Investigation into the circumstances surrounding the death of a man at HMP Wealstun in December 2009

Report by the Prisons and Probation Ombudsman for England and Wales

January 2011

This is the report of an investigation into the death of a man, a prisoner at HMP Wealstun in December 2009. He was 25 years old. He had previously been under the supervision of the probation service but had been recalled to prison on 8 July 2009, having breached the conditions of his licence.

On a morning in December, prison staff went into the man's cell as they were concerned about him and he had failed respond to respond to their calls. They discovered a ligature attached to his neck, tied to the window frame which they immediately cut. However, they did not attempt first aid as it was apparent that he had been dead for some time. Paramedics were called and pronounced him dead at 6.23am. I would like to offer my condolences to his family and friends for their loss.

One of my colleagues conducted the investigation. The local Primary Care Trust was asked to conduct a review of the standard of healthcare the man received in custody. They appointed a clinical reviewer to undertake this and his report is attached as an annex.

I would like to thank the Governor of Wealstun and her staff for their co-operation and assistance with the investigation. Particular thanks go to two members of staff for making all the practical arrangements for the investigator. I apologise for the delay in publishing this report, which was due to the late receipt of feedback to draft report.

After the man was recalled to prison, he initially went to HMP Leeds. Transfers to HMP Lindholme and Everthorpe followed, before he moved to Wealstun on 27 October 2009. At each prison, he had limited contact with the healthcare department but did engage with both primary care mental health nurses, who deal with mild to moderate conditions and the mental health in-reach team, who treat those with more severe diagnoses. However, during these consultations and assessments, he denied any thoughts of harming himself or suicide. He left a note that indicates his reasons for taking his life were the breakdown of his relationship with his partner.

I make eight recommendations on a range of matters, relating to suicide and self-harm monitoring procedures, segregation processes, communication and recordkeeping in relation to mental health care and training for staff on both first aid and the procedure for dealing with the discovery of incidents of self-harm.

Following my draft report the Prison service responded and accepted seven recommendations and partially accepted one other. Their response and actions are added to the appropriate section of this final report.

In addition to the Prison Service response, feedback was also received from the man's family. Some of the points raised by the family have been added to the appropriate paragraphs. Where this has not been possible an additional paragraph on page 33, has been added to provide feedback on the points raised.

This version of my report, published on my website, has been amended to remove the names of the man who died and those of staff and prisoners invoved in my investigation.

Jane Webb
Acting Prisons and Probation Ombudsman **January 2011**

CONTENTS

SUMMARY

The man was recalled to prison on 8 July 2009, and taken to HMP Leeds. He had been at the prison previously and was familiar with the routines of prison life. He was subsequently convicted and sentenced for the offence for which he had been recalled and ordered to serve until the end of his licence period.

No significant physical or mental health concerns were recorded on the man's reception at Leeds. In late August, after moving to another wing against his wishes, he damaged his cell and told staff that he had swallowed broken glass. Staff initiated monitoring under the Assessment, Care in Custody and Teamwork (ACCT) provisions and, at his request, he was taken to the segregation unit. (The ACCT procedure is used in prisons to provide additional, personalised support to those considered to be at risk of self-harm or suicide, and can be opened by any member of staff. The purpose of segregation is to maintain safety, order and discipline. A segregation unit provides temporary accommodation for prisoners that have become violent or disruptive, committed offences against prison rules or require protection if they are under threat from other prisoners.)

This was followed by an ACCT assessment during which the man admitted that he had not actually swallowed glass, but had said it as a way of getting moved from the wing. (The ACCT assessment is completed by a trained assessor and asks a series of questions to ascertain a prisoner's reasons for self-harm and to assess their level of risk.) The monitoring was stopped following the assessment. He remained in the segregation unit following his adjudication hearing for damaging his cell the previous day as he refused to return to any wing other than B wing. (An adjudication is an internal hearing into breaches of prison discipline by prisoners.)

The man transferred to Everthorpe on 4 September. He spent around three weeks at the prison, during which he was recorded as being both threatening and abusive to staff. On 23 September he transferred to HMP Lindholme. While at Lindholme, he was assessed by the Community Psychiatric Nurse (CPN) at the request of wing staff. The nurse concluded there was no evidence of severe, enduring mental illness and a referral to the General Practitioner (GP) did not take place as he failed to attend an appointment with the GP. His behaviour became problematic and he transferred to HMP Wealstun on 27 October.

On his reception at Wealstun, the man told a nurse conducting a health screen that he had been hearing voices and wished to see a doctor, the nurse made a referral to the Mental Health In-reach Team (MHIRT) but he was not seen as a result of this referral, neither did he see a doctor.

In mid-November, a primary care mental health nurse went to see the man as he was said to be 'very stressed'. The nurse recorded that his speech was rapid and he had poor eye contact. When asked about thoughts of suicide or self-harm, he told her that he "would not think like that as he had his partner and her children to think of". A further referral was made to the MHIRT for an in-depth assessment of his mental health.

At the beginning of December, owing to concerns about the man's behaviour, he was sent to the segregation unit. Staff in the MHIRT could not agree on their diagnoses, so they sought the opinion of a consultant psychiatrist who subsequently concluded that there were no signs of psychosis and that it was appropriate for him to be located on a residential wing.

While in the segregation unit, the man had been informed by his partner that she wished to end their relationship. Staff implemented monitoring under the self-harm and suicide prevention measures on 8 December, after he punched a wall out of frustration to hearing this news. This monitoring was stopped on the afternoon of 10 December after he returned to the wing from the segregation unit.

Throughout the remainder of the day, the man was reported to have been engaging positively with both staff and fellow prisoners and attended the gymnasium. He also had positive telephone calls with his ex-partner and mother. He was locked in his cell at around 7.30pm and no concerns were raised during the night.

At 5.40am, the night operational support grade (OSG) began a morning roll check on D wing. When he arrived at the man's cell he looked in via the observation panel and saw him in what he described as a seated position at the back of the cell. The OSG attempted to get a response from him by calling out and banging on the door but no response was made. The OSG asked for assistance from an officer who also tried and failed to obtain a response. They called for further assistance and when they went into the cell, they found that he had a ligature made from torn bedding around his neck, tied to the window clasp. Due to the perceived presence of rigor mortis staff did not attempt to resuscitate him. When ambulance staff arrived, they placed a monitor on him and pronounced him dead at 6.23am. He left a letter indicating that he could not cope with the breakdown of his relationship.

After the man's death, a member of staff went to his mother's home to break the news of his death. She kept in touch with the family for several weeks and assisted with various arrangements such as a memorial service. A debrief was held and staff were offered support.

I make eight recommendations as a result of this investigation. These relate to a number of areas including self-harm and suicide prevention procedures, segregation matters, mental health care record keeping and communication and staff training.

THE INVESTIGATION PROCESS

1. Notices informing both staff and prisoners of the investigation were issued on 14 December. They invited anyone who had information about the man's death to contact the investigator. No responses were received.

2. The investigator telephoned the prison initially on 11 December and spoke with the Governor to arrange for the man's prison and medical records to be made available to him. He then visited the prison on 16 December, where he met with the Governor and a duty governor, who was to act as the liaison during the investigation. He also spoke with a representative from the Prison Officers' Association (POA) and Independent Monitoring Board (IMB) and appraised them of the investigation process. He viewed the cell that had been occupied by the man and spoke briefly to three prisoners that had known him.

3. The investigator visited Wealstun again on 11 and 27 January as well as 1 February. He conducted interviews with seven members of staff who were in regular contact with the man or involved with him during his time at Wealstun.

4. On 27 January, the man met with a Detective Sergeant (DS) and a Detective Constable (DC) from the CID, who had attended the prison following the man's death. The investigator explained the scope of the investigation and it was agreed that both parties would share relevant information. I am grateful to the police for making copies of statements and other relevant documentation available to the investigator.

5. The local Primary Care Trust (PCT) was commissioned to conduct an independent review of the medical care that the man received in custody. The PCT appointed a clinical reviewer to conduct this review. Although the man had little contact with the healthcare department concerning his physical health, he did engage with mental health services. The investigator interviewed a member of the MHIRT at Wealstun and a copy of the transcript was made available to the clinical reviewerto aid his review. I would like to thank him for his report.

6. One of my family liaison officers (FLO) wrote to both the man's mother and his partner on 12 January. She also telephoned his mother the same day to briefly discuss the investigation and offered to visit her, with the investigator. She was appreciative of this and a visit was arranged for 26 January.

7. During the visit to the man's mother and stepfather, the FLO explained the investigation process in more detail. His mother expressed concern that suicide and self-harm prevention monitoring of her son under the Assessment, Custody, Care and Teamwork (ACCT) procedures had stopped shortly before his death, and considered that this had been too soon.

8. She also provided a list of questions that she would like considered during the investigation, these were:

    - Is a report available from the night of her son's death?

- Had her son been subject to suicide prevention monitoring that week?
- Following a telephone call, she had received from the prison on 5 December, notifying her that her son had been moved to segregation, what if any action was taken?
- Was her son subject to any medical/psychiatric assessments prior to his death?
- Why an emergency visiting order was granted to her and what are the procedures for granting such an order?
- Was her son on any form of medication?

9. The matters raised are addressed in the report. I hope the findings provide the family with a better understanding of the events leading up to the man's death.

10. The investigator contacted HM Coroner to inform him of the nature and scope of the investigation and to request a copy of the post mortem report.

HMP WEALSTUN

11. HMP Wealstun is in Wetherby, Yorkshire. It was a category C (closed) prison and category D (open) prison until March 2008. Since then, the category D site has been undergoing rebuilding and refurbishment, and is scheduled to open later in the year as additional category C places. (On arrival into prison, prisoners are risk assessed and given a category based on their offence and the risk that they pose to the public should they escape. There are four categories: A, B, C and D, with category A prisoners being the most dangerous. Category C are prisoners who cannot be trusted in open prison conditions but who would not have the ability or resources to make a determined escape. Category D prisons are for offenders who can be reasonably trusted to serve their sentences in open conditions as there are no physical barriers preventing a prisoner from absconding if they wish to do so.)

12. Wealstun has no medical night cover and relies on an out of hour's service similar to that which is delivered in the wider community. The Primary Mental Healthcare is provided by the PCT, while the Mental Health In-Reach Team, work for The Partnership Foundation Trust, which is part of the Mental Health Trust for Leeds. There is no in-patient facility at the prison.

13. The former Chief Inspector of Prisons carried out an announced inspection of Wealstun in December 2008. In her report, she wrote of the self-harm and suicide procedures in place at Wealstun and concluded:

> " … Suicide prevention and self-harm management were well integrated into most aspects of the establishment and underpinned by a comprehensive safer custody strategy. An at-risk hotline had been implemented, whereby families could contact the establishment and report any concerns they had about a family member or friend. There were good examples of assessment, care in custody and teamwork (ACCT) assessments, and care maps, which set clear objectives to address the triggers of the harmful behaviour. Multidisciplinary case reviews were held. Seventy-five per cent of staff had received ACCT training. Although there had been some near-death incidents during the year, these had not been recorded or action plans devised …"

14. The Chief Inspector also commented that ACCT training was delivered regularly with three-quarters of staff trained. However, some night staff did not carry anti-ligature knives and were not clear about what to do if they were the first to arrive after a prisoner had harmed himself. This issue has also been raised during this investigation.

15. The Prisons Act 1952 requires every prison to be monitored by an Independent Monitoring Board (IMB) appointed by the Secretary of State from members of the community in which the prison is situated. The board is specifically expected to:

- Satisfy itself that those held in custody within its prisons are treated humanely and fairly and that there is a range of appropriate programmes to prepare them for release.
- Inform the Secretary of State promptly of any concerns.
- Report annually to the Secretary of State on how well the prison has met the standards and requirements set and what impact these have on those in its custody.

To enable the Board to carry out those duties effectively, its members have right of access to every prisoner and every part of the prison and also to the prison's records.

16. Wealstun's last IMB report was published in May 2007. The report focused on the planned refurbishment which is now well underway. At that time, the local PCT had also recently taken over the responsibility for the delivery of health services and this was seen as positive. The Board also spoke positively about staff and provisions within the segregation unit and also the changes to safer custody, with the introduction of the Assessment, Custody, Care and Teamwork (ACCT) procedure.

17. The National Offender Management Service (NOMS) publishes quarterly performance ratings for 131 prisons, based on individual prisons meeting 34 key performance indicators. There are four ratings with 1 indicating serious concerns, 2 requiring development, 3 good performance and 4 exceptional performance. Wealstun is currently rated as performing at level 3.

18. The Prison and Probation Ombudsman was given responsibility for investigating all deaths in custody in 2004. Since then there have been three deaths at Wealstun, including that of the man. The two other deaths were from natural causes and one of these is still being investigated. Recommendations made following the first death are not repeated in this report.

KEY FINDINGS

19. The man was recalled to custody on 8 July 2009. He had been released into the community on licence following an earlier sentence but after being charged with committing a burglary his licence was revoked. He was subsequently convicted of burglary and ordered to serve his licence period in custody. He was due to be released in October 2011. He was 25 years old.

20. Following the breach of his licence, the man was taken to HMP Leeds, where he had spent time previously. On his reception into prison, he was assessed by a nurse who completed a health screen. He told the nurse that he did not suffer from any chronic illnesses and had no mental health concerns. He also indicated that he only drank alcohol socially but used cocaine at weekends and had also used Ketamine. (Ketamine is a short-acting but powerful general anaesthetic which depresses the nervous system and causes a temporary loss of body sensation.) When asked about self-harm, he said that he had not previously harmed himself either inside or outside prison, and that he had no current thoughts of self-harm.

21. In addition to the health screen, a suicide risk factor form was completed. The form asks the prisoner a serious of yes or no questions as well as information relating to them, such as age and reasons for custody. If a score of ten or more is given, the form instructs the member of staff completing it that the ACCT procedure must be opened. The man scored five in relation to the answers he provided.

22. On 27 August, he became very angry during a routine strip search. (A strip search requires a prisoner to remove all items of clothing. The top half of the body is searched first and at no time should the prisoner be totally naked. The search must be conducted by two members of staff of the same gender as the prisoner and out of sight or sound of others.) Nurse A was asked to speak with him as he had become very emotional and agitated. He told the nurse that the strip search had brought back memories of childhood events and the nurse made a referral for him to have counselling to help him deal with these feelings. He was also told that he could speak with the nurse if the emotions became more difficult for him to deal with.

23. The following day, the man went to court and on his return was told that he would be moving from B to E wing. He was not happy with this and felt that he was being punished for complaining about the strip search the previous day. Once he moved to E wing, he damaged his cell and told Officer A that he had swallowed some pieces of glass. An ACCT document was opened but he refused to be seen by a nurse.

24. The next morning, the man told staff that he wanted to move from the wing or be taken to the segregation unit. As he was due to have an adjudication later that day for the damage caused to his cell the previous night, staff took him to the segregation unit. He walked to the unit and no force was used.

25. After the man moved, an ACCT assessment was carried out. When asked about the reasons for his alleged self-harm, he said that he was angry at being moved from B wing. He explained that he had been sharing a cell with his brother-in-law, and believed that he was moved because he had made a complaint about a strip search.

26. He told the assessor that he had not previously harmed himself and had no previous thoughts of doing so. He went on to say that although he had told staff that he had swallowed glass, he had not done so and only said this so that he would be moved from the wing. When asked about how he coped with being in custody, he said that he received regular letters and visits from his fiancé and his mother. He acknowledged that he had issues regarding his anger management and that this was something that he needed to deal with. The assessor agreed that any subject of him returning to B wing to resume sharing a cell with his brother-in-law would be discussed once his adjudication hearing for damaging his cell had taken place.

27. Following his assessment, Senior Officer (SO) A spoke to him and conducted a case review under the ACCT provisions. He discussed with him the points that he had raised during his assessment. He told the SO that he would only return to B wing and would not go anywhere else in the prison. The SO considered that given the information that had been provided during the assessment, he was a 'low' risk of further self-harm. The ACCT monitoring process stopped and the document closed. A post-closure interview to monitor how he was coping was arranged for 5 September.

28. The man continued to refuse a move to anywhere in the prison other than B wing and told staff that he intended to refuse food. The prison doctor assessed him during his visit to prisoners in the segregation unit on 29 August, and recorded the following:

> " … the man has decided not to eat as he wants to be on B wing and is not happy to be located anywhere else. The logic and rationale as to why he believes he would be safe on B wing is not clear but in general terms he seems fit and well. He is drinking freely and this includes orange juice. How strictly he is not eating is also not clear but it would seem to apply to main prison meals …"

29. The prison doctor concluded that the man should be reviewed after the weekend. He also wrote that it was likely that his issues would not be resolved to his satisfaction. The doctor recorded that if this was the case the mental health team should be asked to review him to exclude any mental illness.

30. No further concerns were raised by or about the man during the next week and on 4 September, he transferred to HMP Everthorpe. Before leaving Leeds, SO B spoke with him and completed the ACCT post closure interview. He told the SO that he had "coped ok" since the document was closed and that he had found nothing helpful about the process. He also said that he knew when and where to get support if he needed it.

31. On his arrival at Everthorpe, a nurse assessed him and completed a health screen, with much the same answers as recorded at Leeds. However, despite his recent ACCT monitoring, it was recorded that he had not attempted to harm himself in custody before and no mention of the ACCT was made in his medical notes. It is not clear where the closed document was placed when he transferred but it was not available to staff on his reception to the new prison. He only remained at Everthorpe for three weeks and, during his short time there, he was recorded as being abusive and threatening towards staff. He transferred to HMP Lindholme on 23 September.

32. On reception at Lindholme, Nurse B assessed the man and a further health screen was completed. Again, he said that he had no physical or mental health concerns and his previous history of drug misuse was recorded. However, as at Everthorpe, the health screening form indicates no previous self-harm and no previous ACCT history. The nurse would have asked him about this and it is apparent from the document that he chose not to mention the incident at Leeds. The investigation revealed that the closed ACCT document that had been sent from Leeds to Everthorpe was never sent on to Lindholme.

33. Following the reception process, the man was located on J wing. On 29 September, he was assessed by a Community Psychiatric Nurse (CPN) at the request of wing staff. The CPN recorded that he had been very tearful and appeared low in mood due to his present situation and being away from his family and partner. The CPN considered that there was no evidence of severe, enduring mental illness and a referral was made to the primary registered mental health nurse (RMN) and the GP. However, the following day the man failed to attend an appointment with the GP.

34. The CPN spoke to him again on 3 October, after he had demanded to speak with him. The CPN explained that he had referred him to primary care and the GP but pointed out that he failed to attend the appointment. The CPN then telephoned the healthcare department and asked for the man to be seen by the GP the following day. He recorded that he was verbally abusive during the meeting. No further contact with the medical staff at Lindholme is recorded.

35. The man was suspected of involvement in using drugs, mobile telephones and bullying during his short time at Lindholme. He transferred to HMP Wealstun on 27 October.

36. As with previous prisons, a health screen was completed when he arrived at Wealstun. When asked whether he had seen a doctor in the last few months, he replied that he had not, despite having seen the prison doctor at Leeds at the end of August. It was recorded in the health screen document that he was anxious during the screening as he thought that people would be talking about him. He also told the nurse that he had been in contact with the mental health team at Lindholme, but answered ‘no’ to questions about previous self-harm attempts. The nurse asked him what other information he considered to be important and he told her that he ”heard voices sometimes”, and wished to see a GP as soon as possible about this. A referral was made for him to have a mental health assessment.

37. The man's medical notes show no evidence that a mental health assessment took place as a result of this referral. A mental health nurse and member of the Mental Health In-Reach Team (MHIRT) at Wealstun was interviewed during the investigation. She told the investigator that it was her understanding that he had been referred to the primary care mental health service, and would have been placed on their waiting list, which can be quite long. The difference between the primary mental health service and the MHIRT is that the MHIRT will generally work with those considered to have serious mental health illnesses and those with complex needs. The primary care mental health service in prisons focuses more on those with mild to moderate illnesses such as depression and anxiety.

38. On 5 November, the man refused to move from C to B wing. He submitted an explanation giving his reasons for refusing. He said that there were prisoners with whom he had problems outside of prison on the other wings. He considered there might be trouble if he came face to face with them and he wanted to avoid that. He was unable to give names of the individuals concerned, only nicknames and prison staff were unable to identify any individuals. He was subject to an adjudication for refusing to move and subsequently moved to D wing shortly afterwards.

39. On 16 November, workshop staff asked Nurse C if she would speak with the man in her role as primary care mental health nurse as he had told the instructor that "his head was done in". The following day, when she went to D wing to speak with him, he was talking with the wing SO about his release date. She recorded that heappeared surprised when she told him that there had been concerns about his mood. He told her that he had no issues and did not wish to engage with her and that he "felt fine." She advised that if he changed his mind he could contact her via the healthcare department.

40. The next day, Nurse C received a call from an Officer on D wing who told her that the man wished to speak with her, so she visited him on the wing that afternoon. He told her that he was "very stressed" and she recorded that his speech was rapid and he had poor eye contact. She asked him about the statement he had made on reception at Wealstun regarding hearing voices and he said that "the voices talked a load of crap." He went on to tell the nurse that he was unable to concentrate or rest at night but did not expand as to what was bothering him. He added that he was careful how he acted because "people might talk about him". She asked if he had any thoughts about suicide or harming himself and he replied that he "would not think like that as he had his partner and her children to think of". A referral was made to the MHIRT for an in-depth assessment of his mental health.

41. Nurse C spoke with the mental health nurse about her concerns regarding the man and told her that she would welcome a second opinion. The referral submitted by Nurse C was received by the MHIRT on 19 November and discussed at the MHIRT referral meeting later that day. The investigator asked the mental health nurse about the purpose of the referral meeting. She explained that every Thursday she discusses with her colleague all the referrals

that have been forwarded to them. They then decide who will carry out the assessments, depending on individual caseloads, availability, urgency and priority. An appointment was made for the man to be assessed on 30 November, by her.

42. The mental health nurse explained to the investigator that it was normal for a prisoner to wait up to two weeks for an appointment. She said that a prisoner would be prioritised if they were displaying or stating symptoms such as hearing voices, as the man was. However, she said that although someone like this would prompt earlier intervention, in his case his first intervention came from Nurse C in her role as primary care mental health nurse. She explained that a prisoner's case will not actually be taken on by the MHIRT's until an assessment has been conducted.

43. On 30 November, the mental health nurse went to the man's wing in order to carry out his assessment but found that he had gone to work. The investigator asked her if she had access to his medical notes prior to an assessment. She explained that it depended on what system was being used for medical records and that she could have access to a medical file that contained little information. She arranged to see him on the following day,1 December, and when she arrived she was told that he did not wish to see her. She said that she liked people to tell her face to face that they do not wish to be seen. She told the investigator that the nature of mental illness means that someone may be ill but not realise it, and this was the reason for trying to see them. She also said that she had spoken with Nurse C who had concerns about him and she respected her clinical judgement, so wanted to satisfy herself that he was alright.

44. The mental health nurse went to the man's workshop and spoke with him in the office. He told her that he had a course to do and could not spare the time. She replied that it was not a problem, she could visit him in the workshop and they could work out with the instructor a convenient time to do the assessment. She told the investigator that he appeared happy with this and agreed to her arranging an appointment.

45. On 2 December, a security information report (SIR) was submitted raising concerns about the man's increased unpredictable behaviour, and drew attention to his previous history of assaulting staff. The SIR also indicated that he had recently been referred to the MHIRT. (An SIR can be submitted by anyone working within a prison to share information about individual prisoners that may impact on the good order of the prison, such as violence, drugs or possible escape attempts.) A further SIR was submitted the following day that indicated he had assaulted another prisoner, and this was further supported when staff listened to a telephone call made by him in which he was heard admitting to the assault.

46. Due to the concerns raised by wing staff about the man's unpredictable behaviour and the welfare of other prisoners, a duty governor asked a member of MHIRT to assess whether he was alright to remain on the wing. The mental health nurse said that she was not on duty that day, otherwise she would have

seen him so that there was continuity. Her colleague went to see the man in the segregation unit where he had been relocated earlier in the day following the allegations that he had assaulted another prisoner. He concluded that he was presenting some psychotic features and, in his opinion, posed a risk to others. The man agreed that for his own safety and that of others he should be removed from the wing. Wealstun does not have an inpatient healthcare facility and, when asked, the mental health nurse told the investigator that had there been such facilities, it was likely that he would have been located there instead of segregation.

47. A requirement for prisoners sent to a segregation unit is for a safety algorithm to be completed on their arrival. This requires a nurse to assess the prisoner when they arrive to be satisfied that their physical health or mental well-being is not likely to be affected by being located in segregation. Once completed, a governor will then sign the form. The nurse who completed the safety algorithm for the man raised no concerns. In addition, a nurse visits all prisoners in the segregation unit daily. No concerns were raised during these visits about him and he was not receiving any prescribed medication.

48. When the mental health nurse returned to duty the following day, 4 December, she had a discussion with her colleague about his assessment of the man the previous day. She noted on the MHIRT's record that his assessment highlighted concerns about the man hearing voices at night, irritability, feeling stressed and social problems.

49. After their discussion about her colleague's concerns, the mental health nurse went to the segregation unit to speak with the man. She recorded that he did not complain to her about hearing voices but he acknowledged feeling "stressed" due to his social situation. On the notes of the assessment, she wrote that his medical record had not been read by her at this time. She asked him whether he had any thoughts of harming himself and he said no. It was also recorded that he did not appear to be a "vulnerable man" and had no previous history of self-harm.

50. In the record of the MHIRT's interactions with the man, it is clear that the mental health nurse's and her colleague's opinions differed as to the severity of the man's problems. The investigator asked her about these differences and what decision was taken on how to deal with them. She said that her colleague was concerned that he had seen some psychotic features to the man's presentation that she had not and that, in his opinion, the man was at risk of harming others. He felt that the opinion of a psychiatrist should be sought but she told the investigator that she was not in agreement with this assessment. However, she said that they discussed their differing opinions, along with the duty governor and the decision was taken to ask the psychiatrist to assess him.

51. The psychiatrist attends the prison on a fortnightly basis and conducts a morning clinic in support of the MHIRT. The mental health nurse pointed out during her interview that the decision was made because neither she nor her colleague could say definitely what was wrong with the man as he had presented quite differently to each of them. She went back to see him and told

him the decision. When he was told that he would remain in the segregation unit pending the assessment by the psychiatrist on 10 December, he was not concerned about having a further assessment but was unhappy at having to remain on the unit and said that he wanted a transfer to another prison.

52. The mental health nurse talked to the man about the social situation that he had described. He told her that things were difficult for his partner while he was in custody and that this was putting their relationship under pressure. She told the investigator that he spoke a lot about his partner, mother and sister. He became quite upset when they discussed how he felt about his partner, and he talked about feeling paranoid about what his partner may be doing while he was in custody. He acknowledged that this problem and told her that he "did his partner's head in". She explained to him how this might make it difficult for his partner and how he could deal with it. The investigator asked her whether she felt he was open with her during their discussion. She considered that he was, but may not have been with other staff.

53. Later on the same afternoon, the man refused his food and the offer of hot water, telling staff that he would continue to do so until he was returned to the wing. He also asked to speak with a listener and two listeners visited him that evening and spent 20 minutes with him. (Listeners are prisoner volunteers trained by the Samaritans to offer confidential support to fellow prisoners in periods of crisis.) A prisoner can ask to speak with a listener at any time, day or night. If a prisoner in the segregation unit asks for a listener, a risk assessment is completed to determine whether the listener is likely to be at risk. In cases where this is felt to be the case, the prisoner is offered use of a dedicated telephone with access to the Samaritans as an alternative. He had two prisoners present for their own safety.

54. During the morning of 5 December, the man was again allowed to talk to two listeners, at his request. Following their talk, he told Officer B that he intended to go on a "hunger strike" until he was released. The officer recorded on the segregation log that he had spoken with him about this and he later collected his lunch and was observed eating. There were no recorded concerns about him during the remainder of the day. When the night staff came on duty at around 8.00pm, the man asked Officer C to telephone his mother on his behalf to tell her that he had moved wings, and that he would be having a psychological assessment on Thursday. The officer made two attempts to telephone the man's mother and was successful on the second attempt. He told her that her son was now in the segregation unit and that a governor had arranged for her to visit him on Tuesday.

55. Listeners saw the man at his request on 6 December, but no other concerns were reported. On 7 December, the mental health nurse visited him again as she had previously arranged. She recorded that he was appropriate in his behaviour and reported no auditory hallucinations (hearing voices). He did express concern about his partner and admitted to her that he did not trust his partner and would relentlessly question her about what she was doing. She discussed with him the options for dealing with his paranoia and jealousy. He told her that he would try and remain calm while in the segregation unit and

await his assessment with the psychiatrist. She agreed to complete his assessment when he returned to the residential wing.

56. The man also asked her if she would contact his mother on his behalf. She told the investigator that she tried to telephone his mother on two occasions but got no answer. She was aware that his mother went to work each day at 2.00pm so would not try after this. The prison chaplain also attempted to contact the man's mother on his behalf.

57. During the afternoon of 7 December, the duty governor told the man that once he had seen the psychiatrist the following Thursday, a decision could then be made about his location. The governor recorded that he raised no concerns. Later in the afternoon, staff offered him the opportunity to use the telephone and he told them that he wanted to speak with the mental health nurse before doing so. When staff enquired why he had asked other people to contact his mother on his behalf, he became abusive. The nurse contacted the segregation unit and told staff that she had been unable to get through to his mother, but would try again the following day. When he was told this, he was calmer and apologised for his earlier outburst.

58. The following day, the man asked to speak with the chaplain during the morning and the chaplain saw him while visiting the prisoners located on the unit. He said he had been told that someone had died and asked the chaplain if he would telephone his mother. He did so and was told that the father of the man's partner's son had died. He passed this information to the man who became quite tearful. He was offered the support of listeners but said that he was "fine". Staff also arranged for his family to visit him that afternoon and recorded that a telephone call to his partner's son would be facilitated during the afternoon.

59. The man's mother asked the investigator why the special visit had been organised but it was not clear whether the visit she referred to was the one on 8 December. The investigator asked the prison to explain the process for arranging a special visit and the reason it had been done for him. The investigator was told that although there was no record of a visiting order, the governor recalled that he had authorised a two-hour visit for him as he had not seen his family for a while. The usual allowance for prisoners in the segregation unit is 30 minutes.

60. When the man returned from his visit that afternoon he telephoned his partner and staff recorded that, he was "quite emotional". Over the remainder of the afternoon and evening, it is recorded that he was very quiet. Staff observed him at regular intervals, but no concerns were raised. The following day, he was given some emergency credit so that he could telephone his partner. (Prisoners can purchase credits, weekly, to use the telephone system. However, if they run out during the course of the week, staff are able to provide credit if there are compassionate reasons.) He spoke with his partner during the afternoon. After the call, staff recorded that he was very agitated and emotional, he punched the wall when he returned to his cell. Staff asked if he

wished to talk and he declined but asked to use the telephone again and made a further call.

61. The prison provided the investigator with the recordings of the man's telephone calls. He made four calls that afternoon. During one call, his partner told him that she could no longer continue seeing him, as she needed to concentrate on her son following the death of his father. He was clearly upset by this and made a further call to his partner's friend asking her if she could try to get his partner to change her mind. During the evening, he asked staff if he could use the telephone again and was told that, this would not be possible as the unit was on a "patrol state". (A patrol state is when all prisoners are locked in their cells with reduced levels of staff.)

62. Following the draft report the man's family asked whether the calls made had been transcribed. The telephone system used within prisons allows recordings to be saved onto compact disc (CD), and it was a CD that was provided to the investigator. This was listened to in the privacy of our office and no transcription was made.

63. A Principal Officer (PO) was the orderly officer that evening. He told the investigator that as part of his handover he was told that the man had been "a little bit non co-operative and volatile during the day after receiving some bad news from his partner", but the segregation staff were dealing with it. The segregation unit staff contacted the PO during the evening as they felt the man was still being unco-operative and becoming volatile as he could not access the telephone. They asked him to assess the situation and staff told him that they had been trying to facilitate further telephone calls for the man during the afternoon so that he could contact his partner.

64. When the PO arrived in the segregation unit, the man's behaviour had deteriorated. He was punching the cell wall and door out of frustration at not being able to use the telephone. The PO decided that he should not be unlocked unless there were at least three members of staff present. In response to a question from the investigator, he said that he did not consider that the man's mental state had deteriorated. In his opinion, it was just frustration at not getting on the telephone and he was not dealing with the situation of his partner ending the relationship very well.

65. In view of the man punching the cell wall and door, the PO decided to place him under the ACCT monitoring procedures. The PO also asked a nurse to go to the segregation unit to assess any injury to his hand but he refused to be seen. The PO then completed the ACCT document and informed the night orderly officer of his actions before going off duty. The man settled down later in the evening and no further problems were reported during the night. The ACCT document opened by the PO instructed staff to observe him at thirty-minute intervals throughout the night.

66. On 10 December, the man refused his breakfast and asked to use the telephone. He spoke with his partner's friend and was clearly upset about the relationship ending. At 10.00am, he pressed his cell call bell and told Officer D

that “if I do not get out of here something will happen as I have too much thinking time”. The officer recorded that the man then started crying. He was seen shortly afterwards by the prison GP who checked his hand and noted that there was slight swelling but no evidence of any fracture.

67. At 10.50am, the mental health nurse and psychiatrist went to the segregation unit to carry out the planned assessment with the man. The psychiatrist recorded the following on the medical notes:

> “… Seen in segregation unit with mental health nurse. Noted history over the last week. Been in segregation for allegedly hitting someone on wing, although he denies this. It was heard on the PIN phone but he says that he was thinking about hurting someone. He feels that his past reputation works against him and that he is immediately picked out and he recognises he has a very low frustration and can end up hitting walls and in the past has been violent. Says current situation triggered by problems with his girlfriend on the out and the death of her ex partner. Says that he said he was hearing voices so he could get support as he knew that ‘being mad’ was a way of getting people interested. Denies hearing voices now or being overly paranoid. Wishes to get on with ‘being a changed man.’ Willing to engage with the mental health nurse with regards looking at impulsivity and behaviours. Appears relaxed, calm mainly although little agitated when talking about how he believes others perceive him. No evidence of mood or psychotic disorder. Advised governor of the assessment and that no immediate concerns to require further time on segregation …”

68. The mental health nurse also spoke with the man following the psychiatrist’s assessment. He talked about his partner and how she had “finished” with him. He felt his partner “needed space” and said that he was not going to telephone her. The nurse told him that she felt this was sensible and suggested that he wrote a supportive/loving letter to her instead. She offered to contact his partner, but he declined.

69. The man’s family asked after having sight of the draft report, whether the psychiatrist had been aware of the fact that the man had been crying a short while before he conducted his assessment. I am unable to speculate on what the psychiatrist did or did not know prior to his assessment, but there is nothing recorded that shows he was informed of this.

70. Following the assessment with the psychiatrist, the governor authorised the man’s return to D wing. He went back to the wing later that morning. At 2.20pm, Officer E went to D wing in order to carry out an ACCT assessment with him. During the assessment, he told the officer that he considered his current problems had stemmed from the death of his partner’s ex partner. He said that punching the wall the previous evening was his way of dealing with the situation and feelings of frustration and anger, not a cry for help. He said that he had no feelings of suicidal intent at that time or currently and that he had never previously harmed himself. When asked how he was currently

feeling, he said that he was “feeling frustrated at not being able to offer support to his partner and her son at this time”.

71. The man gave his reasons for living as his partner and her son. He told Officer E that he had a reputation for being “a hard man on the wing” and that this would come under scrutiny if he attempted to harm himself. Before the officer concluded the assessment, he said that he could see no reason why he was subject to the ACCT process and asked for it to be stopped. He said the only way that he could deal with his current issues was “in his own way”.

72. The investigator asked Officer E if he had concerns about the man at any time during the assessment. The officer replied that he presented as a very confident person who provided good reasons why he considered he should not have been subject to the ACCT procedures. He added that he asked him about the apparent breakdown of his relationship with his partner. He responded that they had just had an argument, and everything would be sorted out. The officer told the investigator that during the assessment the man had been very calm and methodical in the answers that he provided.

73. After the assessment had been completed, the man returned to his cell while Officer E wrote up his notes of their conversation. The telephone records show that he used the telephone to contact his partner while the officer was doing this. During the call, he was very positive. He told his partner that he understood that things were difficult for her now and he was going to give her space. They discussed their relationship and his partner said that given time there was a chance that they could sort things out and that she still loved him. Compared to earlier calls made by him this appeared to be positive and he sounded more hopeful about the situation.

74. After Officer E had written up his account of the assessment, both he and the man attended a case review with Senior Officer (SO) C. The SO is not a regular manager on D wing but was covering that role on 10 December. He told the investigator that once he was made aware that an ACCT case review was required he contacted the healthcare unit at 2.00pm to arrange for a nurse to attend the review. He was told that somebody would be available at 3.00pm. However, just before 3.00pm, no one had arrived so he contacted them again and was told that the mental health nurse would be attending the review.

75. When SO C contacted the mental health nurse, she was already conducting an ACCT case review on another wing. She had told him that she was unable to attend straight away and he had asked for her views on the man. She replied that given her recent interactions with him, she had no immediate concerns. She would be content for the ACCT monitoring to stop. However, this decision would need to be made on the basis of the information he gave during his assessment and the case review.

76. Once he had spoken with the mental health nurse, the SO began the case review with Officer E and the man at around 3.15pm. He said that during the case review the man was confident and “forward looking”. He told the SO that if he was kept on the ACCT monitoring he would look “weak on the wing”. He

said that he could look after himself and felt soft being subject to the ACCT process. They discussed the problems with his partner. He told him that they had not "split up" and that that was wrong. When asked why the ACCT document had been opened, he told the SO that he had punched a wall out of frustration because he could not be there for his partner. The SO said that everything he told him was positive and about what he was going to do in the future.

77. At the end of the review, those present decided jointly that the ACCT monitoring should stop. Both Officer E and the SO were asked whether the decision was based on the information obtained during the assessment and case review and from the mental health nurse rather than the man's wish for the monitoring to stop. Both confirmed that the decision was based on all of the available information. The SO said that having been involved in quite a number of case reviews, he was fully aware that some prisoners would attempt to "manipulate" being taken off the ACCT procedure. However, if he had sensed the man was not confident or was worried about what was going to happen later then he would have left the monitoring in place.

78. A fellow prisoner and a friend of the man provided a police statement. He said that he spoke to him after he had returned from the segregation unit and he had said he was glad to be back. He knew that he had been having problems with his girlfriend but considered these to be just the "normal" sorts of things that prisoners go through. There had been nothing in his demeanour to suggest that he was unhappy or depressed.

79. SO C spoke to the man again while he was collecting his evening meal and he asked about attending the gymnasium that evening and over the weekend. He went to the gymnasium at around 5.30pm and returned to D wing at 6.50pm. On his return, he telephoned his mother. He told her that he was fine and asked whether she had posted him any money as he wished to purchase items from the canteen. (Canteen is the term for the prison process where prisoners can buy or order goods each week to a limited value.) He also told his mother that things were all right with his partner and she needed time to get her head together. No other concerns were raised by or about him and he was locked in his cell at 7.10pm.

80. A prisoner in the cell next door to the man made a police statement. He said that between 8.00pm and 9.00pm, the man banged on his cell wall and they had a conversation about what was on television. The man told him that he was going to watch Emmerdale. It seemed like a normal conversation and he appeared to be happy. The prisoner said that he turned his television off at 10.00pm and went to sleep. He heard nothing more from him during the night.

81. Officer F and Operational Support Grade (OSG) A had both begun night duty on D wing at around 8.00pm. The officer told the investigator that both he and the OSG would conduct a roll check (count of all prisoners) when they start their duty. He said that it was normal for the two staff to count two landings each, and on that evening, he counted D4, where the man was located and D3. He recalled seeing him in his cell because he had been told that his ACCT

monitoring had stopped earlier in the day. He said that in the handover given by the day staff, he was told that the man was "fine" and there was no reason to worry. When he observed him during the roll check he was standing at the back of the cell with the light on. He did not have any conversation with him and continued with his roll check.

82. During the night, there were no reported problems on D wing and staff had no reason to go to the man's cell. At 5.40am, on 11 December, the OSG began a morning roll check on D wing. When he looked in the observation panel of the man's cell, he saw him in what he described as a seated position at the back of the cell. During the morning roll check, he used a torch as the cells were dark and he wanted to avoid switching on cell lights and disturbing prisoners. As soon as he shone the light onto the man, he felt something was wrong. He then switched on the cell light and attempted to get a response from him by calling out and banging on the door but he did not respond. The OSG was asked whether at this point, he was able to see anything such as a ligature around the man's neck. He said that he could not, but he felt that there was a problem.

83. Officer F was some 25 feet away along the landing. The OSG asked him to have a look at the man as he was concerned by what he had seen. He told the investigator that this took around twenty seconds and they both returned to the cell. The officer said that he had a "bit of a sinking feeling" when he looked into the cell, as something was not right. He saw him sitting low at the back of the cell and it seemed as though he was on the heating pipe that ran along the back of the cell. His head was to one side and his chin was on his chest. He said that at this point he could not see any ligature and he did not look as though he was "suspended". He tried to obtain a response from him as the OSG had done. When this failed, he used his radio to ask the night orderly officer (Oscar 1) to come to the wing immediately as he believed he had a "code blue". (The night orderly officer is in charge of the prison at night. In an emergency, prison staff use codes to indicate the nature of the problem and this allows the medical staff to respond with appropriate equipment. Generally, the codes are blue for breathing/respiratory difficulties and red for bleeding.)

84. Senior Officer (SO) D was the orderly officer on 11 December. He said that he was alerted over the radio to telephone Officer F on D wing. When the SO contacted D wing he was told that there was a possible 'code red' in cell D4-11. He gave the officer permission to break his sealed key pouch containing a cell key for use in emergencies and go into the cell. He then made his way immediately to the wing. The accounts of how he was notified of the problems and the codes used contradict each other but he did arrive on D wing a very short time after the initial call was made. Despite the contradiction it is clear that a coding system is in place at Wealstun.

85. Officer F said that he had only just opened the cell door when the SO arrived onto the landing and they both went into the cell. The SO said that the man appeared to be sitting on the heating pipes. His legs were outstretched and his arms were by his side. The curtains on the window were closed. As he approached him, he noticed that his skin was discoloured, with very deep red

and purple blotches. As he got closer, he saw something around his neck. He then moved the curtain and saw that a ligature had been tied to the window clasp. The SO told the investigator that when he saw all of this he placed his hand on the man's shoulder, he did not know why he did this but recalled saying "bloody hell lad, why?" He could feel that the body was very "stiff" which indicated to him that rigor mortis was present and he gave this as the reason for no resuscitation being attempted.

86. The investigator asked the SO if he could explain when the ligature was removed from the man's neck. He replied that the ligature was not removed but it was cut from the window clasp. Officer F had asked him about cutting the ligature and he had been unsure as to whether it should be or not. He then gave the instruction for it to be cut from the window but it remained attached to the man's neck.

87. Once it was clear to the SO that the man had died and that it was too late to attempt first aid, he instructed the staff to leave the cell and the door was locked. An ambulance called following the original emergency call arrived at Wealstun at around 6.21am. Officer F said that the ambulance staff placed a monitor on the man that confirmed there were no signs of life and pronounced him dead at 6.23am.

88. A letter written by the man and discovered in his cell following his death, indicated that he had taken his life as he could not cope with the break up of his relationship. The letter was taken by the police and a copy provided to his family.

Actions following the man's death

89. The prison appointed an officer to liaise with the man's family. She travelled to his mother's home on the morning of 11 December, to break the news. She kept in daily contact with the family during the first few weeks after his death and arranged for them to visit the prison and meet with his friends. The prison contributed to the funeral costs and the officer attended the funeral at the request of the family. She also organised a memorial service at the prison which was also attended by the family.

90. Staff directly involved on the morning of 11 December were supported by the prison care team and a debrief was conducted, which gave staff the opportunity to raise any issues that they felt needed to be addressed as a result of the man's death.

ISSUES

Clinical care

91. A clinical reviewer carried out a review of the man's medical care while in custody. His report is based on the medical records and transcripts of staff interviews conducted by my investigator. It is attached in full as an annex. He comments on a number of areas, notably the mental health provision at Wealstun. He concludes that the man was suffering from an altered state of mind, namely a psychosis, which caused him to take his life. The clinical reviewer is of the opinion that this could have been prevented if treated earlier. However, the man had been assessed by a consultant psychiatrist who could find no evidence of mood disorder or psychosis and was happy for him to be on a residential wing.

92. The clinical reviewer has made twelve recommendations as a result of his review. Where appropriate, I have recast and incorporated some of them into my own recommendations. Although I have not listed his remaining recommendations, the Head of Healthcare and Governor may wish to consider his findings and respond via the PCT.

93. In response to the draft report the man's family asked whether my office had considered obtaining a psychiatric expert opinion in addition to the clinical review. I am fully supportive of obtaining further expert opinion where this might help, but I am not convinced it would be proportionate in this instance. The opinions of the clinical reviewer can be further explored at inquest if the Coroner considers this necessary.

Mental Health In-Reach

94. The man's interaction with Mental Health In-Reach Team (MHIRT) began at Leeds and continued at Lindholme. There appears to have been no documentary evidence of this at Wealstun other than him mentioning it during a reception assessment. He was initially seen by Nurse C, in her role as a primary care mental health nurse, who then made a referral to the MHIRT. A mental health nurse said that she was unaware of his involvement with MHIRT at previous prisons. This was probably due to the different types of electronic databases used by the prisons and had she been aware of these facts, further information would have been sought.

95. There is some confusion as to whether the man was seen by the MHIRT as a result of the initial reception referral on 27 October or a subsequent one. The mental health nurse thought it was likely that he had been placed on a lengthy waiting list and that her first assessment of him on 1 December was probably due to a further referral by Nurse C.

96. During the investigation, the investigator found that not all interactions with patients by the MHIRT were recorded on System One, the medical database used by the wider healthcare team. This made it difficult to see what treatment had been provided. The mental health nurse explained that since the man's

death changes had been made that now required every referral to be recorded on System One, so that nurses or the wider healthcare team are aware of action taken. Completed or planned assessments are also recorded on the system. In view of these changes, I make no further recommendation on this aspect.

97. When the man moved to the segregation unit on 3 December, she was not on duty. On her return, there was a disagreement between herself and her colleague about the severity of the man's condition. An opinion was appropriately sought from the visiting psychiatrist.

Primary mental health care

98. On his reception into Wealstun, the man told nursing staff about his previous contact with mental health services and that he had been hearing voices. No treatment was considered and a routine referral was made to the MHIRT. He also asked to speak to a doctor but there is no indication that this was followed up and no information sought from his previous prison.

99. Nurse C saw the man again on 17 November after concerns were raised by staff about his behaviour. He told her that he was fine and he was advised to contact healthcare staff if this changed. He then asked to see her again the following day, and said that he was very stressed. She recorded that he had rapid speech and poor eye contact. He again mentioned hearing voices but denied any suicidal intent.

100. Despite the symptoms being recorded by Nurse C on her second assessment of the man, no medication was provided or treatment plan considered. The only action was for a further routine referral to be made to the MHIRT who had yet to respond to the previous request. The clinical reviewer makes a number of recommendations on the management of mental health provision. I recast and endorse the following:

The Head of Healthcare and the Governor should conduct a comprehensive review of how the healthcare and mental health teams manage potentially mentally ill patients so as to optimise their well-being and safety. This should include a process for improved communication between the primary care team and in-reach team to ensure quicker, more thorough and precise assessments.

Assessment Care Custody and Teamwork (ACCT) monitoring

101. Staff at Leeds prison had monitored the man under the ACCT suicide and self-harm prevention measures but this stopped before his transfer to Everthorpe. When he arrived at Wealstun, he told staff that he had not been subject to such monitoring in the past and the ACCT document did not accompany him to the prison. During the investigation, the investigator identified that the man had been managed under the ACCT process and discovered that the closed document had been retained by HMP Everthorpe. Although it had been closed, the document should have been stored in his prison record to be available if he

later transferred to another prison. The information contained within the document may have proved useful to staff.

102. Despite the absence of the ACCT file, the opening of the document and the reasons for it was recorded within the man's medical record. All nursing staff have access to a prisoner's medical record and certainly during the reception screening. There is no evidence that this was picked up by medical staff either at the time of his reception or during the interactions he later had with nursing staff. The safer custody team at Wealstun were able to trace the closed ACCT within a few days after being asked by the investigator. It is clear that if the information had been highlighted at reception or any point during the man's time at Wealstun, it could have been traced and obtained easily.

103. Although not directly linked to ACCT procedures, the failure by staff to identify the previous document suggests that previous entries in medical records are not read. This was also a concern highlighted by the clinical reviewer. I make the following recommendation which also takes account of the comments made by him:

The Governor and Head of Healthcare should ensure that both doctors and nurses are reminded of the importance of reading previous entries in prisoners' medical records before new consultations. Where previous entries contradict information supplied by a prisoner, either during reception or later consultations, staff should seek further information and record the action taken and outcomes.

104. During the investigation, it became apparent that some staff who work permanent night duties had not received regular up to date training on ACCT procedures. In particular, the OSG, who first discovered the man, said at interview that he had been given no recent training. Notably, the Chief Inspectorate found that night staff were not always aware of what to do if a prisoner had harmed himself. With a greatly reduced number of staff on duty at night, it is the sole responsibility of night staff to monitor those who are subject to suicide and self-harm prevention monitoring, and as such it is essential that they are provided with adequate training. I therefore make following recommendation:

The Governor should ensure that all staff who have direct contact with or responsibility for prisoners are provided with adequate training in ACCT procedures. Updates should be provided as necessary on any changes to the procedures. Night staff must be given the same opportunities to attend training as those working day shifts.

105. When the man was in the segregation unit on 3 December, staff do not appear to have considered opening ACCT monitoring. This is despite the mental health nurse identifying someone who, in his opinion, was psychotic. He recorded that he did not consider him as being a risk to himself but, as a precaution, it might have been prudent to provide extra monitoring to ensure that his perceived state of mind did not lead to him harming himself. ACCT monitoring was put in place three days before his death. I make no formal

recommendation on this as I accept that the reasons for segregation are different for each prisoner, but the Governor might wish to ensure that these concerns are shared with the healthcare and mental health teams.

106. My investigator was told that since the man's death changes to ACCT procedures had been initiated at Wealstun. These include the ACCT process remaining open for a minimum of 72 hours after being initiated. However, I feel that further changes are necessary to take account of prisoners on open ACCT monitoring being moved between units, particularly the segregation unit. I therefore make the following recommendation:

The Governor should ensure that when a prisoner moves between wings, particularly from the segregation unit to a residential wing, while on ACCT monitoring, this should remain open for a minimum of 72 hours. This would enable a broader, rather than snapshot view of how an individual is coping. The review on the new unit should be conducted by regular wing staff and, if possible, avoid using staff who have had no previous knowledge of the prisoner.

Segregation

107. The man was segregated on the advice of the MHIRT. However, no reference to his mental health was made on the segregation safety algorithm or by any visiting nurse or doctor while he was in the segregation unit. The safety algorithm is required for all prisoners in a segregation unit to confirm that the individual is medically and mentally fit to be segregated and that it is not likely to affect their mental well-being. While there is no evidence to suggest that his mental health would have been adversely affected or that he was not medically fit, I feel that explicit reference to the individual's mental health concerns should be made.

108. All prisoners within the segregation unit are seen daily by a member of healthcare staff and routinely by a doctor. At no time while on segregation did nursing staff or doctors comment on the man's mental well-being and the entries that were made offered no real insight as to how he was coping. In view of both of these issues I make the following recommendations:

The Governor should ensure that segregation safety algorithms take account of the reasons for an individual's segregation and, where this is related to concerns about an individual's mental health, this must be documented.

The Governor and Head of Healthcare should advise staff that routine segregation rounds by nursing staff and doctors must be followed up by a meaningful entry on prisoners' medical notes and make reference to how they are coping and any mental health concerns.

First aid training

109. As with most category C prisons, Wealstun has no healthcare provision at night. The discipline staff interviewed indicated that none of them had received up to date first aid training. They also pointed out that in the event of a medical emergency, they relied on the local ambulance service and out of hours GP service, and would do what they could until medical help arrived. I am aware that the policy on providing healthcare cover at night is not decided locally. However, it is essential that staff on night duties, in particular, feel confident to administer first aid in whatever circumstances may occur until professional medical assistance arrives. Those staff should also be confident in using any medical equipment available. I make the following recommendation.

    The Governor should ensure that staff are provided with up to date first aid training. Priority for this training should be given to those staff required to routinely work night shifts.

Actions of staff

110. During the investigation, it was clear that staff were quick to raise the alarm and enter the cell when the man was discovered. However, there appears to have been some confusion amongst the staff about what should be done in terms of the ligature. Guidance for staff says that first aid should be given in all cases unless there are clear signs of rigor mortis. The description by staff would suggest that this was the case with the man. While I accept that rigor mortis was considered to have been present when staff entered the cell, the ligature was not removed and remained in place. While the guidelines indicate the actions to be taken if staff consider rigor mortis to be present, they also state that the ligature must be removed in all cases, while preserving the knot. I therefore make the following recommendation:

    The Governor should remind staff of the correct procedures to be followed on the discovery of a prisoner who has harmed himself. This should cover all situations, including discovery at night and all methods used to self-harm.

CONCLUSION

111. The man was used to the routine of every day life in prison and had previously coped well with it. However, before his latest period of custody, he had developed a relationship that clearly was important to him. His friends in prison said that he was someone who could cope with custody, but they did note a change in him during this sentence. They said that unlike other sentences where he only had himself to worry about, on this occasion he felt like he had responsibilities outside of prison and he was concerned about how his imprisonment would affect the relationship with his partner.

112. While in segregation, the man's partner told him that she wanted to end their relationship. This caused him a great deal of upset and frustration as he felt unable to change things from within prison. However, despite the initial concerns that the relationship was over, his last conversation with his ex-partner on the afternoon before his death was positive. He also had a subsequent telephone conversation with his mother that evening.

113. During his period in Wealstun, the man displayed signs of a mental health condition and unpredictable behaviour. However, there was no consensus on the nature of the disorder. He was engaging with the MHIRT and this support was set to continue. It is impossible to judge what happened during the period between his optimistic telephone calls and being locked in his cell, that made him decide to take his own life. The letter that he left referred to his relationship and that he did not wish to continue without his partner.

Familys response to draft report

114. Where it has been possible I have made comment on points raised by the family following the appropriate paragraphs. However, there were some points where I was unable to answer in this way.

115. The family asked about progress HMP Wealstun has made on the recommendations I have made. The prison has provided my office with feedback, indicating what they intend to do and by when. This feedback is recorded within the recommendations section of this report in full.

116. The family asked whether the Pre Sentence Report (PSR) completed on the man would have been available to prison staff including nurses. The PSR is usually stored with other custodial documentation and is available to staff who may need to access it in order to complete certain procedures. This would normally be those relating to sentencing, such as OASys reports, catergorisation etc. I am unaware as to whether any requests were made by healthcare staff or others to access the man's report.

RECOMMENDATIONS

1. The Head of Healthcare and the Governor should conduct a comprehensive review of how the healthcare and mental health teams manage potentially mentally ill patients so as to optimise their well-being and safety. This should include a process for improved communication between the primary care team and in-reach team to ensure quicker, more thorough and precise assessments.

   The Prison Service accepted this recommendation and said:

   Primary Care Mental Health and Mental Health In Reach Teams work to develop effective care pathways for those considered in need of their services. All requests for mental health interventions are processed through the Primary Care Mental Health Team and discussed at weekly "single point" referral meeting.

   An Information Sharing protocol has been developed and signed off by NHS Leeds, Manchester City College, Probation etc and is being used by the Mental Health Teams within HMP Wealstun.

   This target has been completed.

2. The Governor and Head of Healthcare should ensure that both doctors and nurses are reminded of the importance of reading previous entries in prisoners' medical records before new consultations. Where previous entries contradict information supplied by a prisoner, either during reception or later consultations, staff should seek further information and record the action taken and outcomes.

   The Prison Service accepted this recommendation and said:

   Training in witness skills and health records offered to all staff 2009/10, training delivered by Leeds solicitors June 2010.

   Annual records audit adhered to with follow up action plan developed.

   Peer review of medical records commenced with three teams (Wealstun completed July 2010) to be rolled out to whole service in summer 2010.

   Weekly chronic disease clinics in each NHS LCH prison establishments. QOF now being monitored.

   All clinicians reminded of the importance of contemporaneous record keeping as standing agenda item for staff meetings.

   This target has been completed.

3. The Governor should ensure that all staff who have direct contact with or responsibility for prisoners are provided with adequate training in ACCT procedures. Updates should be provided as necessary on any changes to the procedures. Night staff must be given the same opportunities to attend training as those working day shifts.

The Prison Service accepted this recommendation and said:

The establishment have an ongoing ACCT training programme. Currently 72.3% of staff accredited in ACCT foundation training.

Al new staff to the establishment receive 'The introduction to ACCT' training as part of their induction.

ACCT Case Managers refresher training will be scheduled for all Senior Officers, DPSM's and Governors.

All current night OSG's have been trained in ACCT Foundation.

As we recruit additional OSG's they will undertake a 2 week entry level training course which ACCT Foundation is inclusive.

This Target is ongoing.

4. The Governor should ensure that when a prisoner moves between wings, particularly from the segregation unit to a residential wing, while on ACCT monitoring, this should remain open for a minimum of 72 hours. This would enable a broader, rather than snapshot view of how an individual is coping. The review on the new unit should be conducted by regular wing staff and, if possible, avoid using staff who have had no previous knowledge of the prisoner.

The Prison Service partially accepted this recommendation and said:

The establishment have a local policy of not closing any ACCT document before 72 hours after initial opening. (GNTS 251/09)

The local suicide/self harm policy will be amended to ensure ACCT documents will remain open for a minimum of 72 hours for any move into or out of the ASU.

A case review prior to the change of location fom ASU will be instigated and a manager / assigned personal officer from the receiving residential wing must attend.

A multi disciplinary ACCT review will be held on any prisoner on an open ACCT (or during post closure) on location to the ASU.

Target for this is 30 September 2010.

5. The Governor should ensure that segregation safety algorithms take account of the reasons for an individual's segregation and, where this is related to concerns about an individual's mental health, this must be documented.

The Prison Service accepted this recommendation and said:

Any clinical concerns that are raised from the segregation safety algorithms are entered on the electronic medical record System 1 by the clinician attending.

Peer reviews and documentation audits of medical records are carried out annually and include individual records of prisoners assessed in the segregation unit.

This target has been completed.

6. The Governor and Head of Healthcare should advise staff that routine segregation rounds by nursing staff and doctors must be followed up by a meaningful entry on prisoners' medical notes and make reference to how they are coping and any mental health concerns.

The Prison Service accepted this recommendation and said:

Clinical staff are reminded of meaningful entries by staff meetings standing agaenda item, single point referral, peer reviews and documentation audit.

This target has been completed.

7. The Governor should ensure that staff are provided with up to date first aid training. Priority for this training should be given to those staff required to routinely work night shifts.

The Prison Service accepted this recommendation and said:

Emergency aid training has been commissioned for a cross section of staff and will include the entire Night OSG group. The full 1st training course will be offered to identified night staff and those Senior Officers who frequently undrtake night duties to ensure we have adequate first aid provision within the establishment over a 24 hour period.

Target for this is 31 December 2010.

8. The Governor should remind staff of the correct procedures to be followed on the discovery of a prisoner who has harmed himself. This should cover all situations, including discovery at night and all methods used to self-harm.

The Prison Service accepted this recommendation and said:

A review of Self-Harm Know Your Job Sheet (KYJS) is to be undertaken to ensure all types of self-harm are addressed.

A general Notice to Staff will be issued outlining the required actions on discovery of an incident of prisoner self-harm. The updated self-harm KYJS to be published alongside this notice.

Target for this is 30 September 2010