

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# Independent investigation into the death of Mr Jason Willis, a prisoner at HMP Onley, on 6 May 2015

**A report by the Prisons and Probation Ombudsman  
Nigel Newcomen CBE**

## Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

## Our Values

**We are:**

**Impartial:** *we do not take sides*

**Respectful:** *we are considerate and courteous*

**Inclusive:** *we value diversity*

**Dedicated:** *we are determined and focused*

**Fair:** *we are honest and act with integrity*



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The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out **independent** investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

My office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Jason Willis was found hanged in his cell at HMP Onley on 1 May 2015, and died in hospital five days later. He was 45 years old. I offer my condolences to Mr Willis' family and friends.

Mr Willis had a history of mental ill health and I am concerned that Onley failed to provide Mr Willis with adequate support for these previously identified problems. I am also concerned that, in the week leading up to his death, he reported being threatened by other prisoners but not enough was done to protect him. As a result, Mr Willis threatened to hang himself unless he was moved to the prison's segregation unit. Staff appropriately began suicide and self-harm prevention procedures but, sadly, Mr Willis hanged himself less than two hours after arriving in the segregation unit.

While I consider that prison staff were too easily reassured that Mr Willis' risk had reduced significantly once he had moved, they set an appropriate level of observations and I do not believe they could have anticipated his actions. After his death, a toxicology test confirmed that Mr Willis had recently used a synthetic cannabinoid, or new psychoactive substance, which might have affected his reasoning and exacerbated his paranoid tendencies.

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

**Nigel Newcomen CBE**  
**Prisons and Probation Ombudsman**

**January 2016**

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# Summary

## Events

1. On 23 February 2013, Mr Willis was remanded to HMP Belmarsh charged with grievous bodily harm. He was subsequently held at HMP Wandsworth and then HMP Thameside. On 8 August 2013, he was sentenced to four years and six months in prison. Mr Willis had substance use problems and completed a methadone detoxification programme at Thameside. He was under the care of the mental health team at the prison. A visiting psychiatrist diagnosed him with a personality disorder and prescribed quetiapine, an antipsychotic medication. When he did not take his medication, he became very paranoid.
2. On 18 November 2014, Mr Willis transferred to HMP Onley. A nurse in reception noted he had mental health problems but did not refer him to the mental health team. On 8 December, a GP saw Mr Willis about a physical health matter. He noted that Mr Willis had not received quetiapine since he had arrived at Onley and prescribed it again. He referred Mr Willis for a mental health assessment but the mental health team took no action. In January 2015, Mr Willis' prescription for quetiapine was stopped, as he was not collecting it consistently. No one spoke to Mr Willis about this or followed it up.
3. Mr Willis had given staff information about drugs on the wing and on Friday 24 April, he said that other prisoners had found out and threatened him. He stayed in his cell and officers took his meals to him. A Supervising Officer investigated the situation on Monday 27 April and recommended he should move to the induction wing immediately, or to the segregation unit, for his safety. No action was taken.
4. Mr Willis had been suffering from dental problems for some months and had lost some weight. On 29 April, he told a nurse he was convinced he had cancer. The next day, a GP tried to reassure him and prescribed quetiapine again. An officer told the investigator that Mr Willis had been behaving strangely and out of character at the time. The officer said he suspected Mr Willis had been using spice – a new psychoactive substance.
5. Later on 30 April, an officer began Prison Service suicide and self-harm prevention procedures (known as ACCT) when Mr Willis said he would hang himself if he was not moved to the segregation unit. The next day, Friday 1 May, he was twice found with a ligature in his cell. He told a nurse that he had been using spice. After an ACCT case review, officers moved him to the segregation unit at 3.30pm. At a further case review after he moved, the staff assessed him as low risk as he had been removed from immediate threat. However, they maintained the previous level of observations at three times an hour. Checks at 3.50pm, 4.20pm and 4.30pm indicated that Mr Willis continued to behave erratically and appeared very nervous. At the next check, at 5.00pm, an officer found Mr Willis had hanged himself. Staff attempted to resuscitate him until paramedics arrived and took him to hospital. Mr Willis did not recover and died on 6 May, after the hospital withdrew life support. Toxicology tests showed the presence of a synthetic cannabinoid.

## Findings

6. We are concerned that Mr Willis did not get appropriate mental health support at Onley. When he arrived a nurse did not complete a full initial health screen or refer him to the mental health team. This meant he did not initially receive the medication he had been prescribed at his previous prison. Although a doctor later referred him to the mental health team, no one from the team ever assessed him. Healthcare staff stopped his medication when Mr Willis was not collecting it without discussing this with him or monitoring him afterwards.
7. On 27 April 2015, a Supervising Officer investigated Mr Willis' fears that he was under threat and recommended an immediate move from the wing. The manager who received the report did not agree a move and gave no reasons. This meant that Mr Willis was left on the wing, where he was evidently very afraid, for over a week. Eventually, he was moved to the segregation unit, after he threatened to hang himself. There were credible reasons why Mr Willis might have been under threat from other prisoners and we do not consider that the prison properly supported and protected Mr Willis at this time.
8. Staff appropriately began ACCT procedures when Mr Willis threatened to harm himself. The next day, they moved him to the segregation unit. We are satisfied that managers recognised that there had to be exceptional reasons to hold Mr Willis in the segregation unit, once he had been assessed as at risk of suicide and self-harm. However, there was too much confidence that a move to the unit would reduce his risk significantly, even though segregation unit staff noted he continued to appear very nervous. Nevertheless, the staff maintained the same level of observations as when he was regarded as at raised risk and we recognise that it would have been very difficult for staff to have predicted his actions so soon after the move. It is possible that Mr Willis was under the influence of a new psychoactive substance at the time.

## Recommendations

- The Governor should ensure that all information indicating violence, bullying and intimidation is fully coordinated and investigated, that recommendations from investigations are properly considered and actioned and that apparent victims are effectively supported and protected
- The Governor should ensure that prison staff are vigilant for signs of use of NPS, are briefed about how to respond when a prisoner appears to be under the influence of such substances and take the possible effects into account when assessing risk of suicide and self-harm.
- The Head of Healthcare should ensure that prisoners have appropriate health screens when they arrive, which identify any existing health problems and plan subsequent care, including referrals to the mental health team as required. Mental health assessments should be carried out promptly whenever a referral is received

- The Head of Healthcare should ensure, as part of an active care plan approach, that nurses responsible for coordinating mental health care follow up prisoners who do not collect their prescribed medication.

## The Investigation Process

9. The investigator issued notices to staff and prisoners at HMP Onley informing them of the investigation and asking anyone with relevant information to contact him. No one responded.
10. The investigator visited Onley on 13 May 2015 and obtained copies of relevant extracts from Mr Willis' prison and medical records. He interviewed 15 members of staff at Onley in June and July.
11. NHS England commissioned a clinical reviewer to review Mr Willis' clinical care at the prison.
12. We informed HM Coroner for Northamptonshire of the investigation who gave us the results of the post-mortem examination and toxicology results. We have sent the coroner a copy of this report.
13. One of the Ombudsman's family liaison officers contacted Mr Willis' mother, to explain the investigation and to ask if she had any matters she wanted the investigation to consider. His mother was concerned that her son had been neglected at Onley and wanted to know whether he should have been watched more closely. She said that he had called almost every day and had sounded a little fed up during his last call on Wednesday 29 April, when he had asked her to arrange for his probation officer to visit him.
14. Mr Willis' mother received a copy of the initial report. She raised a number of issues/questions that do not impact on the factual accuracy of this report and these have been addressed through separate correspondence. The Prison Service has provided an action plan to the recommendations.

# Background Information

## HMP Onley

15. HMP Onley holds up to 742 men. Healthcare services are delivered by Northamptonshire Healthcare NHS Foundation Trust. A doctor is on duty during normal working hours and nurses are available Monday – Thursday 7:30am to 7.30pm, Friday 7.30 to 6.30pm, weekends and Bank Holidays 8.00am to 6.00pm.

## HM Inspectorate of Prisons

16. The most recent inspection of HMP Onley was in June 2012. The inspection found that prison was safe and new arrivals were well supported. There was little violence but perpetrators were challenged robustly, and victims were well supported. The level of self-harm was low with good case management for those at risk. A high number of prisoners managed under ACCT procedures had been held in the segregation unit, but as a last resort. The mandatory drug test rate was higher than in comparable prisons but the prison was tackling the issue through security measures. Inspectors reported that a well-established team provided good primary and secondary mental health services.

## Independent Monitoring Board

17. 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 latest annual report, for the year to February 2015, the IMB was concerned about staffing levels at the prison and the number of mobile phones and drugs being found. The IMB noted that the segregation unit had been at maximum or near maximum capacity for most of the year.

## Previous deaths at HMP Onley

18. Since 2004, there have been three other deaths at Onley, one self-inflicted death in 2005, and two deaths from natural causes in 2012. There were no significant similarities with the circumstances of Mr Willis' death.

## Assessment, Care in Custody and Teamwork

19. ACCT is the Prison Service care-planning system used to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk, how to reduce the risk and how best to monitor and supervise the prisoner. After an initial assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. Checks should be irregular to prevent the prisoner anticipating when they will occur. There should be regular multi-disciplinary review meetings involving the prisoner. As part of the process, a caremap (plan of care, support and intervention) is put in place. The ACCT plan should not be closed until all the actions of the caremap have been completed. All decisions made as part of the ACCT process and any relevant observations about the prisoner should be written in the ACCT booklet, which accompanies the prisoner as they move

around the prison. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

## Key Events

20. On 23 February 2013, Mr Jason Willis was remanded to HMP Belmarsh, and later transferred to HMP Wandsworth and HMP Thameside. On 8 August 2013, he was convicted and sentenced to 4 years and 6 months in prison.
21. Mr Willis had a history of drug use and completed a methadone detoxification programme. While he was at Thameside, the mental health team saw Mr Willis frequently. He had a history of depression, substance misuse, anger problems, anxiety and insomnia. In May 2014, a consultant psychiatrist diagnosed Mr Willis with a personality disorder, with intense mood swings. The psychiatrist noted that Mr Willis did not have a formal thought disorder but had paranoia based on his life experiences. He prescribed quetiapine, an antipsychotic medication. When Mr Willis did not take his medication at Thameside, he became very paranoid but did not harm himself.
22. On 18 November 2014, Mr Willis was transferred to HMP Onley. At an initial health screen, a nurse noted he had a personality disorder but did not refer him to the mental health team. She did not complete a full health screen as Onley's local policy required, and did not record what medication Mr Willis was taking.
23. On 8 December, a GP examined Mr Willis, who had reported an abscess on his face. The GP prescribed an antibiotic. He noted that Mr Willis had been under the care of the mental health team at Thameside and had been prescribed quetiapine, but had not received this since he had arrived at Onley. He noted that Mr Willis was low in mood, suspected he had a personality disorder and referred him to the mental health team. The GP re-prescribed quetiapine. No one from the mental health team assessed Mr Willis after the referral.
24. On 9 December, a drugs worker recorded that Mr Willis did not want to be referred for any group work for help with substance misuse problems. She discussed harm minimisation with him and gave him information and advice about the risks and dangers of using new psychoactive substances. (NPS - synthetic cannabinoids, often known by names such as spice and black mamba.)
25. On 12 December, Mr Willis barricaded his cell and threatened staff because he did not want to move from H Wing to G Wing. Mr Willis was taken to the segregation unit (known as the care and separation unit (CSU) at Onley.) At a disciplinary hearing on 13 December, Mr Willis said that he did not want to move wings because he had mental health problems and complained that he had not received his medication for three weeks after he had arrived at Onley. He was found guilty of disobeying a lawful order and using threatening abusive or insulting words or behaviour and punished by seven days loss of privileges and 24 days stoppage of earnings at 80%. The manager who held the hearing agreed to contact the mental health team, although there is no record that this happened, and look to move Mr Willis to G Wing.
26. On 15 December, a GP saw Mr Willis in the segregation unit and gave him some ibuprofen gel for a flare up of arthritis, but recorded that he was otherwise fit and well. On 6 December, a member of the mental health team saw Mr Willis in the segregation unit and told him that the mental health team were aware that he needed to be assessed but this would be done once he had returned to his wing.

27. Mr Willis moved to G Wing on 19 December, but never had a mental health assessment. On 30 December, a pharmacy technician noted that Mr Willis had not collected his quetiapine 14 times since 9 December. On 15 January 2015, the pharmacy technician discussed his poor compliance with the mental health team. Mr Willis' prescription chart indicates that, later that day, a GP authorised stopping the prescription of quetiapine.
28. Mr Willis' personal officer told the investigator that Mr Willis worked as a cleaner on G Wing. He said he was polite and interacted well with staff and other prisoners. He said Mr Willis had a single cell on G Wing, but was often out on the landings and mixed with other prisoners.
29. Between December and April, Mr Willis gave staff information three times about named prisoners who he said had drugs hidden in their cells. Mr Willis said he would tell them where the drugs were hidden, in exchange for a transfer out of Onley. Each time, staff completed and submitted a security intelligence report.
30. Mr Willis' prison telephone record shows that the last call he made using the prison's PIN phone system was on 24 January 2015, to his mother. However, Mr Willis' mother said that he called her every day, the last time on Wednesday 29 April. This suggests he used an illicit mobile phone.
31. Mr Willis' prison visits record shows that, while he was at Onley, he had five visits between 8 February and 17 March from someone he said was his niece. On 16 February, an officer who was supervising visits submitted a security report about Mr Willis. Mr Willis had arrived in the visits hall early and said he would wait for his visitor, who was booked to see another prisoner before Mr Willis. His visitor did not arrive in time and Mr Willis went back to his wing. His visitor arrived five minutes after the cut off time. The officer suspected that she had arrived deliberately late, after the drug sniffer dogs had gone.
32. Unless it is legally privileged, prisons check incoming mail to ensure that it does not contain illicit items or any information that would harm security. On 25 April, Mr Willis received a letter. A security officer noted that the word "spice" was mentioned and therefore checked the content. "Spice" is a commonly used term for a new psychoactive substance (NPS). (New psychoactive substances are usually synthetic cannabinoids manufactured to imitate the effects of cannabis. They are usually odourless and difficult to detect.) The security officer noted that the letter said, "This spice has got to stop Jason. Do you know many deaths there have been in prisons and out here? It's poison and it's got to stop. I don't know what you are doing in there and I get deeply upset just thinking about it." The officer recorded the contents of the letter and submitted an intelligence report.
33. On Friday 24 April, an officer noted that Mr Willis had said that other prisoners on the wing had threatened him because he had helped staff. She noted that she had asked the orderly officer, (the manager in charge of the daily operation of the prison) to see Mr Willis as soon as possible. There is no record of whether this happened. An officer noted in the wing observation book that Mr Willis should remain in his cell as he was under threat from other prisoners because he had given officers information about an illicit mobile phone, and that there would be an investigation into his allegations. On 26 April, the personal officer recorded

that Mr Willis had told him he was under threat. He would not come out of his cell and officers had been taking meals to his cell for him.

34. On Monday 27 April, a Supervising Officer (SO) investigated Mr Willis' claims. Mr Willis told her that he had been bullied by other prisoners on G Wing since November 2014. He said he had been assaulted over the weekend and been punched on the cheek. He told her that he feared for his safety. He would not give any names but said that a prisoner on G Wing had been organising associates in the Bedford and Luton area to visit him and hand over unauthorised articles. He said that a "a young black girl" had visited him three times, in January, February and March and had given him a mobile phone and 4oz of spice each time. When he got back to the wing, two prisoners took the items from him. He said that the other prisoners had been on the wing for a long time but would not give other details to help identify them.
35. The SO noted that Mr Willis had said the he was feeling very stressed about this and it had started to affect his eating and sleeping. He said that prisoners from other wings had been shouting to his window that morning threatening him and he felt like a marked man. He wanted to move to the segregation unit for his own protection, as someone had taken photos of him on a smart phone and transmitted them throughout the prison. Mr Willis said that the stress had increased his risk of having a breakdown.
36. The SO recommended that Mr Willis should be considered for a move to H Wing (the first night and induction wing) as soon as possible; a move to the segregation unit for his own protection should be considered; he should submit a transfer application to another prison; and healthcare staff should see him in relation to the alleged assault. She noted that, as Mr Willis was unwilling to give any names of prisoners, no further action could be taken at the time, but she recommended that wing staff use a mobile phone detector. She passed the report to a custodial manager who, on 28 April, noted that he did not support a move to H Wing and that Mr Willis should be moved to another unit (he did not specify which). The custodial manager did not comment on the other recommendations, such as consideration of a move to the segregation unit. Mr Willis remained on G Wing.
37. On 29 April, Mr Willis told a nurse that he was convinced that he had oral or throat cancer and was dying. He was finding it difficult to eat because of ongoing dental problems for which he had been receiving treatment for some time. She arranged for him to have nutritional supplement drinks. She recorded that Mr Willis was in a state of severe anxiety and referred him to see the GP.
38. The personal officer told the investigator that in the days leading up to 30 April, Mr Willis' behaviour became increasingly bizarre and out of character. He said that he thought Mr Willis had taken spice or some other new psychoactive substance. He did not note this at the time and did not take any action about his concerns.
39. On 30 April, a GP saw Mr Willis in response to the nurse's referral. He recorded that Mr Willis was angry, anxious that he had lost weight and was concerned he had cancer. The GP requested full blood tests and prescribed quetiapine again.

He referred Mr Willis to the mental health team and the dentist and arranged to review him in seven days.

40. At 7.10pm that evening, an officer took Mr Willis back to the healthcare unit as he was distressed and said he had not received his medication. Mr Willis refused to go back to the wing. He said he wanted to go to the segregation unit where he could be away from the prisoners who were threatening him. Mr Willis said that if he did not go to the segregation unit, he would hang himself.
41. The officer was concerned about Mr Willis' threat to harm himself and began ACCT procedures. He contacted a custodial manager to see if Mr Willis could move immediately to the segregation unit, but there were no vacant cells. Mr Willis agreed to return to his wing. The custodial manager completed an ACCT immediate action plan and required staff to observe Mr Willis four times an hour.

## 1 May

42. Officers observed Mr Willis throughout the night and did not record any concerns about him. Officer A came on duty at 7.30am on 1 May and made ACCT checks throughout the morning. She noted that Mr Willis refused to come out of his cell as he felt unsafe and wanted to move to the segregation unit. He said that prisoners were setting fires outside his cell door.
43. At 11.00am, Officer A recorded that she had spoken to Mr Willis at his cell door for ten minutes. He told her that prisoners were hiding and if she opened his door they would rush in and get him. She reassured Mr Willis that this was not the case and told him that he could discuss this at an ACCT case review later that day. Mr Willis said that people were talking about him being on "spice" but he said he had not taken anything.
44. At 12.15pm, Officer A recorded in the ACCT document that Mr Willis had triggered the fire alarm in his cell by activating the heat sensor and that staff had responded immediately. A custodial manager decided that a member of staff should supervise Mr Willis constantly until he had his ACCT case review. He did not record this in the ACCT document or amend the required level of observations on the front cover.
45. The personal officer told the investigator that he had responded to the fire alarm but there was no fire in Mr Willis' cell. Mr Willis had said that other prisoners were trying to gas him from the adjoining cells. He said that he had checked the cells either side of Mr Willis' cell to try to reassure him that this was not the case.
46. Officer A stayed at Mr Willis' cell door to observe him. At 12.31pm, she recorded that he became very agitated and began to make a noose from torn bed sheets. He put the noose down when she asked. At 12.41pm, she pressed the general alarm for help as Mr Willis had begun to tie the noose to his cell window bars. Officers responded and went into the cell and removed the ligature. The custodial manager again instructed that a member of staff should remain at Mr Willis' cell door at all times until the ACCT review.
47. Officer A observed Mr Willis at his cell door until 1.15pm, when another officer came to interview Mr Willis to assess him as part of ACCT procedures. Mr Willis told the officer that he was under threat for being a "grass" and had to do

something to get to the segregation unit, but said he did not intend to kill himself. The officer recorded that Mr Willis was very distressed, wanted to move to the segregation unit and was paranoid that other prisoners were out to get him. The interview took 15 minutes. There is no record of any observations in the ACCT document between 1.15pm and 2.30pm, however another officer continued to constantly observe Mr Willis until the ACCT case review.

48. At 2.05pm, a SO arrived on G Wing to hold the first ACCT case review. The SO told the investigator that Mr Willis was very agitated and did not want to leave his cell but he persuaded him that it would be better to hold the review in the wing manager's office where it would be private and away from other prisoners.
49. The SO, an officer and two mental health nurses attended the case review with Mr Willis. Mr Willis said that he was under threat from other prisoners who had pressurised him to bring drugs into the prison through visits. He believed he was in imminent danger and all he wanted was to be moved to the segregation unit. He said that he did not want to die but would harm himself, either by hanging or cutting, to get a move to the segregation unit. The staff assessed Mr Willis as at raised risk of suicide and self-harm and set the level of observations at three every hour.
50. The SO completed an ACCT caremap (which should have agreed actions designed to reduce risk). He noted four actions: that Mr Willis should have a nutritional soft diet (because he was concerned about his mouth and throat); that he should attend three pre-arranged healthcare appointments (listed below); that Mr Willis should move to the segregation unit; and that kitchen and healthcare should assist Mr Willis with getting an appropriate diet and food supplements.
51. Mr Willis' medical records show that the following appointments had been arranged:
  - On 7 May, an appointment with a nurse for blood tests, and then with a GP.
  - On 8 May, a mental health assessment.
  - On 12 May, an appointment with the dentist for a denture fitting.
52. Mr Willis stayed in the managers' office with an officer and the nurses while the SO went to speak to the duty governor about moving Mr Willis to the segregation unit. A nurse told the investigator that, while they were waiting, Mr Willis said that he had used spice in the previous couple of days. At 3.20pm, a senior manager authorised Mr Willis' segregation for his own protection. He noted that the mental health team had advised that the move would reduce his risk (of suicide and self-harm) by removing him from the situation causing him anxiety. The nurse completed a segregation health screen and concluded that Mr Willis would be able to cope with a period of segregation. The SO and officer took Mr Willis to the segregation unit.
53. Mr Willis was given a cell close to the staff office. As his move was for his own protection and not for disciplinary reasons, the staff arranged for him to have a television in the cell.

54. As Mr Willis had now moved to the segregation unit, the SO and a nurse held another case review at 3.30pm. Although he was still anxious about his health, and said that both of his parents had had cancer, Mr Willis said that he now felt relaxed and safe in the segregation unit. They decided that Mr Willis was now at low risk of suicide and self-harm but kept the level of observations at three an hour. The SO set the date of next case review for 6 May. He updated the caremap to show that the action for Mr Willis to move to the segregation unit had now been completed.
55. The SO told us that he then phoned the duty governor. There is an unsigned note in the ACCT document entitled “Defensible Decision to Segregate a Prisoner on an Open ACCT” which said that Mr Willis’ risk would be significantly reduced if, in his perception, he was made safe. The writer said that although he did not initially want to move Mr Willis to the segregation unit, and had explored other options, he felt that a move anywhere else would not reduce Mr Willis’ risk as Mr Willis’ perception was that he would not be safe anywhere else in the prison.
56. The ACCT record shows that an officer checked Mr Willis at 3.50pm, 4.20pm and 4.30pm. He recorded that Mr Willis’ behaviour remained very erratic and he was very nervous when a member of staff approached his cell or went in to give him a television and some food.
57. At 5.00pm, an officer went to Mr Willis’ cell to check him. When he opened the observation panel, he could not see Mr Willis immediately, but then noticed that Mr Willis was in the corner by the cell door and appeared to have something around his neck. He shouted for help and two officers came immediately. They went into the cell and found he had hanged himself with a ligature, made from a shoelace, tied to the light switch. One officer cut the ligature and another officer radioed a code blue medical emergency. The control room log recorded the code blue at 5.00pm and control room staff called an ambulance immediately.
58. Nurses arrived within a minute. Mr Willis had no pulse, was not breathing and showed no signs of life. They started cardiopulmonary resuscitation and applied a defibrillator, which found no shockable heart rhythm. At 5.06, paramedics arrived and took over Mr Willis’ emergency treatment, using specialist equipment. They attached a portable ventilator and took Mr Willis to hospital. He was admitted to the intensive care unit and placed on life support.

#### **Contact with Mr Willis’ family.**

59. The prison chaplain contacted Mr Willis’ family at 6.20pm to let them know what had happened. The Governor and the chaplain met Mr Willis’ family at the hospital. Mr Willis’ condition was critical and the prognosis for recovery was very poor.
60. On 6 May, after an assessment by a consultant, doctors withdrew life support and Mr Willis died that afternoon. His family were with him when he died. In line with Prison Service instructions, the prison contributed to the costs of the funeral.

### **Support for prisoners and staff**

61. The Governor debriefed the staff involved in the emergency response to offer his support and that of the staff care team.
62. The prison posted notices informing prisoners of Mr Willis' death, and offering support. Staff reviewed all prisoners assessed as at risk of suicide and self-harm in case they had been adversely affected by Mr Willis' death.

### **Post-mortem report**

63. A post-mortem examination found that the cause of death was hanging. Toxicology results identified the presence of a synthetic cannabinoid. A consultant chemical pathologist and forensic toxicologist noted that it was possible that this might have affected Mr Willis' cognitive behaviour (the way Mr Willis thought and acted) before his death.

# Findings

## Response to Mr Willis' vulnerability

64. Mr Willis made several disclosures to officers about illicit activity by other prisoners. On Friday 24 April, he told an officer that other prisoners were threatening him because he had helped staff. The officer recorded this on Mr Willis' prison record and notified a manager. Staff advised Mr Willis to remain in his cell until his claims were investigated.
65. On Monday 27 April, a SO interviewed Mr Willis as part of her investigation. She did not come to a clear conclusion in her report as to whether Mr Willis' fears were justified, but she made several recommendations about the further actions she considered necessary to safeguard him. These included a move to H Wing (the induction unit) at the earliest opportunity, a possible move to the segregation unit and that the healthcare team should assess him because of the alleged assault. She then passed the report to a custodial manager.
66. The custodial manager noted on the report that he did not support a move to H Wing and that Mr Willis should be relocated to another unit. There was no indication who should do this and when. He did not comment on the other recommendations. No one from the healthcare team went to see Mr Willis and there was no further consideration of whether he should be moved from G Wing to another location, including the segregation unit.
67. Mr Willis' allegations prompted an investigation, but this had to wait until after the weekend, during which Mr Willis was left fearful in his cell on the wing. We are concerned that the recommendations from the investigation were then largely ignored. The custodial manager did not record why he had rejected the recommendation of an immediate move to H Wing and no further action was taken to protect and support Mr Willis on G Wing. Officers only took action to help support Mr Willis after he threatened to hang himself, more than a week after he had first reported he was being threatened. In the meantime, Mr Willis had been left feeling under threat on G Wing. It appears that his mental health deteriorated during that week and his personal officer described him as paranoid. Staff accepted that there were credible reasons why Mr Willis might be threatened by other prisoners yet no one took effective action to protect him. We make the following recommendation:

**The Governor should ensure that all information indicating violence, bullying and intimidation is fully coordinated and investigated, that recommendations from investigations are properly considered and actioned and that apparent victims are effectively supported and protected.**

## Management of risk of suicide and self-harm

68. On 30 April, an officer appropriately began ACCT procedures, after Mr Willis said that he was under threat from other prisoners and would hang himself if he was not moved to the segregation unit. He considered that Mr Willis was at raised risk of suicide and self-harm and set the level of observations at four an hour until his first ACCT case review.

69. The next day, before the case review, a custodial manager instructed staff to constantly supervise Mr Willis until the review, as Mr Willis appeared paranoid. We agree that this was a reasonable precaution. He did not record the decision in the ACCT document or amend the front cover to show that the required frequency of observations had changed, as we would expect to happen. However, we are satisfied that the staff were fully aware of the requirement and this was done until the first ACCT case review. We are surprised that Officer A did not ask Mr Willis to give her the ligature when he first began to tie one, but recognise that staff removed it shortly afterwards.
70. The first ACCT case review assessed that Mr Willis was at raised risk of suicide, and set the level of observations at three an hour. At the second review, an hour later, after Mr Willis had moved to the segregation unit, Mr Willis was assessed as at low risk of suicide but the level of observations remained unchanged.
71. It does not appear that the second assessment of risk fully took into account all of Mr Willis' risk factors; it placed too much reliance on the fact that Mr Willis now said he felt safe in the segregation unit. Assessing him as low risk did not appear to reflect the fact that he had tied ligatures just two hours before - although we recognise that this had been in the context of trying to get a move to the segregation unit. Mr Willis had said that his main concern was to get away from threats from other prisoners on his wing and it is understandable why the staff were reassured that he was no longer at the same risk as previously. There was no practical implication of reducing the assessed level of risk, as the case review decided to maintain the level of observations at three an hour – the same as when his risk had been assessed as raised.
72. Prison Service Instruction 64/2011 requires that prisoners assessed as at risk of suicide and self-harm must be located in segregation units only in exceptional circumstances and that the reasons must be clearly documented in the ACCT Plan. We are satisfied that staff at Onley appropriately considered this and concluded that there was no other suitable location for Mr Willis at the time. The mental health team had advised that the move would reduce Mr Willis' risk of suicide and self-harm by removing him from the cause of his anxiety and the decision was recorded in the ACCT document.
73. We are satisfied that an officer correctly identified that Mr Willis was at risk of suicide and self-harm and that, overall, the staff managed the ACCT procedures in line with national instructions. They set an appropriate level of observations and we consider that after the move to the segregation unit, there was little indication that Mr Willis was at imminent risk of suicide and that he would hang himself so soon after the move.
74. However, we are concerned that there is little indication that staff took into account that Mr Willis had said that he had used spice, a synthetic cannabinoid, or new psychoactive substance (NPS). Synthetic cannabinoids are chemicals manufactured to imitate the effects of cannabis. They are generally odourless, and difficult to detect. Their psychoactive effects are unpredictable and in investigations into deaths of other prisoners, we have found examples of erratic, violent, paranoid and out of character behaviour when prisoners had been using NPS. For some people, it appears that NPS can be a trigger for self-harm, but it

is difficult to know whether taking NPS is a direct causal factor in self-inflicted deaths. Mr Willis had a range of vulnerabilities, including extreme anxiety, lack of medication and mental health support and felt threatened by other prisoners, and it is possible that use of NPS might have been exacerbated these. The use of NPS in prisons is an increasing concern. In July 2015, we issued a Learning Lessons Bulletin about the use of NPS, including the dangers to both physical and mental health and the possible links to suicide and self-harm. The bulletin identified the need for better awareness among staff and prisoners of the dangers of NPS. While it might not have altered the outcome for Mr Willis, we consider that staff assessing risk of suicide and self-harm need to be alert to the risk of prisoners who have taken NPS and the possibility that they might react unpredictably. We make the following recommendation:

**The Governor should ensure that prison staff are vigilant for signs of use of NPS, are briefed about how to respond when a prisoner appears to be under the influence of such substances and take the possible effects into account when assessing risk of suicide and self-harm.**

### Clinical care

75. The clinical reviewer concluded that there were shortfalls in the standard of care Mr Willis received at Onley and concluded that his care was not equivalent to that he would have expected to receive in the community. He was concerned that at the initial health screen the nurse did not refer Mr Willis to the mental health team, even though he had been diagnosed with a personality disorder, was prescribed an antipsychotic and had been under the care of the mental health team and a psychiatrist at Thameside. Mr Willis did not have a second health screen, which the Head of Healthcare confirmed should have happened.
76. On 8 December, a GP referred Mr Willis for a mental health assessment, but no one from the mental health team followed this up. It is apparent that the mental health team knew this action was outstanding, as the nurse referred to it when she saw Mr Willis in the segregation unit on 16 December. She told Mr Willis that he would be assessed after he had gone back to his wing. Mr Willis returned to G Wing on 19 December, but no one from the mental health team went to see him after that.
77. The clinical reviewer was also concerned that the healthcare team stopped Mr Willis' medication because he was not collecting it consistently, without reviewing or monitoring him to assess any impact on his mental health. Quetiapine is antipsychotic medication that can help to control the effects of personality disorders. One of the effects of Mr Willis not taking his medication was that he was likely to become increasingly paranoid. The Electronic Medicines Compendium (eMC, which contains guidance on the use of medicines in the United Kingdom) notes that physicians should consider the potential risk for suicide-related events if quetiapine is stopped abruptly. Mr Willis was prescribed quetiapine again on 30 April, but it would have taken some time for this medication to have an effect.
78. We do not consider that Mr Willis received an appropriate standard of mental health care at Onley. His initial health screen did not result in a mental health

referral and a second screen did not take place. A mental health referral from the GP was never actioned and Mr Willis' antipsychotic medication was stopped without any mental health assessment or any subsequent monitoring of the impact on Mr Willis' mental health. We make the following recommendations:

**The Head of Healthcare should ensure that prisoners have appropriate health screens when they arrive, which identify any existing health problems and plan subsequent care, including referrals to the mental health team as required. Mental health assessments should be carried out promptly whenever a referral is received**

**The Head of Healthcare should ensure, as part of an active care plan approach, that nurses responsible for coordinating mental health care follow up prisoners who do not collect their prescribed medication.**

