Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Dale Wills a prisoner at HMP Durham on 4 July 2015

A report by the Prisons and Probation Ombudsman
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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*

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 Wills was found hanging in his cell at HMP Durham on 6 June 2015 and died in hospital on 4 July 2015. He was 25 years old. I offer my condolences to Mr Wills' family and friends.

Mr Wills often self-harmed or threatened to do so. His behaviour was difficult to manage and he admitted that some of his self-harming was intended to get what he wanted. However, I am concerned that, because staff appear to have viewed Mr Wills' behaviour as largely manipulative, they failed to recognise that it had become increasingly impulsive and risky in the weeks leading to his death or to manage and co-ordinate their response to this risk effectively. I am also concerned that little action was taken to investigate his claims that he was being threatened by other prisoners, apparently for drug debts, and whether his use of drugs, including new psychoactive substances, increased his risk.

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 **April 2016**

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Summary

Events

1. In October 2014, Mr Dale Wills was sentenced to 38 weeks in prison for theft and was due to be released in March 2015. On 5 February 2015, he transferred to Durham from HMP Northumberland and was charged with further offences. When his sentence expired, he was held on remand. Mr Wills had been in prison many times before, including at Durham. He had been diagnosed with a personality disorder, had a history of substance misuse and a history of self-harm by cutting himself and tying ligatures around his neck. He said that he had considered and attempted suicide before.

2. Mr Wills was monitored under Prison Service suicide and self-harm prevention procedures, known as ACCT, four times at Durham after harming himself. His behaviour was difficult to manage and staff often described him as manipulative. Mr Wills said that he was unhappy at Durham and wanted to transfer to another prison, but he had to stay at Durham until his court appearance in June.

3. A psychiatrist assessed Mr Wills and found no evidence that he was suffering from an acute mental illness. Mental health nurses saw Mr Wills frequently, although he did not always want to engage with them.

4. In April, staff began to suspect that Mr Wills was having problems with other prisoners and, in May, he told them that other prisoners were threatening him and his family. He moved to several different wings in the prison and spent some time in the segregation unit, but continued to complain of problems.

5. Mr Wills often cut himself, and staff found him with ligatures tied around his neck several times. He said he was not suicidal but mental health nurses warned him that his behaviour was dangerous and that he might, accidentally, seriously harm or kill himself. After 15 May, Mr Wills began to harm himself more frequently and appeared to be in a period of crisis. At about 11.30pm on 5 June, a night patrol officer found Mr Wills hanged in his cell. Paramedics managed to restore his pulse, but, sadly, he never recovered and died in hospital on 4 July.

Findings

6. We recognise that Mr Wills was not always easy to manage, but we are concerned that this difficulty meant that prison staff sometimes lost sight of the very real risks he posed to himself. His impulsive self-harming behaviour meant he was at risk of accidental death even if he did not intend to kill himself and it appears that staff underestimated this risk. Despite regular contact with senior managers and mental health staff, no one noted that there had been a worrying increase in incidents of self-harm after 15 May, and particularly in the days before his death.

7. There is little evidence that the prison properly investigated Mr Wills' allegations that he was under threat from other prisoners. It took too long to notify Mr Wills' family that he was in hospital.

Recommendations

- The Governor and Head of Healthcare should ensure that staff manage prisoners at risk of suicide or self-harm in line with national guidelines. In particular:
    - ACCT case reviews assess the level of risk taking into account all information about risk, any recent changes in behaviour and set levels of observations to reflect that risk.
    - All case reviews are multidisciplinary with continuity of case management.
    - A member of healthcare staff should attend all first case reviews and subsequent reviews where relevant.
    - ACCT caremap actions are specific and meaningful, aimed at reducing a prisoner's risk and identify who is responsible for them.

- The Governor should ensure that allegations of violence, bullying, or intimidation are taken seriously, investigated and dealt with in line with local and national policies. Prisoners identified as at risk of violence from other prisoners should be effectively protected.

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

The Investigation Process

8. The investigator issued notices to staff and prisoners at HMP Durham informing them of the investigation and asking anyone with relevant information to contact her. No one responded.

9. NHS England commissioned a clinical reviewer to review Mr Wills' clinical care at the prison.

10. The investigator obtained copies of relevant extracts from Mr Wills' prison and medical records.

11. The investigator interviewed 18 members of staff and two prisoners at Durham in August and September 2015. The clinical reviewer joined the interviewer for some of the interviews.

12. We informed HM Coroner for Durham and Darlington of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

13. The investigator and one of the Ombudsman's family liaison officers met Mr Wills' family to explain the investigation and to ask them if they had information they wanted the investigation to consider. Mr Wills' family asked why, as Mr Wills' had harmed himself before, he was not constantly supervised. Mr Wills' sister had spoken to him a few days before he died, when Mr Wills told her he was feeling suicidal. His sister thought than an officer had been standing close to the telephone and must have heard what Mr Wills said. Mr Wills' family was upset that the prison did not tell them Mr Wills had been admitted to hospital until the morning after his admission, and felt the prison gave them incorrect information about what had happened.

14. Mr Wills' family received a copy of the initial report. They raised a number of issues/questions that do not impact on the factual accuracy of this report and have been addressed through separate correspondence.

Background Information

HMP Durham

15. HMP Durham is a local prison serving the courts of Durham, Tyneside, and Cumbria, which holds approximately 1,000 men. Care UK provides primary healthcare services and Tees, Esk and Wear Valley NHS Trust provides mental health services.

HM Inspectorate of Prisons

16. The most recent inspection of HMP Durham was in December 2013. Inspectors reported that they were not confident that the risks and vulnerabilities of new arrivals were properly identified. They found ACCT suicide and self-harm prevention procedures were poor. ACCT case reviews were often not multidisciplinary and caremaps were not always updated. Entries in ACCT documents did not demonstrate a caring approach and most were merely observational. Some prisoners assessed as at risk of suicide and self-harm said that they felt unsupported by staff.

17. Inspectors were concerned about the quality of violence reduction work and that there was a need for more effective interventions for perpetrators and better support for victims of violence. They praised mental health services at the prison and noted that there was an excellent range of interventions.

Independent Monitoring Board

18. 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 October 2014, the IMB reported that mental health care at Durham was excellent. The IMB considered that the quality and detail of ACCT documents continued to improve.

Previous deaths at HMP Durham

19. Mr Wills' death was the fourth self-inflicted death at Durham since August 2014. In other recent investigations, we have made recommendations about identifying and managing the risk of suicide and self-harm.

Assessment, Care in Custody and Teamwork (ACCT)

20. Assessment, Care in Custody and Teamwork (ACCT) is the care planning system the Prison Service uses for supporting and monitoring prisoners assessed as at risk of suicide and self-harm. The purpose of the ACCT process is to try to determine the level of risk posed, the steps that might be taken to reduce this and the extent to which staff need to monitor and supervise the prisoner. Levels of supervision and interactions are set according to the perceived risk of harm. There should be regular multi-disciplinary case reviews involving the prisoner. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

Key Events

21. On 27 October 2014, Mr Dale Wills was sentenced to 38 weeks for theft and property offences and went to HMP Durham. He had been in prison many times before, generally serving short sentences, and had last been released from prison just 11 days earlier, on 16 October. Mr Wills had a history of intravenous drug use and drank heavily. He often self-harmed by cutting his arms and had attempted suicide by hanging and had threatened to jump from a height in the community. He had been diagnosed with an antisocial personality disorder.

22. On 14 November 2014, Mr Wills transferred to HMP Northumberland. He was due to be released on 8 March 2015, but, on 5 February 2015, was returned to HMP Durham to face charges of assault with intent to rob. When he arrived back at Durham, a nurse recorded that Mr Wills said he was well, and had no concerns. Mr Wills did not have a full health screen because he had transferred from Northumberland.

23. On 12 February, wing staff asked a mental health nurse to see Mr Wills. She noted that Mr Wills was agitated and perplexed. He told her that he found it difficult to share a cell after having a single cell at HMP Northumberland. He said he felt paranoid and suspicious and demanded a single cell. He said he might hurt his cellmate if they did not move him.

24. The nurse told a Supervising Officer (SO) what Mr Wills had said. The SO told Mr Wills that he took the threats seriously, but Mr Wills could not move cell until staff had formally reviewed his level of risk. The nurse noted that a prison psychiatrist had previously assessed Mr Wills and found no evidence of mental illness, but had concluded that Mr Wills had traits consistent with emotionally unstable personality disorder. The nurse wrote that Mr Wills might need an initial mental health assessment and that a nurse would review him if wing staff had further concerns.

25. On the 1 March 2015, Mr Wills told an officer that he was not happy sharing a cell and intended to cut himself. He then made three cuts to his left arm with a razor. A nurse treated the cuts. Mr Wills told her that he was not happy with the mental health care he had received since arriving at Durham. He asked to be referred to the mental health team and said he wanted a different psychiatrist to assess him.

26. The officer began ACCT procedures. He noted that Mr Wills' actions appeared to have been manipulative, because he had been unhappy that staff had not given him a single cell. Staff checked Mr Wills once an hour until he had been assessed as part of the ACCT process.

27. On 2 March, an officer assessed Mr Wills. Mr Wills said that he wanted a single cell and felt that harming himself would help him get one. Mr Wills said he had no thoughts of suicide. A custodial manager and the officer then held the first ACCT case review. No member of healthcare staff attended, although this is a mandatory requirement for first case reviews. The custodial manager recorded that Mr Wills had a very poor attitude and that they had warned him about his 'maladaptive' behaviour. He assessed Mr Wills' risk of harm to self as low (from

options of low, raised and high). He noted that Mr Wills had applied for a single cell and ended the ACCT monitoring. (On 11 March 2015, an officer held an ACCT post-closure review and noted that Mr Wills was now in a single cell on B Wing and had no other concerns.)

28. On 9 March, a nurse referred Mr Wills to the substance misuse team's illicit users' clinic. She noted that Mr Wills said he used subutex (a heroin replacement medication) every now and again. The substance misuse team manager noted that Mr Wills would need to take a drugs test to confirm his drug use, before he could be prescribed methadone (another heroin replacement medication). On 19 March, a doctor saw Mr Wills for an unrelated matter and questioned him about his illicit drug use. Mr Wills told the doctor that he had not used any illicit drugs for a year and had only claimed to use subutex so that he would be prescribed methadone, which would help him sleep.

29. On 8 April, Mr Wills saw a doctor and said that he did not feel well and wanted to be re-prescribed quetiapine (an antipsychotic medication), which he had not been prescribed for some time. The doctor noted that Mr Wills was not making much sense. Mr Wills agreed to be referred to the mental health team.

30. On 9 April, Mr Wills climbed onto the safety netting on B Wing. He was charged with a disciplinary offence and moved to the segregation unit. A community psychiatric nurse assessed Mr Wills and noted that he was angry but found no signs of psychosis or thought disorder. Mr Wills said he had no thoughts of suicide or self-harm. He said that he wanted to be prescribed quetiapine because it helped him to sleep.

31. Mr Wills told a nurse that, if he had to share a cell again, he would stab someone in the neck or eye, so that he would be moved to another prison. The nurse referred Mr Wills to the mental health team for an assessment and completed a security intelligence report.

32. The next day, 10 April, he told a nurse that he could not cope in the segregation unit because he had no tobacco or drugs. He threatened to harm himself and the nurse started ACCT procedures. Staff checked Mr Wills once an hour until he could be assessed.

33. Later that day, an officer assessed Mr Wills and recorded that his problems were that he had no tobacco, felt low in mood and depressed. The officer recorded that Mr Wills was displaying 'maladaptive behaviour'. He had not self-harmed in the previous 48 hours, but said that he wanted to be dead, although he had not planned how to do it. Mr Wills told the officer that he had nobody to live for, although the officer noted that Mr Wills' sister visited him frequently. Mr Wills said that he had climbed onto the landing safety netting the day before, because he wanted to kill himself.

34. Mr Wills was found guilty at a disciplinary hearing of an offence against Prison Rules, by climbing onto the B Wing netting. He was punished by seven days cellular confinement, and 14 days loss of earnings and privileges.

35. At 4.00pm on 10 April, staff held the first ACCT case review. Mr Wills said that another prisoner on B Wing had called him a smack head the day before and this

had upset him. He said that he had often used illicit drugs on B Wing, including spice (a synthetic cannabinoid or new psychoactive substance). A custodial manager noted that the staff at the review thought there were other reasons why Mr Wills did not want to stay on B Wing, but he would not tell them. The manager told the investigator that they thought Mr Wills was in debt. Mr Wills said his head was 'done in' and he needed tobacco, but he said that there was nothing else staff could do to support him. He said that he would harm other prisoners if he was moved back to B Wing, and that he would not be there the next morning. The review team noted that he should be given educational materials to help distract him in his cell.

36. The custodial manager noted on the ACCT caremap that Mr Wills was displaying 'maladaptive behaviour' and needed to follow the segregation unit's management plan. The case review assessed Mr Wills as at raised risk of suicide and self-harm. Staff were instructed to check Mr Wills once an hour and to record three interactions with him each day.

37. Prison Service Instruction (PSI) 64/2011 has a mandatory instruction that prisoners being managed under ACCT procedures should be held in segregation units only in exceptional circumstances. The custodial manager told the investigator that he thought Mr Wills had manipulated the situation in order to be moved to the segregation unit. He said that the review panel concluded that Mr Wills posed a risk to other prisoners if he was moved back to a wing, and so he needed to stay in the segregation unit. He recorded the panel's considerations in the ACCT record and noted that Mr Wills should move to a safer cell (with reduced ligature points) in the segregation unit.

38. At 5.00pm, an officer checked Mr Wills and found him with something tied around his neck and attached to the window bars. Staff went into the cell and removed the ligature from Mr Wills' neck. Mr Wills said that his head was 'battered' from the time he had spent in the segregation unit. Mr Wills moved to a safer cell and officers checked him once an hour.

39. On 11 April, a nurse attended an ACCT case review with staff. The SO noted that Mr Wills wanted tobacco and said that he was in a low mood and wanted to move back to B Wing. The review team assessed his risk as low and set the observation level at once an hour.

40. A nurse noted in his medical record that Mr Wills was unhappy at Durham and preferred HMP Northumberland. He said that he wanted a single cell because he felt anxious when sharing a cell. Mr Wills said he had occasionally used spice and subutex in Northumberland, but felt that he had begun to tackle his drug misuse there, and that being at Durham was going to make the problem worse. Mr Wills agreed to a referral for his substance misuse problem, and to work with the nurse on strategies to manage his anxiety. The SO updated the caremap by noting that a member of the safer custody team would contact the drug and alcohol recovery team. Mr Wills did not have a mental health assessment that day, although PSO 1700, which governs segregation procedures, requires a mental health assessment within 24 hours of an ACCT being opened for prisoners in segregation units.

41. On 12 April, a nurse carried out a mental health review after the referral on 9 April, but Mr Wills did not want to engage in the assessment. The nurse noted that he seemed a little stressed but would not look at any basic anxiety management techniques, or accept any written information about them. Mr Wills said that he needed medication, drugs or tobacco. The next day, 13 April, the member of the safer custody team and segregation unit officers held another case review. The review assessed Mr Wills as a low risk, noted that he had been referred to the mental health team and ended ACCT monitoring.

42. On 15 April, the member of the safer custody team contacted the substance misuse team again and said that she had seen Mr Wills in the segregation unit and that he wanted to be prescribed methadone. Mr Wills had tested negative for opiates and the substance misuse team manager told the member of the safer custody team that they would not prescribe methadone without evidence that Mr Wills was dependent on opiates. On 16 April, Mr Wills moved to a single cell on E Wing.

43. On 17 April made small, superficial cuts to his right forearm. No one began ACCT procedures. A nurse treated the cuts and referred Mr Wills to the mental health team. A community psychiatric nurse saw Mr Wills the next day. Mr Wills said that he used illicit drugs to help control his moods, but the nurse noted that his drug use was not chronic. Mr Wills described frequent thoughts of violence towards others. The nurse wrote that he was not sure whether Mr Wills was exaggerating his symptoms in order to be prescribed sedative medication. The nurse completed a security intelligence report outlining Mr Wills' thoughts of violence, and noted that he would see Mr Wills again to assess his level of risk.

44. On the morning of 21 April, Mr Wills cut his arm and neck. A nurse treated what she described as superficial cuts. Mr Wills said that the prison was doing his head in and he felt like throwing himself off the wing landing with a noose around his neck. An SO re-opened the ACCT plan, which had been closed on 13 April and instructed officers to check Mr Wills twice an hour. Later that day, Mr Wills told two nurses that his head was 'fucked'. Mr Wills agreed to be assessed by a psychiatrist.

45. At 1.25pm on 22 April, an officer carrying out an ACCT check found Mr Wills standing on the top bunk bed with a ligature around his neck. Officers went into the cell and removed the ligature, but recorded in the ACCT record that Mr Wills did not talk to them. At 3.15pm, a member of staff noted in the ACCT record that someone from the mental health team had spent an hour talking to Mr Wills, and that an ACCT review had been held. Despite this escalation in apparent self-harming behaviour, the front cover of the ACCT noted that staff should check Mr Wills once every two hours and record three conversations a day.

46. On Thursday 23 April, staff held an ACCT case review. Mr Wills said that he did not like Durham and wanted to go to HMP Doncaster because it was more relaxed there. The staff group told him that he was still on remand and could not be transferred until after his court case, if he was convicted and sentenced. The nurses told Mr Wills that he had an appointment with the psychiatrist 'on Friday'. (Mr Wills did not see a psychiatrist until Monday 11 May.)

47. On 24 April, a SO chaired an ACCT review with an officer and a member of the chaplaincy team. Mr Wills said that he was low in mood and would harm himself again if he felt like it. He said he was appearing in court on 14 May and would plead guilty. The SO noted that Mr Wills was due to see someone from the mental health team again on 1 May, and scheduled another case review for that day. The SO noted on the ACCT caremap that Mr Wills had been referred to the mental health team. The review assessed Mr Wills as a low risk of harm and reduced the frequency of observations to three recorded conversations a day, one conversation at the beginning of the night duty and four observations during the night.

48. On 30 April, the community psychiatric nurse noted that he had spoken to Mr Wills through his cell door. Mr Wills continued to complain that his head was 'all over', but asked if he could have a prison job so that he could have more access to the gym. Mr Wills said that he still wanted to see the psychiatrist.

49. On 1 May, an SO and a nurse held an ACCT case review. Mr Wills repeated that he was not happy at Durham but said that he would speak to a member of staff if he was thinking of harming himself. The review assessed his level of risk as low, did not identify any further issues and ended the ACCT monitoring. On 8 May, an officer held an ACCT post-closure review, and noted that Mr Wills was in a single cell and could be transferred after he had been sentenced.

50. On 11 May, a psychiatrist saw Mr Wills and noted that there was no evidence of psychosis. The psychiatrist recorded that Mr Wills' primary difficulties appeared to be a result of his dysfunctional personality structure and that he was most likely to benefit from psychological treatments (often known as talking therapies), rather than medication. Mr Wills said that he felt depressed and suicidal all the time, but only sometimes acted on his thoughts. He described cutting himself as offering temporary relief. He also described thoughts of harming or killing others, but said he had no plans to act on his thoughts. The psychiatrist did not consider that Mr Wills needed to be prescribed any medication and identified no immediate risk to himself or others, but recorded that Mr Wills continued to be at risk of suicide by misadventure. Two nurses both told the investigator that they had discussed with Mr Wills the very real possibility that his behaviour could result in his inadvertent death.

51. At 5.30pm on 11 May, Mr Wills phoned his sister from his prison phone account (this was the last recorded call he made from this account). He told her that the prison was doing his head in. He asked his sister if she and his mother could send him £150 because he was in debt. (Prisoners calls are recorded for security reasons and staff listen to a random sample. It does not appear that anyone listened to this call.)

52. Around 3.00pm on 15 May, Mr Wills showed an officer cuts on both of his forearms. She thought that they looked recent and started ACCT procedures. A member of staff assessed Mr Wills, who said that he was seeing a psychiatrist soon, would prefer to talk to the psychiatrist and did not need to be monitored under ACCT procedures. He said that he had made the cuts about a week earlier as a coping mechanism. He said that his head was 'done in' but that he

was not suicidal. Mr Wills said that his mother and sister visited him and that he phoned them.

53. Staff held the first ACCT case review that day. (No member of healthcare staff attended.) They assessed Mr Wills as a low risk of harm and instructed staff to record three observations and three conversations a day, and three observations and one conversation at night. The SO included mental health as an issue in Mr Wills' caremap and noted that he was waiting for an appointment with a psychiatrist. (It does not appear that the SO knew that Mr Wills had seen a psychiatrist on 11 May.)

54. On 17 May, officers found Mr Wills and another prisoner fighting in the showers. Mr Wills was uninjured and said he was all right. He was charged with a disciplinary offence. Later that evening, Mr Wills cut his right arm and a nurse cleaned and dressed the wound. Mr Wills was agitated, but said that he was okay. The frequency of checks was increased to once an hour.

55. The next morning, a SO and two E Wing officers held an ACCT case review. The SO noted that Mr Wills should continue to receive mental health support. Mr Wills said he had issues on D and E Wings (but no other details were recorded) and the SO recorded that he should move to A Wing when there was space. The review assessed Mr Wills as a low risk of harm, noted that he had seen a psychiatrist on 11 May and reduced the frequency of checks to three a day. Later that day, Mr Wills told an officer that he wanted to move to C Wing and would be happy to share a cell there.

56. On 21 May, Mr Wills submitted a statement saying that the prisoner he had fought with in the showers had threatened his family. Mr Wills asked to move to another wing.

57. On 22 May, an SO and an officer held a further ACCT case review. Mr Wills said he was worried about threats from other prisoners. Again, no further information about the threats was recorded. The SO noted that Mr Wills would move to A Wing when there was space. The review assessed him as a low risk and did not change the frequency of observations. Later that day, Mr Wills refused to shower because he was afraid that he would be attacked. At 12.50pm, an officer checked Mr Wills and found him standing on a chair, about to tie a ligature around his neck. The officer noted that a nurse would visit Mr Wills that afternoon, but there is no entry in the medical record to indicate whether he did. That afternoon, Mr Wills moved to A Wing.

58. At 12.00pm on 26 May, Mr Wills collected his lunch and then pressed his cell bell. He told the officer who responded that he had cut his throat. A nurse attended, but Mr Wills refused treatment and said that his head was 'done in' and he wanted to kill himself. An SO and an A Wing officer held an ACCT case review. Mr Wills said he did not know why he had cut his neck, that he had problems on all of the prison wings and wanted to move to the healthcare centre. The review team assessed Mr Wills' level of risk as low and did not change the frequency of observations.

59. At 10.00am on 27 May, an SO and an A Wing officer held an ACCT case review. Before the review, the SO contacted the mental health team for an update. Mr

Wills declined to attend the review, but when spoken to in his cell, said his mood was low. The review assessed Mr Wills' risk as low and did not change the level of observations or make any new caremap entries.

60. At 3.30pm, during the A Wing association period (when prisoners are unlocked from their cells and are able to mix with each other), Mr Wills put a ligature around his neck and tried to jump onto the netting on the second floor landing. Other prisoners stopped him from jumping. Officers took Mr Wills to the wing office and a SO chaired an ACCT review with a prison manager, an officer and a nurse. Mr Wills again said that his head was 'done in'. The staff suspected that he was having problems with other prisoners and wanted to move to another wing, but Mr Wills would not discuss his problems. They agreed that he should move to a safer cell (with reduced ligature points) on E Wing and be checked twice an hour. They assessed Mr Wills as a high risk of harm. The manager made one entry on the caremap, setting out the decision to move Mr Wills to E Wing.

61. At 9.30am on 28 May, a nurse and a student nurse saw Mr Wills on E wing. Mr Wills said that he had problems with other prisoners, who were making threats towards him and his family, and that he no longer felt safe. He said he had had paranoid thoughts about other prisoners and prison staff, which had led him to try to jump off the landing. He said he had no current thoughts of suicide or self-harm and was hoping to move back to A wing. Mr Wills said that he was hearing voices telling him to do things to others, but would not disclose any further details because he was worried that this would affect his move back to A Wing. He then said that he had problems with prisoners on A Wing, and repeatedly asked to be moved to the healthcare centre or the segregation unit. The nurse suggested a review appointment with the psychiatrist, but Mr Wills did not think that this was necessary, as he had not found earlier appointments helpful.

62. Later that afternoon, an ACCT case review was held and decided that Mr Wills should continue to be managed under ACCT procedures. Staff were required to check him three times during the day and once at night. Mr Wills moved back to A Wing that day.

63. At around 5.55pm on 1 June, Mr Wills told a member of the violence reduction team that he feared for his safety. He refused to name anyone, but said that he wanted to transfer to another prison. She told Mr Wills that he could not transfer before his scheduled court appearance on 11 June.

64. On the evening of 2 June, Mr Wills told an officer that he was feeling low and was having negative thoughts. Mr Wills spoke at length to the officer about his family and his girlfriend. After talking, he said he felt better.

65. Around 1.05pm on 3 June, an officer answered Mr Wills' cell bell and saw that he had tied a ligature to the window and had barricaded his cell door. Mr Wills asked the officer to tell his mother and sister that he loved them. Officers tried to open the door, and Mr Wills eventually removed the furniture from behind the door. He said he was hearing voices. Staff were instructed to check Mr Wills four times an hour.

66. At 2.30pm, an SO chaired an ACCT case review with a nurse. Mr Wills attended and engaged well. He said he regretted his earlier actions, but needed help. Mr Wills said that he was struggling with hearing voices and that, in the community, he had managed the voices by using drugs. The nurse did not think that Mr Wills was actively suicidal, and Mr Wills said that it had been an impulsive act rather than a planned attempt to take his life. Mr Wills asked for help with his mental state several times and said that he would continue to work with his mental health nurse. The nurse noted that Mr Wills did not present as significantly depressed, but his risk taking behaviour could result in serious harm. The nurse noted the apparent escalation in Mr Wills' risky behaviour and that she would discuss with Mr Wills' key worker whether he needed another appointment with the psychiatrist. The SO did not record Mr Wills' assessed level of risk but set the level of observations at once an hour during the day, and two an hour at night. The SO noted in the caremap that Mr Wills had no tobacco and could be given a smokers' pack (a supply of tobacco usually given to new arrivals) if he had enough money in his account to pay for it.

67. At 5.30pm that evening, Mr Wills told an officer that he thought other people were trying to poison him. At 8.00pm, he told a night patrol officer that he felt like 'doing himself in' because he kept hearing voices. He then showed the officer a ligature he had made. Mr Wills was moved to B Wing and constantly supervised throughout the night. During the evening, Mr Wills repeatedly complained that he was hearing voices, but the officer monitoring him that night recorded that Mr Wills had slept well.

68. At 8.45am on 4 June, several staff attended an ACCT case review. A nurse noted that Mr Wills said that he continued to hear voices in his head telling him to kill himself and this was the reason he had tied a sheet around his neck the previous day. Mr Wills could not identify any particular trigger for his actions, but the nurse noted that Mr Wills said that he had trouble in the prison and was keen to transfer. (No one recorded anything further about the trouble Mr Wills was experiencing.) Mr Wills said that he did not get the support he needed, but the manager noted that various forms of support were in place. The manager recorded that Mr Wills was due to be sentenced the next week (if convicted) and staff would try to arrange a transfer as soon as possible after that.

69. The manager noted that Mr Wills was actively involved in the conversation. The staff assessed Mr Wills as a low risk of harm and reduced the frequency of observations to once an hour. Mr Wills moved back to A Wing later that day. No further entries were made on the caremap.

70. That afternoon, Mr Wills went to the A Wing office and asked an SO if he could make an emergency phone call to his mother. Mr Wills said that he had not added his mother's phone number to his prison telephone account. She told Mr Wills that this was not what emergency phone calls were for and Mr Wills left the office. At 2.50pm, other prisoners found Mr Wills sitting on the landing netting. He had cut his left forearm.

71. At 3.00pm, staff held an ACCT review. Mr Wills said that he had climbed onto the netting and cut his arm because he could not contact his mother. The review

assessed his level of risk as raised and instructed staff to check him four times an hour. There were no new actions on his caremap

72. At 3.10pm, an officer went to tell Mr Wills that he was moving to a gated cell on F Wing for observation. The officer found Mr Wills tying a ligature around his neck and cut the ligature. Mr Wills moved to a standard cell on F Wing later that day.

73. At approximately 6.10pm, during an ACCT check, an officer found Mr Wills making cuts to his left forearm with a razor blade and a screw. Mr Wills told the officer that he was hearing voices and feeling paranoid, which was causing him to self-harm. She noted in the ACCT record that the duty nurse had been asked to attend. There is no entry in his medical record or the ACCT record to indicate whether a nurse came to see him.

74. At 8.15pm, Mr Wills told the night patrol officer that his head was all over the place. When she asked if he had any thoughts of self-harm, he said that he did not and would tell her if he did. At 8:45pm, Mr Wills pressed his cell bell and told her that he was not getting the help he needed and that the voices were telling him to kill himself. The officer noted that he fell asleep at about 3.00am.

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75. At 9.25am on 5 June, the chaplain spoke to Mr Wills, who said that his head was 'battered' and that he was still hearing voices, but did not have any thoughts of self-harm. At 9.50am, he spoke to an officer and said he was not coping well at Durham, but that he had been fine at HMP Northumberland, where he could use the gym. However, when the officer asked him if he would like a prison job or to be able to use the gym, he said he did not.

76. At 11.00am, staff held an ACCT case review. The officer who completed the summary of the review recorded that Mr Wills was continuing to self-harm in order to force a transfer, even though he had been told that he could not transfer until he had been sentenced. Mr Wills said that he could not guarantee that he would not self-harm in the future if he did not get what he wanted. The officer wrote on the caremap that Mr Wills would not be given a smoker's pack because of his 'poor/maladaptive' behaviour. Mr Wills' level of risk was not recorded, but the review team agreed to reduce the frequency of observations to one check in the morning, afternoon and evening, and three checks during the night.

77. Mr Wills moved back to A Wing at about 2.30pm and spent the rest of the day lying on his bed watching television. At 8.20pm, Mr Wills pressed his cell bell and, when a night patrol officer came to the cell, told him that he was having bad thoughts. The officer said that he stayed and talked to Mr Wills for a while, until Mr Wills said that he felt calmer. He told Mr Wills to press the cell bell again if he needed him.

78. At 10.00pm, Mr Wills rang his bell again and asked the night patrol officer for a pen, which he gave him. At 11.25pm, the officer responded to another cell bell on a different landing. On his way back to the wing office, he decided to check on Mr Wills. When he looked through the observation panel in the cell door, he saw Mr Wills hanging, with a piece of torn sheet around his neck. (It is not clear what Mr Wills had attached the sheet to. He said that it was attached to the cell

light fitting, but other staff who responded said that Mr Wills had wedged the piece of sheet under a ledge in the cell.)

79. According to the prison logs, at 11.30pm, the officer radioed an emergency code blue and the control room immediately called an ambulance. The night patrol officer on E Wing arrived at Mr Wills' cell about 30 seconds later. The officer got permission from the night manager to go into the cell and cut the sheet from the light fitting, while the night patrol officer supported Mr Wills' weight.

80. CCTV records show that staff arrived at A Wing about a minute after the night patrol officer radioed for help. An officer brought emergency medical equipment from E Wing. Another officer cut the ligature from around Mr Wills' neck and began to deliver chest compressions, while the nurse checked his airway. The nurses attached a defibrillator to Mr Wills' chest, but it found no shockable rhythm, so they continued to attempt resuscitation. While carrying out resuscitation, some of the officers saw that Mr Wills had written on his body. Not all of the writing was legible, but Mr Wills had written his name on his stomach, and something like, 'I love mam, I love dad,' on his arm.

81. Paramedics arrived at the prison at 11.34pm, and at Mr Wills' cell at 11.36pm. They took over emergency treatment and managed to restore Mr Wills' pulse and heartbeat. At 12.10am on 6 June, the paramedics took Mr Wills to hospital.

Contact with Mr Wills' family

82. The duty governor for the night of 5/6 June arrived at the prison shortly after midnight, as the paramedics were taking Mr Wills to hospital. He told the investigator that he telephoned the prison's family liaison officer at home and discussed what they should do. He said that they agreed that, because Mr Wills' condition was not yet known, they would not contact his family until later that morning.

83. At 10.55am on 6 June, the family liaison officer and an SO visited Mr Wills' mother and sister at their home. They told them what had happened and that Mr Wills was seriously ill in hospital. Mr Wills' family arrived at the hospital later that day.

84. On 3 July, Mr Wills' life support machine was switched off. Doctors recorded his death at 12.03am on 4 July.

85. The family liaison officer stayed in touch with Mr Wills' family over the next few weeks. They visited the prison, but said they were unhappy that they had received conflicting information about the circumstances in which Mr Wills had hanged himself from the Governor. The prison offered to contribute to Mr Wills' funeral expenses in line with national instructions.

Support for prisoners and staff

86. After Mr Wills had been taken to hospital, the night orderly officer spoke to individual members of staff involved in the emergency response. The next day, the duty governor also talked to staff involved to offer them support.

87. After Mr Wills died, the prison posted notices informing other prisoners 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 Wills' death.

Post-mortem report

88. The post-mortem examination found that Mr Wills died as a result of acute bronchopneumonia caused by a hypoxic brain injury. The toxicological examination found no drugs or alcohol in his body; however, as Mr Wills died almost a month after he hanged himself, we do not know if he had taken any drugs in the days leading to his death.

Findings

Management of the risk of suicide and self-harm

89. When he arrived at Durham, Mr Wills had a number of risk factors for suicide. He had been diagnosed with a personality disorder, was impulsive and had a history of substance misuse. He also had a history of self-harm, usually by cutting his arms, but he had also previously tied ligatures around his neck. He said that he had considered suicide before, and at Durham, said he had thoughts of suicide. At Durham, and at previous prisons, Mr Wills was often managed using ACCT suicide and self-harm prevention procedures.

90. Between 5 February 2015, when he returned to Durham, and 6 June, when he was found hanged in his cell, Mr Wills was monitored under ACCT procedures four times. Three times, staff began ACCT procedures because Mr Wills had self-harmed, but entries in the ACCT records repeatedly referred to his 'maladaptive' or manipulative behaviour. Staff involved in the ACCT process tended to view Mr Wills' behaviour solely as a means of achieving what he wanted – for example, a transfer to another prison, or to another location in the prison, or extra tobacco rather than considering whether it was more complex than that. We recognise that Mr Wills was not easy to manage and sometimes stated himself that his self-harm was a means to an end. However, we are concerned that staff lost sight of the very real risk that Mr Wills would, accidentally or otherwise, seriously harm or kill himself and often underestimated his risk. On one occasion, they did not open an ACCT after Mr Wills had self-harmed.

91. During periods of ACCT monitoring, Mr Wills often voiced concerns such as not being able to contact his mother, worrying about a return to drug use, feeling under threat from other prisoners (which we discuss in more detail below), and wanting access to the gym or other activities. There is little evidence that the ACCT case reviews properly engaged with these concerns or tried to put in place meaningful plans to support Mr Wills. There is nothing to indicate that they considered his use of drugs, including new psychoactive substances, (and possible debt as a result) increased his risk of suicide and self-harm.

92. Prison Service Instruction 64/2011 says that the ACCT caremap should reflect the prisoner's needs, level of risk, and the triggers of their distress. The caremap should consider issues such as level of supervision, location, health/mental health interventions, time out of cell, access to the gym, other regime activities, and family contact. The caremap should identify practical steps to reduce the risk of suicide or self-harm with time-bound actions. Mr Wills' caremaps did not reflect the concerns he had raised in case reviews, contained only perfunctory entries and were rarely updated.

93. After 15 May, Mr Wills' impulsive and risky behaviour became more frequent and he appeared to be in a period of crisis. He cut himself or made ligatures nine times and was constantly supervised throughout the night on 3 June. On 4 June, Mr Wills reported hearing voices telling him to kill himself. Staff refused to allow him an 'emergency' call to his mother; he cut himself twice that day, and had a ligature cut from his neck. Despite this escalation in self-harming behaviour, the

next day, 5 June, an ACCT case review reduced his level of observation to just three checks during the day and three checks at night. It is difficult to see how this reflected Mr Wills' increasing risk at the time.

94. While many of Mr Wills' ACCT case reviews were multidisciplinary, healthcare staff did not always attend the first case review after an ACCT had been opened, which is contrary to national instructions. Although case reviews were often multidisciplinary, and there was apparently a good level of cooperation between prison and healthcare staff, there is little evidence in his ACCT plan that any staff had recognised the increasing risks, or that he needed to be managed any differently after the 15 May, when his self-harm escalated. It is possible that part of the reason for this was the lack of consistency in case management. During his time at Durham, Mr Wills had 16 case reviews chaired by 12 different managers. For the last period of ACCT monitoring from 15 May, there were 10 reviews with eight different case managers.

95. While Mr Wills was always at risk of killing himself death because of his risky self-harming behaviour, we are concerned that staff did not operate ACCT procedures effectively at Durham to recognise and help reduce that risk. We make the following recommendation:

The Governor and Head of Healthcare should ensure that staff manage prisoners at risk of suicide or self-harm in line with national guidelines. In particular:

- **ACCT case reviews assess the level of risk taking into account all information about risk, any recent changes in behaviour and set levels of observations to reflect that risk.**
- **All case reviews are multidisciplinary with continuity of case management.**
- **A member of healthcare staff should attend all first case reviews and subsequent reviews where relevant.**
- **ACCT caremap actions are specific and meaningful, aimed at reducing a prisoner's risk and identify who is responsible for them.**

Response to allegations of threats

96. Prison staff first began to suspect that Mr Wills was having problems with other prisoners in April 2015. One officer told us that they thought Mr Wills might be in debt, but that he refused to discuss his situation. In a phone call to his sister on 11 May, (which staff were unaware of), Mr Wills asked her to send money because he was in debt. On 17 May, he had a fight with another prisoner (which might have been an attack) and then began to complain that he and his family were subject to threats.

97. Some of the ACCT reviews held in May made brief mention of Mr Wills' concerns, but as noted earlier, there were no caremap actions to address them. There is little indication that staff properly discussed Mr Wills' fears with him. On 1 June, Mr Wills spoke to a member of the violence reduction team. He would not name the prisoners he feared and it seems that no further action was taken.

98. We are concerned that staff did not investigate Mr Wills' concerns about his safety sufficiently, ensure he was appropriately supported or consider how this might affect his risk of suicide or self-harm. We make the following recommendation:

The Governor should ensure that allegations of violence, bullying, or intimidation are taken seriously, investigated and dealt with in line with local and national policies. Prisoners identified as at risk of violence from other prisoners should be protected effectively.

Mental health care

99. The clinical reviewer noted that Mr Wills had frequent contact with the mental health in-reach team at Durham. She found that the continuity of care was good and he was generally seen by a small number of nurses who were experienced practitioners and knew his history. He also saw a psychiatrist, who found no evidence of an acute mental disorder, or suicidal ideation. Two of the nurses interviewed as part of this investigation said that they had warned Mr Wills that his risk taking behaviour could accidentally cause his death. However, they said that they did not believe that he was at serious risk of suicide.

100. The clinical reviewer noted the difficulties in providing a mental health service to Mr Wills, because his primary problems related to his personality disorder. She reflected that psychological treatments can be helpful for people with personality disorders, but these tend to be long term. The psychiatrist who assessed Mr Wills in May concluded that he might benefit from talking therapies, but because Mr Wills was, at this point, a remand prisoner awaiting sentence, he was not considered suitable for referral to such interventions at Durham.

101. The clinical reviewer had some concerns about the quality of record keeping at Durham, and that Mr Wills did not have a full health screen when he transferred to Durham from Northumberland in February 2015. She made recommendations about these matters, which the Head of Healthcare will need to address. We do not repeat them here because they were not directly related to the circumstances of Mr Wills' death.

Contact with Mr Wills' family

102. Prison Rule 22(1) requires that when a prisoner is seriously ill "the governor shall, if he knows his or her address, at once inform the prisoner's spouse or next of kin, and also any person who the prisoner may reasonably have asked should be informed". Similarly, Prison Service Instruction (PSI) 64/2011 Safer Custody says, "Where prisoners have suffered sudden life-threatening harm… 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".

103. Mr Wills was taken to hospital shortly after midnight on 6 June but the prison did not inform his family until nearly 11.00am. Mr Wills' family were unhappy that they were not told more quickly. The prison said that they decided to delay telling Mr Wills' family until they knew more about Mr Wills' condition, but we consider that they should contacted them immediately, in line with the Prison

Rule. Mr Wills' family told us that, when they visited the prison after Mr Wills had died, they received conflicting information from senior staff, who seemed unprepared for their visit. We do not know what information they were given but it is important that families are given accurate information as soon as possible and informing them earlier might have helped avoid this. We make the following recommendation:

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

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