", adding that the reason was because he was small. He went on to say that a few people were "picking on him" but not touching him. (My investigator has been unable to establish what the man meant by "leather boots".) The remainder of the call was a normal conversation, with no further reference to any problems in the prison and no suggestion about what the man was to do a few days later.

83. On 18 April at 3.30pm, the man telephoned his mother again. The prison records show that the call lasted 13 minutes and 14 seconds. The transcript shows that, as before, it was a normal conversation. However, they discussed some prisoners calling the man names such as "skinny winks". His mother asked him if any prisoners had touched him. He said they had not and she advised him to ignore them. The man talked to his mother about going to the gymnasium and stopping smoking. Once again, there is nothing in the call to suggest that the man was intending to take his own life. (The prison were not required to monitor the man's telephone calls and so were unaware of the content of the conversations until transcribed for my investigation.)
84. The officer in charge of the police investigation into the man's death gave my investigator a copy of a letter he sent to his sister. The letter, written on 23 April, told her that he had booked a visit for the following month. He also told his sister that he had been punched by an unnamed black prisoner and the injury was still painful. He asked his sister not to tell their mother what he had written. The man went on to write that he was feeling low and had wanted to kill himself. He said he had been to the office and told a member of staff, but nothing had happened. Finally, the man said he was thinking about asking for a transfer out of Whatton. It is not known whether the prison was notified about the content of the letter.
85. On Tuesday 24 April, which was the third occasion that the man went to the New Leaf group, the course tutor noticed that he was much quieter than normal. At interview with my investigator, she said that she became concerned about him and asked him what was wrong. He told her that he was having difficulty stopping smoking. The course tutor asked the man if he would share with the group what it was that was causing the difficulty, but he declined.
86. At the end of the session, the course tutor spoke privately to the man to ask him again what was wrong. He told her that he was being bullied, but would not identify the name of the bully. The course tutor advised him to speak to an officer. The man told her he had previously spoken to an officer, and added that the officer had apparently told the alleged bully of his allegation. He added that the alleged bully had also assaulted him. The course tutor told the investigator that the man was holding his left side when she saw him, although he did not show her any injuries. My investigator has been unable to identify which officer the man said he had spoken to.
87. The man told the course tutor that he "felt like ending it all" and that he had attempted to kill himself previously at another prison. In her police witness statement, the course tutor described the man as "quiet" and "down". She told

the man that she would open an ACCT document. She said he accepted what was going to happen, but told her that he did not like being monitored. He said that his current risk of self harm was “fifty-fifty”.

88. The course tutor opened an ACCT document at 3.20pm, some 15 minutes after the man left the room. She asked her colleague to check that she had completed it correctly, and took it directly to B wing where the man was located.
89. The course tutor told my investigator that, when she arrived on B wing, she handed the ACCT document to wing manager, a Senior Officer (SO). At interview, she said that as well as handing the document to the SO she told him what the man had said that had led her to opening the ACCT. My investigator asked the course tutor what she expected to happen next and she said she assumed prison staff would respond swiftly.
90. The SO is a relief manager for B wing and deputy manager for safer custody. He told my investigator he had completed a half day training course in ACCT case management some time in December 2006. He said that, before working on B wing, he had been a night manager at the prison for about four years and had not previously met the man.
91. At interview, the SO said he was in the wing office with a number of officers when the New Leaf course tutor entered. He said that the course tutor spoke to them all and, after telling them of her concerns, she departed leaving the open ACCT document on the desk. He looked at the ACCT and, as it was towards the end of the day, wrote the level of observation instructions on the front cover. The SO confirmed that he did not complete the Immediate Action Plan until the following day, but stressed that he did complete the front cover instructions straightaway.
92. The ACCT document shows that the frequency of observations was set at “three conversations during the working day” and “hourly at night”. Despite this instruction, the first entry in the document was at 8.30pm that evening, almost five hours after it was opened by the New Leaf course tutor. Entries then continued throughout the night.
93. My investigator considered the meaning of the instruction “hourly at night”. The man died at the weekend, when the wing is locked up and in patrol state at 4.45pm. Prison officers regard night state as the time when night staff are on duty. However, from a prisoner’s point of view, patrol state and night state are exactly the same and they are locked up in their cells. The investigator was told that the “hourly at night” instruction was interpreted by the night officers as meaning during the night, and not from 4.45pm when day staff are on duty and the prison is in patrol state.
94. My investigator asked the SO about his expectations of his written instructions. He said that he intended the instruction to result in hourly checks whenever the man was locked in his cell. As far as he was concerned, the working day was between unlock and lock up. He said the lock up time between Monday and Friday was different from that at the weekend. He explained that at the weekend,

the prisoners are locked up for the night from 5.00pm. The SO said that, in his view, from 5.00pm on Saturday evening the prison was in night state and not patrol state. He said that he expected the man to be seen hourly from 5.00pm on Saturday.

95. The SO was asked if he had considered moving the man to a safer cell. He said that A wing is one of the newer wings, where 50 cells are designed as safer cells, with fewer available ligature points. He added that A wing is used as the induction wing and, when he asked if a cell was available, he was told that to move the man to A wing would mean someone would have to move off as the wing was full.
96. The investigator asked the SO if a crisis suite was available, but he said not. (Crisis suites are used in some prisons, but not all. If required, the suite is unlocked and allows a prisoner and Listener to be together in the same room, where the Listener can offer support.) The SO said that a dedicated mobile telephone is available which connects directly to the Samaritans, but the man apparently declined to use it. Additionally, he said he offered the man a Listener but, as with the telephone, he declined the offer.
97. Soon after leaving B wing, the New Leaf course tutor spoke to a Senior Nurse who is a registered mental health nurse based at the prison. The course tutor told the nurse about her conversation with the man and about opening the ACCT document. The nurse told her he would arrange to see the man the following day. At interview, the course tutor said she thought the man had not attended the appointment with the nurse.
98. The Senior Nurse described his role as assessing and following up on prisoners with mild to moderate mental health problems. He explained this could include people with adjustment disorders entering prison, mild to moderate depression, anxiety and stress. He said he also attends ACCT reviews and represents healthcare at meetings in the prison. The nurse told my investigator that prisoners are either referred to him by nursing staff or can self refer. If a case is urgent, he will see the prisoner within 24 hours. His particular skills are around assessing people who self harm and are suicidal.
99. The nurse told the investigator that he first met the man in October 2006. He remembered that he had a history of depression, but there was no reason to offer follow up appointments as he was settled at the time. He said the man was not referred to him again until a couple of days before he died when the New Leaf course tutor asked him. She told him she was concerned about the man's mental health and had opened an ACCT document. He agreed to see the man the following day as an emergency patient. The nurse sent an appointment slip to B wing, but the man did not attend. Because the man had not kept the appointment, the nurse sent a second appointment for the following Tuesday.
100. My investigator asked the nurse whether he had contacted the wing to find out why the man had not attended. He said it was not something that he routinely did, as he assumed that, as with any appointment at home, it was the person's choice to attend or not. The investigator asked him if he had been invited to

attend the ACCT review. He said not, and he had presumed there were no particular issues requiring his support.

101. The nurse said he was aware that the man had said he was being bullied, although he learnt more about it after he died. He said bullying is a risk in prison and is a major factor for anyone who self harms and is low in mood. He told the investigator that mental health nurses are always informed when ACCT documents are opened and often attend reviews, although they did not in the man's case.
102. The following day (25 April), a Probation Service Officer completed the immediate action plan within the correct timescale. She interviewed the man and also completed the 'Assessment Section' of the ACCT document. At interview, the Probation Service Officer confirmed that she had not met the man previously. In her police witness statement, she described the man as generally in good spirits (unlike the New Leaf course tutor who had described him as "quiet" and "down"). Additionally, and contrary to the course tutor's evidence, the Probation Service Officer said that the man told her that he had not reported the bullying to an officer. The investigator asked the Probation Service Officer if she had considered asking the course tutor to be present at the meeting with the man, but she had not.
103. The Probation Service Officer completed all eight sections of the assessment interview, after which, she, the man and the SO in charge of B wing met to review the assessment. Between them they agreed the section for Action Following Assessment and the CAREMAP in the ACCT document.
104. The SO told my investigator that the man was reluctant to talk about being bullied. The only thing he would say was that he was going to the gymnasium to build himself up because he was small. He said the man would not tell him the name of the bully, but after some questioning the SO believed he identified whom it was. The SO wrote the name of a prisoner he believed to be responsible for bullying the man in the ACCT document. He also noted the name of a prisoner to whom the man wanted to move near on C wing. The SO wrote a summary of the case review which had assessed the current risk of self harm as low. They decided that the ACCT should remain open, with a further case review scheduled for 9.30am on 28 April.
105. The front cover of the ACCT document has a number of boxes where the case review date is noted. In the man's case, box one has an entry dated 28 April. However, the date has been scribbled through and 1 May inserted in its place. The SO said he was mistaken when he planned the review for 28 April when he would not be on duty, and so corrected it to 1 May. He told the investigator that he altered the date immediately he realised his mistake. The record shows that, although he changed the front cover to read 1 May, he did not alter the date recorded inside the ACCT document which still showed the original date of 28 April.
106. My investigator has identified that between 24 April, when the man's ACCT document was opened, and 28 April there were at least five senior management

checks. None of the checks identified that the instruction for hourly checks was ambiguous, or that none had been carried out for the first five hours after the document was opened. Neither did the management checks correct the SO's error with the review date. The investigator asked one of the senior managers, the Head of Residence, about the checks and what it involved. He replied that managers examine the quality of the entries and check whether the document has been completed correctly. The Head of Residence said he did not believe he would have missed the discrepancy between the date on the cover and the one written inside, and doubted whether his colleagues would have missed it either.

107. The SO completed the careplan in the ACCT document. He noted that the man should move to C wing as soon as possible, and that the C wing manager should action the request. However, when the SO contacted C wing, he was told that the man did not meet the wing's criteria as he had more than 12 months still to serve.
108. Following the ACCT review, the SO opened a Violence Reduction Strategy (VRS) monitoring document on the alleged bully. A VRS document had recently been closed on the same prisoner. The SO told the investigator that he had not received any training about VRS. He decided that the monitoring level should be stage one, and that the prisoner would not be told that he was being monitored. The investigator asked the SO what he did with the VRS document after it was opened. The SO said he took it the wing office and left it for other staff to carry out the monitoring. He believed that he also made an entry in the wing observation book noting that VRS had been started.
109. My investigator has examined the VRS trail and confirmed that the SO telephoned the control room, registered the VRS and obtained a reference number which he then transferred to the front cover of the document. The wing observation book refers to the bullying allegation and names the alleged perpetrator. However, contrary to the local policy, it is not written in red, does not state that VRS has started or that an SIR has been raised. Additionally, the SO did not complete Annex D or sign the document. (Annex D records the perpetrator's history and notes any recommended action.)
110. As well as opening the document, and by way of information sharing, the name of any prisoner being monitored under VRS should be entered onto the wing daily log sheet. My investigator has examined the B1 daily log for 24, 25, 26, 27 and 28 April and the name of the prisoner placed on VRS monitoring is not recorded on the sheet. The investigator also asked to view the daily briefing sheet issued for 26 to 28 April, but unfortunately the only one available was for 27 April when the night staff correctly inserted the alleged perpetrator's name.
111. At some point during the week, the officer who tutored the man on the SOTP course spoke to the man. The officer told my investigator that, although he could not recall the date, he was aware that the man was being monitored under the ACCT procedure. The man had told the officer that he thought the SOTP report would go against him when he applied for parole. The officer reassured him, reminding the man of his progress from initially denying his offence to admitting it. The man would not accept this.

112. The man told the officer that he wanted to be transferred to A wing, adding that something was going on in B wing that he did not want to talk about. The officer asked him to explain, but the man would not tell him what the problem was and said that he could cope with it. The officer said he remembered the man talking positively about his family. After speaking to him, the officer went to the wing office and spoke to another officer about the man's words. In interview, the officer could not recall the other officer's name. The officer told him that the man was being monitored on ACCT and said that he knew about his problem.
113. The ACCT observations occurred every hour, almost on the hour, on Thursday and Friday nights. Conversations were recorded as having taken place, although in interview one officer acknowledged that the man did not always want to talk and it was difficult to engage him. The entry for Friday notes that he was in good spirits and attended the gym class.

Saturday 28 April

114. After unlocking the prison for the day, the first formal ACCT conversation with the man was carried out at 8.10am. The officer completing the document noted that the man had asked for a shower and appeared to be in "fairly good spirits". As it was the weekend, the prison regime was restricted to association, gymnasium and domestic visits. The education classes, offender behaviour programmes and workshops were all closed.
115. At 10.55am, a Principal Officer (PO) carried out a management check of the ACCT document. The PO signed the relevant page recording the management check. The next entry was made at 4.10pm, when an officer noted that the man had played snooker during the afternoon and appeared relaxed.
116. Another prisoner who was a friend of the man told one of my investigators that they had known each other since November 2006. He said he used to assist him with his letters. The man's friend was aware that the man had been bullied previously. He used to look after him and continued to do so until he settled down at Whatton. The man's friend described the man as slightly built, immature, and likeable.
117. The man's friend said that on the afternoon before he died, the man was in his cell crying and had told him he had been robbed the day before. Apparently, the man had given a PlayStation to another prisoner but it had been taken off the prisoner concerned. The man's friend added that, although the man had been crying earlier, he saw him laughing whilst in the snooker room. He said he was aware that the man had previously harmed himself, but did not believe he would do so again.
118. At about 4.45pm, the prisoners returned to their cells for the evening and the wing was locked up. This was the first time whilst this ACCT document was open that the man was locked up so early in the day. A roll check of prisoners was carried out and, once the B1 wing total was agreed at 81, an officer signed the wing's lock up sheet to show that the roll was correct. The PO received the signatures

for the remaining wing rolls at about 5.05pm, and signed the prison's lock up sheet to show that the entire prison roll was correct at 755. As the roll was correct, those staff not required in the evening left the establishment and the prison went into patrol state.

119. The patrol officer responsible for B1 that evening carried cell keys but left his radio in the wing office. In interview, he said he was there from about 5.00pm and was assisted by an OSG. The patrol officer explained that another officer and OSG were in the wing office at the same time and were responsible for B2. The man did not ring his cell bell after they came on duty.
120. The patrol officer told the investigator that he had received ACCT training when he transferred to Whatton about twelve months previously. He said that the training concentrated on how the monitoring procedures worked and how to open the ACCT document.
121. The patrol officer said he knew the man fairly well. He described him as a little immature at first, but said that after a while he settled down. He went on to say that the man was a likeable individual who would approach the staff he knew if he had a problem, but who was not comfortable with every officer. My investigator asked the patrol officer if he was aware that the man had alleged he was being bullied. The patrol officer said that, although aware of it since the man's death, he was not aware at the time.
122. The investigator asked the patrol officer what he understood to be the instructions on the front cover of the ACCT document. The officer told him that the man should be spoken to three times during the "core day", that is the main part of the day when activity is taking place. He understood that the instruction to check the man hourly at night referred to when night staff were on duty. The officer understood that evening staff were required to monitor the man by having a conversation with him in the interim before night staff took over. The officer said that night staff would monitor the man every hour.
123. The investigator asked the patrol officer to explain the difference between patrol state and night state. The officer said that night state started when night staff took over for the night shift. He said patrol state was similar, but that staffing levels were different. The officer agreed with the investigator that, from a prisoner's point of view, patrol state and night state were the same in that prisoners were locked up.
124. The OSG who assisted the patrol officer on B wing told the investigator that the officers and OSGs had discussed the meaning of the monitoring instructions recorded on the front of the man's ACCT document. They debated whether to have a conversation with him (as required three times during the working day), whether to begin the hourly monitoring straightaway whilst the prison was in patrol state, or wait until the night staff came on duty. The OSG said that they decided that the instruction meant that a member of staff should have a conversation with the man during the evening.

125. My investigator asked the SO who was Oscar 2 and in charge of half the prison that night, for her understanding of the instructions on the front of the ACCT document. The SO agreed that the instruction of hourly checks at night was ambiguous and, in her view, meant that they should have been done whenever the man was locked in his cell. In her opinion, the hourly monitoring should have started when he was locked up at 5.00pm.
126. At about 7.30pm, the patrol officer decided to check on the two prisoners on his wing who were being monitored under the ACCT arrangements, one of whom was the man. When the officer looked into the cell he immediately saw the man hanging by a ligature, made from a bed sheet, which had been secured to an electrical conduit pipe running along the ceiling of the cell. The officer said the man was suspended approximately three feet off the ground. He tried to obtain a response from him by kicking the cell door and shouting a few times, but he did not react.
127. The patrol officer said he did not think that the man was pretending to hang himself. He said that he was shocked by the sight, which he had not expected. He was not carrying anti-ligature scissors and so ran back to the wing office (which he said is approximately 150 yards away) and told the OSG to contact the orderly officer responsible for B wing (Oscar 2). The officer then collected the self harm kit which contained the scissors.
128. My investigator asked the patrol officer why he did not enter the cell immediately he found the man. The officer said that at the time he did not know what to do, as he was on his own. He added that he did not know how long it would take to obtain assistance and confirmed he had not thought to shout for help. He said that he would have felt safe to go into the cell alone. His decision not to enter was not based on security but because he needed assistance to deal with the situation.
129. The investigator also asked the officer if he was carrying a prison issue radio. The officer could not recall if he had a radio with him. He was asked if he had considered pressing an alarm bell, but he said he had not rung the bell because he would not have obtained a response during the evening. It is not clear how or when the communications room operator was asked to summon an ambulance.
130. Another OSG, also in the wing, used his prison radio and asked the Oscar 2 SO, to go to B1 wing. The radio log shows that the radio operator passed on the request at 7.40.01pm. The SO was asked to go immediately to B1, and she acknowledged the call within seven seconds.
131. A further radio call was made at 7.41.07, this time by a third OSG who had gone to the wing. The OSG asked the communications officer if the Oscar was on the way, and was told yes. The OSG asked the communications officer to make the request for Oscar "more urgent". After just over one and a half minutes, the communications officer asked both Oscar 1 and Oscar 2 to go immediately to B1. The Oscar 1 was another SO, and he confirmed to the radio operator that he had received the message.

132. In the meantime, the patrol officer returned to the cell. He unlocked the door and went inside where he supported the man's body and took the weight off the ligature. He continued to do this until a second officer arrived shortly afterwards. At interview, the second officer to arrive at the cell said she was in B2, which is about 50 to 100 yards away, when she received a telephone call from an OSG telling her that a prisoner was hanging in B1. The officer immediately ran to B1 and went to the man's cell. She saw the patrol officer standing up, supporting the man by the legs. There was a green ligature around the man's neck, which was secured to a lighting conduit pipe running across the ceiling. (I say no more about the conduit in this report. However, the Governor will wish to satisfy himself that such pipes do not constitute avoidable weaknesses in the safety of the cell design.)
133. The patrol officer told the second officer to arrive at the cell to cut the ligature with the scissors which he had placed on the bed. Once the ligature had been cut, he was able to lay the man on the bed. After laying the man on the bed, the patrol officer checked for signs of life by nipping his ear and his nose. He did not obtain a response. He confirmed in interview that he did not check for a pulse. The second officer to arrive at the cell passed him a mouth to mouth aid and he started to administer Cardio Pulmonary Resuscitation (CPR).
134. The second officer to arrive at the cell said that, shortly after she went into the cell, the Oscar 2 SO arrived and assisted the patrol officer with CPR. The second officer at the cell told the investigator that she did not assist with CPR and confirmed that she did not see any sign of life. She said that she left the cell and went outside to wait for the ambulance which she later escorted to the wing. In her police witness statement, she said that the ambulance took 40 minutes to arrive.
135. The Oscar 2 said that, as she was leaving the Care and Separation unit, she received a radio message asking her to go immediately to B wing. She said the distance was about 400 to 500 yards and it took her between two and three minutes to get there. When the Oscar 2 reached the wing, she saw the second officer to arrive at the cell who summoned her to the man's cell. As she went into the cell, she saw the patrol officer performing CPR on the man. He told her that the man had been found hanging and had been cut down.
136. The Oscar 2 assisted by carrying out chest compressions whilst the patrol officer continued with the breaths. The Oscar 2 instructed the second officer to arrive at the cell to collect the defibrillator and, in the meantime, they continued with CPR. The Oscar 2 told my investigator that, in her opinion, there did not appear to be any sign of life.
137. She remembered hearing a further radio message, this time asking for Oscar 1 to go to B wing. Soon after hearing the message, the Oscar 1 arrived and also assisted with CPR. The Oscar 2 confirmed that CPR continued until paramedics arrived and took over. The Oscar 2 asked my office to pass on her condolences to the man's family. She felt that staff could not have done anything more to save him after he had been found.

138. The OSG who was assisting the patrol officer on B wing said he went to the man's cell to offer assistance and the second officer to arrive at the cell asked him to accompany her to the pharmacy to collect the defibrillator. The defibrillator was missing from its holder on the wall. The OSG Fisher said that the second officer to arrive at the cell returned to the man's cell to report that the defibrillator could not be found. In the meantime, he tried to get into healthcare to find one. Unfortunately, his keys did not allow access into the treatment rooms which is where he thought there might be a second defibrillator. He was uncertain whether additional defibrillators were available, but continued to search for one until he was asked by the Oscar 1 to go to the command suite to collect the prison contingency plans for dealing with a death in custody. (My investigator subsequently learnt that the defibrillator was locked in the cell where another prisoner had died the previous week.)
139. The patrol officer and the Oscar 1 continued to administer CPR whilst waiting for the paramedics to arrive. Once the paramedics were at the cell, they took over responsibility for the man's care and the officers left the area.
140. Whilst in A4 unit, the Oscar 1 received a radio message asking him to go to B wing. He told the investigator that there was no urgency to the message. He began to make his way to B wing, which he estimated to be approximately 350 yards and which took him about two minutes to get there. My investigator gave the Oscar 1 a copy of the radio log transcript which shows the radio message was sent to Oscar 2 at 7.40pm, and the radio operator asking Oscar 2 to attend immediately. The Oscar 1 said he vaguely remembered hearing the message asking Oscar 2 to attend immediately.
141. The Oscar 1 told the investigator he had not received any specific training at Whatton in dealing with incidents. However, at a previous prison, he had been a first on scene instructor and had re-written their contingency plans. He said that, as far as he knew, there was no specific training for senior officers at Whatton in how to manage an incident and they were merely expected to read the local contingency plans. He explained that, as orderly officer, he is issued with a master set of keys. He believed that the keys gave access to most areas of the prison, although he did not know with any certainty if this included access to healthcare.
142. When the Oscar 1 arrived at B wing, he met the second officer to arrive at the cell who asked if he was carrying a defibrillator. He told her that he was not, and told the investigator that he was unaware of the reason why he had been asked to go to the wing or that a defibrillator was required. The Oscar 1 followed the officer to the man's cell, where he saw the Oscar 2 and the patrol officer carrying out CPR.
143. Seeing that the Oscar 2 was tired, the Oscar 1 took over from her, and the Oscar 2 then took over from the patrol officer. The Oscar 1 continued CPR for a further 15 minutes, but then felt nauseous and had to leave the cell. The Oscar 2 and the patrol officer continued with the resuscitation attempts.
144. The Oscar 1 left the area and went to the communications room where he started to implement the contingency plans for a death in custody. He confirmed with the

officer in the communications room that an ambulance had been called and then began to contact the Duty Governor. He returned to B wing and, as he arrived, he met another officer and asked her to assist him.

145. The officer had heard over the prison radio that there was a problem in B wing. She was in the Care and Separation Unit and was due to go off duty for the evening but instead went to offer assistance. The officer arrived as the Oscar 1 returned to the wing. Shortly afterwards, although the Oscar 1 was not certain in which order, the Duty Governor, also the Head of Residence, and the paramedics arrived at the prison. The Oscar 1 told them what had happened and explained that staff had been trying to resuscitate the man for about 50 minutes with no sign of response.
146. At interview, the officer who attended the wing with the Oscar 1 said she went to the man's cell and saw a police officer outside the cell. She looked inside and saw the Oscar 2 and the patrol officer performing CPR on the man. She described them both as looking very tired but they were persisting. She offered to take over the chest compressions. Just as she was about to take over, two paramedics arrived and took responsibility for the man's care. The officer said the paramedics attached their own equipment to the man and, after carrying out their own checks, confirmed that he had died. She said that they completed their checks in about two minutes and then left.

Following the man's death

147. The ambulance log shows that the prison rang the emergency services at 7.42pm, but that the ambulance crew were not mobilised for a further 15 minutes. It was a further 20 minutes before they arrived at the prison and an additional five minutes before they were with the man. The paramedics noted that he was pale and cyanosed (a blue colour to the skin), and at 8.30pm stopped any further attempt to resuscitate him.
148. The officer who attended the wing with the Oscar 1 was asked by the Oscar 1 to restrict access into the cell and take over the log of all those attending. The officer said a number of police officers arrived, including officers from the scenes of crime unit. The officer told the investigator that the police confirmed that the man's death was not being treated as suspicious.
149. After the police completed their enquiries, the officer decided to remain with the man as she felt it appropriate that he was not alone. She described how peaceful he looked. She stayed to assist a police officer prepare him for transfer to the mortuary. She said she wanted the man's family to know that he was cared for.
150. On Sunday 29 April, the officer who had tutored the man on the SOTP course returned to duty and was told that the man had died. At interview, he said he was amazed as he was the last person he expected would kill himself. The Governor arranged for the prison chaplain, a manager and the SOTP course tutor to go to the man's home and meet his family. The SOTP course tutor told my investigator that he was pleased to be asked to go and said the man's family made them welcome.

151. The man's friend and fellow prisoner said that he thought that the man was manipulative, and believed his action was a cry for help which went wrong. He said the man believed he could obtain a transfer to another wing by claiming he was being bullied, but knew he did not fit the criteria. The man's friend said he did not see anyone bullying him and the man had never spoken to him about it.
152. The Governor ensured that the local staff care team was notified and available for all staff. He also asked for extra staff support from the area, and arranged for the staff care team to chair a critical incident de-brief meeting on 10 May. He also ensured that all prisoners being monitored under ACCT were reviewed. Additionally, the Governor reminded his staff of the need to support prisoners.
153. My investigator spoke to an officer who had previously been one of the man's personal officers. She said the man would not open up and did not want to sit and talk to her. She described him as erratic and said trivial things would cause him to "blow his top". He would get angry and become fixated on one particular point. The officer gave an example of when she woke the man during the night, following which he would not speak to her for a couple of days. He then returned to his normal self.
154. The officer said the man did not discuss being bullied with her. However, after his death, two prisoners spoke to her about the man being teased over his legs. They told her that the man was conscious about his small size. He would get anxious about walking past other prisoners whilst he was wearing his shorts and vest on the way to the gymnasium. The officer remembered the man telling her how difficult he found having to talk about his offence on the SOTP course. She told him about support networks, and he said he could talk to two other prisoners on the wing if necessary. On one occasion, the officer and the man had spoken about his previous experience of being monitored on ACCT. He had said he found it difficult to be locked in his cell for long periods of time and was anxious about his status.
155. The officer described the system for ACCT reviews and said that personal officers are not always invited to attend the review. In hindsight, it would be better if they were asked to attend. She thought that one person should be identified to engage with the prisoner, rather than anyone who happened to be in the area.
156. The investigator spoke to the Head of Operations and Security. She said that, the day after the man died, the alleged bully was moved to the Care and Separation Unit, partly for his own safety and so the prison could investigate the allegations. She said that some of the allegations apparently related to the man's PlayStation. The Head of Operations and Security said that the man had either lent his PlayStation to a prisoner or it had been taken from him, but whatever the circumstances it was found in a waste bin after his death. The alleged bully was interviewed in the course of the police enquiries, but I do not know the outcome. I am aware that, due to hostility from other prisoners, he was transferred to another prison.

Family Contact

157. At the meeting with the man's family on 24 June, his mother asked my FLO a number of questions. I hope that my report has managed to answer them and given his family a clearer understanding about what happened. The man's mother wanted to know:

- Was the prison carrying out anti-bullying observations correctly?
- When was the alleged perpetrator moved from the wing?
- Was the man monitored correctly for acts of self harm?
- How many safe cells does the prison have?
- Why was the man not moved to a safe cell?
- Were the Ombudsman's notices displayed?

158. The man's mother also told my FLO that, when she went to the prison to see where her son died, she had not been given his belongings. She wanted to know why there was a delay in clearing his property and returning it to the family, and whether this meant that the police were making further enquiries.

159. I can confirm that the police were not making further enquiries and the property should have been returned as soon as the cell was returned to the Governor. It would appear that a genuine mistake was made as a result of a misunderstanding that the cell should remain sealed pending approval from my investigator to release it.

ISSUES

Assessment, Care in Custody and Teamwork (ACCT)

160. The ACCT document relating to the man was not completed correctly and the review date had been amended from 28 April to 1 May. Although the alteration had not been made in an attempt to erase the original date, it was nevertheless difficult to read. Prison staff are advised that, whenever they make a written mistake, they should simply strike one line through the error, initial the mistake and then insert the correct information. By doing this, anyone can see that it is simply an error and not suspicious.
161. Although ACCT monitoring began on the same day as the document was opened by the New Leaf course tutor, it was almost five hours before the first entry was made in the record. Additionally, the immediate action plan was not completed until the following day, some 18 hours later.
162. The record shows that the New Leaf course tutor was not part of either the Immediate Action Plan meeting or the Assessment Interview. I believe it is best practice, wherever possible, to invite the person who opened the ACCT document to attend both the meeting and the interview. Their attendance gives continuity to the prisoner and ensures that the initial concerns are communicated directly.

The Prison Service may wish to consider revising the ACCT procedure to ensure that, wherever possible, the person opening the ACCT document attends the Immediate Action Plan meeting and Assessment Interview.

163. The instruction to check the man "hourly at night" was generally thought to refer to "night state", when the prison was fully locked up and staffing levels at a minimum. Staff did not consider that hourly monitoring was required whenever the man was locked alone in his cell. This meant that staff did not intend to check him from the time he was locked in his cell at 4.45pm on Saturday 28 April until the night staff came on duty at 8.45pm. In the event, the patrol officer decided not to wait this long and went to check the man at 7.30pm.
164. The PCT comments that instructions written in ACCT documentation should leave no room for interpretation. It considers that checks should take place irregularly, as should the conversations (which should be meaningful interactions). The ACCT assessor and prisoner should both be involved in planning the level and nature of the support. In the PCT's view, the culture of on the hour serves no purpose and does not lead to reductions in self-harm.
165. The PCT describes ACCT as a process of supporting an individual through a period of crisis. Irregular checks and meaningful interactions agreed both by prison staff and the prisoner may be more effective in reducing self-harm. It comments that an ACCT culture of regimented hourly observations, together with the period between lock up and the next expected check, may well have given the man an opportunity when he knew he would unlikely be disturbed. However, the opportunity to have saved his life from hanging would only have been a few minutes, and even irregular checks within the hour would have been unlikely to

have saved him. The only way he might have been prevented from hanging himself would have been with constant observations, which his behaviour on Saturday 28 April did not warrant.

166. The man was not to know that the instruction in respect of checks had been interpreted in the way it was. And we can never know whether, had the instruction been clearer and he had indeed been monitored every hour, the circumstances might have been different. However, it is manifest that hourly checks would have meant that he would have been discovered earlier.
167. After the man's death, the Governor reviewed his ACCT document and discovered weaknesses similar to those I have identified. I understand that he has carried out his own internal investigation and has already implemented changes to rectify the failures. Additionally, I understand the Governor asked the Area Safer Custody Manager, a member of the area manager's support team, to review the ACCT procedures at Whatton. The Area Safer Custody Manager endorsed the Governor's findings and the necessary changes.
168. I am satisfied that the Governor has identified the shortcomings in the ACCT procedures and introduced changes to ensure the same mistakes cannot be made again.
169. My investigator was impressed by the level of commitment shown by the New Leaf course tutor. She recognised during the course that the man was unhappy and, although he would not discuss his problems in open forum, she did not ignore her concern and spoke to him privately at the end of the session. After hearing what was troubling him, she quickly opened an ACCT document and delivered it personally to the wing manager. She then spoke to a mental health nurse and made him aware of what the man had said. Her entry in the ACCT document is informative and a model of good practice. Although I make no formal recommendation, the Governor may wish to consider sharing my comments with the course tutor and her employer.

Violence Reduction Strategy (VRS)

170. I have explained the purpose of the VRS and how it is meant to function. It is clear that the alleged bully, who was meant to be observed at stage one, was not correctly monitored. There are no entries in the VRS document or, as a safeguard, in the Wing Observation Book and B1 Daily Log Sheet, although I understand the daily briefing sheet did contain the information.
171. I am not satisfied that the VRS monitoring of the alleged bully was at all satisfactory. This leads me to believe that the man might well have remained in a vulnerable position.

The Governor should satisfy himself that the Violence Reduction Strategy is operating correctly. Additionally, he should ensure that there is a suitable monitoring system in place to assess the quality of the documents and entries.

172. The VRS PSO gives a mandatory instruction that Governors are responsible for the implementation and maintenance of their local Violence Reduction Strategy. It adds that it is both central to the aims of the Prison Service and fulfils a duty of care under Health and Safety legislation. Although not a mandatory instruction, the PSO goes on to say that local training and or guidance will be needed to inform and engage staff in the local strategy and processes. It goes on to say that, 'Governors will need to ensure that the necessary training is built into the training programme.'
173. I am aware that the Governor of Whatton has issued written guidance and made the instruction available on the prison's intranet. I also understand that he has set every member of staff an objective within their annual staff appraisal that they familiarise themselves with the VRS process. Direct training has not been provided.
174. In order to satisfy himself that staff did understand what was required of them, the investigator asked an officer to identify where the blank and open VRS documents were kept. The officer was unable to answer with any certainty, believing it might be either on the office desk or in a tray. I am not certain that each member of staff understands the VRS process, as in the man's case it was initially completed incorrectly and was then not dealt with at all.

The Governor should consider training all his staff in the local Violence Reduction Strategy.

Senior Officer (SO), B wing manager

175. My investigator made further enquiries about the VRS process from the prison's Anti Bullying Co-ordinator. He told the investigator that he was on annual leave when the man's document was opened. On his return to duty, he learnt of the man's death and his allegation of bullying. The co-ordinator went to B1 wing and asked to see the anti-bullying document, but was told that it could not be located. He eventually found it in a drawer in the B2 office. When he examined it, he saw that there were no records of any observations and drew the matter to the attention of the Deputy Governor.
176. The co-ordinator said that each wing SO is responsible for ensuring that the log is completed each day, and that one day's training had been delivered to managers. However, it is not mandatory and the training record for the SO who was the B wing manager does not show him as receiving the training. Subsequently the Deputy Governor advised that the SO – despite saying that he had not been trained – had actually been present. Whether or not he had been trained, he made a number of errors in the VRS document which the investigator highlighted to the Governor. The Governor has commissioned his own internal disciplinary investigation.

The patrol officer

177. The patrol officer is an experienced prison officer with approximately 13 years service. He went to the man's cell to carry out an ACCT check and found him hanging from a ligature.
178. Prison officers are told that in a life threatening situation they can enter a cell alone, but only after summoning assistance and, more importantly, if it is safe to do so. The patrol officer was carrying his security keys and could have opened the door. At interview, he told the investigator that he did not feel that his own safety was in jeopardy. He could not recall if he was carrying a prison issue radio, and an examination of the communications room log does not make the matter any clearer. However, as the wing patrol officer, I suspect that he was issued with a radio, but cannot be certain that he had it with him at the time he found the man.
179. Having seen the man hanging, the patrol officer realised he could not deal with the situation alone and had to make a snap decision about what to do next. Although he had a number of options available to him, he decided to leave the man and returned to the wing office to summon assistance and collect an anti-ligature knife. In reality, even if the officer had entered the cell and supported the man's body, I doubt whether this alone could have relieved the pressure on his neck. Because the man was fully suspended, the ligature was extremely tight.

Summoning Emergency Assistance

180. The patrol officer said he went to check the man at approximately 7.30pm. I have described above what happened next in relation to him finding the man hanging. What is not clear from the investigation is at what point the communications room was asked to summon the emergency services. The reason for the confusion is that the times given by the staff involved are approximate and, as a radio was not used to request an ambulance, there is no accurate time recorded in the radio log. However, what is certain is the time the emergency services received the call from the prison. This is logged at 7.41pm. This means that there is a possible gap of 12 minutes before the emergency services were called.

The officer who stayed with the man's body

181. After receiving confirmation that the man had died, one officer decided to remain with him so that he would not be alone, and then stayed to assist a police officer prepare the man for transfer to the mortuary. She particularly wanted his family to know that he had been cared for.
182. I have been moved by the actions of the officer towards the man. She demonstrated a level of care and decency over and above that which is usual. She felt it important for the man not to be alone and for his family to have the comfort of knowing that he was cared for.

The officer should be commended for the high level of decency and care she showed to the man following his death.

Clinical Care

183. In the clinical review, the PCT comments on two more aspects of the care provided for the man. It is satisfied that a comprehensive health screening took place when the man arrived at Whatton and appropriate ongoing care plans were made. It also says that the officers attempting to resuscitate the man did everything they could to save him. It adds that all those involved in the CPR should be praised for their efforts and professionalism during what it describes as a traumatic and tragic incident.

Emergency Services

184. There was a delay before the ambulance reached the prison and the paramedics were available to treat the man. The operation of the emergency services is outside the terms of my investigation, but the clinical reviewer has made enquiries. It found that the emergency call was made by the prison at 7.41pm and a paramedic crew was mobilised one minute later. However, they were stood down and at 7.57pm a second crew was asked to attend. The reason for standing one crew down and mobilising a second was because the second was expected to get to the prison more quickly. The call was coded by the ambulance service as a category B incident, for which they are expected to arrive within 19 minutes. Unfortunately, the second crew did not arrive until 8.17pm, which was 35 minutes later and 16 minutes longer than the target.

185. I will be forwarding a copy of this report to the local Ambulance Service for their information. Whilst I do not make a formal recommendation, I hope that they may consider the events of 28 April and the actions of their control room staff to see if there are any lessons to be learnt.

186. The clinical review notes that the prison's location means that, unless an ambulance is passing when an emergency call is made, there can be no external medical assistance for at least 20 minutes. In its opinion, employing trained paramedics to be on duty at the prison would not be justified as the infrequent demand would not warrant their level of expertise. It suggests that 24 hour medical staff would be able to respond to emergencies and reliably identify the assistance required.

Provision of a defibrillator

187. In its clinical review, the PCT notes that the man was fully suspended before being cut down and the post mortem confirmed that asphyxia was the cause of his death. A defibrillator could not be located and so staff worked without one. The PCT adds that, whatever the cause of death, hanging usually leads to unconsciousness within 30 seconds and death after about three minutes. In its opinion, the absence of the automated defibrillator, the delay before the paramedics' arrival, and the absence of medical staff on duty, would not have made a difference to the outcome for the man. Nevertheless I am pleased to learn that the Governor has taken steps to purchase additional defibrillators to prevent any further similar occurrence.

CONCLUSION

188. The man made it clear that he was being bullied and thinking about ending his life. The New Leaf course tutor immediately and correctly opened an ACCT document and alerted the wing manager. She also informed a mental health nurse and asked for the man to be assessed. Tragically, from then on neither the ACCT nor the VRS systems were managed correctly. The ambiguous instructions on the ACCT document did not help the situation and neither did the failure by the wing manager to implement the violence reduction procedure correctly.
189. Additionally, the officer who found the man hanging did not enter the cell immediately and instead went to the wing office to summon assistance and collect anti-ligature scissors. We cannot know whether the delay before he was lifted and the pressure taken from the ligature affected the outcome. However the clinical review suggests that the man had already died when the prison staff reached him.
190. Having made his feelings known, I conclude that the man was not given the level of support and protection that he was entitled to receive. We do not know if he was subjected to further bullying, but it has to be a distinct possibility. We can only further speculate whether such bullying influenced the sad events described in this report.

RECOMMENDATIONS

1. The Prison Service may wish to consider revising the ACCT procedure to ensure that, wherever possible, the person opening the ACCT document attends the Immediate Action Plan meeting and Assessment Interview.

The Prison Service has partially accept the recommendation. Their response is: Locally, at HMP Whatton, this is regarded as good practice and is done where practical and appropriate. However, this needs to be considered on a case by case basis and in some cases it may not be appropriate for the person who opened the ACCT to attend the Immediate Action Plan Assessment Interview.

2. The Governor should satisfy himself that the Violence Reduction Strategy is operating correctly. Additionally, he should ensure that there is a suitable monitoring system in place to assess the quality of the documents and entries.

The Prison Service has accepted the recommendation.

3. The Governor should consider training all his staff in the local Violence Reduction Strategy.

The Prison Service has accepted the recommendation.

4. The officer who stayed with the man's body should be commended for the high level of decency and care she showed to him following his death.

The Prison Service has accepted the recommendation.