

**Investigation into the circumstances surrounding
the death of a man in November 2011
at Stoke Mandeville Hospital, while in the custody of
HMYOI Aylesbury**

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

September 2012

This is the report of the investigation into the death of a man, who died in November 2011. He was found hanging in his cell at HMYOI Aylesbury. Despite attempts to resuscitate him, he was pronounced dead on arrival at Stoke Mandeville hospital. He was just 21 years old. I offer my condolences to his family and friends.

The investigation was carried out by an investigator. NHS Buckinghamshire appointed a panel to review the clinical care the man received at Aylesbury. Their review is attached as an annex of this report. Staff at HMYOI Aylesbury co-operated fully with the investigation.

The man was remanded into custody in 2008 and sentenced in 2009. It was not his first custodial sentence. By all accounts, he was a troubled and challenging young man to manage. He had a long history of threatening behaviour and carrying out acts of self harm. He had been assessed for a number of psychiatric and behavioural disorders but was not considered to be seriously mentally ill.

Once in prison, he frequently threatened self harm, although he generally quickly withdrew the threats. He told staff that he threatened self harm in order to get what he wanted and ensure that he was listened to. On one previous occasion before his death, he had been found hanging. He was often monitored under Prison Service suicide prevention measures.

The man was released in October 2010 but was quickly recalled to prison for breaking the conditions of his licence. He arrived at Aylesbury in February 2011. His behaviour continued to challenge both mental health professionals and officers. Our investigation found that there was no clear strategy for managing his behaviour or the risks he posed which meant he was not dealt with robustly or consistently.

No one believed that the man ever genuinely intended to take his life. However, the report concludes that the risk assessments carried out did not fully reflect that his impulsive, reckless and violent behaviour increased the risk of serious harm occurring. Accordingly, the report makes a number of recommendations which highlight our belief that improved processes could lead to safer outcomes for young adult prisoners, at Aylesbury and elsewhere. One general concern to emerge was the apparent lack of understanding that young prisoners may have about the dangers inherent in tying items tightly around the neck as a form of self harm. While I recognise that any attempts to inform suggestible young people of these risks must avoid inadvertently encouraging such risky behaviour, I recommend that the National Offender Management Service undertake research to determine the most effective way for establishments to communicate this crucial message.

This final version of the report reflects both the man parents' and the National Offender Management Service (NOMS) response at the consultation stage.

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

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Prisons and Probation Ombudsman

September 2012

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SUMMARY

1. The man was remanded into prison in July 2008, accused of sexual offences. He was convicted in June 2009 and, in December, was sentenced to three years and six months imprisonment. It was not his first time in custody.
2. He had a history of self harm by a variety of means and he regularly threatened to self harm. He had been assessed a number of times by mental health professionals who had suggested that he might suffer from a range of mental health problems. In prison, he often threatened self harm and was monitored under the prison's suicide prevention measures. Staff reported that he said that he made such threats to get what he wanted, such as access to the telephone. He assured staff that he had no intention of actually causing harm to himself. However, when agitated or frustrated, he punched the walls of his cell and as a result, often required treatment for his injuries.
3. In January 2010, the man transferred to HMYOI Aylesbury. One month later, an officer found him hanging from material tied to the window bars in his cell. He was not seriously injured but was monitored under suicide prevention measures.
4. The man was released on licence in October 2010. Within one month he had been recalled to HMP High Down because he had broken the conditions of his licence. Again, his behaviour was unpredictable and impulsive. When his demands were not met, he often threatened to harm himself.
5. On 1 February 2011, the man returned to Aylesbury. He continued to threaten to self harm regularly, but usually quickly withdrew the threats. He told staff that he was not suicidal and had no actual plans to harm himself. He said that he used the suicide monitoring procedures to make sure that staff listened to him and in an effort to get what he wanted.
6. Between February and November 2011, the man was monitored under suicide prevention measures on six occasions (including at the time of his death). He complained of feeling angry and frustrated but repeatedly told staff that he had no intention of harming himself.
7. In April 2011, the man was referred to the mental health inreach team (MHIT). He was assessed again by the psychiatrist who found no symptoms or signs of mental illness. However, he agreed to prescribe a low dose of an anti-psychotic medication to help the man control his moods.
8. Within days of starting the medication, the man developed a painful rash on his leg and decided he would not continue to take the medication. He became threatening and abusive and had to be moved by force from his cell. He was monitored under suicide prevention measures again. Once the rash had cleared, the psychiatrist prescribed a different anti-psychotic medication. He was also referred to the psychologist to work on his anger management. Initially, he agreed to attend therapy sessions but ceased to engage after two appointments.

9. Over the following months, the man was often monitored under suicide prevention measures. His risk of self harm was judged to be closely linked to his relationship with his girlfriend and the frequency of telephone calls with her. He also complained of being frustrated with the new prison regime (which came into effect in September). Staff recorded that they tried to reassure him and that, once calm, he maintained that he had no intention of harming himself.
10. On 28 October, the man was monitored under suicide prevention measures again after threatening to hurt himself. On 3 November, he threatened to make a noose. Staff did not consider this behaviour to be particularly unusual because it was linked with access to the telephone and his contact with his girlfriend. The following day, the man's solicitor visited and had no concerns about him. Staff agreed that he could have an emergency telephone call from the staff office the following day because he had run out of money to make calls.
11. On the day he died, the man became very angry when his girlfriend did not answer the telephone. He punched walls, pressed his emergency cell bell and asked to be observed constantly because he felt like killing himself. The officers on duty did not believe that he genuinely intended to harm himself. He was allowed another telephone call later that morning and spoke to his girlfriend for some time. It seems that he was calmer after their conversation and did not raise any further concerns with staff.
12. Prisoners on G wing were locked in their cells at about midday. The man was checked at 1.00pm and said that he was fine. An officer returned to the wing landing again at about 2.17pm and checked him again. She saw him suspended from the air vent in his cell with a sheet around his neck. Resuscitation was attempted and he was taken to hospital but despite the efforts of officers, nurses, paramedics and hospital staff, he was declared dead on arrival at the hospital at 3.08pm. He was 21 years old.
13. It is clear that both officers and MHIT staff found the man a challenging and demanding young man. This investigation has found that the lack of clearly devised strategies (including by the MHIT) to manage his behaviour meant that opportunities to challenge and address it were missed. We make a number of recommendations focusing on how this could have been done better. We also make recommendations about suicide prevention measures at Aylesbury and how risk should be assessed.
14. A number of interviewees said that they thought the man's death had been accidental. It is not possible to know whether this was the case. However, we make a national recommendation about educating prisoners of the very specific risks of tying items around their necks as a form of self harm.

THE INVESTIGATION PROCESS

15. The Ombudsman's office was informed of the man's death in November 2011. An investigator visited Aylesbury to open the investigation. During her visit, she met the governor and other senior staff. She also met a member of the Independent Monitoring Board (IMB). The investigator was provided with copies of the documents relating to the man's most recent prison sentence. She was also given CCTV footage covering G wing on the day he died and recordings of the telephone calls the man made using his unique pin phone code between 1 and 4 November.
16. Notices were issued to staff and prisoners at Aylesbury informing them of the investigation and inviting them to contact the investigator should they wish to talk to her. The investigator was contacted by the assistant Anglican chaplain at Aylesbury, who said that a number of young men at the prison wanted to speak to her. The investigator returned to Aylesbury in December 2011 and interviewed eight prisoners. Another prisoner was interviewed in January 2012 along with members of staff. One prisoner had been transferred to another prison and was interviewed by one of the investigator's colleagues in February. The prisoner who had a cell next door to the man declined to be interviewed. (Prisoners cannot be compelled to take part in the Ombudsman's investigation and will only be interviewed if they agree.) The man's solicitor was spoken to by telephone.
17. NHS Buckinghamshire appointed a panel to review the clinical care the man received at Aylesbury. The investigator and members of the panel carried out joint interviews with general and mental healthcare staff and the head of prison safety. The governor was provided with verbal and written feedback following interviews. The deputy governor responded in writing in March 2012.
18. The Coroner for Buckinghamshire was informed of the investigation. He provided the investigator with a copy of the post mortem and toxicology reports. A copy of this report will be sent to him to assist with his enquiries.
19. One of the Ombudsman's family liaison officers contacted the man's parents outlining the purpose of the investigation and inviting them to raise any concerns. In January 2012, the family liaison officer and the investigator met the man's parents and their legal representatives. During the meeting, the man's parents raised a number of concerns about the care their son received at Aylesbury, summarised as follows:
 - Whether the man received support from the mental health team and was prescribed appropriate medication for his mental health problems.
 - Whether he received appropriate treatment for his leg injury.
 - Whether wing staff responded appropriately to his threats of self harm on the day he died and on earlier occasions.
 - Whether he was being monitored under suicide prevention measures at the time of his death, and if so, the frequency of observations being carried out.

- Whether G wing is covered by CCTV (and whether footage was available) and whether cell bell use is logged on the wing.
 - Whether the safer custody team meeting minutes would be reviewed for reference to the man.
20. We hope this reports give the man's family a better understanding of his time in prison and the circumstances surrounding his death.
21. The man's parents and their legal representative received a copy of the report at the consultation stage and made written representations in response to the investigation findings. The man's parents do not accept that their son would threaten self harm to get what he wanted, as described in the report, and said that they had never witnessed him behaving in this way in the community. They described him as erratic, impulsive and tending to act on the spur of the moment. They were concerned that the report portrayed their son negatively and did not give a true reflection of his personality.
22. The man's parents remain concerned about aspects of the care provided to their son at Aylesbury. They are dissatisfied with the crisis management approach taken by the mental health inreach team to manage his mental health problems. They feel that this approach was insufficient and did not work. They were concerned that, having been offered psychological therapy, little seemed to be done to investigate his non-engagement or encourage him to attend sessions.
23. They are also concerned about aspects of the staff response on the day their son died. They believe that staff should have instigated a full cell search when it was suggested that he had made a noose.

THE MAN

24. The man was brought up in Brighton and, for the most part, lived with his parents and younger sister. He was permanently excluded from school when he was 15 years old and then began working with his father. He was known to use illicit drugs and alcohol. In October 2006, he was remanded into custody for the first time, aged 16.
25. When he was seven years old, he saw a child psychiatrist. He saw many different psychiatrists throughout his life. He was under the care of the Child and Adolescent Mental Health Services (CAMHS) from the age of 16. According to a community psychiatric nurse's assessment in 2006 when he was 16, his challenging behaviour "consisted mostly of uncontrollable violent temper tantrums when he did not get his way or things were not done quickly enough for him". The man had a history of self harm, including walking onto live train tracks, cutting his arms, taking overdoses of medication, pouring petrol over himself and tying things around his neck.
26. Between 2006 and 2009, the man underwent a number of mental health assessments. The earlier assessments concluded that he did not appear to have a "major psychiatric illness" but did have "complex behavioural issues". Over time, mental health professionals suggested that he might suffer with conduct disorder (a psychological disorder which results in long term behavioural problems), Attention Deficit Hyperactivity Disorder (ADHD) and Asperger's syndrome, a form of autism. However, it seems that no formal diagnosis was ever made. In 2006, the man was prescribed risperidone (an antipsychotic medication which can also be used, in low doses, to control behaviour outbursts). In 2007, he was prescribed Concerta XL (used to treat ADHD).
27. Prison Service staff interviewed as part of the investigation said that the man found it difficult to cope with life in prison. He was frustrated by the restrictions placed on him and did not like being locked in his cell. But they said that he liked order and structure and to be able to plan his day. As a result, he found it difficult to cope with change and was frustrated if aspects of the prison regime were altered or cancelled at short notice.
28. Most interviewees agreed that the man could be very demanding, "childish" and difficult to deal with. He apparently did not like to talk about how he felt. He experienced frequent outbursts of anger but would calm down quickly and often apologise to those affected. He was evidently popular at Aylesbury and both staff and prisoners interviewed appeared to have genuine affection for him. He was described as being a funny, jovial and likeable young man, who could be "quite a pleasure" to deal with.

HMYOI AYLESBURY

29. HMYOI Aylesbury holds up to 444 young adult males, aged between 18 and 21, who have received prison sentences of between two years and life imprisonment.
30. Prisoners are held on one of the prison's eight wings. Most (including G wing, where the man lived) are general wings. In addition, there is an induction wing for new arrivals, a wing for those who are considered less well able to cope and a wing for those prisoners who have received particularly long sentences.
31. General healthcare services are provided by Care UK and mental healthcare provision is delivered by Oxford Health NHS Foundation Trust.

HM Chief Inspector of Prisons (HMCIP)

32. The last inspection of Aylesbury was an unannounced short follow up inspection in May 2011 of a previous full inspection in March 2009. The Inspectorate reported that the prison had made good progress to improve its self harm prevention procedures. Assessment, Care in Custody and Teamwork (ACCT) plans were said to be better managed and indicated meaningful interactions by staff with prisoners. Case reviews were well attended and more meaningful. However, the Inspectorate reported that generally relationships between staff and prisoners remained distant.
33. Healthcare provision was considered reasonable, but at the time, there was no primary mental health provision. The good secondary mental health service could only meet the needs of a small number of prisoners with complex mental and behavioural needs. The Inspectorate recommended that all staff receive regular mental health awareness training.
34. Time out of cell, exercise and association (when prisoners are unlocked and can socialise and use the telephones and showers) had been areas of concern in the last full inspection. The Inspectorate reported that insufficient progress had been made by the time of the follow up inspection. Unlock time remained limited, association was often cancelled and slippage in the daily regime appeared to be routine. The inspectorate found that 44 percent of prisoners were locked behind their cell doors during the working part of the day.

Independent Monitoring Board (IMB)

35. Each prison is monitored by an Independent Monitoring Board of independent, unpaid volunteers from the local community. Board members monitor all aspects of prison life to ensure that proper care and decency are maintained. The most recent IMB annual report for Aylesbury covers the period July 2010 to June 2011.

36. The IMB reported that the Governor and his staff continued to work hard to provide as safe and as caring an environment as they could with the resources provided. The Board commented that the care and support offered to prisoners at risk of suicide and self harm was very good. However, the IMB noted that there was insufficient activity for the prisoners at Aylesbury, with only activity spaces for only around 50 per cent of the population.

Previous deaths at Aylesbury

37. The man was the third prisoner apparently to take his life at Aylesbury since 2004, when this office began investigating deaths in prisons. We have not yet reported on the death of one prisoner, who died in March 2011. While we considered suicide prevention processes and practices in relation to the first death we investigated at Aylesbury in 2008, we do not repeat any recommendations made in relation to that death in this report.

Assessment, Care in Custody and Teamwork (ACCT)

38. ACCT, the Prison Service process for supporting and monitoring those prisoners thought to be at risk of harming themselves, was introduced in 2007. An ACCT plan can be opened by anyone working in the prison if they have any concerns that a prisoner might have tried, or, in the future, might try to harm himself. The purpose of ACCT is to try to determine the level of risk posed, the steps that might be taken to reduce this and the extent to which staff need to monitor and supervise the prisoner. Levels of observations (where staff must check the prisoner) and interactions (where staff must have a conversation with the prisoner) are flexible and can be set according to the perceived risk of harm. If staff perceive the risk of harm to be very high, the prisoner may be constantly observed, with a member of staff positioned outside their cell at all times. Where the perceived risk is lower, the level of observations may be several times an hour or day. Observations also take place during the night.
39. Part of the ACCT process involves drawing up a Caremap. A good Caremap will identify the prisoner's most urgent and pressing issues, set achievable goals to help resolve the issues and identify who is responsible for resolving each goal. The ACCT plan should not be closed until all of the actions on the Caremap have been completed.

Pin telephone system

40. All prisons in England and Wales use the pin telephone system. On arrival in prison, each prisoner is issued with a personal identification number (pin) which they must enter before dialling the number they wish to call. Prisoners can only make calls to specified numbers which have been agreed by prison staff. Calls made by each prisoner are logged and recorded. Most prisons listen to a random sample of telephone conversations. In addition, the security department might decide that there is sufficient information to warrant monitoring all of a particular prisoner's telephone conversations.

41. Prisoners are required to buy pin phone credit using their own money. Each week, they are able to purchase credit up to the maximum amount allowed. It is the prisoner's responsibility to manage their credit. In certain circumstances, when a prisoner has run out of pin credit, staff can use their discretion to allow emergency credit.

Emergency cell bells

42. Each cell at Aylesbury is fitted with a call bell for use in an emergency. When prisoners are locked in their cells, they can use the bell to alert staff. When the bell is pressed an alarm sounds in the staff office and on the landing and a red light shows above the cell door. On G wing, a panel outside the staff office on the ground floor shows on which landing the alarm has been raised, but not the specific cell number. The alarm can only be reset by pressing a button outside the cell door, however, it can be silenced in the staff office. G wing does not have an electronic system to record when or where bells are pressed or how quickly staff respond.
43. Because the bells are intended for emergency use only, the governor told the investigator that he expected staff to respond as soon as practicably possible. Misuse of cell bells can result in sanctions under the Incentives and Earned Privileges (IEP) scheme. (The IEP scheme is designed to encourage appropriate behaviour by rewarding good behaviour by allowing certain privileges and punishing misbehaviour by taking privileges away.)

KEY EVENTS

44. The man was remanded into custody on 23 July 2008, charged with attempted rape. He was convicted of the offence in June 2009, and in December of that year, was sentenced to three years and six months imprisonment. (At the time of his death, he was seeking advice about appealing against his conviction.) During his first eighteen months in prison, the man was held at HMP & YOI High Down and HMYOI Feltham. Records for that period show that he sometimes harmed himself, or threatened to do so. It seems that, generally, he behaved in this way when he wanted to achieve something, thought that he was being treated unfairly or was agitated. Notes in his medical record also indicate that he punched the walls of his cell when he became frustrated.
45. In September 2009, the man was assessed by a doctor and was prescribed Concerta XL, used to treat Attention Deficit Hyperactivity Disorder (ADHD) in children. However, he did not comply with the prescription and, after one week, did not collect the medication as directed and so the prescription was stopped.
46. The man transferred to Aylesbury on 18 January 2010. His mental health was assessed on 11 February. He denied any thoughts of suicide or self harm, although he reported a history of self harm by various methods. As a result of the assessment, the man was referred to a consultant forensic psychiatrist (who specialises in work with mentally disordered offenders), who assessed him a week later. The man told the consultant forensic psychiatrist that his behaviour had deteriorated since he had stopped taking Concerta XL.
47. The psychiatrist noted that the man had last harmed himself three months ago but had “never intended to kill himself” and generally acted to “manipulate his environment and people”. The psychiatrist wrote that the man seemed “unwilling to take any responsibility for his behaviour”, choosing instead to blame ADHD. The psychiatrist decided to seek further information from CAMHS, the man’s mother and prison staff before deciding what further treatment was necessary. The psychiatrist spoke to the man’s mother as a result.
48. The psychiatrist was interviewed during the investigation. He explained that the man was referred to him because staff believed he might have a mental health disorder. Having assessed the man, the psychiatrist concluded that he did not have any diagnosable disorder serious enough to warrant involvement with the Mental Health Inreach Team (MHIT). In addition, the psychiatrist said that the man was reluctant to engage.
49. On 26 February, both the man and another prisoner in a nearby cell were found suspended from the bars of their cell windows with material tied around their necks. Staff intervened and neither prisoner sustained any injuries. The man was placed on an ACCT plan and, for a short while, was constantly supervised by staff sitting outside his cell. The following day, he told staff that he had not been trying to kill himself, but was feeling angry.

50. The psychiatrist saw the man again on 25 March. The man said that he wanted to complete the Controlling Anger and Learning to Manage it (CALM) and Prisoners – Addressing Substance Related Offending (P-ASRO) courses. He said that he was annoyed that staff had not arranged this for him. The man did not turn up for his next two scheduled appointments with the psychiatrist, however, he did attend his appointment on 17 June. The man said that he was doing well and was working on the servery and as a cleaner. He said that he had no thoughts of self harm and did not need any further support from the mental health inreach team. He completed P-ASRO in July.
51. The man was released on licence on 22 October 2010. Under the conditions of his licence, he had to live at an approved premises (probation hostel) and tell his offender manager if he developed any relationships with women. Initially it seemed that he was settling well, however, his behaviour “deteriorated suddenly and rapidly” and he became aggressive and intimidating. On 17 November 2010, he was recalled to High Down because he had not told his offender manager that he was in a relationship.
52. Once back in custody, the man periodically threatened to harm himself. The records suggest that, on most occasions, he retracted the threats the following day, normally explaining that he had threatened self harm because he was frustrated, fed up or wanted something. On 10 and 11 December 2010, staff talked to him about his behaviour and told him that he needed to find more appropriate ways to deal with his concerns.
53. In January 2011, the man asked to be prescribed Concerta XL again. Healthcare staff at High Down recorded that they were having problems confirming that he had been prescribed this in the community. Apparently his community doctor, CAMHS and Feltham had no record of him having been prescribed Concerta XL before, although his mother said that CAMHS had prescribed it in the past (and it had been prescribed in prison in 2009). The issue had not yet been resolved when the man transferred back to Aylesbury on 1 February.
54. On the man’s arrival, a nurse assessed his physical and mental health and recorded that he was not prescribed any medication, was physically well and had no current thoughts of suicide or self harm. The man was given a single cell (G3-14) on the second floor of G wing.
55. On 16 February, staff completed a Security Information Report (SIR). (SIRs are used to report any information which might compromise the safety of the public or anyone in the prison.) They reported that the man was kicking the cell door and threatening to smash the furniture in the cell. Staff spoke to him and calmed him down, but reported that he threatened to “put a noose around his neck or tell staff that he was suicidal” in order to get out of his cell. Staff continued to talk to him and reported that he said that he was not suicidal and had no intention of harming himself but that he would “use the ACCT process” to get out of his cell and get work.

56. Between 28 February and 25 April, the man completed two education courses, on personal money management and family relationships. Prisoners are paid a small wage to attend education.
57. The man was placed on an ACCT plan on 10 March after night staff monitoring prisoners' telephone calls heard him tell his girlfriend that he would kill himself that night. The duty manager spoke to him immediately who said that he and his girlfriend were having problems but that he would not do anything to hurt himself that night. Officer A carried out the ACCT assessment interview the following morning, the man said that he had "lots of family issues" and had run out of pin phone credit and so was unable to call anyone. He said that he would try and kill himself if he was not able to speak to his family over the weekend. He maintained that he was not using the ACCT system to get extra pin credit. Officer A noted that he would "see what he could do". The first case review took place that afternoon with Officer A, Senior Officer (SO) A, a member of the chaplaincy team and the man present. Officer A wrote four goals on the Caremap, all of which related to the man contacting his girlfriend and family. Later that day, staff allowed the man emergency pin credit so that he could telephone his family.
58. The following week, wing staff overheard other prisoners on G wing complaining that the man was always using the telephones. The information was recorded on an SIR because one prisoner was overheard saying that he would "knock out" the man. (At the time, G wing only had one telephone for 30 prisoners to use. Due to the prison regime, use of the telephone is normally restricted to specific times of the day, for example during association periods. This can lead to queues and a prisoner who is considered to spend too long on the telephone might become the victim of bullying.) Staff completed another SIR the following day when the man claimed he would be stabbed by other prisoners for using the telephone for too long. An ACCT case review was held on 17 March and the man admitted that he had upset other prisoners on the wing by "hogging" the telephone. No new entries were made on the Caremap. (The ACCT plan was closed on 21 March when the man and staff agreed that he was not likely to try to harm himself.)
59. As a result of both SIRs, wing staff told the man that he could not use the telephone in the morning so that other prisoners could do so. Staff recorded that they were trying to manage the time he spent on the telephone to reduce the risk that he would be bullied.
60. As part of the investigation, a number of other G wing prisoners were interviewed. They were asked whether the man was the subject of bullying because he used the telephone so much. They all agreed that he was not bullied. Although they acknowledged that he used the wing telephones a great deal, they said that prisoners on the wing understood how important contact with his girlfriend and family was to the man and apparently took his extensive use of the telephones in good humour. None was aware of any threats being made against him.

61. On 14 April, another ACCT plan was opened because the man and his girlfriend had a “very heated” conversation after which he repeatedly punched the wall of his cell. Staff described him as “extremely volatile”, making threats to hurt himself because he had “had enough and didn’t care”. He was taken to the accident and emergency department at Stoke Mandeville Hospital so that his hand could be x-rayed. The hospital confirmed that he had injured the soft tissue in his right hand, but had not broken any bones.
62. The ACCT assessment was carried out by Officer B later that day. The man told the officer that he was feeling very angry and was having problems controlling his anger. However, he said that he had not harmed himself for at least a year and had no intention of harming himself now (it seems he did not include punching his cell wall as self harm). He said that he felt very depressed and “hopeless”. In the case review that followed, the man explained that he was frustrated about several things. He and the staff at the review discussed coping strategies and alternatives to punching the wall. The man said that he got “wound up” easily and needed activities that he could complete in his cell to help distract him. Staff referred him to the MHIT for assessment and noted that a member of the MHIT should come to the next review.
63. Senior Officer (SO) B, the ACCT case manager and the prison’s safer custody co-ordinator, made three entries on the Caremap. He noted that staff needed to interact with and observe the man and encourage him to talk about his thoughts. The SO also wrote that the man was bored and needed to be given activities that he could complete in his cell. The third entry focused on the man’s concerns about his mental health and noted that he had been referred to the MHIT. (The Caremap was updated on 3 May and staff noted that the man had been given puzzles and model making equipment to keep him occupied.)
64. The next ACCT case review was held on 19 April, with officers and two general nurses present. The man was reluctant to attend the review, but eventually did so. He said that he had no thoughts of suicide or self harm but felt “angry all of the time” and did not know why. Staff noted that someone from the MHIT was due to speak to him later that week to discuss his concerns.
65. The MHIT team leader visited the man on G wing later that day. She noted that MHIT staff had tried to see him on 15, 18 and earlier on 19 April, but he had been away from the wing on each occasion. When the MHIT team leader saw the man he was “very distressed”. He said that he had split from his girlfriend and felt like doing something that would lead to him being taken to the segregation unit. (The segregation unit is a small unit in the prison where prisoners who cannot be managed on the normal prison wings can be held for a short time or are held for punishment. Generally, the regime in the segregation unit is more restricted than the rest of the prison.) The MHIT team leader spent 40 minutes talking to him. The man told her that he did not know how to deal with his feelings except by using violence. He said that he woke each morning at 4.00am and could not get back to sleep. As a result

his concentration was poor and he was not eating well. He said that he did not need to be prescribed antidepressants.

66. The MHIT team leader returned to see the man two days later, on 21 April. He was “much more relaxed” and had resolved the issues with his girlfriend. During their conversation, the man talked about having violent thoughts and “fantasising” about violence. He talked about his early life and acknowledged that his behavioural problems began at a young age. The man told the MHIT team leader that his mother had been trying to get him help for years. He said that he wanted to change and learn to manage his anger, but that he did not want to stop using violence. The MHIT team leader arranged to see him again in two weeks.
67. In interview, the MHIT team leader said that the man’s engagement with mental health services was sporadic. She described him as ambivalent about addressing his problems. When he was upset, she would try to see him once a week. However, once the distress had passed, he would stop engaging and would refuse appointments that were offered to him. Because of this, the MHIT team leader described the MHIT involvement with him as crisis based. She explained that, had the man been willing to engage, the focus would have been on addressing his anger. She said that he would “suddenly erupt ... which is when he tended to become more self-destructive” by punching the cell walls or threatening to harm himself.
68. On 26 April, staff and the man met for another ACCT case review. The man wanted the ACCT to remain open because he believed it was the only way that people would listen to him. He said that he still got angry very quickly and wanted to be prescribed medication.
69. The man had an appointment with the psychiatrist on 28 April during which he described having outbursts of anger that he could not control. He said that they happened for no reason but that they were the result of his diagnosed ADHD. The psychiatrist concluded that the man showed no symptoms of a mental illness such as psychosis or depression. The man said that he wanted to be prescribed Concerta XL or he would assault people and not be responsible for his behaviour. He said that he did not like dealing with people in authority and that the restrictions of prison life made him angry. He explained that he had been recalled to prison after 26 days on licence because he could not cope with the restrictions of his licence conditions.
70. The psychiatrist concluded that there was little evidence that the man had ADHD and so it was not appropriate to prescribe Concerta XL. In interview, the psychiatrist explained that the man had never apparently received a firm diagnosis of ADHD and that his behaviour since returning to custody did not support a diagnosis. He said that the man’s main problem was impulsivity but that he was also susceptible to stress (which the doctor explained is common among young men in prison). The psychiatrist offered to prescribe the man a low dose (0.5 milligrams) of risperidone as a short term measure.

71. The psychiatrist wrote that the man might have some kind of personality disorder, noting that he apparently took no responsibility for his actions, preferring to blame others. The psychiatrist said that the man's anger management problems, impulsivity and fluctuating moods meant that he was suitable for referral to the psychologist. He explained: "I said that he should really consider seeing a psychologist because his problems wouldn't go away with just medication, he needed to understand what he was doing." The psychiatrist said that, in his view, psychological therapy was likely to be the most successful treatment option for the man. The man reluctantly agreed to be referred.
72. On 4 May, a psychiatric nurse visited the man on the wing. He said that he had started taking risperidone the previous day and could already feel the benefits. The nurse arranged to review his progress the following week.
73. The man developed a painful rash on his leg on 7 May. On 9 May, he barricaded himself in his cell, demanding to be taken to the healthcare department. A nurse came to see him in his cell and discussed treatment options with him. However, he was still unhappy and demanded to be moved to the segregation unit. Later that day, the prison doctor examined the man in his cell. He examined the rash and listened to the man's chest, which was clear. The doctor diagnosed erythema nodosum, an inflammatory disorder which causes painful red bumps to appear under the skin. The doctor ordered blood tests, a chest X-ray (to rule out tuberculosis, which is sometimes linked with the disorder) and prescribed ibuprofen and diclofenac (anti-inflammatories) to relieve the pain. The doctor noted that erythema nodosum could take up to two months to resolve. (There is nothing in the medical record to confirm when the man underwent the chest X-ray or the result.)
74. In interview, the doctor explained that the standard treatment for erythema nodosum is to prescribe symptomatic relief to manage the pain and irritation. Normally erythema nodosum resolves itself in a matter of weeks. The doctor said that he frequently explained to the man that there was no other medication that could be prescribed.
75. The doctor said that he knew the man was also working with the MHIT. The doctor explained that representatives of both teams meet every Monday morning and discuss complex cases. He could not recall whether the man had ever been discussed at the meeting and there are no entries in the medical record relating to this. However, both he and a nurse who was interviewed said that the man was often discussed in the healthcare department.
76. On 10 May, the blood test results revealed that the man did not have a bacterial infection (which can sometimes lead to erythema nodosum). The man believed that the rash was caused by the risperidone and so he told the psychiatric nurse that he would not take any more. He said that he was sad to stop taking the medication as he thought it was working. In interview, the psychiatrist said that there is no known link between erythema nodosum and

risperidone, but that because the man was adamant the two were linked, mental health staff agreed that he should stop taking it. The psychiatric nurse recorded that the psychiatrist would discuss alternative prescriptions with the man.

77. Between 8.30pm on 10 May and 4.00am on 11 May, the man's behaviour deteriorated. He made threats to injure staff or to seriously harm himself. He said that he wanted to be taken to hospital, but that if staff entered his cell he would assault them. He threatened to set fire to his cell, to "create mayhem" and to incite other prisoners to smash up their cells. He had a plastic knife, which he threatened to use as a weapon. According to an SIR, at 11.30pm, staff removed him from his cell using control and restraint (the use of specific physical techniques to bring a prisoner under control). The man was moved to the segregation unit and the ACCT observations were increased to five an hour. A nurse assessed him as suitable to be segregated and she said she reassured him about the treatment he was receiving.
78. An ACCT case review was held in the afternoon of 11 May. The MHIT team leader and a general nurse were also present. The group discussed the man returning to the wing and he said that he felt happier. The level of observations was reduced to hourly observations throughout the day and night.
79. The man was charged with two counts of disobeying a lawful order and one of threatening and abusive behaviour as a result of his behaviour on the night of 10 May. On 24 June, he was found guilty of threatening behaviour and lost 50 percent of his earnings, was barred from association and lost other privileges for two weeks. However, the punishment was suspended for six months. One charge of disobeying a lawful order was not continued with, but he was found guilty of the other on 27 August. The punishment he received was to lose 75 percent of his earnings, not to be able to use the canteen facilities, loss of association and removal of his television for two weeks, 21 days removal from the wing and seven days cellular confinement. Again, the punishment was suspended for three months. He returned to G wing later that day. The man's health was monitored over the next few days.
80. On 16 May, the MHIT team leader attended an ACCT case review following which she noted that the man had thoughts of suicide and was very worried about his physical health. He was concerned that he had not yet received the results of his blood test the previous week. He complained of being cold and the MHIT team leader noted that he was shivering. His legs were still swollen and hot to the touch. The prison doctor told the investigator that he had discussed the blood test results with the man, but could not remember when he did so. He did not make an entry in the medical record to confirm that the test results had been shared with the man.
81. In interview, the MHIT team leader was asked whether she had ever thought that the man would take his life. She said that "there were times when he was very angry and he was making threats and he would do a gesture to go with

that threat ... [but] I never got the impression from him that he genuinely wanted to die". This view was shared by most interviewees.

82. The following day (17 May), staff completed an SIR. The man told staff that he would continue to misbehave if his "requests are not acknowledged" and that his misbehaviour would include self harm and "making nooses". Information on the SIR notes that staff had talked to the man about his comments and the dangers of self harm. Wing staff had been made aware and were challenging accordingly.
83. Later that day, the man punched the wall of his cell and refused to let the nurse examine his hand. He did allow her to examine his legs and she noted that they were much improved with less swelling and pain. The prison doctor confirmed this when he examined the man the following day.
84. On 23 May, the man's case was considered by the Parole Board, an independent body which decides whether prisoners are suitable for release. The Board decided that the man was not suitable for release because he had not been truthful about developing a relationship while on licence. Later that day, the man talked with the assistant Anglican chaplain. He told her that he was "desperate" to get a job and asked why his applications kept being turned down. The assistant Anglican chaplain made an entry in his ACCT document noting that she had explained that this was because of his poor behaviour, which meant that he was considered to pose a high risk. The prison said that no applications for work made by the man were rejected.
85. The man met the clinical psychologist on 24 May. He agreed to work with her for eight weeks to address his behavioural problems. The psychologist noted that the work would focus on finding alternative ways to manage his anger and frustration. In interview, she explained that her approach uses a range of different "talking therapies". She works with patients for a set length of time, normally once a week for up to a maximum of 24 weeks. The psychologist said that she planned to help the man to work better with other people and channel his anger and frustration.
86. In the first session, the psychologist explained the work she planned to do with the man and gave him a psychotherapy file to complete. She said that the purpose of the file is to encourage the patient to look at their patterns of behaviour and their relationships with others. The man appeared to be comfortable with the approach and the psychologist had no concerns about his ability to complete the file. She described the man as a likeable young man who, following the initial session, seemed keen to engage. A second appointment was arranged for 31 May.
87. On 25 May, the man began a painting and decorating course at the request of wing staff. However, he was removed from the course on 9 June because of his poor behaviour and for using threatening language.
88. The psychiatrist assessed the man on 26 May and noted that he had been feeling very angry recently because he felt that services at the prison were not

helping him. He said that the prison doctor had not taken his problems seriously and that he still did not know the result of the blood test taken earlier in the month. He asked the psychiatrist to prescribe medication, but the psychiatrist suggested that they wait until the cause of the erythema nodosum had been established. The psychiatrist encouraged the man to work with the psychologist, but the man said he did not think it would help.

89. On 30 May, staff conducted an ACCT case review, during which the man was angry and threatening. He told the staff present that he would kill himself because staff kept promising him a job, a review of his medication and a move to D wing, but nothing happened. Staff noted that they had tried to reason with him to no avail. He continued to threaten to kill himself unless he was moved from the wing. His observation levels were raised to four an hour because of the risk he posed to himself. A fourth goal was added to the Caremap noting that the man wanted a job (no mention was made of the painting and decorating course), to be prescribed medication and to move from G wing. G wing staff were instructed to look into the three issues. Staff noted that someone from the MHIT and someone who could discuss education and work should be invited to the next review. The ACCT remained open.
90. The man had a second appointment with the psychologist on 1 June. She recorded that he had not completed the psychotherapy file because it was too difficult to understand. The man talked about enjoying violence and using it as a pressure release. He said that he did not want to change that part of his behaviour. In interview, the psychologist said that, in her view, he had not completed the psychotherapy file because he did not want to rather than because he was unable to. There is also a pictorial version of the file designed for individuals with more limited literacy skills, which they could have completed together in the session had the man been interested. The psychologist said that she had a clear sense that there was very little that she could achieve with him because he did not want to change. However, she said that she continued to offer him appointments.
91. On 3 June, the man attended an ACCT case review. He was in a positive frame of mind and said that his only concern was being able to telephone his family. Officer A, who chaired the review, arranged for the man to be able to use the telephone every day on his return from work, before the evening meal was served. This arrangement was recorded on the Caremap. However, the staff at the review stressed that the man was responsible for managing his pin phone account and ensuring he had enough money to make daily telephone calls. Because the staff agreed that the man posed a low risk to himself, the level of observations was reduced to one recorded conversation a day. On 17 June, after two uneventful weeks, the ACCT plan was closed.
92. In interview, Officer A explained that most staff knew how important telephone calls were to the man. He said that the arrangement made following the ACCT case review was "special" and was intended to reassure the man that he would always be allowed a telephone call, even if evening association was cancelled. Officer A said that he and the man had a good relationship. He

said that he spent time talking to him when he threatened self harm and was able to calm him down. He said that he usually gave the man a telephone call as he knew this would also help to calm him. Officer A did not know whether all staff took the same approach with the man.

93. Other staff interviewed agreed that the man tended to calm down and respond better when staff took the time to talk to him. The co-ordinating chaplain at Aylesbury, said that, although the man could be “such a pain” at times and very demanding, he responded very well when treated with respect. The co-ordinating chaplain said that some officers knew how to manage the man’s behaviour but that others did not. (In interview, the co-ordinating chaplain raised a number of concerns about G wing officers. They were brought to the attention of the Governor and are addressed later in the report.)
94. On 28 June, the man went to the healthcare department for an appointment with the psychologist. According to her entry in the medical record, the man refused to wait while she saw another prisoner. The MHIT team leader saw the man instead. She noted that he became agitated, threatened to “smash up” and demanded to be prescribed medication. The man said that his counselling sessions kept being cancelled. He demanded to see the psychiatrist and threatened violence when he was told that this would not be possible until the following week. The psychologist did not see the man again. In interview, she said that she thought that he stopped attending appointments but that she should have made entries in the medical record to this effect (there are no further entries by the psychologist in the record). The psychologist emphasised that psychotherapy depends on the patient’s willingness to engage.
95. SO C placed the man on a Personal Intervention Plan (PIP) on 7 July because of his poor behaviour. The PIP activator form, which should document in fuller detail the reason for the PIP and what steps have already been taken to address the behaviour was not completed. The first PIP review was held that day but no details were recorded. Two entries were made on the PIP plan – that the man should talk to healthcare staff about personal issues and that he should adhere to wing rules. According to the daily supervision record, the man misused his cell bell on 7, 8 and 10 July. By 11 July, staff recorded that he was well behaved and displaying a mature attitude. It appears that the PIP was closed on 20 July.
96. Another ACCT plan was opened on 25 July after the man threatened to kill himself because he thought that staff did not understand him. He punched his cell walls several times, injuring his hand. Staff opening the ACCT plan noted that the triggers to his anger and self harm were when things did not work out for him and not having enough pin phone credit due to administrative errors. Officer B carried out the assessment interview and concluded that the man was angry but probably not intending to harm himself.
97. SO D chaired the first case review and established that the amount of money available to the man for telephone calls had been wrongly calculated, due to an administrative error. The man said that he relied on support from his

family and was not able to telephone them because of the error (which was rectified that day). He said that he had punched the wall in frustration rather than because he wanted to hurt himself. Initially, the level of observations was set at four times an hour and two recorded conversations per day. After the first case review, the observations were adjusted to three recorded conversations each day. Staff completing the Caremap noted that the man needed to be more careful with his pin phone money and limit his calls to save money. They also noted that he needed to find ways to control his anger and frustration, including talking to staff more.

98. The doctor examined the man's hand later that day and advised that he be taken to Stoke Mandeville Hospital for an X-ray. The man said that he would refuse to undergo an operation or wear a cast. He was given pain relief medication.
99. On 28 July, the man had another appointment with the psychiatrist during which he admitted to feeling very angry. He said that he was stressed because he was away from his family and that this resulted in him becoming angry and aggressive. He said that he knew this was not the right way to deal with his feelings, but could not control himself. The man denied feeling suicidal or depressed. He said that he was mixing with other prisoners on the wing and that his relationships with staff were okay. He said that he wanted to be prescribed medication to calm him. In interview, the psychiatrist said that the man had very fixed ideas that he needed to be prescribed medication but that he told the man that medication could not resolve his mental and behavioural problems. The man accepted this but said that he wanted to try something anyway. The psychiatrist agreed to prescribe quetiapine (another anti-psychotic medication which can help to manage behavioural outbursts) and arranged to review the man in a few weeks.
100. Staff conducted an ACCT review on 1 August (no one from the MHIT or healthcare was present). The man repeated that the only way he knew to vent his frustration was to punch the wall. He said that he had recently been prescribed medication which he hoped would help. He was in a positive frame of mind and all present agreed that the ACCT could be closed.
101. The man had another appointment with the psychiatrist on 11 August, during which he was reported to be very well, relaxed and chatty. The psychiatrist wrote that since being prescribed quetiapine, the man was managing his anger, impulsivity and general behaviour much better. Although he still got angry, the episodes were short lived and he was able to calm down more quickly. The man said that he was using the gym frequently and attending education. He had no concerns about the medication and the psychiatrist continued the prescription for another four weeks.
102. On 17 August, the man was overheard threatening to kill himself during a conversation with his girlfriend. Staff thought that he sounded tearful and an ACCT plan was opened as a result. Later, he punched his cell walls again and was examined by the prison doctor. The doctor advised that the man be taken to hospital but he initially refused and signed a disclaimer. However, it

seems that the man did agree to an X-ray as the doctor reviewed the results that day. The man had not seriously injured his hand on this occasion.

103. The ACCT assessment interview was carried out at 9.40am on 19 August. The man said that he had family issues but did not want to talk about them. He said that he had now calmed down. G wing staff agreed to let him out of his cell as often as possible to help the wing cleaners so that he did not spend too much time locked up. During the ACCT case review held later that afternoon, the man said that he felt suicidal. He said that he was frustrated about not being able to keep in contact with his family and about having been recalled to prison. He told the staff that there was little anyone in the prison could help with because the problems would only be resolved when he was released. Because he was considered to pose a raised risk, staff were directed to observe him every two hours and to record two conversations with him in the ACCT plan. One entry was made on the Caremap which noted that the man needed to understand the rules and regimes in prison and that this might be better achieved if he moved to a different wing. (Although the possibility of the man moving to another wing at Aylesbury is mentioned on several occasions, there is no evidence that any action was taken to explore this further.) The ACCT plan was closed on 29 August when the multi-disciplinary case review team and the man agreed that he was much calmer and had resolved his problems.
104. The psychiatrist reviewed the man's progress on 15 September. Initially, he said that he was feeling much calmer and better able to control his temper since being prescribed quetiapine. However, as the appointment progressed, he said that he felt like stopping taking the medication because he thought it was not doing anything. The psychiatrist noted that the man's opposing views were curious and might reflect his general way of thinking, which was very black and white. The psychiatrist told the man that it was his choice whether to take the medication or not and he agreed to continue to take it. The psychiatrist arranged to review the man in two months. In interview, the psychiatrist agreed with the MHIT team leader's view that the MHIT was essentially offering a crisis based intervention during periods of distress.
105. At 9.41pm on 2 October, Officer D opened an ACCT plan for the man after he threatened to make a noose because night staff had refused to get sugar from another prisoner on G wing for him. He said that he would cause trouble for staff. Staff checked him at least once an hour during the night. The following day, temporary SO (TSO) A carried out the ACCT assessment interview. The man said that he had become agitated when night staff would not do as he asked. He said that staff had been rude to him, which led him to threaten self harm. He said that he had not made a noose and that it was a spur of the moment comment.
106. The man told TSO A that he felt absolutely fine and had no intention of harming himself, particularly as he was due for release within the next eight months. The man emphasised that he had a lot to live for and was happy with life and the future ahead of him. He asked for the ACCT plan to be closed.

107. TSO A, the man and another officer then met for the ACCT case review. The man repeated that he had no plans to harm himself and said that he used the ACCT process to get staff to listen to him. TSO A completed the Caremap, noting that the man was frustrated with staff and needed to find other ways to communicate. She wrote that he should use the anger management techniques that he had learnt. Observations remained at one every hour and staff were instructed to record at least one conversation each day in the ACCT plan.
108. At 2.30pm the following day, 4 October, staff recorded that the man was constantly pressing the emergency bell in his cell because he could not get his own way. He wanted to be given an extra telephone call, which staff noted was a regular habit. Staff told him that he would be given a telephone call at 4.00pm but he said that it had to be now because his family was expecting to speak to him. Staff thought he was trying to manipulate them. The man then punched the cell wall and healthcare staff were contacted. The man asked to be placed on a constant watch (where staff are positioned outside the cell at all times to support and monitor the prisoner). He was told that this was not possible and then threatened to hang himself. Staff noted in his ACCT plan that he had made such threats numerous times before but did not act on them. The level of observations was increased to twice an hour.
109. Later that afternoon, Officer E talked to the man about his behaviour. He recorded details of their conversation in the ACCT on-going record. The officer noted that the man was not happy and wanted to harm himself so he would be taken to hospital. He told the man to calm down and offered his support, but said the man was not interested.
110. Officer E was the man's personal officer. The personal officer scheme is intended to provide prisoners with a named officer that they can approach with questions or concerns. Wing officers normally act as the personal officer to a number of prisoners. The personal officer should make regular entries in the prisoners' files. Officer E said that he got on reasonably well with the man, but described him as an angry, childish, frustrated young man who was much more demanding than other prisoners on G wing. The officer said that the man was always asking for telephone calls and would over-use his cell bell or threaten to kill himself if he did not get what he wanted. Despite the man frequently threatening suicide or self harm, Officer E said that he never thought that the man intended to kill himself.
111. On 7 October, SO E, Officer F, Officer G and the man met for the ACCT case review. The man said that he had no thoughts of self harm. He said that his outbursts were the result of his frustrations. The group talked about how he might change this behaviour. All present agreed that the ACCT could be closed. An ACCT post-closure review was carried out by SO F on 11 October. (The purpose of the post-closure review is to discuss how the prisoner is feeling at the time and consider whether the ACCT should remain closed.) The man was described as in good spirits and talked about his future plans. He said that he had no intention of harming himself as he wanted to see out his sentence.

112. At 11.30am on 28 October, the MHIT team leader visited the man at his request. He was very agitated and told the nurse that he was not coping and wanted to “do something”. The MHIT team leader spent some time talking to him and eventually, he told her that he was upset by frequent disruptions to the normal regime. The man explained that he had been expecting to use the gym that morning but had not been able to because of staff shortages, remaining in his cell instead. The man told the MHIT team leader that he felt he had to make a point and let staff know how unsettling this was for him and other prisoners on the wing. He said that he bore no animosity towards staff but that he would make a noose, hang himself or headbutt the wall until he was placed under constant observation. As a result of the conversation, the MHIT team leader opened an ACCT plan and instructed staff to check him four times an hour.
113. In interview, the MHIT team leader said that he was very angry that morning and had demanded to see people from various different prison departments so he could complain. She did not think that he would harm himself that day.
114. TSO A carried out the ACCT assessment interview at 2.10pm. The man repeated his dissatisfaction with the new regime. He thought that he was missing opportunities to exercise because he attended education. TSO A noted that the man had been given a copy of the new regime timetable but that he thought it was always being changed. This was making him feel stressed. The man told the TSO that his family and girlfriend were supportive and that he had no other issues with life at Aylesbury. However, he said that he wanted to transfer to another prison. He said that he had no plans to harm himself and repeated that he used the ACCT process to get himself heard. TSO A noted that the man’s triggers for threatening self harm were disruptions to his normal routines and his anger problems.
115. A new regime was introduced on 25 September 2011. The purpose was to allow prisoners to be unlocked earlier on weekday mornings, giving them more time out of their cells. Under the new regime, on weekdays, prisoners who did not attend work or education were given an hour of association and half an hour’s exercise between 8.45am and 10.15am. The man had classes in the morning and believed that he was missing out on association – and opportunities to telephone his girlfriend and family. All prisoners had association between 5.15pm and 7.15pm, as long as staffing levels allowed. Staff interviewed said that there had been some initial problems establishing the new regime.
116. TSO A, Officer A and the man met for the ACCT case review at 4.30pm that afternoon. The MHIT team leader told the investigator that she went on leave after opening the ACCT plan and so was not available to attend the case reviews. She said that, normally, another member of the team with some clinical knowledge of the prisoner would attend if she was unable to. However, the only available member of the MHIT was a nurse, who had only just started working at Aylesbury and did not know the man. As a result, the

MHIT was not represented at either of the two case reviews held before the man died.

117. During the case review on 28 October, the man repeated that he had no intention of harming himself and only said that he would annoy staff because he did not like the new regime. He also mentioned that he did not get on very well with an officer on the wing, and that he wanted to talk this through with the officer. Officer A wrote that the man was very talkative during the review and that they had discussed coping strategies. The level of observations was reduced to one conversation each day. Officer A recorded that the man posed a low risk to himself. The next ACCT review was due to take place on 4 November and the man's personal officer was to be invited.

118. In interview, Officer A explained that he was happy for the level of observations to be reduced to one conversation a day because the man had said that he was not suicidal or thinking of self harm. He explained:

"That [one conversation a day] would give him an opportunity not to be isolated. It would give him the opportunity, you know, to bring up any problems or let us know if he felt like self harming or let us know if he had any problems or if he had a bad phone call we could get him out. So that was his opportunity to speak to a member of staff."

Officer A clarified that the man would continue to have regular contact with staff in any case, and would have other opportunities to raise concerns if he needed to. The officer said that the man was happy with the decision to reduce the observation level and was laughing and chatty during the case review.

119. Officer A and TSO A completed the Caremap. The first issue identified was that the man wanted to transfer to another prison. TSO A recorded that the man had completed a transfer application that afternoon. The man was also apparently having problems with his offender manager and had been told to make an application to see someone from the offender management unit. The third identified issue focused on his difficulties with the new regime. TSO A noted that the goal was for him to remain calm and talk to staff about any problems he had with the regime. Officer A wrote that the man felt that he could not talk to the officer he had problems with. It was decided that a meeting would be arranged between the man and the officer and that TSO A would also be present (this had not yet taken place when the man died).

120. The prisoners interviewed during the investigation were asked about the man's relationships with staff. Most agreed that he preferred to talk to members of the chaplaincy team. They also agreed that he often deliberately wound up the staff by pressing his cell bell frequently. However, they said that the man seemed to get on reasonably well with all staff. None could name any particular staff that he did not get on with and none mentioned any problems between the man and any officer.

121. At 7.15pm on 3 November, the man rang his emergency cell bell. Officer H responded and the man said that he wanted to speak to the duty manager or he would make a noose. Five minutes later, Officer I, the suicide prevention co-ordinator and SO A went into his cell to talk to him. The suicide prevention co-ordinator arranged for the man to be allowed to make a telephone call the following morning. Staff noted that the man seemed calmer after their conversation but the level of observations was increased to once an hour during patrol state (when prisoners are locked in their cells and staffing is at a minimum) and overnight.
122. The man was let out of his cell at 8.30am the following morning, 4 November, to make a telephone call. The investigator was provided with a recording of the conversation between the man and his girlfriend. He told his girlfriend that he was feeling happy because his solicitor was due to visit that day. He said that he was going to ask staff for £2 emergency pin phone credit because he was running very low. He had apparently sent an unpleasant letter to his girlfriend earlier that week and during the conversation he asked if she had received it yet. She said she had not and he told her to rip it up without reading it. He said he had only written unkind things because he thought she was going off him. The man said that he hoped to be transferred to HMP Lewes, which would make it easier for her and his family to visit him. At the end of the conversation, he said that he would try to telephone her again later that day if he could arrange extra credit.
123. At about 10.00am that day, the man's solicitor visited. The investigator spoke to the solicitor by telephone during the investigation. He said that the meeting was quite positive because the two men discussed the man's next parole review, which was due sometime after Christmas. They discussed the progress that the man was making and the solicitor told the man that he needed to continue to behave well. The solicitor said that he knew the man was being monitored on an ACCT plan and asked how he was feeling. The man said that he was okay and that everything was fine. The solicitor said that he had no concerns about either the man's mental health or his risk to himself during the meeting. He said that if he had been at all worried about the man, he would have alerted staff as he left the prison.
124. SO E, Officer J and the man met at 2.10pm for the second ACCT case review. The man told the staff that, although he got frustrated, he had no real issues and was not thinking of self harm. He said that he knew how to get support if he needed it. SO E noted that the man said he felt settled on G wing but thought it was time that he moved to an adult prison. The group agreed that the ACCT should remain open, with observations reduced to one recorded conversation each day and hourly observations at night. The man said that he was worried about contacting his family and SO E agreed that he could make a telephone call from the staff office. (He made an entry in the wing observation book to that effect so that all the staff working on the wing were aware.) The SO updated the Caremap noting that the man needed to speak to staff when he felt angry or frustrated and to listen to their advice about possible changes to the regime. The staff judged the man to pose a

low risk to himself. The next review was due to take place on 11 November and SO E directed that staff from the MHIT be invited.

Saturday 5 November

125. Several of the prisoners interviewed during the investigation provided information about events that occurred on 5 November. Some said that they had seen or heard things themselves; others reported information that they had overheard other prisoners discussing or that was “common knowledge” on the wing. Few of the prisoners were able to provide more than very approximate timings. The evidence from the prisoners is sometimes contradictory. The following paragraphs draw on evidence from the prisoners, staff on duty on 5 November, documentary evidence and the CCTV footage provided by Aylesbury.
126. The CCTV footage covers the four cameras on G wing between 9.00am and 3.00pm on 5 November. The footage, which has no sound, is broken down into hour long segments. It does not include the time that events occurred, however, by using the length of time the footage had been playing, approximate timings have been calculated.
127. At about 9.20am, the man was unlocked and allowed to telephone his girlfriend from the staff office. Officer J recorded in the ACCT ongoing record that his girlfriend did not answer and the man became very angry. He asked to return to his cell. Some of the interviewed prisoners saw him punching the landing walls as walked back to his cell.
128. The man’s girlfriend telephoned the prison several times at about 9.30am. She spoke to SO G who wrote an account of his contact with her. SO G wrote that the man’s girlfriend said that she had missed a call from the man earlier that morning and asked if he could be given a call from the office because he had no pin phone credit. SO G said that he would check whether the man had tried to call her and confirm that he was okay. He did so and was told by wing staff that the man was locked in his cell. He relayed this information to the man’s girlfriend who again asked if the man could be allowed another telephone call. SO G checked the man’s pin phone account and confirmed that he had no credit left. The SO saw that the man was on an open ACCT plan and asked staff to check his most recent recorded telephone calls. They did so and confirmed that nothing of concern was said during the calls. SO G then contacted SO E who said that he had instructed wing staff to allow the man to make another call from the office. The man’s girlfriend was informed.
129. Mr A, who lived in cell G3-07, told the investigator that he spoke to the man between 9.00am and 9.30am. He said that the man asked him for a cigarette, which Mr A gave him. Mr A said that the man then told him that he planned to kill himself that day and showed Mr A a noose he had made. Mr A said that shortly afterwards he was being escorted to the segregation unit and told the officer who was escorting him what the man had said. Together, they went to

speak to Officer K in the G wing office. Mr A said that Officer K told them that staff were busy and the man would “have to wait”.

130. Officer K was interviewed and said that sometime during the morning, Officer L, who was on the wing to move Mr A to the segregation unit, told him that the man had made a noose. Officer K could not recall whether the man had told Officer L about the noose or whether the officer had heard about it from someone else. Officer K said that, as a result, he went to the man’s cell and “had a little look round with him”. He did not find a noose and the man denied any plans to harm himself. The officer said that he did not hear the man make any threats to harm himself that day. The level of ACCT observations was not changed as a result of the information and no case review was held.
131. During this investigation, Officer L was interviewed by telephone as he no longer works at Aylesbury. He said that, while escorting Mr A to the segregation unit, Mr A asked him to check the man because he was worried about him. Officer L said that Mr A did not say why he was worried. Officer L passed this message to Officer K as he left the wing. While he was in the segregation unit office, he overheard a telephone conversation between Officer K and SO E, during which the SO agreed that the man could be given another telephone call. Officer L was clear that although Mr A had said he was worried about the man, he did not mention him having made a noose. Officer L told the investigator that he challenged Mr A about this after the man’s death, when he became aware of what Mr A had said. Officer L said that he would have gone to talk to the man himself if Mr A had told him about a noose. None of the other prisoners interviewed mentioned the man having made a noose that day.
132. The investigator spoke to Officer K again in April, in light of Officer L’s evidence. Officer K said that he could no longer recall whether Officer L did or did not mention the man having made a noose. However, he said that he definitely had a brief look around the man’s cell. According to the CCTV footage, Officer K only went into the man’s cell once on the morning of 5 November (as detailed below).
133. Some of the prisoners said that the man constantly pressed his cell bell and kicked his cell door during morning association (which is held between 8.45am and 11.45am). CCTV footage shows that he pressed his cell bell about one minute after he was locked in his cell (which was sometime around 9.30am). About five minutes later, Officer K came to the cell and reset the bell by pressing a button outside the cell door. The man immediately pressed the bell again. Under a minute later, Officer K returned and talked to him through the observation hatch in the cell door but did not reset the bell.
134. Officer J wrote in the ACCT ongoing record that, having returned to his cell, the man “spent the next ten minutes banging on his door and ringing his cell [bell] ... He was shouting ‘put me on a constant watch, I am going to kill myself’.” Again, the level of ACCT observations was not adjusted in response and a case review was not arranged. The man told Officer K that he had punched the cell wall and wanted to be examined by a nurse. Officer K wrote

that he had telephoned the healthcare department and that someone would come and see him as soon as possible. (According to the CCTV footage and the medical record, the man was not examined by healthcare staff before his death.)

135. Immediately after speaking to Officer K at his cell door, the man pressed his cell bell again. This time, staff did not return to reset the bell for over 15 minutes. Officer K and Officer E spoke to the man shortly after 10.00am. The man again pressed his cell bell immediately they had walked away and staff did not respond for about 20 minutes. Officer K went into his cell at about 10.26am and spent four minutes in the cell with the man. According to the CCTV recording, the man did not press his cell bell again after 10.30am.
136. Three prisoners, Mr B, Mr C and Mr D said that at some point that morning, the man told a member of staff that he would kill himself if he was not given another telephone call (although their recollections of the time that this happened vary). Mr B and Mr D said that staff ignored the man and closed the observation panel in his door. Mr C said that the officer (who he named as Officer M) told him to “carry on”. As noted above, Officer K said that he did not hear the man make any threats to harm himself that day. Officer E could not recall having any direct contact with the man that morning or hearing him threaten to harm or kill himself. The only other staff on duty on G wing that morning were SO E (who, in fact, said that he spent most of the morning away from the wing) and Officer J (who recorded in the ACCT plan that the man had threatened to kill himself that morning). In interview, Officer M categorically denied having had any contact with the man on 5 November.
137. The CCTV footage shows that the man was unlocked shortly after 11.00am and he was allowed to call his girlfriend from the wing office. (Because this call was made using the office telephone, it was not recorded and so was not available for the investigator to listen to.) Officer K remained in the office during the call but said that he tried not to listen to what the man was saying to give him privacy. However, he remembered that the man and his girlfriend had talked for about half an hour and that, at times, the man shouted at his girlfriend and was unpleasant to her. The officer said that he wanted to make sure the conversation ended at a “good point” and so he let them talk for some time. When he did end the call, the officer thought that the man was in a good mood. Since the publication of the draft report, our office has spoken to the man’s girlfriend. She reported that their conversation was difficult and that they both were tearful and upset. She said that the call ended abruptly and that the man was till upset and crying. This conflicts with Officer K’s evidence that the conversation ended at a good point. Without the benefit of a recording of the conversation, we can only reflect the differing accounts.
138. Shortly before midday, prisoners on G wing, including the man, collected their lunch and were locked in their cells. Mr B said that he talked to the man, who was angry. He said that he was going to ask staff for another telephone call because his girlfriend had told him that she wanted to end the relationship. Mr B said that the two men continued to talk once they were locked in their cells. (Mr B had cell G3-10 and explained that prisoners talk through the gaps

down the sides of the cell door.) The CCTV footage shows that the man did not press his cell bell between midday and 1.00pm when he was next checked. No staff came to his door during that hour. Most prisoners with cells on G3 agreed that the man did not press his cell bell or kick the cell door after lunch had been served.

139. Mr C, in cell G3-12, said that he also spoke to the man after lunch. He said that the man told him he was going to hang himself. Mr C replied that he would press his cell bell and alert staff. The man reassured him that he was joking. However, Mr C said that the man then repeated that he planned to kill himself. Mr C said that he did not raise the alarm because he still thought the man was joking. It seems that no other prisoners in cells nearby heard this exchange.
140. Officer J was on duty on G wing over the lunch time patrol period. According to the CCTV, at shortly after 1.00pm, she checked all of the prisoners on G wing by looking through the observation hatch in the door. Officer J recorded in the ACCT ongoing record that the man was sitting at his desk writing a letter. In interview, Officer J said that she knocked on his observation window and asked if he was feeling better having spoken to his girlfriend. She said that he turned down his music and spoke to her at the door. The man told Officer J that he was fine. The man did not press his cell bell after Officer J's check. In interview, several of the prisoners said that the 1.00pm check did not occur.
141. After the man's death, a letter he was writing to his girlfriend was found in his cell. He had started the letter the evening before and noted that he was continuing it at 11.45am that morning. He apologised again for what he had written in his last letter and described how hard he found it to have run out of credit and not be able to find out how she was feeling about him. The police investigating the man's death did not consider the letter to be a suicide note. It contains no clear indications that the man intended to harm himself although he wrote about how difficult he found life in prison.
142. At about 1.45pm, Officer J said she and Officer E were given permission to unlock prisoners on the wing. G wing prisoners were not having association that afternoon due to staff shortages and so she only unlocked prisoners who needed to work. According to the new regime, on Saturdays, prisoners who need to attend work or who had a booked visit were unlocked between 1.30pm and 1.45pm. Remaining prisoners are normally unlocked for association at about 2.00pm. Staff told the investigator that the lunch time roll check (when all prisoners are counted) was late that day and was not pronounced correct until some time after 12.30pm. As a result, the afternoon programme was also slightly delayed. Staff were unable to confirm whether the man knew that he would not be unlocked for association that afternoon. However, Officer J thought that the man might have expected staff to be on the landing at around 1.30pm to unlock other prisoners.
143. The ACCT observation level set at the case review the previous day meant that staff were not required to check him frequently during the day. However,

Officer J said that she always checks prisoners more frequently than is required. At about 2.17pm, she returned to G3 and checked all the prisoners again.

144. Mr E, a prisoner and laundry orderly, had already been unlocked and was talking to another prisoner on the landing at his cell door. Officer J reached the man's cell and looked through the observation hatch. In interview, she said that he had covered his cell window with material so the room was quite dark. Initially, she thought he was standing on the end of his bed frame, but then realised that his feet were suspended and he had a sheet tied around his neck. At about 2.18pm, she used her radio to raise a code red alarm which indicates a serious medical emergency and ensures that available staff and the emergency response nurse attend with the correct equipment.
145. Officer J knew that Officer E (the only other member of staff working on G wing at the time) had left the wing to escort a prisoner to work. As a result, she asked Mr E if he would come into the man's cell with her, because she realised that she would not be able to support his weight alone. In interview, Mr E said that he knew something bad had happened and after a brief hesitation, agreed to help. Officer J climbed on the bed frame to cut the ligature using her anti-ligature knife and Mr E tried to support the man's weight. Mr E said that the man was heavy and the two of them found it difficult to move him into the middle of the cell.
146. Officer E reached the man's cell less than a minute after the alarm had been raised, quickly followed by SO E, Nurse B and Nurse C. At this point, Mr E and Officer J were ushered from the cell and looked after by other staff. Nurse B checked the man for signs of life and, on finding none, instructed staff to begin cardio pulmonary resuscitation (CPR – a mixture of rescue breaths and chest compressions in an effort to manually maintain oxygen flow around the body).
147. On hearing the code red alarm, SO A asked the control room to call for an emergency ambulance. The first response paramedics (who usually travel by car or motorbike) arrived at the prison gates at 2.24pm, with two further ambulances arriving at 2.32pm. According to the CCTV, the first paramedics reached the man's cell at about 2.25pm. The paramedics administered drugs directly into his veins, a tube was placed down his throat to help give oxygen and he was attached to a defibrillator. (In certain circumstances, a defibrillator can deliver electric shocks to help re-establish a normal heart rhythm.) Nurse B said that the defibrillator (which gives audible instructions) instructed that no shock should be administered.
148. The man was taken from the landing on a stretcher at about 2.46pm, with paramedics and staff continuing to administer CPR. The ambulance left the prison gate at 2.52pm. Despite the best efforts of prison staff and nurses, the paramedics and hospital staff, the man could not be resuscitated and at 3.08pm on arrival at Stoke Mandeville Hospital he was found to be dead.

Contact with the man's family

149. The head of prison safety was appointed as the family liaison officer. He arrived at the man's parent's address in West Sussex at 6.50pm and broke the news of the man's death. The head of prison safety remained in contact with the man's parents and, offered financial assistance with the cost of the man's funeral, in line with prison service policy.
150. The man's parents initially told his girlfriend of his death. However, the head of prison safety spoke to her by telephone on 6 November to try to answer questions she had.

Support for prisoners and staff

151. Mr E said that he was well supported after the man's death. On the afternoon of 5 November, the Imam took him from G wing to the prison mosque where they sat and talked. Over the following days, officers and healthcare staff frequently checked Mr E's well being.
152. Most of the prisoners interviewed said that they knew something had happened that afternoon, either because they heard events unfolding or saw the man being taken off the wing on a stretcher. Most remained locked in their cells until tea was served that evening, however one or two were unlocked for visits or work. These prisoners were told by staff that the man had died and word spread quickly around the wing. However, the news of his death was not formally broken until the morning of Sunday 6 November. In the meantime, all prisoners on open ACCT plans were checked and case reviews held.
153. The prisoners said that they too had been well supported following the man's death. They were particularly positive about the support offered by the chaplaincy team but also mentioned that wing staff had been helpful. A memorial service was held in the prison a short while after his death. It was apparently well attended by both prisoners and staff.
154. Most of the staff interviewed said that they had been adequately supported by the prison. In line with PSI 64/2011, a hot debrief was held on 5 November. (The purpose of the hot debrief is to provide reassurance to staff involved in a serious incident and allow them to talk about their experiences.)

Post mortem and toxicology reports

155. The post mortem report concluded that the man died as a result of hanging. Samples of his blood, urine and fluid around the eyes were tested for the presence of blood and a range of drugs, including illicit substances and prescribed medication. The tests were negative for all substances, indicating that the man might not have been taking quetiapine as prescribed.

ISSUES

Meeting the man's mental and physical health needs

156. The man had a lengthy history of involvement with mental health services in the community and in custody. However, opinion was divided about the exact nature of his behavioural problems. He had been prescribed medication to treat ADHD in the past but had a poor history of compliance with taking it. The mental health professionals interviewed explained that the man did not meet the threshold for the Care Programme Approach (CPA – the holistic approach to treating a patient with a severe mental illness).
157. NHS Buckinghamshire commissioned a panel of reviewers to consider the clinical care offered to the man at Aylesbury. The panel note the good teamworking displayed by the general healthcare team and the MHIT. Staff interviewed described communication between general and mental healthcare staff as regular and consistent.
158. MHIT and general healthcare staff make entries on shared records, meaning that the entire record is available to all healthcare staff. Generally, the panel found the man's medical record to be "continuous and comprehensive", with entries reflecting decision making, involvement in ACCT plans and prescribing decisions. However, the investigation highlighted occasional gaps in the medical record, such as the results of the chest X-ray ordered in May 2011, the reason for the man's missed psychotherapy appointments and notes of the joint meetings held on Mondays.

The Head of Healthcare should ensure that all healthcare staff comply fully with the requirements for accurate and contemporaneous record keeping in accordance with the required standards of the General Medical Council and the Nursing and Midwifery Council.

159. While at Aylesbury, the man had regular contact with staff from the MHIT, particularly the MHIT team leader and the psychiatrist. In interview, both described the MHIT work with the man as crisis based. The clinical review panel note that his records do not include a "clearly articulated therapeutic plan against which progress could be measured". This was, perhaps, in part because he was not being managed under the CPA.
160. The psychiatrist thought that psychological therapy was likely to be the most appropriate and successful treatment for the man's problems. However, he was reluctant to engage and, once referred to the psychologist, did not complete the task set and, eventually, missed his appointments and ceased to engage. When the man withdrew from psychological therapy, no alternative strategy was formulated. The panel note that "it is possible that that no alternative strategy would have been effective but those in day to day contact with [the man] would need to know this in order to manage his behaviour". The psychologist explained that her time at the prison is limited, considering the number of prisoners who might benefit from working with her. Perhaps because of this, there is no evidence that any further work was done to

encourage the man to engage. The panel makes the following recommendation which we endorse:

The Head of Healthcare should ensure that a documented therapeutic plan with clear objectives is devised when the MHIT engages with a prisoner, even when the threshold for formal CPA is not met.

161. The psychiatrist did not think that the man was suffering any serious diagnosable mental health condition. However, he said that the man remained convinced that he needed to be prescribed medication. The psychiatrist initially agreed to prescribe a low dose of risperidone, which was changed to quetiapine after the man suffered erythema nodosum. The panel explain that the use of low doses of anti-psychotic medication to help reduce impulsivity and mood swings is “not unusual”. The man sometimes thought that the medication was helping him and sometimes said that it was not. The toxicology report found that the man might not have been taking quetiapine as prescribed. The panel conclude that, as it was not being prescribed to treat a major mental illness, his non-compliance was unlikely to have significantly impacted on his mental health.

How the man’s behaviour was managed

162. The man struggled to cope with the restrictions of prison life and a clear trigger to his volatile and impulsive behaviour was being unable to speak to his girlfriend or family. He frequently threatened serious self harm and punched walls on a regular basis. He could be threatening and abusive towards staff and was often accused of misusing his cell bell. Most of those interviewed, although clearly fond of him, acknowledged that he could be one of the most demanding and exasperating prisoners in their care. Given these characteristics, a key consideration has been how his behaviour was managed on a day to day basis.
163. The responsibility for managing the man’s challenging behaviour fell largely on G wing officers. Most of the officers interviewed said that they could seek support and guidance from MHIT staff, senior officers or the safer custody team. However, none could recall ever having seen or been involved in devising a formal strategy setting out how the man’s behaviour should be dealt with. There was little evidence of a robust and consistent approach being taken or of more than sporadic attempts being made to encourage the man to reflect on or address his behaviour.
164. In interview, the head of prison safety explained the importance of structuring, managing and changing prisoners’ learned behaviour. He said that establishing a behaviour management strategy can be done in a variety of ways, including using the wing observation book or a Personal Intervention Plan (PIP). Indeed, the man was monitored on a PIP in July 2011 because of his bad behaviour. It seems that he responded well to the intervention. However, due to the lack of information recorded in the PIP it is not possible to fully understand how or why this approach worked. A review of the minutes of the safer custody team meetings held between June and September

showed that, while individual prisoners had been mentioned and strategies discussed, the man was not specifically discussed.

165. Over time, the man was also monitored on a number of ACCT plans. PSO 2700 – Suicide prevention and self harm management (replaced in April 2012 by Prison Service Instruction 64/2011 – Management of prisoners at risk of harm to self, to others and from others (Safer Custody)) contains guidance about how staff might use the ACCT enhanced case review process to deal with prisoners whose behaviour includes self harm and violence or disruption.
166. Membership of an enhanced case review should include “more specialists and a higher level of operational management” than a typical ACCT case review. The PSO suggests that a representative of the mental health team, the residential manager, the personal officer, a psychologist, a member of the chaplaincy team, the offender supervisor and any other specialists working with the prisoner should be invited, as well as the prisoner. The clinical review panel emphasised the importance of involving the MHIT in devising a behaviour management plan for the man.
167. Section 9.4 of the PSO outlines the aims of the enhanced case review process as:
- Providing “consistent, integrated care by all staff involved with the prisoner” by ensuring that the Caremap includes “*a named key worker(s), strategies for encouraging pro-social behaviour, and agreed strategies for responding to each individual problem behaviour that the prisoner displays: both those problems that involve self-harm and those that involve anti-social behaviour.*” (Mandatory instructions are written in italics in the PSO.)
 - Including “*an active, on-going, persistent attempt to engage the individual and build a positive, on-going relationship with him*” by appointing a member of staff to act as the key worker.
 - Ensuring that “*adequate support for members of staff*” is built into the process.
 - Encouraging the prisoner to reflect on their triggers and try to understand their behaviour.

PSI 64/2011 notes that the enhanced case review process can be very effective in reducing prisoners’ risk of harm to others as well as to themselves.

168. Although the man was monitored on several ACCT plans while at Aylesbury (and a later section focuses on the ACCT processes in place there), the enhanced case review process was never used, and apparently not considered. We believe that this would have been a highly appropriate way of supporting him and staff and we make the following recommendation:

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

169. The head of prison safety said that mental health awareness training, to be delivered by the MHIT, was planned for all officers but had not been carried

out for a number of reasons. Most of the officers interviewed thought that such training would help them in their day to day work, although acknowledging that they were not mental health practitioners. It is our opinion that, given the background of the population at Aylesbury, giving officers a basic grounding in mental health awareness could improve outcomes for prisoners.

The Governor should ensure that officers receive regular mental health awareness training appropriate to their role, to educate them about some of the more common mental health problems affecting the population at Aylesbury.

Assessing the risk the man posed to himself

170. Given the man's history of making threats and committing acts of self harm, the investigation has considered how professionals working with him assessed the risk he posed before and on 5 November.
171. Following his return to Aylesbury in February 2011, the man was monitored on an ACCT plan on six occasions (including at the time of his death). Generally, the ACCT plans were opened because he had threatened to harm himself. On some occasions, he expressed suicidal thoughts. All of those interviewed were asked about how his risk to himself was assessed. The responses indicated that neither staff nor prisoners believed that the man ever genuinely wanted to die or intended to take his life. He often quickly withdrew his statements of intent and normally told staff that he threatened self harm because it was the only way he knew how to get what he wanted.
172. The clinical review panel note that there was no evidence that the man suffered with depression or experienced genuine suicidal thoughts. However, the assessments of risk carried out did not always reflect his impulsive behaviour, difficulties managing anger and frustration and tendency to violence. The panel note that "the possibility of unintended serious self harm should also be considered" in a prisoner who threatens self harm as the man did. Clearly, some staff feared just this. Officer A told the investigator that "if there was ever to be an accidental death in custody it would be [the man]." The assistant Anglican chaplain said that she had tried to talk to the man about the inherent dangers in his behaviour. The majority of interviewees said that they did not believe that the man had intended to take his life, but that it was the result of a tragic accident. However, the ACCT plans do not reflect any serious considerations of how the man's behaviour might increase the risk of unintended self harm.
173. PSI 64/2011 contains a helpful list of risk factors which are recognised to increase an individual's risk of suicide, including a history of deliberate self harm, contact with mental health inreach services, a diagnosis of a personality disorder and impulsiveness. As this report makes clear, several of these factors applied to the man. We make the following recommendation:

The Governor should ensure that assessments of the risk of self harm include all relevant factors additional to depression and suicidal thoughts such as volatility, impulsivity, violence and personality disorder.

174. The MHIT team leader opened an ACCT plan for the man on 28 October after he threatened self harm. She said that there was nothing in his behaviour or demeanour that day that caused her to be more concerned about him than usual. Nor was his behaviour over the following few days unusual. The man repeatedly told staff, as he had done on many other occasions, that he had no intention of harming himself.
175. On 5 November, he had no pin phone credit and so staff allowed him to try telephoning his girlfriend from the staff office. When she did not respond on the first occasion, the man became very angry. He punched the walls and demanded to be placed on constant observation, saying that he would kill himself. The G wing officers on duty that day did not consider this behaviour to be out of the ordinary for the man, and given the context, we think this was an understandable response.
176. However, Mr A said that, on the morning of 5 November, the man showed him a noose he had made and said that he planned to kill himself that day. Officer L said that, while Mr A expressed concern for the man he did not say that he had made a noose. Officer K initially said that Officer L told him that the man had made a noose, and that he spoke to the man and briefly checked his cell as a result. When approached again about the matter later in the investigation, Officer K said that he could no longer remember whether Officer L had or had not mentioned a noose. However, he could remember checking the man's cell so he must have had some concerns. Clearly these are conflicting accounts and as there is no independent corroborative evidence, we are unable to do more than reflect what the three individuals involved said. However, if either of the officers were told that the man had made a noose or that he had threatened to kill himself they should have recorded the information in the man's ACCT plan. It should also have triggered an ACCT case review and review of the level of observations.

The Governor should remind all staff that all risk related information should be recorded in a prisoner's ACCT plan and that, depending on the information, a case review should be convened at the earliest opportunity and the level of observations reviewed.

177. Having been allowed another telephone call to his girlfriend, the officers on duty said that the man was calmer and more settled. Some prisoners interviewed said that he continued to press his cell bell over the lunch period, but this is not supported by the CCTV footage. Mr C said that the man threatened to kill himself over the lunch period, but because he thought the man was joking, did not raise the alarm. When he was checked at 1.00pm, the man was sitting at his desk writing. He raised no concerns with Officer J, and told her that he was fine. We do not think that his behaviour or demeanour gave any indications of a substantially increased risk.

The ACCT process

178. Because the man was monitored on ACCT plans while at Aylesbury, we have considered the extent to which the documents followed guidance and met the objectives of the process. According to the Prison Service guidelines, the ACCT process should be a multi-disciplinary one involving key people who know the person at risk or are involved in his care. On a number of occasions, the man's case reviews were attended by the MHIT team leader or another member of the MHIT. General nursing staff also attended some reviews and members of the chaplaincy team were present at some. The chaplains and healthcare staff interviewed said that they received daily notifications of all open ACCT plans and were suitably involved in ACCT case reviews. Although it was unfortunate that the last two ACCT reviews were not multi-disciplinary, most were and there were plans for the mental health nurse to attend the next one.
179. The PSO also contains guidance on how the Caremap should be completed. Entries on the Caremap should "aim to address the problems identified in the ACCT assessment interview and the case review as contributing to the person's distress and leading them to self-harm or think of suicide". They should be devised to meet the specific needs of the individual and they should be time bound. There is evidence that staff tried to complete the man's Caremaps in line with guidance, but it is our view that the lack of an overall strategy for dealing with his behaviour impacted on their ability to do so.
180. The ACCT plans generally demonstrate that staff responded appropriately to the man's level of risk. We consider that decisions to open and close ACCT plans were appropriately made and took into account his state of mind at the time. Observation levels were generally adjusted according to relevant information. Post-closure reviews took place after each ACCT plan was closed. However, we do not think that the ACCT plans sufficiently acknowledge the man's frequent wall punching to be acts of self harm. As a result, the plans make little reference to this behaviour.

The Governor should remind staff of the broad range of behaviours that constitute self harm and which should be addressed as part of the ACCT process.

Educating prisoners about the risks of ligatures

181. In interview, the head of prison safety said that he was concerned by how little awareness prisoners at Aylesbury seem to have about the dangers of tying things tightly around their necks. He thought that prisoners were under the incorrect impression that they would easily be able to remove a ligature once it had been tied and thus not risk harming themselves. The clinical review panel note the dangers in this, writing that within 10 to 15 seconds of the item being tied around the neck and tightened the individual will be unconscious; in one to two minutes, their heart will have stopped beating and within 10 minutes, they will have died.

182. The head of prison safety said that he would like to issue guidance to prisoners alerting them to the specific dangers of this method of self harm however had been advised against this by the Offender Safety, Rights and Responsibilities group (OSRR - the department in the National Offender Management Service (NOMS) responsible for policies relating to prisoner safety). The investigator spoke to OSRR. They explained that providing guidance about the dangers of a specific method of self harm might serve to encourage those considering suicide to use that method.
183. We understand that concern, particularly when dealing with suggestible young people, but this office has investigated a number of deaths in which we believe there are indications that the prisoner did not intend to cause his or her death when they tied something around their neck and hanged themselves. The clinical review panel has made it clear how quickly someone becomes unconscious and ultimately dies once the noose is tightened. In light of this, it is our view that NOMS should commission research as to how best establishments could communicate prisoners of the dangers of this method of self harm.

The Chief Executive of NOMS, in liaison with the Department of Health, should commission research on how best to provide appropriate guidance to prisoners that clearly sets out the specific risks of tying items tightly around the neck as a form of self harm.

The emergency response

184. Officer J saw the man hanging in his cell at 2.18pm and called a code red emergency. At the time, she was the only officer on the wing because Officer E was escorting prisoners to work. She said that she knew she would not be able to support the weight of the man's body alone because he was a tall, muscular young man. He was also fully suspended from the cell floor. As a result, she asked Mr E to help her while she waited for assistance from colleagues. It is very unusual, although not unheard of, for prisoners to be asked to assist staff in an emergency. It is clearly not ideal, not least because of the distress caused to the prisoner. Additional staff arrived at the man's cell within one minute of the radio call, however, in that time, Officer J and Mr E had cut the bedsheet and lowered the man to the floor. The speed of the response is crucial in cases such as this. For this reason, we believe that it was not wrong of Officer J to ask Mr E for help. Fortunately, Mr E said that he felt well supported both immediately after the man's death and in the days that followed.
185. The CCTV footage shows that the response from officers and nurses was prompt. They began CPR quickly and continued until the paramedics arrived. That the paramedics were at the man's cell so quickly after the alarm was raised indicates that the prison's contingency plans worked well.

Informing prisoners of the man's death

186. Most of the prisoners interviewed said that they knew that something serious was happening because they could hear staff coming and going on the wing. Some said that they saw the man being taken from the wing on a stretcher. One prisoner who was unlocked for a visit that afternoon said that an officer told him that the man had died. Understandably, word spread quickly around the wing and, by tea time, it seems that most prisoners knew of the man's death. However, the news was officially broken the following day when officers and chaplains gathered the prisoners together. We find that the breaking of the news was handled sensitively and that prisoners were offered excellent support, particularly by the chaplaincy team. However, we think that, ideally, the prisoners on G wing should have been informed on 5 November, to avoid the potential for additional upset, misinformation and rumour. The man's parents had been told by 7.00pm, after which, prisoners could have been told.

The Governor should ensure that prisoners are informed of a death in custody at the earliest opportunity.

Concerns raised by the co-ordinating chaplain

187. In interview, the co-ordinating chaplain raised several concerns about the actions of G wing staff. He said that he had overheard officers in the G wing office talking about the man in a derogatory way, within earshot of other prisoners. He said that the man was aware of this.
188. Officers are expected to behave in a professional manner at all times. However, as already discussed, the YOI population (and indeed all other prison populations) can be demanding, challenging and frustrating. It would be unreasonable and unworkable to recommend that staff never discuss those frustrations in the workplace. However, officers must ensure that such discussions are managed appropriately. Clearly, they should not take place in the presence of or within earshot of prisoners. The Governor was informed of the co-ordinating chaplain's concerns and, on 13 February, issued a Governor's notice to staff instructing staff to ensure their conversations cannot be overheard by prisoners.
189. The co-ordinating chaplain was also concerned that officers often asked prisoners to respond to emergency cell bells. In interview, officers admitted that they either knew that this happened, or indeed had themselves asked prisoners to answer bells. Some prisoners said that they had done so at the request of staff. Again, this matter was raised with the Governor. A Governor's order was issued on 9 February confirming that the practice is "unacceptable, indefensible and must cease immediately". We endorse that approach.

CONCLUSION

190. There is no doubt that the man was a challenging and demanding prisoner to manage. While in custody, staff reported that he used threats of self harm to get what he wanted and this continued in custody. He possibly suffered a number of mental health problems, but inconclusive diagnoses meant that he was not consistently prescribed medication. Once at Aylesbury, he was referred to and worked sporadically with the MHIT, but the responsibility for most of the day to day management of his behaviour fell on the officers on the wing.
191. This investigation has found that no appropriately robust strategy for challenging and managing the man had been drawn up. As a result, he was not always dealt with consistently. Both he and staff were clearly frustrated by the repeating patterns of behaviour. However, the man had always maintained that he had no plans actually to harm himself. He was apparently positive about his future after release.
192. On 5 November, the man was found hanging in his cell and he could not be resuscitated. We cannot know whether his death was accidental or intended. However, we conclude that officers responded reasonably to his threats that day and that the level of monitoring was appropriate. We make nine recommendations as a result of the investigation.

RECOMMENDATIONS

The NOMS response is detailed in italics beneath each recommendation.

1. The Head of Healthcare should ensure that all healthcare staff comply fully with the requirements for accurate and contemporaneous record keeping in accordance with the required standards of the General Medical Council and the Nursing and Midwifery Council.

This recommendation has been accepted: "Health Care staff have been reminded of their responsibilities in this area and this will be monitored by managers. Quarterly audits of documentation now take place."

2. The Head of Healthcare should ensure that a documented therapeutic plan with clear objectives is devised when the MHIT engages with a prisoner, even when the threshold for formal CPA is not met.

This recommendation has been accepted: "Each patient accepted onto the case load of MHIRT will have a treatment plan in place, addressing that patients identified needs."

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

This recommendation has been accepted: "PSI 64/2011 Management of prisoners at risk of harm to self, to others and from others (Safer Custody) provides guidance for the management of Complex needs prisoners which will facilitate assessment and multi-disciplinary intervention and strategy. The Safer Custody department will carry out a monitoring function."

4. The Governor should ensure that officers receive regular mental health awareness training appropriate to their role, to educate them about some of the more common mental health problems affecting the population at Aylesbury.

This recommendation has been accepted: "New Mental Health Awareness Training package is now included in the Establishment's Training Plan. Training will commence in June 2012."

5. The Governor should ensure that assessments of the risk of self harm include all relevant factors additional to depression and suicidal thoughts such as volatility, impulsivity, violence and personality disorder.

This recommendation has been accepted with the same response as recommendation 3.

6. The Governor should remind all staff that all risk related information should be recorded in a prisoner's ACCT plan and that, depending on the information, a

case review should be convened at the earliest opportunity and the level of observations reviewed.

This recommendation has been accepted: "A Governors Notice to Staff will be issued to remind all of the importance of recording any risk information in ACCT plans and the importance of case managers/zone managers to convene case reviews to address the risk information. The Safer Custody department will carry out a monitoring function."

7. The Governor should remind staff of the broad range of behaviours that constitute self harm and which should be addressed as part of the ACCT process.

This recommendation has been accepted: "The following methods of self harm, as listed on the F213SH form, will be disseminated to all staff through a Governor's Notice to Staff. Hanging, self strangulation, cutting/scratches, self poisoning/overdose, burning self, swallowing objects, head banging/wall punching, suffocation, wound aggravation, noose/ligature making. The notice will instruct staff of the need to open an ACCT Plan if not already open, in any of these circumstances."

8. The Chief Executive of NOMS, in liaison with the Department of Health, should commission research on how best to provide appropriate guidance to prisoners that clearly sets out the specific risks of tying items tightly around the neck as a form of self harm.

This recommendation has been partially accepted: "Offender health will share this report with Prof Susan Bailey, forensic child and adolescent psychiatrist and Jenny Shaw, Professor of Forensic Psychiatry, Deputy Director National confidential inquiry into suicides and homicides for their ideas on the management of repeatedly harming impulsive young men in custody."

9. The Governor should ensure that prisoners are informed of a death in custody at the earliest opportunity.

This recommendation has been accepted: "This has been included in the Contingency plans for a Death in Custody."