

A Report by the
Prisons and
Probation
Ombudsman
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CBE

**Investigation into the circumstances
surrounding the death of a man at HMP
Wymott in June 2013**

Our Vision

*'To be a leading, independent investigatory body,
a model to others, that makes a significant contribution
to
safer, fairer custody and offender supervision'*

This is the investigation report into the death of a man, who was found hanging in his cell at HMP Wymott in June 2013. He was 39 years old. I offer my condolences to his family.

A clinical review of the man's clinical care at Wymott was undertaken. The prison cooperated fully with the investigation.

The man, who was serving a life sentence for murder, had requested a transfer to Wymott to be nearer to his family and arrived there on 18 April 2013. Within days of his arrival, he told prison staff that he feared for his safety as he believed associates of his victim were at the prison and wanted to hurt him and his family. At the end of May he began to be monitored as a potential victim of intimidation and in June he also began to be monitored under suicide prevention procedures after a minor act of self-harm. There was some evidence that he was being intimidated by another prisoner. He was moved for his own protection but the potential bullying does not appear to have been fully investigated.

Subsequently, the man voiced increasingly irrational fears about his and his family's safety. Members of the mental health team who saw him did not consider he was mentally ill but, despite his concerning behaviour, he never had a full mental health assessment. Towards the end of June it was found that he had blocked the observation panel on his cell door and made a barricade. The door was forced open and he was discovered hanging from the window by a shoelace.

The investigation has identified some shortcomings in the operation of anti-bullying and suicide prevention procedures at the prison. I am also particularly concerned at the lack of mental health assessment which might have identified the extent of the man's distress. Nevertheless, it would have been difficult for the staff to have predicted and prevented his actions.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman

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CONTENTS

Summary

The Investigation Process

HMP Wymott

Key Events

Issues

Recommendations

SUMMARY

1. The man was serving a life sentence and transferred to HMP Wymott on 18 April 2013. After a week at the prison he told staff that he feared for his and his family's safety as he believed that associates of his victim were also at the prison and had made threats against him. He did not give the names of anyone who was threatening him. He refused to move to the vulnerable prisoners' wing, so it was agreed that he could remain in the prison's induction wing. Because of his fears, his offender supervisor began to make arrangements for him to transfer to a different prison.
2. Over the following weeks, the man continued to tell his family that he was concerned about his safety. On 28 May, prison staff began monitoring him under the prison's violence reduction arrangements after he alleged that other prisoners were going to attack him. Officers noted that he often remained in his cell and seemed afraid to come out, but occasionally he mixed with other prisoners.
3. On 17 June, the man made cuts to his face and he began to be monitored under suicide and self-harm prevention procedures. Monitoring stopped later that day but began again the next day after he harmed himself again.
4. Between the 18 June and 26 June, the man's risk of suicide and self-harm was reviewed on four occasions. At three of the reviews, a representative from the prison's mental health team was present, and no concerns about his mental health were noted. However, no formal mental health assessment was conducted. On 21 June, he agreed to move to the vulnerable prisoners' landing on the induction wing. During this time his fears that his family had been harmed intensified, but when mental health staff spoke to him he accepted that this was not the case and that some of his fears were irrational.
5. In the days before his death, the man had spoken to Listeners a lot. (Listeners are prisoners trained by the Samaritans to give confidential support to other prisoners in distress.) On the night before his death, he spoke to the Samaritans by telephone during the night. In the morning it was found that he had barricaded his cell door and blocked his observation panel. This delayed officers getting into the cell. When they went in they found him hanging from his window by a shoelace. Attempts to resuscitate him were unsuccessful and paramedics pronounced him dead at 9.45am.
6. The investigation has identified some deficiencies in the operation of self-harm and anti-bullying procedures and we are concerned that the man had no formal mental health assessment despite evident concerns. Nevertheless, he was monitored as expected and it would have been difficult for staff at Wymott to have predicted or prevented his actions. We make five recommendations.

THE INVESTIGATION PROCESS

7. The investigator issued notices to staff and prisoners at Wymott informing them of the investigation and inviting anyone with information to contact him. He interviewed fourteen members of staff and spoke to six prisoners. He obtained all relevant documents from the man's time in prison and recordings of telephone calls with his family. He gave feedback to the Governor about his initial findings after the interviews.
8. NHS England Lancashire Area Team commissioned a clinical reviewer to review the standard of clinical care the man received at Wymott.
9. A copy of this report has been sent to HM Coroner.
10. Some of the issues raised in this report involve and cover allegations which are not proven.
11. One of our family liaison officers contacted the man's family. The family liaison officer and investigator met the man's family who had a number of concerns which they wanted the investigation to cover including:
 - That his self-harm monitoring was not managed appropriately. He had access to items with which he could have harmed himself and that staff missed opportunities, such as his increased use of Listeners, to identify that he was at increased risk.
 - That he was being bullied.
 - That his address book, which went missing, was returned five weeks after his death. The family believe that someone who was threatening him might have had access to their contact details.

We have answered a number of other points raised by the family separately in correspondence. They received a copy of the final report but made no further comment.

HMP WYMOTT

F Wing

12. HMP Wymott is a category C prison holding over 1,100 adult male, sentenced prisoners. F wing consists of three landings. The first landing forms the prison's self-contained segregation unit. The other two landings are used as the prison's induction unit, one of which is for vulnerable prisoners who might be at risk from other prisoners, usually because of the nature of their offence. The two landings are separated by a locked gate and prisoners cannot mix with each other. Prisoners are able to communicate by shouting through cell windows or by speaking between the two open landings, but staff discourage this.

Healthcare

13. Health services at Wymott are commissioned and provided by Lancashire Care NHS Foundation Trust. A private company provides GP services and out of hours medical cover. There are no inpatient beds, but there is 24 hour nursing cover.
14. Mental health care is provided by an integrated team, an amalgamation of primary and secondary services. There are six full time mental health nurses and access to primary counselling and psychology services.
15. The mental health team is informed of any act of self-harm and invited to attend all ACCT case reviews. Attendance at an ACCT review does not constitute a formal mental health assessment, but is used to help decide whether a further formal assessment is required.

Assessment Care in Custody and Teamwork

16. Assessment, Care in Custody and Teamwork (ACCT) is the Prison Service process for supporting and monitoring prisoners at risk of harming themselves. The purpose of the 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. Checks should not be carried out at predictable intervals to prevent the prisoner anticipating when they will occur. Part of the ACCT process involves assessing immediate needs and drawing up a caremap to identify the prisoner's most urgent issues and how they will be met. Regular multi-disciplinary reviews should be held. The ACCT plan should not be closed until all the actions of the caremap have been completed.

Tackling Anti-Social Behaviour

17. Prisoners who are considered to be bullies, or are victims of bullying, are monitored under Tackling-Social Behaviour (TAB) procedures at HMP Wymott. TAB Perpetrator (TAB P) procedures are opened for those suspected of or proven to have been involved in anti-social behaviour and bullying. TAB Victim (TAB V) procedures are opened for victims of bullying to support and monitor

them. For bullies, there are three stages: TAB 1 is discrete monitoring, TAB 2 formal monitoring, and TAB 3 involves the bully being moved or segregated and placed on a formal violence reduction programme. Monitoring of both types of TAB include formal interviews and reviews and frequent observations which must be noted at least three times a day.

HM Inspectorate of Prisons

18. The most recent inspection of Wymott was a short follow up inspection in November 2011 of a full inspection in October 2008. Inspectors commented that, although the management of suicide and self-harm had improved considerably since their last inspection the quality of assessment, care in custody and teamwork (ACCT) procedures still required improvement. They reported that targets in caremaps were often too brief and were not well developed.
19. Inspectors reported a low level of violence and that there was a clear and comprehensive violence reduction policy. They noted that the tackling antisocial behaviour (TAB) system was well used and understood by staff, but that training in its operation was limited.

Independent Monitoring Board Report

20. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who oversee all aspects of prison life to help ensure prisoners are treated fairly and decently. In their most recent annual report, for 2011/12, the IMB identified that the anti-social behaviour (TAB) procedures had improved and that there were frequent management checks to ensure they were completed accurately and correctly. However, the IMB noted that not all areas of the prison operated the procedure and that there was a need to train staff to identify incidents of bullying.
21. The IMB reported that the administration of the ACCT system had improved and that Listeners continued to provide an excellent service to other prisoners and had also received mental health awareness training.

Previous self-inflicted deaths at HMP Wymott

22. The man's death is the fifth self-inflicted death that the Ombudsman has investigated at Wymott since 2004. This investigation identifies some similar themes about the operation of anti-bullying procedures, as in a previous investigation into the death of a prisoner at Wymott in April 2011.

KEY EVENTS

23. The man was convicted of murder on 7 June 2000 at Crown Court. He was sentenced to life imprisonment with a minimum time to serve of twelve years before he could be considered for release. (Known as the 'tariff'.) He transferred to HMP Frankland in 2001.
24. At Frankland it was reported that the man worked well, adhered to prison regimes, was respectful to staff and mixed well with other prisoners. He gave staff no cause for concern and kept in contact with his family and friends. He was often referred to by staff as a 'model prisoner'.
25. The man's tariff expired in June 2011. A Parole Board review, in June 2012, concluded that his risk to the public remained too high for the Board to recommend a move to open conditions. He recognised the need to complete further rehabilitation courses.
26. After completing a number of courses at Frankland and having his security category reduced in March 2013, the man requested a transfer to HMP Wymott to be nearer his family. His offender supervisor at Frankland said that before his transfer she completed security checks to establish if there were any security issues that would have prevented his transfer, including if any known associates were at Wymott. No problems were identified. His offender supervisor said that he was desperate to move closer to his family and had worked hard to achieve his move.
27. The man rarely used healthcare services at Frankland. On the few occasions that he did it was about his physical health, anxieties about weight loss and a fear of having cancer. He had no contact with the prison's mental health team.

HMP Wymott

28. On 18 April, the man transferred to Wymott and was allocated a cell in the prison's induction unit on F wing. On 20 April, he asked an officer to help him apply to speak to his offender supervisor. He telephoned his mother to make arrangements for visits. His mother said she was concerned about him, but he reassured her that he knew people at the prison, that he was fine and was about to start a week on the induction wing.
29. The man had a routine health screen on 22 April. No physical or mental health issues were identified.
30. In a telephone call on 25 April, the man asked his mother to contact his solicitors to inform them that members of his victim's family were also at Wymott and had threatened him. His mother rang the prison and said that her son was in danger. He also told staff about his concerns. An officer recalled that he had told her that he believed that prisoners related to his victim were at the prison and he feared for his safety. However, he was unable name them. Prison staff told the investigator that there was no direct evidence that he was being bullied but there

was no investigation into his concerns to see if they were true. However, because of his fears it was agreed that he should remain living in the induction unit. On occasions around this time he refused to come out of his cell or take part in activities.

31. In a telephone call to his family on 28 April, the man said he was okay but had made a “blunder” by going to Wymott. He said he had seen members of his victim’s family on the exercise yard and trusted no one. He therefore stayed in his cell as he was afraid he would be stabbed.
32. On 30 April, the man told his offender supervisor that he was afraid of remaining at Wymott and he only left his cell to collect meals. He said that his parents had also been threatened. He declined an offer to move to the vulnerable prisoners’ landing on the induction unit and requested to transfer to the Yorkshire area, where he would not be known but would still be able to receive family visits. His offender supervisor began to look into the possibility of a transfer to HMP Lindholme.
33. On 10 May, the man told his mother in a telephone call that some prisoners had been calling him a “nonce”, but that others were all right. He said he hoped to move to another prison. The next day he again told his mother that it had been a mistake to go to Wymott. He said that other prisoners were talking about him and knew his name and prison number so could inform prisoners in other prisons. He said he did not want to move to the vulnerable prisoner landing and said that he would feel safer in the segregation unit. He told his mother that he had told his offender supervisor that he would “string himself up” and that the prison would be sued as a result. He said that his supervising officer had told him that he would be put on a suicide watch if he made such comments. We were unable to interview the offender supervisor for his account of this conversation as he was on long term sick leave.
34. On 14 May, Lindholme prison told the offender supervisor that they would consider the man’s suitability for transfer and he let the man know. That evening, the man complained to his mother about general conditions at Wymott, that there were few officers visible on the landings and about his parole. He had another similar telephone conversation with her on 16 May,
35. On 28 May, wing staff began to monitor the man as a potential victim under the Tackling Anti-Social Behaviour (TAB) procedures as he had written to say that other prisoners were going to attack him. He asked to be moved to the segregation unit for his own safety and reiterated that he did not want to be moved to the vulnerable prisoners’ landing. He ended by saying that if he was harmed or killed the Governor would need to explain.
36. On 30 May, the man told his mother that he had been told he would not be moved to the segregation unit but would remain living in the induction unit. He told her that he stayed in his cell most of the day as he felt threatened by other prisoners, and that staff were trying to arrange a transfer to another prison.

37. At a TAB review on 3 June a supervising officer noted that there was no evidence that the man had been bullied since the document had been opened. Daily entries had identified no concerns and noted that he mixed well with other prisoners. It was agreed the TAB monitoring would continue for another week, when it would be closed if there was no change.
38. On 4 June, a nurse, the prison's mental health lead, completed a sentence planning and review report in preparation for the man's forthcoming Parole Board review. She noted, "There is nothing in relation to his mental or physical health that would affect his sentence planning or review or have any impact upon release plans".
39. At interview Prisoner A, who knew the man, said that around 5 June, the man began to be bullied by other prisoners calling him a "nonce" and a "grass". He said that he had advised him to speak to a chaplain and ask to move to the vulnerable prisoners' landing. He said that he had told him that he was getting stressed and was in two minds about killing himself or someone else and that he could not cope any more. He said that he talked in this way once or twice further, but that he did not take it too seriously as he believed that he was just angry and wanted to get things off his chest. He said that the man did not say that he had any specific plans to kill himself and generally kept himself to himself.
40. In a telephone call to his mother on 6 June, the man said that he would not be transferred until after his Parole Board hearing had taken place on 24 June and asked his mother to contact his solicitor about this. He said he wanted to "slash up" and was not using the showers as other prisoners were calling him a nonce. He said he did not like Wymott, was just getting grief and should never have gone there. He said that he had refused to move to the vulnerable prisoners' landing and had been told that a move to the segregation unit might jeopardise his transfer to another establishment.
41. A Supervising Officer (SO) conducted a further TAB V case review on 10 June, but the man was not present. (The main purpose of a TAB V is to ensure that a potential victim is monitored. Meaningful observations are expected to be recorded at least three times a day and significant events and conversations noted. The TAB also enables staff to draw up care plans and to hold frequent reviews at which the victim should be present.) The SO noted that there had been no incidents until 9 June, when he had reported that he had heard he was going to be hurt and that people thought he was a rapist. He did not give any names of prisoners involved. The SO noted that staff wondered whether that this could have been a way to manipulate a move off the induction wing, but officers were to continue monitoring and supporting him. The SO told the investigator he had thought this as there was no specific intelligence at the time to indicate that he was being bullied and he was unable to provide any names. Other entries in the TAB document noted that, although on occasions he remained in his cell during unlock periods, on some occasions he mixed well with other prisoners during association periods.

42. On 12 June, in a telephone call to his mother, the man said prisoners were shouting things about him out of their cell windows and that he was going to get hurt. She tried to reassure him that some of the people he had said were in the prison were not actually there.
43. The man came out of his cell and mixed with other prisoners during an association period on the evening of 13 June. The prison later became aware that, at 6.15pm that evening, Prisoner B on his wing tried to call the man's mother. The call was not connected as the number had not been approved for his account. It is unclear whether the man was present at the time. (His mother's number was later approved for the prisoner's account but at an unknown date.)
44. On 15 June, the man played snooker with other prisoners in the morning. In the afternoon he asked to be located in the segregation unit for his own safety, as he was being threatened by other prisoners. Again he did not give the names of any prisoners who were threatening him. An officer offered to move him to another wing, but he refused and said that he had problems with others throughout the prison. He remained in his cell and was told that arrangements would be made for him to speak with the wing's custodial manager. There is no evidence that this ever happened.
45. On 16 June, at his request, the man stayed locked in his cell all day. The next day he also remained in his cell. He asked to receive his meal after all the other prisoners had taken theirs. An officer said that he often refused to leave his cell and would not collect his meal until other prisoners had done so, but at other times he seemed happy to leave his cell.
46. At 1.20am on the morning of 17 June, the man showed an operational support officer a small cut he had made to the side of his face. A nurse assessed that he did not need treatment as the wound had dried. In line with Wymott's policy about self-harm the nurse informed the mental health team. He said he had self-harmed so he could be moved off the wing, but had no intention of killing himself. An ACCT document was opened and he was observed hourly. He said he did not want to speak to a Listener or use the Samaritans phone (a cordless phone which allows prisoners to speak directly to the Samaritans from their cells).
47. At an ACCT assessment later that day, the man told an officer that he was being threatened by other prisoners, he was anxious about new prisoners coming onto the wing and that one prisoner knew his mother's address. He said he had self-harmed due to stress, but had no thoughts of suicide.
48. After the assessment a SO chaired the first ACCT review. An officer was also present but there was no representative from healthcare. The man said that being on an ACCT would be the first and last time, adding that things had got on top of him, and that he had no intention of killing himself. The SO told the investigator that the man said he was afraid of being recognised by other prisoners, but he was unable to provide the names of the people he was frightened of. The SO said that he had had mental health awareness training

and he did not think the man had any pressing mental health problems at the time. He decided to close the ACCT at the first review as he did not consider that he was at risk of suicide or self-harm. The SO told him that he would speak to his offender supervisor about what was happening about his transfer. The SO told the investigator that because he had cut himself with a razor it would have been removed from his cell.

49. That afternoon a mental health nurse contacted the man's wing and spoke to a SO. The SO told her the ACCT had been closed so she did not attend.
50. At 8.10pm on 18 June, the man told staff he had cut himself with a razor blade and had swallowed half of it. A nurse cleaned and dressed a number of superficial cuts to the right side of his chest. The nurse found no abdominal pain or evidence of bleeding, but noted he was to be reviewed if he became unwell. His ACCT was reopened. He was to be observed hourly and he accepted an offer to sit with the wing Listeners and then went back to his cell.
51. In the early hours of 19 June, the man barricaded his cell door by placing some cell furniture behind it. He said that this made him feel safe but removed it when staff asked him to do so.
52. A SO chaired a second ACCT review at 10.10am. A nurse from the prison's mental health team, an officer and a member of the chaplaincy team attended. The SO noted that they discussed the man's issues, which remained the same. The nurse thought that he looked dishevelled but he was not concerned about his mental health at the time. The nurse noted that he was unable to explain why he had self-harmed, but said that he remained frustrated about his transfer. At the review he was to name or provide any details of those who he felt were threatening him. It was agreed that he should be observed three times during the night and that staff should have a minimum of three quality interactions with him during the day. He said that he would not self-harm again and later told an officer that he had felt a lot better.
53. The SO completed an ACCT caremap which identified two ongoing issues. The first, a transfer to Lindholme, was noted as being organised by the man's offender supervisor. The second was for him "to stop cutting up". It was recorded that razors had been removed from him and that he should talk to staff if he felt like harming himself.
54. After the ACCT review, a Listener and friend of the man's, told the offender supervisor that the man was being bullied by Prisoner B. He said that he believed the prisoner was "messing with his head", and blackmailing him for canteen (goods ordered from the prison shop) by threatening to pass his mother's contact details to his victim's family. He said that the man was "petrified" about this and said he had told him to tell staff, as the bullying would not stop unless he did. However, he said that the man's "head had gone by then" and that he appeared to be a different person. He said that when the man was moved to the vulnerable prisoners' landing on 21 June, the bullying stopped. The offender supervisor passed the information to the SO and Prisoner B began

to be monitored under the TAB scheme as a potential bully. It was agreed that a member of the mental health team should attend the man's next ACCT review on 26 June.

55. Immediately after the ACCT review the SO and offender supervisor reviewed the man's TAB document. The SO noted the allegations that had been made against Prisoner B. He set two targets on the TAB caremap: for wing staff to monitor Prisoner B and for the man's transfer to be pursued. Before this there had been no TAB caremap.
56. An officer opened TAB P procedures for Prisoner B. (The main purpose of a TAB V is to ensure that a potential victim is monitored. Meaningful observations are expected to be recorded at least three times a day and significant events and conversations noted. The TAB also enables staff to draw up care plans and to hold frequent reviews at which the victim should be present.) Although the SO had noted that the prisoner had been interviewed about the allegations, there is no record of an interview and no details were recorded in the TAB document. There is no record that any further investigations were made. The prisoner was advised to stay away from the man in order to prevent any further accusations.
57. In a telephone call to his mother on 19 June, the man said he could not stay at the prison any longer as he was being called a nonce, that someone in the segregation unit had said he had raped their relatives and that he was being talked about on Facebook. He told his mother that he had self-harmed and suggested that things were so bad he might kill himself. He said that other prisoners were threatening to hang him and if he was found hanging he would not have done it himself.
58. On 20 June, the man spoke to a member of the prison's chaplaincy, who offered to take him to the chapel. That evening he spoke to Listeners in his cell. In the early hours of 21 June, he told an operational support officer on the wing that night that he was worried and had a number of problems both inside and outside prison. She told him that he should ring his cell bell if he needed anything during the night.
59. At 6.00am on 21 June, the man made a number of superficial cuts to his left arm and said that he wanted to speak to a Listener. A nurse treated his cuts and informed the mental health team. He was told that as soon as the two Listeners were awake he could speak to them. In the meantime he was offered the Samaritans' phone but declined. A nurse noted that she saw him at the treatment hatch later, when he was making jokes and smiling.
60. A SO held an ACCT case review at 2.25pm. A nurse who happened to be on the wing at the time was invited and attended, as did the Head of Safer Custody. The man said he could no longer cope on the wing because of threats he had received and that if he was moved his risk of self-harming would significantly reduce. The Head of Safer Custody again offered to move him to the vulnerable prisoners' landing until he could be transferred. This time he agreed. Later that afternoon he told an officer that he felt more secure after he had moved. The

nurse said he had had no concerns about his mental health during the case review.

61. In the early hours of the 22 June, the man pushed a letter and some pictures under his door and asked the operational support officer on duty to arrange for them to be passed to his mother. The officer returned them to him. At 5.00am, he told the officer that he would pass his tobacco under his door for other prisoners. The officer suggested that this was not a good idea and he noted in the ACCT on-going record that the man was distracted and that it was difficult to communicate with him.
62. At 7.55am, the man asked an officer if he could speak to members of his family who were on other wings at the prison. (He had no family members at Wymott.) He told the officer that he was going to be shot or hanged if he left his cell and he had seen people constructing scaffolding on the landing during the night. The officer recorded this interaction in the ACCT on-going record which a SO later noted.
63. At 9.20am the man told an officer that he had been speaking to his mother about five members of his family who had been executed. He said his mother had been standing outside the prison's perimeter fence. The officer told the investigator that she told a SO and another officer about the conversation and phoned the mental health team and reported what he had said and that she was concerned about him. She was told that they were aware of the situation and she understood they intended to raise it with him at his next review. At 10.45am, the officer noted that he had spoken earlier to a Listener who had been concerned about his state of mind. She also recorded that he had been shouting out of the window during the night and a number of other prisoners on the landing had asked if he had mental health problems. At 11.10am he told an officer that he had to attend the funerals of six family members who had been killed. The officer told him that his family would have phoned the prison had there been anything wrong. During the morning, he left his cell, mixed with other prisoners and collected his lunch.
64. The man spent several hours with two of the wing Listeners that evening and then went back to his own cell in the early hours of 23 June. He told an operational support officer that he could hear voices through the cell wall. Half an hour later he told him that he had seen someone have their head cut off. At the early morning roll check, at 5.15am, the officer found that he was standing at his cell door and he suggested that he should try to get some sleep.
65. During the morning shift handover, the operational support officer suggested that the man might need to see the mental health team. Shortly after unlock, he told an officer that a person he named as a female had been shouting to him from outside the prison. The officer tried to make him understand that this was unlikely to have happened without saying she disbelieved him. She also recorded in the ACCT document that a prisoner the man had spoken to the previous night, had reported that the man had told him that a prisoner on F wing

at Wymott at the time had raped and murdered his mother.

66. 23 June, a SO arranged a meeting with the man, a mental health nurse, a nurse, two officers and a custodial manager also attended. It was the first time the mental health nurse had met him and she explained that she just happened to be on the wing at the time when the SO invited her to join them. She said he appeared quite relaxed and was rational. After discussion he accepted that the execution of family members in the prison segregation unit could not have happened. She said he was anxious about staying at Wymott and about his forthcoming parole hearing. He said that he felt institutionalised and was scared about the possibility of being released. She told him he needed to be more appropriate in his responses to anxiety and advised him to speak with staff about any concerns in future. She told the investigator that the meeting was not formally to assess his mental health and that she did not believe a fuller assessment was required at the time.
67. Later that afternoon, officers noted that the man had been out of his cell during the association period, had cleaned his cell, collected his meal and was seen laughing and joking with other prisoners that evening. In the evening he spent several hours with two Listeners. Five minutes after he returning to his cell, at 11.35pm, he rang his cell bell and told the operational support officer that he would give him £50 if he could stop his sister's execution. At 12.25am, on 24 June, the officer offered him the use of the Samaritans phone, but he did not want it. At subsequent checks during the night he was noted to be awake and sitting in his cell, but by 7.00am he was asleep.
68. On the morning of 24 June, the man told staff that he was very tired as he had not slept during the night, and wanted to sleep. He collected his lunch and said that he was fine when he was asked. The next night it was reported that he was more settled.
69. At 9.30am on 25 June, the man told a nurse that all of his family had been killed in prison, his son had died and he was depressed. She told him that the events he described had not happened and that it was unlikely that he was under threat on the vulnerable prisoners' landing. She said he did not engage further but just stared at her. The nurse informed an officer and phoned the mental health team to discuss her concerns and asked them to review his notes.
70. At 9.45am, the man saw two of the wing's Listeners. Before he spoke to the man, one of the Listeners told the officer that he believed he should be located in a camera cell (where prisoners at risk can be observed by CCTV). He spent more time with the Listeners that afternoon after collecting his lunch. He later told an officer he was okay.
71. During the day, the offender supervisor was informed that Lindholme were just awaiting final approval for the man's transfer to the prison. His fears and concerns were discussed at the monthly suicide prevention and violence reduction meeting. Although the nature of his concerns was discussed, no

actions were agreed to deal with these.

72. On the night of 25/26 June, the man was noted to have been asleep when first checked but in the early hours of 26 June he asked an operational support officer if his cell could be unlocked. The officer told him that was not possible. At 7.35am, an officer noted that he was up and dressed, but appeared unsettled as he had been awake for most of the night.
73. At 10.10am on 26 June, a SO chaired the man's fourth ACCT case review. A nurse and another SO were present. Before the review the nurse had contacted Frankland and confirmed that he had never had any contact with mental health services there. She said that during the review he could not explain the things he had been saying or why he had self-harmed. She told him that she did not consider he was mentally ill and did not need to be referred to a psychiatrist. She said he agreed.
74. The nurse told the investigator that she did not make a referral as the man had never had a formal mental assessment. She planned to complete an assessment at a one to one meeting with him the next week. During the ACCT review he spoke to his mother on the telephone, who reassured him that the family were all fine and that there was nothing to worry about. The nurse said he had appeared a little embarrassed and told his mother that he would send her a visiting order. He was told to "refrain from his recent behaviours" and he laughed and said that he would try. The level of staff observations remained unchanged and a review was set for 3 July. There was no review or update of his caremap.
75. Prisoner B's TAB P was reviewed by a SO at 11.00am. It was noted that there were some ongoing issues regarding the man, but that he had now been moved to the vulnerable prisoners landing.
76. That afternoon the man said he was happier after speaking to his mother. He collected his evening meal and mixed with other prisoners. In three telephone calls to family members that evening, lasting a total of almost 45 minutes, he discussed at length his concerns and thoughts about being in prison. He said he heard voices and people shouting out that he would be "strung up" because other prisoners thought he was a "nonce". He feared he would be stabbed, as other prisoners had keys to his cell. He said he did not want to take any medication, but thought he was hallucinating and would feel safer in the prison's healthcare unit. He said he was desperate to leave the prison and was going to be sent to Lindholme. At the end of his second telephone call he was asked to phone again in the morning. He said he would if he were still there.
77. On the morning of 27 June, the man phoned his mother again. He told her that he had not been sleeping because he was concerned that he would be attacked. He said that although he was being watched by officers he did not trust them and was afraid that they had given prisoners keys to his cell. His mother questioned him about things he had said the previous day and he replied that he must have been hallucinating but he did not want any medication.

78. An officer noted that morning in the man's TAB document that there had been no evidence of anyone bullying him. Other staff reported that he appeared a lot better, had collected his meals and raised no issues or concerns. That evening he mixed with other prisoners on association and appeared cheerful. He watched television in his cell into the early hours of the following morning.
79. On 28 June, the man told staff that he was okay and he was seen to mix with other prisoners. One of the prison chaplains visited him that afternoon. He said he had no thoughts of self-harm and the chaplain advised him to speak to Listeners or Samaritans if he needed to. During the day, he told officers on the wing that he was okay and in the evening he collected his meal and mixed with other prisoners. As on the previous night, he was noted to be watching television into the early hours. When checked he said he was okay.
80. On the morning of 29 June, the man joined other prisoners for the association period. An officer noted that he appeared to be in good spirits and when he collected his lunch he said he was fine. One of the Listeners said that during the day the man mixed with other prisoners and thanked him for everything he had done for him. The Listener said that he appeared to have cleaned himself up by taking a shower and shaving and was wearing his own clothes. He said the man played a game of pool and appeared to have a spring in his step.
81. The Listener said the change was good to see compared to how the man had been earlier in the week. Staff noted that he had a quiet afternoon and later he collected his evening meal but at 6.48pm he was hiding under his bed. An officer told him to stay visible. At 9.10pm, an operational support officer saw him standing in the dark in his cell. He told the officer that he was okay.

Events leading up to the incident

82. At 00.15am, the operational support officer could not see the man when he went to check him. He called for help and he and another officer went into the cell and found him under the bed. He said that he was hiding from the people who had murdered his family and that he had earlier spoken to his daughter. The officers told him that no one else had been on the landing. The officer said he was crying like a child but with no tears. The officer reassured him that that nothing had happened; that the operational support officer was patrolling the wings and that he was safe.
83. The man rang his cell bell at 2.50am and the operational support officer again asked the officer for help. They went into the cell again and he told them that a carrier pigeon had told him that seven members of his family had been murdered. He was given the Samaritans phone to keep until the next morning. Before he left the landing, the officer observed him, and saw him begin to use the phone. At 5.55am he was using the phone when the operational support officer checked him. He told him that he was okay but wanted to continue talking to the Samaritans.

84. A Listener on the wing said that he had heard nothing from the man's cell during the night but, at around 7.30am, he heard him shouting for the police saying his family had been killed in the prison. He said he stopped shouting after about ten minutes. Two prisoners on the wing said they both heard him shouting in the early hours of the morning and that there was no more shouting after about 7.30am. The operational support grade said that when the man arrived on the wing he had seemed very level headed and he was staggered that he had deteriorated in such a short space of time. A prisoner said the man did not mix with many other prisoners and that those with whom he did were a "poor choice".
85. At 7.30am, the operational support grade handed over to Officer A. He told her that the man had had the Samaritans phone during the night and that when he had last checked, at 6.00am, he had been awake. She said that she then tested the alarms and fire doors. She also checked prisoners on open ACCTs, including him. At 7.40am she said she saw him during a brief check sitting on his bed with his legs outstretched. She said he purposely did not look at her but at the wall, and that he did not speak to him. She said she saw him move and closed the flap and walked on.
86. Officer A later briefed a SO and the other day staff when they came on duty, that the man had used the Samaritans' phone during the night and that it needed to be collected from him.
87. A prisoner, who was a wing cleaner, was unlocked at about 8.20am. He said he had walked past the man's cell at 8.45am and noticed that the observation panel was blocked. He then alerted Officer B, who went to the cell to check on him and to collect the Samaritan's phone. The officer arrived at the cell just before 8.52am and was joined by Officer C, who had been opening cells for prisoners who wanted to attend the morning chapel service. The observation panel was blocked and he did not respond when called, so Officer B unlocked the door. The door was obstructed and the officers were unable to push it open. After trying for about 30 seconds the officers decided they needed further help. Officer C, who had been carrying a cup of tea as he unlocked the cells, walked down to the wing officer on the landing below to get help, still carrying his cup of tea. Officer B at the cell door and did not radio for help. At one point another prisoner came along and tried to look into the cell. The CCTV footage shows him looking over the landing railing about a minute later as if to see whether other staff were on their way.
88. After they had been summoned by Officer C, more staff arrived at the cell just after 8.55am, about three or four minutes after the first two officers had attempted to open the cell. One of the officers radioed for urgent healthcare assistance. They forced the door open enough to remove a locker which had been wedged behind it and got into the cell at 8.56am. A SO and an officer saw that the man was hanging from the window at the back of the cell. The SO lifted him to enable the officer to cut a shoelace from around his neck. The SO lowered him to the floor and checked for a pulse but was unable to find one. He ensured that the man's airway was clear and immediately began cardiopulmonary resuscitation (CPR), by giving compressions to his chest. He

was assisted, and later relieved, by other officers before healthcare staff arrived.

89. A nurse was in the healthcare centre at the time when she heard a request for urgent assistance, followed immediately by a request for an ambulance to be called. She arrived at the man's cell at 8.58am followed by another nurse ten seconds later. Other colleagues arrived with emergency resuscitation equipment that they had collected from the nurses' station on the wing.
90. The first nurse said that when they arrived officers had already begun CPR. The nurses could not find any signs of life and noted that the man's eyes were fixed and dilated. He was still warm and they continued the resuscitation attempts. They used a defibrillator (a portable electronic device that detects activity in the heart and advises whether an electric shock is appropriate to assist in restarting it). The defibrillator advised not to shock but to carry on CPR. Paramedics arrived at 9.13am and took over his care but pronounced him dead at 9.45am.

Events after the man's death

Family Liaison

91. At 10.25am, an officer was appointed as the prison's family liaison officer. Enquiries were made and the duty governor instructed an operational manager and the officer to break the news of the man's death to his family by telephone. The duty governor spoke to the man's sister later that afternoon and tried to answer a number of questions his family had.
92. On 3 July, the officer, operational manager and the Governor of Wymott visited the man's family at their home to express their condolences and offer support. The family visited the prison on 8 July. In line with Prison Service guidance, the prison contributed towards funeral expenses.

Hot debrief

93. A hot debrief was held for the staff involved in the emergency response. (A hot debrief is a meeting to give staff involved in a traumatic incident, the opportunity to share their feelings and for support to be offered.) Most of those involved said they found it helpful and that they had been well supported by the prison's care and welfare team. However, two of the officers involved said that they had not been invited to the hot debrief.

Post-mortem

94. A post-mortem examination concluded that the man's death was caused by hanging.

Further information

95. On 2 July, Wymott received confirmation from Lindholme that they would accept the man's transfer to the prison.
96. In a security information report, submitted on 7 July, Officer B wrote that information provided by another prisoner on the induction wing, indicated that Prisoner B had still been manipulating the man before his death and had coerced him into giving him his home address so they could keep in touch if the man was given parole. The prisoner alleged that Prisoner B then sold this information to the family of the man's victim and that it was this which had prompted his bizarre and erratic behaviour before his death.
97. On 10 July, Prisoner B informed staff that he had the man's mother's phone number registered as an authorised number on his prison telephone account and asked for it to be removed. There is no evidence of any investigation to establish how he had managed to get the telephone number added to his account. A SO told the investigator that after the man's death there was an unsubstantiated rumour among prisoners on the wing that Prisoner B was responsible for what had happened to him, as he had been bullying him and taking canteen from him.
98. Several weeks after his death, an address book and other correspondence belonging to the man was found in the prison's laundry. This was handed to the prison's safer custody team and subsequently returned to his family. The investigator asked the prison to make further enquiries about the circumstances in which the correspondence was found but Wymott were unable to provide any further information about this or how it got there.

ISSUES

Tackling Anti-social Behaviour (TAB)

99. Wymott's Violence Reduction Strategy includes guidance and support structures for officers to use with prisoners who are suspected of being victims or perpetrators of bullying using the tackling anti-social behaviour (TAB) procedures. The main purpose of a TAB V is to ensure that a potential victim is monitored. Meaningful observations are expected to be recorded at least three times a day and significant events and conversations noted. The TAB also enables staff to draw up care plans and to hold frequent reviews at which the victim should be present. The TAB P is a similar tool for staff to monitor and observe alleged bullies and record their interactions with others.
100. Within days of his arrival at Wymott, the man told officers that he felt threatened and on 28 May staff opened TAB V procedures in response to a letter he wrote. He said that he feared that friends and family of his victim were going to attack him at the prison, but was unable or unwilling to give staff the names or identify anyone specific. On 19 June, staff learnt that Prisoner B was allegedly bullying him and opened TAB P procedures for him.
101. The investigation found that TAB procedures did not operate effectively at Wymott and that key requirements of the system were not done. Daily entries were brief and uninformative and on some occasions there were gaps of several days between entries. The issues and goals described in caremaps were not clearly defined and it was not apparent how they could have been achieved. There was no evidence that any investigation into the man's claims had been made. Managers noted some of these deficiencies when checking the documents but this did not appear to improve their quality. We are also concerned that Prisoner B appears to have managed to get the man's mother's telephone number added to his list of authorised numbers without any questions being asked, even though the man was being monitored at the time.
102. A SO told the investigator that officers are challenged if the standard of TABs was below that which was expected. However, he agreed that the quality of TAB documentation in the man's case did not appear to reflect his needs and that it was an issue that the prison needed to address. At the last inspection of Wymott in 2011, Her Majesty's Inspectorate of Prisons noted that although TAB procedures were frequently used, there had been limited training in its operation and there were no interventions to address the attitudes and behaviour of perpetrators or to help victims cope.
103. In our investigation into the death of a man at the prison in 2011 we were concerned that anti-bullying procedures at the prison did not appear to be sufficiently robust. This meant that intelligence was missed and therefore not acted upon. We make the following recommendation, similar to one made by the Inspectorate at the 2011 inspection:

The Governor of Wymott should ensure that the tackling anti-social behaviour procedures operate effectively and that all staff who have contact with prisoners are confident in their use, know how to recognise problem behaviour and maintain appropriate records.

ACCT

104. Staff opened ACCT procedures on 17 June after the man made a small cut to his face but closed the ACCT the same day at the initial review. This appears to have been a premature decision as the ACCT was reopened the next day after he harmed himself again. We are surprised that the original ACCT was closed so quickly as none of the issues he had identified as causing him the stress which had led to his self-harm had been resolved. There was no healthcare representation at the review and the SO who chaired the review relied on his mental health awareness training to conclude that he had no pressing mental health problems.
105. An ACCT caremap was completed on 19 June at the ACCT review, the day after the man had self-harmed for the second time. After the review it had been brought to the attention of staff that Prisoner B had allegedly been bullying him. His first caremap goal was “to transfer to Lindholme” the responsibility for which was given to his offender supervisor. The second was “to stop cutting up” with both him and wing staff being responsible. This was to be achieved by the removal of razors and by him talking to staff.
106. It is important for prisoners identified as at risk of suicide or self-harm to be given some responsibility for improving their situation but they also need support from staff. The caremap should have detailed time-bounded actions aimed at reducing the risk posed by the prisoner and reflect the prisoner’s needs, level of risk and the triggers of distress as identified at the ACCT assessment and subsequent reviews. The target for the man to stop self-harming was too simplistic and did nothing to identify and deal with the underlying cause of his anxiety. He had been identified as a possible victim of bullying at the time the ACCT was opened and was being monitored under the anti-social behaviour procedures. It is apparent that the fear of attack played significantly on his mind at the time yet this does not appear as an issue to be addressed in his caremap. He was anxious about his family and was allowed to speak to his mother during his ACCT review on 26 June, but family contact was not identified as an issue which might help to reduce his stress. Although it is apparent that some of these issues were discussed at ACCT reviews there was little reference to the caremap at reviews.
107. Staff attendance at the man’s ACCT reviews was generally consistent and multidisciplinary and apart from the first review, a member of the mental health team attended each of the three subsequent reviews. The reviews clearly refer to his fears and, although little detail is recorded, it is apparent that his presentation and anxieties about what was happening to his family were discussed at the reviews, as were arrangements for his transfer. However, although the same manager conducted ACCT reviews and in two cases the TAB

reviews there is little evidence to suggest that there was any cross referencing of issues between the two processes. In particular the ACCT caremap did not identify that he was being monitored as a victim of bullying.

The Governor of Wymott should ensure that ACCT caremaps reflect all the prisoner's identified needs, risks and triggers of distress and have time-bounded goals aimed at reducing risk which are discussed, reviewed, updated and recorded at each ACCT review.

108. We note that the man's level of monitoring remained at three conversations during the day and three observations at night from 26 June. After his move to the VP landing he appeared a little more settled. In the early hours of 30 June, he appeared distressed and to be hallucinating. We have considered whether his presentation that night should have indicated a need for an increased level of observations. While it might have been better to have recorded this formally, in practice this is what happened and he was checked five times from midnight until he was discovered at the morning unlock. These observations were not cursory checks. An OSG took time to speak him and try to reassure him. He called for help and an officer attended and unlocked the cell twice and again tried to reassure him. He was also given the Samaritans phone for the rest of the night. The OSG spoke to him again just before 06.00am before he went of duty. We are satisfied that he received appropriate care that night.

Mental Health

109. The man first came to the attention of mental health staff on 17 June, when they were notified that he had self-harmed. No further action was taken when a nurse from the mental health team was informed that the ACCT had been closed immediately that day. A nurse from the mental health team attended the ACCT reviews on 19 June and 21 June (although the latter attendance appears to have been by chance as he was on the wing at the time). She identified no concerns about his mental health at either of these reviews, but there was no formal mental health assessment.
110. On 23 June, a nurse, attended a meeting with the man, although this was not a planned involvement. The meeting had been arranged because of concerns about him, including that he believed that five members of his family had been executed in the prison's segregation unit, said that he had spoken to his mother who was standing outside the prison's external fence and then reported that a prisoner on his wing had raped and murdered his mother. Despite this the nurse did not consider that he needed a full mental health assessment. After attending a further ACCT review on 26 June, she concluded that he did not need to be referred to a psychiatrist. Although she told the investigator that she had planned to have a one to one meeting with him the next week there was no evidence that one had been scheduled. The clinical reviewer found that a full mental health assessment should have been carried out and is critical of the decision not to make a referral. We agree that in the circumstances it is difficult to understand why he was not referred for a full mental health assessment when

there were evident concerns about his mental health which prison staff drew to the attention of the mental health team several times.

The Head of Healthcare should ensure that prisoners identified as at risk of suicide and self-harm have a full mental health assessment when prison staff identify concerns about their state of mind.

Removal of items from prisoners at risk of suicide and self-harm

111. The man's family asked why he was allowed to keep items such as a television, bed sheets and laces when he was regarded as at risk of suicide and self-harm. Reducing access to the means of suicide or self-harm can sometimes form part of the care of people considered to be actively suicidal or who frequently self-harm but he had never been considered as a high risk of suicide and had been placed on an ACCT as a supportive measure after relatively minor acts of self-harm. He made further superficial cuts to his arm on 21 June but after that there was no evidence of further self-harming behaviour. He had been assessed as at low risk of suicide and self-harm at ACCT reviews and had no previous history of self-harm or mental health problems. Removing personal belongings from a person who is feeling hopeless and depressed (especially items of clothing, belts or shoelaces) can increase feelings of distress and therefore increase the risk of suicide and self-harm. Fear of losing their normal possessions can discourage prisoners from disclosing suicidal feelings and the guidance to prisons is that where possible, prisoners at risk should be allowed to retain their belongings unless it is clearly unsafe to do so.
112. On 17 June, the man cut himself, although it is not clear what he used. The next day he cut himself with a razor blade and told staff that he had swallowed half of it. A SO told the investigator that any razors would have been removed from his cell after the first incident, but there is no record that this happened. It is noted in the ACCT caremap of 19 June, that razors had been removed, but there is no record that his cell was searched to remove the items and there was no reference to this at the two subsequent ACCT reviews on 21 June and 26 June. The review on 21 June was in response to him making further superficial cuts to his arm. There is no record of what he used to make the cuts.
113. We are satisfied that there were insufficient reasons to remove any items from the man's cell other than his razors which he had used to cut himself with. We note that even with razors removed he would have had access to other implements to make superficial cuts. However, after the original decision to remove razors was made there was no further discussion at ACCT reviews about whether these could have been returned or should continue to be withheld and whether any additional items needed to be removed as Prison Service instructions require. Nor was there any evidence from wing observation books, or other records that wing staff were alerted to the fact that he should have only supervised access to razors. We make the following recommendation:

The Governor should ensure that decisions about whether items should be removed from prisoners are discussed and recorded at ACCT case reviews

and that the reason for removing items is documented in the ACCT Plan and all relevant staff are made aware.

Emergency response

114. When it was discovered that the man had blocked his observation panel and had also barricaded his cell door, neither officers radioed for help. Officer B said she did not radio for assistance because at that stage she was not aware that it was an emergency situation. The officers agreed that Officer C would alert other staff to the problem by walking down to the wing office. Neither of the officers seemed to consider that finding a the observation panel blocked and the door barricaded of a man who was identified as at risk of suicide and self-harm was an urgent matter, to the extent that Officer C went off to seek help still carrying the cup of tea he had with him when he was unlocking the cells for prisoners attending chapel.
115. As the man had obstructed the door getting into the cell immediately was not possible. Officer C said that she did not believe that the man had harmed himself because she had checked the ACCT documents when she had started her shift and had noted that Officer A had recorded that he was fit and well and sitting on his bed not long before.
116. While we cannot know whether this would have affected the outcome for the man, we are concerned that the officers did not appear to recognise the gravity of the situation. He was on an ACCT and the officers were aware that there had been serious concerns about him during the night such that he had been left with the Samaritans phone. Although there was no significant delay, we consider it would have been prudent in the circumstances to radio for help. We make the following recommendation:

The Governor should ensure that staff summon help immediately by radio when a cell containing a prisoners on an open ACCT is barricaded and the observation panel is blocked.

Location

117. We are satisfied that the man's transfer from Frankland to Wymott was appropriate. He had requested a transfer to be near his family and Frankland had checked that there were no known security reasons to prevent his transfer. Although shortly after he arrived at Wymott, he became concerned that members of his victim's family were at the prison the investigation has found no evidence that this was the case.
118. Because of the man's fears the prison agreed he could remain living in the induction unit while they sought a transfer to another prison. He was moved to the vulnerable prisoner landing to help reassure him further of his safety. Although he had requested a move to the segregation unit we consider that this would not have been an appropriate location. A transfer was arranged and agreed quickly but sadly he died before the transfer could take place.

RECOMMENDATIONS

1. The Governor of Wymott should ensure that the tackling anti-social behaviour procedures operate effectively and that all staff who have contact with prisoners are confident in their use, know how to recognise problem behaviour and maintain appropriate records.
2. The Governor of Wymott should ensure that ACCT caremaps reflect all the prisoner's identified needs, risks and triggers of distress and have time-bounded goals aimed at reducing risk which are discussed, reviewed, updated and recorded at each ACCT review.
3. The Head of Healthcare should ensure that prisoners identified as at risk of suicide and self-harm have a full mental health assessment when prison staff identify concerns about their state of mind.
4. The Governor should ensure that decisions about whether items should be removed from prisoners are discussed and recorded at ACCT case reviews and that the reason for removing items is documented in the ACCT Plan and all relevant staff are made aware.
5. The Governor should ensure that staff summon help immediately by radio when a cell containing a prisoners on an open ACCT is barricaded and the observation panel is blocked.

ACTION PLAN: The Man at HMP Wymott June 2013

No	Recommendation	Accepted/Not accepted	Response	Target date for completion and Function Responsible	Progress (to be updated after 6 months)
1	The Governor of Wymott should ensure that the tackling anti-social behaviour procedures operate effectively and that all staff who have contact with prisoners are confident in their use, know how to recognise problem behaviour and maintain appropriate records.	Accepted	Training will be delivered at the next full staff training day. Daily quality checks are completed by Residential Custodial Managers, Band 4 Offender Supervisors and the Safer Custody team. Improving prisoners' awareness of anti bullying will form part of the standing agenda at the monthly Prisoners Consultative Committee.	30 June 2014 Head of Residence and Safety / Head of Residence and Services	
2	The Governor of Wymott should ensure that ACCT care maps reflect all the prisoner's identified needs, risks and triggers of distress and have time-bounded goals aimed at reducing risk which are discussed, reviewed, updated and recorded at each ACCT review.	Accepted	All staff responsible for the completion of ACCT documents have been trained within the last 12 months. The training covers appropriate use and completion of care maps and ensuring that goals are time bounded and identify measures to reduce risk. Compliance checks are carried out by the Safer Custody team and Band 4 Supervising Officers when detailed Oscar roles.	30 June 2014 Head of Safer Prisons and Equality	

3	The Heads of Healthcare should ensure that prisoners identified as at risk of suicide and self-harm have a full mental health assessment where prison staff identify concerns about their state of mind.	Accepted	A pathway has been put in place by the Mental Health Team to ensure that a mental health assessment will be conducted on all prisoners subject to ACCT where concerns about the mental health have been identified.		Completed
4	The Governor should ensure that decisions about whether items should be removed from prisoners are discussed and recorded at ACCT case reviews and that the reason for removing items is documented in the ACCT Plan and all relevant staff are made aware.	Accepted	A Notice To Staff will be issued to this effect. Further instructions will also be disseminated through the monthly Safer Custody meeting. Compliance checks will be completed by the Residential Custodial Managers, Band 4's covering Oscar roles and the Safer Custody team.	30 April 2014 Head of Safer Prisons and Equality	
5	The Governor should ensure that staff summon help immediately by radio when a cell containing a prisoner on an open ACCT is barricaded and the observation panel is blocked.	Accepted	A Notice To Staff has been issued giving instructions as to how to summon assistance when a prisoner requires medical treatment under the Code Red / Code Blue protocol outlined in PSI 03/2013. The notice will be re-issued including instructions on what to do if the cell of a prisoner on an open ACCT is barricaded.	30 April 2014 Head of Safer Prisons and Equality	