

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Andrew Cross a prisoner at HMP Wayland on 13 September 2018

A report by the Prisons and Probation Ombudsman

Our Vision

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

Our Values

We are:

Impartial: *we do not take sides*

Respectful: *we are considerate and courteous*

Inclusive: *we value diversity*

Dedicated: *we are determined and focused*

Fair: *we are honest and act with integrity*



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

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

Mr Andrew Cross was found hanged in his cell at HMP Wayland on 13 September 2018. He was 52 years old. I offer my condolences to his family and friends.

Mr Cross had been in prison for a number of years and had no recent history of self-harm. He had previously received antipsychotic medication but had stopped taking it in May 2018.

While I am satisfied that there was no clear indication that Mr Cross was at imminent risk of suicide, I do not consider that staff took sufficient action to support him when he made it clear that he had a number of unresolved concerns and had started to refuse food in protest.

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

Elizabeth Moody
Deputy Prisons and Probation Ombudsman

May 2019

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Summary

Events

1. In August 2014, Mr Andrew Cross was remanded in custody to HMP Pentonville, charged with grievous bodily harm with intent. He was later sentenced to nine years in prison. In September 2017, Mr Cross was transferred to HMP The Mount. On 23 July 2018, he was transferred to HMP Wayland.
2. On 20 August, a mental health worker started suicide and self-harm prevention procedures (known as ACCT) after Mr Cross said that he would “leave the prison in a box”. The mental health worker thought that Mr Cross was frustrated that he would have to see a psychiatrist before receiving medication. Later that day, prison staff closed ACCT procedures at the first case review when Mr Cross said that he did not intend to harm himself.
3. Mr Cross was frustrated about a number of matters. He remained concerned about his continued wait to see a psychiatrist and he believed that a recommended offender management course was not appropriate for him. In a telephone call to his mother, Mr Cross said that he believed that his mail was going missing and that the prison was stealing money from his account.
4. On around 9 September, Mr Cross started to refuse food in protest. Two days later, he lost his prison job after a number of unacceptable absences from work.
5. At midday on 13 September, a senior nurse and the healthcare manager spoke to Mr Cross about his food refusal. Mr Cross agreed to start eating again if his concerns were addressed.
6. At around 8.45pm on 13 September, the night officer saw Mr Cross in a seated position on his cell floor. When he switched on the cell light, he saw a ligature attached to Mr Cross’ neck. The officer summoned assistance and staff went into the cell, cut the ligature and began cardiopulmonary resuscitation (CPR). Paramedics arrived 20 minutes later and took over CPR, but their attempts were unsuccessful and, at 9.20pm, they pronounced that Mr Cross had died.

Findings

7. There were deficiencies in the way staff operated ACCT processes. In particular, ACCT monitoring was stopped at the first ACCT review without input from the healthcare team. There was no caremap, even though Mr Cross raised a concern at the review.
8. Staff did not record when Mr Cross started to refuse food and no one considered whether to start ACCT procedures in line with Prison Service instructions.
9. While there was little delay in the emergency response, the first officer at the scene was unaware that he could enter a cell alone, if he judged it appropriate to do so.

Recommendations

- The Governor should ensure that prison staff manage prisoners at risk of suicide or self-harm in line with national instructions, including that:
 - first case reviews are multidisciplinary and always include a member of healthcare staff;
 - ACCT caremap actions are set at the first case review, are specific and meaningful, and address all the issues identified at assessment interviews and case reviews; and
 - ACCT plans are not closed at the first case review unless all issues identified at the assessment interview have been resolved.
- The Governor should ensure that all staff are aware of the appropriate management of prisoners refusing food, including that:
 - staff complete daily food refusal observation sheets in line with local policy; and
 - staff consider carefully the use of ACCT to monitor and assist prisoners refusing food in accordance with PSI 64/2011, and start ACCT procedures when indicated.
- The Governor should ensure that all prison staff are made aware of and understand their responsibilities during medical emergencies, including that 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. Two prisoners responded.
11. The investigator obtained copies of relevant extracts from Mr Cross' prison and medical records. He interviewed 13 members of staff at Wayland on 9 and 10 October 2018, and subsequently spoke to two other witnesses by telephone.
12. NHS England commissioned a clinical reviewer to review Mr Cross' clinical care at the prison. They jointly interviewed clinical staff.
13. We informed HM Coroner for Greater Norfolk of the investigation who sent us the results of the post-mortem examinations. We have given the Coroner a copy of this report.
14. We contacted Mr Cross' next of kin, his brother, to explain the investigation process and to ask if the family had any matters they wanted the investigation to consider. The family did not raise any matters.

Background Information

HMP Wayland

15. HMP Wayland is a medium security training prison in rural Norfolk, near Thetford. The prison holds just under 1,000 convicted adult male prisoners. Virgin Care provides healthcare services. There are no nurses on duty at night.

HM Inspectorate of Prisons

16. The most recent inspection of Wayland was in June 2017. Inspectors found flaws in the ACCT case management documentation for prisoners at risk of suicide or self-harm, including that caremap actions were not completed and ACCT monitoring was sometimes stopped too quickly. Inspectors found that staff took a courteous and constructive approach to prisoners with most prisoners being reasonably positive about staff engagement with them. Inspectors noted that too many prisoners arrived at Wayland without an up-to-date OASys (offender assessment) report.

Independent Monitoring Board

17. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report for the year to May 2018, the IMB reported its concerns about staffing. It noted that while staffing levels had risen significantly since the previous reporting year, this meant that many officers were new in post, with less than one year in service. The IMB noted that both officers and prisoners acknowledged that this had impacted on safety and discipline on the wings.

Previous deaths at HMP Wayland

18. Mr Cross was the seventh prisoner to die at Wayland since December 2015, and the fourth to take his own life. Our investigations into the previous deaths included one where there was a similar failure to hold multidisciplinary ACCT reviews with healthcare staff at the first case review. We made a recommendation to Wayland about this which they accepted.

Assessment, Care in Custody and Teamwork

19. Assessment, Care in Custody and Teamwork (ACCT) is the Prison Service care-planning system used to support prisoners at risk of suicide and 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. There should be regular multidisciplinary review meetings involving the prisoner. As part of the process, a caremap (a 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.

Incentives and Earned Privileges scheme

20. Each prison has an Incentives and Earned Privileges scheme, which aims to encourage and reward responsible behaviour, encourage sentenced prisoners to engage in activities designed to reduce the risk of reoffending and to help create a disciplined and safer environment for prisoners and staff. Under the scheme, prisoners can earn additional privileges such as extra visits, more time out of cell, the ability to earn more money in prison jobs and to wear their own clothes. There are three levels: basic, standard and enhanced.

Key Events

21. In August 2014, Mr Andrew Cross was charged with grievous bodily harm with intent and remanded to HMP Pentonville. He was later sentenced to nine years in prison. Mr Cross had been to prison eight times before. Prison staff had previously managed him under ACCT procedures.
22. On his arrival in Pentonville, Mr Cross was prescribed olanzapine which he had been receiving during a previous prison sentence and in the community. (Olanzapine is an antipsychotic medication used to treat schizophrenia and bipolar disorder.) Mr Cross was first prescribed olanzapine when he reported experiencing auditory hallucinations.
23. In March 2017, Mr Cross' probation officer recorded in his OASys report (an assessment of his risk and needs) that Mr Cross was not motivated to complete any offence-focused work in custody and accepted that he would not be released at a parole meeting.
24. On 29 September 2017, Mr Cross was transferred to HMP The Mount. Prison staff started ACCT procedures on 9 March 2018, when Mr Cross reported that he felt depressed, that he could hear voices, and that he felt he would harm himself. Mr Cross said that he had stopped taking his prescribed antipsychotic medication, olanzapine. Prison staff stopped ACCT procedures on 22 March, when Mr Cross reported that he did not want to kill himself and had not harmed himself.

HMP Wayland

25. On 23 July, Mr Cross was transferred to Wayland. A nurse saw him on arrival and, due to his previous contact with mental health services, referred him to be assessed by the mental health team the next day.
26. On 24 July, a mental health practitioner assessed Mr Cross. He told her that he had previously been prescribed olanzapine but had not taken it for the past three months. She noted that Mr Cross appeared generally stable but reported hearing voices. She told the investigator that she was not entirely convinced by Mr Cross' description of the voices, but she listed him for discussion at the next multidisciplinary team meeting.
27. On 1 August, the multidisciplinary team meeting discussed Mr Cross and added his name to the list for secondary mental healthcare. An appointment was made for him to see a psychiatrist on 19 September.
28. On 16 August, Mr Cross attended an orientation board, where he met staff from different functional areas. A member of staff from the Offender Management Unit told the investigator that the purpose of the board was to discuss with each prisoner what they wanted to do at Wayland and to discuss their future prospects and what the prison could do to upskill them. They also discussed a prisoner's sentence plan and what they needed to do to prepare to move to a Category D (open) prison or for release. She said that Mr Cross' sentence plan included that he needed to complete the Resolve course for anger management, but he said that he would not do that course. She told him that that was his choice, but that it

might be easier to do it in prison as otherwise, he might have to do it after release. She said that Mr Cross seemed to accept her advice.

29. On 17 August, the cell bell system on A Wing, where Mr Cross lived, stopped working when the wiring was damaged. Wayland reported the problem to regional and national managers. A Wing held 120 prisoners and, due to the number involved, Wayland had to produce plans to mitigate risk, pending a managed reduction of prisoners until the wing could be closed for repairs. The plans to mitigate risk included moving prisoners being managed under ACCT procedures to different wings, and issuing remaining prisoners red cards that they were to push beneath their doors if they needed assistance. Increased wing patrols were put in place to answer any red cards. (On 28 September, the remaining prisoners on A Wing were moved to new locations and the wing was closed for repair.)
30. On 20 August, the mental health practitioner saw Mr Cross again for a mental health review. She told the investigator that Mr Cross was angry and frustrated that day. He said that he had been transferred to Wayland to complete the Resolve course but on arrival, he was told that he would have to do the Kaizen course instead. (Kaizen is an offender management course aimed at prisoners assessed as posing a high risk of violence. It is unclear whether Mr Cross had been told he would have to do this course.) He was also frustrated that he had not yet seen the psychiatrist. She told Mr Cross that he had an appointment with the psychiatrist on 19 September, who would consider whether to re-prescribe olanzapine. Mr Cross said that he “would end up leaving the prison in a box”. He then tried to retract the statement when she told him that she would have to start ACCT procedures. She told the investigator that she believed that Mr Cross had made the statement to manipulate an earlier appointment with a prison GP.
31. Later that day, an officer conducted an ACCT assessment. Mr Cross said that his main problem was that he was not yet receiving medication for his mental health. He said that he did not have any current thoughts about self-harm and that he would ask for staff support if he began to have any such thoughts. The officer noted that Mr Cross was calm and in control.
32. A Supervising Officer (SO) told the investigator that he joined an officer and Mr Cross at the end of the assessment interview and he then chaired the first ACCT case review. Mr Cross said that he had no past or present thoughts of self-harm but needed medication. The SO said that Mr Cross was calm and articulate and displayed no obvious signs of mental illness. Mr Cross also said that he had friends and a support network on A Wing. The SO said that he, the officer, and Mr Cross were content that it was appropriate to close ACCT procedures and to pursue a medication review. The SO said that he had asked if there was a nurse available for the review but it seemed that none were available. He told the investigator that he had never been told that he needed to have a healthcare representative at the first ACCT case review. The SO did not complete a caremap.
33. On 21 August, a prison GP prescribed Mr Cross a five-day course of zopiclone (a sleeping tablet).

34. On 22 August, a multidisciplinary team meeting discussed Mr Cross. They agreed that he should wait until his appointment with a prison GP before further considering his request to be prescribed olanzapine.
35. On 27 August, the SO conducted an ACCT post-closure assessment. Mr Cross said that he had a job in one of the workshops, that he had support from his family and that he was coping well. He said that he was still awaiting an appointment for a medication review. The SO told the investigator that he did not consider that there were any grounds to restart ACCT procedures.
36. An officer told the investigator that he had contact with Mr Cross on most days during his time in Wayland. He said that Mr Cross was always friendly but had problems that he was trying to resolve. He would raise issues such as his sentence plan, the offender course he was required to do and his Incentives and Earned Privileges (IEP) level. (Mr Cross was on the enhanced IEP level – the highest level – and this did not change while he was at Wayland.) The officer thought that Mr Cross believed that people were deliberately setting up obstacles for him.
37. On 5 September, Mr Cross asked the same officer to contact his offender supervisor, as he needed to discuss his sentence plan. The officer emailed his offender supervisor but she was on annual leave at the time.
38. The mental health practitioner was due to see Mr Cross on 5 September for a review, but she had to reschedule his appointment to 7 September. She said that she contacted A Wing to let them know. However, it would seem that the message was not passed on to Mr Cross, as the wing staff telephoned healthcare at 5.13pm to say that Mr Cross was angry as he had waited all day for the appointment.
39. On 7 September, at their rescheduled appointment, Mr Cross told the mental health practitioner that he believed that staff were “blocking him”. He said that he had asked where he was on the waiting list to move to F Wing, an enhanced wing, but staff had said that it was impossible to tell him. She told the investigator that she thought Mr Cross was possibly the type of person who wanted something straightaway. She said that she tried to explain to him that staff may sometimes be too busy to deal immediately with his questions. She said that Mr Cross again reported that he was hearing voices and would benefit from medication. She reminded him that he was booked to see a prison GP on 19 September to discuss this. She noted that Mr Cross had engaged well, that his mood was stable and that he shook her hand at the end.
40. On 9 September, Mr Cross telephoned his mother. (Prisoners’ telephone calls are recorded and we listened to recordings of Mr Cross’ calls. Unless there are security grounds to target calls, prison staff listen to a random sample of telephone calls, but had not listened to Mr Cross’.) Mr Cross complained to his mother about a number of matters. He said that prison staff had stolen his mail and his money, that they had made negative behavioural entries in his records, that they had not told him about medical appointments, and that they had blocked him from moving to other wings. Mr Cross said that it was pointless carrying on and that he would kill himself. He also asked his mother to send him some money.

41. Later on 9 September, an officer noted in Mr Cross' electronic prison records that Mr Cross was unhappy that he had been deemed to have failed to go to work when his reason for missing work was because he had medical appointments. The officer's entry went on to say:
- "... stated for the time being he wishes to remain behind his door and has handed in his TV and has said he will refuse food if it is delivered to the door. He feels somebody is against him and trying to stop him progressing."
42. On 10 September, Mr Cross' offender supervisor e-mailed the officer who had previously mailed her to say that she had booked an appointment to see Mr Cross on 21 September. The officer told Mr Cross about the appointment, but he who said that another officer had already told him about the appointment. (Had Mr Cross attended that meeting, his offender supervisor would have been able to explain to him which of the offender management courses would have been most appropriate for him.)
43. Another officer told the investigator that he was a newly appointed officer and met Mr Cross during his early weeks while shadowing more experienced staff. He said that Mr Cross would frequently come to the wing office with questions and problems that he wanted resolved, such as negative entries in his records. An officer said that when he 'went live' as an officer, Mr Cross would always acknowledge him and would often make jokes about him being a 'newbie'. The officer said that he knew Mr Cross was from East London and was a Chelsea supporter and that led to them having more conversation and establishing a rapport.
44. Mr Cross was dismissed from his prison job on 11 September, following four unacceptable absences from work. The four absences did not include instances when he was either ill or attending healthcare appointments: these instances were categorised as acceptable absences. (The only instance when a record was made of Mr Cross' refusal to attend work was when he said that he would not attend until his probation officer's telephone number was added to his PIN telephone account.) Despite losing his job, Mr Cross remained at enhanced level on the prison's IEP scheme.
45. On the afternoon of 12 September, Mr Cross telephoned his mother. He said that "someone was out to get him" but he would "not go down without a fight" and that he had not eaten for four days. He told her that he would telephone her again in a couple of days' time.
46. Another officer told the investigator that she had a number of conversations with Mr Cross during his time at Wayland. She said that Mr Cross complained to her about various matters including that he was not receiving mail. He said that he thought this was due to HMP The Mount not forwarding mail that had been sent there. On the evening of 12 September, an officer spoke to Mr Cross about not taking his meal. He told her that he was not refusing food as an act of self-harm, but as a statement against his sentence calculation, which he said had changed once again (his sentence calculation had not changed). The officer recorded in the wing observation book that Mr Cross had refused food for 72 hours and would need to be seen by healthcare staff the following day.

47. At around 7.00pm on 12 September, a Custodial Manager (CM) spoke to Mr Cross about his food refusal. The CM told the investigator that he had known Mr Cross for a number of years and he believed that they had a good working relationship. The CM said that he told Mr Cross that prison protocols meant that staff would usually start ACCT procedures once a prisoner had reached 72 hours of food refusal. That would mean moving him from A Wing due to the problem with the cell bell system. Mr Cross said that he did not want to leave A Wing as there were staff to whom he felt that he could talk to. The CM told the investigator that he was content that Mr Cross did not seem to be at risk so he told him that he would leave matters as they were for the time being, but would see him again the following day.
48. The CM said that he was extremely busy on 13 September, and did not therefore have an opportunity to see Mr Cross as he had promised. He said that he planned to visit Mr Cross on 14 September instead.
49. An officer who had a lot of contact with Mr Cross said that when he was supervising prisoners on the exercise yard, Mr Cross would often chat to him about his time in different prisons. The officer said that Mr Cross never caused problems on the wing and while he became frustrated at times, he was never confrontational.

13 September

50. The same officer said that Mr Cross spoke to him on the morning of 13 September and asked if he was working on the wing that day. He told Mr Cross that he was working nights, that he was just about to go off duty and would see him again that evening. He said that Mr Cross was walking towards the healthcare unit and that he seemed upbeat.
51. Later that morning, a prison GP discussed Mr Cross' blood test results with him. (A prison nurse had taken Mr Cross' blood on 5 September.) The test results showed that Mr Cross had vitamin D and folic acid deficiencies. The prison GP told the investigator that Mr Cross said that he had refused food for a number of days as his IEP level had been reduced, but also said he had an appointment to speak to someone about this (Mr Cross' IEP level had not been reduced). He said that the consultation ended amicably and Mr Cross shook his hand. He said that there was nothing about Mr Cross' demeanour to indicate that he might consider harming himself.
52. Another officer also spoke to Mr Cross on the morning of 13 September. He said that Mr Cross was his usual self that morning and he gave no indication that he might be at risk of harming himself.
53. At around 1.00pm, a senior nurse (the manager of the mental health team) and the Head of Healthcare visited Mr Cross because he had now seemingly gone 72 hours without eating. The senior nurse told the investigator that when she looked into Mr Cross' cell, she saw that it was reasonably tidy, without sign of significant neglect. She also noticed a plate and a bowl that looked as though they had some food remnants that did not look particularly old or encrusted. She said that Mr Cross agreed to speak to her and the Head of Healthcare and they went to a wing office.

54. The senior nurse said that Mr Cross was angry that he was still waiting to see a psychiatrist, and about a number of prison processes such as having to complete an offender management course. She said that there were no indications that Mr Cross had a thought disorder, and he was concise and focussed with his frustrations about the prison. She asked him if he would start eating again if his concerns were resolved and he agreed that he would do so. She said that she told Mr Cross that they would not be able to bring forward his psychiatric appointment, but they would discuss with one of the prison doctors the possibility of prescribing olanzapine until the psychiatric review. She said that Mr Cross thanked them at the end of the consultation and shook their hands. She said that she had seen no grounds to start ACCT procedures.
55. The Head of Healthcare gave similar evidence to the senior nurse's. He confirmed that it was standard practice for the healthcare team to visit and review all prisoners once they had reached 72 hours of food refusal. He confirmed that Mr Cross appeared to agree to the plan suggested by the nurse.
56. A prisoner at Wayland told the investigator that he had known Mr Cross for 30 years. He said that he bumped into Mr Cross towards the end of July and that they spoke regularly after that. He said that Mr Cross was irritated about a number of matters, including the waiting list to start the Resolve course and that his medication had been stopped. He said that he was aware that Mr Cross had stopped going to work: his job entailed shredding of old clothing and Mr Cross found the work demeaning. He said that the last time he saw Mr Cross was at about 3.00pm on 13 September when he made a comment that he "would have the last laugh". He said that he did not understand what Mr Cross had meant by that remark and there had been nothing about his demeanour at any time to cause him to think that Mr Cross might harm himself.
57. At around 7.00pm, an officer completed a count of prisoners. When he arrived at Mr Cross' cell, he saw that he was lying in bed on the bottom bunk. He said that Mr Cross looked towards his door, held up his hand and said, "All right Gov." The officer went off duty around 30 minutes later.
58. Shortly after 8.30pm, another officer began the final count of prisoners of the evening. As he was working a night shift, his cell key was in a sealed pouch. He reached Mr Cross' cell at about 8.45pm. He told the investigator he was immediately concerned as the cell was in complete darkness and the television was off, when it was usually switched on. The officer shone his torch into the cell and saw Mr Cross apparently sitting on the floor with his back leaning against the bottom bunk. He said that there was no colour in Mr Cross' face. He then switched on the cell light and he could see a ligature running down to Mr Cross' neck directly in line with the bed post. CCTV footage shows that the officer spent 17 seconds looking into Mr Cross' cell before he radioed a code blue medical emergency, indicating a life-threatening situation. Another officer arrived 27 seconds later. (The control room logged the code blue at 8.48pm and an emergency ambulance was called immediately.)
59. As the other officer was working a day shift, he was still carrying an open key. He looked into the cell and then unlocked the door. He cut the ligature, which was made from a computer cable and which had suspended Mr Cross with his

bottom around an inch above the floor. After checking for a pulse, he picked up a cloth from the cell floor, made a small hole through it and used it as an improvised mouth shield to give emergency breaths. Another officer then arrived and began chest compressions and continued doing so, alternating with the other officer.

60. Prison staff applied a defibrillator, which advised that no shock could be given and that they should continue chest compressions. The staff continued giving chest compressions and emergency breaths until paramedics arrived at around 9.06pm. The paramedics attempted to resuscitate Mr Cross for almost 15 minutes, but at 9.20pm they confirmed he had died.

Contact with Mr Cross' family

61. An officer and a member of staff were appointed as family liaison officers. At 2.14am on 14 September, they visited Mr Cross' mother and sister and told them of his death. Wayland contributed to the cost of Mr Cross' funeral in line with national instructions.

Support for prisoners and staff

62. The duty governor debriefed the staff involved in the emergency response. Follow-up checks were made on three officers who also attended the incident, but who were not at the debriefing meeting. The staff care team also offered support.
63. The prison posted notices informing other prisoners of Mr Cross' 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 Cross' death.

Cause of death

64. Mr Cross' post-mortem report gave his cause of death as hanging. Results of toxicology tests found no alcohol or drugs in his blood or urine.

Findings

Managing the risk of suicide and self-harm

65. A mental health practitioner appropriately started ACCT procedures on 20 August when Mr Cross said that he would leave “the prison in a box”. However, the procedures were poorly managed and not in line with Prison Service policy.
66. Prison Service Instruction (PSI) 64/2011 contains guidance and mandatory instructions on managing prisoners at risk of suicide and self-harm. It requires ACCT case reviews to be multidisciplinary, where possible, and requires a healthcare representative to attend the first case review. Despite healthcare staff starting ACCT procedures, no one from the healthcare team attended the first case review. We found a similar failing at Wayland after a death in March 2016.
67. PSI 64/2011 also states that a caremap must be completed at the first case review, which should reflect the prisoner’s needs and must aim to address the issues identified at the assessment interview. The caremap should set time bounded actions allocated to an individual or team. Mr Cross’ need for a review of his medication appears to be an obvious issue to be included on a caremap. Despite this, no one completed a caremap at Mr Cross’ first case review.
68. Guidance in the ACCT document says that staff can end ACCT procedures at the first case review, if the case review team believe it is safe to do so and if all issues identified in the assessment interview are resolved. At the assessment, Mr Cross said that his main concern was that he did not have any medication for his mental health issues. This had not been resolved when the ACCT procedures were closed around an hour later.
69. An SO told us that he closed the ACCT procedures because Mr Cross was calm and articulate and said he had friends and a support network on A Wing. He also said that Mr Cross displayed no obvious signs of mental illness although, without a member of the mental health team present, we are not satisfied that it was appropriate for him to reach this conclusion. We are concerned that he made the decision to close ACCT procedures at an ACCT case review which was not multidisciplinary and without resolution of the issues Mr Cross had raised. We make the following recommendation:

The Governor should ensure that prison staff manage prisoners at risk of suicide or self-harm in line with national guidance, including that:

- **first case reviews are multidisciplinary and always include a member of healthcare staff;**
- **ACCT caremap actions are set at the first case review, are specific and meaningful and address all the issues identified at assessment interviews; and**
- **ACCT plans are not closed at the first case review unless all issues identified at the assessment interview have been resolved.**

Food refusal

70. PSI 64/2011 contains instruction on the management of prisoners who refuse food. It explains that it is important that a prisoner's decision to refuse food is taken seriously and is recorded properly. PSI 64/2011 also explains that while a decision to refuse food is not considered in law to be a form of self-harm, the ACCT process might nevertheless provide a useful way of recording the care offered to the prisoner and to facilitate sharing of information.
71. At Wayland, staff are required to complete observation sheets to record when a prisoner refuses food. In Mr Cross' case no observation sheets were completed so it is not clear precisely when he began to refuse food. His reasons for refusing food are also not entirely clear: he clearly had a number of concerns including his request for medication, his sentence calculation, the offender management course he was asked to undertake, possible missing mail and possibly his IEP level. In addition to refusing food, he also failed to attend work without adequate reason leading to him losing his job on 11 September.
72. The evidence from staff indicates that Mr Cross frequently brought matters to their attention but that he would be quickly placated when he was told that the matter would be reviewed. However, the precise details of his individual concerns and how they were being explored is unclear. Mr Cross appeared to believe that his concerns were genuine and he was frustrated with the way these concerns were being handled by prison staff.
73. If staff had started ACCT procedures when Mr Cross began to refuse food, this should have led to a multidisciplinary case review and the construction of a caremap listing Mr Cross' concerns with a plan to address those concerns. We cannot say whether this might have had an impact on the outcome, but without an ACCT there was no structured or consistent approach to monitoring, assessing and assisting Mr Cross with his apparent dissatisfaction with the prison. We make the following recommendation:

The Governor should ensure that all staff are aware of the appropriate management of prisoners refusing food, including that:

- **staff complete daily food refusal observation sheets in line with local policy; and**
- **staff consider the use of ACCT to monitor and assist prisoners refusing food in accordance with PSI 64/2011, and start ACCT procedures when indicated.**

Entering Mr Cross' cell

74. At night, officers carry a key in a sealed pouch for use in an emergency. Prison Service Instruction 24/2011, which covers management and security at nights, says that staff have a duty of care to prisoners, to themselves, and to other staff. The preservation of life must take precedence over usual arrangements for opening cells and where there is, or appears to be, immediate danger to life, then cells may be unlocked without the authority of the night orderly officer and an individual member of staff can enter the cell on their own. Staff are not expected to take action that they feel would put themselves or others in unnecessary

danger. What they observe and any knowledge of the prisoner should be used to make a rapid dynamic risk assessment.

75. The CCTV recording shows that an officer looked into Mr Cross's cell for 17 seconds before calling for assistance. He told us that he was trying to assess the situation in this time as the cell was in complete darkness and Mr Cross appeared to be sitting on the floor. When he saw a ligature running from Mr Cross' neck he called for assistance. The officer told us that his understanding was that officers should not enter a cell alone. The CCTV shows that an officer arrived 27 seconds after being called and he unlocked the cell door. (The officer was carrying a sealed key but another officer was completing his day shift and still carrying an open key.)
76. We recognise that it can be difficult for staff in such situations to make instant decisions, but when there is a potentially life-threatening situation, it is essential to act quickly. Once the officer could see that Mr Cross appeared to be hanging by a ligature, we would expect him to make a rapid dynamic risk assessment with the aim of entering the cell as soon as possible, in case there is a chance of saving someone's life.
77. Even with a correct understanding, the officer might reasonably have concluded that the situation was not sufficiently clear for him to enter the cell alone and nor can we say whether any delay might have affected the outcome for Mr Cross. Nevertheless, it is important that prison staff properly understand their roles in a medical emergency as early intervention when someone is found hanging can be crucial. 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 staff enter cells as quickly as possible in a life-threatening situation.

Clinical care

78. The clinical reviewer noted that on his transfer to Wayland, Mr Cross was placed into the care of the in-reach mental health team. He concluded that Mr Cross received a reasonable standard of care, equivalent to that which he could have expected to receive in the wider community. He noted that on 13 September, a nurse and the Head of Healthcare told Mr Cross that they planned to ask a GP to prescribe olanzapine until he had seen a psychiatrist.
79. The clinical reviewer made a number of recommendations which the Head of Healthcare will need to address. These include recommendations about the need for mental health practitioners to attend ACCT reviews and to ensure that a consultant psychiatrist, or equivalent, attended each planned psychiatric clinic.

**Prisons &
Probation**

Ombudsman
Independent Investigations