A Report by the
Prisons and
Probation
Ombudsman
Nigel Newcomen CBE

Investigation into the death of a man at HMP Wymott in March 2014

Our Vision

‘To be a leading, independent investigatory body,
a model to others, that makes a significant contribution to
safer, fairer custody and offender supervision’

This is the investigation report into the death of a man, who was found hanging in his cell at HMP Wymott in March 2014. He was 43 years old. I offer my condolences to his family and friends.

A clinical review of the care the man received at Wymott was undertaken. The prison cooperated fully with the investigation.

The man had been in prison since October 2011, serving an indeterminate sentence for public protection for burglary and theft. In 2012, he self-harmed by cutting his wrist and, in April 2013, threatened to jump from a landing because he was in debt to other prisoners. The prison supported him through suicide and self-harm prevention measures. On 23 January 2014, he transferred from HMP Featherstone to HMP Wymott to be near his family and to address his substance use problems. Reception staff at Wymott were satisfied that he presented no current risk of self-harm, although the reception nurse mistakenly recorded that he had not previously harmed himself. He went to the drug therapeutic community on K wing.

For the next two months, the man participated actively in the therapeutic community programme. No one had any concerns about his state of mind and he appeared to have settled well and be positive about his future. However, one afternoon in March another prisoner found him hanging by a torn bed sheet in his cell. Officers cut him down, but did not begin cardiopulmonary resuscitation, which was delayed until a nurse arrived five minutes later. Shortly afterwards, a prison GP pronounced him dead. After his death some prisoners said that he had been in debt to other prisoners who had traded their prescribed medication.

I am satisfied that staff at Wymott could not have anticipated the man's actions in March and, therefore, could not have been expected to put in place measures to help prevent it. However, I am concerned that the emergency response was poorly managed and that none of the staff who first found him hanging had had any recent first aid training and made no attempt to resuscitate him. While there is no clear evidence that he was in debt to other prisoners, or that this was a factor which led to his death, toxicology reports indicated he had taken medication which he had not been prescribed. There is a need for the prison to tackle the problem of prisoners diverting and misusing prescribed medication.

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 **January 2015**

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SUMMARY

1. In October 2011, the man was charged with burglary, harassment and fraud and remanded to prison. He had a history of drug and alcohol misuse. He was convicted on 2 February 2012 and received an indeterminate sentence with a minimum period to serve of four years and 219 days before he could be considered for release.

2. The man harmed himself in 2012, when he cut his wrist and, in 2013, he threatened to jump from a prison landing because he was in debt to other prisoners. Both times, he was managed under Prison Service suicide and self-harm prevention procedures, known as ACCT. He continued to get into debt to other prisoners by borrowing tobacco.

3. On 23 January 2014, the man transferred to HMP Wymott. There was no reason for reception staff to identify that he was at risk of suicide or self-harm, although a reception nurse wrongly recorded that he had not harmed himself in prison before. He was located on K wing, which houses the drug therapeutic community at Wymott. He appeared to settle well and no one had any concerns about him.

4. One afternoon in March, prisoners were unlocked to collect their weekly prison shop orders. The officer who unlocked the man's cell did not see him and, at 2.05pm, another prisoner went to his cell and found him hanging from a ligature made from a bed sheet. An officer raised a general alarm but did not call an emergency medical code. No one attempted to resuscitate him until the prison nurse and GP arrived five minutes later. At 2.23pm, the prison GP pronounced him dead. After his death, other prisoners said that he was in debt to other for illicit drugs and prescribed medication. Toxicology reports showed the presence of tramadol and codeine in his body which he had not been prescribed.

5. We consider that there was little to indicate to prison staff at Wymott that the man was at risk of suicide. It would therefore have been difficult for staff to have done anything to help prevent his death. However, we are concerned that the reception nurse did not note his previous self-harm and that the officer who unlocked his cell on that afternoon did not check on his wellbeing. The emergency response was poor and officers did not attempt resuscitation when they first found him hanging. We have been unable to establish whether he was in debt to other prisoners, but it is apparent that he had been using diverted medication – a problem the prison needs to tackle. We make five recommendations.

THE INVESTIGATION PROCESS

6. The investigator issued notices to staff and prisoners at HMP Wymott about the investigation asking anyone with relevant information to contact him. No one responded.

7. The investigator obtained the man's prison records and copies of his telephone calls and CCTV footage. In May and June 2014, he interviewed staff and prisoners at Wymott. He informed the deputy governor of his initial findings.

8. NHS England, Lancashire Area Team, commissioned a clinical reviewer to review the man's clinical care at Wymott.

9. We notified HM Coroner for Preston and West Lancashire of the investigation who provided a copy of the post-mortem report. We have sent the Coroner a copy of this report.

10. One of our family liaison officers contacted the man's mother to explain our investigation process. She wanted as much information as possible about the events which led to her son's death.

11. The family received a copy of the draft report. They did not make any comments.

HMP WYMOTT

12. HMP Wymott is a medium secure (category C) prison holding over 1,100 men. K wing operates as a self-contained therapeutic community for prisoners committed to becoming drug-free.

13. Health services at Wymott are commissioned and provided by Lancashire Care NHS Foundation Trust. A private company provides GP services and out of hours medical cover. There is 24 hour nursing cover, but no in-patient facility.

HM Inspectorate of Prisons

14. The most recent inspection of Wymott was in July 2014. The inspection report has not yet been issued, but in preliminary feedback, the Inspectorate told us that the prison had no local suicide and prevention policy. We understand that inspectors also found that medication queues were not effectively supervised which increased the risks of diversion of medication. The previous inspection was a short follow-up inspection in November 2011 of a full inspection in October 2008. Inspectors commented that drugs services were well developed. The therapeutic community was staffed appropriately, although the unit accommodation was too small to hold full therapeutic community meetings.

Independent Monitoring Board

15. Each prison in England and Wales 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 2012-13 annual report, the IMB was concerned that there had been a significant increase in incidents in the therapeutic community and that some prisoners said that they did not feel safe there. The IMB noted that the availability of drugs and misuse of medication remained a security issue.

Previous self-inflicted deaths at HMP Wymott

16. The man's death is the seventh self-inflicted death that the Ombudsman has investigated at Wymott since 2004. We have previously made recommendations about emergency response procedures.

Assessment, care in custody and teamwork (ACCT) procedures

17. Assessment, Care in Custody and Teamwork (ACCT) is a Prison Service process for supporting and monitoring prisoners thought to be at risk of harming themselves. The purpose of ACCT 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 review meetings involving the prisoner. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

KEY EVENTS

18. The man had a long history of substance and alcohol misuse. He had been released from a 27 month prison sentence for manslaughter in 2008.

19. In October 2011, the man was charged with burglary, harassment and fraud and remanded to HMP Preston. On 2 March 2012, he received an indeterminate sentence for public protection with a minimum period to serve of four years and 219 days before he could be considered for release.

20. The man completed an opiate withdrawal programme in prison and spent time at HMP Preston, HMP Forest Bank, HMP Dovegate and HMP Featherstone before he moved to Wymott. He had a record of taking illicit subutex (an opiate substitute) in prison.

21. In April 2012, the man made a minor cut to his wrist while at Forest Bank and was managed under ACCT procedures. In April 2013, he threatened to jump from some stairs at Featherstone and said that he was in debt to other prisoners. An ACCT plan was opened but closed after five days, when he had repaid most of his debt. He did not attend a mental health assessment.

22. While the man was at Featherstone, between March 2012 and January 2013, officers made many entries in his prison record noting that he was helpful and had a good work ethic. However, he frequently got into difficulty with other prisoners by borrowing tobacco and not repaying the debt. For this reason, he told staff that he was being threatened by other prisoners and feared for his safety. He would not name the prisoners involved and did not want to move wing. In October 2013, he applied to transfer to Wymott as he wanted to be closer to his home and family. Drug support workers applied on his behalf for him to join the drug therapeutic community at Wymott.

23. In December 2013, staff recorded that the man attitude and behaviour were poor. He had repeatedly refused to attend work and to move to another wing and was put on a basic regime. Staff noted that he would behave well to get a privileged job and would then abuse the trust given to him. They were concerned that he was still getting into debt for tobacco.

24. On 7 January 2014, the man failed a mandatory drug test and was punished at a subsequent disciplinary hearing, by 35 days loss of canteen (use of the prison shop).

HMP Wymott

25. On 23 January 2014, the man transferred to Wymott. It was noted on his escort record that he had previously self-harmed, had drug and alcohol issues in prison, but did not have any known physical or mental health problems. He signed prison compacts in reception and staff noted no concerns.

26. A nurse examined the man and noted that he had no physical or mental health problems and interacted well. He was not prescribed any medication, but had a history of cannabis and benzodiazepine misuse. He told a nurse that he used to drink ten units of alcohol a day in the community. He said he had no current thoughts of suicide or self-harm. He then went to K wing, the therapeutic

community, and staff gave him information about the regime as part of his induction.

27. On 27 January, a SO, who was also the man's offender supervisor, saw him. (Offender supervisors are responsible for helping prisoners meet their sentence plan targets.) The SO recorded that he was upbeat and said that he was happy to be on K wing which would be a fresh start for him. The SO suggested that he should complete the therapeutic community programme before his next parole hearing (scheduled for 1 December 2014). They discussed his previous problems with getting into debt and he did not say that this was still an issue. The SO asked him to talk to wing staff if he had any problems. The SO told the investigator that he had briefly read his record and was aware of his conduct at Featherstone, but did not know about any previous self-harm.

28. The man's personal officer, saw him most days. (Personal officers are expected to get to know the prisoners they are responsible for, act as a first point of contact for any problems, help with resettlement issues and make regular entries in their records about their progress). The officer told the investigator that the man settled well, was happy to be nearer to his family and was always polite. He appeared to get on well with other prisoners. On 5 February, the officer recorded that he was keen to complete the therapeutic community programme and was currently working on the welcome desk (greeting and assisting visitors to the therapeutic community), as a cleaner and in the servery. The officer told him that he could talk to him about any problems. He last saw him on 17 March and had no concerns about him at the time.

29. The man telephoned his mother on 18 March and 20 March. Transcripts of these calls do not indicate anything that would suggest that he intended to take his own life.

Events leading up to the incident

30. On the day of the incident, the man gave a presentation about support networks to other prisoners as part of the therapeutic community programme. Prisoner A, who was at the presentation, told the investigator that the presentation had been well received.

31. The course facilitator told the investigator that the man appeared highly motivated to complete the programme and had agreed to do the presentation to help improve his confidence. He had been nervous that morning, but she said that this was to be expected. She said that he had delivered the presentation very well.

32. A therapeutic community facilitator saw the man on the wing after the presentation. He told the facilitator that the presentation had gone well and he was pleased about the response. The facilitator told the investigator that the man seemed to be in a good mood.

33. The man went to Prisoner A's cell and had a cup of coffee with him. The prisoner said he had no concerns about him. The man went to the servery to help serve lunch at about 11.45am and invited Prisoner A and Prisoner B to have a cup of tea with him. Prisoner B said that they went to see him at about

12.00pm and stayed for ten minutes. Both prisoners said that they had no concerns about him at the time.

34. At about 12.45pm, Prisoner A said he saw the man on the landing and he thanked him for helping him to write a Mothers' Day card. He had hugged the prisoner and said he loved him. They then went back to their cells for the afternoon roll check. The prisoner told the investigator that when he got to his cell, he had been slightly worried about him as he had never displayed such emotion before and he thought that this was strange. However, he soon dismissed this thought and believed that he had appeared to be okay.

35. At 12.45, an officer conducted the 12.45pm roll check and locked the cells. He said that the man was on his bed watching television when he got to his cell and said hello to him. He raised no concerns. Prisoners remained locked in their cells until about 1.30pm when two officers began unlocking them to collect their weekly prison shop orders, known as canteen. Officer A said she had unlocked his cell about 2.00pm, but did not talk to him or open the door wide enough to see him. Once all prisoners were unlocked, the officers began issuing the canteen orders.

36. Prisoner B said that he had joined the queue to collect his canteen when his cell was unlocked. He noticed that the man was not in the queue and thought he might be sleeping. He went to his cell and found the door shut but unlocked. He went in and found him hanging by a strip of bed sheet attached to the top of the shower area doorway. He immediately went to alert staff.

37. Prisoner B told Officer A what had happened and she ran to the cell and shouted to two officers for help. At 2.05pm, an officer pressed the general alarm button. Officer A went into the cell and saw the man hanging. His eyes were open and his skin was grey and she believed he looked dead. Both officers arrived at the cell within seconds. Officer A cut the ligature from around his neck and as she did, he fell to the floor, hitting his head. At 2.06, an officer radioed for the healthcare responder to attend K wing urgently.

38. None of the officers had had any recent first aid training and Officer A said they were unsure whether to start cardiopulmonary resuscitation. They believed the man was dead, although none of them had checked him for any signs of life. They waited at the door of the cell for a nurse to arrive.

39. An officer who was first aid trained arrived at the cell within a minute of hearing the general alarm. He saw the man lying on the floor on his back and thought he looked dead. He removed the ligature from his neck, but said that before he was able to check for any signs of life. An operational manager ushered him and other officers away from the cell to wait for the nurse to arrive.

40. The operational manager went into the cell. He told the investigator that the man looked dead, but he did not check him for any signs of life. He had not had any recent first aid training. He asked the staff outside the cell to call an ambulance and the healthcare team. The control room log recorded that an ambulance was requested at 2.11pm. He told the investigator that he and the other officers had been shocked when they found him. He stayed at the cell door and ensured that no one else went in until the nurse arrived.

41. A nurse responded to the request for a nurse to attend K wing, but told the investigator that he did not think it was an emergency. CCTV footage shows that the nurse arrived at the cell just after 2.11pm. The nurse said that the man had a prominent ligature mark around his neck, had no pulse, was not breathing, his body was cold and mottling of the skin was evident on his chest. The nurse asked the operational manager to ensure that the prison GP came to the wing.

42. The nurse left the cell to get an emergency bag, including oxygen and a defibrillator, from the treatment room on K wing. He said this took him less than two minutes and he arrived back at the cell at 2.15pm. The GP arrived at 2.16pm with two other nurses. He helped the nurse with cardiopulmonary resuscitation while the other nurses attached a defibrillator which detected no heart rhythm. The GP told the investigator that the man showed no signs of life at all and he believed he had been dead for some time. He pronounced him dead at 2.23pm. The cell was sealed at 2.25pm. Paramedics arrived at the cell at 2.29pm after the doctor had confirmed his death.

43. Notices were issued informing prisoners of the man's death and outlining the support that was available to them. All prisoners subject to suicide and self-harm prevention procedures were reviewed in case they had been adversely affected by his death. Staff offered Prisoner B support and referred him to the healthcare team.

44. The Head of Security held a debrief to support the officers involved in the emergency response. The care team and members of the prison chaplaincy team attended the wing to support staff and prisoners. The operational manager told the investigator that he had not been aware that a debrief had taken place. The nurse said that healthcare staff had been invited to attend the debrief, but none of them did. He said they went back to the healthcare centre where they discussed what had happened and supported each other.

Family Liaison

45. The man had nominated his mother as his next of kin. The deputy governor and two managers went to his mother's home at 4.00pm to break the news to her. The deputy governor went to see her again the next day to offer further support and information. Subsequently, the prison's family liaison officer contacted the man's mother and sister and gave them information about matters relating to the funeral, post-mortem and inquest. The prison offered financial assistance towards funeral costs in line with Prison Service guidance. The funeral was held on 11 March 2014.

Issues raised after the man's death

46. After the man's death, the prison's security department received information from some prisoners that he had been in debt to other prisoners after obtaining prescribed medication and drugs from them. The investigator interviewed a number of prisoners but was unable to get any further information about this. The prison said that he had approximately £40 in his prison cash account at the time of his death. He was due to collect his canteen order, which included tobacco, on the day he died.

Post-mortem

47. The post-mortem examination found that the cause of the man's death was hanging. The toxicology report indicated the presence of tramadol and codeine (both opioid drugs). He had not been prescribed any medication at the time of his death.

ISSUES

Clinical care

48. The clinical reviewer considered that the standard of healthcare the man received at Wymott was equivalent to that he could have expected to receive in the community.

Management of risk of suicide and self-harm

49. Prison Service Instruction (PSI) 64/2011 lists risk factors for suicide and self-harm and also states that "all staff who have contact with prisoners must be aware of the triggers that may increase the risk of suicide, self-harm or violence and take appropriate action". A list of risk factors for suicide includes previous deliberate self-harm.

50. At the time that the man transferred to Wymott on 23 January 2014, he had not been identified as a risk of suicide and self-harm. Prison staff at Wymott would have seen his escort record which noted his previous self-harm and they did not have any concerns about him. We were unable to interview the nurse who conducted the reception health screen and mistakenly recorded that he had not previously harmed himself. This suggests that she had not seen his escort record or read his medical record, which contained references to his previous self-harm at Forest Bank in 2012 and his threat to self-harm at Featherstone in 2013. We are satisfied that there was no reason to open an ACCT when he arrived at Wymott. His previous self-harm had been very minor and some time in the past. However, important information, which could be crucial in another case, was overlooked. We make the following recommendation:

    The Governor and Head of Healthcare should ensure that all healthcare staff in reception see information about risk from escort records and review previous medical records when assessing risk of suicide and self-harm.

Unlocking cells

51. For their own safety, officers are expected to make contact with a prisoner through the observation hatch before opening a locked cell door. When unlocking a cell they should take active steps to check on a prisoner's wellbeing. The Prison Officer Entry Level Training (POELT) manual states that "Prior to unlock, staff should physically check the presence of the occupants in every cell. You must ensure that you receive a positive response from them by knocking on the door and await a gesture of acknowledgement. If you fail to get a response you may need to open the cell to check. The purpose of this check is to confirm that the prisoner has not escaped, is ill or dead".

52. Officer A said she did not try to get a response from the man or check on his wellbeing when she unlocked his cell at 2.00pm. Other officers at Wymott told the investigator that it was not their usual practice to do so. This meant that there was a delay of approximately five minutes before he was found hanging and this was by another prisoner and not a member of staff. We make the following recommendation:

The Governor should ensure that, when a cell door is unlocked, staff satisfy themselves of the safety of the prisoner and that there are no immediate issues that need attention.

Emergency response

53. The three officers responded immediately when they were informed that the man was found hanging. One officer pressed the general alarm on the way to the cell, but she did not know the nature of incident. When the officers arrived at the cell and found that he was hanging, none of them radioed a code blue emergency as national instructions and Wymott's local policy requires. This meant that other staff who responded did not know the nature of the incident and that the control room did not call an ambulance immediately as should have happened. One officer contacted the control room and asked for healthcare staff to attend but did not ask for an ambulance to be called or give details about the emergency. An ambulance was not requested until 2.11pm, at least five or six minutes after the man had first been found hanging.

54. Prison Service Instruction 3/2013 (issued February 2013) requires that prisons must have a medical emergency response code protocol which ensures that an ambulance is called automatically in a life-threatening medical emergency. The protocol should give guidance on efficiently communicating the nature of a medical emergency to help ensure 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. Wymott has local procedures, which are in accordance with the protocol, but they were not followed. Even a short delay in such circumstances can have a significant impact on a person's chance of survival and it is important that prison managers make sure that all relevant prison staff understand the emergency procedures. We make the following recommendation:

The Governor should ensure that all relevant staff are familiar with and act on the PSI 03/2013 and Wymott's local protocol for calling an emergency ambulance (40/2013) and are aware of their responsibilities during medical emergencies which should include:

- **Efficiently communicating the nature of a medical emergency;**
- **Ensures staff initiate basic life support as needed until health care staff arrive;**
- **Ensuring staff called to the scene attend as quickly as possible and bring the relevant equipment; and**
- **Ensures there are no delays in calling, directing or discharging ambulances.**

Resuscitation

55. At least five members of staff arrived at the man's cell before the nurse, yet none of them examined him for any signs of life or attempted resuscitation. The first three officers at the cell had not received first aid training for at least four years and, in one case, not at all. One of the officers said that they had gone into shock.

56. The clinical reviewer notes that there is no evidence to suggest that, had resuscitation been attempted immediately, there would have been a different outcome. However, it is vital that if a person is unconscious, cardiopulmonary resuscitation is started as soon as possible to improve the chances of survival. Unless there are clear signs of death, staff should attempt resuscitation and continue until expert help arrives. We make the following recommendation:

The Governor should ensure that there are sufficient first aid trained staff on duty at all times and that when a prisoner is not breathing all officers understand how to begin basic life support and do so until trained staff arrive, unless there is clear evidence that it would be futile in the circumstances.

Information about trading in illicit drugs and medication

57. The investigator was not able to find any evidence to confirm the information, received after the man's death that he was in debt to other prisoners after obtaining illicit drugs and medication from them. His prison record indicates that he had a history of getting into debt with other prisoners, usually for tobacco, but access to tobacco does not appear to have been a problem at the time of his death. (Although tobacco is often used as a currency to pay for other drugs.) He had ordered tobacco from the prison shop and had sufficient money in his prison account to pay for it. We know that he must have taken some illicitly obtained medication as the toxicology test, conducted as part of the post-mortem examination, found tramadol and codeine present in his blood. He had not been prescribed either medication.

58. Codeine and tramadol are often diverted and misused in prisons for their euphoric potential and can be quite valuable as commodities for trading. We understand that, since the man's death, tramdadol is no longer prescribed 'in possession' and all such medication is given under supervision to help reduce opportunities for diversion and misuse. We note that the Independent Monitoring Board for Wymott indicated in their latest published annual report that the misuse of drugs and medication was a problem on K wing. There is no clear evidence that abuse of medication was a factor in his death, but such use, particularly if it leads to associated debt, can be a factor which increases the risk of suicide and self-harm. Mental health nurses at the prison told us that issues arising from debt between prisoners are a significant problem at the prison. We make the following recommendation:

The Governor should ensure that Wymott has effective strategies to reduce the availability of illicit drugs and trading of prescribed medication and to tackle issues arising from prisoners in debt to each other.

RECOMMENDATIONS

1. The Governor and Head of Healthcare should ensure that all healthcare staff in reception see information about risk from escort records and review previous medical records when assessing risk of suicide and self-harm.

2. The Governor should ensure that, when a cell door is unlocked, staff satisfy themselves of the safety of the prisoner and that there are no immediate issues that need attention.

3. The Governor should ensure that all relevant staff are familiar with and act on the PSI 03/2013 and Wymott's local protocol for calling an emergency ambulance (40/2013) and are aware of their responsibilities during medical emergencies which should include:

    - Efficiently communicating the nature of a medical emergency;
    - Ensures staff initiate basic life support as needed until health care staff arrive;
    - Ensuring staff called to the scene attend as quickly as possible and bring the relevant equipment; and
    - Ensures there are no delays in calling, directing or discharging ambulances.

4. The Governor should ensure that there are sufficient first aid trained staff on duty at all times and that when a prisoner is not breathing all officers understand how to begin basic life support and do so until trained staff arrive, unless there is clear evidence that it would be futile in the circumstances.

5. The Governor should ensure that Wymott has effective strategies to reduce the availability of illicit drugs and trading of prescribed medication and to tackle issues arising from prisoners in debt to each other.