Investigation into the circumstances surrounding the death of a man at HMP Wymott in September 2008

Report by the Prisons and Probation Ombudsman for England and Wales

November 2010

This is the report of an investigation into the circumstances of the sudden death of a man at HMP Wymott on 28 September 2008. He was found collapsed in his cell by evening duty staff. Efforts were made to resuscitate him but were unsuccessful. A post mortem found that his death was due to choking on a foreign object.

The man was not in contact with any of his family and had nominated a chaplain in the community as his next of kin. My colleagues and I would like to extend our condolences to all those affected by his death. I apologise for the delay in issuing my report and additional distress this may have caused.

An investigator from my office led the investigation. An independent review of the man's medical care in prison was commissioned from the Central Lancashire Primary Care Trust (PCT) and was carried out by the Head of Healthcare at HMP Haverigg. I am most grateful for their assistance. I would also like to thank the management and staff at HMP Wymott for their co-operation during the course of this investigation and their patience with my delay.

The man was convicted and sentenced to four years imprisonment with a four year extended element in 2002. He completed the custodial portion of his sentence in May 2005, but was recalled to prison in June 2006 for breaching the terms of his licence. During his time in prison, the man was under continual review by medical and mental health staff having suffered from depression and the effects of sexual abuse as a child. Later in his sentence, he began to harm himself by superficial cutting and drug overdoses. His mental condition deteriorated throughout 2008.

I am satisfied that the man received equitable and responsive care throughout his time at Wymott. His death was not preventable. However, I make six recommendations. Three are addressed to the PCT about healthcare staffing, medical record keeping and obtaining previous health records. A further two are jointly addressed to the PCT and Governor regarding attendance by patients at appointments and the availability of mental health assessments during weekends. I also reiterate a recommendation I have made in previous investigations at other prisons regarding the need for up to date information on prisoners' next of kin.

I am pleased to record that all my recommendations have been accepted and with the exception of one the necessary changes have already been implemented.

Jane Webb
Acting Prisons and Probation Ombudsman **November 2010**

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SUMMARY

A male prisoner at HMP Wymott, died on the evening of 28 September 2008 in his cell on G wing. He was serving a four year prison sentence and a four year extended term imposed in 2002. He had been released from custody after serving the custody portion of his sentence but was recalled to prison for breaching the terms of his licence. He returned to prison on 30 June 2006 and transferred to HMP Wymott on 11 August, where he remained until his death.

The man was generally physically fit, apart from a sports injury to his knee, for which he took analgesics. He was later referred to the local hospital for an operation on his knee which he refused preferring to wear a support and continue taking analgesics. As his mental condition deteriorated, he became fixated about acquiring these drugs. He also suffered from depression for which he was prescribed and held his own medication. He had previously self-harmed by cutting himself but, at the time of his recall, his mental condition was stable and he was not thought to be at risk of harming himself.

Soon after the man's arrival at Wymott, he was assessed by a visiting psychiatrist who thought that his main issues were anxiety and depression brought about by being sexually abused as a child. During the following months, the psychiatrist altered the man's medication as appropriate and referred him to a cognitive behaviour therapist. Mental health staff continued to review the man regularly and his medication was varied in response to his needs.

In early 2008, the man's mental condition began to deteriorate. He reported bullying by other prisoners, missed his mental health appointments and reported auditory hallucinations that told him to assault staff which later, on a single occasion, he did. He also started to harm himself and was subject to the Assessment, Care in Custody and Teamwork (ACCT) process (The ACCT procedure provides additional monitoring and personalised support for prisoners considered to be at risk of harming themselves or suicide.) In mid-May, a voluntary referral was made for an assessment of his mental condition at HMP Preston but he became anxious about the move and it was postponed. His deterioration continued and in mid-July, staff reactivated the voluntary referral and he transferred to Preston. On arrival, he became anxious about returning to Wymott, becoming insistent that he no longer wanted to remain at Preston. The man returned to Wymott eight days later.

The man's condition continued to deteriorate and his medication was reviewed and adjusted as necessary. The psychiatrist attributed his increased physical symptoms, rigidity, grimacing and tremors, to the anti-psychotic drugs which he reduced over an appropriate withdrawal period until they were stopped.

On Thursday 25 September, the man was unwell and anxious. He was referred, as an urgent case, to a Primary Care Mental Health Team nurse who saw him the same evening and referred him the following morning back to Preston for a medical and mental assessment. Preston agreed to arrange the assessment the following Monday. The man remained depressed, although his spirits lifted periodically, throughout the weekend.

During the late afternoon of Sunday 28 September, the man missed his tea meal and had not collected his breakfast pack for the following morning. A wing officer took the pack to him in his cell. Nothing about his mood or wellbeing alerted her to any change.

The man was found collapsed and unresponsive on his cell floor an hour and a half later. Prison and healthcare staff, then subsequently ambulance service paramedics attempted to resuscitate him. Sadly, they were unsuccessful and paramedics confirmed his death just before 7.00pm. The prison contingency plan for a death in custody was immediately implemented. Wymott experienced difficulty in contacting the man's named next of kin and police later undertook to inform him.

A post mortem examination took place at the local hospital on 30 September. The pathologist found that the man had died from choking on a wrapped cereal biscuit, which was part of his breakfast pack. The police were initially involved but took the view that the man's death was not suspicious.

As the man had no family to arrange the funeral the prison made the arrangements. The Salvation Army Chaplain arranged and officiated at the man's cremation, which Wymott funded. Following the cremation, a memorial service was held in the Chapel at Wymott which was attended by the man's friends and some staff. His nominated next of kin was present and, following the service, took away his ashes for burial in his parish churchyard.

I make six recommendations. Five relate to clinical matters, including medical records, staffing, attendance for appointments and the availability of mental health assessments. A further recommendation relates to updating next of kin details.

A response, dated 1 November 2010, to my report was received from the National Offender Management Service accepting all my recommendations. Necessary actions have been taken by HMP Wymott and Central Lancashire Primary Care Trust to implement the changes.

INVESTIGATION PROCESS

1. An investigator undertook the initial stages of the investigation but, owing to ill health, was unable to continue. The investigator met representatives of the Prison Officers' Association and the Independent Monitoring Board at the outset of his investigation.

2. Another investigator took over the investigation in October 2009 and visited HMP Wymott on 17 November 2009. He met the Deputy Governor, and the liaison officer, who gave him a full briefing about the circumstances surrounding the man's death. The investigator re-issued notices to staff and prisoners inviting anyone who might have information relating to the man to make themselves known to him.

3. No prisoners spoke to the investigator as a result of the re-issued notice but one was interviewed informally. The investigator also met relevant prison staff including members of the chaplaincy and medical departments and others who knew the man. Wymott provided copies of the man's prison record. The police were involved briefly and took statements from relevant staff but decided at an early stage that the circumstances surrounding the man's death were not suspicious.

4. The Chief Executive of the Central Lancashire Primary Care Trust commissioned a clinical review that was carried out by a member of staff who is a Registered General Nurse (RGN), a Registered Mental Nurse (RMN) and the holder of a Diploma in Community Nursing (DCN) and is Head of Healthcare at HMP Haverigg. The report of the review was received in February 2009.

5. One of my family liaison officers spoke to the man's nominated next of kin on 22 October 2008, to offer him the chance to raise any questions or concerns. His only question was whether the man's death was self-inflicted or due to natural causes. The family liaison officer was unable to contact any of the man's family.

HMP WYMOTT

6. HMP Wymott is a purpose built prison near Leyland in Lancashire which opened in 1979. It is a category C training prison holding convicted adult male prisoners with facilities for vulnerable prisoners who are held in separate accommodation. (On arrival into prison, prisoners are risk assessed and given a category based on their offence and the risk that they pose to the public should they escape. There are four levels of category: A, B, C and D, with category A prisoners being the most dangerous. Category C is for prisoners who cannot be trusted in open prison conditions but who would not have the ability or resources to make a determined escape.) At the time of the man's death, Wymott held around 1,140 prisoners. There have been eight deaths in custody at Wymott since April 2006, none of which appear to be similar to the man's death.

7. Since April 2004 healthcare at Wymott has been provided by the Central Lancashire Primary Care Trust (PCT). Primary healthcare staff are employed by Central Lancashire PCT. Mental healthcare staff are provided by the NHS Foundation Trust (Lancashire Care) and are the secondary mental health care provider for individuals with severe and enduring mental health problems. Central Lancashire NHS PCT provides primary mental health care for individuals with mild to moderate needs. The local mental health in-reach team (MHIT) is based in Leyland and at the time of the man's death was staffed by two community psychiatric nurses both registered mental nurses (RMN's). Since his death, funding levels have risen and the team numbers have increased to five. Wymott is not staffed or equipped to undertake mental health assessments. HMP Preston has facilities to do so and is tasked by the PCT to maintain designated regional mental health beds for that purpose by prisons in the area.

8. Wymott prison provides Type 3 healthcare which maintains 24 hour nursing support but has no in-patient facilities. There is a main healthcare centre with treatment areas on the wings that are used for dispensing medication to prisoners. Appointments for clinics are made at the healthcare centre.

9. A three-stage tackling anti-social behaviour (TAB) process to manage bullying was introduced during 2008. It comprises observation at stage one, formal warnings and monitoring at stage two and the use of sanctions, including transfer out of the prison, at stage three.

10. HM Chief Inspector of Prisons (HMCIP) made an announced inspection of Wymott during October 2008, shortly after the man's death. The Inspectorate made several comments in the report that are relevant to this investigation commenting that, "There was a tackling anti-social behaviour (TAB) policy to deal with bullying, but staff had not been trained in its use and its application was poor." and "No central log of investigations into allegations of bullying was kept." The Independent Monitoring Board (IMB) for 2008 – 2009 echoes the Inspectorate concerns about the TAB process.

11. The Inspectorate's report also identified that:

"The mental health in-reach team were able to access the past history of local patients through the mental health trust electronic records; if patients were from other areas, records often had to be started from scratch."

12. The IMB also comments on mental health issues relevant to the man's case:

- "The Board welcomes the increase in and re-organisation of the Primary Care Mental Health Care team. However, there remains the accepted fact that prisoners with mental health problems should not be held in this type of prison"

  "Although the Board considers that discipline staff cope well with prisoners who have a mental health disorder, their training should include content that would help them deal better with the ensuing behavioural problems."

- "The Board suspects that some prisoners resort to the ACCT system in order to resolve problems that could be resolved in other ways. ACCT documents do not always follow prisoners to workshops or education, so that not all officers or instructors are aware of the prisoners' state of mind. Additionally the Board considers that observational and conversational entries in ACCT documents are not always meaningful."

KEY EVENTS

13. The man was released from HMP Whatton on licence on 10 May 2005. Before his discharge, a consultant forensic psychiatrist completed a psychiatric assessment report, dated 5 May 2005. She concluded that there was no indication that he suffered from any mental illness and was unconvinced that he suffered from Asperger's syndrome. She considered that the man had borderline learning difficulties. The consultant forensic psychiatrist referred to a previous clinical psychology report from 2002 by a consultant clinical psychologist, who concluded that "he has social and communications difficulties". The consultant forensic psychiatrist recommended that there were no clear grounds for referral to mental health services and hoped that the conditions in his extended licence would provide a protective structure and a context for ongoing relapse prevention work.

14. The man was recalled to prison at HMP Altcourse on 30 June 2006, because he had not complied with the terms of his licence. He asked for vulnerable prisoner status which was granted and he was accommodated in the prison healthcare department until 3 July, where he also underwent alcohol detoxification treatment.

15. During his initial healthcare assessments, the man was recorded as having an old sporting injury to his right knee for which he received analgesics (pain relievers). He had also been diagnosed with depression for which he was prescribed citalopram and chlordiazepoxide (antidepressants). He said that he had been in contact with a community psychiatric nurse (CPN) and had previously self-harmed by cutting himself but said that he was alright. His mental condition was noted as normal. A warning, dated 20 July, from the public protection meeting noted that female staff coming into contact with the man should be cautious. He remained at Altcourse until 11 August, when he transferred to HMP Wymott.

16. On arrival at Wymott, the man had a further healthcare reception screening where he confirmed that he had a history of drug and alcohol abuse and suffered from depression. His medication was pain relief for his knee injury and citalopram once daily which the man held in his own possession. He was fit for most work and the gymnasium but was excluded from work in some workshops and noisy environments. He was allocated to B wing, accommodation for vulnerable prisoners, where he could associate freely with other prisoners on the wing.

17. During the man's initial mental health screening he said that he was in touch with an MHIT and that he suffered from autism, Asperger's Syndrome and obsessive compulsive disorder (OCD). The man also said that he had harmed himself in the past and that he was subject to a F2052SH (a document formerly used to monitor prisoners who were at risk of self-harm – now superseded by the Assessment, Care in Custody and Teamwork (ACCT) procedure which assesses, observes and supports prisoners who are considered at risk of harming themselves). Documentary evidence confirms

that these procedures were closed prior to his release from HMP Whatton in November 2004.

18. The man had no other significant healthcare issues and he signed Wymott's medication policy. He was referred to the MHIT and saw one of their registered mental nurses (RMN) on 16 August. After that meeting, he referred the man to the visiting psychiatrist, resolved to "liaise with outside agencies for more background" and added him to the MHIT caseload.

19. The man was assessed on 31 August by the doctor at Wymott about the pain in his right knee. He was referred for x-ray examination at a local hospital and received an appointment for 29 September. After examination, an operation was planned and a further appointment made for 12 December. The man wrote to the doctor on 25 October, declining the operation and electing instead to continue wearing a knee support and take pain relieving medication. He completed a refusal of treatment disclaimer and cancelled all subsequent appointments at the hospital regarding his knee. His decision was passed to the hospital on 1 November. He was advised to lose weight and treatment for the injury was regularly reviewed.

20. Having complained of restlessness, low mood and panic attacks, the man was seen on 25 September by a psychiatrist. The psychiatrist thought that the man's main issues were anxiety and depressive symptoms brought about by his alleged history of being sexually abused, the associated auditory hallucinations (hearing imagined voices which the man called "flashbacks") and drug and alcohol problems. The psychiatrist concluded that, due to the man's worsening anxiety and depressive symptoms, his antidepressant medication was no longer appropriate and should be altered to an increasing dose of trazodone (an antidepressant). The psychiatrist arranged to see the man again in four weeks and noted that he had no thoughts of harming himself.

21. The man's knee remained painful and he continued to receive analgesic treatment. During October and November, he refused to attend several medical appointments and his general behaviour deteriorated. He also made several complaints about his mail and pain relief medication which were dealt with under the Prison Service formal complaint procedure.

22. Another psychiatrist reviewed the man on 26 October and found that the change to trazodone had not taken place. He wrote asking that the medication be changed in line with the request made by the psychiatrist in September and this was altered gradually over the following month. The other psychiatrist conducted a further review on 23 November, after the medication change and found that the man's mental state was improving and he had no thoughts of self-harm. He said that trazodone was helping him to sleep and to lift his mood but reported that he occasionally became irritable. The doctor recommended that the dose should be increased, which was done immediately, and a further review was set for three months time.

23. An RMN from the local MHIT reviewed the man on B wing on 15 January 2007. The man said that the trazodone was not helping him, he still suffered significant mood swings during the daytime and considered that he needed further medication. The member of staff discussed the matter with the second psychiatrist who raised the trazodone dose gradually over the following three months. The man was also referred for cognitive behavioural therapy.

24. When the psychiatrist saw the man on 2 March, he said he was anxious, on edge and under stress, which was related to his recall review. The doctor concluded that the man was undergoing moderate depression and again increased his dose of trazodone. He also noted that he had no thoughts of harming himself or others and that he was exhibiting no psychotic symptoms. The man saw the second psychiatrist again on 18 May and told him that his mental state was improving although he experienced flashbacks from his past abuse. The psychiatrist noted that the man was looking forward to being released from prison. He made a further appointment to see the man in three months.

25. During the first half of 2007, the man suffered a range of minor dental and medical complaints for which he received treatment. He also complained about his medication, treatment and food all of which were resolved using the formal complaint procedure.

26. On 15 June a nurse examined the man in his cell. He said that he had vomited a small amount of blood two days earlier and had slight abdominal pain. Apart from tenderness in his abdomen the results were normal. He was given lansoprazole to decrease the production of stomach acid and a note made that if the bleeding recurred he would be taken to hospital. On 29 June, the man had a blood test including a full blood count, urea and electrolyte levels, thyroid and liver function tests. The results of the tests were recorded in his medical record although there is no interpretation of these results.

27. The man lost his job in the prison kitchen on 8 August, after a month's trial, as he struggled to cope with the day to day tasks in the washing up area. On the following day, 9 August, the man's trazodone dose was altered from 150mg twice daily to 300mg at night.

28. Having collapsed in the healthcare waiting room, the man was taken by ambulance to outside hospital on 5 September. The prison doctor wrote in the referral letter that he thought that the man's collapse was a vaso-vagal event (fainting as a result of a drop in the heart rate). The man had told him that he had epigastric pain (pain in the upper central region of the abdomen) for a few weeks. Exploratory tests were carried out and he remained in hospital for seven days. His discharge notes confirm that his stomach and duodenum (the first part of the small intestine) were normal.

29. On 22 September, the man complained about the reduction in the pain relief medication for his knee and the prison doctor referred him to a local hospital. He was strongly advised of the medical need to reduce his weight and agreed to reduce his co-codamol (pain relief) use to seven tablets per day.

30. The man had a review with a different psychiatrist on 8 October. He told the doctor that he had flashbacks and nightmares over the past two years which had increased from twice weekly to four times weekly and were related to the sexual abuse he had suffered. The psychiatrist discussed the possibility of taking an antipsychotic drug, olanzapine, and planned to see him in one month. The psychiatrist discussed the case with a consultant psychiatrist. They concluded that the man did not meet the criteria set out in the International Criteria for Disease 10th revision (ICD-10) for diagnosis of post traumatic stress disorder (PTSD) but that his problems were related to the sexual abuse he had endured. The outcome was to prescribe olanzapine (5mg) once daily when the psychiatrist saw him next and the MHIT would monitor the man fortnightly.

31. The man asked for a meeting with the MHIT RMN that saw him on the 16 of August, this took place on 12 October. He told the MHIT RMN he was reluctant to wait until his next appointment with the psychiatrist to be prescribed olanzapine. The MHIT RMN agreed to speak to the doctor about bringing this forward and the medication was dispensed to the man on 16 October. The man also started counselling sessions on 21 November which he regularly attended until the course was completed on 12 March.

32. On 25 October, the man had considerable pain in his right knee. The prison doctor referred him to the orthopaedic department at a local hospital and increased his pain relief medication. As the doctor considered the man's increasing weight was the main aggravating factor, she also referred him to the prison physical education department for remedial exercise. His co-codamol prescription was increased and an anti-inflammatory drug (diclofenac) was also prescribed.

33. Throughout November, the man lodged a series of seven complaints about a reduction in his pain relief medication, his requested increase in the olanzapine prescription, his dental aftercare and about a warning he had received from a nurse about trying to collect his medication early. Enquiries were made of the appropriate doctors and timely replies sent to him. He was also referred to MHIT because he wrote in one complaint that, if his olanzapine was not increased, he could become violent. The psychiatrist he last saw was contacted immediately but refused an increase in the medication until he reviewed the man on his next visit. An unsigned note written on the in-possession page of the drug administration chart covering this period reads "Please do not alter psychotropic medication".

34. The prison doctor, saw the man in his cell on 23 November about an infected toe. While she was there she asked the man why he quite happily sat in consultations with her and then returned to his cell to write extensive letters of complaint. He told her that he had no problems today. The man made a formal complaint on 1 December about the possibility that he would be released before his sentence expiry date, as he wished to remain in prison until then. The senior probation officer responded to the complaint explaining the process adopted by the Parole Board and possible outcomes.

35. The psychiatrist he had last seen reviewed the man on 7 December and increased his olanzapine to 10mg nightly. He also prescribed sertraline 50mg (an antidepressant) to be taken every morning. During the review, the psychiatrist noted that the man's trazodone medication had been stopped suddenly at the beginning of November. No reason for the cessation is evident and the psychiatrist wrote to a doctor at the Lancashire Care NHS Trust about the abrupt termination. The psychiatrist recorded that the man felt his future was bleak and he preferred not to think about his release although on some days he felt excited and wanted to be out of prison. The doctor set the next review for one month's time.

36. A doctor at a local hospital examined the man's knee on 12 December and he underwent an MRI (magnetic resonance imaging) scan and x-rays. The man wrote a letter to the healthcare manager at Wymott on 18 December requesting that all further escorted hospital appointments be cancelled because he found them degrading and uncomfortable. He wrote a further letter to the manager about the orthopaedic consultant's view that he had severe arthritis in his right knee and there was not much that could be done about it. He cited this as the reason for cancelling any further appointments at either Chorley or Preston hospitals.

37. The man was reviewed by the psychiatrist on 4 January 2008, when he told the doctor that his auditory hallucinations had lessened slightly but that he was edgy, sometimes verbally aggressive and less motivated. He said the sertraline had produced side effects affecting his stomach and bowel, and so the prescription was discontinued. They discussed the doctor's intention to prescribe Zispin (an antidepressant) to help him sleep and stimulate his appetite. He warned the man about the common side effects he might experience. His intention was also to increase the man's olanzapine but he was unable to do so immediately because the prescription card was still with the pharmacy on B wing. They discussed the change and, with the man's agreement, decided to make the alterations on his next visit. The man made a formal complaint the following day about the lack of the prescription card. He received an appropriate response on 7 January from a nurse.

38. The man wrote to the MHIT RMN on 6 January, complaining that he had not yet received the Zispin. He asked him to find out why and visit him to let him know the outcome. The MHIT RMN contacted the psychiatrist who agreed that the prison doctor could prescribe the medication in his stead. The MHIT RMN wrote to the prison doctor on 7 January requesting the alterations. A handwritten note on that letter reads "done 10.1.2008" which is initialled but is illegible. No supporting note on the prescription chart or in the medical record documents this change. The man submitted a further formal complaint about not receiving Zispin on 11 January and refused to be seen by the prison doctor that afternoon. The response to the man's formal complaint dated 15 January, from a nurse, includes a reference to a prescription sheet. The sheet identifies that he received four 15mg tablets on 10 January which were to last until 13 January when a week's supply could be given to him. No record of the prescription is available.

39. The MHIT RMN saw the man again on 23 January at his request. The man was feeling under pressure because his new probation officer wanted him to complete a sex offender treatment programme (SOTP). He also said that he felt no benefit from the Zispin he had been taking and requested that the dose be increased. The MHIT RMN said he would speak to either the prison doctor or the visiting psychiatrist on his next visit to Wymott.

40. The man's request for paracetamol for a cold on 1 March was refused as he was already receiving co-codamol and had been issued with 16 paracetamol tablets on 24 January. The nurse advised the man about the dangers of paracetamol overuse. She also completed an incident form in respect of his attempt to obtain the drug. During the following weeks the man declined to attend dental appointments for continued treatment. He also refused to move cells when required and was dealt with under prison disciplinary rules.

41. Due to a shortage of time, the man was not seen by the psychiatrist on 15 February and a further appointment was made for one month's time. He was reviewed on 14 March and the doctor noted in his report that the man looked distressed and lost. The man told the doctor that he had begun to hear voices again telling him to hit "figures of authority". He mentioned that he now quarrelled with other prisoners when they bullied him. He also told the doctor that since his last review he had taken five overdoses of ibuprofen and co-codamol (28 tablets on each of two occasions) and with co-proximol (unspecified quantities on the other three occasions) which he had obtained from other prisoners. According to the man, his intention on two occasions was to sleep and to kill himself on the other three. None of these incidents came to the attention of prison staff. He denied, during the review, any existing ideas, intent or plans to harm himself. The man's next review date was set for one month later and the MHIT was to see him in seven days. His olanzapine prescription was raised to 20mg and his Zispin increased to 15mg both to be taken nightly. Both were to be administered by the nurses rather than held in his possession because of his reported overdoses. His co-codamol prescription was similarly put on a "not in possession" basis except for one tablet each day to be taken at lunchtime.

42. In the first few days of April, the man's personal officer, reported that he seemed withdrawn. He was not mixing during wing association and was quiet towards staff. When he was approached about the change in mood he told the officer that he thought it was due to his medication and no other issues were apparent.

43. An entry on the man's wing history sheet dated 16 April alerted night staff that he had spoken of harming himself. When interviewed, he said that the comment had been made in a "mad moment" and he did not mean it. He reaffirmed this a week later when spoken to about starting a SOTP course which he said he was looking forward to. On 18 April, the man declined to see the psychiatrist and was rescheduled for the psychiatrist's next visit.

44. A security information report was submitted on 23 April, detailing suspicion by wing staff that the man was being bullied for his medication. As a result, a

Tackling Antisocial Behaviour (TAB) document was opened in relation to the man and the man suspected of bullying him. The man also made a formal complaint to the healthcare manager about the reduction of his co-codamol prescription by the prison doctor.

45. The MHIT RMN saw the man in B wing on 2 May following concerns expressed by healthcare staff about how he was functioning and the deterioration in his mental health. The man denied any mental health concerns and showed no overt symptoms, although the MHIT RMN thought that he was experiencing auditory hallucinations. He described the man's mood as flat and his movements rigid. The MHIT RMN requested a physical examination, which was performed in a series of appointments over the following week. The man did not complete his final appointment on 7 May, returning to his wing from healthcare before the scheduled blood pressure and electro cardiogram (ECG) tests were performed.

46. The man was told on 6 May by a senior psychologist, that he would no longer start the SOTP because of concerns about his physical and mental health. He replied that he was fine.

47. The psychiatrist and the MHIT RMN reviewed the man in B wing on 9 May. He had refused to see them in healthcare due to feelings of paranoia while in the waiting room. He looked unwell, said he felt low and continued to experience auditory hallucinations. A plan was formulated, dependant on the outcome of a re-scheduled ECG, to modify his medication by either increasing mirtazapine (an antidepressant) or replacing it with trazodone. Finally, a referral was completed for the man to be transferred to the healthcare centre at HMP Preston for a period of assessment. The referral was faxed to Preston that day.

48. The MHIT RMN saw the man again on 23 May in B wing where he asked about the proposed medication change. The MHIT RMN explained that the change would not happen until the ECG had taken place and gained agreement from the man that he would attend healthcare for it. The man raised the subject of his transfer to Preston saying that, because he thought that he would not return to his cell on B wing at Wymott, he did not want to go. The MHIT RMN considered that the man was unlikely to engage with the assessment process. He contacted Preston with a request to put the transfer on hold and planned to discuss the matter with the psychiatrist, re-list the man for the ECG at Wymott and consider referring him back again to Preston if there was any further deterioration in his condition. The man refused to attend healthcare for the ECG on 29 May, which was re-listed for 5 June.

49. The psychiatrist again reviewed the man on B wing on 30 May. He noted that because the man had missed the previous three appointments, it was necessary to see him on the wing. This was not an ideal situation as the appointments were restricted to ten minutes which was insufficient to complete a review. The psychiatrist recorded that the man appeared unwell and had a vacant expression. He requested further blood tests and, if the results were normal, to increase the man's mirtazapine from 15 mg to 30 mg

and then to 45mg two days later. He also emphasised that the man was not to have any medication in his possession and noted that the MHIT RMN would review the man after the medication changes had taken place. If he was no better, a transfer to Preston should be organised.

50. The man's ECG took place on 5 June and test results were within normal limits so his mirtazapine was adjusted on 9 June in line with the psychiatrist's instruction. The man did not attend the subsequent review of his case on 20 June. His personal officer observed that because the man was now being supervised by healthcare staff and he was receiving the proper level of medication, his behaviour had improved. He was in better spirits but confined his personal interactions to one other prisoner.

51. Prisoners on B wing reported to staff that the man had become incontinent on several occasions. A nurse spoke to the man who thought it was caused by his olanzapine prescription. She referred him to the prison doctor and the MHIT team. Due to the man's condition, on 25 June he was placed on the waiting list for I wing, a small unit specifically for elderly and disabled prisoners.

52. Following an argument with another prisoner on the morning of 30 June, the man made several superficial scratches on his left forearm. Healthcare staff attended to him and immediately placed him on the ACCT procedure An ACCT assessor and member of the Wymott chaplaincy, interviewed him noting that he had no intention of killing himself and was very anxious that he move cell and receive his medication. A comprehensive care plan was written part of which involved the man being moved to a cell on another spur. The man remained on the ACCT procedure until his death.

53. The MHIT RMN met the man on B wing on 3 July and discussed the proposed increase in his mirtazapine prescription. The man agreed with the increase to 45mg but said that if that did not work he wished to go back to trazodone. The MHIT RMN agreed to discuss this with the psychiatrist. The following day the man was reported by workshop staff to be asking other prisoners for paracetamol. He denied this, but said that he had toothache. He reported "special sick" (a procedure available to prisoners to see medical staff at short notice without the normal application process) on four occasions between 28 June and 6 July and on each occasion was given analgesics.

54. The man spoke to a Listener (a prisoner trained by the Samaritans to provide confidential emotional support to other prisoners in distress) on Saturday 5 July, who referred him to mental health services. An officer also spoke to the man that day who told him that he had experienced a flashback during the previous night and, as a result, had wanted to cut himself. The officer relayed the information to healthcare staff who said they would tell mental health staff on Monday.

55. On Sunday 6 July, a nurse gave the man two paracetamol tablets because he had refused co-codamol. He also asked for some to take away which she refused. Another nurse, later that same day, was called to B wing where the

man said he had taken eight paracetamol tablets for toothache. The nurse told him that he would be given no more paracetamol that day and made him aware of the dangers of taking more than the permitted dose of the drug.

56. Some ten minutes later, staff saw the man collecting paracetamol tablets from other prisoners and told them he intended to kill himself. The nurse was recalled to the wing immediately where the man told her that he had taken ten more paracetamol and said that he was determined to take his own life. The man was taken to a local hospital at about 12.30pm and told escorting staff that he was being bullied on the wing. Later the same afternoon, medical staff at the Accident and Emergency (A&E) unit discharged the man back to Wymott as no treatment was required. On his return, he was transferred from B wing to a single cell on G wing.

57. The man saw the MHIT RMN on G wing after his first ACCT review on 8 July and told him that he felt much better since his move. He felt safer and had no thoughts of harming himself. He said that the overdose was as a result of bullying on B wing, which he was then reluctant to discuss, and a re-emergence of his flashbacks which distressed him. The MHIT RMN broached the subject of reactivating the referral for a mental health assessment at HMP Preston. To his surprise, the man agreed and the MHIT RMN said he would see him again later in the week.

58. A Senior Officer (SO), and G wing manager, said that it was apparent that the man's mental state was deteriorating. The SO said that his "speech wasn't right" and for want of a better description, he held his hands in front of himself "like a begging dog" and grimaced. He reported these changes to healthcare staff before the man's voluntary transfer to the mental health ward at HMP Preston. His opinion, in common with other staff who dealt with the man, was that he should not have been in Wymott because of his mental condition.

59. The man spoke to a Listener early on the evening of 10 July about his anxieties. Later he was happier and mixing with other prisoners on G wing. However he told G wing staff at 10.30am on 11 July that he had taken ten paracetamol at about 8.00pm the previous evening and a further two that morning. A nurse contacted the poisons unit at St. Thomas' Hospital, London who advised that if the man weighed over 80kg his body should be able to cope with the paracetamol levels indicated. The man was 87.5kg and so no medical intervention was necessary. The nurse contacted the MHIT RMN who saw the man later that day and noted that he gave recurring flashbacks as the reason for taking an overdose. The MHIT RMN planned to see the man again on 14 July and requested a review by the psychiatrist after his return from annual leave.

60. Preston mental healthcare staff visited and saw the man on 15 July and agreed to accept him for a period of assessment the following day. The man then attended an ACCT review. It was agreed between him and mental health staff, (including those from Preston) that the ACCT process should remain in place and be reviewed on his reception at Preston. During the

meeting, the man said that he was concerned that he would “do something stupid” if the ACCT process ceased.

61. The man was received into healthcare at HMP Preston during the late morning of 16 July where his medication was continued as prescribed at Wymott. At 1.55pm he spoke to a registered mental nurse and expressed thoughts of harming himself because he was anxious about whether or when he could return to Wymott. He had an ACCT review at 4.45pm and told the staff that he had current thoughts of harming himself. The ACCT process remained open. He was observed hourly throughout the day and night and was reported to be more settled during that evening.

62. Over the following few days, the man settled down although he repeatedly asked when he would return to Wymott. He periodically said that he was experiencing thoughts of harming himself and was depressed. The man had a further ACCT review on 21 July. He became more persistent about his return to Wymott and reported that he was being bullied by other prisoners. He became adamant that he no longer wanted a psychiatric assessment or to remain at Preston and signed a disclaimer to that effect. Arrangements were made with the MHIT and Wymott for him to return on 24 July.

63. On 23 July, the man was in good spirits and went to an appointment at a local hospital about his two episodes of fainting earlier in the year. On his return to Wymott on 24 July, no change in the man’s health was recorded and he was considered to be physically fit. He underwent his sixth ACCT case review that evening. He was in good spirits, although he regretted not being able to complete his assessment at Preston where he said he felt threatened and intimidated by other prisoners. A further ACCT review was scheduled for 28 July. The man was subsequently observed half hourly throughout the night.

64. In the late morning of 26 July, a prisoner told an officer that the man was trying to obtain paracetamol from other prisoners. He spoke to the man then searched him and his cell but found no medicines. He spoke to him again at about 5.00pm. The man was very subdued and anxious that he may be moved from G wing although no such move was planned.

65. At 11.05am on the morning of 27 July, the man asked a member of staff for a sticking plaster. He said that he had caught his arm on his door bolt but emphasised that it had not been a deliberate act. At 2.30pm, he made the same request but this time he had made superficial cuts on his wrists with a razor blade which he said he had inflicted because of flashbacks. Healthcare staff treated him and, later that afternoon, the G wing SO, his ACCT case manager, and an officer reviewed his case. The man appeared to have no other coping mechanism other than cutting himself. The officer demonstrated an alternative strategy which would not cause any injury. The man spoke to the officer who had searched him the previous day again at around 4.45pm and was again anxious about moving from G wing.

66. On Monday 28 July, the man was upbeat. He told staff that, although he felt depressed, he was coping and was looking forward to attending work as a

cleaner in the tailors' shop that afternoon. However he later changed his mind telling staff that he did not like one of the prisoners working there and asked to be moved to the laundry. By 11.30am on 29 July, the man was asking staff "every five minutes" to be allowed to work in the laundry but, because of his mental state, his request was refused. The man was moved into a Listener's cell over the lunch period. He attended work in the afternoon and later told the G wing SO that he was being called names and wanted the prisoner involved removed from the tailors' shop. The SO told him that he would open a TAB document so that the situation was monitored.

67. That afternoon, the MHIT RMN reviewed the man who was in a persistent low mood. He felt that his current antidepressant was not helping him and wanted a change back to trazodone. He also described experiencing intrusive thoughts telling him to attack officers and staff which had led to him "pushing past" one of the female instructors.

68. The MHIT RMN confirmed that the incident had taken place and wrote that wing staff should be made aware that the man was feeling violent. He recommended that the man see the psychiatrist as soon as possible and be designated unfit for work due to his mental state. He went to work on the morning of 31 July and was later charged with an offence under Prison Rules for assault on the member of staff. The man told a member of staff that it was the only way he could get out of the workshop and said that he was being bullied. At an ACCT review at 2.30pm that day, he told the staff, which included a member of the MHIT, that he had "seen red" and the instructor reminded him of his childhood abuser.

69. The man asked to see a Listener at 6.10am on 1 August but spoke to the night officer instead, telling him he was anxious that he would lose his privileges as a result of the assault on a staff member. He returned to bed and was asleep again by 7.00am. The man was taken to the Care and Separation Unit (CSU) at 8.45am for a disciplinary hearing. The duty nurse noted that he was fit for the adjudication but was not fit for cellular confinement (a possible punishment if found guilty). The case was adjourned and referred to the Wymott police liaison officer who considered that there was not enough evidence to take police action for indecent assault. He later warned the man about his behaviour.

70. Following the outcome of the adjudication and his return to G wing, the man made superficial cuts to his wrists with a razor blade. He was seen as an emergency by the nurse and the wounds were dressed. At about 4.00pm, he took part in an ACCT review. The MHIT RMN, who was at the review, said he would discuss the alteration of the man's medication with the psychiatrist.

71. A nurse was called by wing staff to see the man at 6.15pm on 3 August. He complained of vomiting and had a rash round his eyes, nose, ears and forehead but was otherwise well. The nurse advised him that, if the rash got worse or spread, he should report it to staff immediately. The nurse returned at 7.30pm and noted that the rash had reduced but was still on his face. The prison doctor examined the man the following day and reviewed his pain relief

medication. The man's co-codamol prescription was stopped and he was given Piriton (an anti-histamine) and Gaviscon (for heartburn and indigestion) to alleviate his symptoms. A note was made that, should the man vomit again, he should be referred to the A&E department at the local hospital.

72. During 4, 5 and on the morning of 6 August, the man asked to speak to Listeners. He stayed in a Listeners' cell with two Listeners over lunchtime on 6 August. The MHIT RMN reviewed the man again that afternoon after which he contacted the psychiatrist who agreed to increase his mirtazapine prescription. The MHIT RMN wrote to the prison doctor requesting the change. He also planned to speak to the counsellor who saw the man earlier in the year to establish whether he was suitable for a further period of support from her.

73. The Salvation Army chaplain at Wymott spent some time with the man in the chapel during the morning of 7 August and commented that he appeared relaxed and comfortable. However, later in the morning the man complained about another prisoner calling him names. Later the same day, he was wandering about the wing "acting strangely" and asking to see a Listener. However, when the Listeners arrived, he ignored him. Over the following few days the man made further requests to see Listeners. He also became agitated on a number of occasions because healthcare staff were late arriving on G wing to issue medication. His mood fluctuated between high spirits and telling jokes to staff and being agitated or in a low mood. During his next ACCT review on 11 August, he said he was still anxious about the outcome of his adjudication and that he had asked for a transfer to HMP Usk.

74. The MHIT RMN spoke to the man at around 12.30pm and again at 4.00pm on 14 August. The man complained at the later meeting that the provision of his mirtazapine at 45mg was erratic, as he often only received 30mg. The relevant Prescription and Administration Chart indicates that the man received 30mg until 11 August after which the dosage was increased to 45mg. Despite the increased prescription the man felt no better and the MHIT RMN noted that he was due to see the psychiatrist in about two weeks.

75. Wing staff noted that during the next few days the man was wandering around the wing and often seemed anxious until he received his medication. He also spoke to Listeners on 19, 20 and 21 August. Throughout this period he was observed to have restful nights and mixed well with his peers on the wing. On Sunday 24 August, he was recorded by the officer, who had offered advice about coping strategies, as spending most of the afternoon waiting near the wing treatment room for his medication. The same officer noted the following morning that the man was again outside the treatment room waiting for his medication. The man made the effort to speak to the officer and tell some jokes and said that he had followed the advice about coping strategies instead of cutting himself. Another officer later also recorded that the man was often waiting outside the treatment room.

76. The man was now working in the commercial engineering workshop full-time and it was recorded on 26 August that he was happy there. During an ACCT

review, he said he had no issues with his medication and no problems on G wing. He did however say that over the past week he had thoughts of harming himself but re-iterated that he had overcome them and spoken to Listeners. A decision to extend the ACCT process for a further seven days was made and the next review was scheduled for 1 September. He remained in good spirits for the next few days.

77. An officer, a Counselling, Assessment, Referral, Advice and Throughcare service (CARATs) worker, spoke to the man on 28 August. The man told him that he was having flashbacks and was not feeling well but was not worried about harming himself. (CARATs is a scheme for prisoners with substance misuse problems that gives advice and support, runs programmes and refers them to other services.) The man asked the officer if CARATs staff could see him on a monthly basis. He noted that the man was more mobile and lucid than he had appeared lately.

78. The following day, the psychiatrist and the MHIT RMN reviewed the man. He appeared to have deteriorated and they noted that he grimaced involuntarily. He initially agreed to a change in his antidepressant medication but, as the meeting concluded, changed his mind and said he wanted to remain on his current prescription. The MHIT RMN undertook to monitor the man's response to his medication and to see him weekly if possible. The psychiatrist planned to see him again in four weeks, when he would conduct a neurological examination.

79. At 8.45am on 30 August, the man pressed his cell call bell and told wing staff that he had cut his wrist with a razor blade in response to a flashback. He also told staff that he had flushed the blade down the lavatory. On searching his cell officers found a bloodied razor blade hidden in a cupboard. Healthcare staff cleaned and dressed the wound. An ACCT review was convened that afternoon where the man apologised for his actions. Staff again advised him about coping strategies. He remained settled for the remainder of that day but seemed periodically anxious about his medication the following day.

80. When he returned to work on Monday 1 September, the man's mood was stable and he remained settled until 9.30am on 3 September, when a member of the workshop staff saw him scratching at his arm with a small clip. He was taken to the healthcare centre but no treatment was required. Later that day, the man attended an ACCT review where he explained that he had attempted to harm himself because he was experiencing flashbacks. He apologised for causing any trouble. The tone of this review was more robust than usual in that the MHIT RMN told him that he must take responsibility for his actions, for using his coping mechanisms and listening to advice. The man agreed that he would try and the MHIT RMN referred him for further counselling regarding his alleged childhood abuse. The workshop staff also agreed to allow the man back to work on a last chance basis.

81. On 4 September, the man saw the Salvation Army chaplain, as part of a regular interaction. The chaplain said that they discussed some of his

problems and the man was anxious to see him again the following Thursday. The man remained calm and in a positive mood for several days, although anxiety about when or whether he would get his medication was always present.

82. During the man's ACCT review on 10 September, the staff present, including the MHIT RMN, agreed that there was no justification for the suicide and self-harm monitoring process to continue. The man became very concerned and said he would feel better if it were left in place. After a lengthy discussion, a compromise was reached to keep the process open until 16 September. Another prisoner reported to workshop staff on 11 September that the man tried to obtain the other man's prescription medication. He denied the accusation.

83. The man was given two paracetamol on 12 September after reporting "special sick" complaining of a headache. On the same day, while waiting to see the psychiatrist in the healthcare centre, the man claimed that other prisoners were bullying him over the assault on a female staff member. Healthcare staff recognised this was his strategy to get staff to send him back to G wing before seeing the psychiatrist and moved him to another waiting room. On examination, he was found to have rigidity in his upper extremities, tremors and was grimacing. The doctor felt the symptoms could be related to the olanzapine prescription and instructed that the dosage be reduced gradually and be stopped after six days. The reduction started on 16 September and ceased on 21 September.

84. On 16 September, the man was allowed to stay with a Listener in his cell over the lunch period. An ACCT case review was conducted at 3.00pm where the subject of closing the process was discussed. The man did not initially agree but when it was explained that there would be no decrease in support for him he agreed and a post closure review was scheduled for a week later. On the following morning, he became very anxious because he was not required for work. An ACCT case review was convened at 9.30am and monitoring under the process was reactivated, although the man assured the meeting that he had no intention of harming himself. The Salvation Army chaplain saw him on 18 September and thought he was relaxed and on a more even keel and they discussed the possibility of him starting an art course. The man later reported "special sick" with a headache and was given two paracetamol tablets.

85. At about 8.00am on Friday 19 September, the man asked wing staff if he could speak to a Listener. The duty officer asked him if he could wait 15 minutes until cells were unlocked and the man agreed. No record of him seeing a Listener is available but at 8.52am he told an officer that he had taken 24 paracetamol and 12 Brufen (ibuprofen, a painkiller) tablets at about 8.15am. Healthcare staff were called who administered carbomix (a charcoal based medication administered to absorb toxic substances in the stomach) and he told them he had only swallowed 15 tablets. A nurse reported the matter to the doctor and MHIT and undertook to perform a blood test four hours later. These tests revealed that the levels of paracetamol and salicylate

(a substance found in aspirin based medicines) in the man's blood were below that which could be detected by analysis at the local hospital.

86. At lunch time, the man asked to be put in a cell with a Listener and, later in the day, he took full part in the association period with other prisoners and collected his medication as normal. The night officer checks made on him during that night indicate that he appeared to sleep throughout. The man remained positive during that weekend until late Sunday morning, when at 11.45am staff were told that the man was trying to obtain paracetamol from other prisoners. He and his cell were searched but no medicines were found.

87. During the morning of 22 September, the man went to work and had a good morning there. Later in the afternoon, he went to the chapel and took part in an Alpha course (a course on the basics of the Christian faith, which is described as an opportunity to explore the meaning of life). Three reports by staff on that day say that he thoroughly enjoyed the course and was in an upbeat mood. The man used the "special sick" procedure and obtained two paracetamol for a headache. He remained in a positive frame of mind until lunchtime on 23 September when he asked to speak to a Listener and remained in the Listener's cell over the lunch period. At 3.30pm, he attended an ACCT review and said that due to his continuing flashbacks he felt low but that the Alpha course was the only positive thing.

88. On the morning of 24 September, the man told workshop staff that he was having flashbacks. They considered that the risk of keeping him in the workshop was too high and sent him back to his wing. Later in the morning, he spoke to the Salvation Army chaplain and became more relaxed. He used the "special sick" process again to obtain two paracetamol tablets. The man remained anxious for the rest of the day and at 5.10pm used the Listeners service. At 7.30pm, he was still anxious and ten minutes later he was reported by prisoners to be asking others for medicines. A G wing SO and other wing staff recovered an unspecified quantity of paracetamol tablets from him. She, the SO, considered that the man required excessive staff resources. She contacted a Registered Mental Nurse (RMN) and member of the Primary Care Mental Health Team (PCMHT), who told her that the man was due for a computerised tomography (CT) scan which he would try to bring forward. (A CT scan is a computerised x-ray process which shows more detailed images than those from a traditional x-ray.)

89. During the late evening of 24 September, the man appeared to have settled. However, by 11.00pm he had attracted the attention of the night patrol officer, and asked for a Listener because he was having more flashbacks. When officers came to unlock him, he refused to speak to the Listener. Half an hour later, just after midnight, he again rang his cell call bell and again asked to speak to a Listener. The Listener went into the cell with him for about 40 minutes but later told staff that the man had not spoken to him and appeared to be abusing the Listener system. At just after 2.30am on 25 September, the man rang his cell call bell complaining that he was continuing to have flashbacks and that the Listener could not give him any advice. The night patrol officer asked him if he had hurt himself. He replied he had not, so she

advised him to get some sleep and see healthcare staff the following day. The man seemed content and went to bed. The night patrol officer noted that the man had used the cell call bell on 15 occasions that night and asked day staff to speak to him about abusing the facility.

90. At 8.00am, the officer conducting the roll check reported that the man was feeling unwell and had vomited into his cell lavatory. (The roll check is the physical count of the number of prisoners on each wing.) At 9.00am, he attended the chapel where, the Salvation Army chaplain said, he was clearly unwell and anxious about not going to work. At around midday an officer said that the man appeared very vacant and confused. He therefore telephoned healthcare staff and asked them to check him when he collected his medication. The SO wing manager also contacted healthcare staff in the early afternoon raising concerns about the man's health and mental state and asked them to see him. Two Staff Nurses examined the man at around 2.45pm and said that he appeared to have deteriorated. They noted that he had a shuffling gait and his arms and hands shook. They described him as vacant, only answering questions after a pause and noticed a rash around his eyes and head which he told them he had been scratching. The man also told them he was feeling low and felt unwell. One of the nurses tried, during the afternoon, to contact MHIT staff, without success. She eventually left a voicemail message for the PCMHT asking them to assess the man.

91. A PCMHT RMN assessed the man at 7.15pm on G wing. He noted his physical condition, including the rash on his forehead and swelling below his eyes. The man said that these were not bothering him, in contradiction to what he had told nursing staff earlier. The PCMHT RMN made a three point plan for the following day requesting a routine blood test, an ECG and planned a discussion with Inpatient Services at HMP Preston, with a view to them admitting the man to a regional mental health bed, at the prison, for assessment. By 7.45pm the man had gone to bed and slept through the night.

92. At 8.00am the following morning, Friday 26 September, the man was anxious. Despite the arrangements made by the PCMHT RMN, the man went to the workshop and missed his medical appointment. A request for a full medical and mental assessment was however sent to Preston at 10.00am, who responded that they would arrange an assessment the following Monday. The man remained anxious and returned to his wing in the middle of the morning. He was reassured by wing staff about his removal from the workshop which he appeared to accept. An officer spoke to him around 12.30pm after he had collected his medicine and lunch and he appeared happy. Ten minutes later, he said that he felt low about losing his job and asked to speak to a Listener, with whom he spent the lunch period in his cell. Later, in the evening he was mixing with other prisoners and engaging in conversation with staff. A wing SO thought he seemed more settled than earlier.

93. The man appeared to sleep during that night but rang the cell call bell at 5.55am on Saturday 27 September. He told the night patrol officer that he

was depressed and experiencing flashbacks. She offered the use of a Samaritans telephone (a telephone dedicated for use by prisoners who want to contact the local Samaritans service) but he declined. She spoke to him for a few minutes finally advising him to try to get some sleep. At 8.00am, the man told the officer unlocking the cells, that he felt depressed. The officer said that it would be about half an hour before a Listener could speak to him which he accepted and replied that he was going to get some rest. The officer noted in the man's ongoing ACCT observation record that he had made comments about depression and feeling sick. The man had a quiet day punctuated by sleeping and collecting his medication. An officer did however note at 4.30pm that the man had missed his lunch but he would ensure that he received his evening meal. The man was checked by evening and night duty staff and appeared to sleep through the night.

28 September

94. At 6.05am on the morning of 28 September, the man told the night officer that he wanted to speak to a Listener but was asleep when the day staff saw him at 8.00am. He later went to chapel.

95. In a note retrospectively made in the man's Continuous Clinical Record on 29 September, a nurse said that she was told by wing staff that the man had complained of coughing up blood. She checked him at around 2.00pm but saw no evidence of the condition. She noted that he had complained recently of similar events, although no record of them is available. The nurse also saw the man at about 3.30pm when she dispensed his medication and asked if he had coughed up more blood. He had not and said he felt alright.

96. A G wing officer, spoke to the man several times during the day and said he appeared "quite chipper". He told her at around 11.30am that he was going to have a sleep in the afternoon. When she saw him again later, he said that he could not sleep and wandered off aimlessly about the wing. He spoke to her later and asked if she thought he would ever get over his depression. She told him that with the right help from the MHIT it was possible. He told her that he was going to the chapel on Monday which he said he enjoyed.

97. At about 4.30pm, prison staff on G wing began locking prisoners in their cells. The officer locked up G1 landing after the prisoners returned with their meals. When she locked the man's cell, G1-17 she saw that he was in bed and had not collected his meal. After locking up the cells she spoke to the officer in charge of the food servery, who confirmed that the man had not collected his tea or his breakfast pack. (Prisoners are given a plastic bag pack containing the following morning's breakfast at the same time as they collect their tea.) They were aware that the man had taken his lunch. The officer thought that going without food for 24 hours from lunchtime to lunchtime was too long, so she took a breakfast pack to the man in his cell. When she arrived, he got out of bed and collected the pack from her and wished her goodnight. After leaving his cell she went to the wing office and made her final observation entry in his ACCT document at 5.00pm.

98. On weekend evenings, prisoners on G wing remain in their cells. There is a single patrol officer on the wing and the period is known as “patrol state”. The evening patrol officer in charge of G wing on the evening of 28 September had worked for the Prison Service for three months at the time. The patrol officer carries a pass key to allow him access to the wing but because he is on his own does not carry a cell key. He does however carry a sealed pouch containing a cell key for access to cells in an emergency if it is safe to do so. He also carries a radio.

99. The evening patrol officer took over at about 5.25pm following a briefing by the day duty senior officer. He checked the five open ACCT documents on the wing noting the frequency of visits required by each. He remembers that the man who died was last visited by staff at 5.00pm and required one visit during the evening. The evening patrol officer then went round the wing ensuring that all cell doors were shut, including G1-17. At about 6.00pm, he answered a cell call bell on G2 landing and spoke to the prisoner requiring attention. Just after 6.20pm he went round the wing counting and checking all the prisoners.

100. When the evening patrol officer reached G1-17 he saw the man lying on his back on the floor. His head was underneath the bed on the left side of the cell with his body and legs stretched across the cell towards the cupboard on the right side. The man was wearing only his boxer shorts which were around his lower legs. He also saw a patch of brownish vomit on his chest. The evening patrol officer called him by name several times while knocking and kicking the door but got no response. He radioed the prison control room at 6.25pm asking for medical assistance for a Code Blue emergency on G wing. (A Code Blue call signifies that the patient is experiencing breathing difficulties or is not breathing.) No further details are given across the radio network for security reasons. He then ran to the wing office, where he telephoned the control room to give them more detail.

101. Returning immediately to the cell, the evening patrol officer met the orderly officer, who in response to the radio message had come to the wing via the outside door next to G1-17. (The orderly officer is the member of staff in charge of the prison during the patrol state.) The evening patrol officer told the orderly officer what he knew and, after looking through the observation panel, he went into the cell. The evening patrol officer remained outside. The orderly officer went in, stepped over the man, turned towards the door and knelt beside him. He tried to get a response from the man by shouting his name and shaking his arm. He also tried to find a pulse in his neck but found no signs of life. He said that the man was warm to the touch.

102. Control room staff contacted the healthcare centre just after 6.25pm and told the duty nurse, that there was a Code Blue emergency on G wing. She went immediately to the wing, entering through the outside door adjacent to G1-17, arriving at the cell a few minutes after the orderly officer who told her the man was not breathing. She told him to start cardiopulmonary resuscitation (CPR) and to call an ambulance. She then went to the wing treatment room on the second landing to collect the emergency response bag and defibrillator. (A

defibrillator is a portable electronic device which measures electrical activity in the body and advises on action to be taken.) At Wymott emergency response bags containing medical equipment are held in wing treatment rooms so that medical staff have access to appropriate equipment on arrival rather than trying to hurry to a medical emergency carrying a heavy bag of equipment having first collected it from HCC. The treatment room on G wing is about 30 yards away from the man's cell and up one set of stairs. The control room log shows that orderly officer used his radio to ask for an emergency ambulance which was called at 6.33pm.

103. While the duty nurse was away from the cell, two officers arrived. The first officer to arrive went directly into the cell to assist the orderly officer in giving the man CPR. The other officer, observing from outside the cell, said that from the man's position on the floor and the faeces on the back of the lavatory, it was his impression that he had been using the lavatory, had risen from it and fallen forward to the floor.

104. The duty nurse arrived back at the cell a few minutes later with the emergency bag. She attached a defibrillator to the man's chest and allowed the machine to cycle through its automatic process. It did not detect a shockable rhythm and CPR was continued. This process was repeated several times. The man was not breathing and the nurse could not find a pulse, or get a reaction from his eyes by shining a torch into them.

105. From what he had seen of the man's condition the officer that had remained outside the cell formed the opinion that he may already have died. He went to the Security Department office to collect a camera to photograph the cell and returned about five minutes later. When he returned, he saw that the man had been moved to allow resuscitation attempts to take place but took a series of photographs. Those photographs are no longer available having been deleted from the computer on which they were stored.

106. Prison staff continued CPR until a paramedic from the local ambulance service arrived at around 6.45pm. The duty nurse briefed him on the man's condition. He removed the prison defibrillator from the man's chest and attached the one he had brought with him. At around 6.50pm two further ambulance crew joined their colleague at the cell. The paramedics could get no response from the man and they confirmed a few minutes later that he had died.

After the man's death

107. After confirmation of the man's death the orderly officer left the assistant orderly officer at the cell and returned to the control room to implement Wymott's contingency plan for a death in custody. When he arrived at the control room the duty governor was there and was aware of the situation. The orderly officer confirmed the man's death to the duty governor and between them they fully implemented the contingency plan. All individuals and organisations identified in the plan were told of the death and the log completed. The duty nurse told the healthcare manager and the local PCT.

108. Immediately after the man's death his cell was locked and an officer was appointed log keeper outside cell G1-17. In these circumstances a log keeper maintains written notes of staff, police and other legitimately interested people visiting the cell and any relevant actions. He remained at the cell maintaining the log until relieved at 9.00pm.

109. A police sergeant and police constable went into the cell at 8.07pm. Later, at 8.20pm a member of staff from Wymott Independent Monitoring Board visited the cell. At 9.05pm, the Governor, the police constable and two funeral directors removed the man's body which was taken from the prison to the mortuary at the local hospital.

110. The duty governor held a hot debrief for prison staff involved before they went off duty. (A hot debrief is a meeting for staff to discuss emotive issues and any lessons learned following serious events such as deaths in custody.) A member of the Wymott Care Team also spoke to all staff that were on duty at the time of the man's death and offered them support.

111. As the man's next of kin details were not up to date, the Governor asked the senior probation officer at Wymott to trace any family. He made exhaustive efforts using Probation Service and police resources to contact both the man's family and his last named next of kin. He was unsuccessful but police later traced and broke the news to his nominated next of kin.

112. A post mortem was held on Tuesday 30 September at the local hospital. During the examination, a wrapper containing a biscuit was found in the back of his throat obstructing his airway. Another similar wrapper was found in his mouth. Post mortem samples of blood were examined which found that the man had traces of mirtazapine and olanzapine. These were deemed by the pathologist to be at a level within the therapeutic range and played no part in the man's death. The pathologist concluded that the cause of death was:

- acute upper airway obstruction and
- choking on foreign material (biscuit encased in wrapping)

113. The Salvation Army chaplain arranged and officiated at the man's funeral at the local crematorium. The prison met the expenses. The funeral was attended by two funeral directors and crematorium staff. Following the cremation, a memorial service was held in the chapel at Wymott and was well attended by the man's friends and some staff. His next of kin was present and, following the service, received his property. He also took away the man's ashes for burial in his parish churchyard.

ISSUES CONSIDERED DURING THE INVESTIGATION

Clinical care

114. A clinical review was commissioned from the Central Lancashire Primary Care Trust and was carried out by the Head of Healthcare at HMP Haverigg. The review was received in February 2009.

Physical health

115. From the outset, the man was in close contact with healthcare staff. He had no significant physical healthcare issues on reception, except an old sporting injury to his right knee for which he received appropriate pain relief medicine. He was referred to the local hospital and an operation was planned which he declined, electing instead to continue wearing a knee support and take analgesics. He cancelled all subsequent appointments.

116. The man gradually became much more focused on his medication, particularly the analgesics. He made a series of formal complaints about variations in his medication which attracted appropriate responses. In the main, his prescriptions had been varied by doctors and were responsive and proportionate to his needs. However, one of the man's medicines (trazodone) had been stopped suddenly at the beginning of November for no apparent reason. The prescribing psychiatrist wrote to the Lancashire Care NHS Trust about the abrupt stopping of the drug. There is no recorded outcome resulting from that letter.

117. The man's worsening physical appearance during 2008 caused concern among healthcare and wing staff. During early August, the man had a rash around his eyes, nose, ears and forehead and complained of vomiting but was otherwise well. In the early morning three days before his death, a wing officer reported the man vomiting in his cell. At around midday, the wing manager was concerned about him and asked healthcare staff to see him. Two staff nurses did so and saw deterioration in his physical condition. Primary Care Mental Health Team staff were asked to assess the man urgently and saw him that evening. A blood test and ECG were requested for the following morning and arrangements were made with wing staff for the man to attend healthcare. However, he went to work and missed his appointment. A referral to HMP Preston for a medical and mental assessment was made later that day but he died before that assessment took place.

118. The clinical reviewer comments that staff at Wymott felt that the man had "impaired mental clarity, poor motivation and concentration". It is of concern that there appears to be no robust method to ensure that a patient, who is mentally unwell is reminded or encouraged to attend appointments. While it would be wrong to compel prisoners who decline or refuse treatment, it is of concern that a man who was anxious and depressed missed appointments because of his incapacity.

The PCT and Governor should put in place a robust process to ensure that prisoners with reduced mental capacity attend their appointments with healthcare professionals.

119. The man was again examined by a nurse on the afternoon before his death, having complained that he was coughing up blood. She saw no evidence of it but was aware that he had complained recently of similar events. The nurse saw the man later that afternoon to dispense his medication and he told her that it had not happened again.

120. Commendably the G Wing officer was concerned that the man, having missed his tea meal and not collected his breakfast pack, would not eat again until mid-day on the following day. She took him a breakfast pack before going off duty. He was alone in his cell. He wished her goodnight and appeared quite normal to her.

121. The man was found collapsed in his cell an hour and a half later and was pronounced dead half an hour after that. A post mortem examination indicates that he died as a result of an obstruction, a wrapped cereal bar which was part of the breakfast pack, in his throat. How that obstruction got into his throat is not known. However the officer who gave him his breakfast pack should not feel that she was responsible for the man's death.

122. When the man was found, the single nurse on duty at Wymott attended. On her arrival at the cell, she relied upon the assistance of a first aid trained prison officer to continue CPR while she collected equipment from the wing treatment room. The outcome of the attempt to preserve the man's life is unlikely to have been different had more than one nurse been present. However, both the clinical reviewer and HM Chief Inspector of Prisons, in paragraph 4.7 of her 2008 report, indicate that a single nurse on duty at Wymott at this time of day is unsatisfactory. The staffing profile recommends three duty nurses. The clinical reviewer recommends a review of staffing levels and an increase to meet the optimum level. I agree.

The PCT should review nurse staffing levels to ensure that adequate nursing cover is available at all times.

<u>Mental health</u>

123. Within a few weeks of his recall to prison, the man had undergone mental health screenings at two prisons and held his antidepressant medication in-possession. He was referred to the MHIT and saw a psychiatrist in September 2006, who thought his mental health issues were brought about by suffering sexual abuse during childhood and consequently, he suffered auditory hallucinations.

124. The clinical reviewer identifies that no previous records from the community were available in the man's medical record and that healthcare staff do not routinely request community records or information. She concludes that "it may not be relevant to the care the man received but should be a

consideration for its relevance in other incidents". An inspection by HMCIP, which took place soon after the man's death, found that the mental health in-reach team were able to access the past history of local patients through the mental health trust electronic records. However, if they were from other areas new records had to be started. The MHIT RMN made an action note in August 2006 to seek further information from outside agencies about the man. There is evidence to suggest that he did so, indeed his interaction with and knowledge of the man suggests that he probably had such information. He did not, however, record or file that information in the man's medical records.

125. There is no record of staff seeking the man's permission to request his previous medical and mental health records. No-one appears to have made a formal request for such records or, if they did, the request and its outcome were not recorded. In the normal course of events, as time progresses, historical information of that nature becomes less pertinent but at the outset could be an important factor in the decisions made by clinicians. I fully endorse the clinical reviewer's view that this did not affect the treatment the man received, but it is conceivable that in a different set of circumstances that information may be important.

The PCT should ensure that staff comply with the requirements of PSO 3050 (Chapter 2, Retrieving Information) regarding the acquisition of previous medical and mental health records.

126. During the following months, the psychiatrist altered the man's medication as appropriate and referred him to a cognitive behaviour therapist. Mental health staff continued to review the man regularly and, following deterioration in his mental health, his antidepressant medication was varied and increased. In late 2007, an anti-psychotic drug was also prescribed and the dose was steadily increased. In early January 2008, the psychiatrist discussed with the man his intention to start him on another antidepressant drug. He was unable to prescribe it immediately and arranged, with the man's agreement, to make the prescription on his next visit some weeks later. The next day, the man wrote a letter of complaint to the MHIT RMN about not yet receiving the new prescription. In an attempt to alleviate the man's worry, the nurse arranged for the medication to be given to him a few days later. However, no note to document that event is evident on the prescription chart or in the medical record. The only indication that the drug was dispensed is in a response to a formal complaint made by the man about not receiving it. The response identifies that he received an interim supply of tablets and a further supply a few days later. I am satisfied that the drug was prescribed and issued to the man, but the lack of documented evidence is of concern.

The PCT must ensure that staff adhere to the Nursing and Midwifery Council guidelines and on record keeping is consistent with all current professional guidance. Medical record entries should include the accurate completion of medication prescription and administration charts.

127. In February, the man missed his next appointment with the psychiatrist but was seen in mid-March when his condition had worsened. During this assessment he reported auditory hallucinations that told him to hit figures of authority. He also said that he was being bullied by other prisoners, an accusation he made frequently in support of various requests. The man also claimed that he had recently taken five overdoses of analgesics. None of these overdose events were reported to or witnessed by prison staff and, consistent with previous assertions, he denied having ideas of self-harm. During early April, the man had become withdrawn from staff and prisoners. Later in the month, he declined to see the psychiatrist after becoming anxious about being in the healthcare waiting room, a pattern he repeated on several further occasions, resulting in missed appointments.

128. In response to concerns raised in early May about the man's deteriorating mental health, a full physical examination was requested to take place in a series of appointments over the following week. The man became anxious while waiting for the final appointment and returned to his wing before the tests were completed. He refused to see the psychiatrist and MHIT RMN in the Healthcare Centre. In mid-May, a voluntary referral was made for him to transfer to a regional mental healthcare bed at HMP Preston for assessment but he became anxious about the move and it was postponed. The senior psychologist, reacting to concerns about his mental condition, removed the man from a proposed SOTP course.

129. Having missed several more appointments, the psychiatrist visited the man on his wing for about ten minutes, insufficient time to complete a meaningful review. However, further blood tests were carried out and the results triggered a further increase in his medication after which, on several occasions, the man became incontinent. In an attempt to reduce his anxiety he was put on the waiting list for a place in Wymott's unit for elderly and disabled prisoners.

130. Wing staff reported a further deterioration in the man's condition highlighting rigidity in his body and involuntary contortion of his face. In mid-July the MHIT RMN, with the man's agreement, reactivated the voluntary referral for assessment at HMP Preston. He was quickly assessed by Preston mental health staff and transferred the following day. He immediately became anxious about his return to Wymott and over the following days became more insistent that he no longer wanted to remain at Preston. In support of that decision, he reported that he was being bullied by other prisoners. It was evident to mental healthcare staff that in his current state of mind the man could not draw benefit from the assessment and, as a voluntary patient, he was returned to Wymott eight days after arrival.

131. The man's mental condition took a worrying turn when he reported hearing voices telling him to attack prison staff. Wing staff were warned and he was referred to the psychiatrist. The following day, he assaulted a female staff member. His explanation was that he was being bullied and it was the only way he could get out of the workshop. Later, he gave a different explanation saying that he had assaulted her because she reminded him of his alleged

abuser. He was assessed by a nurse prior to his adjudication hearing, who deemed him fit for the procedure although not for cellular confinement. The case was adjourned, referred to the police and the man was eventually warned by police regarding his future conduct.

132. The man's antidepressant medication was again increased. Although his concern about obtaining his medication was ever present, that anxiety increased markedly whenever there was a delay in issuing it. His moods fluctuated between high spirits and low moods and/or agitation. The psychiatrist found increased rigidity, grimacing and tremors, symptoms which he attributed to the anti- psychotic drug. In response the medication was reduced over six days until cessation and a neurological examination was requested for one month later.

133. On Thursday 25 September, wing staff reported that the man was clearly unwell and anxious. Nursing staff also noted a marked deterioration in his condition. He was seen during the evening, as an urgent case, by a Primary Care Mental Health Team nurse who arranged for blood and ECG tests the following morning and planned to discuss the man with Inpatient Services at HMP Preston. The following morning the man remained anxious, went to work and missed his appointment. (I have made a recommendation on this point earlier in my report.) At 10.00am, a request for a full medical and mental assessment was sent to Preston who said they would arrange it the following Monday. The man remained anxious but appeared to improve during that day.

134. The clinical reviewer recommended that the referral process to Preston in-patient facility be reviewed. Her view is that the assessment agreed for the man between Wymott and Preston to be arranged on Monday 29 September may not have prevented his death, but the availability for assessments to take place over the weekend, and I would add any other public holiday period, would improve the referral process to prevent delays in transfer. She recognised that to do so would increase staffing levels at Preston. With minor modification, I re-iterate that recommendation.

The PCT and Governor should review the referral process to the HMP Preston In-Patient facility, with a view to putting in place out of hours assessments of patients who may need to transfer.

135. The day before his death, the man told staff he was depressed but refused the use of a Samaritans telephone. At 6.05am on Sunday 28 September, he asked to speak to a Listener but was asleep when staff went to his cell. He spoke to healthcare staff and a wing officer several times and was thought to be in good spirits. They spoke about his depression and he told the officer that he was looking forward to going to the chapel on Monday. When the officer took his breakfast pack to him in his cell nothing in his demeanour or mood alerted her to any change. The man was pronounced dead two hours later.

136. Owing to his deteriorating mental health, the man required a high degree of input from healthcare, mental health specialists and wing staff over his time at Wymott. His case underlines the difficulties in managing mental illness in a prison environment and the view was expressed by some wing staff that he should not have been at Wymott. Their view being that he would have been better served by being transferred to either a health service or prison establishment specialising in mental healthcare. It is a view echoed generally in the IMB annual report for 2008-2009 but the clinical reviewer made no comment on this aspect.

137. The man's case was managed on a daily basis by wing and healthcare staff who were aware of and reactive to his needs. It is my judgement that the man received treatment at least equitable to that he could have expected in the community. I have found that he was given thorough, detailed and individualised support from a range of professionals who worked consistently together. I also note that wing staff and managers were sympathetic and supportive throughout.

Self-harming

138. The man was recalled to prison having been released a year previously. He was known to have self-harmed during his earlier custodial period and had been subject to suicide and self-harm prevention measures. Although he was a depressive, he regularly maintained that he was not at risk of harming himself. He told the psychiatrist in March 2008 that he had taken a total of five overdoses of analgesics during the recent past. None of these events were reported to or seen by prison staff and he again denied that he had any intention to harm himself.

139. As prison staff were unaware of these instances, implementation of the suicide and self-harm monitoring process was not considered as a result of the man's revelation. However, the man's assertion was rightly taken seriously and his permission to hold in-possession medication was immediately withdrawn, except for a single analgesic tablet in-possession daily. Immediately after the psychiatrists review, the man tried to obtain additional analgesics in-possession from healthcare staff. The request was refused and the nurse correctly completed a security incident form in relation to the attempt. The man maintained that he was not at risk of harming himself.

140. At the end of June, the man began harming himself by superficially cutting his arm with a razor blade. He was immediately, and correctly, made the subject of the ACCT monitoring procedure. He also reported several times that he had taken overdoses of drugs, which on each occasion turned out to be false. Once on the ACCT process, he quickly came to rely on it for support. Supervising staff made proper efforts to bring it to a close, as the need for it reduced, but the man reacted adversely to the proposal and remained subject to monitoring until his death.

141. The man's death was due to an obstruction, a wrapped breakfast cereal bar, in his throat. Although not certain, it is likely that the man's reported vomiting and coughing of blood just prior to his death was the result of his inserting objects into his throat. Given the evidence in the post mortem of bruising to the back of the throat and the presence of petechial haemorrhages, it appears that this action probably formed part of his self-harming behaviour. His death was due to his own actions and we do not know whether his intentions were to take his life. I judge that the man was well supported by wing, medical and mental health staff at Wymott during his sentence.

Bullying

142. The Chief Inspector of Prison's report commented that there is a strategy to tackle bullying at Wymott but that it was deficient in several areas, namely that staff had not been trained in its use and its application was poor. The Independent Monitoring Board's report for 2008 – 2009 also expressed similar concerns.

143. The man complained of bullying in the last nine months of his life. His complaints were often in support of various requests he made such as to move from Preston back to Wymott, or returning to the wing from healthcare before appointments were fulfilled. On one occasion, staff thought he was being bullied for his medication and opened an anti-bullying document (TAB) which was closed soon afterwards when it became apparent that it was not the case. They were also reactive to his complaints, although it was apparent that they were triggered by his mental condition, again opening a TAB document and closing it soon afterwards when no evidence of bullying was discovered.

144. I am in no doubt that the Chief Inspector's comments were valid and current at the time of the man's death. However, in my opinion the man was appropriately supported in relation to his allegations of bullying whether they appeared to be genuine or as a result of his mental health issues.

Family issues

145. The man was not in contact with any member of his family. He was thought to have no family outside those he alleged had abused him as a child, although he did make references on one or two occasions to other family members. Their whereabouts however is unknown. The people with whom he had corresponded and telephoned were solicitors and probation officers. The man named, as his next of kin, a clergyman who worked in a hostel where he lived prior to his recall to prison. At the Governor's instigation, extensive efforts were made by the senior probation officer at Wymott to contact the man's nominated next of kin or a family member regarding his death. The officer was unsuccessful as the details were out of date. His named next of kin was eventually traced and informed by the police.

146. It is saddening when a prisoner dies without anyone, other than people who deal with them professionally, knowing about their death. There appears to be no standard guidance on the maintenance of next of kin information and I have commented and made recommendations on this in previous investigation reports.

The Governor should implement a formal process to ensure that up to date next of kin data is maintained throughout a prisoner's sentence. An annual check of the information held by the prison should be carried out during the sentence planning process.

147. The Salvation Army chaplain at Wymott organised and conducted the man's funeral which was only attended by the funeral directors and crematorium staff. It is regrettable that no member of the prison management team or wing staff that knew the man represented HMP Wymott at the funeral. The subsequent memorial service was well attended by prisoners and staff. In my view, representation by senior Wymott staff would have been appropriate and within the spirit of the guidance for family liaison officers supplementary to PSO 2710.

CONCLUSION

148. The man had a long history of offending and was known to mental health professionals for many years prior to his recall to prison in 2006. He had regular contact with both primary medical and mental health professionals from his reception until his death almost two years later.

149. Following his recall to prison, he refused surgical intervention to rectify an injury, preferring to be treated by the regular use of analgesics. The medication became problematic in that they gave him an unhealthy focus which, as his mental condition deteriorated, evolved into a fixation with acquiring them.

150. The man's mental health issues were quickly recognised after reception and were appropriately treated. He was monitored and reviewed regularly and his therapies were adjusted as circumstances indicated. Over many months his mental condition deteriorated and he required increasing support which he drew from prison staff, Listeners and medical and mental healthcare professional staff all of whom contributed to a resource intensive support network. It was mentioned during several interviews with staff that the man should not have been in prison at all and staff felt ill equipped to deal with his problems. While this is a view that attracts some sympathy, the reality of the matter is that he was at Wymott, his was a difficult case, and the staff caring for him did so to the best of their ability. I commend them for their continued support for the man.

151. The man's self-harm was either superficial in the case of cutting himself or overstated when claiming to have overdosed. His actions appear to have been a mechanism to cope with his escalating mental problems and were directed at gaining attention rather than a serious attempt to hurt himself. It is likely that his unexplained vomiting was as a result of a similar strategy where he pushed objects into his throat. Tragically, on the evening of 28 September a wrapped breakfast cereal bar became lodged in his throat leading to his, probably, unintended death.

152. The man benefited from continuous review and treatment by mental health professionals and he was well supported by all those staff that regularly came into contact with him. I judge that he received a good standard of care and treatment to manage his medical, and particularly, his mental healthcare needs which was sustained throughout his time at Wymott despite being a significant drain on resources. I judge that the man's death could not have been prevented.

RECOMMENDATIONS

1. The PCT and Governor should put in place a robust process to ensure that prisoners with reduced mental capacity attend their appointments with healthcare professionals.

   The recommendation was accepted and HM Prison Wymott commented that:

   "If prisoners with reduced mental capacity are not attending appointments with healthcare professionals then the following action takes place:

   For mental health appointments or reviews the Healthcare professional visits the patient on the residential unit ensuring attendance or questioning non attendance

   For routine GP / Nurse Practitioner appointments requested by the prisoner, the prisoner is provided with an appointment slip and advised by Residential staff at unlock times of their appointment. There would not normally be a follow up however if a GP has requested to see the prisoner this would be followed up by nursing staff.

   If a prisoner fails to collect routine treatments from the hatch nursing staff would approach Residential Officers to ensure the prisoner is aware he has treatments to collect and ensuring that he receives his medication."

   The action has been completed.

2. The PCT should review nurse staffing levels to ensure that adequate nursing cover is available at all times.

   The recommendation was accepted and HM Prison Wymott commented that:

   "Staffing levels are maintained to ensure there are 3 Nursing staff on duty until they handover to the night shift Nurse."

   The action has been completed.

3. The PCT should ensure that staff comply with the requirements of PSO 3050 (Chapter 2, Retrieving Information) regarding the acquisition of previous medical and mental health records.

   The recommendation was accepted and HM Prison Wymott commented that:

   "Central Lancashire PCT and Lancashire Care Foundation Trust Service managers should review there systems to ensure that the requirements of PSO 3050 (Chapter 2, Retrieving Information) are followed."

   The action is to be completed by March 2011.

4. The PCT must ensure that staff adhere to Nursing and Midwifery Council guidelines and record keeping is consistent with all current professional guidance. Medical record entries should include the accurate completion of medication prescription and administration charts.

   The recommendation was accepted and HM Prison Wymott commented that:

   "All patient records at HMP Wymott are maintained electronically as of July 2010. All PCT staff have received a clinical update regarding record keeping and medicines management to ensure they are aware of and compliant with Nursing and Midwifery Council Guidelines."

   The action has been completed.

5. The PCT and Governor should review the referral process to the HMP Preston In-Patient facility, with a view to putting in place out of hours assessments of patients who may need to transfer.

   The recommendation was accepted and HM Prison Wymott commented that:

   "The PCT transfer policy into HMP Preston in-patient facility has been reviewed and the requirement to assess prisoners prior to admission has been removed. This will enable those prisoners who present with an acute need to be admitted at the earliest opportunity, including out of hours if required."

   The action has been completed.

6. The Governor should implement a formal process to ensure that up to date next of kin data is maintained throughout a prisoner's sentence. An annual check of the information held by the prison should be carried out during the sentence planning process.

   The recommendation was accepted and HM Prison Wymott commented that:

   "A process to ensure next of kin information is up to date has been introduced through the Personal Officers scheme on the residential units. This information is checked at least annually by the Offender Management Unit to inform the sentence planning process."

   The action has been completed.