PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent Investigations

A Report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

Investigation into the death of a man in December 2014 while a prisoner at HMP Wayland

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 hanged himself in the segregation unit at HMP Wayland on 26 November 2014. He died in hospital on 1 December. The man was 25 years old. I offer my condolences to his family and friends.

An investigator was appointed. A clinical reviewer reviewed the man's clinical care in prison. The prison cooperated fully with the investigation.

In 2008, the man was sentenced to an indeterminate sentence for public protection and had served his minimum term by 2013. He appeared to be frustrated by his lack of progress towards release and had attempted to kill himself at three other prisons earlier in 2014. Each time, the trigger was segregation or a transfer. Staff began suicide and self-harm prevention procedures four times between February and June 2014. In July, the man moved to Wayland. There was little recorded about him over the next five months and no evidence that he showed any further intent to harm himself. In November, managers authorised the man's segregation after receiving security information that he was a threat to the safe running of the prison. They moved the man to the segregation unit and he hanged himself an hour later.

The clinical reviewer considered that the man was a vulnerable prisoner, at high risk of suicide, who had spent long periods in prison from a young age and had significant substance misuse problems. Various professionals had described him as having a personality disorder but did not refer him to a psychiatrist and, without a formal diagnosis, his care was uncoordinated.

I am concerned that a nurse discharged the man from the care of the mental health team at Wayland without fully assessing his risk or following the proper consultation procedure. Another nurse, who assessed the man's suitability for segregation on 26 November, did not identify the man's risk from his clinical record. The managers who segregated the man did not check his history, but would have found it difficult to recognise his risk from his prison record, as staff at other prisons had not clearly entered risk alerts.

I am also concerned that the officers who found the man hanged in his cell did not use the required emergency medical code, which caused a delay in the emergency response. Subsequently, there was also a delay in informing the man's family that he was in a critical condition.

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 **August 2015**

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SUMMARY

1. The man was imprisoned in 2006 and released on licence in early 2008. He then reoffended and was sentenced to an indeterminate prison sentence. He saw a number of mental health staff in prison but no firm diagnosis was made. He took a medication overdose in 2011 but suffered no ill effects. The man became eligible for release in November 2013, but was still regarded as a risk to the public. In February 2014, at HMP Ranby, the man tried to hang himself when managers told him he was transferring to HMP Gartree. Staff began Prison Service suicide and self-harm monitoring procedures, known as ACCT, and went ahead with the transfer.

2. At Gartree, staff closed the ACCT the next day and a mental health nurse decided that the man did not need ongoing care. In March, the man again tried to hang himself when managers told him they were moving him to the segregation unit. Staff monitored him for a week under ACCT procedures and the mental health nurse saw him regularly for support.

3. In May, the man transferred to HMP Highpoint. Three weeks later, he climbed on the roof and said he would kill himself. Staff opened an ACCT. After a period of constant supervision, they moved him to the segregation unit. A mental health nurse did not consider that the man had any treatable symptoms. In June, the man tried to kill himself again, when managers told him he was transferring prisons. Staff monitored him for a fourth time.

4. In early July, the man transferred to HMP Wayland, and was under the care of the mental health team. He did not harm himself again and at the end of September, a mental health nurse discharged him. In October, the man was segregated for three days because security information connected him with drugs and weapons in the prison. In November, the Parole Board again decided not to release him.

5. At 10.00am on 26 November, officers took the man to the segregation unit, after managers received further security information. Managers planned to transfer him but had not informed the man. A nurse assessed that there was no clinical reason why he could not be segregated, but did not spot the indicators of risk in his record. At 10.55am, officers found the man had hanged himself in his cell. The officers did not use the appropriate emergency code, which caused a delay in the emergency response. There was also a delay in informing the man's family. Paramedics took him to hospital in a critical condition and he died in hospital on 1 December.

6. The investigation found a number of failings in the man's mental health care with inconsistent and ad hoc support at different prisons. The clinical reviewer considered he should have been referred to a psychiatrist and possibly managed under the NHS Care Programme Approach to ensure adequate and consistent support. Managers, who segregated him at Wayland, did not check his records, but staff at Ranby and Highpoint did not record adequate alerts in the man's records about his risk of attempting suicide when faced with segregation or transfer. We make six recommendations.

THE INVESTIGATION PROCESS

7. The investigator issued notices to staff and prisoners at HMP Wayland about the investigation, inviting anyone with information to contact him. No one responded.

8. NHS England East Anglia Area Team commissioned a clinical reviewer to review the man's clinical care.

9. The investigator visited Wayland on 4 December 2014 and obtained relevant documents from the man's prison and clinical records. He interviewed 16 members of staff and two prisoners in February 2015. The clinical reviewer joined him for interviews with healthcare staff.

10. We informed HM Coroner for Norfolk of the investigation and have sent her a copy of this report.

11. One of our family liaison officers contacted the man's family to explain the investigation process and to invite them to identify relevant issues they wanted the investigation to consider. His family had the following questions, which we have addressed in this report:

    - Why was the man taken to the segregation unit on 26 November?
    - What happened when the man was escorted from his residential wing to the segregation unit?
    - Why was the man located alone in the segregation unit and was he being monitored?
    - How was the man able to hang himself in a cell in the segregation unit? Was it a specially designed safe cell and why did he have access to bedding to tie around his neck?
    - Why did it take several hours to inform his family that the man was in a critical condition?

12. The man's family received a copy of our draft report. We have responded to their comments in separate correspondence.

HMP WAYLAND

13. HMP Wayland is a medium security prison, near Thetford in Norfolk, holding over 1,000 men in thirteen residential units. Virgin Care provides healthcare services.

HM Inspectorate of Prisons

14. HM Inspectorate of Prisons last inspected Wayland in August 2013. The number of violent incidents, some serious, was slightly higher than in similar prisons. Inspectors found that prisoners at risk of suicide and self-harm were well cared for. Security was proportionate and use of force was well managed and only used as a last resort. Inspectors were concerned about the limited regime offered to prisoners held in the segregation unit and recommended that the policy for managing prisoners in the segregation unit needed to be fully implemented. The weakest area inspected was staff-prisoner relationships. Inspectors noted that some staff were dismissive and disinterested and did not engage with prisoners.

Independent Monitoring Board

15. 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 year ending May 2014, the Board was concerned about the workload of the mental health team. The IMB reported that there had been a recent increase in disruptive activity and violent incidents, which meant that the segregation unit was often full. The IMB was concerned that the segregation unit was not fit for purpose and that violent and disruptive prisoners often disrupted its use by destroying the fabric of the building.

Assessment, Care in Custody and Teamwork (ACCT)

16. ACCT is the care planning system the Prison Service uses to support prisoners at risk of suicide or self-harm. Once a prisoner has been identified as at risk, the purpose of the ACCT process is to try to determine the level of risk, the steps that might be taken to reduce this and the extent to which staff need to monitor and supervise the prisoner. Part of the ACCT process involves assessing immediate needs and drawing up a caremap to identify the prisoner's most urgent issues and how they will be met. Regular multi-disciplinary reviews should be held. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

Previous deaths at Wayland

17. Since 2012, four other prisoners have died at Wayland. Three of the deaths were self-inflicted and one was from natural causes. In our investigation into a death at the prison in February 2014, we made recommendations about mental health services and emergency response procedures. These were also issues in this investigation.

KEY EVENTS

18. On 20 July 2006, the investigator was sentenced to 54 months in prison for offences including aggravated burglary. He was released on licence on 5 February 2008, but recalled to prison two months later, charged with further offences of robbery and burglary. The man received an indeterminate sentence for public protection with a minimum period to serve of four years and six months before he could be considered for release. This period, known as the 'tariff', expired on 22 November 2013.

19. The man spent time in a number of prisons. A mental health nurse assessed him at HMYOI Hindley in August 2006 when he was 17 years old. He reported bereavement issues and possible trauma after his uncle was shot in 2002. In December 2006, the same nurse saw him after he had been placed on an ACCT. The man said that this had been a misunderstanding and the nurse decided there was no need for any mental health follow up. On 11 June 2007, a reception assessment at Hindley indicated that he was fit and well and that there was no need for a medical or psychiatric report.

20. There were no further entries about the man's mental health until 2 March 2010, when it was noted at HMP Preston that an antidepressant he had been prescribed in 2009 for post traumatic stress disorder should be stopped, as there were no further concerns about his mental health. In March 2011, he was prescribed an antidepressant again because he was in a very low mood. The man had feelings of hopelessness resulting from his indeterminate sentence. He said that his cousin had hanged himself. Later in March, the man took an overdose of citalopram, his antidepressant. He appeared to suffer no ill effects.

HMP Ranby

21. On 25 November 2011, the man was transferred from HMP Lowdham Grange to HMP Ranby. He asked for a single cell and said that he was anxious as he had been sexually abused for most of his teenage years. (It was not clear whether this was in custody or the community.) His request for a single cell was not allowed. He began the Self Change Programme, an offending behaviour programme which aims to reduce violence in high risk repetitively violent offenders. The programme targets offenders' patterns of anti-social thinking and beliefs that support violence. However, the man was removed from the programme as he did not engage properly.

22. In August 2013, the man told an occupational therapist at Ranby that he was low in mood, anxious and struggling to cope. The Parole Board had recently reviewed his case and decided that he should not be released when his minimum term of imprisonment expired in November and that he was not suitable to move to an open prison. The man explained that he had previously had regular contact with a psychiatrist and a counsellor at HMYOI Lancaster Farms. He also said that he had used cannabis and 'mambo' (a new psychoactive substance) in the recent past. The occupational therapist placed the man on the waiting list for an assessment by the primary care mental health team.

23. Three months later, in November, a mental health nurse assessed the man and he was allocated to the primary care mental health team for work on post traumatic stress disorder (PTSD) and anxiety. However, he then did not attend or walked out of three successive monthly appointments with a mental health nurse between December 2013 and February 2014.

24. On 19 February, prison managers told the man that he was transferring to HMP Gartree for his own safety, as other prisoners had threatened to kill him. The man was one of a number of prisoners from the Manchester area who were moved quickly from Ranby after staff received information that a gang of prisoners from the Nottingham area were planning to attack them.

25. After he was told about the transfer, the man tried to hang himself but an officer found him and cut him down before he harmed himself seriously. The man said that this had been a moment of madness and he had not done anything like this before. Staff began ACCT suicide and self-harm prevention procedures and the man was transferred to Gartree later that day.

HMP Gartree

26. The man was constantly supervised by two escort officers under ACCT procedures during his transfer to Gartree. A reception nurse referred him to the mental health team. At the man's first ACCT case review, held in the prison's reception area, he was assessed as a low risk of suicide and self-harm and the next day, 20 February, at a second review, staff closed the ACCT.

27. A mental health nurse assessed the man the same day. The man said that he knew how to cope with his PTSD and how to get further support if he felt he needed it. The mental health nurse decided that the man did not need the support of the mental health team. On 27 February, the man told a GP that he had smoked 'spice' (slang for what are often referred to as 'legal highs' or new psychoactive substances) for two years.

28. On 11 March, the man barricaded his cell door and blocked his observation panel. Officers got into the cell and found that he had attempted to hang himself. They cut through the ligature and a nurse gave him oxygen. The man said that he had had enough, had settled his affairs with his family and would try to kill himself again.

29. The man said he had decided to take his own life after staff told him they were moving him to the segregation unit. (The reason for segregation was not clear from the records.) He believed that he was going to be transferred to a different prison. The man told staff that he had tied a ligature around his neck at Ranby to try to prevent a transfer, as he believed that prisons did not accept transfers if the prisoner was being managed under ACCT procedures at the time. Staff opened an ACCT. Staff at the first case review assessed the man as a high risk of suicide and decided that he should be constantly supervised.

30. The mental health nurse assessed the man's mental health again on 12 and 13 March. The man described feelings of desperation and hopelessness but said he had no further active plan to harm himself. He was frustrated by his

lack of progress and lack of control over which prison he was sent to. The mental health nurse accepted the man onto his caseload. The ACCT panel reduced the frequency of observations at the next two case reviews on 12 and 13 March and closed the ACCT on 18 March.

31. On 31 March, prison managers informed the man that he was now subject to child contact restrictions for public protection reasons as his criminal behaviour had put his daughter at risk of violent retribution. The man was tearful and angry and said he felt that this was the final straw.

32. On 9 April, the man told staff that he kept seeing a childhood friend who had died. He blamed himself for his friend's death. Staff did not begin ACCT procedures because he said that he was not suicidal, but the mental health nurse reviewed him on 10 April. He completed a depression questionnaire which indicated that the man was severely depressed. The mental health nurse was due to see the man again on 29 April, but he refused to attend the appointment.

HMP Highpoint

33. After one night at HMP Bullingdon on 30 April, the man was moved to HMP Highpoint on 1 May. (There is no documented explanation for the move and managers at Gartree could not give the investigator a reason.) A reception nurse at Highpoint noted the man's suicide attempt a few weeks earlier and that he had not yet started medication for depression. The nurse referred him to the mental health team.

34. On 21 May, the man climbed onto the gymnasium roof and stayed there for several hours. After staff brought him down, he was very emotional and said he would kill himself. Staff began ACCT procedures and constantly supervised the man in the healthcare unit. The next day, he was still tearful and a nurse observed that he remained 'helpless and hopeless'. She completed a full mental health assessment on 23 May, but found no evidence of a mental illness.

35. On 27 May, an ACCT review decided to end constant supervision. The same day, staff moved the man to the segregation unit. They continued to manage him under the ACCT procedures but gave no exceptional reasons for holding a prisoner on an ACCT in the segregation unit. The man told staff that he was on a hunger strike. He refused to eat for a while but soon began again. On 10 June, staff closed the ACCT.

36. The man's said that he would climb back onto the roof if he returned to a standard residential wing. On 18 June, staff told the man that he was being transferred to HMP Wayland because he would not return to a residential unit at Highpoint. He blocked the cell door with some furniture, put a plastic bag over his head and tied a ligature around it. Officers got into the cell and removed the bag and ligature. A nurse checked the man and he recovered quickly. He said that he had not wanted staff to rescue him. He had written on a birthday card, 'Couldn't take it anymore. Sorry Mum. Love you forever and always, your son xxx.'

37. Staff began ACCT procedures and postponed the transfer to Wayland. The man said that he had wanted to kill himself because of his indeterminate prison sentence, but also because he wanted other people, who he saw as responsible for his situation, to face up to their responsibilities. A nurse noted that it was difficult to gauge if the man was actively suicidal because, as soon as he learnt that he would not be transferring, he seemed much happier. At a fourth ACCT case review on 30 June, the man said that he had only wanted to annoy prison managers and had never intended to harm himself. The panel ended ACCT monitoring.

38. The man remained in the segregation unit and maintained that he would go on the roof again if he went back to a standard wing at Highpoint. A prison manager, told the investigator that the prison was left with no choice but to transfer the man to a different prison. The man agreed to transfer to Wayland without any further protest.

HMP Wayland

39. On 7July, the man was moved to Wayland. A nurse assessed him in reception and recorded that he had a history of severe personality disorder, paranoia, self-harm and recent suicide attempts by hanging. The man said that he had no current suicidal thoughts. He asked for mental health treatment and said that he had not been able to start this because of prison transfers. A nurse referred him to the primary mental health team. The man was assessed as a high risk of violence towards a cellmate. He had a single cell on the second landing of A Wing.

40. On 8 July, a nurse, from the primary care mental health team, assessed the man. The nurse noted that the man felt very low and seemed worried and subdued. He told the nurse that he had been a victim of sexual and physical abuse and had been in prison most of his adult life. He was not distressed and showed no symptoms of psychosis. The man said that he had no active plans for suicide and self-harm and that antidepressants had previously improved his mood. The nurse planned further one-to-one work to monitor the man's mental state and a prescription for antidepressants. However, the man did not see a doctor at the time and was not prescribed antidepressants until September.

41. On 9 July, the man moved into a cell on the second landing of C wing, where he worked as a cleaner. On 10 and 17 July, the man saw the nurse. He said that life was too difficult for him, but he was not thinking about harming himself. The nurse completed a PHQ-9 depression questionnaire with the man. He scored 23, which indicates severe depression.

42. The man's new offender supervisor saw him after he arrived at Wayland. (Offender supervisors in prisons are responsible for implementing sentence plans.) She told the investigator that his offender manager (probation officer) in the community and his offender supervisor at Highpoint South, who had completed reports for his next parole review, had not recommended his release, so the man would have known that the Parole Board were not going to approve his release at his review In the autumn. The offender supervisor and the man agreed that he would have to complete the Self Change

Programme, from which he had previously been deselected, before it was likely that the Parole Board would consider release.

43. On 7 August, a nurse from the mental health team reviewed the man. He noted that the man spent most of his time in his cell. The man said he did not want medication for his low mood but found the one-to-one sessions with a mental health nurse useful as a safe space to discuss his feelings. He said that he had witnessed negative events throughout his childhood and mentioned previous self-harm. He said he had no current plans to kill himself. A nurse planned monthly mental health reviews.

44. On 5 September, a nurse held another mental health review. The nurse thought that the man was depressed because of his current circumstances, rather than clinically depressed. Although he reported episodes of extreme low mood, he did not have an active plan to end his own life. The nurse completed another PHQ-9 depression questionnaire and scored the man 16 (moderately severe depression). That day, a doctor prescribed 20mg of fluoxetine (an antidepressant) daily for 30 days. This was the first time that the man had been prescribed antidepressants since 2011. He received monthly repeat prescriptions, which he was allowed to keep in his cell.

45. On 30 September, a nurse reviewed the man's mental health. The man said that he had settled at Wayland, he was now used to his medication, his mood was level and stable and he no longer had suicidal thoughts. He said that he had a supportive family, received regular visits and was getting enough food and sleep. After the review, the nurse decided that the man did not need any further support from the primary care mental health team and discharged him from their care.

46. Nurses are supposed to discuss patients with the primary care mental health team before discharging them from the team's care. The nurse told the investigator that she had met colleagues to discuss the man's case. However, there is no record of any discussion or input from other colleagues in the man's healthcare record.

47. Each prisoner has a personal officer who acts as a point of contact for help or questions. The man's personal officer, was away for some weeks between 9 July and 17 October and made no entries about the man in his prison record. There are very few entries by any staff in the man's record over this period and nobody took over the personal officer role in the officer's absence.

48. On 17 October, after the security department received information linking the man to the increased availability of drugs, weapons and mobile phones in the prison, a manager authorised the man's segregation. He had converted to Islam at Wayland and staff suspected that he had influence over other Muslim prisoners and was planning a disturbance at Friday prayers. The nurse assessed the man as fit to be held in the segregation unit.

49. The man seemed subdued but did not disclose any active suicidal thoughts. A segregation unit officer, said that the man had been a little anxious, but had cooperated and engaged well and he had not had any concerns about him. A nurse saw the man each day in the segregation unit and did not identify any concerns about him.

50. While the man was in the segregation unit, the Head of Security and Intelligence, went to see him. The man asked to return to a wing for a fresh start, to progress his sentence. He offered to provide security information and suggested that he had done this in other prisons. On 20 October, the head of security and intelligence agreed to let the man leave the segregation unit. He moved into a cell on the second landing of C wing and worked in the wing servery. The head of security and intelligence said that the man subsequently handed in a couple of weapons to the security department. It was not clear if they had belonged to him or another prisoner. The man did not become an informer or 'work' for the security department in any capacity.

51. On 24 October, at a meeting with the offender supervisor, the man seemed in good spirits. At first, the programmes manager had decided that the man would have to wait to restart the Self Change Programme, but the offender supervisor appealed this decision and they agreed that the man could attend, but would have to begin again from the first module. There was no start date, but before joining the programme, he had to complete an assignment to explain the reasons for his previous deselection and demonstrate his renewed motivation.

52. On 11 November, the Parole Board decided not to direct the man's release or recommend a transfer to an open prison. The prison received the decision on 19 November. An administrator, passed a copy of the letter to the man. The administrator received a slightly amended copy of the Parole Board's decision on 25 November, to correct some factual errors the man had pointed out. He did not send a copy to the man before his death. The decision in the second letter was the same.

Wednesday 26 November

53. The security department had continued to receive intelligence which suggested that the man was responsible for supplying drugs and weapons in Wayland. The head of security and intelligence believed that, for the good order of the prison, it was no longer safe to keep the man at Wayland and planned to transfer him. On Wednesday 26 November, the head of security and intelligence (and in charge of the prison that day) and the person in charge of the segregation unit decided to move the man to the segregation unit. They did not know about the man's history of attempting to hang himself earlier in the year, when he was due to be segregated or transferred.

54. The head of security and intelligence authorised the man's segregation. At about 9.50am, two SO's and an officer joined him on C wing. One of the wing officers took the man to the office. As soon as the man saw the other staff, he guessed they were taking him to the segregation unit. He protested, said that he had been helping the security department and asked to speak to the head of security and intelligence. The head told the man that he was being segregated because he was suspected of supplying drugs and weapons.

55. The man walked freely to the segregation unit and arrived there at 10.00am. No force was used. The staff strip-searched him, placed him in a standard segregation single cell and gave him a new set of prison clothes and bedding. (The man had not been identified as at high risk of suicide and self-harm and

there was no reason for staff to limit his access to clothes or bedding. None of the cells in the segregation unit at Wayland are 'safer cells' designed with fewer ligature points.) The man repeatedly asked to speak to the head of security and intelligence about the reason for his segregation and kept claiming that he had been giving the security department information. An SO advised the man to keep his voice down for his own safety because other prisoners might hear him. The SO said the man wanted to see the head of security and intelligence.

56. At 10.15am, the man seemed calmer and asked the officer when the head of security and intelligence was going to visit. The officer telephoned the head of security and intelligence and asked him to make time to speak to the man.

57. Within two hours of a prisoner's arrival, a doctor or registered nurse must complete an initial segregation health screen to determine if there are any healthcare reasons why the prisoner should not be segregated and to give a 'snap-shot' of the prisoner's mental wellbeing at the time of the screen. The prison manager authorising segregation should sign the health screen to indicate they have seen it. The officers asked the nurse, who was already in the segregation unit, to complete the man's health screen.

58. Before completing the screen, in order to check for signs of mental distress, healthcare staff are expected to have a discussion with the prisoner, refer to his clinical record and any other relevant documentation such as an incident report, gather information from other members of the healthcare team and prison staff and review the nature of the incident which led to segregation. The nurse went to the healthcare unit to check the man's clinical record. He did not identify any concerns that he considered would prevent the man from being segregated.

59. At 10.30am, the nurse assessed the man in his cell with two officers present. He did not remember asking the man about suicide and self-harm, but one officer thought that he had done so. The health screen is based on an algorithm, which the nurse did not complete fully. He identified that the man had previously self-harmed during his sentence, but then did not complete the box to record whether or not he thought that the man's mental health would deteriorate significantly if he was segregated. However, the remainder of the form is completed in such a way as to suggest that he did not think that it would. The nurse signed the form and recorded that the man was medically fit to be held in the segregation unit. A manager was expected to come to the segregation unit to sign the health screen and authorise the man's segregation.

60. The man asked for his fluoxetine and the nurse told him that someone would collect it from his cell and a nurse would give it to him later. The nurse left and the man told the officer quietly that he had information for the head of security and intelligence but would not elaborate further. The officer telephoned the head of security and intelligence, who said that he would come and speak to the man when he had time.

61. At 10.55am, the two officers went to the man's cell door. One officer asked him if he wanted to come out for exercise, a shower or to make a telephone call, but the man did not respond. The officer looked through the observation

panel but it was very dark and he could not see the man. He unlocked the door but it would not open easily because the man had placed a plastic chair and table against it. The officer pushed the door, made enough of a gap to get through and he and the other officer went in.

62. The man was in the corner of the cell. At first, because the light was poor, the officers said they could not tell if he was standing or hanging. He had a large towel over his head, and when the officers removed it, they saw that the man had tied a piece of green bed sheet around his neck attached to a hinge on the cell window. He was facing the window.

63. The officer radioed the following: 'Medical assistance in the segregation unit, cell number 1'. The officer said that the ligature around the man's neck was very tight and he cut through the length of torn bedding attached to the window frame. The man dropped suddenly and the officer caught and supported him. The other officer opened the door fully and pressed the general alarm bell.

64. Two other officers arrived. One of the officers cut the ligature from around the man's neck. Two officers checked for a pulse, could not find one and at first placed the man in the recovery position. They then placed the man onto his back on the floor and tilted his head. The three officers were not first aid trained. Around three minutes later a prison manager, arrived and was the first member of staff to begin cardiopulmonary resuscitation by chest compressions.

65. Two nurses were in the nearby healthcare unit and went to the segregation unit. They did not take emergency equipment, as the designated emergency response nurse had just taken the healthcare unit's emergency bag and defibrillator to D Wing, where another prisoner had tied a ligature around his neck. There was another set of emergency equipment in a medication room in a different part of the prison but this would have meant a significant detour for the nurses. As there had been no emergency medical code to indicate the nature of the emergency, the nurses went straight to the segregation unit to establish what was happening.

66. As soon as the nurses saw what had happened, the nurse began to help the prison manager with resuscitation and the other urse went to get emergency equipment. The nurse asked the officers if anyone had called an ambulance and, at about 10.59am, the manager, who had arrived to help, telephoned the control room and asked them to call an ambulance, giving them some details about the man and his condition. At 11.01am, control room staff telephoned the ambulance service, who said that it would take 20 minutes for an ambulance to arrive, so they also dispatched an air ambulance.

67. A healthcare assistant radioed the emergency response nurse and asked her to bring the emergency equipment to the segregation unit. A nurse the emergency response nurse as she was coming back from D Wing and they took the emergency equipment, including oxygen and a defibrillator, to the segregation unit. The healthcare assistant joined them.

68. The healthcare assistant and nurse gave the man oxygen while the nurse and the prison manager gave chest compressions. The nurse attached the

defibrillator to the man, which repeatedly advised them to continue attempting resuscitation and not to shock. The emergency response nurse telephoned the duty GP and then brought more oxygen. The GP arrived at 11.11am.

69. The orderly officer, had sent officers to the gate to ensure that paramedics could be escorted to the segregation unit without delay. A first response paramedic arrived in the segregation unit at 11.21am. The paramedic attached a heart monitor, which found some cardiac activity, so the staff stopped performing chest compressions while the paramedic stabilised the man. Two more paramedics reached the segregation unit at 11.24pm. The air ambulance crew arrived in a third vehicle at midday, because their helicopter had been unable to take off due to fog.

70. The man was in a critical condition and, at 12.25pm, an ambulance took him to the Norfolk and Norwich University Hospital. Three officers went with him.

71. That afternoon, managers reviewed all prisoners subject to ACCT monitoring, in case they had been affected by hearing about the man's actions. The duty governor debriefed the prison officers and the healthcare staff involved in the emergency response and offered support.

72. Neither of Wayland's two trained family liaison officers was on duty that day, but managers asked one of them to come in. Meanwhile, a prison manager, found the contact details for the man's mother, who lived near Manchester. The prison manager and the deputy governor, considered asking a family liaison officer from HMP Manchester to visit his mother, but decided to ask the local police to inform her instead.

73. At 12.50pm, Wayland's police intelligence officer contacted the Greater Manchester Police and asked them to visit the man's mother. The police agreed to do this within the hour. The prison manager and the police intelligence officer contacted Manchester police three times, at 2.40pm, 3.05pm and 3.20pm, to check progress, but they had still not informed the man's mother. The deputy governor then telephoned HMP Manchester and fifteen minutes later, a family liaison officer at Manchester called the prison manager and agreed to visit the man's mother.

74. At 3.55pm, the prison manager was about to cancel the police visit, when they telephoned him from the man's mother's home. The prison manager spoke to the man's mother and the police agreed to stay with her until the family liaison officer from Manchester arrived. However, the man's family wanted to leave as quickly as possible. At 10.30pm, they arrived at the hospital in Norwich, where the prison manager and family liaison officer met them.

Thursday 27 November – Monday 1 December

75. On 27 November, the prison manager reduced the number of escort officers to two, without uniform. On 28 November, the man's doctor advised his family that he would not recover. His family asked for him to be transferred to a Manchester hospital to die, but the hospital consultant would not agree. The deputy governor submitted an application for the man's early release on compassionate grounds to the National Offender Management Service headquarters, but no decision was reached before his death.

76. Doctors pronounced the man brain stem dead at 3.54pm on 1 December, at which point, escort officers withdrew. The man was kept on life support until his organs could be donated, at his family's request.

77. The post-mortem examination found that the man died from hanging, resulting in bronchopneumonia in hospital. The marks on his neck were consistent with hanging and there were no external signs of violence or trauma.

ISSUES

Clinical care

78. Although the man had taken an overdose in March 2011, there were no other recorded significant acts of self-harm until February 2014, when he tried to hang himself at Ranby, after learning he was being transferred to Gartree. The same day, a mental health nurse at Gartree decided that he did not require any treatment. The man tried to hang himself at Gartree three weeks later, when he learnt he would be moving to the segregation unit. The same nurse then saw the man regularly. Shortly after, at Highpoint, he climbed onto the roof, was subject to ACCT procedures, segregated and made another attempt to kill himself when staff told him they were moving him. A mental health nurse assessed him but found no treatable symptoms, so he had no ongoing care from the mental health team. The man transferred to Wayland and began seeing a mental health nurse regularly, which he said he found helpful. He was also prescribed an antidepressant. However, at the end of September, a nurse discharged him from the care of the mental health team. On 26 November, the other nurse regarded him as fit for segregation.

79. The clinical reviewer, considered that the man was a vulnerable prisoner, who had spent long periods in prison from a young age and had a significant substance misuse problems. He noted that there was little reason to disbelieve the man's account that he had suffered sexual abuse in the past. Throughout his time in prison, various professionals had described the man as having personality problems or a personality disorder. The clinical reviewer believed it would have been prudent to have referred the man to a psychiatrist of a psychologist for a diagnosis. This might have led to him being managed under the NHS Care Programme Approach with a care coordinator and multidisciplinary input. Instead, the man's mental healthcare was ad hoc, inconsistent and unplanned at each prison.

80. The nurse discharged the man from the care of the mental health team at Wayland on 30 September, but told us that she had not looked back at his clinical record and was unaware of his repeated attempts to hang himself earlier in the year. She said that she held a meeting with colleagues to discuss the man's discharge, but there is no evidence of this meeting in the clinical record. When the nurse assessed the man as suitable for segregation on 26 November, he also did not read the clinical record properly and did not identify the man's risk from his previous suicide attempts. While the man's death might not have been prevented by more effective clinical assessment, this reduced the opportunities to keep him safe. We make the following recommendation:

    The Head of Healthcare should ensure that all healthcare staff review prisoners' clinical records appropriately, when making decisions about their future care or making assessments of risk, such as suitability for segregation, and implement a risk management plan if necessary.

81. The clinical reviewer was concerned that the overall standard of mental healthcare at Wayland was not good enough to meet the needs of prisoners. He considered that the failings were systemic, rather than the responsibility of individual clinical staff. The clinical reviewer had similar concerns when he

reviewed the care of a man who died at the prison in February 2014, which NHS England assured us the new healthcare provider, Virgin Care, would address.

82. The clinical reviewer's findings were published alongside our draft investigation report in October 2014 and we accept there was insufficient time for Virgin Care to improve clinical standards before the man died. However, the prison's action plan indicated that Virgin Care would implement changes by the end of January 2015. The new Head of Healthcare who took on the role in January, was unaware of these undertakings when the investigator spoke to her in March. We make the following recommendation:

The Head of Healthcare should ensure, in conjunction with NHS England East Anglia Area Team, that previous commitments to improve mental health services at Wayland are implemented without delay.

Managing the risk of suicide and self harm

83. From the beginning of 2014, segregation and associated transfers were evidently risky periods for the man. He had tried to hang himself at Ranby on 19 February when told he was transferring to Gartree and then again at Gartree, on 11 March, when staff said they were moving him to the segregation unit. On 18 June, at Highpoint, he tried to kill himself in the segregation unit when staff told him he was moving to Wayland.

84. On 26 November, the head of security and intelligence decided to segregate the man and then planned to transfer him. He had not yet been to see the man to tell him that he would be moving prisons when he hanged himself. The head of security and intelligence, and two managers were unaware of the risk that the man might try to hang himself once he was segregated or faced the prospect of a transfer.

85. The overall failures of staff at various prisons to identify the man's risk and create a multidisciplinary risk management plan contributed to Wayland staff's lack of awareness of his risk of suicide if he was segregated or transferred. He was no longer under the care of Wayland's mental health team and the number of recent transfers had not helped continuity of care. There was little about the man's behaviour after he arrived at Wayland that had suggested to staff that he was at serious risk of suicide and self-harm. He had been in the segregation unit in October and had caused no serious concerns. On 26 November, he gave no indication to the officers who took him to the segregation unit or the staff working in the unit that he planned to take his own life. To that extent, his actions were sudden and unpredictable.

86. Prison Service Instruction 73/2011, about P-NOMIS, (the computerised prison record system) states that a self-harm alert must be entered on a prisoner's record whenever there is an incident of self-harm and an ACCT alert must be recorded whenever staff begin ACCT procedures. When used appropriately, these alerts are the simplest way for prison staff to identify any concerns about past behaviour. Staff at Ranby, Gartree and Highpoint had recorded P-NOMIS alerts about the four periods of ACCT monitoring in the first half of 2014, yet only Gartree recorded a separate alert for the incident of self-harm

(suicide attempt) or referred to the man's reason for attempting suicide.

87. The managers who authorised segregation on 26 November did not consult the man's record for any relevant alerts but, even if they had, they could not easily have recognised a pattern of risk associated with segregation or transfer. There should have been a clear alert for each incident of self-harm, briefly describing the circumstances, on the man's prison record. We make the following recommendation:

The Governors of Ranby, Highpoint and Wayland should ensure that each incident of self-harm and relevant information about the circumstances is recorded as an alert on a prisoner's NOMIS record and that managers check records for relevant alerts before authorising segregation.

Transfer to the segregation unit

88. The man's family wanted to know whether anything had happened on the way to the segregation unit which affected his risk. There are no CCTV cameras in the segregation unit at Wayland. Although there are CCTV cameras on the route between C Wing and the segregation unit, the footage from 26 November had been automatically deleted, as a standard routine, before the investigator could view it. The staff who took the man to the segregation unit said that, although at first he was inevitably unhappy about the move, he complied and walked to the segregation unit without incident. There is no evidence of any use of force and officers said that the man had been calm and compliant. Although he objected to his location and asked to see the head of security and intelligence, they did not consider that he seemed suicidal or significantly distressed. There is nothing to indicate any reason for concern about the operational management of the man's escort to the segregation unit.

Support and welfare checks

89. When the man arrived at Wayland in July 2014, he had been subject to four periods of ACCT monitoring, had tried to kill himself three times and had transferred between four different prisons since February. We would therefore have expected to find evidence, particularly during his induction period and his early days at Wayland, to demonstrate that staff supported him and checked his welfare. However, we found very few entries in the man's record to indicate that staff interacted or were vigilant about his wellbeing. We make the following recommendation:

The Governor should ensure that officers have meaningful recorded contact with every prisoner, particularly in their early weeks at the prison. All prisoners should have a named officer who should be aware of their individual needs and makes regular checks on their wellbeing, backed up by good quality entries in their case notes.

Emergency response

90. Prison Service Instruction (PSI) 03/2013 requires all prisons to use medical emergency response codes. A local Governor's Order implementing the

Prison Service Instruction was issued to staff at Wayland on 10 July 2014; over twelve months after the PSI came into effect. In line with the PSI, the local order correctly instructs staff to use an emergency code blue in circumstances such as when they find a prisoner unconscious or not breathing. The order requires control room staff to call an ambulance automatically as soon as they receive the emergency code, without waiting for further instructions.

91. When the officers found that the man had hanged himself, the officer radioed for medical assistance but did not use an emergency medical code. The officer pressed the general alarm. This meant that other staff did not immediately realise the urgency and nature of the emergency. Not all available healthcare staff responded and the emergency response nurse, who was attending another incident at the time, was unable to decide on priorities. There was an unacceptable four-minute delay in calling an ambulance, which did not happen until a manager telephoned the control room staff with further information.

92. The two officers both told the investigator that they had received mixed messages in the past from managers about how to use the emergency response codes. Because they are not clinical staff, they believed they were required to ask a nurse to assess the situation first. This is entirely contrary to the intention of PSI 03/2013, which explicitly states that it should not be a requirement for a member of the prison healthcare team or a manager to attend the scene before emergency services are called, that staff should use the appropriate emergency code and that control room staff should call an ambulance immediately. Although the prison has appropriate local emergency instructions, it appears that these were issued only belatedly and are not understood and followed. There is a need for managers to make it clear to all staff what is expected. We make the following recommendation:

The Governor should ensure that all prison staff are aware of PSI 03/2013 and local guidance and understand their responsibilities during medical emergencies, including that:

- **Staff use the appropriate code to communicate a medical emergency;**
- **Staff called to the scene take the relevant equipment; and**
- **The control room calls an ambulance immediately an emergency medical code call is received.**

Family Liaison

93. It was five hours after prison staff found the man hanged in his cell and three and a half hours after he was taken to hospital in a critical condition, before anyone informed his family what had happened. The delay was because managers decided to use the local police to break the news in person. This took longer than anticipated. Managers then tried to arrange for a family liaison officer from a nearby prison to contact the man's mother, who was his nominated next of kin.

94. While well intentioned, we consider that this approach was misguided and appears to have been based on procedures designed to inform families of a

death. However, when a prisoner is critically ill in hospital, most families will prefer to be informed as soon as possible; otherwise, they might miss the opportunity to see their loved one while he or she is still alive.

95. Prison Rule 22(1) requires governors to inform the prisoner's family 'at once' if a prisoner becomes seriously ill or sustains any severe injury. PSI 64/2011 advises that where prisoners have suffered sudden life-threatening harm and is unable to communicate his wishes 'the prison must contact the next of kin or a nominated person who must be given an accurate account of what has happened, including treatment given, whether the prisoner is in hospital, and information about visiting the prisoner'. We consider that the delay in informing the man's family was too long. As the prison was unable to inform his family in person about what had happened, a manager should have telephoned his mother immediately. We make the following recommendation:

The Governor of Wayland should ensure that a manager or family liaison officer informs a prisoner's family as soon possible when a prisoner becomes seriously ill or seriously harms himself.

RECOMMENDATIONS

1. The Head of Healthcare at Wayland should ensure that all healthcare staff review prisoners' clinical records appropriately, when making decisions about their future care or making assessments of risk, such as suitability for segregation, and implement a risk management plan if necessary.

2. The Head of Healthcare at Wayland should ensure, in conjunction with NHS England East Anglia Area Team, that previous commitments to improve mental health services at Wayland are implemented without delay.

3. The Governors of Ranby, Highpoint and Wayland should ensure that each incident of self-harm and relevant information about the circumstances is recorded as an alert on a prisoner's NOMIS record and that managers check records for relevant alerts before authorising segregation.

4. The Governor of Wayland should ensure that officers have meaningful recorded contact with every prisoner, particularly in their early weeks at the prison. All prisoners should have a named officer who should be aware of their individual needs and makes regular checks on their wellbeing, backed up by good quality entries in their case notes.

5. The Governor of Wayland should ensure that all prison staff are aware of PSI 03/2013 and local guidance and understand their responsibilities during medical emergencies, including that:

    - Staff use the appropriate code to communicate a medical emergency;
    - Staff called to the scene take the relevant equipment; and
    - The control room calls an ambulance immediately an emergency medical code call is received.

6. The Governor of Wayland should ensure that a manager or family liaison officer informs a prisoner's family as soon possible when a prisoner becomes seriously ill or seriously harms himself.