

**Investigation into the circumstances surrounding the
death of a man at HMP Wakefield
in July 2007**

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

June 2008

This is a report into the death of a man, a life sentence prisoner at HMP Wakefield, in July 2007, who died having taken an overdose of prescribed medication. He was aged 41.

I would like to offer my sincere condolences to the man's family and friends for their loss. I must also apologise for the delay in issuing this report.

Two of my colleagues conducted the investigation. I would like to thank the Governor of Wakefield for making my investigators welcome and for arranging the necessary facilities to enable them to carry out their work. I am also grateful to the prison's liaison officer who gathered all the relevant documentation.

As part of the investigation process, Wakefield Primary Care Trust conducted a clinical review of the man's care. I am grateful for his invaluable contribution. Those are extended to the pharmacist who contributed to the review.

One of my Family Liaison Officers contacted the man's next of kin to inform them of my investigation and to offer the opportunity to raise any concerns. I hope this report answers any questions they may have about the circumstances surrounding his death.

The man had a history of violent behaviour. He also frequently spoke to prison staff about his intention to take his own life, and was subject to the Prison Service's monitoring and support procedures (ACCT) for those believed at risk of self harm and suicide for the two years before his death. He was regularly prescribed medication for various physical ailments. He held these medicines in his own possession as no risks had been recognised. A week before his death, he was mistakenly prescribed double the amount of one of his regular medications.

On the morning of 12 July 2007, the man's ACCT document was closed after being open continuously for two years. Within 24 hours, he was found unconscious and was later pronounced dead by paramedics. A large quantity of medication was discovered in his cell and more was missing. A suicide letter was also in his cell. According to the post mortem examination, the cause of death was ischaemic heart disease combined with a drug overdose.

I make five recommendations, one of which concerns the involvement of mental health staff with new receptions that I have made previously. I also comment on the closure of the man's ACCT document by a single member of staff. Although there were some mitigating circumstances, and while I do not criticise the decision itself, this was wholly contrary to the ACCT guidelines.

Not surprisingly given the circumstances, the clinical reviewer has commented on medication management. I have been pleased to learn that some new systems have now been implemented.

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

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SUMMARY

The man who is the subject of this report was 41 years old when he died. He was serving a life sentence at HMP Wakefield, having transferred from HMP Manchester. An ACCT plan (a system for managing, monitoring and supporting prisoners in distress who might pose a danger to themselves) had been opened by Manchester in 2005. It remained open for the next two years because of his repeated threats to commit suicide.

During the majority of the time the man spent in custody, he rarely agreed to healthcare intervention other than for his physical ailments. His medication included diltiazem (for angina) and gabapentin. He was not assessed as at risk when holding this medication in his own possession. A week before his death, he was mistakenly prescribed a double dosage of gabapentin.

Mental health assessments had been carried out on the man, but he was considered to have a personality disorder rather than a mental health problem. It appeared to staff that his threats to take his own life were not meant seriously.

Several ACCT reviews had considered closing his ACCT plan and the observation levels were reduced. The ACCT document was eventually closed on 12 July 2007 by the man's case manager. Neither the man nor anyone else was present.

No concerns were raised about the man's wellbeing during that day and several staff spoke to him. He was last seen alive at around 8.00pm and gave no cause for concern. However, when his cell was unlocked the next morning, he was discovered to have died. Resuscitation was not attempted as rigor mortis had already set in. The paramedics formally pronounced his death.

The police retrieved large amounts of medication from the man's cell, including a number of empty blister packets. A suicide letter addressed to a friend was also discovered. This intimated that the man had taken a drug overdose.

A post mortem examination found that the man had ischaemic heart disease that, coupled with a mixed drug overdose of diltiazem, gabapentin and paracetamol, caused his death. There was no evidence to suggest third party involvement.

Although the process was flawed, I do not criticise the decision to close the ACCT form on the day before the man's death. It had been discussed over the previous two months and staff had no grounds for thinking he was at particular risk. It is possible that the pure chance that he had been provided with surplus medication presented itself as an opportunity for him to take his own life. However, as he had long been in receipt of medication without proper risk checks, he could have taken his life at any point. I also judge that he was unlikely to be aware of the extent of his heart disease.

THE INVESTIGATION PROCESS

1. The investigation was formally opened on 18 July 2007 by one of my investigators. My investigator met the Governor, Deputy Governor, Prison Family Liaison Officer, Prison Liaison Officer, Vice Chair and the Head of Healthcare at Wakefield. My investigator was briefed about the circumstances leading to the man's death and a number of relevant files and records were examined. My investigator also met a member of the local Prison Officers' Association (POA) and the Independent Monitoring Board (IMB) to brief them about the investigation process. They were informed that they could speak with him at any time during the course of the investigation should they have any relevant information.
2. My investigator visited the wing where the man died. He also visited all other parts of the prison. My investigators subsequently interviewed a number of prison staff and four prisoners. Due to a number of staff being unavailable for interview, this investigation report has been delayed.
3. The Wakefield Primary Care Trust conducted a clinical review of the man's clinical care and treatment whilst at Wakefield. The clinical reviewer also took the opportunity to assist my investigator with some of the interviews. As pharmaceutical issues were raised during the investigation, a pharmacist kindly assisted the clinical reviewer in his review. The clinical review and recommendations will be shared with Wakefield PCT upon completion of the investigation.
4. The man's next of kin was listed as a friend. The man was also in regular contact with another friend. The prison contacted both men to inform them of the man's death. One of my Family Liaison Officers (FLOs) tried to contact them shortly after the investigation was opened but only one responded. She explained the role of the PPO and provided information about the investigation process. Although he was not listed as next of kin, the man's friend was given the opportunity to raise any concerns he had relating to the death.
5. A short while afterwards, the prison informed my investigators that they had managed to contact the man's aunt and uncle. My FLO contacted them to offer the opportunity of a meeting to discuss any issues or concerns. The family has said they would like to see a copy of the report once the investigation had been concluded.
6. The man's friend and his family had the following concerns:
 - Could the man have been monitored more closely?
 - Was he allowed to keep his medication in his own possession?
 - They believe that the man had made it very clear that he was going to take his life. This included writing to other prisoners to inform them. How did the prison react to this?

- The man had lost his step-father before he went into prison and then his mother died shortly afterwards. This, along with receiving a life sentence, had caused him to feel hopeless.
7. My investigators wrote to HM Coroner to inform him of the nature and scope of my investigation and to request a copy of the post mortem report. Upon completion, this report will be sent to the Coroner to assist in his enquiries into the man's death.
 8. Since my office took responsibility for investigating deaths in prison custody, there have been five previous deaths at Wakefield, four from natural causes and one that was apparently self-inflicted.

HMP WAKEFIELD

9. There has been a prison on the site of HMP Wakefield since 1595. In its current form, it dates back to 1845. The prison's healthcare centre is separate from the main residential areas. All the cells have integral sanitation and the prison has recently undergone refurbishment.
10. Wakefield is a male prison for those serving four years or over as well as life sentence prisoners. It forms part of the high security estate housing prisoners who potentially pose the greatest risk to the public or state. It specialises in the treatment of serious sex offenders.
11. The prison provides workshops and an education department offering both full and part time education. The programmes department offers a range of offending behaviour courses including FOCUS (drug programme), Personal Development (PDC), Sex Offender Treatment Programme (SOTP) and the Enhanced Thinking Skills (ETS) programme.
12. The most recent report by HM Chief Inspector of Prisons, Ms Anne Owers, was published in 2005 following an unannounced follow up inspection. The report says:

“Overall, Wakefield was clearly a prison on the move. But there was a great deal of movement still required in order to make it a fully effective prison, able to engage properly with the serious and difficult offenders that it holds.”

Healthcare

13. HMP Wakefield provides 24-hour nursing care for prisoners and has a 20-bed inpatient facility. A mental health in-reach team is provided by South West Yorkshire Mental Health Trust. The team comprises one on-site Community Psychiatric Nurse (CPN) supported by three visiting consultant Forensic Psychiatrists providing three sessions a week.
14. The prison has developed a First Contact nurse-led clinic. The clinical reviewer comments that it provides a new way of working for both nurses and prisoners alike. It has enabled the nurses to develop a service that has been well received by the prisoners, and has helped the nurses develop their skills and confidence in first contact care within the areas of acute care, disease management and health promotion. It has changed the terminology from 'Sick Parade' to 'First Contact', implying a modernisation of the service on offer to prisoners.
15. A permanent pharmacist, employed by Wakefield District Primary Care Trust, is now in post. The pharmacist is supported by pharmacy technicians and between them they deliver a full range of pharmaceutical services to the prisoner population.

16. A report by the prison's Independent Monitoring Board (IMB) in August 2004 praised the healthcare department which was about to undergo the transition to the local Primary Care Trust.
17. In 2005 the Chief Inspector of Prisons' report said of healthcare:

“There had been little change in healthcare facilities since the last report. Wakefield provided 24 hour care for prisoners and had a 20 bed inpatient facility. Staff were enthusiastic and committed to improving services but there appeared to be a lack of strong clinical leadership particularly in primary care area.”
18. The clinical reviewer reports that since the Chief Inspector's inspection, efforts had been made to strengthen staffing. A recent initiative had been to train Discipline Officers to NVQ Level 3 and recruit further nursing grades.

Medication management in prison

19. The clinical reviewer has also commented on medication management at Wakefield. The Government has said it is committed to providing a health service to prisoners that is equivalent in quality and range to that in the wider community. Under Prison Service Instruction 028/2003 (“A Pharmacy Service for Prisoners”), medicines in use, together with associated monitoring and administration devices, should normally, as a matter of principle, be held in the possession of prisoners. Each prison should have a policy and risk assessment criteria for determining on an individual basis when medicines may not be held in the possession of a prisoner. Although the risk assessment tool was in use at Wakefield, the clinical reviewer has found flaws in the way it operated.

Reception

20. On arrival at HMP Wakefield, all paperwork for prisoners is checked before they are taken off the escort vehicle. Staff check warrants to ensure they have the correct prisoners in custody, and then set up the necessary records. The prisoner is taken from the vehicle and booked in by the senior officer on the front reception desk. Personal and offence details are taken, together with any known or identified concerns.
21. All prisoners see the first night in prison officer, reception officers and the nurse on duty. During this process, staff obtain address and next of kin details. Prisoners are strip searched, their property is logged, and they are health screened, before being placed in a holding cell ready for locating staff to take them to a wing.

Emergency alarm codes

22. The alarm system used in Wakefield is a two tone system. If a member of staff presses an alarm bell, it is transmitted over the hand-held radios. A code red or blue system is used for emergency response.

Insiders and Listeners

23. As is common with most prisons, Wakefield uses experienced prisoners to operate as Insiders and Listeners. Insiders welcome new prisoners, highlight any concerns and explain the processes the newcomers will encounter in the early days of custody. Listeners assist those prisoners who require additional support at any time in their period in custody. They are provided with training from the Samaritans to support them in this role.

Roll Check

24. The roll check is the physical count of the number of prisoners on each wing within a prison. Roll checks occur on a number of specified occasions during the day and night, and staff must sign that the roll is correct.

Safer cells

25. Wakefield has a number of 'safer cells', which are specially designed to contain as few ligature points as possible. They are used for prisoners assessed to be at risk of harming themselves.

Cell Sharing Risk Assessment (CSRA)

26. In order to make sure that unsuitable prisoners do not share cells (e.g. a racist prisoner and one from a visible ethnic minority or a mentally disturbed prisoner with a violent one), a cell sharing risk assessment form should be completed by reception when a prisoner is first admitted.

Assessment, Care in Custody and Teamwork (ACCT)

27. As at all prisons, ACCT has been introduced at HMP Wakefield to monitor and support prisoners assessed as at risk of suicide or self harm. (The previous system was known as the F2052SH procedure.) Once placed on ACCT, the prisoner is observed at pre-determined intervals according to the perceived level of risk. At ACCT plan review meetings, a prisoner's level of risk can be reviewed and noted as either 'Low, Raised or High' depending on the level of concern staff have about an individual.
28. Each prisoner is assessed within 24 hours (ACCT assessment) and then reviewed further at intervals decided on an individual basis. The ACCT guidance says that, to be effective, the review should involve the people who know the person at risk or are involved in their care. The key questions for each review are listed as:
- have the problems that caused the ACCT plan to be opened now been resolved?
 - if not, what needs to be done to resolve them?
 - have any further problems arisen that are now causing distress and more risk?
 - if so, what action can be taken to address these?

- is the person at risk now in contact with friends, family or other support?
- does the person at risk now have something in their lives that they feel good about?
- if not, how can this be improved?

29. Over time, the reviews should also consider other factors such as:

- distress – has anything changed to make the person at risk more or less desperate?
- resources – has anything changed that makes the person at risk now feel more or less alone?
- previous suicidal behaviour – has anything changed that makes suicide more familiar or more acceptable to the person at risk?
- suicide intention or plan – has anything changed to show that the person at risk is more or less prepared to kill themselves?
- pattern of self harm – is self harm becoming more or less frequent?

30. Amongst other things, the ACCT guidance states that prisoners should be cared for in a safe environment. It is for the case review team to decide the most appropriate place to locate an individual prisoner.

31. HM Chief Inspector of Prisons' report found that levels of self-harm were low but it was difficult to establish any trends from the records. Between October 2004 and March 2005, 17 prisoners at Wakefield had self-harmed, eight of whom did so regularly. Twelve prisoners were currently on open F2052SHs (ACCTs).

Multi-Agency Public Protection Arrangements (MAPPA)

32. The MAPPA is a formal partnership between police, probation, prisons and other statutory and non-statutory agencies that assesses and manages offenders in order to minimise the risk of serious harm they may pose to the public.

33. Offenders who come within the MAPPA remit are classified according to the nature of the risk and its management. The higher the risk, the higher the level at which they are managed. Level one offenders are managed by one agency, usually the police or probation service. Level two offenders are managed jointly by all the MAPPA agencies and level three offenders are managed by the Multi-Agency Public Protection Panel (MAPPP) made up of senior managers from the MAPPA agencies.

Licence/Recall

34. Once released, a prisoner can be recalled to prison if they breach the conditions of their licence. The Parole Board will consider the details of the breach and make a recommendation to the Secretary of State with whom the final decision rests.

Incentives and Earned Privileges Scheme (IEPS)

35. The IEPS was introduced to encourage and reward good behaviour in prisons. There are three levels - Basic, Standard and Enhanced. Incentives include access to in-cell television, more private cash to spend, wearing own clothes, more time out of cell, and community visits.

Personal officer

36. All prisoners at Wakefield are assigned a personal officer. Their role is to meet with the prisoner on a regular basis and to discuss any issues or concerns the prisoner may have.

Canteen

37. Prisoners can obtain various foodstuffs and other items as 'canteen' from the prison shop. They also have access to a water boiler and are provided with a weekly tea pack, bread and other food items.

KEY EVENTS

Prior to Friday 13 July 2007

38. On 3 May 2005, the man who is the subject of this report was released on licence from HMP Acklington on what was considered a robust Risk Management Plan. He was a MAPPA level 3 offender. As part of his licence conditions, he was to wear an electronic tag and reside at an approved premises (a probation hostel). His licence was due to expire in 2011.
39. The man was arrested again on 10 July and charged with a total of 11 offences. He appeared at the Magistrates' Court in July 2005 and was subsequently recalled back to prison because he had breached the conditions of his licence. The man later pleaded guilty to the offences at court, and would return at a later date to be sentenced. He was transferred to HMP Forest Bank.
40. When he arrived at Forest Bank, the man was interviewed as part of the normal prison reception screening process. This included an examination by a member of the healthcare team. The man asked to be separated from the main prison population because of the nature of the offences he had committed. He was located in the segregation unit.
41. Two days later, on 14 July, the man disclosed to staff that he would kill himself because he was having difficulty in sleeping. As he had admitted to possible self-harm, the self-harm document FS2052SH (the form used prior to ACCT) was opened by staff, and he was monitored frequently.
42. On 17 July, the man was interviewed by healthcare staff. His mood was described as okay, but he was angry. He said he was unhappy in prison, wanted to hurt others, kill himself and felt that there was no point in living.
43. At the beginning of August 2005, the man again told staff that he intended to kill himself and refused to eat any food. On 24 August, he wrote to a fellow prisoner in another prison saying he intended to take his own life. Still on an open F2052SH, he continued to be monitored and offered support by staff. Despite these offers, he declined to take advantage of any of the support that was offered.
44. The following month, staff recorded in the man's wing history sheet that he had calmed down over the last week and was apologetic for his angry behaviour towards them. However, he still maintained that he wanted to take his life.

The man's transfer to HMP Manchester

45. The man was transferred to HMP Manchester on 27 September 2005, having spent around five months at Forest Bank. He again went through the normal induction screening interviews. He was interviewed by the prison doctor who identified that his mood was low and he was depressed. The man's response was that he did not want to be around and wanted to harm himself.

46. Given his mood, the man was immediately admitted into the healthcare unit. He was located in a single cell and placed on constant medical and psychiatric observation. The doctor prescribed medication of tildiem (for diabetes), aspirin, omeprazole (for stomach ulcer condition), citalopram (an anti-depressant), and salbutamol inhaler. The man was also taking medication for angina.
47. As part of an ongoing risk assessment to gauge the level of risk he posed to others, a cell sharing risk assessment (CSRA) was conducted. He was assessed as a high risk to others. Following further assessments throughout his entire time in prison, he remained at this level.
48. Manchester had by this time moved from using the F2052SH to using ACCT. Because of the man's continuing threats of self harm, the ACCT plan remained open and he was again offered support and monitored by staff.
49. On the morning of 28 September 2005, the mental healthcare nurse attempted to speak to the man. He was verbally abusive and refused to engage in conversation. He told the nurse that he would refuse any medication and intended to kill himself within two weeks. He also declared that he did not intend to eat any prison food. This behaviour was repeated for the next few months with the man saying that, once he had spoken to his solicitor, he would take his life.
50. At the beginning of December 2005, the man was told that his mother was terminally ill. He was allowed to ring the hospital ward to speak to staff. His mother subsequently died and her funeral (cremation) was scheduled to take place on 7 December.
51. On 6 December, the prison doctor ceased prescribing the man with medication for his depression and sleeping problem. The man was very angry about this and in protest said he would refuse to take his angina medication. Again he said he wanted to die. He made violent threats against the doctor and said he needed the medication because his mother had recently died. He was not happy that his mother was being cremated and said that the prison staff were to blame for arranging this.
52. The following day, although the man displayed no anger towards other healthcare staff, he again made threats to harm the doctor. Staff tried to persuade him to take his angina spray with him when he went to his mother's funeral, but he adamantly refused to do so. His ACCT monitoring continued.
53. On the night of 12 December, healthcare staff were called to the wing because the man complained of dental and chest pain. He was given paracetamol and ibuprofen for the pain. A few hours later, he was experiencing severe pain, had ripped his bed sheets and was threatening to kill himself. He was relocated to a cell on B wing that contained CCTV, and given tramadol to help with the pain. The following day, he was diagnosed as having a tooth infection.
54. The man continued to reiterate his intention to take his own life in January 2006. He continued to be monitored under the ACCT procedures but continued

to refuse help or support for his suicidal thoughts. The prognosis made by the prison doctor was that the man had displayed no evidence of mental illness, depression, self-harm or suicidal intention. It was felt that he had a borderline personality disorder. As there had been no attempt at self-harm or suicide, intermittent observation of him was to cease.

55. The man was informed on 1 February that he was fit for ordinary location and would be moved from the healthcare unit. Not happy about this decision, he refused to move and applied to be located in the vulnerable prisoners unit (VPU) unit because of his offence.
56. Still being monitored under the ACCT procedures, the man was subsequently relocated to E wing VPU. He was visited on a regular basis by the mental healthcare nurse. His mood was still hostile and he continued to refuse food. Around two weeks later, however, staff noted that the man obtained water and snacks from his canteen. He remained in his cell most of the time and did not socialise with others.
57. On 6 March, the security department informed wing staff that the man had written to a prisoner in another prison intimating he was going to kill himself. He said he had nothing in his life and knew when and how he intended to end it. He refused to engage with wing staff or members of the mental healthcare team, and was subsequently returned to the healthcare unit.
58. The man was assessed on 10 March 2006 by the prison doctor and two mental healthcare nurses. He had not made an active attempt to harm himself since his admission to the healthcare unit. The doctor again noted that he showed no evidence of depression or mental illness, but had a 'antisocial/borderline personality disorder with manipulative behaviour using his suicidal threats to achieve his aim'. The man was prescribed medication, and he was observed to see what effects it would have.
59. When the man was examined again by the doctor on 16 and 17 March, he was relaxed and cooperative. He disclosed that his mother's death had left him feeling upset and angry. He was prescribed medication to control his anger and his impulsive behaviour. His level of observations was reduced to intermittent watch. Preparation was also made for his return to ordinary location.
60. The intermittent observations ceased on 30 March. The man had complied with his medication and shown no evidence of depression or self-harm. This pattern of behaviour was replicated throughout April.
61. The man's ACCT plan was reviewed twice in May. On each occasion staff from healthcare, the wing and the man attended. His mood was low which he attributed to the anniversary of his step-father's death. He was still having thoughts of self-harm, although he believed he could manage them and said that he would tell staff if the need for support arose. His ACCT document remained open, and his level of risk was considered to be 'Low'.

62. Security information was received on 29 May 2006 about the man from HMP Acklington. He had written to a prisoner there that he intended to kill himself within the next two weeks. At the ACCT review meeting a week later, he disclosed that his low mood was due to the death of his mother earlier in the year and the forthcoming anniversary of her birthday. Staff offered support, and the man said he would utilise this if necessary. As his mood was low, his ACCT risk level was increased to 'Raised'.
63. In June 2006, the man was escorted to the Crown Court where he was sentenced to life imprisonment with a minimum term of 12 years before eligibility for release on licence.
64. He later returned to Manchester where he was assessed again by the doctor and nurse in reception. He displayed no evidence of psychosis and appeared physically and mentally stable. Aware that he had now been sentenced, he was offered support, admitted back to a safer cell in the healthcare unit, and placed on intermittent observations. Again, he told staff that he intended to kill himself.
65. For the next two days, the man remained in his cell, refusing to talk to staff or to be examined by the doctor and mental healthcare nurse. Attempts were made to talk to him about his personal hygiene, but he ignored them and reiterated his intention to kill himself rather than serve his sentence. However, the ACCT review decided that intermittent observations could be reduced.
66. The man was told on 27 June he would be located to ordinary location to which he agreed. Since receiving his life sentence he had made no attempts to self-harm. His ACCT monitoring continued and his level of risk remained 'Low'.
67. The following day, the security department passed on information to wing staff indicating that the man had a ligature hidden in his cell. He was questioned by staff, became argumentative and repeated that he intended to kill himself. Staff carried out a full cell search. A ligature was found along with a suicide letter and some other documents relating to the man's offence.
68. Following the ligature find, an immediate case conference was convened to discuss the man's future location and treatment. The review was chaired by a Governor and attended by two senior officers and a healthcare nurse. The review concluded that, although it was considered that the man was being manipulative to gain a move back to healthcare, this was probably the best place for him at the present time. The decision was taken that he would soon be transferred to another prison.
69. The next ACCT plan review was held on 3 July. Four members of staff as well as the man attended. He displayed no obvious signs of depression or psychosis and simply laughed and joked throughout, whilst reminding the staff of his suicidal intention.

The man's transfer to HMP Wakefield

70. The man had spent approximately ten months at Manchester before being transferred to Wakefield on 4 July 2006. He arrived and went through the normal prison reception screening process. His ACCT plan, as well as his assessment as a high risk to others, was passed on to Wakefield.
71. A Senior Officer (SO) interviewed the man in reception. The man was calm and disclosed the anger he felt towards other prisoners. He also talked about the recent death of his mother. The SO updated the man's wing history sheet and CSRA form, and noted that he gave no indication that the transfer to Wakefield was of any concern to him.
72. Immediately after this interview, the man was examined by a healthcare nurse. He disclosed to the nurse that he had seen a doctor in the past few months because of suicidal thoughts. He said he suffered from angina and was currently taking tildiem and simvastatin (a cholesterol-lowering angina spray). He was noted as allergic to penicillin. The man said that he had only ever harmed himself once, 20 years previously, when he had taken an overdose of tablets.
73. The nurse noted that the man's current mood and behaviour was appropriate to his situation. His mood did not appear to be low, but he said he intended to kill himself and that depression had always been a factor in his life. Aware that he was already being monitored under the ACCT procedures, the nurse made a referral for him to be seen by the doctor the following morning.
74. Later that evening, the man was located to A wing. He was placed in a single cell, the norm for all prisoners at Wakefield. A possible risk to female members of staff was also recorded.
75. The next morning, the man was examined by the doctor. He disclosed his medical history and said he had no present thought of suicide. The doctor assessed that he was fit for normal location and should be observed on the wing for any mood changes. He had no concern about the man's mental health. Over the next couple of days, the man received his prison induction.
76. On the morning of 7 July 2006, an ACCT assessor conducted a care assessment interview with the man. This was normal practice for a prisoner who had transferred into the establishment on an open ACCT plan.
77. At interview, the man disclosed that in the last 13 months some four members of his family had died - including his mother. He said he felt more relaxed at Wakefield than at Manchester, although boredom made him feel stressed. Depression had also been a factor in his life for some time. He said that although he had previously self-harmed, this was something he was not interested in now.
78. With regard to his life sentence, the man said he was not worried as he had nothing to live for, and had every intention of killing himself soon. He indicated that he would do this once his mother's estate was settled and would not tell anyone of his plans. The outcome of the review was that he remained on

ACCT. He would be reviewed regularly and encouraged to engage with staff and prisoners. He would also be encouraged to undertake a bereavement counselling course and to engage in some of the prison activities, such as education classes and workshops.

79. Later that afternoon, the man attended his first ACCT plan review at Wakefield. The ACCT assessor, two SO's (one of whom was the man's ACCT case manager) and the man all attended. At interview with my investigators, the man's ACCT case manager said that he chaired the reviews and, as far as possible, invited other interested parties, including the man. Interested parties could include a prisoner's personal officer, the chaplain or a member of staff from the wing or healthcare.
80. During the review meeting, the man reiterated his intention of wanting to kill himself. He had been making this statement now since he was first placed in prison custody, but was always vague about how he intended to do it. He said that he had no contact with any family members and intended to commit suicide as soon as his deceased mother's estate was settled. This information, as well as other dates such as specific anniversary dates, had already been recorded as trigger points on his ACCT plan. This served to alert staff to possible times and events that might cause a change in his behaviour.
81. The man's risk level was assessed as 'Raised', and staff were instructed to monitor and interact with him. He was initially placed on three observations during the day when staff would have to interact to gauge, monitor and document his mood. During the night, he would be observed on five separate occasions that would be documented at the end of the shift. Night staff would visit his cell at five random times throughout the night and look through the cell observation panel to confirm he was okay. Should the man's risk of self-harm change, his level of observations could be increased or decreased.
82. The man's second ACCT plan review took place on 17 July. The case manager, another SO and the man were all in attendance. The case manager noted that the man remained upbeat about his induction, but said he was still determined to kill himself when his mother's estate was settled. He had already started the legal process by enquiring about legal aid and solicitors. The case manager referred the man to the prison chaplaincy to consider attending a bereavement course. His level of risk was reduced to 'Low'.
83. Over the forthcoming weeks, the man settled into life at Wakefield without any problems. However, staff did have to remind him about the cleanliness of his cell. He was still located on A wing, a normal residential wing. He was socialising with others, but remained quiet and engaged in limited conversation with staff. The man had gained employment in the textiles workshop number eight which made clothing items. This was an area of work he had experienced in other prisons.
84. On 31 July 2006, an ACCT review meeting took place. The man attended along with the SO who had attended the review meeting on 7 July 2006 and an officer. It was noted that the man was associating on the wing and had made a

few friends. He was told that he could attend the next bereavement course which was due soon. The man once more disclosed that he was intent on taking his own life in the near future. The ACCT plan remained open and his level of risk was again recorded as 'Low'.

85. Three ACCT review meetings took place in August. At least two members of staff were present at each meeting and the man attended two of them. They noted that there was no change to his mood or behaviour, and he was still adamant that he would take his own life soon. He further added that he did not wish to engage with any probation or psychology staff. His level of risk remained 'Low'.
86. The SO who had attended reviews on 7 and 31 July carried out an ad-hoc ACCT review on 19 September. Security information had been received indicating that the man was planning to escape from prison. At the meeting, he was immediately placed on what is called the E-list. He was given E-list clothing (highly visible clothing) to wear at all times and was not allowed to leave his cell unless he was wearing it. The man denied that he had planned to escape and was upset at the prison's action. His ACCT document remained open. His monitoring level was changed to frequent and irregular observations, the risk level remaining 'Low'.
87. On 21 September, the man refused to wear his E-list clothing and eat his meals. The next day, he met the mental healthcare nurse. At interview with my investigators, the nurse said that the man was not happy having to wear E-list clothing, and as a result said he would refuse food until the restriction was lifted. The nurse attempted to assess the man, but he refused to cooperate. He was abrupt and obstructive to any help and support offered.
88. The man was again seen by the healthcare nurse on 24 September. He still refused to eat and had begun to experience chest pains. He was advised that he needed to go to the Accident and Emergency Department at the local hospital. The man refused despite being advised strongly that he was putting himself at risk of a possible coronary attack.
89. Until 25 September, the man refused to wear the E-list clothing, but then decided to conform to the instruction to do so. On the afternoon of the following day, the man's personal officer introduced himself. The man disclosed that he was not eating prison food in protest at having to wear the E-list clothing. He said this was also why he had refused to attend hospital recently, although he did say he was eating his canteen.
90. The Independent Monitoring Board (IMB) regularly meets prisoners who are reported as giving concern. As the man was refusing food, the information was passed to the IMB. At interview with my investigators, an IMB member said she interviewed the man on 26 and 27 September. On both occasions he explained his reasons for refusing food. He said he had no intention of escaping, had no one to escape to, and for this reason refused to wear the clothing. He was not feeling weak and was not bothered if he died. After the second meeting, the man said he had no reason to meet with the IMB again.

91. A further ACCT review took place on 28 September. It was chaired by the SO who had carried out reviews on 7 and 31 July and 19 September, with a mental health nurse and the man in attendance. It was noted that the man still refused to eat his meals. He was offered bereavement counselling and medical interventions but refused. He again disclosed his intention to kill himself. During the review, he became abusive and obstructive, and was returned to his cell. Staff felt the man was still at risk of self-harm and the ACCT document remained open with frequent and irregular observations. In spite of the man saying on numerous occasions that he would take his life, so far he had not attempted to do this.
92. On 5 October, staff reported that the man spent most of his time in his cell. This became a frequent occurrence and he still refused food although occasionally ate his canteen.
93. On 18 October, the man was referred to the mental health team because of his continued refusal to eat food, and his expressed suicidal intention. He was interviewed and assessed by a nurse. The man told the nurse that he was depressed, was not sleeping well, did not feel mentally well and that these symptoms were possibly due to his living conditions. He was not participating in work or education and had few friends on the wing. He had also stopped taking the medication for his angina. He told the nurse that he was a diabetic, although this illness was yet to be confirmed. The man disclosed that he intended to sort out some business with his solicitor during the week, and then he would join his mother in heaven.
94. The nurse noted that the man presented as calm and co-operative during the examination. He displayed no symptoms of psychosis or neurosis, and said that taking his own life was a logical decision he had made. He reiterated that he did not wish to be offered any support for how he was feeling.
95. An ACCT review took place on 24 October with an SO, an officer and the man in attendance. The man still spent a lot of time in his cell. At the meeting he maintained that he would kill himself, saying he would do so between 27 November 2006 and the New Year. However, he had now ended his food refusal and his personal and cell hygiene had improved. He was still not interacting with other prisoners and, despite being offered the services of Listeners and the chaplain, still refused all support. His level of risk remained 'Low'.
96. As the man appeared to pose no risk of escape, he was taken off the E-list on 7 November. He had showered and seemed in much better spirits than previously, although was still interacting with only a few prisoners. However, he was now having regular and polite conversations with staff. The man had also resumed working in the workshop. He said the workshop was something that made him happy.
97. The ACCT case manager chaired the next ACCT plan review, held on 27 November, with an SO who had attended the review on 17 July. Just before

the meeting, the case manager spoke to the man who refused to attend. It was noted that he was still enjoying the workshop. The anniversary of his mother's death was approaching on 1 December and that of his grandmother on 8 December. Given these factors and possible triggers to self-harm, his ACCT document was to remain open.

98. A Risk Assessment Board was convened on 30 November. The Board consists of a multi-disciplinary team and the purpose is to look at a prisoner's sentence planning targets. (These might include the prisoner maintaining settled behaviour on the wing, or being assessed for offending behaviour programmes.) The man refused to engage.
99. On the night of 1 December, and aware that it was the anniversary of the man's mother's death, an officer spoke with him to check that he was alright. She told my investigators at interview that the man seemed fine and his mood was upbeat.
100. No concerns were recorded during the next fortnight. On 15 December, an officer introduced himself to the man as his new personal officer. At interview, the officer told my investigators that when he first took on this role the man was having problems with toothache but was talkative and in good spirits. He described him as someone who did not interact with many prisoners or staff. As his personal officer, the officer said he tried to speak with the man on a regular basis. Although the man spent lots of time in his cell, he did engage in conversation.
101. Following the death of a prisoner in another part of the prison, an additional ACCT case review was held with the man on 18 December 2006. The SO who had attended reviews on 17 July and 27 October conducted the review and was accompanied by an officer (who had previously attended the man's review on 31 July), the Safer Custody Officer. The man said he was not aware of the other prisoner and his death had had no impact on how he was feeling.
102. The man's scheduled ACCT review was carried out four days later on 22 December. The case manager chaired the review with an officer and the man in attendance. Consideration was given to closing the ACCT document. The case manager noted that the man had good and bad days, but was working well and interacting with staff and other prisoners. The man said he wanted the Christmas period to pass before the ACCT was closed. It was agreed that it would remain open for a further two weeks.
103. On the morning of 12 January 2007, the mental health nurse interviewed the man following a request from wing staff who were concerned about him. His physical appearance had deteriorated and he was not taking his medication. Despite the nurse offering support, the man refused to see a psychiatrist and refused to take any medication. He said he was still adamant that at some point he would take his life, would never be admitted to healthcare, and did not want any help from the mental healthcare team.

104. An ACCT review was carried by the case manager during the morning. Another officer and the man were present. The man said that, now his mother's estate was being dealt with by solicitors, he felt the time was near for him to end his life. His ACCT document therefore remained open, with an observation level of hourly throughout the night and intermittently during the day.
105. On 23 January, the man's personal officer had a long chat with him whilst he was working in the textile workshop. The man was polite throughout their conversation and said he enjoyed working in the workshop. He was experiencing some back pain but refused to take any medication to relieve it. He also said it was only a matter of time before he killed himself. He was not upset when he said this and just mentioned it in the conversation with his personal officer. Despite his personal officer trying to persuade the man not to take his own life, he said he was intent on doing so.
106. The personal officer met the man again on 14 February for a general chat to discuss his wellbeing. His personal and cell hygiene were still considered poor and, although the personal officer told him it could result in his IEP level being reduced to basic, the man was unconcerned. He still only associated with a few other prisoners and, despite still enjoying the workshop, he continued to reiterate his intention to take his life soon.
107. A week later, the security department were alerted to a letter the man had written to a prisoner in another prison. In the letter, he said he was suffering from clinical depression and no longer took any of his medication. He said he was weakening and getting closer to his goal. He had planned to die that day but had made a promise to finish some work in the workshop. He would keep his word to complete this before he pulled "the plug".
108. At their meeting on 26 February, the personal officer reported no problems raised by the man. There was still no change in his behaviour: the man's association with others was still limited to a select few and the threats of killing himself continued.
109. On 14 March, the personal officer noted that the man was polite, in good spirits and still enjoyed the workshop. His personal and cell hygiene remained unacceptable. With regard to self-harm, the man told his personal officer that he wished the ACCT document to remain open.
110. Two weeks later, the man spoke to his personal officer to ask if he knew why he was no longer required in the workshop. His personal officer was unaware and said he would make enquiries, and that the man should remain optimistic. He said it was not uncommon for the work to be limited every now and again.
111. The ACCT case manager held an ACCT case review on 1 April, with only the man in attendance. He was still not required in the workshop. He was interacting with other prisoners on association but still reiterated his intention to take his own life. The case manager spoke with the man again about the support networks available to him.

112. Throughout April, the personal officer noted no concerns with the man. He remained polite and continued to socialise with a few prisoners. His cell and personal hygiene had improved slightly. Later in the month, the personal officer was reassigned to other duties and no longer had the responsibility of being the man's personal officer. He told my investigating officers that, in his contact with the man, he never had any concern that he would take his life. This was despite his repeated statements of his intention to do so.
113. From 9 May, the man resumed working in the workshop. Three days later, the ACCT case manager carried out an ACCT case review. No other members of staff were present and the man also refused to attend. There was no change from the last review.
114. Having attended the treatment clinic for abdominal pains the previous month, the man was diagnosed on 15 May as suffering from diabetes and prescribed metformin by the doctor. He had raised glucose levels and increased complaints of thirst. The appointment was followed up by a specialist nurse at the prison's diabetic clinic.
115. At the next scheduled ACCT review on 12 June, the man refused again to attend or speak with staff. An SO chaired the review (in the absence of the case manager) alongside Safer Custody Officer Brown. The SO noted that the man had been more settled recently and was interacting well with staff and prisoners. It was agreed that his observations and interactions could be lowered with a view to closing the ACCT document at the next review. His level of risk remained 'Low'.
116. Two days later, an additional review was conducted because of a further death of a prisoner in the prison. The man again said that he was not affected. He had recently taken his medication and had experienced a bad night's sleep, although he was feeling much better now.
117. On the night of 15 June, the man disclosed to staff that he was a little depressed as it was a day before the anniversary of his mother's birthday. He talked to the night officer and later appeared to be in a better mood.
118. A further ACCT plan review took place on 16 June, the anniversary of the man's mother's birthday. The review was chaired by the SO who had chaired the review on 12 June with an officer. The man attended on this occasion but refused to talk about his mother, saying it made him feel depressed. He had taken some medication that had helped his mood, but again said that he intended to take his own life at some point and staff could not change his mind. The man said he liked the current night staff, so would not take his life on their shift. He was once more reminded of the support mechanisms that were available to him. He again declined the offer.
119. At interview with my investigators, The ACCT case manager said that the staff had discussed closing the man's ACCT plan for at least a month before it was finally closed. The man had a period of more settled behaviour. It was agreed that the observations and interactions by staff should be lowered, with a view to

closing the document at the next review. The case manager told my investigators that the man's observations were eventually lowered to one observation during the day, and one during the night.

120. On 27 June, an officer noted in the man's wing history book after a conversation with him. The man was going to work regularly and was still enjoying the workshop. Despite his cell and personal hygiene being poor, the officer had no concerns about his wellbeing. The next day, the man attended the diabetes clinic to be assessed by the specialist nurse who also referred him to the optician.
121. The man was seen by the one of the prison doctors on 2 July. He had long been in receipt of regular monthly repeat prescriptions for his physical ailments and his low moods. He was prescribed his usual medication (set out below), which included gabapentin for his diabetes:
 - 84 gabapentin capsules
 - metformin 500mg tablets
 - 28 simvastatin 40mg tablets
 - 28 diltiazem (Tildiem) LA 200mg capsules
 - 28 aspirin 75mg dispersible tablets
 - 1 beclometasone 100 Inhaler
122. The medication was dispensed to the man the following day by the pharmacist. None of the medication was listed as unsuitable for IP under prison policy. Neither healthcare nor wing staff had raised any concern about any risk associated with him being responsible for his own medication. As noted, he had always kept his medication in his possession.
123. For some months now, the man had given staff no general cause for concern. Often, he was reported as being pleasant and in a good mood. His attendance at workshops was regular and he continued to enjoy his work. He socialised on the wing, ate regularly and was regularly observed playing his PlayStation game, sometimes until the early hours of the morning.
124. On 10 July, the man was seen by a different doctor. On this occasion he was prescribed the medication erythromycin (an antibiotic) 250mg tablets and 168 gabapentin 300mg capsules (one month's supply). Both were, as usual, dispensed to him by the pharmacy the next day.
125. My investigators liaised with the police and clinician regarding the man's receipt of this quantity of gabapentin in such a short period of time. It appears that an entry was missing on his medical records when the second doctor saw him on 10 July. (This entry then subsequently appears out of chronological order.) The doctor was therefore not aware that the man had been prescribed gabapentin only a week earlier.
126. Gabapentin is not on the prison's list as a high risk drug. No further risk checks were carried out, therefore, when it was prescribed. The pharmacist is also not routinely informed of prisoners who are on an open ACCT. Prisoner officers

escort prisoners to the medication hatch to collect medication, but are not involved in the actual transaction, respecting an individual's right to medical confidentiality.

Events on Thursday 12 July

127. On the morning of 12 July, the ACCT case manager spoke with the man at breakfast time. An ACCT review was scheduled to take place and, as usual, the case manager invited the man to attend. He said he was busy at the workshop and unable to be present. When asked how he was feeling, he expressed no concerns. The case manager told him that he intended to close his ACCT plan. The man shrugged his shoulders, said fine and walked away.

128. The case manager held the ACCT review meeting at 9.00am. No other members of staff were in attendance. On closure of the ACCT plan, the case manager noted the following:

“The man did not attend this review but expressed his feeling saying he was feeling fine and ok with himself. Since he arrived at HMP Wakefield he has not self-harmed and has had many trigger points. I currently have no areas of concern with him. He is aware of the help available and support.”

129. The case manager told my investigators that he had discussed the closing of the man's ACCT document at the beginning of the week with two SOs who had been present at other of the man's ACCT review meetings. All were in agreement that the document could be closed at the next review on 12 July. This was a decision that the SOs believed could have been taken months ago. The man had given the staff no reason for concern, despite his continual statements that he intended to take his life.

130. A prisoner on the man's wing, told the investigation that he recalled that the man had his dinner that evening and seemed fine. The prisoner told my investigators that he was aware that the man had at times bought drugs off other prisoners for recreational purposes. He said that two or three days prior to his death, the man told him that he had received double his medication (by accident). The prisoner said he did not believe the man intended to take his life.

131. A second prisoner also confirmed that he was aware of the man being prescribed double medication. In previous conversations, the man had talked a lot about suicide and feeling depressed, and had written a number of suicide notes before disposing of them in the bin. At interview with my investigators, the prisoner said that at around 6.40pm that evening, the man had told him he had stomach pains. At no point, however, did he mention taking his own life.

132. The officer on duty on A wing began his duty around 7.50pm. He had worked on A wing for some time and was familiar with the prisoners. On reading through the wing paperwork, he discovered that there was no ACCT plan for the man, and it was recorded in the wing sheet that the ACCT had been closed

that morning. At interview with my investigating officers, the officer said he had previously been informed that the man's ACCT plan was to be closed.

133. The officer explained that, if a prisoner is not on an ACCT and not a category A prisoner, staff would only check on them at the beginning and end of their nightshift. However, if an officer had concerns about a prisoner, they would carry out periodic checks to make sure they were okay.
134. At around 8.00pm, with all prisoners already locked in their cells, the officer carried out his roll check. On looking through the observation panel of the man's cell door, he observed he was awake playing on his PlayStation. He asked him how he was, and received the response 'I'm okay boss' followed by a comment about the game he was playing.
135. After the officer completed the wing roll check, he attended the centre office to sign off the figures in the log book. This was at approximately 8.30pm. As he approached the centre, he noticed paramedics headed towards C wing as a prisoner had attempted suicide. After completing the log book, the officer went to assist on C wing. Soon afterwards, he was required to escort the prisoner to outside hospital and so did not return to A wing until the following night.
136. Another officer relieved the A wing officer of his duties. He carried out the night checking procedures as normal and checked any prisoners on an ACCT, as well as those that were category A. At the end of his shift, the relief officer carried out a full roll check count. On checking the man's cell, he saw him in bed. He appeared to be asleep.

Events on Friday 13 July

137. On the morning of Friday 13 July 2007, a wing officer arrived on A wing at 7.30am to start her shift. She attended the usual morning briefing meeting in the wing office. Staff were told that the man and another prisoner had had their ACCT documents closed the previous day. They were also told, however, to keep a watchful eye on the two men.
138. Around 8.00am, the officer made her way up to the third landing where the man was located. The general call was given for all prisoners to be unlocked and, along with another officer, she unlocked the cells on the third landing. On arriving at the man's cell, the officer unlocked it and continued to unlock other cells along the landing (the officers would then return to make sure that all prisoners were awake). When the officer completed the unlock, and conscious that the man's ACCT document had recently been closed, she returned to his cell to check on him.
139. The officer pushed the man's cell door open and thought that everything looked normal. She told my investigation that the man was lying in bed on his back as usual, was half dressed and his legs were spread apart. He appeared to be asleep and so she called to him to wake up. There was no response. For safety reasons as a woman officer, the officer called her male colleague to the

cell to try and wake the man up. The female officer in the cell remained at the cell door whilst the male officer went in.

140. The male officer told my investigators that he walked up to the side of the bed and tried to wake the man. Having received first aid training, he checked him for signs of life. There was no response. The female officer heard the male officer say that something was wrong, and so called to two other officers on the landing. One of those officers came into the cell and pinched the man's leg to see if he could get a reaction. His leg was cold and there was no response. As not all officers carry radios, the female officer was told to call the Principal Officer (PO) and healthcare staff. She proceeded to the wing office to do so.
141. At interview, the PO told my investigators that he was in close proximity to the man's cell when he noticed the female officer looking distressed. He recalled her saying that she thought the man was dead, and saw her make her way down to the wing office. As the PO was a wing manager, he used his radio to contact the Communication Control Unit to request a member of healthcare staff attend the wing immediately. He then proceeded to the man's cell where he was directed in by other staff. On entering, the PO touched the man's wrist and arm. Both were cold and stiff and he believed that the man was dead. The healthcare nurse then arrived at the cell and took charge.
142. At interview with my investigators, another nurse said she was on duty on the morning of 13 July. She had been rostered to be 'Hotel 5', which is the emergency response for healthcare. A code blue alarm on A wing came through over the radio at 8.06am. The nurse was aware that her colleague, the first nurse to arrive at the cell, was working in the centre treatment room which was next door to A wing. So that the alarm could be responded to quickly, she telephoned and asked him to attend the emergency on A wing. The emergency response nurse made her way to the healthcare treatments room to collect the emergency bag, and then went on to A wing.
143. As the first nurse to arrive at the cell was not available to be interviewed during the investigation period, his prison incident report was reviewed by the clinical reviewer and my investigators. It shows that he arrived at the cell within two minutes. He asked for an update of the situation and whether anyone had attempted cardio pulmonary resuscitation (CPR) on the man. Staff had not yet begun CPR so the nurse asked for the man to be laid flat on the floor so that he could conduct further assessments with a view to starting resuscitation. Once the nurse examined the man and observed that rigor mortis had set in, he formed the opinion that the man had been dead for some time. Resuscitation was therefore not carried out.
144. The emergency response nurse arrived at the man's cell to find her colleague dealing with the situation. As the first nurse on the scene said that he did not require any further nursing assistance, the emergency response nurse continued with the rest of her normal duties.
145. At interview with my investigators, one of the SOs present at the ACCT closure meeting said that the female wing officer arrived in the wing office about two

minutes after the wing unlock call had been given. She had said that staff were having difficulty waking the man, and she thought he was dead. The SO immediately used his radio to notify the healthcare unit, and the two members of staff made their way back to the man's cell. On arriving, the healthcare nurse was already in attendance. The female officer remained outside the cell.

146. An ambulance had been called and paramedics arrived at the prison at 8.12am. Following their examination, they declared that rigor mortis had begun and that the man displayed no signs of life.
147. The Governor told my investigators at interview that he was in the control room when he heard the emergency call, code blue, on A wing come through between 8.00am and 8.05am. He quickly made his way towards the main prison. En route, a call was made over his radio for Victor 1 (there was a request for the duty governor to attend A wing immediately). He arrived at the man's cell within ten minutes. Staff explained that the man had been found unconscious and the PO was keeping a log. The man's death was confirmed at 8.35am by the paramedics.

After the man's death

148. The Governor ensured that the prison's death in custody contingency plan was followed and the control room contacted all the necessary parties including the man's next of kin and the police. He arranged a hot debrief later that day with the staff involved and ensured staff completed incident reports. The Staff Care and Welfare Team was deployed to support staff, especially the officers who had found the man. They were given the opportunity to be relieved of their duties for the day.
149. All prisoners on a current ACCT document, or one that had been recently closed, were reviewed. The Governor asked staff to be aware of any changes in prisoners' behaviour and moods.
150. The man's cell was sealed. When the police later arrived, copious amounts of different medications were found in a cabinet on the wall. Numerous blister packets were also found in the wastepaper bin. A handwritten letter was found within an envelope and this was addressed to one of the man's friends. The letter indicated that the man had taken an overdose of his medication.
151. The following medication was recovered from the man's wall cabinet:
- Simvastatin 40mg
 - Gabapentin 300mg
 - Salamol inhaler
 - Tildiem
 - Metformin 500mg
 - Aspirin 75mg
 - Beclometasone Inhaler
 - Nitromin spray 400mg
 - Glyceryl TNT spray 400mg

- Empty unlabelled bottle
- Empty bottle of gabapentin (issued 3/7/07 - should have contained 84 capsules)
- Salbutamol inhaler
- Tube of ibuprofen pain gel cream
- Saccharin 12.5mg

152. The following empty blister packets were found in the wastepaper bin:

- Four empty packets of tildiem (diltiazem) 200mg which should have contained 14 tablets each
- Six empty blister packets of gabapentin 300mg capsules - each packet should have contained 10 capsules

153. A total of 56 tildiem 200mg and 60 gabapentin 300mg capsules was missing.

Post Mortem

154. The post mortem results found that the man had ischaemic heart disease. It was this, coupled with a mixed drug overdose of diltiazem, gabapentin and paracetamol, that caused his death.

ISSUES CONSIDERED IN THE INVESTIGATION

Mental healthcare

155. The man remained on an ACCT plan for a long time, but never actually harmed himself. But even before he was transferred to Wakefield in July 2006, he had made his intention to take his life very clear. He reiterated this intention to the nurse during his reception screening on arrival at Wakefield. Despite this admission, and the fact that – as the clinical review shows – the man fitted the referral criteria, a referral was not made to the mental health in-reach team.
156. It was not until October 2006 that the man was assessed by a mental health nurse (he presented no signs of mental illness). After this, the in-reach team attempted to assess and support him on numerous occasions, but on most occasions he was resistant. However, he did accept healthcare attention to his physical needs.

It is recommended that consideration be given to all new receptions receiving oversight from a Registered Mental Nurse. (This recommendation was also made in a previous clinical review carried out by this reviewer in June 2007.)

In the interim, all nurses and the doctors should receive an urgent update upon the implementation of referral protocols to Mental Health In-Reach.

Stockpiling of medication

157. No risks had been associated with the medication the man had in possession or indeed his IP status. At interview with my investigating officers, wing staff said that during routine cell searches they would not normally question medication found in a prisoner's cell, so long as it was clearly labelled as belonging to them. Staff were also not necessarily aware of what medication a prisoner was taking. This was described as the responsibility of the healthcare team.
158. Given the profile of its population, security is a prime consideration at Wakefield. The most recent IMB report (2007) said that the establishment had seen an increase in the number of wing (cell) searches and searches carried out in the workshops. Staff told my investigators that routine cell searches are carried out approximately every six weeks. The man's cell was last searched on 22 June 2007 when it was recorded that 'Nil' was found. This search made no note of the large quantity of IP medication the man obviously should have had in his possession.
159. The clinical reviewer comments that he found there can be a different nurse/healthcare officer present in the treatment room each day giving out medication to prisoners, and that they rely on prison officers updating them on the ACCT status of an individual. The prison pharmacy confirmed that they were not made aware of prisoners on an open ACCT.

160. When the man received a duplicate prescription, it resulted in him receiving a total of 252 gabapentin capsules in possession over a period of nine days. The original 84 supplied to him on 3 July were never reclaimed, presumably because the pharmacist/healthcare staff were unaware of the error.
161. Since the man's death, Wakefield PCT has taken steps to improve communication and record keeping by running workshops for staff. A new system has also now been implemented and the pharmacy receives a daily record of every prisoner who is subject to an ACCT plan.

It is recommended that a procedure should be put in place to retrieve medication that has been changed or stopped before the new supply is given to the patient to prevent excess medication being held in possession.

162. The post mortem report highlighted that paracetamol was one of the drugs on which the man had overdosed. According to his medical record, he was last issued with eight paracetamol tablets on 13 December 2006. Where he obtained the additional paracetamol (assuming he had not stored it from 2006 or earlier) is unknown. Other prisoners suggested that the man tried to buy medication for recreational purposes, but there is no further evidence to support this. It is quite possible that having obtained paracetamol, he took it to alleviate the stomach pain he was reported as having the evening before his death.
163. I believe staff should be more vigilant when carrying out cell searches in checking medication.

The Governor should remind staff that, should they discover large excesses of IP medication, advice should be sought from a member of the healthcare team.

Medication risk assessment

164. The clinical review lists a number of recommendations. It was known by all on the wing that the man received regular medication and was deemed suitable to hold it himself. However, despite his repeated spoken intention to take his own life, a risk assessment had not been completed in relation to the medication he was taking. This was despite his admission, at the reception screening interview, that he had once tried to commit suicide by taking an overdose.
165. The risk assessment tool is a multi-disciplinary document involving input from the healthcare nurse, the pharmacist and the doctor. The outcome would have decided if the man should be allowed in possession medication and, if so, for how long. Had this occurred, it might not have prevented his death but staff would have been able to review the amount of medication he was in possession of at any one time.
166. I am pleased to report that since the man's death the risk assessment document has been reviewed and amended in respect of its use. The medication gabapentin has also been reviewed and had now been added to the

high risk column of drugs. Although I make no formal recommendation, it would be sensible for this new process to be fully documented.

Closure of the ACCT document

167. The ACCT guidelines state that reviews should include the key people who know the person at risk or are involved in their care. However, the man's persistent refusal of mental health intervention meant that there was an absence of multi-disciplinary input at a number of his ACCT reviews. Furthermore, when the ACCT document was closed, there was still no reference to any input from the in-reach or healthcare team.
168. The guidelines also say that a 'case review team' should be present to close the ACCT document. Staff had previously discussed and agreed the man's monitoring would cease so it was of no surprise when it eventually was. It was, however, closed by only one member of staff (the case manager). Given that the closure of the ACCT document had been discussed for some time, I think there were mitigating circumstances. However, the case manager told my investigators that he was unaware that a team had to be present when closing the ACCT document. The man who died's review was not the only one conducted with a single member of staff.
169. I agree with the clinical reviewer's comments that the closing of the ACCT document may not on this occasion have been influenced by the lack of healthcare input. I also appreciate that there can be restraints on staff availability to attend reviews. However, the quality of decision-making is self-evidently weakened if a range of staff and disciplines are not involved. It was for exactly this reason that the ACCT system was introduced.
170. I am pleased to say that, since the death of the man, the Governor has reissued a notice to all staff reminding them that ACCT reviews should not be conducted single-handedly. My recommendation is simply to confirm the importance that I attach to this.

The Governor should remind staff that all ACCT reviews should be attended by a multi-disciplinary panel.

CONCLUSIONS

171. The man who is the subject of this report was a damaged man who had threatened to take his own life over a period of years. However, while he had experienced some significant bereavements, he seemed to show an improvement in his general wellbeing in the time he was at HMP Wakefield. The fact that he had never actually attempted to self harm during two years led staff to believe he was using his suicidal threats to manipulate them. Although the process was flawed, I do not think the decision to close the ACCT form on the day before his death can be criticised. I do not think that staff had any reasonable grounds for thinking he was at particular risk.
172. This investigation has shown that staff consistently offered support to the man throughout his time in custody.
173. It is possible that the chance event that he had been provided with surplus medication presented itself as an opportunity for the man to take his own life. It was further chance that this coincided with closure of the ACCT document. However, as he was in receipt of regular medication without proper risk checks, he could have taken his life at any earlier point. And while he suffered from angina, there is no reason to suppose that he was aware of the extent of his heart disease.

RECOMMENDATIONS

- 1. It is recommended that consideration be given to all new receptions receiving oversight from a Registered Mental Nurse. (This recommendation was also made in a previous clinical review carried out by this reviewer in June 2007.)**
- 2. In the interim, all nurses and the doctors should receive an urgent update upon the implementation of referral protocols to Mental Health In-Reach.**
- 3. It is recommended that a procedure should be put in place to retrieve medication that has been changed or stopped before the new supply is given to the patient to prevent excess medication being held in possession.**
- 4. The Governor should remind staff that, should they discover large excesses of IP medication, advice should be sought from a member of the healthcare team.**
- 5. The Governor should remind staff that all ACCT reviews should be attended by a multi-disciplinary panel.**