

A Report by the
Prisons and
Probation
Ombudsman
Nigel Newcomen CBE

**Investigation into the death of a man
at HMP Wayland in February 2014**

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 hanged in his cell at HMP Wayland on 23 February 2014. He was 36 years old. I offer my condolences to the man's family and friends.

An investigator was appointed. A clinical reviewer reviewed the man's clinical care at the prison. Wayland cooperated fully with this investigation.

The man was convicted of murder on 11 April 2003. He did not accept his guilt and was supported by a public campaign. Suddenly, in July 2013, after 10 years of strenuously protesting his innocence, he admitted his guilt. Throughout his time in prison, the man had frequently harmed himself and had attempted suicide. After he admitted his guilt, staff managed the man under suicide and self-harm prevention procedures. In September 2013, the man moved to Wayland and twice said that he had taken an overdose of medication. Prison staff monitored him under suicide and self-harm prevention procedures until December 2013, but early in the morning of 23 February, an officer found the man hanged in his cell. Officers were unable to resuscitate him, and shortly after paramedics arrived, they pronounced the man's death.

The man had an extensive history of attempting suicide and harming himself, but staff at Wayland did not regard him as at raised risk at the time of his death. It would therefore have been difficult for them to have predicted and prevented his actions on 23 February. However, I am not satisfied that prison staff fully recognised the impact of the man's admission of guilt on his state of mind. The investigation found a number of deficiencies in the operation of suicide and self-harm prevention procedures, which the prison will need to address. The clinical reviewer also identified scope for improvements in the provision and delivery of mental health services at Wayland and I am pleased that NHS England has committed to ensuring these are addressed by the new healthcare provider at the prison. I am also concerned that the prison did not communicate effectively with the man's family when he was taken to hospital after an overdose and after he died.

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

February 2015

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SUMMARY

1. On 27 July 2002, the man was remanded to HMP Norwich charged with murder. On 11 April 2003, he was convicted and received a life sentence.
2. The man attempted suicide and harmed himself many times during his sentence. Prison staff managed him under suicide and self-harm prevention procedures, known as ACCT, more than 20 times. The man protested his innocence and, in 2008, he married his wife. In December 2012, the man moved to Hollesley Bay open prison where his mental health appeared to deteriorate. He took an overdose in February 2013 and, in July 2013, over ten years after his conviction, he confessed that he had committed the murder. Staff managed the man under ACCT procedures.
3. In September, the man moved back to HMP Wayland because of concern that his mental state might lead him to abscond, and to allow better access to mental health support. Staff at Wayland ended ACCT monitoring a week after he arrived. On 28 September, staff managed him under ACCT procedures again, but just for three days, after he threatened to kill himself. On 30 November, the man stayed in hospital for a night, after taking an overdose of paracetamol. Prison staff did not tell the man's wife that he was in hospital. The prison continued to manage the man under ACCT procedures until 27 December.
4. The man's admission of guilt had evidently caused some tension in his relationship with his wife and family and he said that he was unsure about his future. On the evening of 22 February, he had a difficult telephone call with this wife. Early the next morning, at 5.20am, a night patrol officer found the man hanging in his cell from bedding attached to the bunk bed. He requested emergency medical assistance, went quickly into the cell and cut the ligature from around the man's neck. There was a slight delay before a standard emergency code was used and an ambulance being called. Officers attempted cardiopulmonary resuscitation until paramedics arrived and confirmed that the man had died. Prison staff did not notify the man's wife of his death until several hours later.
5. We are not satisfied that the man was appropriately supported after he took an overdose on 30 November. ACCT procedures were not completed properly; reviews were often not multidisciplinary and staff closed the ACCT without the input of mental health staff. The clinical reviewer has identified a number of areas for improvement in mental health procedures which the prison will need to address. We were also concerned that, despite his risk of overdose, the man was allowed to keep supplies of medication in his possession. Although there was only a very short delay, which was unlikely to have affected the outcome for the man, staff did not follow the required emergency procedures when they first found the man hanging. We consider that Wayland should have informed the man's wife when he was taken to hospital on 30 November, and it took too long to inform her of his death. We make six recommendations.

THE INVESTIGATION PROCESS

6. On 24 February 2014, the investigator issued notices to staff and prisoners at Wayland, informing them of the investigation and inviting anyone with relevant information to contact him. No one responded.
7. The investigator visited Wayland on 27 February and obtained copies of the man's prison and healthcare records. NHS England appointed a clinical reviewer to review the man's clinical care at the prison. In March, the investigator and the clinical reviewer interviewed eight members of staff and two prisoners at Wayland. The investigator wrote to the Governor on 2 April, about the preliminary findings of the investigation.
8. The investigator informed HM Coroner for the Greater Norfolk District of the investigation, who sent us the results of the post-mortem examination. We have sent the Coroner a copy of this investigation report.
9. One of the Ombudsman's family liaison officers spoke to the man's wife's legal representative and other members of the man's family. The family liaison officer informed them separately about the investigation process and invited them to raise any matters that they wanted the investigation to consider. They had a number of questions and concerns including:
 - What self-harm monitoring measures were in place?
 - What medication was the man taking?
 - Was the man taking any form of illicit drugs?
 - What input from mental health professionals did the man receive?
 - How had the man been able to store up paracetamol?
 - Why was the man's wife not informed when the man was taken to hospital on 30 November?
 - What risk factors and assessments were taken into account when the man's welfare was being considered?
 - The man's wife was concerned about the delay in informing her of the news of his death.

The man's family received copies of the draft report as part of the review period. Comprehensive written representations were provided by the solicitor representing the man's wife. The solicitor pointed out some factual inaccuracies. This report has been amended accordingly. The solicitor also raised a number of questions that do not impact on the factual accuracy of this report. We have provided clarification by way of separate correspondence to the solicitor. Written representations were also provided by the man's brother. The man's brother also raised a number of questions that do not impact on the factual accuracy of this report and these have been addressed through separate correspondence.

HMP WAYLAND

10. HMP Wayland is a medium secure prison in south Norfolk holding over 1,000 men in thirteen residential units. Until 31 March 2014, Serco ran healthcare services at the prison, which Virgin Care now provides. The healthcare service at Wayland is not a 24 hour service.

HM Inspectorate of Prisons

11. HM Inspectorate of Prisons last inspected Wayland in August 2013. Inspectors found that levels of self-harm were low, and that fewer ACCT documents were open compared to similar prisons. They reported that there was good mental health input into ACCT reviews, but other disciplines and prison departments were not involved much. Inspectors described mental health services as good, and said that other healthcare services had improved since their last inspection. Inspectors found that the in-possession medication policy was not followed. Drug test results suggested that illicit drug use in Wayland was low.

Independent Monitoring Board

12. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its most recent annual report for the period ending 31 May 2013, the IMB reported that the mental health team appeared to be delivering a good service and more qualified mental health trained nurses had been recruited. However, the IMB was concerned about the reduction in psychology services, which would limit the number of prisoners who could be offered individual help. They said illicit drug and alcohol use was low.

Assessment Care in Custody and Teamwork (ACCT)

13. 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 staff might take to reduce this and the extent to which staff need to monitor and supervise the prisoner. Checks should be at irregular 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. Staff should hold regular multidisciplinary reviews and should not close the ACCT plan until all the actions of the caremap are completed. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

Previous deaths at Wayland

14. There have been two self-inflicted deaths at Wayland since the Ombudsman began investigating deaths in prisons in 2004, both in 2012. There were no significant similarities between these and the circumstances of the man's death.

KEY EVENTS

15. On 27 July 2002, the man was remanded into custody at HMP Norwich charged with murder. The man had been in prison before. On 11 April 2003, he was convicted of murder. He received a mandatory life sentence.
16. The man moved between a number of different prisons during his sentence, including HMP Wormwood Scrubs, HMP Dovegate, HMP Swaleside, HMP Kingston, HMP Pentonville, HMP Blundeston and HMP Chelmsford. Prison staff managed him under ACCT suicide and self-harm prevention procedures over 20 times. The man strongly denied committing the offence. In 2008, while he was at Kingston, the man married his wife..
17. On 4 December 2012, after a Parole Board recommendation that the man was suitable for open prison conditions, he moved to HMP Hollesley Bay, an open prison in Suffolk.
18. On 3 January 2013, the man told a prison doctor, that his mood was low, he had no motivation and his sleep was affected. The man said that he had no thoughts of suicide or self-harm. The doctor prescribed citalopram (an antidepressant) and referred the man to the mental health team.
19. On 8 January, a nurse from the mental health team, reviewed the man as a result of the doctor's referral. The man told her he was sleeping better, but that dealing with the circumstances of his imprisonment caused him stress. He said that he was innocent and had found it difficult to come to terms with being in prison. The nurse noted that the doctor had prescribed citalopram and the man would have weekly sessions with a member of the mental health team to help him deal with his emotions. She advised him on coping mechanisms to help overcome his low mood.
20. On 14 January, the nurse saw the man for a mental health review. The man said that he was happy to take citalopram, but did not want to engage further with the mental health team or have counselling. He said if he needed to talk to someone, he would talk to his wife, who could visit him regularly now that he was at Hollesley Bay. The man said that he had no thoughts of suicide or self-harm. The nurse removed the man from the primary mental health caseload.
21. On 25 February, at 4.10am, the nurse went to the man's unit after he had taken an overdose of Zyban (a smoking cessation medication) which the man had been given on 22 January. An SO told the nurse that the man had been having fits. The man was taken to hospital and stayed there until 28 February. In hospital, staff reported that he was agitated and hallucinating and was sometimes aggressive to the nurses. The prison received intelligence that the man had smoked spice (a synthetic form of cannabis) every day since he had arrived at Hollesley Bay.
22. When he returned to prison, staff opened an ACCT. An officer assessed the man, who said that he had no recollection of why he had taken the overdose. He said that he did not feel suicidal and was happy to be in open conditions. The deputy governor then held a case review, with the officer, a nurse and the case manager. The man said that he was uncertain about his relationship with his wife, and that he had been taking drugs at Hollesley Bay. He said he felt

stupid about his actions. The review decided that staff should observe the man four times an hour and make one documented entry in his ACCT record each hour. They assessed his risk of suicide and self-harm as raised. The deputy governor started a caremap, with actions to provide the man with tobacco and telephone credit, and for the healthcare team to control the man's medication.

23. Staff held five further ACCT reviews and noted that the man made good progress and was working in the kitchen. On 18 March, staff closed the ACCT and regarded the man's level of risk of suicide and self-harm as low.
24. On 27 March, the man did not attend an appointment with a consultant psychiatrist. The reasons were not recorded. The next day, the man went to the healthcare unit and told the nurse that he did not have any thoughts of harming himself but he needed to be sectioned under the Mental Health Act. The nurse opened an ACCT. That afternoon, he told a psychiatric nurse that he was having difficulties with his wife and felt paranoid. He thought that he needed to get therapy in a secure hospital so he could talk to someone about his issues. They discussed medication, and the man asked if he could be prescribed cannabis, as that calmed him down. The nurse did not think that the man displayed any particular signs of anxiety or stress. At an ACCT review later that day (28 March), the man said that he felt positive about his interactions with the mental health team. Staff closed the ACCT on 2 April.
25. On 3 April, the nurse saw the man again and they discussed his relationship issues. The nurse explained the process for admission to a secure hospital and told the man that he did not meet the criteria as he did not have a severe mental illness.
26. On 13 May, a doctor saw the man and recorded that his mental state appeared normal. He considered that the man might be suffering from recurring mild depression or a long-standing stress reaction to his belief that he did not commit the offence. The doctor did not think that the man needed any treatment at the time.
27. On 23 July, the man asked to speak to the nurse and told her that he had after all, committed the murder for which he had been convicted. He said that he had been living a lie. He became distressed and tearful, and said that he did not deserve to live, would abscond from the prison and needed sectioning. He said that he had been smoking spice and could not control his thoughts. The nurse opened an ACCT, and the nurse and the healthcare manager provided support. On 25 July, he said that he had made a noose. He was then constantly supervised until 29 July, when a review reduced his observations to hourly. At the ACCT review, the man said that he was in debt to other prisoners for spice and had to use goods he had ordered from the prison shop to pay them back.
28. On 7 August, staff held an ACCT review when they learnt that the man's confession to the murder was going to be reported in the local press. Several senior managers at the prison, a nurse, a psychologist, another nurse, a member of the IMB attended and decided that staff should constantly supervise the man again. After daily ACCT reviews, on 13 August, staff reduced the level of observations to hourly. The man moved to another unit as he said that he felt unsafe on his current unit and another prisoner had advised him to move.

On 22 August, staff closed the ACCT when the man said that he had settled well on the new unit. The man said that his relationship with his wife was up and down, but he would cope if it ended.

29. On the evening of 7 September, the man told a custodial manager, that he had taken an overdose of pain relief tablets two days earlier but this had not worked. He said he had then tried to stab himself with a knife while he was working in the prison kitchens. The custody manager immediately opened an ACCT document. He noted that the man said that he wanted to go to a closed prison where he could get help. He said that he had a split personality that on one side was calm and rational and, on the other side, prompted him to kill himself. The custody manager set the level of observation at every 30 minutes. He recorded that the man was aware that he could speak to the Samaritans or the Listener service (Samaritan trained prisoners) and was able to contact his wife.
30. On 8 September, at 7.39am, a nurse recorded in the man's medical record that they had received information from the man's wife, that he had told her he had taken 30 gabapentin tablets (for moderate to severe pain relief) on 5 September. The nurse recorded that the clinical advice for an overdose of gabapentin was to observe the patient for six hours immediately after they had taken the overdose as any symptoms would occur within that time. The possible symptoms included drowsiness, vomiting with mild diarrhoea, slurred speech, dizziness, dilated pupils, respiratory depression and convulsions. Officers told the nurse that the man had none of these symptoms and appeared well. The nurse noted that it was three days since the man claimed to have taken the overdose and she had no clinical concerns about him.
31. At 9.20am, a custodial manager, assessed the man. The man told him that he had become very anxious and paranoid over the previous few days and that his past was playing on his mind. He said he had taken many pain relief tablets, which had made him sick and had then tried to stab himself while working in the prison kitchen. The man said he wanted to be able to cope and, although his relationship with his wife had ended, she remained supportive. The man said he had no current intention of harming himself.
32. At 11.00am, the Head of Reducing Re-offending, held the first ACCT case review, which the custody manager, an officer and the nurse attended. The man said that he had taken approximately 30 gabapentin tablets, which he had obtained, from another prisoner. He had hoped that these would cause a seizure but they had only made him a little sick. He had suffered no other side effects. The man said that he did not tell officers that he had taken the tablets, as he knew that they would open an ACCT. However, he had told his wife, who he thought would probably call the prison.
33. The Head of Reducing Re-Offending recorded that the man was at high risk of suicide and self-harm and that he was at risk of absconding. The review agreed that staff should constantly supervise the man who would remain in his residential unit until a further review the next day. The custody manager completed the ACCT caremap and wrote that the man should be stay in his residential unit and be given a job there, see the healthcare team daily and also see a psychiatrist.

34. On 9 September, the Head of Reducing Re-Offending chaired another ACCT review attended by the custody manager, another nurse, two officers and a psychologist. The man said that he still felt anxious and paranoid, but had no current thoughts of suicide or self-harm. He said he had been thinking of absconding so he could get a move to a prison where he could get help for his problems. The psychologist said that he did not think that a therapeutic community would be suitable for the man as he needed to be fully assessed first. The man said that it would be a relief if he killed himself, but the thought of how this would affect others prevented him. The review concluded that the man was at raised risk of suicide and self-harm and that staff should continue to supervise him constantly.
35. That afternoon, a doctor recorded in the man's medical record that he had been asked for an opinion about the man after the ACCT review. He did not see the man in person, but noted that he was familiar with the circumstances of his overdose and relationship problems. The doctor thought that it was reasonable to expect the man to be in turmoil after he had admitted guilt, but this did not mean he was suffering from a mental illness. He noted that many prisoners have difficulty in dealing with catastrophic events that cause stress, such as his confession, and that the man would be likely to pose a risk of suicide and self-harm for some time. The doctor believed that sedative medication would be counter-productive and that the man did not meet the criteria for transfer to a secure hospital under the Mental Health Act.
36. On 10 September, the Head of Reducing Re-Offending chaired an ACCT review, which the custody manager and an officer attended. The man said that he felt slightly better than the previous day and had slept well. The Head of Reducing Re-Offending told the man that he would move to HMP Wayland where he would have more treatment options. The man said he was happy with this and felt it was the best option for him. The review concluded that the man remained at raised risk of suicide and self-harm. Staff continued to observe him constantly, and a further review was planned once the man arrived at Wayland
37. The man arrived at Wayland that afternoon and the Head of Safer Prisons and Equality, chaired an ACCT review which a custodial manager attended. No one from the healthcare team was present. The man said he was happy to be in a closed prison as he felt that he would get the support to help him deal with his issues and that he had no current thoughts of suicide or self-harm. The Head of Safer Prisons and Equality recorded that the man was in good spirits and needed to work with the mental health team and the offender management unit. The review concluded that the man remained at raised risk of suicide and self-harm, and should continue to be supervised constantly. A further review was arranged for the next day, at which a member of the mental health team would be present. The man's ACCT caremap was not reviewed or updated.
38. A nurse completed a reception health screen when the man arrived at Wayland. Despite the man's reported overdose only days earlier, and his overdose of a Zyban in February, the nurse noted that he was a low risk for holding medication in possession. She recorded that he had no history of self-harm or overdosing on prescribed medication and that there were no other concerns about him keeping supplies of medication.

39. On 11 September, the Head of Safer Prisons and Equality chaired an ACCT review with the custodial manager and a nurse from the mental health team. The man said that most of his anxieties had gone, now that he was in a closed prison. He said he had no thoughts of suicide or self-harm. The man said that he had spoken to his wife the previous evening, but she was unhappy that he had moved. The review team assessed that the man was now at low risk of suicide and self-harm. The review reduced the level of observation to hourly and set a further review for 16 September. They did not reassess the ACCT caremap or update it.
40. On 12 September, the nurse saw the man for a mental health review. The man told her that he was paranoid about other prisoners finding out about his offence. He explained that his suicidal thoughts had been caused by his feelings of self-hatred about his offence and that he had let others campaign for him, even though he was guilty. He said that he did not want to kill himself and that the acts of self-harm were a cry for help. The man said that he had suffered physical and sexual abuse when he was a child and had committed his offence as a form of revenge. The man said that he did not have any current thoughts of suicide or self-harm. The nurse recorded that the man was not taking any prescribed medication and there was no evidence that he suffered from any mental health issues.
41. On 13 September, the man's wife contacted Wayland, and said that the man had told her that someone had put a newspaper article about his offence under his cell door. The nurse went to see the man who said that he was afraid for his safety and wanted to stay in his cell. The nurse recorded that she had reassured the man that officers would monitor his situation and would keep his cell door locked if he wanted. The next day, the nurse recorded that the man appeared much brighter and more relaxed and had come out of his cell several times. The man told her that he felt safer than the day before and more positive.
42. On 17 September, a custodial manager, and the nurse held an ACCT review. The man said that he had settled in well at Wayland and had received ongoing support from the mental health team. He had been spending more time out of his cell and socialised with other prisoners. He said that he had not suffered any intimidation or threats. The man said he had been managed under ACCT procedures many times in the past, sometimes because he had manipulated the situation. The custodial manager and the nurse considered that the man was at low risk of suicide and self-harm, and agreed to close the ACCT. They agreed to hold a post-closure review on 24 September.
43. On 24 September, the custodial manager and the nurse spoke to the man who said that he had settled at Wayland and was waiting to get a prison job. He said he enjoyed reading and music and was aware of the support available from officers and the mental health team. The custodial manager and the nurse did not consider there was any need to re-open the ACCT.
44. Immediately afterwards, the nurse reviewed the man's mental health with him. The man was tearful and emotional and said that his relationship with his wife was difficult, but he understood why. He said that he was unable to take responsibility for his actions and made excuses for his behaviour. The man told the nurse that the psychologist had written to him to say he would visit Wayland

to complete a psychological assessment. The man said that he did not go to the gym as he was afraid that other prisoners might hurt him, but said that he felt safe on the wing. He said that that he had no thoughts of suicide or self-harm. The nurse recorded that the mental health team would continue to monitor the man.

45. At 6.10pm on 28 September, the officer opened an ACCT. He recorded that the man had been speaking to someone on the wing telephone and had said that he intended to kill himself. The man gave the officer his razor. A custodial manager, completed an immediate action plan and recorded that she had offered the man access to the Samaritans and the Listener service. She set the level of observations at hourly, until the ACCT assessment interview and first review the next day.
46. On 29 September, an officer interviewed the man for an ACCT assessment. The man said that he had told his wife some of the things he had done in the past and wanted to get his thoughts out into the open so he could get the help he needed. He said he felt lonely, feared rejection and had violent thoughts. He said he had no family, apart from his wife, but their relationship was difficult.
47. Immediately after the ACCT assessment, the custodial manager chaired the first ACCT review, which the officer, the custodial manager and a nurse attended. The man said that he often thought about his offence and childhood and that these issues distressed him and his wife. The man said that he did not have any thoughts of self-harm and had no plans to die. The review assessed that the man was at low risk of suicide and self-harm and they kept the level of observation at hourly. They set the next review for 1 October. The custodial manager completed an ACCT caremap and recorded that a member of the mental health team would see the man the next day, and that they had referred the man to the chaplaincy for counselling.
48. On 30 September, the nurse saw the man who told her that he had argued with his wife and had said several things that were untrue. He said he had done this to hurt her emotionally and ended the conversation by saying he wanted to kill himself, although he did not intend to do so. The man said that their relationship was volatile, but he continued to telephone her because they needed each other. The man said he had told his wife that in the past he had a variety of sexual relationships. The man said he said certain things because he wanted people to think he was crazy and that this would make his crime more acceptable. He said he found it difficult to accept responsibility for his actions and always looked for an excuse. He thought that his problems were mostly related to sex. The nurse recorded that the man had no thoughts of suicide or self-harm and that it was inappropriate for the ACCT to remain open.
49. On 1 October, a custodial manager, chaired an ACCT review with the nurse. The man said that he had had a very fraught conversation with his wife and had said several offensive and inappropriate things to her. He said he did not intend to kill himself. The review assessed that the man was at low risk of suicide and self-harm and decided to close the ACCT with a post-closure review on 8 October.
50. On 8 October, Supervising Officer (SO) reviewed the man who said that he was more positive about how he would deal with his issues and he knew he had

support from the mental health team. The SO did not consider that the ACCT should be re-opened.

51. Between 8 October and 29 November, a member of the mental health team reviewed the man five times. The psychologist saw the man twice to complete a psychological assessment. The psychologist discussed his report with the man on 15 November. He thought that the man's needs would be best met in the immediate and medium term (two to three years) by psychodynamic psychotherapy at a prison with a therapeutic community. (Psychodynamic psychotherapy is aimed at revealing the unconscious content of the psyche to help to alleviate psychic tension.) The psychologist recorded that the man had understood the recommendation and agreed to be referred to a therapeutic community.
52. An offender supervisor, spoke to the man twice at this time about his offence. She recorded that she thought that the man was coping with huge amounts of shame, embarrassment, guilt, lack of understanding and despair. The man said he had finally admitted his guilt, as he could no longer continue with the pretence that had become his life and that his family and friends had campaigned for him since his conviction. He said that his wife had now left him and he had no hope. The man described having very frightening dreams that involved 'horrible' sexual images and thoughts. The offender supervisor recorded that the mental health team had assessed the man and he did not present as being mentally ill and was not taking any prescribed medication. She thought that the man might need some kind of therapy.
53. On 30 November, at 4.50am, the man handed a night patrol officer, a note in which he said he had taken 35 paracetamol tablets between 7.00pm and 11.00pm the previous evening. (The man had not been prescribed paracetamol.) The officer immediately opened an ACCT document.
54. The custodial manager, who was the night orderly officer in charge of the prison at the time recorded that the prison had called an ambulance. He set the level of observations at hourly. (An ACCT immediate action plan, which is expected to be done within an hour was not completed until 5 December.) The man went to the Norfolk and Norwich Hospital, escorted by two officers. The prison did not inform the man's family that he had been taken to hospital.
55. An officer completed an ACCT assessment at the hospital at 9.40am. The man said that he had tried to kill himself in the previous two weeks, but had not told officers. On one occasion, he said he had attempted to hang himself with his dressing gown belt, but it had broken. On another occasion, he said he had taken an overdose. The man said he had only begun to feel suicidal after he had admitted his guilt. He said he had horrible thoughts and had had enough of life. He said Wayland was a horrible place and he did not get any support.
56. The man stayed in hospital overnight. On 1 December, the hospital discharged him and he went back to Wayland. A custodial manager, chaired an ACCT review with an SO. The date, time and location of the review were not entered on the ACCT document and there is no record that any healthcare staff attended. At the review, the man said he felt much better and had no current thoughts of suicide or self-harm. The man said that he had been using spice (synthetic cannabis) at Wayland. The review assessed the man as a low risk of

suicide and self-harm, kept the level of observation at hourly and set the next review for 5 December. The manager completed the ACCT caremap and recorded that the Head of Offender Management, would follow up the psychologist's recommendation that the man should move to a therapeutic community. The manager referred the man to the substance misuse team as he had admitted using spice.

57. On 3 December, a nurse saw the man for a mental health review. The man said that he had suffered from fleeting thoughts of suicide after he had admitted his guilt and felt he had nothing to live for, but did not want to die. He said he had no active thoughts of suicide or self-harm but wanted to be prescribed antidepressants. The nurse recorded that the man had symptoms of depression and made an appointment for him to see a nurse practitioner (a nurse qualified to prescribe certain medications) on 6 December.
58. On 5 December, the offender supervisor and the custodial manager saw the man to reassure him that he had support from all staff at Wayland. The man said he continued to hate himself and his behaviour. He said he had contacted his wife and parents and told them he had not committed the offence and then told them he had, which had clearly upset them. The offender supervisor recorded that she had told the man what avenues of support were available to him, and that he had a sentence planning board on 19 December.
59. Later that morning, a supervising officer, a SO held an ACCT review, which the custodial manager attended. There was no member of healthcare staff present. The man said that he felt positive after speaking to the offender supervisor and the custodial manager and he knew that he could talk to officers. The review team assessed that the man remained at low risk of suicide and self-harm and reduced the level of observations to one each morning, afternoon and evening with three irregular checks during the night. They set the next review for 12 December. They did not review or update the ACCT caremap.
60. On 6 December, the man did not attend the appointment with the nurse practitioner which the nurse had arranged. The nurse saw him later and he told her that he was settled and had no thoughts of suicide or self-harm.
61. On 12 December, the manager and nurse from the mental health team held an ACCT review. The man said, although he was anxious about going to a therapeutic community at either HMP Grendon or HMP Dovegate, he wanted to move as soon as possible. However, the offender supervisor had told him that he was not ready and that he might have to wait for up to a year. He said he missed the appointment with the nurse practitioner on 6 December, because he had been at a music course, which he enjoyed. The level of ACCT observations remained the same. There is no record that the caremap was reviewed or updated. The nurse noted in the man's medical record that he would have an appointment with a nurse practitioner as soon as possible.
62. On 13 December, the nurse saw the man who said that he had been finding it difficult to cope after he had admitted his guilt. He said that his wife had decided to move on and he did not have any contact with his parents, although he had written to them. He said that he wanted to move to a therapeutic community, felt positive about the future and did not want to end his life. The

man told the nurse that he had taken antidepressants in the past and did not want to be prescribed fluoxetine, venlafaxine or citalopram. The nurse assessed that the man was depressed and prescribed an antidepressant, sertraline, for issue each day, because of the man's history of overdose.

63. On 16 December, a member of staff from the mental health team, saw the man for a mental health review. The man said that the paracetamol overdose he had taken at the end of November had been a serious attempt to end his life. He said that he had not yet started to take sertraline, as he did not like to queue for his medication.
64. On 19 December, the offender supervisor chaired a sentence planning board, with the psychologist and a probation officer. The board agreed that the man would benefit from a transfer to Grendon. They considered that this should take place as soon as possible, as Wayland could not provide the level of support the man needed to deal with his risk factors, characteristics and emotions.
65. That afternoon, the manager chaired an ACCT review, attended by an officer. No one from the healthcare team was present and no one had contacted them in advance. The man said that he struggled to control his emotions and found it difficult to deal with his situation. He said that he had no suicidal intentions, but wanted to continue being managed under the ACCT procedures, as he took comfort from being checked. The review team assessed that the man remained at low risk of suicide and self-harm and kept the level of observations the same. A further review was set for 27 December, with a request for a member of the mental health team to be present. The review did not update the ACCT caremap.
66. On 20 December, the psychologist saw the man for a mental health review. The man said he was relieved that the sentence planning board had agreed to support his transfer to Grendon, but he was scared that he would have to open up about his emotions. The psychologist said he would continue as his mental health key worker until he transferred and the man said he was happy about that.
67. On 23 December, a nurse practitioner, reviewed the man's medication with him. The man said that he had stopped taking sertraline after one week, as it made him feel worse. He said he was on an ACCT and was waiting for a transfer to Grendon, where he thought that he would be able to address his problems. He said that he felt suicidal at least once a day. The nurse stopped the prescription of sertraline and noted that the man would continue to receive support from the mental health team.
68. On 27 December, the SO chaired an ACCT review with just the officer. No one from the mental health team was present as had been planned at the last review and the SO had not contacted them in advance. The man said that he had come to terms with his offence and was looking forward to moving to Grendon. The man said that he had some good friends on the wing and was not afraid to approach officers if he needed help. The review concluded that The man remained at low risk of suicide and self-harm and agreed to close the ACCT. A post-closure review was planned for 3 January 2014, with a request for a member of the mental health team to be present.

69. At a mental health review on 30 December, the man told the psychologist that Boxing Day (the day before the ACCT was closed) had been a bad day for him. He said that he was no longer supported by ACCT and that his wife was no longer interested in talking to him. The man said that he had decided not to take antidepressants as he did not want to take any drugs unless they were essential, like antibiotics. He said he was anxious about the prospect of moving to Grendon but realised he needed to go there.
70. On 3 January 2014, a SO interviewed the man for the ACCT post-closure interview. No one from the mental health team joined him. The man said that he had problems, but knew that killing himself was not the answer. He said that his family were not supportive, but he hoped he would be able to regain their support. The man said he knew he had support from the mental health team and officers.
71. On 6 January, the man told the psychologist that he was feeling low as he had a lot of unanswered questions about his future. He knew that prisoners could not transfer to Grendon if they had been managed under ACCT procedures within the previous month. The man said that he was unsure whether to contact his parents. He said he had written letters for his wife but had not sent them, as he felt she did not understand him.
72. On 27 January, at another mental health review, the man told the psychologist that he had completed forms for his transfer to Grendon. He said he had spoken to his wife several times and this had been helpful. The man said that he had completed his music course and was now doing a media course, which he enjoyed. The psychologist arranged to see the man four weeks later, but told the man that he knew how to contact him if necessary.
73. Between 28 January and 21 February, the man had no contact with the healthcare team. An officer, the man's personal officer, noted in his prison record that, during this period, there were no issues or concerns.
74. On the evening of 22 February, the man made a ten minute telephone call to his wife. The man's wife was angry and said that he had lied to her, that he had changed since his mother had visited him and that his mother controlled him. (The man's mother had visited him on 30 January.) His wife asked if he had stopped taking drugs and the man told her that he had. The man's wife told him that he was deluded, was making no effort and she would cut him off completely.
75. A prisoner on the man's wing, told the investigator that he and the man had been good friends for about six months. He said that officers liked the man and no one bullied him and he had not been in debt. The prisoner said that the man smoked spice once every three or four weeks, but, so far as he was aware, had not done so on the day before his death. The prisoner said that the man had told him that he and his wife did not get on and that she wanted a divorce. He said that the man spent a lot of time on the telephone, which annoyed other prisoners. On the evening before his death, he said that the man had argued with his wife and had then gone to the prisoner's cell where they had watched the football results together. The prisoner considered that the man had appeared all right at the time.

76. Another prisoner who lived in the cell next to the man, told the investigator that he and the man used to write songs together. The prisoner said that the man had told him that he and his wife argued a lot. The prisoner said he had spoken to the man on the evening before he died when the man had given him a DVD to watch and he had seemed his usual self.
77. There was a night patrol officer on 22/23 February. Day staff handed over to him and did not mention anything about the man. At approximately 9.30pm, the officer completed a roll check of all prisoners on the wing and noted no concerns about any of them. He heard nothing further during the night to concern him. At 5.20am on 23 February, the officer started an early morning roll check. When he got to the man's cell, he found the observation panel covered by a towel and reported this to the control room. The officer thought that something was wrong and opened the inundation port (which allows staff to use a fire hose without opening the cell door) to try and move the towel out of the way. He managed to do so and could see the man, but he was not moving. The officer told the investigator that he radioed for permission to open the cell and to get help as he thought the man was hanging. He heard other staff running towards him, so he opened the door, turned the light on and went into the cell. The officer told the investigator that he was aware that he should have radioed a code blue medical emergency.
78. The officer found the man hanging from a ligature made from bedding attached to the upturned bunk bed. The officer cut the bedding from around the man's neck and laid him on the floor. Other officers then arrived and started cardiopulmonary resuscitation (CPR). An officer radioed the control room to request an ambulance. The control room made a 999 call at 5.23am. The officers used a defibrillator (a life-saving device that gives the heart an electric shock in some cases of cardiac arrest) which found no shockable rhythm. Paramedics arrived at the cell at 5.29am and took over the man's care. At 5.40am, they confirmed that the man had died.

Contact with the man's family

79. A trained family liaison officer, and the custody manager, visited the man's wife at approximately 11.30am on 23 February, to break the news of the man's death and offer support. The prison continued contact with the man's wife for ongoing support and offered financial assistance towards the funeral expenses, in line with national guidance.

Support for staff and prisoners

80. A manager held a debrief on the afternoon of the man's death for the staff involved in the emergency incident to discuss what had happened and to offer support and the services of the prison's care team.
81. The prisoner told the investigator that he had heard a commotion at about 5.00am and officers told him later that morning, what had happened. The prisoner found it difficult to accept that the man had taken his own life. The prisoner said that an officer had told him personally that the man had died. Officers and members of the chaplaincy supported prisoners affected by the

man's death. Staff reviewed prisoners assessed as at risk of suicide or self-harm, in case they had been adversely affected by the man's death.

Post-mortem and toxicology

82. A consultant forensic pathologist, conducted a post-mortem examination and recorded the cause of the man's death as hanging. A toxicology analysis did not find any trace of alcohol, medication or any illicit drugs, including synthetic cannabinoids.

ISSUES

Management of risk of suicide and self-harm

83. Prison staff had identified the man as at risk of suicide and self-harm many times during his sentence and had managed the man under ACCT procedures on 26 separate occasions. ACCT procedures are designed to help identify prisoners at risk and to help reduce the incidence of suicide and self-harm. Ultimately, it is very difficult to prevent someone who makes a determined decision to kill himself from carrying out that plan, but the Prison Service instruction, PSI 64/2011, which governs ACCT procedures, requires prisons to follow prescriptive procedures to help reduce the risk. This investigation has identified some concerns about the operation of the ACCT procedures at Wayland.
84. Prison staff appropriately opened an ACCT after the man took an overdose of paracetamol on 30 November 2013. Unaccountably, an immediate action plan was not completed for five days. Although the man had gone to hospital at the time, this was some days after his discharge and it is difficult to understand the purpose. No member of the healthcare team was present at the first ACCT review held on 1 December, after the man's discharge from hospital, a mandatory requirement of PSI 64/2011. This is particularly concerning as the man's physical and mental health would have been significant factors in his care in the immediate aftermath of his discharge from hospital.
85. At the first review on 1 December, the caremap was completed with actions for a referral to the substance misuse team and for the possibility of the man's transfer to Grendon to be followed up. These objectives, while helpful steps to take, amounted to no more than referrals to services and did not result in any meaningful action to help reduce the man's immediate risk of suicide and self-harm or ensure that he received the support he needed at the time.
86. No one reviewed the careplan objectives at the subsequent four ACCT reviews or added any new ones. The man was evidently going through a period of turmoil after he had spent ten years denying his offence. Unsurprisingly, this had had a significant impact on external supportive relationships, particularly when his family and friends had spent ten years protesting his innocence and campaigning for his release. The breakdown of his supportive relationships was not identified as a possible trigger for further suicide and self-harm and there was no careplan action to help with this aspect of his risk.
87. We are concerned that prison staff seem to have underestimated the man's risk of suicide in the light of his changed circumstances and the psychological impact on him after his admission of guilt. On 30 November, at his ACCT assessment, he said that he had only begun to feel suicidal after he had admitted he was guilty of his offence. Yet a day later, after taking an overdose and saying he had had enough of life, staff at an ACCT review assessed his risk of suicide and self-harm as low. It is difficult to understand how they reached this conclusion.
88. No members of the mental health team were present at the review that closed the ACCT on 27 December, which the clinical reviewer, considered inappropriate and we agree. As the man was under the care of the mental

health team we consider someone from the team, preferably his key worker, should have attended each ACCT review. We are concerned that the man had told a nurse practitioner just four days earlier that he felt suicidal at least once a day. This information was apparently not available to the review on 27 December, which closed the ACCT, because there was no member of healthcare staff present. When the ACCT was closed, the review noted that a member of mental health team should attend the post-closure review on 3 January, but this did not happen.

89. The lack of effective multidisciplinary input into ACCT procedures seems to have been a significant flaw in the procedures, which made it difficult for reviews to take appropriate decisions about the man's level of risk, based on all the information available. We are also concerned that the lack of consistent case management did not help continuity of care. Three different case managers chaired the five ACCT case reviews, and another different manager conducted the post-closure review. It is not possible to know whether more accurate assessment of risk and more effective support mechanisms would have prevented the man's actions, but we are concerned that the ACCT procedures at Wayland were not managed as well as they should have been. We make the following recommendation:

The Governor should ensure that prison staff manage prisoners at risk of suicide or self-harm in line with national guidelines, including that:

- **A member of healthcare staff always attends the first ACCT review;**
- **Multidisciplinary case reviews are held with a consistent case manager and include all relevant people involved in a prisoner's care;**
- **All known risk factors are considered when determining the level of risk of suicide and self-harm or closing an ACCT plan;**
- **Case managers set meaningful caremap actions aimed at reducing risk, which are reviewed and updated at each ACCT review; and**
- **ACCT monitoring continues until the risk posed by the prisoner has reduced and all caremap actions have been completed.**

Clinical care

Mental health services

90. The clinical reviewer found that the man's care at Wayland was not of an equivalent standard to that he would have received in the community. He found that there did not appear to have been any effective communication, discussion or handover of care between the consultant-led clinical service at Hollesley Bay and the healthcare team at Wayland. The clinical reviewer considered that there was not enough done to communicate the level of the man's risk and, in his opinion, there did not appear to have been a sufficiently qualified, trained and supervised mental health team at Wayland capable of managing a volatile prisoner like the man. He considered that the mental health team at Wayland should have referred the man – who had arrived there with an explicit warning that he might attempt suicide – to a consultant psychiatrist. The clinical reviewer also considered that the man should have been assessed by a specialist secure personality disorder unit. He concluded that the man's care was not appropriate or timely.

91. The clinical reviewer was clear that it was appropriate for the man to have been moved from Hollesley Bay back to closed conditions, although he also recognised that this in itself might have been a stress factor that added to the man's risk. (Although the man had asked to move to a closed prison.) He was also critical that a nurse prescriber had prescribed antidepressant medication, sertraline, and another nurse prescriber had stopped the prescription. In his opinion, antidepressant medication should only have been prescribed with the involvement of a doctor.
92. In his review, the clinical reviewer made a number of recommendations, mostly about the provision of mental health services at Wayland. Serco Health, which was the health provider at Wayland at the time of the man's death, is no longer responsible for services at the prison. NHS England, which commissions health services in prisons, has informed the investigator that the recommendations contained in the clinical reviewer's review will be addressed with the new health provider at Wayland. We are satisfied that NHS England will address the individual improvements the clinical reviewer has identified and so do not repeat them all in this report. We make the following recommendation:

The Head of Healthcare should agree a time bound action plan with NHS England East Anglia Area Team to ensure that the clinical reviewer's recommendations for improvements in mental health services at Wayland are implemented.

Medication in possession

93. The man arrived at Wayland only a few days after taking an overdose of medication. However, the nurse recorded in the man's medical record that he was a low risk for holding supplies of his medication in his own possession. We do not consider that this judgement was based on a proper assessment of the facts. We have not seen any evidence that this assessment was reviewed after he took another overdose in November. Although the man's risk appears to have been considered when a nurse prescribed sertraline in December, there was no formal risk review. While, the man did not die from an overdose, we are concerned that the in possession medication assessment was not reviewed when he had such a clear history of taking overdoses. We note that inspectors found, during their inspection in August 2013, that staff at Wayland were not following the in possession medication policy. We make the following recommendation:

The Head of Healthcare should ensure that in possession medication assessments take account of a prisoner's history and are reviewed if the prisoner harms himself.

Emergency response

94. The officer found the man hanging in his cell at 5.20am and radioed for urgent assistance. The prison called an ambulance at 5.23am, paramedics attended the man at 5.29am and declared that he had died at 5.40am. The clinical reviewer found that all the officers who attended the scene were properly equipped, applied their training properly and without hesitation.

95. Prison Service Instruction (PSI) 03/2013 - Medical Emergency Response Codes - gives staff guidance on communicating the nature of a medical emergency and ensuring there are no delays in calling ambulances. It requires staff to call a standard emergency code in life-threatening situation which should prompt the control room to call an ambulance immediately. Wayland has local emergency procedures based on the national instruction.
96. The officer who found the man hanging reacted very quickly, but did not use the required code blue. We note that this led to only a short delay before an ambulance was called. The prison's emergency response was very swift and paramedics also arrived very quickly, so this delay is unlikely to have had any impact on the outcome for the man. However, in other cases, even a short delay could be crucial. We make the following recommendation:

The Governor should ensure that in a life threatening situation prison staff use the appropriate emergency code which triggers the control room to call an ambulance immediately.

Liaison with the man's family

97. Prison Rule 22 states:

'Notification of illness or death

'22 – (1) If a prisoner dies, becomes seriously ill, sustains any severe injury or is removed to hospital on account of mental disorder, the governor shall, if he knows his or her address, at once inform the prisoner's spouse or next of kin, and also any person who the prisoner may reasonably have asked should be informed.'

98. The man's wife was concerned that the prison did not tell her that he was in hospital after he took an overdose of paracetamol on 30 November. This was a particular issue for her as Hollesley Bay had informed her when he had taken an overdose of zyban, in February 2013. The hospital treated the man and he recovered quickly enough to be discharged after an overnight stay, but the consequences could have been very serious. We consider that staff at Wayland should have told his wife that he was in hospital, because of the possible consequences of the overdose. We make the following recommendation:

The Governor should ensure, in line with Prison Rule 22, that the next of kin of seriously ill prisoners are informed as soon as possible and that they are able to visit them in hospital without delay.

99. Prison Service Instruction 64/2011, which covers safer custody issues, usually requires a family liaison officer and another member of staff to visit a prisoner's next of kin in person to break the news of a death. The PSI notes that time is of the essence to ensure that the prisoner's family does not hear of the death by other means.

100. Paramedics pronounced the man's death at 5.40am. However, it took prison staff nearly six hours to inform the man's wife of his death, although she lived just 50 miles or so from the prison. We consider that the delay in informing her of the man's death was too long. We make the following recommendation:

The Governor should ensure that, in line with PSI 64/2011, the next of kin are informed as soon possible after a prisoner's death.

RECOMMENDATIONS

1. The Governor should ensure that prison staff manage prisoners at risk of suicide or self-harm in line with national guidelines, including that:
 - A member of healthcare staff always attends the first ACCT review;
 - Multidisciplinary case reviews are held with a consistent case manager and include all relevant people involved in a prisoner's care;
 - All known risk factors are considered when determining the level of risk of suicide and self-harm or closing an ACCT plan;
 - Case managers set meaningful caremap actions aimed at reducing risk, which are reviewed and updated at each ACCT review; and
 - ACCT monitoring continues until the risk posed by the prisoner has reduced and all caremap actions have been completed.
2. The Head of Healthcare should agree a time bound action plan with NHS England East Anglia Area Team to ensure that The clinical reviewer's recommendations for improvements in mental health services at Wayland are implemented.
3. The Head of Healthcare should ensure that in possession medication assessments take account of a prisoner's history and are reviewed if the prisoner harms himself.
4. The Governor should ensure that in a life threatening situation prison staff use the appropriate emergency code which triggers the control room to call an ambulance immediately.
5. The Governor should ensure, in line with Prison Rule 22, that the next of kin of seriously ill prisoners are informed as soon as possible and that they are able to visit them in hospital without delay.
6. The Governor should ensure that, in line with PSI 64/2011, the next of kin are informed as soon possible after a prisoner's death.

ACTION PLAN

No	Recommendation	Accepted/Not accepted	Response	Target date for completion and function responsible	Progress (to be updated after 6 months)
1	<p>The Governor should ensure that prison staff manage prisoners at risk of suicide or self-harm in line with national guidelines, including that:</p> <ul style="list-style-type: none"> ▪ A member of healthcare staff always attends the first ACCT review; ▪ Multidisciplinary case reviews are held with a consistent case manager and include all relevant people involved in a prisoner's care; ▪ All known risk factors are considered when determining the level of risk of suicide and self-harm or closing an ACCT plan; ▪ Case managers set meaningful caremap actions aimed at reducing risk, which are reviewed and updated at each ACCT review; and ▪ ACCT monitoring continues 	Accepted	<p>Further training and guidance for all staff (and particularly those that conduct ACCT reviews) is underway.</p> <p>A weekly assurance check of all ACCTs is now in place to ensure that any non-compliance with the correct processes is identified and rectified at the earliest opportunity.</p> <p>All staff have been made aware of the need for multi-disciplinary Case Reviews and the Head of Healthcare is aware of the requirement for attendance at ACCT reviews by either clinical or Mental Health Team staff.</p> <p>Further training and 'best practice' guidance for the management of CAREMAPs is being undertaken with key staff</p>	<p>Head of Safer Prisons & Equality End Dec 2015</p> <p>Head of Safer Prisons & Equality End Dec 2015</p> <p>Head of Safer Prisons & Equality End Dec 2015</p> <p>Head of Safer Prisons & Equality End Dec 2015</p>	

	until the risk posed by the prisoner has reduced and all caremap actions have been completed.				
2	The Head of Healthcare should agree a time bound action plan with NHS England East Anglia Area Team to ensure that The clinical reviewer's recommendations for improvements in mental health services at Wayland are implemented.	Accepted	To be undertaken by Virgin Care in line with the recommendation of The clinical reviewer	Head of Healthcare End Jan 2015	
3	The Head of Healthcare should ensure that in possession medication assessments take account of a prisoner's history and are reviewed if the prisoner harms himself.	Accepted	Head of Healthcare will ensure that a documented assessment of risk is undertaken for all offenders subject to ACCT processes regarding their in possession medication	Head of Healthcare End Dec 2015	
4	The Governor should ensure that in a life threatening situation prison staff use the appropriate emergency code which triggers the control room to call an ambulance immediately.	Accepted	The Governors Order on the use of emergency codes has been re-issued and all staff made aware. This will be reissued on a 6 monthly basis	Head of Safer Prisons & Equality End Nov 2015	
5	The Governor should ensure, in line with Prison Rule 22, that the next of kin of seriously ill prisoners are informed as soon as possible and that they are able to visit	Accepted	Healthcare will be asked to provide improved information on the the seriousness of an prisoner's health to allow contact to be made with the prisoner's next of kin.	Head of Healthcare & Head of Safer Prisons & Equality End Dec 2015	

	them in hospital without delay.				
6	The Governor should ensure that, in line with PSI 64/2011, the next of kin are informed as soon possible after a prisoner's death.	Accepted	All practical efforts will be made to minimise the delay in informing the next of kin of a death.	Head of Safer Prisons & Equality End Dec 2015	