



**Investigation into the circumstances surrounding the
death of a man at HMYOI Aylesbury in March 2011**

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

March 2013

This is a report into the death of a man, who was found hanging in his cell at Aylesbury prison in March 2011. Despite attempts to resuscitate him, he did not regain consciousness and died in hospital. He was just 19 years old. I offer my condolences to his family for their loss.

The investigation was carried out by an investigator. The local Primary Care Trust (PCT) appointed a clinical reviewer to undertake a review of the clinical care the man received while at Aylesbury. The clinical reviewer had the benefit of input from a specialist in learning disability. HMYOI Aylesbury cooperated fully with this investigation. I am sorry that this report has been delayed.

The man was a very vulnerable young man who had been held, firstly, in mental health secure accommodation and, then, in the Keppel Unit at Wetherby which is designed to deal with some of the most damaged children in custody. At Aylesbury, he displayed some challenging behaviour which staff often found difficult to manage. However, wing officers gave him time and attention and tried to manage him with rewards and sanctions and seemed genuinely to care about his well being. He was well supported by the chaplaincy.

The man frequently harmed himself and was often subject to suicide and self-harm prevention procedures, but these were not always well managed. On the night he was found hanging in his cell, he had written a note to a friend in a nearby cell expressing his intention to harm himself. The note was passed to the other prisoner by a member of prison staff who did not read it so was unaware of its contents.

Despite the frequent efforts of staff to support the man, I am concerned at the lack of holistic oversight of his complex needs. This meant that work regarding his learning difficulties, mental health issues, self-harm and challenging behaviour took place largely in isolation, without a co-ordinated approach and was not informed sufficiently by previous assessments and records. Accordingly, the report makes a number of recommendations, including a national recommendation about care planning for those with learning difficulties. I trust the Prison Service will learn lessons from the man's tragic death.

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 involved in my investigation.

Nigel Newcomen CBE
Prisons and Probation Ombudsman

March 2013

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SUMMARY

1. The man was 16 when he came to the attention of York Youth Offending Team in 2008 on his arrest for a number of serious sexual offences. Initially, he was subject to a hospital order due to his learning difficulties. Later, this was re-assessed and it was decided that a full hospital order was not necessary. He was transferred to HMYOI Wetherby and held on the Kepple Unit (a dedicated enhanced supervision unit designed to look after the most vulnerable young people in custody with behavioural, anti-social and self-harming histories).
2. In July 2009, the man was sentenced to an indeterminate sentence with a minimum of 27 months imprisonment. He remained at Wetherby until May 2010, when he transferred to HMYOI Aylesbury.
3. During his time at Aylesbury, the man built up positive and supportive relationships with members of staff on his wing and members of the prison's Chaplaincy. The Chaplaincy encouraged his interest in music, gave him a guitar and involved him in the Chaplaincy's music group.
4. Despite these positive points, the man's time at Aylesbury was turbulent. He was sometimes violent and had worrying incidents of self-harm. He would frequently cut his arms, as a reaction to things that upset him. A frequent trigger for his self-harm was a lack of tobacco or coffee, but more deeply he suffered feelings of loneliness and isolation. He missed his family, who lived a long distance away.
5. The man was subject to suicide and self-harm monitoring procedures on a number of occasions. After he harmed himself he told prison staff that he was fine, and had not intended to take his life.
6. The man needed a sex offender treatment programme adapted for prisoners with learning difficulties, but Aylesbury did not provide this. HMYOI Swinfen Hall offered the adapted programme but declined to take him because of his physical health problems (in particular bed wetting), his vulnerabilities and history of harming himself. At the time of his death, this issue had still not been resolved. He did, however, have the support and input from the Ridgeway Partnership Team (also known as Oxfordshire Learning Disability NHS Trust) which provides assessment, health and support services at Aylesbury for young men with learning difficulties.
7. During the afternoon of 9 March 2011, the man made superficial cuts to his forearms when he was already subject to suicide and self-harm monitoring procedures. That evening, he was excited about playing guitar in a concert for the Bishop of Aylesbury. When he returned from the concert, he appeared to be in a very cheerful mood. However, sometime that evening, his mood changed significantly. At around 10.30pm, he gave a member of night staff a letter, which he asked to be passed to another prisoner. Without reading the entire note, the member of staff did so. If he had read what was written he would have been alerted to the fact that he was threatening to take his life.

8. At 11.50pm, the member of staff started a check of the wing. When he arrived at the man's cell he was unable to get a response. His observation panel was obscured, but he could be seen through a gap between the wall and the door that he appeared to be suspended by a ligature. The member of staff radioed an emergency call, entered the cell and began to attempt resuscitation. He continued this un-assisted until paramedics arrived. The man was taken to hospital but did not regain consciousness. Several days later the hospital advised his family that he had sustained such a severe brain injury that his life support should be switched off. He died at 10.10pm with his family around him. He was 19 years old.
9. This report makes 13 recommendations. One of these is a national recommendation about care planning for those with learning disabilities. We also identify some problems with the ACCT process, and passing materials between cells. The recommendations also relate to action when prisoners obscure the observation panel in their cell door, support for staff involved in a death in custody and first aid training.

THE INVESTIGATION PROCESS

10. The Ombudsman's office was notified of the man's death on 17 March 2011 and the case was allocated to an investigator. Another investigator carried out an opening visit on behalf of the allocated investigator on 22 March 2011. During his visit he met the Governor and Deputy Governor, the Head of Healthcare, the prison's family liaison officer and a member of the Independent Monitoring Board. He was given copies of all prison documentation relating to the man and details of his next of kin.
11. The investigator issued notices informing staff and prisoners of the Ombudsman's investigation and invited them to contact her with any relevant information. Two prisoners responded to the notice and were interviewed by her.
12. The local Primary Care Trust (PCT) appointed a clinical reviewer to undertake a review of the clinical care the man received while at Aylesbury. It was particularly helpful that a consultant psychiatrist for people with learning disabilities was part of the clinical review panel. The report of the clinical review was received on 1 December 2011.
13. The investigator carried out 22 interviews over four days (17 May, 2 June, 14 June and 5 July). She also had a conversation with an Anglican chaplain. As it was an informal discussion, this was not recorded.
14. The investigator provided written feedback to the Governor on 18 May about her initial findings
15. HM Coroner for Buckinghamshire was informed of the investigation and provided a copy of the post mortem report. The Coroner will be sent a copy of this report to assist with his enquiries.
16. One of the Ombudsman's family liaison officers contacted the man's parents to invite his family to be involved in the investigation process. The investigator and family liaison officer visited the man's mother on 9 June. The family liaison officer explained the process for investigating a death in custody and the purpose of the investigation. The family raised the following issues:
 - The man's mother said that she did not accept her son would have taken his own life. She added that the prison had told her that her son had cut his arms in the days before he died, but they looked like old wounds to her.
 - She also said that the prison chaplain had told her that the night before he died; he had seemed "bright and bubbly" and had been playing the guitar at a concert being held in the chapel. His family wanted to know what had suddenly changed and why something was not done sooner.
 - The investigator explained that the man had written a note the night he died. The family had not been aware of this and were upset that the

prison had not told them. They wanted to know whether the member of staff who was handed the note had read it.

- The family also asked who the last person the man had spoken to was and whether the checks he was subject to were carried out properly. They asked why there had been a delay in notifying them after he was taken to hospital.
 - The man's mother also asked about her son's telephone contact while at the prison. She wanted to know who he had been in touch with, as his brother and sister were close to him and tried to keep in touch. She wondered whether there had been a problem with him using the telephone, as he had started to call less often.
 - The man's brother asked how the ligature had been tied, as his brother had trouble tying his shoelaces. He could not understand how he could have tied a ligature. The man's mother added that she wanted to know how her son was able to reach the window in the cell to attach the ligature, as he was not very tall.
17. As part of the consultation process, the family and their legal representatives received a copy of the draft report. We have responded to their concerns and comments in correspondence and have amended this report where appropriate to correct factual inaccuracies.
 18. During the consultation period, additional CCTV evidence came to light. The family were concerned that the CCTV showed different events to those recorded in the draft report. After securing another copy of the CCTV, the investigator was able to view the images and agreed that accounts differed. This has now been reflected in the report. CCTV footage from 10.00pm to 11.00pm remains unavailable.
 19. The family were concerned that some of the recommendations made by the clinical reviewer were not incorporated in the report and appear to not be accepted. The recommendations made about the ACCT process reflect the areas raised by the clinical reviewer, and these recommendations have been accepted.
 20. The Ridgeway Partnership Trust also gave additional information about their role and interactions with the man. A number of their comments have been reflected in this report, while others are noted but not included.
 21. We regret and apologise for the length of time it has taken to issue this report caused by work pressures in the Ombudsman's office.
 22. Some child protection issues arose as a result of the investigator's interview with a chaplain. These were raised with the relevant authorities by this office.

HMYOI AYLESBURY

23. HM Young Offender Institution Aylesbury holds up to 444 young adult men between 18 and 21 years of age, serving sentences from two years up to life imprisonment. There are eight wings.
24. F wing at Aylesbury where the man lived houses prisoners who are described as 'poor copers'. That is, prisoners who are considered likely to experience problems living and integrating well in the main prison because of a range of vulnerabilities.
25. There has been one previous self inflicted death since the Ombudsman took over responsibility for undertaking death in custody investigations in 2004. This was in 2008 and there do not appear to be any similarities between the circumstances of that death and that of the man.
26. Since the man's death, one other prisoner has apparently taken his own life. This report repeats a recommendation made in that case regarding enhanced case reviews as part of the ACCT process. Although the circumstances of the case are different, both prisoners displayed challenging and disruptive behaviour and might have benefited from additional support.

HM Inspectorate of Prisons (HMIP)

27. HMIP carried out an unannounced short follow up inspection of Aylesbury in May 2011. The Inspectorate reported that the prison had made good progress to improve its self harm prevention procedures. Assessment, Care in Custody and Teamwork (ACCT) plans were described as "better managed and indicated meaningful interactions by staff and prisoners".
28. With regard to bullying and violence reduction, HMIP said that there was a high level of violence but despite this prisoners said they felt relatively safe and there was an active strategy to reduce violence and confront bullying. The safer custody team was supported by effective safer custody management meetings. The anti-bullying process was well run and included meaningful interventions.
29. The self harm and suicide policy document was up to date and comprehensive. Relevant monitoring data was provided to the safer custody committee and used effectively. There was a multi-disciplinary approach to caring for those at risk, but also examples of poor practice and lack of staff engagement in self harm monitoring documents.
30. There was satisfactory access to primary care services and the GP services and nurse led clinics. Mental health services were described as good, but prisoners had poor perceptions of care in this area.

Independent Monitoring Board (IMB)

31. All prisons have an Independent Monitoring Board of unpaid volunteers from the local community to help ensure prisoners are treated humanely and with dignity. The most recent IMB report for Aylesbury covers the period July 2010 to June 2011.
32. The IMB reported that the Governor and his staff “continue to work hard to provide as safe and as caring an environment as they can with the resources provided”. The Board commented that the care and support offered to prisoners at risk of suicide and self harm was very good.

Suicide and self harm monitoring

33. Assessment, Care in Custody and Teamwork (ACCT) procedures in prisons aim to support and monitor prisoners at risk of harming themselves. The key aims of ACCT are to create a safer environment, identify prisoners’ individual needs and provide care and support before, during and after a period of crisis. Once an ACCT is closed, a post closure review should be held within seven days.

Aylesbury’s Violence Reduction Policy

34. Aylesbury’s violence reduction policy defines bullying as:

“Conduct motivated by desire to hurt, threaten or frighten someone. It can be physical, verbal, psychological, emotional or economical and often very subtle. It is usually repeated behaviour, unprovoked and intended to cause fear or harm to the victim”.
35. The policy also defines a vulnerable prisoner as:

“Anyone who has difficulty coping with the prison environment and/or likely to be a target of abuse/victimisation.”
36. The policy explains how instances of bullying should be dealt with, how it should be reported, and what action needs to be taken by staff.

Youth Offending Team (YOT)

37. A Youth Offending Team is run by every local authority and combines representatives from all of the local services required to care for young people involved in the criminal justice system.

Ridgeway Partnership Trust

38. The Ridgeway Partnership Trust is independent of the prison’s healthcare and not based on site. They are commissioned to provide screening for learning disabilities and advice to prison staff on how to deal with this where appropriate. The Ridgeway Partnership Trust is not a mental health service.

Youth Justice Board

39. The Youth Justice Board for England and Wales (YJB) is an executive non-departmental public body. Its board members are appointed by the Secretary of State for Justice.

The YJB:

- oversees the youth justice system in England and Wales
- works to prevent offending and reoffending by children and young people under the age of 8
- ensures that custody for them is safe, secure, and addresses the causes of their offending behaviour.

KEY EVENTS

40. The man was born in July 1991 and lived with his mother, stepfather and brother near York. He first came to the attention of York Youth Offending Team in May 2008 when he was 16 and arrested for a number of serious sexual offences. In June 2008, he was committed to Barton Moss Secure Care Centre in Manchester on remand. While on remand, he was charged with a number of other offences. Information from the Youth Justice Board (YJB) described him as having been diagnosed with learning difficulties, attention deficit hyperactivity disorder (ADHD) Asperger's Syndrome, emotional and behavioural disorders, child narcissistic personality traits, speech difficulties and incontinence.
41. It is noted in court reports that the man co-operated well with staff at Barton Moss and appeared to make progress, particularly regarding his attendance at education.
42. On 25 October 2008, the man completed a mental health assessment with a staff nurse. She noted that he had cut his wrists when he was 11 years old. He had also threatened to cut his own throat in the past. The nurse added that he did not have a formal diagnosis of ADHD, but that he found it difficult to concentrate on any one task for long periods of time. She wrote that she felt he was "incredibly vulnerable" and in need of constant support. She noted that she would discuss him with child and adolescent mental health services (CAMHS).
43. A nurse from CAMHS saw the man on 7 November. She recorded that CAMHS found it difficult to assess him due to his level of understanding and a review was planned for the following week. It was noted that he was seen again on 18 November and that a doctor would see him two days later for an assessment. There is no record of this assessment taking place.
44. The man was due to be sentenced on 2 December 2008, but this was adjourned to enable a referral to a learning difficulties clinic. He was assessed for a place at Roycroft Unit in Newcastle. The Roycroft Unit is a specialist unit for those with learning difficulties who also meet the criteria for detention under the Mental Health Act 1983. A month later, a report submitted to the court advised that he had been assessed as suitable for the Lennox Ward in the Roycroft Unit and an interim hospital order was imposed.
45. Records from the YJB show that, six months later, the man was assessed as not requiring a full hospital order and therefore not suitable for continued detention at Roycroft. A referral to the Keppel Unit at HMYOI Wetherby was made. This unit was opened in 2008 and is designed to be a safe and supportive environment for children aged 15 to 17 who find it difficult to cope in a mainstream young offender institution (YOI) environment. Court reports noted that he made a smooth transition to Wetherby and engaged in education and other activities. However, it was later noted that his behaviour began to deteriorate and he became more anxious as his court date approached.

46. On 22 July 2009, the man was sentenced to 27 months and remained at the Keppel Unit. It was suggested in a report completed by a seconded probation officer after his court appearance that he should be placed on ACCT procedures and monitored until assessed otherwise. This was because, in her opinion, when the length of the sentence sank in, he might react badly. There is no document to indicate whether monitoring took place at that stage.
47. It was noted in the report that the man had nocturnal enuresis (bed wetting) which was managed by prescribed medication and waking him throughout the night to use the toilet. The report recorded that he was prescribed desmopressin 0.2 mcg (to reduce urine production) oxytetracycline 250mg and benzyl peroxide 2.5% (for the treatment of acne). The report also said that he had "low average intelligence, emotional and behavioural disorder and childhood narcissistic personality traits".
48. The YJB provided information that, from November 2009, discussions took place between Keppel Unit and Swinfen Hall YOI about transferring the man. Swinfen Hall was the preferred option because it ran an adapted Sex Offenders Treatment Programme (SOTP) designed for people with learning difficulties.
49. On 25 January 2010, the man was seen again by CAMHS for speech and language therapy. On assessment, his speech was found to be adequate, and it was noted that he had significant learning difficulties. The plan was for staff to help develop his skills. He was seen again by CAMHS on 1 February. He completed a vocabulary assessment which scored him at a level of a ten to 12 year old.
50. Throughout this time, the man remained on medication for enuresis and appeared to wet his bed approximately once a month. On 22 February, he joined a guitar group, which he seemed to enjoy.
51. There are a number of entries in the man's prison records about his time in the Keppel Unit. There were occasions when he was bullied by other prisoners and times when he was the perpetrator of bullying which appeared to be monitored and addressed. Overall, he seemed to have made good progress, and on 17 May he completed a City and Guilds examination in Literacy.
52. On 25 May 2010, the man was transferred from Keppel Unit to HMYOI Aylesbury (via HMYOI Glen Parva for one night) by which time he was ten months past his 18th birthday. This was because Wetherby had been trying to find a suitable establishment running an SOTP programme, and also because there were concerns that moving him too often could make his problems worse. Swinfen Hall had not accepted him.
53. The man was seen in reception at Glen Parva for his overnight stay. It was noted that he was receiving medication for enuresis and acne. He also told reception staff that he had previously attempted to harm himself.

54. When the man arrived at Aylesbury the next day he had a health screening (by a prison nurse), a cell sharing risk assessment and an induction talk which included information about wing rules and suicide monitoring procedures. He was considered to be a high risk of harming other prisoners if he shared a cell. It was noted that he had been on an ACCT before, when he was low in mood and had scratched his arm, but this had been closed on 13 November 2009. During the health screening he said that he had not previously harmed himself, contrary to what he had told staff at Glen Parva the previous day. He was required to complete a 'Young Prisoner Disability Questionnaire' and signed to say he had learning disabilities. He signed a disclaimer to say that he did not want to engage with CARATs (Counselling, Advice, Throughcare services, an organisation specialising in the treatment of substance abuse) as he was not a drug user.
55. During his induction the man met the co-ordinating chaplain at Aylesbury. Members of the chaplaincy aim to meet with all new prisoners within 24 hours of their arrival. It became apparent to the chaplain that the man loved music and played the guitar. He said during his interview with the investigator that the man spoke openly about his offence and of his remorse. He also said he felt abandoned by his family and felt extremely lonely, although prison records show that he had telephoned his father and his sister. The chaplain arranged for a second induction talk with another member of the chaplaincy that afternoon. From then on they saw him regularly. The chaplain arranged for him to be loaned a guitar. He said that as he had a history of self-harm (which he had spoken to him about) he had some concerns about him having a guitar and guitar strings, but he believed this would help him. The chaplain set up a music group, which he joined. He integrated into the group well and the chaplain said he was very keen about it.
56. In mid-August 2010, the man transferred to F wing at Aylesbury. This wing is generally known as a 'poor copers' wing, and runs the Sex Offenders Treatment Programme (SOTP). An entry in his records on 23 August notes that he was settling in well and had a safer cell (a cell which has reduced ligature points). However, he had an issue with some other prisoners which had resulted in him punching a wall. It was decided at the time that an ACCT did not need to be opened as managers were satisfied that he did this out of frustration, rather than a desire to harm himself.
57. The SOTP treatment manager at the time told the investigator that the man was not suitable to attend the SOTP course at Aylesbury because of his low IQ. The programme run at Swinfen Hall would have been suitable for him, because it is adapted for prisoners with learning difficulties. She confirmed that Swinfen Hall would not take him and instead she and the Ridgeway Team were examining alternative ways to help him address his offending behaviour.
58. On 1 October, it was noted that the man was being intimidated and threatened by another prisoner and that staff were monitoring the situation as the other prisoner had a history of bullying. It was agreed that a senior officer on F wing would speak to the other prisoner and review his suitability to

remain on F wing. He was to be offered support. After a review it was determined that the other prisoner should be moved off the wing.

59. Three days later, the man saw a member of the Ridgeway Partnership Team, who recommended that he take part in the adapted SOTP run at Swinfen Hall. Negotiations began again with Swinfen Hall to try to arrange a transfer for him. An assessment, made with additional information from Keppel Unit, concluded that he did not have a learning disability, but was "within the lower part of below average". This still meant his level of comprehension and communication would have been better supported with adapted work. Members of the Ridgeway Team began to see him fortnightly. During their interview with the investigator they said that his attempts to harm himself coincided with running out of tobacco or coffee, as these were things that were really important to him. Lack of tobacco seemed to be one of the triggers for him to self-harm, and this was noted in future ACCT reviews.
60. On 12 October, a nurse noted in the man's medical records that he had made superficial cuts to his arms with a CD case. He was given advice and an ACCT was opened for him. There are no ACCT documents for him for that time, among the documents provided to the investigator.
61. An e-mail from the offender supervisor at Swinfen Hall, dated 14 October 2010, to the SOTP treatment manager, gave further information about their reasons for refusing the man's transfer to them. He wrote that Swinfen Hall had received requests to accept him from Aylesbury and previously Wetherby during November 2009, January 2010, February 2010, and August 2010. He said there were three main reasons why they refused him. These were:

"1) His own safety would be in jeopardy:-

Due to current & Previous ACCT, the requirement for V.P Support (we have no VP wing and would be considered very vulnerable on general location), threats of suicide. His own medical requirements would also make him vulnerable and adds to his poor coping.

2) Concerns for other prisoners regarding cross-contamination our healthcare have stated:-

"My concerns are that he has spent his time at Wetherby in a vulnerable unit and being thrust into a main prison environment could have a negative effect. The prison would also need to consider infection control and Health and Safety as although controlled he continues to have problems at night occasionally, where the staff have to provide red bags for disposal of bed linen and clothing. This will make him more vulnerable to other prisoners who will quickly pick up on this."

3) His suitability to undertake the programme:-

We have concerns as to the ability to undertake this demanding programme considering he is considered very vulnerable and previous threats of suicide."

62. In addition to those three areas, concerns were raised that the man had already served longer than the minimum term of his sentence. He did not have an up to date sentence plan or parole dossier.
63. On 25 October, the man was seen in his cell by someone, noted in prison records, as being from Community Health Support. He admitted to scratching his arm with a broken CD case. He sustained superficial cuts which did not require treatment. He said that he used self-harm as a way of managing his emotions and that he had no intention of causing significant damage to himself or had any suicidal intent. He told her about his feelings of isolation and loss of family contact. He also said that he was being bullied by another prisoner.
64. The man also told her that he had been seen by mental health workers at Wetherby and had found this helpful. She agreed to discuss his needs with the mental health team. She noted in his medical records "Reminder/Alert: Open ACCT – superficial scratches to inner right forearm – High Priority". Again, there is no record of an ACCT being opened at this time, and it does not appear that she did so herself. However, a senior officer (SO) in Security must have been made aware of the issue of bullying as she e-mailed the Safer Custody Department and senior managers on F wing and asked them to speak to him about who was bullying him and to raise a victim referral.
65. On 26 October, an entry in the man's prison records noted that he had been given a first written warning for pressing his cell bell to request tobacco. He had been warned by staff against doing this previously. He responded to the warning by becoming angry and saying he did not care if he was "put on basic". (There are three levels of prison regime under the Incentives and Earned Privileges (IEP) scheme, basic, standard and enhanced. The higher the regime, the more privileges a prisoner is allowed. Basic regime can be imposed for a number of reasons including bad behaviour and a failure to comply with sentence planning.)
66. An entry in the man's medical records on 27 October indicates that he was seen by nursing staff from the Ridgeway Partnership Team. On the same day there is an e-mail in his paperwork from a senior officer to staff on his wing. It says that he had scratches on his arm from self-harming, which he said was because he was bullied by other prisoners on the wing. The e-mail was copied to the Safer Custody Manager, and asked that staff speak to him about who was bullying him and the need to raise a victim referral if he was being bullied. A security record noted that safer custody were aware of this and that the victims and perpetrators would be closely monitored. There is no further information in prison records regarding this.
67. On 28 October, an entry in the man's medical records states that he injured his hand on his cell door. His hand was bruised, but he did not require any treatment. No action was taken and it is not clear whether this was a possible act of self-harm or just an accidental injury.

68. Throughout this time, the man was given a number of verbal warnings by staff on the wing for a variety of matters. He did not keep himself or his cell clean and tidy, he was rude to staff and pressed his cell bell for non urgent matters. He also received some written warnings.
69. On 14 November, an ACCT was opened by an officer because the man had made superficial cuts to his right arm. He said it was because he was angry and upset over recent discipline issues about his behaviour. He said he had subsequently spoken to the Samaritans and felt a lot better. The officer wrote up an immediate action plan (part of the ACCT process) to try to help him. He recommended that he remain in the cell he was in, that he would be observed hourly and that he would hand in the broken CD case, with which he had cut himself. The officer noted that he had spoken to the Samaritans but did not need to speak to anyone else at that stage.
70. The next day, 15 November, the man attended an assessment followed by a case review with the officer and a senior officer. He said that he had no thoughts of harming himself and his mood had improved. The ACCT was closed. A post closure review took place on 22 November, where he was said to be coping better.
71. Also on 15 November, the man was downgraded to a basic regime because of his continuing disruptive behaviour. There was no reference to the fact that his ACCT had just been closed earlier that day and whether this might affect his vulnerability. He was reported to continue to press his cell bell for non-emergency reasons, was rude to staff and refused to clean his cell.
72. On 17 November, the man received another verbal warning for pressing his cell bell for non-emergency reasons. It is noted in prison records that he was aware of the implications of his continuing bad behaviour and that this would mean he was likely to remain on a basic regime. However, he continued to break wing rules and press his cell bell intermittently over the next few days.
73. In November 2010, an officer was transferred to work on F wing. He had previously known the man for a brief time while they were both on D wing. He recalled during his interview with the investigator that he spoke to him about a broken guitar he saw in his cell. He spoke about his love of playing the guitar, so the officer arranged to get him new strings for it. He fitted them for him, tuned it and listened to him play. The officer said he was very impressed and from then on a positive relationship between them developed.
74. On 30 November, it was recorded that the man had punched the wall in anger. He was seen in healthcare and prescribed paracetamol. It is not clear from prison documentation why he did this. However, on this date he and another prisoner had spoken to staff about being bullied on the wing. They said it was because of their offences. It was agreed that staff would monitor this with a view to moving the offending prisoner off the wing. The prison documentation is largely illegible, but it appears that the prisoner was subsequently removed from the wing. Another undated report indicates that he spoke to another member of staff about being bullied by "the lads in his

wing". He would not identify which prisoners were bullying him, so it was agreed that staff would monitor the situation for any problems. Prison security records note that he would be asked again who was bullying him. They had an idea who the prisoner might have been and he had already been moved off the wing (the reason this prisoner was moved was not recorded).

75. On 8 December, an officer opened another ACCT for the man. This was because he had made small cuts to his right lower arm. He said he had done this because he was bored and had run out of tobacco. An immediate action plan was raised which was agreed by the Night Orderly Officer (NOO) and two other members of staff. It was noted that he would be checked hourly and be given access to the Samaritans if required. (It appears that he was given the Samaritans telephone that night.)
76. The next day, 9 December, the man threw a chair at an officer and was restrained. He also made superficial scratches to his left forearm. He did not require any treatment. During an ACCT review that day, he said that he had been feeling low and anxious and had been thinking of his family. He added that he had run out of tobacco and coffee and could find no distraction from his thoughts. He said that, although he was not "having any mental problems", he was worried about becoming depressed and feeling tearful. However, he was very clear that he did not want to take his life. At the meeting they discussed the need for him to transfer to Swinfen Hall to undertake the SOTP programme, that he felt he needed some "anger management" and his ongoing involvement with the Ridgeway Partnership Team. Staff noted that "He has been on ACCT plans before – knows the procedure. Is aware that a case review is required". A SO agreed to take up the issues that had been discussed and a routine mental health referral to the prison's mental health team was made. Another review was scheduled for 13 December and in the ACCT caremap (a part of the ACCT designed to help a prisoner reduce the risk of harming themselves) the goals for him were noted and a plan of action agreed. However, there is no evidence that a referral to the mental health team was made.
77. An ACCT review was held on 13 December as scheduled. As well as the man, two SOs and an officer attended. He said he had no intention of harming himself and appeared to be in a good mood. It was noted that his behaviour had still not been acceptable and that he should remain on the ACCT. It was noted that there was soon to be a review of his basic status and if he was to remain on a basic regime, he might not react well, and a further ACCT review might be needed. A review was scheduled for 16 December.
78. On 16 December, a safer custody meeting was held. The Head of Prison Safety chaired the meeting. These meetings are held monthly and the membership comprises staff from all areas of the prison. In the minutes there is a note made about the man which says:

"This young prisoner has mental health issues and a low intellect level. He often gets angry when he is told no. He has been known to throw his

chair around and has also gone for staff but following each event he calms down and states he is sorry. He is difficult to manage. He also thinks he will return to his home address when he is released but...this is unlikely to happen. We have tried to move him to Swinfen Hall but they have refused to take him. He is working with the Ridgeway Team..."

79. Also on 16 December another ACCT review was held with the man and two SOs. It was noted that he seemed a lot happier and confident and "had really picked up emotionally". It is recorded that he was no longer subject to the basic regime although there is no record of when this changed. The ACCT was closed and a post closure review took place on 23 December and no concerns were identified.
80. On 27 December, another prisoner reported that the man was being bullied by a prisoner he worked with on the "Estates party" (a group of prisoners responsible for cleaning and maintaining the prison's gardens and outside areas). A member of staff in security e-mailed staff on F wing and the safer custody team about this. The plan was to challenge the prisoner about his behaviour and if necessary remove him from the Estates party. It is not clear from prison records what, if any, action was taken.

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81. Staff continued to monitor the man on the wing and he continued to incur verbal and written warnings for his behaviour. There is little else of note until 18 January 2011, when he made superficial scratches to his right arm. (He did the same on 3 February. No treatment was required on either occasion.)
82. An ACCT was again opened for the man on 18 January at 11.55pm by the Night Orderly Officer. He said he had felt lonely and became depressed listening to music that reminded him of his family. He had made superficial cuts to his arm with a CD case. A SO asked him to pass his CDs to him, but they got stuck under the door. It is not clear from the ACCT what action the SO then took and whether he unlocked the cell to remove the CDs. The SO said they spoke at length and he appeared to settle. He agreed to clean and tidy his cell to keep himself occupied. The SO initiated an immediate action plan for him, under which he was to remain on F wing and be observed by staff every hour. He declined the offer to use the telephone to call anyone and did not want to speak to a Listener.
83. The next day, an ACCT assessment was carried out by an officer. The man repeated that he had been listening to music which had reminded him of his family and his mother in particular. This had made him feel depressed which is why he harmed himself. He said he was also unhappy that he had run out of cigarette papers. He said he had made superficial cuts and it was not an attempt to take his life. This was not the first time that not being able to smoke had been an issue for him.
84. The man said he had been subject to a number of ACCTs previously, always for scratching his arms. He added that he slept well and felt "OK" but was

keen to speak to his father. He said he had no thoughts of harming himself or suicidal intentions.

85. An ACCT review followed. Present were the man, an officer and a SO. It was noted that he was upbeat and said that he was only on an ACCT because he had run out of cigarette papers. He said he had no thoughts of harming himself further. It was decided that, as the ACCT was opened as a result of him having no cigarette papers, it would be closed. No caremap was completed and there was no reference to the assessment which indicated that he was feeling lonely and missing his family. A post closure review was scheduled for 26 January. The post closure review was carried out by an officer. He said he had no thoughts of suicide or harming himself. He said he was fully aware of the support available to him at the prison and felt settled on the wing.
86. An officer opened another ACCT on 3 February after the man again tried to cut himself using a broken CD case. The officer noted in the ACCT that he had found a package in the prison yard which he had handed in and was being called a "snitch" by other prisoners. It was decided that staff should observe him twice a day and record three meaningful conversations with him each day. He discussed with staff that he did not receive family visits as they lived too far away, but that he had a prison visitor (volunteers appointed by prisons, who visit prisoners to offer friendship to them). It was agreed that he would be reviewed more frequently, but there is no further information about this. The caremap noted that he felt isolated, was missing his friends and had an issue controlling his tobacco. It was agreed that staff would interact more with him on the wing, that he would associate with other prisoners where possible and that he could be issued tobacco a little at a time so he could make it last. The triggers and warning section of the ACCT (used to identify issues that may warrant immediate review) simply recorded what had happened and did not identify areas that might trigger a review.
87. Prison records show that the man made four telephone calls on 3 February to family members, including his father. There is nothing significant during those calls to suggest that there was a reason for him harming himself, although he does mention that he had cut his arms.
88. On 4 February, the man was seen by a general practitioner, at the request of the Ridgeway Team. They discussed the man's nocturnal enuresis. He said he had not experienced this since July 2010, so the doctor agreed to prescribe desmopressin only if the problems reoccurred. They then discussed his encopresis (involuntary passage of stools, which he told the doctor had been a lifelong issue) and problems with acne. The doctor agreed to continue oxytetracycline for his acne but noted that he did not want to examine him for the encopresis, as this would have been done already. Instead it appears from the medical records that the doctor intended to request a copy of his medical records from the hospital (which he did).
89. On 8 February, an entry in the man's records noted that, because of his behaviour, a regime review would take place and it was possible that he

would return to the basic regime. It is not clear whether this review took place before he died. He was still on standard regime on 8 March.

90. On 10 February, an officer on F wing noted that the man had made an effort to improve his behaviour. He told the officer he felt better than he had for a while, his skin was clearing up and his personal hygiene was improving. He attended an ACCT later that afternoon with two members of wing staff. It was noted that he was in good spirits. He was fully aware of the support networks available to him and said he would use them if he felt he needed to and the ACCT was closed. A post closure review was scheduled for 17 February, but it does not appear that this was completed.
91. On 17 February, an entry in the wing observation book by an OSG at 12.10am, noted that the man had made further scratches on his right arm. The OSG noted that his ACCT was re-opened and he informed the night orderly officer. The night orderly officer made a further entry in the observation book that night. He went to see him after being informed by the OSG what had happened, and saw that he had made superficial cuts to his right arm. The officer wrote that he appeared to be in a good mood and laughed and joked with him. He had rinsed his arm under cold water and there were no signs of an open cut or bleeding. He said he felt stressed as he had no tobacco. The ACCT was re-opened for hourly observations.
92. Later that day, a SO spoke to the man about what he had done during the night. He explained that he had made the scratches to his arm because he had run out of tobacco. He said he knew the governor working that night was a smoker and that if he said he felt he wanted to harm himself, he would be given some tobacco. He apologised for his behaviour. The SO noted that the ACCT was closed again, as he presented no "self harm or suicide risk at all".
93. On 24 February, another entry in the wing observation book by an OSG noted that the man rang his cell bell at 9.35pm to alert him that he had harmed himself. He had made cuts to his right arm. He said he had done so because he had been thinking about his past, his offence and being in prison. The OSG wrote that his ACCT had been re-opened and he was on hourly observations.
94. An ACCT review was held at 1.30pm the following day and attended by the man, staff from F wing, a member of chaplaincy and the duty governor. They discussed why he had harmed himself and he said it was because of his offence. However, he said he felt much better since getting some sleep and had no intention of harming himself again. He agreed to speak to staff if his mood changed. The next review was scheduled for 2 March
95. On 27 February, an entry made by an officer in the wing observation book at 10.30pm noted that the man had again scratched his arm with a broken CD case. He said he had done so because the officer would not pass him any cigarette papers. A SO was informed and, as he was already on an ACCT, it was decided that the level of observations should remain the same. This did not prompt an additional case review.

96. The next evening, an officer made another entry in the observation book. The man had sat behind his door and the officer was unable to see or check on him. He said he had cut himself and was bleeding. The rest of the entry does not explain what happened or whether they entered his cell, but reads "When staff looked they could only find scratches from earlier and no blood". This was noted in the ongoing records part of the ACCT¹.
97. Another ACCT review was conducted on 2 March. It was attended by staff from the wing, a member of healthcare and chaplaincy. The man appeared positive and said that he had been stressed due to a lack of tobacco. He said his father and friends had spoken to him about self harm. He agreed to have his tobacco allocation managed and was happy to come off of the ACCT monitoring. The ACCT was closed and a post closure review date set for 7 March.
98. Also on 2 March, the man made three telephone calls in total to his father and sister.
99. The contents of these calls were noted by security staff on 11 March (staff were not aware of the content of the calls prior to 11 March. The calls were transcribed following the man's self harm on 9 March). In the second call at 9.11am he spoke to his father. They spoke about why he had been cutting his arms. He said there were a number of reasons he did this, but did not go into detail. His father told him he must stop doing this. He mentions a friend he had at the prison. He also said that he would send his father a visiting order and would write to him. He said he felt upset at the thought that his father might not want to visit him. His father once again asked him to stop harming himself, but he replied that he would not. They both end the call by saying "I love you".
100. Prison records show that the man rang his father again an hour later and spoke to a woman but it is not clear who she was. She told him he must stop harming himself. He responded that he had been doing so for nine years and that his friend said he did it for an adrenalin rush. He added that he harmed himself if he ran out of tobacco, if staff 'pissed him off' or if he had family issues.
101. Later that afternoon the man rang his father again. This time his mood seemed less upbeat and he said he felt grumpy because of "the parole thing". He said he would not get parole and that there were only two ways to get out of prison, escaping or hiding (he was not being considered for parole at this time). His father told him to wait and see the outcome of any parole decision. They spoke again about him harming himself, but the subject quickly changed. They talked about his father visiting and his father said he did not think he would be able to do so. He replied "don't piss me off". He added that his father might be able to get free transport from the council to enable him to

¹ The ongoing record details all of the observations and notes of a prisoner's behaviour whilst on an ACCT and forms a part of the record.

visit and his father said he would make enquiries. He spoke about running out of tobacco and how he “kicks off” then. He added that he would borrow some from someone he knew. He was passed to speak to someone else and is asked whether he had got his bed wetting problem sorted out. He said that he had.

102. On 4 March, a prisoner rang his cell bell at approximately 3.00am to say that the man (who was in the cell next door) had cut himself. An officer went to speak to him, who denied this and showed the officer his arms. He did not appear to have cut himself and came across to the officer as “his usual bubbly self”. However, ten minutes later he rang his cell bell and admitted he had cut his right arm and dried the blood with a tissue. The officer informed the Night Orderly Officer. The ACCT was reopened.
103. An ACCT review was held at 3.50pm on 4 March with a SO, officer and the man. A member of healthcare staff was due to attend but was called away to an incident. He explained that he had harmed himself because he had been thinking about things “on the outside”. He said he had no thoughts of harming himself again but did not want his observations to be reduced in case his mood changed. He said he was limiting his tobacco but it was pointed out that he often gave it away and should stop doing so. It was agreed to maintain hourly observations and to record three meaningful conversations with him every day. The next review date was set for 7 March. His caremap was not updated.
104. An ACCT review was carried out on 7 March at 9.45am. The man attended with staff from the wing. It was noted that he seemed positive and was keen to manage his own finances that week. He said he had no thoughts of harming himself. It was decided to reduce his observations to four a day, along with four meaningful conversations daily. The next review was scheduled for 14 March.
105. On 9 March at 2.30pm, the man saw representatives from the Ridgeway Team. He had drawn them a picture of a football shirt and they had a joke about the football teams they supported. He spoke about the good week he had had, especially with his music group. He was looking forward to singing and playing in front of the bishop in a concert in the church, later that evening. However, he also said he had had a mixed week and was on an ACCT. He told them that he had cut himself the week before but that things were better now.
106. A prisoner recalled that, at approximately 5.15pm, he spoke to the man, who said he was going through ‘a lot of crap’ and ‘can’t do this anymore’. The prisoner asked whether he had enough tobacco, as he knew this affected his moods. He did not, so he gave him a cigarette. Five minutes later, he said he felt a bit better and thanked him.
107. Also on 9 March, an officer recalled that the man had been ‘kicking off’ that afternoon as he had had an argument with another officer. She sat with him for quite some time and removed pieces of broken CD cases from his cell.

Although this is noted in the ongoing record part of the ACCT document, and there is a note that other staff were briefed about this incident, no ACCT review was scheduled or undertaken. Eventually he calmed down and she left his cell. She knew he was playing in a concert that evening as the music group were taking part in a service arranged by the chaplaincy to baptise a number of prisoners and which the Bishop of Aylesbury attended. She told him she would go to watch him but, at the last minute she was assigned to work in another part of the prison and missed the concert.

108. A chaplain recalled that he received a call that afternoon from an officer on F wing, asking him whether he could come and see two prisoners, the man and his friend. He was busy setting up the chapel for the service and arranged for two chaplaincy volunteers to see him. They had come in the prison to attend the concert, but had arrived early. It is recorded in the ACCT that they went to his cell at 3.55pm and they spoke to him for a short while.
109. An officer walked the man over to the chapel that evening at approximately 6.15pm (although the CCTV showed this happening at 7.53pm) and told him she would be unable to watch the concert due to her re-arranged work responsibilities. He said to her that, after she had left his cell that afternoon, he had cut himself. He refused to show her, but said he would show her later. She told the chaplaincy staff what had happened and, in light of this, his ACCT was amended to hourly observations.
110. A chaplain remembered that the man had seemed in good humour when he arrived at the chapel and performed well. He told him how proud he was of him and said the man was in "great spirits". As he left the chapel, he told the chaplain that when he got back to his cell he was going to write a letter to his mother to tell her he had performed in front of the Bishop. The chaplain said his main motivation was to receive a letter, or have some contact with his mother.
111. At 7.30pm when the man returned from the concert, he showed the officer his scratches. He told her that she had missed a 'good concert' and she replied that he would have to play his guitar for her the next day.
112. An OSG began his night shift at 9.00pm on 9 March and received a handover from an officer. (The OSG had worked at the prison for ten years and had just begun to work a permanent night shift a few months earlier.) The officer told him that six prisoners on the wing were on ACCTs and that the man was on hourly observations. The man's fellow prisoner was also on an ACCT and was on a half-hourly watch. The OSG decided that, as the two prisoners were only one cell away from each other, that he would also check the man at half hourly intervals, when he checked the other prisoner, although the CCTV shows that he did not always check both prisoners at the same time. The OSG told the investigator that he varied the exact timings of the checks, so the prisoners were unaware when he would next arrive at their cells. He said that he checked on the man six times that evening, up until 11.50pm (the ACCT records five checks). These were at 8.44pm, 9.30pm 10.30pm, 11.00pm and 11.50pm (when he was discovered hanging). These times are

not confirmed by the CCTV. He said that, before the last check, the man had told him each time he was fine, and had been lying on his bed. When he checked on him at about 9.30pm he noticed that he was writing a note. In the other checks he noted that he was reading and watching television.

113. The other prisoner's ACCT document also has observations recorded by the OSG. These are timed at 8.42pm, 9.28pm, 9.55pm, 10.32pm, 10.55pm, and 11.30pm. These times broadly correlate with the times the OSG noted that he checked on the man, although there is no note that he observed him between 11.00pm and 11.50pm. There is no record on the ACCT that the OSG passed the prisoner a note, although such an action would not necessarily be written on the ACCT document.
114. At interview, the OSG said he checked on the prisoner at approximately 9.00pm or 9.15pm in the cell next to the man. (Although this does not reflect the times recorded in the ACCT, the OSG was speaking from memory.) The prisoner asked for some tobacco but the OSG said this was not possible. When he next went to check on him, the observation panel was obscured. The OSG said he could see into the cell through a gap between the wall and the cell door. He could see the prisoner standing in his cell and asked him to remove the obstruction. He refused. The OSG did not challenge this further, but instead went to check the man.
115. The next time the OSG went to check the prisoner, the panel was still covered. However, he was not concerned as he could see him through the gap, as before. At interview, the OSG said that he reported the covered observation panel to a SO. He could not remember the exact response he received from the SO, but thought it was along the lines that he (the OSG) should deal with it. The SO did not go over to F wing to check on the situation.
116. The times recalled by the OSG at interview do not agree with the times of the checks he recorded in the man's ACCT document. In the ACCT, the OSG noted that he checked on him at 8.44pm and saw that he was sitting on his bed reading. His next entry in the ACCT was at 9.30pm, and noted that he was in bed watching television and a further entry at 10.30pm noted the same. He wrote in the ACCT that the man was in bed reading at 11.00pm, but that the observation panel was covered at 11.50pm. There is no mention in the ACCT of being passed a letter or asking to speak to another prisoner. Although the time of the entry is 11.50pm, it is not known exactly when he made this entry. As he also wrote about finding the man hanging and subsequent actions, it is apparent that it was completed as a later account.
117. During his interview, the SO said that he remembered that the OSG telephoned him because the prisoner's observation panel was covered. He told the investigator that it was fortunate at Aylesbury that prisoners could be seen through the cracks between the wall and the cell door. If a member of staff could see a prisoner by that means, and get a response from them, then he was happy. If there was no visibility whatsoever, then action would be

taken after informing the duty governor. The prison's local instructions (2.77) state that:

"Where observation panels are covered, the NOO (Night Orderly Officer) should be informed immediately and staff deployed to the cell."

118. The OSG said he spoke to the prisoner at approximately 10.30pm. His observation panel was still covered but he said he was 'fine'. As he passed the man's cell, he called out to him. He slipped a note under the cell door and the OSG picked it up and began to read it. He said he read it to the point where it said "please come to talk to me". He asked him if he wanted to speak to him, but he said the note was not for him but was for the other prisoner. The OSG then took it to the prisoner and used it as a way to persuade him to uncover his observation panel. He uncovered the panel, and the OSG passed the note to him. The OSG said he watched him read the note and then throw it in the waste paper bin. He asked if he was going to speak to the man, but he replied that he was not. Although he would not have been able to go to the man's cell, they could speak to each other when they were both standing by their cell doors.
119. At interview, the OSG said that it was not unusual for prisoners to pass notes and sometimes magazines during the night and he believed that this was permitted. He agreed with hindsight he should have read the entire contents of the note at the very least, but said at that time he was more concerned about the other prisoner.
120. The prisoner's account differs. At interview he said that the OSG gave him the letter from the man and he was shocked and did not know what to do. He said he rang his cell bell and when the OSG arrived he told him that the man needed some help. He said the OSG replied that he would check on him. He said a short time later he called out to the man but got no reply. He called the OSG again and asked him to see if he was alright. He also said that he gave the letter back to the OSG.
121. The investigator viewed CCTV from the wing to try to verify this account. It was difficult to make much out as the landing light was not on and the time recording was incorrect. The prisoner said he argued with the OSG and clearly pointed out what the man had said in his note, but the OSG said he was unable to do anything. This does not accord with what the OSG said. F wing does not record when a prisoner presses his cell bell, so we were unable to verify the prisoner's account against a cell bell print out.
122. Just after 10.30pm, the OSG said that the man pressed his cell bell. He responded and he asked him to check on the other prisoner as he was concerned about him. He went to the prisoner's cell and the observation panel was once again obscured and he refused to remove it. There is no mention of this in the ACCT record. This is when the OSG radioed through to the SO about the blocked observation panel mentioned above.

123. The OSG recorded in the man's ACCT document that he checked on him at 11.00pm. At 11.50pm, the OSG undertook a roll check. This is carried out to ensure that all the prisoners who are supposed to be on the wing are present. When he arrived at the man's cell he saw that the observation panel on his door was covered and he could not see into the cell. He called to him a couple of times but got no response. He then put the cell light on and looked through the gap in the frame of the door and saw that he was by the far wall and appeared to be hanging from the window bars by a bed sheet, directly above a large pipe. It is possible he stood on this to reach the window bars.
124. The OSG radioed a code red (the code at the prison for an emergency call to alert staff to a serious situation and to request assistance). He then broke the seal on his pouch which contains a cell key for emergencies and entered the cell. He pulled the ligature off the man (he did not need to use the anti-ligature knife supplied to all staff) and laid him on the floor. He checked for signs of life and determined that he was not breathing. He said he then put a call over the radio to request an ambulance and began CPR (cardio pulmonary resuscitation), although he was not first aid trained.
125. It is clear that the OSG quickly assessed the situation and determined that the man needed help, so he correctly entered the cell.
126. At 11.56pm, the SO, the night orderly officer responsible for the prison at night, received a radio message to attend F wing. The night officers were stationed in healthcare at the time. The SO, along with two other officers attended the wing straight away. Once at the cell they saw the door was open, the man on the floor and the OSG was attempting to administer CPR. A bed sheet was attached to the bars of the window. The OSG confirmed he could continue with CPR and the SO and an officer left the cell at 12.01am to radio for an ambulance and escort it to the scene. (The incident log notes the time as 12.01am. There is no record of the OSG's request for an ambulance a few minutes earlier in the log.) The CCTV showed that the OSG left the cell at 12.10pm and 51 seconds for 22 seconds. The OSG could not recall doing so and said that he must have been in shock.
127. There is one defibrillator at the prison (a machine to detect whether a person's heart can be shocked into a rhythm again) and is located in healthcare. There is no evidence to suggest that anybody asked for the machine (or if they were aware there was one).
128. An officer remained by the cell with the OSG, although he did not assist in the resuscitation attempt. The OSG continued to administer CPR, two breaths to every six to eight chest compressions (the ratio should have been two breaths to every 30 chest compressions). Nobody offered to assist the OSG and none of the staff who attended were first aid trained. The officer found a note in the man's cell, left on his bed. It read "sorry, I am dead".
129. The CCTV showed that the OSG left the cell a second time at 12.14pm and six seconds. The officer had also left the cell. The man was left in the cell on

his own for six seconds. The OSG could not recall leaving the cell or for what reason, again he thought he must have been in shock.

130. The SO and officer went to the gate to await the arrival of the ambulance which arrived at 12.05am. The SO escorted the first response car to the scene, while the officer escorted the ambulance. Four paramedics in total took over CPR from the OSG and moved the man onto the landing to continue CPR. After the paramedics worked on him for approximately half an hour, he was taken in the ambulance to hospital. The ambulance left the prison at 12.37am and two officers accompanied him.
131. After the man left the prison, the OSG continued to carry out his duties. The SO asked how he was, but he did not recall anyone else checking on him and nobody suggested that he should go home (although there is evidence that he spent some time with members of the prison's Care Team and had spoken to the Duty Governor). At approximately 3.00am, another member of staff was called to F wing to help him. Members of the staff care team arrived for duty at approximately 6.00am, although it is unclear whether anybody from the care team spoke to the OSG. He continued his shift until 6.15am and then stayed in the prison to attend a hot debrief called by a governor at 8.00am. This was attended by all of the staff still at the prison who were involved in the incident and members of the care team. The OSG was told to take a couple of nights off before he began a scheduled week off.
132. The Head of Prison Safety was appointed as the prison's family liaison officer (FLO). He telephoned the man's father at 2.46am and told him what had happened. He then rang the man's mother. Originally there was no answer, but he got through five minutes later. His mother said she wanted to visit him, but would have difficulty getting there. The FLO agreed to arrange transport for her and other family members.
133. Two chaplains went to the hospital immediately after being notified about what had happened to the man at 2.38am. They sat with him, who remained unconscious.

After the man was taken to hospital

134. At approximately 12.40am, the OSG went to check on the other prisoner. His observation panel was still covered, although he spoke to the OSG through the door. He was checked again at 1.00am, when the observation panel was still obscured. He agreed to uncover the panel on this occasion, and told the OSG he felt down because he had "no burn". There is no mention of what had happened to the man. The OSG said at interview that the prisoner then passed back the man's letter that he gave him earlier. He told him that he (the OSG) should have done something to prevent what had happened. The OSG said it was only then that he read the entire note. He said he immediately passed the note to the Head of Prison Safety, who put the note in an evidence bag and sealed it to pass to the Governor. Subsequent checks were carried out on the prisoner through the night. It was noted that he was

often asleep. The OSG's last check was at 6.00am, when he passed his watch over to an officer.

135. The co-ordinating chaplain came to the prison at about 6.30am and suggested to the Governor that it was best to get all the prisoners from F wing together and explain to them what had happened.

Care for prisoners

136. An officer recalled at interview that the next morning all the prisoners on F wing were gathered in an association room and told what had happened. The Governor, healthcare staff and other staff came to speak to them and reminded them of the services available to them if they felt affected. All prisoners on open ACCT documents were reviewed. The co-ordinating chaplain and other members of the chaplaincy spent time on F wing talking to prisoners. Governor Leggett issued notices to staff and prisoners. The notice to the prisoners offered the support of Samaritans and Listeners.

Care for staff

137. The notice to staff from the Governor reminded them of the services of the Care Team or the Samaritans if felt they needed to talk about what had happened.
138. The OSG was about to begin two nights off. However, at about 3.00pm on 10 March, he received a telephone call from a SO at the prison asking if he could attend for duty that night. He said he had had a bad day and had not slept well so could not go in. The SO telephoned again an hour later and said the prison was desperate for staff and could he please come in. He therefore agreed.
139. A memorial service was held for staff and prisoners on 21 March and a critical incident debrief was held for staff on 24 March.
140. The OSG sent the investigator a note on 2 June 2011. He said that he was no longer able to work night shifts because of what had happened and now worked only during the day. He added that he had found it difficult to cope since the man died and was seeking help.

While the man was in hospital

141. At 12.40pm on 10 March, the FLO met the man's mother and father and other family members at the hospital. Intensive Care Unit (ICU) staff at the hospital told them that he had had a CT scan and had suffered brain damage. His parents left the hospital at approximately 2.15pm. The FLO arranged transport for them to return the following day.
142. The next morning the FLO went back to the hospital and met the family. At this stage there was little change. The man had a chest infection, but was breathing with support from a ventilator. Later the FLO and the family saw a

consultant, who explained that his prognosis was not good, but they intended to keep him on life support. They were also able to telephone the ICU for updates about his condition.

143. A member of the prison staff remained at the hospital at all times with the man, but no restraints were used. The purpose was to liaise between the prison and the hospital.
144. On 14 March, the man was transferred from that hospital to another hospital in Oxford.

Events leading up to the man's death

145. At 9.30am, a few days later an operational manager at Aylesbury was telephoned by an officer, who was at the hospital carrying out the bedwatch. She said that there was a view among medical staff that life support might be withdrawn at some point that day. He informed the Governor. Approximately two hours later, he spoke to the co-ordinating chaplain, who said he would visit the man that afternoon.
146. At 1.25pm a doctor from the hospital telephoned the operational manager. He said that following a clinical meeting it was decided that it was 'futile' to continue treating the man due to the severity of his brain injury. A decision had been made by hospital staff to withdraw treatment for maintaining his life. However, they would continue to make him comfortable and mentioned administering morphine. The doctor also said that he would contact his parents and inform them of this decision. Once again, the operational manager informed the Governor. Twenty minutes later he spoke to another doctor at the hospital. This doctor said the hospital had spoken to the man's parents and it was agreed that no action would be taken towards withdrawing life support until the family visited the hospital that afternoon.
147. The operational manager then telephoned the man's mother and spoke to her and her partner. Due to the distance from the family home to the hospital, he telephoned Askham Grange prison (the nearest prison to the family) and asked them to arrange for a local taxi to bring six members of the family to visit the man at the hospital. He also passed on his contact details in case they needed to speak to him. He then contacted the man's father to offer him the same support. The man's father said that his son's mother had been in touch and they were considering visiting the prison together.
148. Later that afternoon, the operational manager contacted the officer at the hospital for an update. At that point the man's family had not arrived and his condition remained unchanged. The officer volunteered to stay at the hospital to brief another officer who was due to relieve her, and to provide the operational manager with an update at 8.00pm. The co-ordinating chaplain remained at the hospital to be with the family, who arrived at approximately 8.15pm.

149. The operational manager was telephoned by the prison at 10.15pm and was told that the man's life support had been removed at 9.15pm and he died just under an hour later at 10.10pm. A doctor at the hospital completed a medical discharge summary and recorded the cause of death as "Hypoxic brain injury (lack of oxygen to the brain) and self hanging".
150. Throughout this time, the man's family remained at the hospital and were supported by the co-ordinating chaplain. The operational manager telephoned the hospital and spoke to an officer. He asked her if she needed any assistance from the Care Team, but she said that it was not necessary. He updated the Governor and informed the Chair of the IMB.
151. The man's mother and father visited the prison and the co-ordinating chaplain took them to his cell. The cell had been cleaned and tidied by other prisoners in preparation for their visit
152. On 17 March, the FLO telephoned the man's mother. He offered bereavement counselling details but she declined. She asked for the co-ordinating chaplain to conduct the funeral service and asked that she be the contact for all funeral arrangements. The FLO took the details of the funeral director to deal with directly and told her that the prison would pay all reasonable funeral expenses, in line with national guidance. After making initial funeral arrangements the FLO spoke to her later that afternoon and confirmed that the co-ordinating chaplain would conduct the funeral service.
153. On 23 March, a Security Information Report (SIR) was submitted by a chaplain, saying the prisoner had told her that he was re-living the night of 9 March and said that he had given the OSG the man's letter and had asked the OSG to do something about it. He said nothing was done. It was agreed by staff considering this document that the information should be passed to those investigating the man's death.
154. The man's funeral was held on 31 March in his home area. The service was conducted by the co-ordinating chaplain and attended by the FLO. The prison paid all funeral costs.
155. The prisoner was interviewed by the investigator on 2 June. He said he had known the man very well and they had worked together on the Estates party. The man told him that he felt down because of his offence and because he missed his family. He would often telephone his father or his sister and he had a prison visitor who he saw once a fortnight. The investigator interviewed the prisoner again on 14 June (and 5 July at his request). He reiterated what he had said at his original interview regarding the letter and the OSG.
156. On 14 June, the investigator met another prisoner on F wing. She wanted to get further information about the relationship between the man and the prisoner and what happened on 9 March. This prisoner recalled that night that the man had seemed excited when he returned from the concert. All prisoners were in their cells by 8.00pm. An hour later he shouted to him and they spoke about general things for an hour or so. He fell asleep and woke

up about midnight. He shouted out to the man and the prisoner, but neither answered him. He assumed they were both asleep.

157. The next morning, he found out what had happened to the man. He said he had heard that another prisoner felt guilty because he had received a letter from him but had not passed it over quickly enough to staff. He spoke to the prisoner about this. The prisoner said that he had not handed the letter in soon enough, but that there would have been nothing anyone could have done for him anyway. He also said that a member of staff would take the blame as it was his fault. He said that staff had a duty to protect prisoners and he had not done his job.

Post mortem report

158. The post mortem was carried out on 22 March. The pathologist noted that there were no grip marks or other marks of restraint to indicate any third party involvement in the man's death. He found the cause of death to be irreversible cerebral hypoxia due to suspension (hanging). A toxicology report found no traces of alcohol or drugs in his system. However, due to the length of time between finding him in his cell and taking the sample, the possibility that alcohol and certain drugs may have been present at the time of the incident could not be excluded.

ISSUES

The man's clinical care

159. The man was identified by the education system as having special educational needs. His sexualised behaviour before the offence for which he was convicted resulted in a referral to a Community Mental Health Team from which he received treatment for a period of three years from April 2005. He exhibited self-harming behaviour before his conviction including a serious episode aged 11 years when he cut his wrists.
160. Although his records are not consistent, the clinical review comments he “clearly exhibited evidence of learning disability and personality disorder. At times, diagnoses of Attention Deficit Hyperactivity Disorder (ADHD), Autistic Spectrum Disorder and Narcissistic Personality Disorder were considered. Communication difficulties and a possible eating disorder are also cited in the records”.
161. The man had assessments in Wetherby and Aylesbury (and very briefly for an overnight stay at Glen Parva). The clinical review notes “it is unclear how much of his medical history, previous assessments or current records from the transferring institution were available to inform the assessments. In the absence of other sources of information, the initial assessments relied on self-reported information to a significant extent”. All the records from Wetherby were supplied to the investigator from the Youth Justice Board and were not with his records at Aylesbury. This would indicate that Aylesbury did not have all the information available about him.
162. The man's responses to the mental health section of the assessment at Aylesbury contain false negative responses to the following questions:
- “Have you ever received treatment from a psychiatrist outside prison?”*
“Have you ever tried to harm yourself?”
163. It is not clear how much medical information transferred with the man at the time of his transfer. Earlier assessments carried out at the request of the court do not form part of the medical record and information relating to possible personality disorders and learning disability was not therefore available to the medical team responsible for him in Aylesbury. The clinical review notes that as the Ridgeway Team do not use the prison medical record, instead using their own system, the purpose and extent of their involvement remains unclear. Their records were supplied to the clinical reviewer. The records contain no clearly articulated management plans in relation to learning disability, mental health or self-harming behaviour.
164. The clinical review goes on to say that as initial assessments (reception screening) rely to a large extent on self reporting of key information, the presence of learning disability and personality disorder may render such information unreliable.

165. The clinical review states

“Learning disability, personality disorder, emotional instability, self-harming behaviour, previous suicide attempt, volatility, sexual offending. It is the opinion of the panel that he, in all probability, had an Emotionally Unstable Personality Disorder. This disorder would mean that he would take extreme views of people as being either good or bad and that he would have significant issues with abandonment.”

166. The man’s reception screening assessments did not identify significant concerns but it should be noted as the clinical reviewer has said, they were not informed by the relevant past history and relied on inaccurate self reported information.

167. Despite the intent evident from the medical records, and from the ACCT documentation, no psychiatric assessment or formal risk assessment was carried out during the man’s stay at either Wetherby or Aylesbury. This was a serious omission. The clinical review panel considers that one should have been conducted “as a clinical understanding of the learning disability and personality disorder dimensions are necessary in order to evaluate the risk of self-harm with reasonable confidence”.

168. The man was vulnerable and had a number of difficulties. He was convicted of serious sexual offences committed at a young age (unusual offences for his age group). He was originally held in a secure unit in May 2008 and then, in December 2008, moved to a specialist mental health unit for those with learning difficulties. He was treated there for six months before transferring to the Keppel Unit which is designed for particularly traumatised and damaged children. Throughout this time, various professionals described his vulnerabilities.

169. It is unusual for young people to stay at the Keppel Unit beyond the age of 18. Usually it would be because they had little more time left to serve. The man remained at the Keppel Unit 10 months beyond his 18th birthday. This was because staff there were concerned about him and wanted him to have minimal disruption.

170. It is a matter of serious concern that Aylesbury had so little information about the man. The limited information regarding his assessments before and including his time at Wetherby were given to this office by the YJB, rather than the prison. The clinical review makes a number of recommendations regarding these matters. We have recast and repeated the fundamental and significant recommendations.

The Chief Executive of NOMS and Offender Health should develop a Care Programme Approach to prisoners with learning disabilities so that prisoners with complex needs have clearly recorded care plans which are articulated, documented and monitored.

The Head of Healthcare should ensure that all psychiatric assessments and other relevant medical information are obtained and held in the medical record to ensure continuity of care

The Head of Healthcare should ensure that undue reliance is not placed on screening tools for prisoners with learning disabilities based on self-reported information without validating this information from another source.

The Head of Healthcare should ensure there is a robust process in place to ensure that appropriate psychiatric referrals are made, actioned and a response received by the primary healthcare team.

The Head of Healthcare should ensure that all health teams make entries on a single medical record including the mental health in reach team and learning disability team.

Sex Offender Treatment Programme (SOTP)

171. This was the man's first experience of imprisonment. He seemed to have difficulty understanding the gravity of his offence and the significance of his sentence. He was committed to Barton Moss Secure Care Centre on remand in June 2008. Following his court appearance, he was remanded to the Keppel Unit at HMYOI Wetherby. The Keppel Unit is a small enhanced supervision unit designed to look after the most vulnerable young people in custody with behavioural, anti-social and self-harming histories. There was concern about how well he could cope in prison. The intention was for him to be transferred to Swinfen Hall. He needed to complete the SOTP as part of his sentence plan, as Swinfen Hall runs an adapted SOTP for those with learning difficulties.
172. An email from Swinfen Hall in October 2010 outlines the reasons they did not accept the man. They were concerned about his bed wetting and the healthcare implications, but also that he would be vulnerable to bullying from other young people. They were concerned about his ability to cope as they did not have a dedicated vulnerable prisoner unit. They were also concerned about his ability to participate in the course given his previous threats of suicide.
173. While the man continued to have problems with incontinence at Aylesbury, this was managed by medication and by being woken in the night. The references to this problem become less frequent during his time in custody and it appears to have been well managed. Aylesbury only have healthcare staff on duty during the day, and this is the same at Swinfen Hall. It is therefore not clear why Swinfen Hall were not able to cater for his physical health needs in the much same way as Aylesbury.
174. There are no formal records of the continued efforts to transfer the man to Swinfen Hall. What is recorded, is that part of the reason he stayed on the Keppel Unit for such a long time after he turned 18 was to avoid too many

moves that could be disruptive to his care which would not be in his best interests. Apart from the vulnerable prisoner unit, it is unclear why he was better catered for at Aylesbury than Swinfen Hall. Nor is it clear how he was expected to address his offending behaviour when he was denied the opportunity to transfer to Swinfen Hall and therefore make progress in his sentence.

The Governor of Swinfen Hall should ensure that prisoners are not denied an opportunity to undertake the adapted SOTP unless there are exceptional and fully justified reasons.

ACCT

175. The man was on a number of ACCTs while at Aylesbury, for various different reasons. He cited a lack of tobacco and coffee as a reason for harming himself, and this appeared to be a trigger for him to self-harm. He also explained that he was lonely and felt isolated. There were times when he said he had been bullied. These concerns were followed up by staff, although he often did not wish to give any further information about the details of who was involved. He also said that he missed his family, who lived a long distance away.
176. The man's behaviour was challenging. Nevertheless, staff were aware of ways in which they could encourage him by giving him goals to aim for and praising and rewarding him when it was appropriate to do so.
177. However, most of the man's ACCT reviews (with the exception of the ACCT opened on 8 December 2010) lacked any in-depth analysis of his situation. Too much reliance was placed on his assertions that he was fine. Most of the reviews were attended only by him and wing staff, with little input from healthcare or staff from other areas of expertise. Of the seven occasions an ACCT was closed, six were at reviews with just two wing staff. Given the complexity of his issues, a multi disciplinary approach was necessary. There was little reference in the medical records to the fact he was subject to ACCT procedures.
178. Some of the ACCT's were closed too quickly without evidence of assessment that the risk had diminished. For example, the ACCT opened and closed on 19 January 2011, was closed as it was assessed the man had self harmed due to not having tobacco and now had some. However, in his ACCT assessment he talked of feelings of isolation and loneliness. These were not addressed.
179. There were also occasions when the "risks and triggers" section of the ACCT contained information of the self harm incident, rather than detailing issues for staff to be alert to, that might trigger further self harm.
180. The ACCT opened on 8 December and case managed by a SO, was of a good standard. The caremap was thorough, with meaningful action to help

alleviate some of the problems the man was facing. The caremap was referred to in case reviews, and updated.

181. PSO 2700 – Suicide prevention and self harm management (replaced in April 2012 by Prison Service Instruction 64-2011 – Management of prisoners at risk of harm to self, to others and from others (Safer Custody) contains guidance about how staff might use the enhanced case review process to deal with prisoners whose behaviour includes self harm and violence or disruption. This would seem an appropriate consideration in the man’s case. Membership of an enhanced case review should include “more specialists and a higher level of operational management” than a typical case review. An enhanced case review aims to provide a named keyworker on the caremap, strategies for encouraging better behaviour and agreed strategies for responding to “each individual problem behaviour that the prisoner displays”. It also encourages the prisoner to reflect on what their triggers are and to understand them.
182. The enhanced case review does not seem to have been considered for the man and we consider that it would have been a more appropriate way of supporting him further.

The Governor should ensure that the enhanced case review process is initiated for prisoners who are considered to pose a risk to themselves or others and who display challenging and disruptive behaviour.

The Governor should ensure that ACCT reviews are attended by a multi disciplinary team.

183. On two occasions, the man self harmed while already on an ACCT. The guidance in place at the time of his death is quite clear; further self harm should warrant another case review.
184. Most significantly, he cut himself on 9 March. An officer reported that the level of observations had been increased, but no case review took place.

The Governor should ensure that ACCT reviews take place following an incident of self harm.

ACCT checks on evening 9 March

185. The times given by the OSG at interview do not fully correlate with the times of the checks he recorded in the man’s ACCT document, but we understand that the OSG was trying to recall distressing events on a traumatic evening. In the ACCT, he noted that he checked him at 8.44pm and saw that he was sitting on his bed reading. His next entry in the ACCT was at 9.30pm, and noted that he was in bed watching television and a further entry at 10.30pm noted the same. He wrote that the man was in bed reading at 11.00pm, but that the observation panel was covered at 11.50pm. (The latter is the time he was reported to have been found hanging.) There is no mention in the ACCT document of being passed a letter or asking to speak to another prisoner.

186. The investigator watched the events on the wing that evening through recorded CCTV coverage and could see that the OSG was regularly in the area of the man's cell with apparent interaction. Not all of these were recorded in the ACCT document but we are satisfied that the OSG regularly monitored him throughout the evening.

Passing letters to prisoners

187. The OSG took a note from the man and passed it to another prisoner. Regrettably, he says he did not read the whole note, which said that he would harm himself if the prisoner did not come to his cell door and speak to him. During his interview with the investigator, the OSG was unsure what could be passed from one prisoner to another, he thought that perhaps papers or magazines were acceptable. During interviews, other staff seemed unsure what the correct procedure was for passing things between prisoners. Some thought that magazines and papers, once checked, could be passed, while other staff said that nothing should be as it was against prison rules.
188. The investigator made enquiries with the Head of Security at the prison. She was told that there are no notices to staff or instructions about what, if anything, can be passed between prisoners. Staff generally believed that passing newspapers, magazines and tobacco was acceptable, although this situation differs in the segregation unit, where no materials can be passed. The investigator was told that staff are aware of sensitive issues such as bullying and would not pass materials if they were suspicious of its contents.
189. The OSG acknowledged that rather than just read the first two lines of the note he should have read it in its entirety. If he had done so, he would have been alerted to the man's intentions and could have taken some action. He said at interview, that with hindsight he should have read the note. We believe that his failure to read the note in full and to pass it on at all is a serious matter, particularly as both the prisoners involved were regarded as at risk of suicide and self-harm. Nevertheless, we note that this error is mitigated by the fact that the prison acknowledges there are no clear instructions or guidance to staff about what to do in such circumstances. We therefore recommend:

The Governor should ensure that staff are aware of what, if any, materials can be passed between prisoners and that these should always be checked beforehand.

190. We consider that the OSG's account of what happened to the letter seems more credible than that of the prisoner. There is no evidence to suggest that the prisoner gave the OSG the note back at the time he said he did and another prisoner's interview seems to bear this out. When the OSG was given the note from the prisoner, he passed it to the Head of Prison Safety as evidence. Further, the investigator read the police interview statements. In the prisoner's statement he says that he received the note from the OSG

between 11.30pm and midnight and that he had “since” given the letter to the OSG.

Prisoners covering their observation panel

191. A number of times during the night of 8 March, the man, along with another prisoner on an ACCT, covered their observation panels. The prison’s local instructions regarding opening cells at night (number 2.77 issued on 26 January 2010) state that:
192. The prison’s local instruction (2.77) has a clear message which states that:

“Where observation panels are covered, the NOO (Night Orderly Officer) should be informed immediately and staff deployed to the cell.”
193. When the OSG telephoned Oscar 1 for advice, he was told that as long as he continued to receive a response from the prisoners, and could see them through the gap in the door, then this was acceptable. He continued to do this, although he did not have sight of the whole cell and could only see the prisoners if they were in a certain place. It is important when monitoring a prisoner at risk of suicide or self-harm that there is as full a view of the cell as possible, otherwise items indicating an intention to self-harm could be missed.
194. The Head of Security told the investigator that sometimes, when a prisoner’s observation panel is covered, that the inundation point in the cell is removed, so the prisoner can be observed. (An inundation point is a usually covered drilled hole in which a hose can be passed through in the event of a fire).

The Governor should ensure that staff know and understand how to appropriately manage a prisoner who has covered his observation panel.

First aid training for night staff

195. It is important that there are staff on duty at night in prisons who are trained in first aid. The investigator requested a copy of first aid records for night staff at Aylesbury. None of the permanent night staff were first aid trained, although one officer was trained in Heartstart in December 2004. Particularly as there are no healthcare staff on duty at night, this is very unsafe practice and a serious deficiency.
196. None of the staff on duty on the night of 8 March were current first aiders, and the OSG was the only staff member who attempted CPR. However, he did not administer this at the correct ratio and did not know what that was. He said that he had gained his knowledge by watching television programmes. Nevertheless, the prompt actions of the OSG were commendable and managed to keep the man alive.
197. The clinical reviewer comments on the emergency response by staff. He notes that the OSG acted promptly in raising the alarm. He acted on his own

initiative and personally instituted CPR. However, “his training in CPR was not current, the ratio of breaths to chest compressions he employed was not that which is currently recommended and he continued to act alone after the arrival of other officers although the standard recommendation is that two people should work together to deliver CPR wherever possible”.

198. A defibrillator was not collected or used. It is not possible to know if this would have affected the outcome for the man, but it is clear that the facilities and training to deal with such an emergency should be in place.

The Governor should ensure that sufficient staff working at nights have been trained in basic life support and the use of defibrillators.

Care for staff

199. Whilst the appropriate de-briefs were held for staff and support was available to them, the OSG did not seem to receive the consideration and support he needed. Once the paramedics arrived to attend to the man, the OSG continued with his work. Another member of staff came onto the wing to assist him at 3.00am, but apart from the SO Bonham, the OSG did not recall anyone else asking how he was or whether he needed to go home.
200. At the hot de-brief the OSG was told he could take two nights off before commencing a week off (following a week of night duty). He was glad of this as, understandably, he had found it difficult to sleep when he arrived home on the morning of 9 March. However, he was telephoned twice during the day asking whether he could come in to work again that night. The first time he told the prison that he did not feel that he could, but the second time he was persuaded to go into work as the prison were short staffed. This is unacceptable. No matter what the staffing situation at the prison, it should have been acknowledged that the OSG had had a traumatic experience, had been responsible for carrying out CPR alone for ten minutes and had not received satisfactory support.

The Governor should ensure that all staff affected by deaths in custody are appropriately supported.

CONCLUSION

201. The man was clearly a troubled young man. He had a complex history of emotional and learning difficulties, and serious offending. This was taken seriously and because of his vulnerabilities, he was treated in a secure unit, before moving to the specialist unit for vulnerable young prisoners at Wetherby. Efforts to ensure his needs could be met included him remaining at this unit at Wetherby until some 10 months after his 18th birthday. This is unusual and demonstrates how vulnerable he was seen to be and how difficult it was to find a suitable place to meet his needs.
202. In Aylesbury, the man received some support from a learning disability team, and in particular from the Chaplaincy. He frequently self-harmed and was subject to ACCT monitoring on a number of occasions. Although there is evidence of some good interaction between him and staff, there were some deficiencies in the ACCT process, with few multi-disciplinary reviews. We consider it would have been prudent to instigate the enhanced case review system for him, given his vulnerability, self-harm and violent outbursts.
203. The night of 9 March was difficult for just one OSG working on F wing. As well as his usual duties, he had a number of prisoners who were on the ACCT monitoring and required observation. Two of them had obscured their observation panels and rang their cell bells a number of times. The OSG interacted regularly with the prisoners needing observations but should not have passed a note from the man to another prisoner. Once he was found hanging the OSG acted promptly when he found him and attempted CPR alone until the paramedics arrived.
204. This report identifies a number of lessons that can be learnt from the man's death, including the need for better planning and care for young prisoners with learning disabilities, more effective information sharing, improved procedures to support extremely vulnerable young men subject to ACCT monitoring and more effective mental health support.

RECOMMENDATIONS

To the Chief Executive of NOMS and Offender Health:

1. The Chief Executive of NOMS and Offender Health should develop a Care Programme Approach to prisoners with learning disabilities so that prisoners with complex needs have clearly recorded care plans which are articulated, documented and monitored.

This recommendation was accepted.

To the Governor of Aylesbury:

2. The Governor should ensure that the enhanced case review process is initiated for prisoners who are considered to pose a risk to themselves or others and who display challenging and disruptive behaviour.

The Governor accepted this recommendation

3. The Governor should ensure that ACCT reviews are attended by a multi disciplinary team.

The Governor accepted this recommendation

4. The Governor should ensure that ACCT reviews take place following an incident of self harm.

The Governor accepted this recommendation

5. The Governor should ensure that staff are aware of what, if any, materials can be passed between prisoners and that these should always be checked beforehand.

The Governor accepted this recommendation

6. The Governor should ensure that staff know and understand how to appropriately manage a prisoner who has covered his observation panel.

The Governor accepted this recommendation

7. The Governor should ensure that sufficient staff working at nights have been trained in basic life support and the use of defibrillators.

The Governor accepted this recommendation

8. The Governor should ensure that all staff affected by deaths in custody are appropriately supported.

The Governor accepted this recommendation

To the Governor of Swinfen Hall:

9. The Governor of Swinfen Hall should ensure that prisoners are not denied an opportunity to undertake the adapted SOTP unless there are exceptional and fully justified reasons.

The Governor accepted this recommendation

To the Head of Healthcare:

10. The Head of Healthcare should ensure that all psychiatric assessments and other relevant medical information are obtained and held in the medical record to ensure continuity of care

The Head of Healthcare accepted this recommendation

11. The Head of Healthcare should ensure that undue reliance is not placed on screening tools for prisoners with learning disabilities based on self-reported information without validating this information from another source.

The Head of Healthcare accepted this recommendation.

12. The Head of Healthcare should ensure there is a robust process in place to ensure that appropriate psychiatric referrals are made, actioned and a response received by the primary healthcare team.

The Head of Healthcare accepted this recommendation

13. The Head of Healthcare should ensure that all health teams make entries on a single medical record including the mental health in-reach team and learning disability team.

The Head of Healthcare accepted this recommendation