

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# Independent investigation into the death of Mr Gary Young a prisoner at HMP Wayland on 19 July 2016

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

## Our Vision

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

## Our Values

**We are:**

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

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

**Inclusive:** *we value diversity*

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

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



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

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

Mr Young was found hanged in his cell at HMP Wayland on 19 July 2016. He was 51 years old. I offer my condolences to Mr Young's family and friends.

I am concerned that prison staff did not appear to have taken sufficient account of Mr Young's risk factors and the clear evidence of his increased vulnerability when managing his risk of suicide and self-harm. Although Mr Young raised concerns about bullying, staff did not investigate, manage or monitor the apparent perpetrators in line with local policy. There were also deficiencies in the emergency response, caused by faulty equipment that should have been rectified earlier.

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**

**March 2017**

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# Summary

## Events

1. On 26 February 2016, Mr Gary Young was sentenced to nine years and five months in prison. In his first weeks in prison at HMP Pentonville, Mr Young said he felt distressed by his sentence and unsafe on his wing. Prison staff noted several times that he appeared upset and emotional. No one began suicide and self-harm prevention procedures (known as ACCT).
2. On 8 July, Mr Young was transferred to HMP Wayland. At an initial health screen, he said he was unhappy with his transfer and was concerned he might be assaulted at Wayland. Two days later, an officer noted that Mr Young had not collected any meals since he arrived at the prison. Mr Young said he was not hungry and still settling into the prison.
3. On 13 July, Mr Young was very upset during his education induction. He said he was frustrated at Wayland and had not been eating. When a supervising officer spoke to him on 15 July, Mr Young said other prisoners had made comments about his sexuality and he felt at risk of violence.
4. On 16 July, other prisoners stole tobacco and other items from Mr Young's cell. He reported the theft, and wing staff identified three potential perpetrators. Staff created a perpetrator monitoring alert for only one of the three, and none were challenged.
5. After Mr Young's death, other prisoners told staff that one of the prisoners suspected of stealing from Mr Young had assaulted him on 18 July. Mr Young did not report this and no one told prison staff at the time.
6. At around 5.17am on 19 July, the night patrol officer found Mr Young hanging from a ligature in his cell. Her radio battery did not work, and she therefore went to the wing office to telephone for emergency assistance. The night manager and other staff opened Mr Young's cell and began cardiopulmonary resuscitation. Paramedics arrived and recorded that Mr Young had died.

## Findings

7. Although staff at Wayland were aware that Mr Young had several issues at the prison, they did not consider the impact of these on his risk of suicide and self-harm. We found that staff should have been more alert to Mr Young's risk factors and are concerned that no one appeared to consider that his fears for his safety, the verbal abuse he said he had received and his apparent vulnerability might have increased his risk.
8. We found that prison staff did not follow local violence reduction procedures as they should have done. They failed to challenge or monitor the prisoners potentially involved in stealing items from Mr Young's cell.
9. The night patrol officer did not have a working radio, as she should have done, which meant there was a delay in asking for help, opening Mr Young's cell and giving cardiopulmonary resuscitation.

## Recommendations

- The Governor should ensure that all staff have a clear understanding of their responsibilities to manage prisoners at risk of suicide and self-harm in line with national guidelines and, in particular, the need to record, share and consider all relevant information about risk, and start ACCT procedures when indicated.
- The Governor should ensure that all information about bullying and intimidation is fully coordinated and investigated, including that:
  - Those suspected of involvement are appropriately challenged and monitored.
  - Apparent victims are effectively supported and protected with meaningful, long-term solutions, which address their individual situations.
  - Staff consider whether victims are at increased risk of suicide or self-harm.
- The Governor should ensure that all prison staff are made aware of and understand their responsibilities during medical emergencies, including that:
  - Night staff ensure they have a working radio, including a spare battery, at the beginning of their shift.
  - Night staff use their radio to communicate the nature of a medical emergency quickly and effectively.
  - Night staff enter cells as quickly as possible in a life-threatening situation.

## The Investigation Process

10. The investigator issued notices to staff and prisoners at HMP Wayland informing them of the investigation and asking anyone with relevant information to contact him. No one responded.
11. The investigator visited Wayland on 25 July 2016. He obtained copies of relevant extracts from Mr Young's prison and medical records, and interviewed one prisoner who knew Mr Young.
12. The investigator interviewed 20 members of staff and two prisoners in August and September.
13. NHS England commissioned a clinical reviewer to review Mr Young's clinical care at the prison. She joined the investigator for interviews with clinical staff.
14. We informed HM Coroner for Greater Norfolk of the investigation. We have given the coroner a copy of this report.
15. One of the Ombudsman's family liaison officers contacted Mr Young's friend, his nominated next of kin, to explain the investigation. Mr Young's friend did not have any specific issues for us to address.
16. Mr Young's friend received a copy of the initial report. She raised a number of issues that do not impact on the factual accuracy of this report and have been addressed through separate correspondence.

## Background Information

### HMP Wayland

17. HMP Wayland is a medium security prison in Norfolk. It holds over 1,000 men in thirteen residential units. Virgin Care provides healthcare services.

### HM Inspectorate of Prisons

18. The most recent inspection of HMP Wayland was in July 2013. Inspectors reported that prisoners did not receive a comprehensive first night risk assessment, and there was limited positive interaction from induction staff. They found that there were more assaults than at similar prisons, but staff took appropriate disciplinary action against identified bullies. However, they found that too few monitoring entries, designed to investigate alleged bullying, recorded interaction with the alleged victims or perpetrators. Inspectors found comparatively low levels of self-harm at Wayland. They also found that staff offered little support to gay prisoners.

### Independent Monitoring Board

19. 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 May 2016, the IMB reported an increase in violence against prisoners. They commended the safer custody team for their management of challenging situations.

### Previous deaths at HMP Wayland

20. Mr Young was the fifth prisoner to die at Wayland since December 2015, and the third to take his own life. Our investigations into the previous deaths found no significant similarities to the circumstances of Mr Young's death.

### Assessment, Care in Custody and Teamwork

21. ACCT is the Prison Service care planning system used to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk, how to reduce the risk and how best to monitor and supervise the prisoner. After an initial assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. Checks should be irregular to prevent the prisoner anticipating when they will occur. There should be regular multi-disciplinary review meetings involving the prisoner. As part of the process, a caremap (plan of care, support and intervention) is put in place. The ACCT plan should not be closed until all the actions of the caremap have been completed. All decisions made as part of the ACCT process and any relevant observations about the prisoner should be written in the ACCT booklet, which accompanies the prisoner as they move around the prison. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

## Key Events

### HMP Pentonville

22. On 26 February 2016, Mr Gary Young was convicted of wounding and sentenced to nine years and five months in prison. Mr Young had committed his offence in 2002. He had previously served three short prison sentences, the last of which was in 1991. When he arrived at HMP Pentonville, Mr Young did not declare any physical or mental health issues, or a history of harming himself. He said that the long sentence he had received had “stressed him out”. Mr Young said he was a heavy drinker in the community, and began an alcohol detoxification programme.
23. Over the following month, prison staff noted several times that Mr Young appeared upset and emotional. He said he felt distressed by his sentence and unsafe on his wing. Mr Young referred himself to the prison’s mental health team, who asked a dual diagnosis worker to assess him.
24. On 29 March, the dual diagnosis worker assessed Mr Young, and noted that he cried throughout the conversation. Mr Young said that other prisoners verbally abused him because of his sexuality and he was in fear of assault. He said he had no thoughts of harming himself. She referred Mr Young to the prison’s equality and diversity officer, and he later attended group meetings for gay, bisexual and transgender prisoners.
25. During the next few weeks, Mr Young appeared to settle more into prison life. He began working as a wing cleaner and received positive reports from officers. Mr Young sometimes said he still felt fearful of attack from other prisoners and, on 7 June, prison staff referred him to the mental health in-reach team as he had become increasingly anxious. Mr Young did not attend his appointment at the mental health clinic on 14 June.

### HMP Wayland

26. On 8 July, Mr Young was transferred to HMP Wayland. This was a progressive move to allow him to complete the offending behaviour programmes required in his sentence plan. At a routine health screen, Mr Young told a nurse that he was unhappy that he had been transferred as he thought he fitted in at Pentonville. He said he was concerned he might be assaulted at Wayland. She did not record whether she asked Mr Young why he thought he might be assaulted. She referred him to the mental health team.
27. An officer completed Mr Young’s first night interview. Mr Young said he was upset about his transfer and was adamant that he did not want to share a cell. He said he did not feel like harming himself and did not feel anxious. The officer allocated Mr Young a single cell.
28. On 10 July, an officer spoke to Mr Young, as he had not collected any meals since he arrived at the prison. Mr Young said he was not hungry, had a headache and was settling into the prison. He said he had eaten food he had bought from the prison shop. She said this was not unusual for prisoners new to Wayland, and she did not take further action.

29. On 11 July, a mental health nurse completed an initial assessment for Mr Young. Mr Young told the nurse he did not think he needed to see him. The nurse asked Mr Young to contact the mental health team if he changed his mind. Mr Young did not raise any concerns about his physical or mental health at his secondary health screen that afternoon.
30. On 13 July, Mr Young saw an education guidance advisor for an education induction session. She said that Mr Young became upset during their discussion and cried several times. He said he felt frustrated because his cell was very dirty and he had not eaten because of this. Mr Young said he had reported this to wing staff but the issue had not been resolved. Mr Young said he did not understand why he had transferred to Wayland and thought it must be a punishment for something he had done wrong. She said that Mr Young spoke about what he wanted to do when he left prison, and she did not therefore think he was at risk of suicide or self-harm. After the meeting, she telephoned B Wing, where Mr Young lived, and told an officer (she did not remember which one) what Mr Young had said. The officer told her that he would speak to Mr Young, but there is no record that anyone did.
31. On 14 July, Mr Young saw the education guidance advisor again, as he had not completed the required education assessments the previous day. Mr Young said that wing officers had not spoken to him about his concerns, and that he now had further issues with the radio and television in his cell. She said that Mr Young was not as emotional as the previous day and appeared more settled. She emailed the custodial manager who managed D Wing, to ask him to arrange to speak to Mr Young. She mistakenly thought he was a B Wing manager. He forwarded the email to a Supervising Officer (SO), who was Mr Young's offender supervisor.
32. The SO spoke to Mr Young on 15 July. Mr Young said he was still coming to terms with his sentence and intended to appeal it. He said that some prisoners had made comments about his sexuality and he was concerned that he might be at risk of violence. The SO recommended that Mr Young apply to move to the prison's wing for prisoners over the age of 50 years old.
33. On 16 July, Mr Young told the SO and an officer that other prisoners had stolen tobacco, cigarette papers and lighters from his cell. They watched CCTV footage and identified three prisoners as potentially involved. One of these prisoners had been linked to another cell theft and other recent incidents of bullying, and the SO therefore opened a perpetrator log and alert (for wing staff to monitor his activities and make a daily entry about his involvement in anti-social behaviour). No one challenged the prisoner or took action against the other two prisoners thought to be involved. The SO arranged for the identified prisoner to move to another wing, although this did not happen before Mr Young's death due to a reported lack of space elsewhere in the prison. The SO opened a victim log and alert for Mr Young, and arranged for staff to give him a smoker's pack to cover some of the stolen tobacco.
34. An officer spoke to Mr Young on 17 July. Mr Young said he was concerned that the prisoners who stole from him were still on the wing. The officer explained that they would move the perpetrator when there was a space available

elsewhere. He made a victim entry in Mr Young's prison record. No one made a perpetrator entry in the record of the suspected bullies.

### Events of 18 July

35. At around 8.20am on 18 July, one of the other prisoners identified as having been involved in the theft from Mr Young, went into Mr Young's cell. He was in the cell for around three minutes. This only came to light after Mr Young's death when several prisoners reported the incident to staff and said that Mr Young had been assaulted. It does not appear that Mr Young or anyone else reported any assault to prison staff at the time.
36. Mr Young was due to start work in one of the prison workshops on 18 July, but did not attend. None of the staff who worked on B Wing that day said they were aware of this and no one could remember speaking about it to Mr Young.
37. Later that morning, Mr Young spoke to a SO. Mr Young explained that his tobacco had been stolen and said that someone (Mr Young did not say who) had told him that the full amount would be reimbursed. Mr Young said this had not yet happened. The SO advised him to complete an application for reimbursement and said he would pass it to the duty governor to consider. The SO said that Mr Young was frustrated at the time but he did not think he was at risk of harming himself.
38. The duty governor replied to Mr Young's application later that day, and declined it. He wrote that Mr Young should take care of his property and keep it safe. He said he did not speak to Mr Young and had never met him.
39. None of the officers who worked on B Wing on 18 July recalled any significant interaction with Mr Young. No one made a victim entry in his prison record, and no one made a perpetrator entry in the suspected bully's record. Prisoners who knew Mr Young said he spent most of the day in his cell.
40. An operational support grade (OSG) was the night patrol officer on A Wing and B Wing on the night of 18 to 19 July. She said she did not speak to Mr Young all night and he did not call her to his cell. At around 4.00am on 19 July, the battery in her radio stopped working. The radio pack should contain two batteries, but she said that her pack only had one battery that night. She said she reported the failed battery and the night manager brought a replacement, but she could not find where he left it.
41. At around 5.15am, the OSG began a count of prisoners in their cells. She arrived at Mr Young's cell at 5.16am. She said that she thought Mr Young was standing up, having just got out of bed. She left the cell and continued with the count. At 5.17am, she returned to Mr Young's cell as she wanted to check him again. She switched the light on and could now see Mr Young hanging from a bed sheet that he had tied to the light fitting. She went to the wing office, where she telephoned the control room and told them that she needed immediate assistance as she had found a prisoner hanging. The control room operator telephoned for an ambulance immediately.
42. The OSG then returned to Mr Young's cell, at 5.20am. Around 30 seconds later staff arrived and opened the cell. The night manager removed the ligature and

began cardiopulmonary resuscitation. Two officers and the OSG continued to try to resuscitate Mr Young. They applied a defibrillator, which advised them not to apply an electric shock and to continue with chest compressions.

43. Paramedics arrived at Wayland at 5.38am and at Mr Young's cell at 5.43am. They initially continued cardiopulmonary resuscitation, but recorded that Mr Young had died at 6.16am.

#### **Contact with Mr Young's family**

44. A family liaison officer contacted an operational manager at HMP Wandsworth and asked him to visit Mr Young's friend, his nominated next of kin, to inform her of Mr Young's death. (Wandsworth is close to where Mr Young's friend lives.) He visited several times on 19 July, but Mr Young's friend was not at home. In the evening, the family liaison officer and an operational manager at Wayland, visited Mr Young's friend, but she was not at home. They then visited Mr Young's stepson (who lived nearby), and informed him of Mr Young's death. He telephoned Mr Young's friend to inform her.
45. The family liaison officer telephoned Mr Young's friend the next morning. Mr Young's funeral was held on 17 August. In line with Prison Service instructions, Wayland contributed to the costs.

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

46. After Mr Young's death, the duty governor debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.
47. The prison posted notices informing other prisoners of Mr Young's death, and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Young's death.

#### **Post-mortem report**

48. A post-mortem examination established cause of death as hanging.

# Findings

## Identifying risk of suicide and self-harm

49. Prison Service Instruction (PSI) 64/2011, which governs ACCT suicide and self-harm prevention procedures, requires all staff who have contact with prisoners to be aware of the risk factors and triggers that might increase the risk of suicide and self-harm and take appropriate action. Any prisoner identified as at risk of suicide or self-harm must be managed under ACCT procedures. We have considered whether staff at Wayland should have recognised Mr Young as at risk and begun ACCT procedures to support him.
50. Mr Young had a number of risk factors for suicide and self-harm. He had been the victim of a cell theft and had spoken several times of his fears that other prisoners would assault him. Mr Young said he had been the victim of verbal abuse due to his sexuality. He told prison staff he was concerned that the perpetrators of the theft were still on the same wing, and he did not attend his first day of work shortly afterwards, which might have indicated increased vulnerability. Mr Young had been tearful and emotional several times in his first week at Wayland and had reportedly not collected or eaten meals in his first days at the prison. PSI 64/2011 notes that early days in a new prison, even following a progressive move, can increase risk. Mr Young was also the alleged victim of an assault on 18 July (although we appreciate that staff did not know about this at the time).
51. Staff at Wayland recognised that Mr Young had some issues at the prison. However, we are concerned that staff appeared to treat each incident in isolation, and there was no holistic consideration of Mr Young's wider range of risk factors. In our Learning Lessons thematic report into self-inflicted deaths in 2013-14, we found that staff too rarely considered that bullying, or a fear of violence and intimidation, made prisoners more vulnerable and could increase their risk of suicide. We consider that staff at Wayland should have been more alert to Mr Young's risk factors for suicide and self-harm. While this would not automatically have led them to open ACCT procedures, they should at least have considered it in the light of his ongoing risk factors. We make the following recommendation:

**The Governor should ensure that all staff have a clear understanding of their responsibilities to manage prisoners at risk of suicide and self-harm in line with national guidelines and, in particular, the need to record, share and consider all relevant information about risk, and start ACCT procedures when indicated.**

## Bullying

52. Wayland has a local violence reduction strategy which highlights the process of raising and investigating any identified or suspected act of aggression, bullying, intimidation or violence. There are various mandatory actions that wing staff should complete if a prisoner is identified as a bully by another prisoner or is witnessed demonstrating violent or antisocial behaviour. This includes staff challenging the prisoner, giving clear guidance on expected improvements of behaviour, and activating bullying perpetrator alerts. The alert should remain in place for a minimum of 14 days, with a review to take place then. Although not

explicit in the policy, all of the staff we interviewed understood that anyone identified with either a victim or perpetrator alert should have a daily entry made regarding their conduct and any indicators of antisocial behaviour.

53. Prison staff identified three prisoners as potentially being involved in the theft from Mr Young's cell on 16 July, but only one had a perpetrator alert activated. None of the three were challenged. One of the two prisoners who did not have an alert opened apparently returned to Mr Young's cell two days later and assaulted him. No one made monitoring entries for Mr Young on 18 July or for the suspected bully on either 17 or 18 July.
54. A PPO publication of June 2011 regarding self-inflicted deaths 2007-2009, found there was evidence of bullying and intimidation in 20% of self-inflicted deaths we investigated. In our PPO thematic report into self-inflicted deaths in 2013-14, we found that reports or suspicions that a prisoner is being threatened or bullied need to be recorded, investigated and robustly responded to. We make the following recommendation:

**The Governor should ensure that all information about bullying and intimidation is fully coordinated and investigated, including that:**

- **Those suspected of involvement are appropriately challenged and monitored.**
- **Apparent victims are effectively supported and protected with meaningful, long-term solutions, which address their individual situations.**
- **Staff consider whether victims are at increased risk of suicide or self-harm.**

### **Emergency response**

55. Prison Service Instruction (PSI) 03/2013 requires that the Governor must have a medical emergency response code protocol in place which ensures that an ambulance is called automatically in a life-threatening medical emergency. The protocol gives guidance on efficiently communicating the nature of a medical emergency, ensuring that staff take the correct equipment to the incident and that there are no delays in calling an ambulance. It explicitly states that all prison staff must be made aware of and understand the protocol and their responsibilities during medical emergencies.
56. The OSG did not radio for emergency help, which would have been the quickest means, because her battery did not work. Although she had asked for a spare battery earlier in the night, a misunderstanding meant she could not find where the night manager had left it. However, her pack should have contained a spare battery when she collected it at the start of her shift. She should have reported this at the time and obtained a spare battery as soon as possible.
57. If the OSG had a working radio, she could have radioed for emergency help much more quickly and effectively. This should also have allowed her to open Mr Young's cell, remove the ligature and begin cardiopulmonary resuscitation before her colleagues arrived. We make the following recommendation:

**The Governor should ensure that all prison staff are made aware of and understand their responsibilities during medical emergencies, including that:**

- **Night staff ensure they have a working radio, including a spare battery, at the beginning of their shift.**
- **Night staff use their radio to communicate the nature of a medical emergency quickly and effectively.**
- **Night staff enter cells as quickly as possible in a life-threatening situation.**

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