Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Jamie Whyte, a prisoner at HMP Wayland, on 22 April 2020

A report by the Prisons and Probation Ombudsman

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Our Vision

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

Our Values

We are:

Impartial: *we do not take sides*
Respectful: *we are considerate and courteous*
Inclusive: *we value diversity*
Dedicated: *we are determined and focused*
Fair: *we are honest and act with integrity*

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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 Jamie Whyte was found hanged in his cell in the segregation unit at HMP Wayland on 22 April 2020. He was 46 years old. I offer my condolences Mr Whyte's family and friends.

Mr Whyte had a number of risk factors that indicated he was at risk of attempted suicide and self-harm, particularly what appears to have been a significant deterioration in his mental health in the days before his death. He was managed under Prison Service suicide and self-harm monitoring procedures (known as ACCT) but we consider that more should have been done to support and manage his risks.

Although we cannot be sure, we are concerned that the COVID-19 restrictions may have meant that the deterioration in Mr Whyte's mental health was not identified as quickly as it might have been if he had been having regular, meaningful contact with prison and mental health staff.

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

Sue McAllister, CB
Prisons and Probation Ombudsman **February 2021**

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Summary

Events

1. On 30 August 2019, Mr Jamie Whyte was sentenced to four years in prison for robbery and burglary and was sent to HMP Thameside.

2. Mr Whyte had a history of attempted suicide and self-harm, substance misuse and mental illness (including paranoid schizophrenia) and had spent some years in a secure psychiatric hospital. His identical twin brother had killed himself in February 2019.

3. In October 2019, Mr Whyte was transferred to HMP Wayland. He was seen regularly by a mental health nurse and he was reviewed on three occasions by a consultant psychiatrist who adjusted his medication. He was mentally stable and compliant with his medication. He settled well at Wayland, although he continued to suffer from anxiety and paranoia, and in January 2020 he was placed on the 'enhanced' regime.

4. From 24 March, all prisoners were subject to a very restricted regime in response to the COVID-19 pandemic.

5. On 25 March 2020, Mr Whyte was informed that he would face trial on further charges on 22 April and he told his mental health nurse that he was worried that he was facing a long sentence.

6. On 15 April, Mr Whyte asked to see his mental health nurse. Due to restrictions in response to the COVID-19 pandemic, it had been decided that the mental health team would only visit urgent cases. Mr Whyte case was not assessed as being urgent and he was discharged from the prison's mental health team.

7. On 18 April, Mr Whyte barricaded his cell door with furniture and made cuts to his arms. Following unsuccessful attempts to engage with him, staff forcibly entered his cell for his own safety and restrained him and he was taken to the segregation unit. Staff began suicide and self-harm monitoring procedures (known as ACCT). His ACCT observations were set at once an hour and he was referred to the consultant psychiatrist (although he was not seen before he died).

8. On 20 April, a Duty Governor went to talk to Mr Whyte in his cell. Mr Whyte threw a flask at him, hitting his head. Mr Whyte refused to engage with his ACCT review and it was rescheduled for 21 April. A member of the mental health team went to see Mr Whyte, but he refused to engage with them. Later that evening, he refused his meals and medication.

9. On the morning of 21 April, a supervising officer held an ACCT review on his own. He made no changes to Mr Whyte's level of risk or frequency of observations. Mr Whyte refused his meals and medication again during the day. That evening, he rang his emergency cell bell, was agitated and told staff that his mother was being hurt. Staff tried to reassure him that this was not the case.

10. At 5.40am on 22 April, Mr Whyte told an officer carrying out a routine ACCT observation that he was feeling poorly. The officer told him to ring his emergency bell if he began to feel worse and that a GP would see him later that day.

11. At 6.35am, the officer found Mr Whyte hanging from his bedframe. He radioed an emergency medical code. Staff attended and started cardiopulmonary resuscitation (CPR). Ambulance staff arrived at 7.00am and at 7.10am, they confirmed that Mr Whyte had died.

Findings

Management of Mr Whyte's risk of suicide and self-harm

12. We found failings in the identification and assessment of Mr Whyte's risk. Staff did not recognise that he had a number of risk factors for suicide and self-harm, including the death of his twin brother, an imminent court hearing (scheduled for the day he was found hanged) and deteriorating mental health.

13. The second ACCT case review was completed by a single officer. We are concerned that there was no recognition at this review that Mr Whyte's mental health appeared to be deteriorating and that his risk was increasing. We are concerned that, as a result, his ACCT observations were not sufficiently frequent. We are also concerned that staff carried out ACCT observations at predictable intervals.

14. Mr Whyte's key worker told us that he saw Mr Whyte on the wing during the course of his work, but that he was not allocated specific time for his key worker duties (as required by Prison Service policy). As a result, he does not seem to have known Mr Whyte well. This may have been a missed opportunity to understand Mr Whyte's concerns and to identify that his mental health was deteriorating in the days before his death.

Impact of COVID-19 restrictions

15. As a result of the COVID-19 restrictions, Mr Whyte spent most of the day alone in his cell from 24 March onwards and there is little evidence that staff had any meaningful contact with him during this time. We consider that this is likely to have had a detrimental effect on his mental health and would also have meant that staff were much less likely to identify a deterioration in his mental health.

16. For most of his time at Wayland, Mr Whyte was seen regularly by a named mental health nurse (which was good practice). However, he was discharged from the mental health team's caseload a few days before his death as a result of COVID-19 restrictions. We are concerned that this may have been a missed opportunity to identify that his mental health was deteriorating.

Clinical care

17. The clinical reviewer concluded that the clinical and mental healthcare Mr Whyte received at Wayland was of a reasonable standard and equivalent to that which he could have expected to receive in the community.

Recommendations

- The Governor should ensure that staff manage prisoners at risk of suicide and self-harm in line with PSI 64/2011, including that:
    - they consider all relevant information that affects risk when completing the immediate action plan and set appropriate levels of observations and caremap objectives;
    - they review the prisoner’s level of risk whenever there is an event or change of circumstances that could impact on risk; and
    - ACCT reviews are multi-disciplinary.
- The Governor should:
    - share this report with the SO in the segregation unit and discuss the Ombudsman’s findings with him; and
    - review the SO’s suitability to be an ACCT case manager or trainer.
- The Governor should ensure that key workers are each allocated an average of 45 minutes per week to spend on key worker duties with each of their allocated prisoners, including having regular meaningful conversations, in line with HMPPS policy.

The Investigation Process

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

19. Due to restrictions in response to the COVID-19 pandemic, the investigator was unable to visit Wayland. She obtained copies of relevant extracts from Mr Whyte's prison and medical records by email.

20. NHS England commissioned a clinical reviewer to review Mr Whyte's clinical care at the prison. They jointly interviewed by telephone 13 staff on 28 and 29 July and 19 and 21 August 2020.

21. We informed HM Coroner for Norfolk of the investigation. The coroner sent us the results of the post-mortem examination. We have sent the coroner a copy of this report.

22. The Ombudsman's family liaison officer contacted Mr Whyte's mother to explain the investigation and to ask if she had any matters she wanted the investigation to consider. Mr Whyte's mother raised concerns about:

    - the management of Mr Whyte's risk of suicide and self-harm
    - his access to medication
    - if the prison GP spoke to him
    - why he had his shoe laces in his possession.

    We have addressed her questions in this report.

Background Information

HMP Wayland

23. HMP Wayland is a medium security prison in Norfolk, near Thetford. The prison holds just under 1,000 convicted adult male prisoners. Virgin Care provides healthcare services. Drug and alcohol services are provided by Phoenix Futures. There are no nurses on duty at night.

HM Inspectorate of Prisons

24. The most recent inspection of HMP Wayland was in June 2017. Inspectors found that staff took a courteous and constructive approach to prisoners, with most prisoners being reasonably positive about staff engagement with them. Inspectors also found that there were flaws in the ACCT case management documentation for prisoners at risk of suicide or self-harm, that caremap actions were not completed and ACCT monitoring sometimes stopped too quickly. Following the eight deaths in custody since the previous inspection, a healthcare action plan had been put in place and most recommendations had been satisfactorily implemented.

Independent Monitoring Board

25. 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 that it was concerned about staffing at Wayland. It noted that while staffing levels had risen significantly since the previous reporting year, this meant that many officers were new in post. The IMB noted that both officers and prisoners acknowledged that this impacted on safety and discipline within the prison.

Previous deaths at HMP Wayland

26. Mr Whyte was the fourth prisoner to die at Wayland since April 2018. Of the previous deaths, one was a self-inflicted death, one was a drug-related death and one death was from natural causes.

27. We have previously made a recommendation to Wayland about the need for ACCT caremap actions to be specific and meaningful and to address issues identified at assessment interviews and ACCT case reviews. The prison provided a comprehensive response setting out the actions they were taking to improve the quality of ACCT management.

Assessment, Care in Custody and Teamwork (ACCT)

28. ACCT is the Prison Service procedure used to support prisoners at risk of self-harm or suicide. 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.

29. There should be regular multi-disciplinary review meetings involving the prisoner. Part of the ACCT process involves assessing immediate needs and drawing up a caremap to identify the prisoner's most urgent issues and how they will be met. Guidance on ACCT procedures is set out in Prison Service instruction (PSI) 64/2011.

The key worker scheme

30. The HMPPS key worker scheme is intended to be an important means of reducing violence and self-harm in prisons. Under the Offender Management in Custody model each prison officer is the named key worker for five or six prisoners and should be allocated an average of 45 minutes per week to spend on key work duties with each prisoner, including having regular meaningful conversations with each prisoner.

Coronavirus (COVID-19)

31. On 11 March, the World Health Organisation declared COVID-19 a worldwide pandemic. To reduce the spread of the virus, the Government introduced voluntary and mandatory actions, such as 'social distancing' and 'lockdown' (on 16 and 23 March respectively).

32. On 13 March, Public Health England (PHE)'s National Health and Justice team issued an interim notice providing advice on preventing and controlling outbreaks of COVID-19 in prisons. HMPPS issued further instructions over the following weeks with guidance on the appropriate use of personal protective equipment (PPE), hygiene, cleaning schedules and stock checks.

33. On 24 March, HMPPS issued an instruction to all prisons to implement a restricted regime and to enforce social distancing of two metres for staff and prisoners wherever possible. The most vulnerable prisoners were to be identified and put into protective isolation.

34. On 31 March, HMPPS, in consultation with PHE, issued an order to significantly reduce transfers between prisons. Other measures, known as 'compartmentalisation' were also announced. These measures were designed to be implemented at local level, depending on the needs of each individual establishment, and included protective isolation units to accommodate known COVID-19 cases and shielding units to protect the most clinically vulnerable prisoners.

Key Events

35. Mr Whyte received his first custodial sentence in 1993 and had been in prison many times since. In August 2019, Mr Whyte's licence was revoked and he was recalled to HMP Thameside. On 30 August 2019, he was sentenced to four years in prison for attempted burglary of a dwelling with intent to steal, theft of a motor vehicle, and driving offences.

36. In 2010, Mr Whyte had been sectioned under the Mental Health Act and spent three and a half years in a medium secure psychiatric hospital. He was diagnosed with paranoid schizophrenia, schizoaffective disorder and social phobia and was prescribed antidepressants and antipsychotic medication.

37. Mr Whyte also had several physical health issues following a car crash in 2019 when he had sustained multiple fractures, including fractures of his spine.

38. Mr Whyte had a long history of drug misuse from the age of 12 years. During his time in prison custody, he was supported by the prisons' drug intervention teams and had successfully completed several detoxification programmes.

39. During a previous period in prison in April/May 2019, Mr Whyte was managed under ACCT procedures after he made cuts to his arms and said he was having suicidal thoughts. He said it was because he was grieving for his identical twin brother who had died in February.

40. When he arrived at Thameside in August 2019, he was located in the prison's healthcare unit because of his mental and physical healthcare issues. Staff recorded that he got on well with staff and other prisoners, was polite and complied with the regime.

HMP Wayland

41. Mr Whyte was transferred to HMP Wayland on 21 October 2019.

42. When he arrived, healthcare staff noted that he had a history of self-harm and suffered from social anxiety. He was referred to the mental health team. A nurse was appointed as his named mental health nurse and he was referred to the consultant psychiatrist.

43. In December, he was seen by the consultant psychiatrist. He said he heard voices. The psychiatrist noted that the diagnosis was unclear: the voices could be a sign of psychosis or could be the result of trauma/anxiety. He prescribed antipsychotic medication. The psychiatrist saw Mr Whyte again in January and February 2020.

44. Mr Whyte saw the mental health nurse every three or four weeks, with additional appointments as and when needed. She said he engaged very well and was mentally stable until just before his death with no sign that he was hearing voices. He told her that he suffered from anxiety triggered by thoughts of his dead twin, and that he struggled in large groups. She tried to help him with his social anxiety but there were occasions when he felt unable to come out of his cell to collect his medication.

45. Mr Whyte settled well at Wayland, obtained employment and worked with Phoenix Futures (the drug and alcohol service). His key worker saw him once or twice a month and reported that he was in good spirits and raised no issues. In January 2020, he was placed on the ‘enhanced’ regime.

46. On 27 February, the mental health nurse saw Mr Whyte for one of their regular meetings. She recorded that he said his main cause of stress was his ongoing court case and that it had been his twin brother who had committed the offences. He also told her that the previous day had been the anniversary of his twin’s death and that he was sleeping badly. This was her last meeting with Mr Whyte until just before his death.

47. In March, an officer who worked on Mr Whyte’s wing introduced himself to Mr Whyte as his new key worker. At interview the keyworker said he was not allocated dedicated time to carry out his key worker role because of staff shortages, so he did not have specific key worker sessions with Mr Whyte, but that he spoke to him in the course of his work on the wing and updated NOMIS regularly. He said that Mr Whyte got on well with staff and other prisoners but he was independent and seldom asked for anything. He said he was aware that Mr Whyte had a court case coming up and was expecting a long sentence, but he said Mr Whyte did “not seem fazed by that at all”. He said he was also aware that Mr Whyte had a twin brother but he did not know he was dead and had killed himself.

48. In common with other prisons in England and Wales, Wayland introduced a very restricted regime from 24 March, designed to restrict the spread of COVID-19. As a result, prisoners were locked in their cells for around 23 hours a day and only allowed out for essential purposes such as exercise and collecting meals and medication.

49. On 25 March, Mr Whyte had a court hearing via video link for outstanding charges of kidnap related to his current offence. A trial date was set for 22 April. Mr Whyte said that these offences had been committed by his twin brother. He was concerned that if convicted, he would receive a long custodial sentence. Because of the outstanding charges, Mr Whyte was to be transferred to HMP Norwich, and his enrolment onto offending behaviour programmes was placed on hold.

50. On 4 April, Mr Whyte’s key worker recorded that, although they had had several dealings, there was nothing of note to report and that the ongoing COVID-19 lockdown meant that “there is nothing much happening in general”.

51. On 15 April, Mr Whyte made a self-referral to the prison’s mental health team. The mental health nurse and the mental health in-reach team lead considered whether Mr Whyte met the temporary COVID-19 criteria for mental health care under the guidance issued by the healthcare provider. They agreed that Mr Whyte should be discharged from the prison’s mental health team under the criteria because his presentation was stable, he was compliant with his medication and he was under the supervision of a consultant psychiatrist. This meant that Mr Whyte would not receive any contact from the mental health team unless he or a member of staff asked to see them. Mr Whyte was informed of this decision by letter.

52. On 17 April, the keyworker recorded that Mr Whyte was "generally getting on with things" and said he did not need anything. At interview the keyworker said he had not seen Mr Whyte that day and his entry referred to the previous days.

Events of 18 April

53. At lunchtime on 18 April, the keyworker noticed that Mr Whyte had not come to collect his meal and went to call him. He said Mr Whyte was sitting at the back of his cell and did not respond, which was unusual. Shortly afterwards, at 12.45pm, Mr Whyte barricaded himself behind his cell door with furniture and refused to speak to staff or remove the barricade. He passed a note under his cell door saying that he wanted to be taken to the segregation unit.

54. A Supervising Officer (SO) from the Safer Custody Team spoke to him from outside the cell window to try to engage him and get him to remove the barricade. The SO told the investigator that Mr Whyte was sitting on his chair and he could see that he had made cuts to his arms using a tin lid. He said Mr Whyte initially responded but did not say why he was harming himself and that he was very quiet and appeared to be scared, and that he made further cuts to his arms every time he spoke. At 1.00pm, staff began ACCT procedures.

55. A Duty Governor decided that staff needed to intervene and enter the cell for Mr Whyte's own safety. At 1.30pm, staff forcibly entered Mr Whyte's cell and restrained him. The keyworker said that Mr Whyte went "absolutely wild" when staff entered the cell and reacted so violently that he cracked the officers' shield. He said he was shocked as this was out of character. CCTV footage shows staff making attempts to de-escalate the situation and Mr Whyte struggling and being violent toward staff while being restrained and handcuffed. He was taken to the segregation unit.

56. At 1.53pm, the SO completed an immediate ACCT action plan. He assessed Mr Whyte's level of risk as 'raised' and set observations at five times an hour until his ACCT assessment, which was scheduled for 3.00pm.

57. When he arrived at the segregation unit, Mr Whyte was seen by a duty nurse. The nurse dressed the cuts he had made to his arms and recorded that he had not received any injuries from being restrained.

58. Staff started a defensible decision log (record of manager's decisions) and considered the items Mr Whyte had in his possession and the risk they posed, including his clothing and items in the cell. As Mr Whyte had become calm and compliant, he was allowed to keep his possessions, except for a television as there was no electricity in the cell.

59. Because Mr Whyte was on an ACCT, the Duty Governor considered alternative options to segregating him. She concluded that there was no alternative to the segregation unit because of the violence he had displayed to staff. She recorded that a mental health nurse agreed with this decision and said that she was concerned about locating him on a wing.

60. At 3.00pm, a trained ACCT assessor carried out an ACCT assessment. She recorded that Mr Whyte said he had self-harmed because he believed other prisoners were trying to get at him and torture him, and that it had been a

genuine attempt to kill himself. He said he had had “a lot of loss” recently, that he was potentially facing a long sentence at his imminent trial, that he wanted to stay in the segregation unit where he felt safe, and that he wanted to be sectioned under the Mental Health Act.

61. At 3.15pm, the SO chaired Mr Whyte’s first ACCT case review. Mr Whyte, the trained ACCT assessor and a nurse attended. The SO recorded that Mr Whyte displayed poor eye contact and spoke about his thoughts of people wanting to harm him, wanting to be hospitalised and about the therapy had had received in the past which he said was helpful. It was agreed that he would stay in the segregation unit because he felt safe there. They identified Mr Whyte’s risk factors as his brother’s death and his imminent court case. They assessed his level of risk as ‘raised’ and the frequency of observations was set at hourly intervals.

62. There was only one caremap action: “to maintain dialogue with the mental health in-reach team”. It was agreed that the prison’s mental health team would discuss Mr Whyte with his consultant psychiatrist (who was more familiar with him) on 20 April; and that he would be supported by a prison healthcare nurse and the prison’s mental health team. (The 20 April appointment did not take place.)

63. At interview, the SO said that Mr Whyte seemed happy to be in the segregation unit and just wanted to be left alone. Neither he nor the unit staff were concerned about him. He said Mr Whyte spent his time lying on his bed staring into space and did not ask staff for anything, and there was, therefore, nothing they could “progress”.

64. The SO said that during the ACCT review Mr Whyte mentioned the death of his twin brother and that he had previously been in a secure psychiatric hospital and “all his information was passed to the mental health team and they were going to be doing the investigation on it to find out the truth”. He said there was only the one caremap action because at that time they “wanted to see if what [Mr Whyte] was saying was honest and open” and then they would “look at that and work on that and then to ascertain why”. However, he said they did not hear back from the mental health team before Mr Whyte’s death.

Events of 19 April

65. At 9.34am on 19 April, Mr Whyte telephoned his mother. He told her that he had barricaded himself in his cell and that staff had used force to remove him. He said that his “head was coming off” so he just wanted to have some time behind his door. He spoke about his imminent court case and said he was desperate to see his psychiatrist on 20 April. Mr Whyte told his mother that he was taking his medication and that he was ok.

66. During the day, staff recorded that Mr Whyte said he was happy to be in the segregation unit and that he was polite and raised no issues apart from asking for his glasses and to see someone from psychology.

Events of 20 April

67. At 8.39am, staff offered Mr Whyte breakfast, but he declined. He said that he wanted to be left alone. When a prison GP conducted a check on him at 8.50am, he told her that he had no issues.

68. At 9.30am, the Duty Governor opened Mr Whyte's cell door to talk to him. Mr Whyte threw his flask at him, hitting his head.

69. At 9.35am, the SO attempted to hold an ACCT case review but Mr Whyte refused to engage. The SO recorded in the ACCT document that Mr Whyte was too great a risk to unlock his cell to conduct an ACCT case review and that he would reschedule the review for 21 April. He did not change Mr Whyte's level of risk or frequency of observations.

70. At interview the SO said that he did not consider whether Mr Whyte's aggressive behaviour should have prompted him to review Mr Whyte's risk. He said that if he had been instructed by a governor grade to reassess Mr Whyte's risk after the incident, he would have done so, but he did not know what had led to the incident – it might have been "a one off" - and he did not consider it was for him to get involved with as he was managing Mr Whyte's act of self-harm.

71. Later that day, the Duty Governor placed Mr Whyte on a disciplinary charge for assault. A hearing was scheduled for 22 April. His unlock level was raised to four officers in personal protection equipment (PPE).

72. At 10.15am, a nurse spoke with Mr Whyte through the observation panel of his cell door. She did not enter the cell because of his aggressive behaviour earlier that day. She told the investigator that Mr Whyte was lying on his bed and said that he said he wanted to be left alone and had nothing he wanted to discuss. The nurse considered that his behaviour was due to possible drug use or stress relating to his pending court case. She recorded in his medical record that he had no acute mental illness.

73. Apart from taking his medication at 5.40pm, Mr Whyte refused his meals and medication for the remainder of the day. Staff said that they tried to engage with him but that he was 'dismissive'. Staff did not review his level of risk or frequency of observations.

Events of 21 April

74. At 9.40am, the SO carried out an ACCT review. The review was carried out without Mr Whyte's participation (because he refused to engage). Healthcare staff provided their input via telephone. The SO recorded that he had been to see Mr Whyte to try to persuade him to engage but that Mr Whyte would not speak to him and that unit staff said he had refused any form of regime and "worryingly declined his medication which is beneficial for him to take". He made no changes to Mr Whyte's level of risk, the frequency of observations or caremap actions, noting that there was "no significant change of risk to himself".

75. At interview, the SO said that he did not know Mr Whyte was refusing food and medication. When he was asked if this would have changed his assessment of Mr Whyte's risk, he said "potentially", but that the reasons for his food refusal

would have been risk assessed separately and that he did not know what effect not taking the medication might have. He emphasised that governor grades saw Mr Whyte regularly and that if they had told him that Mr Whyte's risk needed to be reviewed or his observations needed to be changed, he would have done it.

76. Between 6.00pm and 6.10pm, Mr Whyte pressed his emergency cell bell, banged on his door and shouted. Officers responded and Mr Whyte came to his door to talk to them. Staff said that it was difficult to understand what Mr Whyte was saying and that he appeared distressed. He told them that he wanted his mother and asked them to stop hurting her. They reassured Mr Whyte that this was not happening, which they said calmed him down. Staff did not review his level of risk or frequency of observations.

Events of 22 April

77. At 5.40am, an officer went to check Mr Whyte as part of his routine ACCT monitoring. He told the investigator that Mr Whyte had been asleep in bed when he had conducted the previous checks, but he was awake this time and said he was not feeling well. The officer said he told him to press his emergency cell bell if he started to feel worse and that a prison GP would see him later. The officer said that Mr Whyte said that he would be alright and that he was just feeling "a little rough".

78. At 6.35am, the officer checked on Mr Whyte again. He looked into the cell and saw Mr Whyte with his shoelaces around his neck hanging from his bedframe. He immediately radioed an emergency code blue, indicating that a prisoner is unresponsive or having breathing difficulties.

79. A Principal Officer (PO) responded. He was outside the segregation unit having just arrived on duty for the day. He immediately entered Mr Whyte's cell, followed by the officer. He told the investigator that when he arrived at the cell, the officer looked shocked, but this did not delay them entering the cell. An ambulance was called at 6.39am.

80. The PO cut the ligature from around Mr Whyte's neck and together they laid him on the floor. They checked for signs of breathing and pulse but found none. More staff arrived and they started CPR while the officer collected a defibrillator. Staff applied the defibrillator, but no shock was advised.

81. Staff can be seen on CCTV leaving the cell, securing the door then returning shortly after. The PO told the investigator that the emergency ambulance operator advised them to continue with CPR, but the defibrillator advised no shock to be applied. Staff said that it was evident that Mr Whyte had died, and PO Reed decided to stop CPR.

82. At 7.00am, an ambulance arrived at the prison and at 7.10am, paramedics confirmed that Mr Whyte had died.

Contact with Mr Whyte's family

83. At 9.20am on 22 April, a prison Family Liaison Officer (FLO) contacted Mr Whyte's mother, his named next of kin, to inform her of her son's death. Due to COVID-19 restrictions, the FLO made contact by telephone instead of visiting Mr

Whyte's mother in person. He remained the point of contact for the family, providing support.

84. The prison contributed to the cost of Mr Whyte's funeral in line with prison policy.

Support for prisoners and staff

85. The Governor conducted a debrief with staff closely involved in the care and emergency response for Mr Whyte, and the staff care team offered support.

86. The prison posted notices informing prisoners of Mr Whyte'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 Whyte's death.

Post-mortem report

87. The pathologist concluded that Mr Whyte died from ligature compression of the neck.

88. The toxicology report did not detect any illicit substances in Mr Whyte's blood and urine. There was a therapeutic level of mirtazapine (an antidepressant which Mr Whyte was prescribed) and low levels of his other prescription drugs, including quetiapine (an antipsychotic) and dihydrocodeine (a painkiller). The toxicologist said this was consistent with Mr Whyte having taken his medication irregularly or having stopped taking it in the days before his death.

Findings

Management of Mr Whyte's risk of suicide and self-harm

89. Mr Whyte was being managed under ACCT procedures when he hanged himself. We have, therefore, considered whether his risk to himself was appropriately assessed and managed.

90. PSI 64/2011 lists a number of risk factors and potential triggers for suicide and self-harm. It says all staff should be alert to the increased risk of self-harm or suicide posed by prisoners with these risk factors and should act appropriately to address any concerns.

91. Until the last few days before his death, Mr Whyte was on the 'enhanced' regime level and apparently got on well with staff and other prisoners. He was well-supported by his named mental health nurse, he was considered to be mentally stable and he had not self-harmed for the six months he had been at Wayland. The investigation found that most of the staff responsible for Mr Whyte's care knew him relatively well and thought his behaviour of barricading and aggression on 18 April was very out of character. We are concerned they did not give enough consideration to whether this sudden and dramatic change in his behaviour indicated that there had been a significant deterioration in his mental health.

92. At his ACCT assessment later that day, Mr Whyte said he had barricaded and self-harmed because he was hearing voices and thought other prisoners were going to get into his cell and torture him and was adamant that the voices he heard were 'real'. It is possible that Mr Whyte's mental health had deteriorated very suddenly, with no warning. However, we are concerned that there may have been signs that went unnoticed because of the COVID-19 lockdown which meant that staff had less contact with Mr Whyte. We note that Mr Whyte had asked to see his named mental health nurse on 15 April and, although this was not particularly out of the ordinary for him, it may have been an indication that he felt his mental health was deteriorating. We are concerned that he was not seen by the nurse as he had been discharged from the mental health team under the COVID-19 guidance as he was considered to be mentally stable.

93. Mr Whyte had a number of risk factors for suicide and self-harm in the days leading to his death including acts of self-harm, deteriorating mental health (including increased paranoia and possible delusions), anxiety about his imminent court appearance scheduled for 22 April, ongoing grief about the death of his identical twin, and refusal of medication and food.

94. Prison staff appropriately began ACCT procedures after Mr Whyte self-harmed on 18 April. However, we consider that they did not explore and address all of Mr Whyte's issues, including the reasons for barricading himself in his cell and self-harming, throwing a flask at a Duty Governor, refusal of food and medication, disengaging with staff, or his paranoid concerns about staff hurting his mother.

95. Although Mr Whyte was appropriately referred to the consultant psychiatrist at the ACCT review on 18 April, the appointment planned for 20 April did not take place. We found the SO's explanation of the reason for the mental health referral

- that it was to check if what Mr Whyte said about his brother's death and his previous time in a psychiatric hospital was true – very difficult to understand and we were not confident that the SO understood that Mr Whyte's behaviour might be the result of mental health problems.

96. We are also concerned that the SO (who had never met Mr Whyte before 18 April) saw Mr Whyte's uncharacteristic aggression towards the Duty Governor on 20 April purely as a behavioural issue, quite separate from Mr Whyte's self-harm, and did not consider whether it might be a sign of deteriorating mental health. As a result, he did not consider reassessing Mr Whyte's risk after the incident on 20 April and did not raise his level of observations. We consider that this was an error of judgement.

97. A further cause for concern was that Mr Whyte refused food from lunchtime on 20 April and medication from the evening of 20 April. At interview, the SO said he did not know this, but it is clear from his NOMIS note that he did know when he conducted Mr Whyte's ACCT review on the morning of 21 April. When asked he said that Mr Whyte's food refusal would have been assessed separately and that he was not medically trained and therefore he did not know what effect not taking the medication would have. We consider that he should have checked the possible effects with healthcare staff and that this should also have prompted him to consider whether Mr Whyte's risk should be reassessed or his observations increased.

98. We are also concerned that the SO considered that there was nothing staff could "progress" unless Mr Whyte engaged with them and made his needs known. Mr Whyte had told the ACCT assessor on 18 April that he was hearing voices and feeling paranoid and fearing for his safety. The SO could not, therefore, assume that he was thinking rationally and would be able to tell staff what he needed. It was for staff to identify what he needed to keep him safe and to put that in place. We consider that should have involved more frequent observations until he could be assessed by the psychiatrist.

99. In addition, although Mr Whyte had said at his ACCT assessment on 18 April that he was concerned that he was facing a long sentence at his trial (which was scheduled for 22 April), there is no evidence that the SO considered whether this increased Mr Whyte's risk, particularly as the date drew nearer.

100. Although we recognise that the SO acted conscientiously, and that he was shocked and distressed by Mr Whyte's death, we are concerned that he did not have a good understanding of risk assessment and management, particularly since he trains new staff on ACCT. He repeatedly said at interview that he would have reassessed Mr Whyte's level of risk or increased the frequency of his observations if he had been told to by a governor grade. However, we consider that it was his responsibility as the ACCT manager to make these decisions and he could have sought advice if he was uncertain.

101. We are also concerned that the SO conducted the ACCT review on 21 April by himself, although healthcare staff apparently contributed in advance by telephone. As Mr Whyte's mental health was a key risk factor, we consider that the ACCT reviews should have been properly multi-disciplinary. We do not know if

healthcare staff did not attend in person because of COVID-19 restrictions or if they were not invited to attend.

102. Finally, we are concerned that staff carried out ACCT observations at predictable intervals.

103. We make the following recommendations:

The Governor should ensure that staff manage prisoners at risk of suicide and self-harm in line with PSI 64/2011, including that:

- **they consider all relevant information that affects risk when completing the immediate action plan and set appropriate levels of observations and caremap objectives;**
- **they review the prisoner's level of risk whenever there is an event or change of circumstances that could impact on risk; and**
- **ACCT reviews are multi-disciplinary.**

The Governor should:

- **share this report with the SO in the segregation unit and discuss the Ombudsman's findings with him; and**
- **review the SO's suitability to be an ACCT case manager or trainer.**

The key worker scheme

104. In prisons where the key worker role is working well, key workers can play an important role in identifying a prisoner's underlying issues and picking up on changes in a prisoner's mood and behaviour. However, although Mr Whyte's key worker put reasonably regular entries on Mr Whyte's electronic record, he told us that he did not have dedicated time to spend on his key worker role and simply spoke to Mr Whyte in the course of his work on the wing (which is not how the key worker scheme is intended to operate). He did not, therefore, have the opportunity to have any meaningful conversations with Mr Whyte and seems to have seen his role mainly as that of resolving any specific issues Mr Whyte might raise with him. In practice Mr Whyte did not raise any issues.

105. As a result, it is clear that the keyworker did not know Mr Whyte well – for example, he did not know his twin brother was dead – and was not well placed to pick up on Mr Whyte's concerns or any changes in his mood. This was not keyworker's fault, but the lack of a properly functioning key worker scheme was a missed opportunity to have identified a potential deterioration in Mr Whyte's mental state in the days before his death. We recommend:

The Governor should ensure that key workers are each allocated an average of 45 minutes per week to spend on key worker duties with each of their allocated prisoners, including having regular meaningful conversations, in line with HMPPS policy.

Segregation and ACCT

106. PSI 64/2011 says that prisoners assessed as at risk of suicide and self-harm should be segregated only in exceptional circumstances and that the reasons must be clearly documented in the ACCT record, to include other options considered and discounted. Mr Whyte was segregated on the same day that his ACCT was opened. We are satisfied that staff documented their consideration of his risk and alternative options to segregation. We make no recommendation.

Impact of COVID-19 restrictions

107. The restrictions introduced in response to the COVID-19 pandemic impacted on Mr Whyte in two main ways. First, it meant that from 24 March onwards, he spent around 23 hours a day alone in his cell with very little contact with staff or other prisoners. We are concerned that this may have had a negative effect on his mental health and may also have meant that signs that his mental health was deteriorating went unnoticed.

108. Second, it meant that he was discharged from the mental health team's caseload (as he was considered mentally stable). He had not been seen by his named mental health nurse after 27 February and was not seen when he asked to see her on 15 April. Again, we are concerned that signs that his mental health was deteriorating may have gone unnoticed as a result.

Emergency response

109. Prison Service guidance on resuscitation says resuscitation must be started on all prisoners who are found not breathing and/or pulseless unless certain conditions exist. The European Resuscitation Council Guidelines for Resuscitation 2015 say that "resuscitation is inappropriate and should not be provided when there is clear evidence that it will be futile" (for example, where rigor mortis has set in and where blood polling has occurred).

110. The PO made the decision to stop CPR despite being told by the emergency services to continue. Mr Whyte was described as having no colour, blood pooled in his feet and ankles, and no apparent life signs. The PO concluded that Mr Whyte had clearly died and that to continue would have been distressing for staff and undignified for Mr Whyte. We consider that the PO acted in accordance with the guidance and we make no recommendation.

Clinical care

111. The clinical reviewer found that the physical and mental healthcare Mr Whyte received at Wayland was of a reasonable standard and equivalent to that which he could have expected to receive in the community.

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