Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Lewis Johnson, a prisoner at HMP Wealstun, on 12 December 2019

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Our vision

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

Our values

We are:

Impartial: we do not take sides

Respectful: we are considerate and courteous

Inclusive: we value diversity

Dedicated: we are determined and focused

Fair: we are honest and act with integrity

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

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

Mr Lewis Johnson died in hospital on 12 December 2019, after being found hanging in his cell at HMP Wealstun earlier that day. He was 34 years old. I offer my condolences to Mr Johnson's family and friends.

Staff monitored Mr Johnson under suicide and self-harm prevention procedures (known as ACCT) from 23 to 26 October, after he said he had made a noose. He was not being monitored when he died.

Mr Johnson had a history of substance misuse and used psychoactive substances (PS) on at least four occasions at Wealstun. He spent six weeks on the basic regime in October and November because of his drug use. Around a month before he died, he stopped going to his education classes because he said he had 'safer custody issues', though he did not give details. It became apparent after his death, from telephone calls he made to his mother, that he felt under threat from other prisoners because of drug debts.

The investigation found that the ACCT procedures were poorly managed, with inadequate caremap actions to address Mr Johnson's risks. Violence reduction measures were not started, despite staff knowing that Mr Johnson was refusing to attend classes because of fears for his safety. There were also failings in how Mr Johnson's period on the basic regime was managed.

The investigation also found there were significant delays in the emergency response when staff found Mr Johnson hanging. I cannot say whether the delays made a difference to the eventual outcome but we know that in an emergency situation, a delay of a few minutes may be critical.

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 **July 2020**

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Summary

Events

1. Mr Lewis Johnson was recalled to prison on 26 April 2019, after breaching his licence conditions and committing further offences. He was moved to HMP Wealstun on 9 May.

2. Mr Johnson had a history of substance misuse and mental health issues. He was found under the influence of psychoactive substances (PS) at Wealstun on four occasions: in August, twice in October and three days before he died. As a result, he was on the basic level of the Incentives and Earned Privileges (IEP) scheme from 6 October to 15 November, and from 9 December.

3. Between 23 and 26 October, staff managed Mr Johnson under Prison Service suicide and self-harm prevention procedures (known as ACCT) after Mr Johnson said that he had made a noose. He told staff that he was not sleeping well and that he had been doing silly things as a result.

4. In November, Mr Johnson stopped going to his education classes because he said he had 'safer custody issues' but was reluctant to give details. Mr Johnson made several telephone calls to his mother in the week before he died, during which he told her that he felt under threat because he owed money to other prisoners. Staff were unaware of the content of these calls, though they suspected Mr Johnson had drug debts.

5. On 12 December at around 4.42am, the night patrol officer saw Mr Johnson hanging in his cell. He called for assistance and officers arrived. They cut him down and asked the control room to call an ambulance. When the custodial manager arrived, he asked staff to leave the cell and they all returned to the wing office. When one of the officers queried why they had not started cardiopulmonary resuscitation (CPR), staff returned to the cell and started CPR.

6. Paramedics arrived at the cell at 5.18am. They managed to re-establish a pulse and took Mr Johnson to hospital. However, Mr Johnson did not regain consciousness and at 10.56am, he died.

Findings

7. Staff managed the ACCT procedures poorly in October. The caremap was inadequate and staff stopped ACCT procedures before all the caremap actions were completed. When Mr Johnson was found under the influence of drugs during the post-closure period, nobody considered reassessing his risk.

8. Staff were aware that Mr Johnson was self-isolating and refusing to attend education classes due to 'safer custody issues', yet no one considered starting violence reduction measures or reassessed his risk of suicide or self-harm.

9. Mr Johnson spent 41 days on the basic IEP regime during October and November. There is no evidence his IEP status was considered during the ACCT reviews, no evidence of meaningful interaction to help him progress to the

standard regime and the objectives set were generic, with little meaning. Although Mr Johnson was listed as a complex case for discussion at a weekly multidisciplinary meeting, there is no evidence his needs were discussed or properly considered.

10. The clinical reviewer concluded that the mental health care Mr Johnson received at Wealstun was not equivalent to that he could have expected to receive in the community. When he arrived at Wealstun, Mr Johnson was not referred to the mental health team as he should have been and his request for medication to help him sleep was never addressed.

11. The emergency response was very poorly managed. There was a delay when Mr Johnson was found hanging. Staff failed to call a medical emergency code, which led to a delay in calling an ambulance, and staff delayed starting CPR. The ambulance was also delayed getting through the prison gate. It is not possible to say whether these delays affected the eventual outcome for Mr Johnson, but we know that in an emergency situation, a delay of a few minutes could be critical.

Recommendations

- The Governor and Head of Healthcare should ensure that staff manage prisoners at risk of suicide and self-harm in line with national guidelines, in particular, staff should:
  - ensure case reviews are multidisciplinary, with healthcare staff in attendance where appropriate;
  - set caremap actions that are specific, meaningful and tailored to the individual to reduce their risk;
  - ensure all actions are completed before stopping ACCT procedures; and
  - reassess risk if a significant event occurs during the post-closure period and restart ACCT procedures if necessary.

- The Governor should ensure that staff identify and manage prisoners at risk of bullying, intimidation or violence in line with the prison's violence reduction policy. In particular all staff should:
  - receive training on CSIP and understand the referral process and expectations of their role;
  - provide effective support and protection for apparent victims with meaningful objectives and long-term solutions, which address their individual situations; and
  - consider whether apparent victims are at increased risk of suicide and self-harm.

- The Governor should ensure prisoners on the basic IEP regime:
  - are given clear and realistic targets to help them progress to standard, and these are recorded on the prisoner's prison record; and
  - are given appropriate support to help them progress where they have been identified as being at risk of suicide and self-harm.

- The Head of Healthcare should ensure that:
    - reception staff make mental health referrals where appropriate;
    - prison GPs work more proactively with the mental health service to ensure that other treatment options are considered if they feel a suggested medication is not appropriate;
    - when prisoners have multiple services involved, such as DARS and mental health, they consider using a care co-ordinator or lead professional to coordinate care plans and interventions; and
    - all users of the electronic medical record (SystmOne) are provided with training on how to check on the completion of tasks, to reduce the likelihood of missed tasks.

- The Governor should ensure that all staff understand PSI 03/2013 and their responsibilities during medical emergencies, including that:
    - staff carry out basic life support without delay until healthcare or ambulance staff arrive; and
    - all staff know where defibrillators are located.

- The Governor should share this report with a CM and personally discuss the Ombudsman's findings with him.
- The Governor should share this report with a SO and an Officer and arrange for a senior manager to discuss the Ombudsman's findings with them.

The Investigation Process

12. The investigator issued notices to staff and prisoners at HMP Wealstun, informing them of the investigation and asking anyone with relevant information to contact her. Nobody responded.

13. The investigator obtained copies of relevant extracts from Mr Johnson's prison and medical records.

14. NHS England commissioned an independent clinical reviewer to review Mr Johnson's clinical care at the prison.

15. The investigator interviewed ten members of staff at Wealstun on 22 and 23 January. The clinical reviewer accompanied her on 22 January. In addition, the investigator interviewed a nurse by telephone in February 2020.

16. We informed HM Coroner for Yorkshire West Eastern of the investigation. The coroner gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

17. The investigator contacted Mr Johnson's next of kin to explain the investigation and ask if the family had any issues they wanted the investigation to consider. Mr Johnson's next of kin wanted to know what happened in the weeks leading up to Mr Johnson's death and on the night he died. We have answered her questions in this report.

18. Mr Johnson's next of kin received a copy of the initial report. She did not identify any factual inaccuracies.

19. The prison also received a copy of the report and did not identify any factual inaccuracies.

Background Information

HMP Wealstun

20. HMP Wealstun is a category C prison near Wetherby, West Yorkshire, which holds up to 832 men. Care UK provides health services.

21. In August 2018, Wealstun was selected to be part of the '10 Prisons Project', which seeks to improve safety, security and decency in the prisons involved. The project is focusing on reducing violence, improving living conditions, preventing drugs from entering the establishment and enhancing the leadership and training available to staff.

HM Inspectorate of Prisons

22. The most recent inspection of HMP Wealstun was in October 2019. Inspectors reported that there had been a decline in safety and purposeful activity since their last inspection. Healthcare provision was good, as were staff prisoner relationships.

23. Inspectors reported that the ready availability of illicit drugs undermined much of what the prison was trying to achieve. 69% of prisoners said it was easy to obtain drugs, and nearly a quarter of all prisoners said they had acquired a drug habit since entering the jail. The prison had benefitted, belatedly, from being part of the '10 Prisons Project' and as a result now had some modern technology in place to help detect drugs and enhanced physical security to help keep them out.

24. Inspectors found the positive impact of technology and physical security improvements was compromised by the lack of response to intelligence reports. Far too little targeted searching or testing had been carried out which, because the intelligence itself appeared to be of good quality, was a missed opportunity. There was no clear overall strategy to deal with the drugs supply problem.

25. Inspectors were disturbed to find that levels of self-harm had increased six-fold since the last inspection. Prisoners who were subject to ACCT case management procedures generally felt well supported. However, inspectors found the quality of recording in ACCT documents was far too variable.

26. Inspectors noted that the staffing of the safer custody team had recently been increased, which allowed them to be more proactive in their approach, and three safer custody officers now investigated every violent incident. The new head of function had provided clear direction, targeting the use of challenge, support and intervention plans (CSIPs) more effectively. These plans were of good quality and provided effective actions and monitoring to support the individuals involved. Wing managers acted as the case managers for these CSIPs, holding reviews and sharing information among wing staff, who were aware of each case on their wing.

27. The monthly safety meeting had been combined with the security meeting, and a large amount of data was fed into this forum. This was a detailed meeting and it had an overview of all cases of self-harm and violence across the prison, viewed all quality assurance data and brought together a number of key areas in creating

a safer prison. However, it did not produce any focused actions or plans to reduce violence across the prison.

28. Targets for prisoners on the basic level of the incentives and earned privileges (IEP) scheme were not always individualised, and reviews were sometimes late or missed.

Independent Monitoring Board

29. 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 most recently published annual report for the year ending 31 May 2019, the Board noted that it had been an extremely difficult year for Wealstun, impacted by a significant level of violence and self-harm.

30. The Board found the volume of drugs entering the prison fluctuated, but had not significantly reduced. However, positive mandatory drug tests had fallen from 50% to 20.9%. The Board noted the volume of violence, bullying and self-harm remained high.

31. The Board identified that continued changes of role for senior staff hampered continuity of management and that the majority of wing staff had less than two years' experience. The Board considered the lack of support, staffing shortfalls and frequent changes of leadership roles resulted in the prison struggling to achieve satisfactory standards at times.

Previous deaths at HMP Wealstun

32. Mr Johnson was the fifth prisoner to die at Wealstun since December 2017. Of the previous deaths, two were self-inflicted (one soon after release), one was drug-related and the cause of death in other is not yet known. In previous investigations we have highlighted the need for improved suicide and self-harm awareness procedures, an effective drug strategy and the correct use of emergency codes.

Assessment, Care in Custody and Teamwork

33. ACCT is the Prison Service care-planning system used to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk, how to reduce the risk and how best to monitor and supervise the prisoner.

34. After an initial assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. Checks should be irregular to prevent the prisoner anticipating when they will occur. There should be regular, multi-disciplinary review meetings involving the prisoner. As part of the process, a caremap (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.

35. 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, Safer Custody.

Incentives and Earned Privileges Scheme (IEP)

36. Each prison has an incentives and earned privileges (IEP) scheme which aims to encourage and reward responsible behaviour, encourage sentenced prisoners to engage in activities designed to reduce the risk of re-offending 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 wear their own clothes. There are four levels, entry, basic, standard and enhanced.

Psychoactive Substances (PS)

37. Psychoactive substances (formerly known as 'new psychoactive substances' or 'legal highs') are a serious problem across the prison estate. They are difficult to detect and can affect people in a number of ways including increasing heart rate, raising blood pressure, reducing blood supply to the heart and vomiting. Prisoners under the influence of PS can present with marked levels of disinhibition, heightened energy levels, a high tolerance of pain and a potential for violence. Besides emerging evidence of such dangers to physical health, there is potential for precipitating or exacerbating the deterioration of mental health with links to suicide or self-harm.

38. In July 2015, we published a Learning Lessons Bulletin about the use of PS (still at that time NPS) and its dangers, including its close association with debt, bullying and violence. The bulletin identified the need for better awareness among staff and prisoners of the dangers of PS; the need for more effective drug supply reduction strategies; better monitoring by drug treatment services; and effective violence reduction strategies.

39. HM Prison and Probation Service (HMPPS) now has in place provisions that enable prisoners to be tested for specified non-controlled psychoactive substances as part of established mandatory drugs testing arrangements. Testing has begun, and HMPPS continue to analyse data about drug use in prison to ensure new versions of PS are included in the testing process.

Key Events

40. Mr Lewis Johnson was released on licence from HMP Leeds on 12 February 2019. On 15 February, his probation officer recalled him because he had failed to attend his appointments, but police did not arrest him until 25 April. The next day, Mr Johnson appeared at Leeds Magistrates' Court, charged with new offences of fraud, and was sentenced to 24 weeks imprisonment. He was sent to Leeds.

41. Mr Johnson had a history of depression and anxiety, and an extensive history of alcohol and drug misuse. When Mr Johnson arrived at Leeds on 26 April, he tested positive for opiates and methadone (an opiate substitute). He also showed signs of alcohol withdrawal. A prison GP prescribed methadone and medication for alcohol withdrawal, and staff monitored him regularly.

HMP Wealstun

42. Mr Johnson was moved to HMP Wealstun on 9 May. At his initial health screen, A nurse noted Mr Johnson's history of alcohol and drug misuse and referred him to the drug and alcohol recovery service (DARS – a service provided by Inclusion). Although she noted that Mr Johnson would be referred to the mental health team, there is no evidence he was. Mr Johnson's methadone prescription was continued.

43. On 17 May, a member of staff from the DARS team, completed a substance misuse assessment. Mr Johnson told him that after he was released in February, he had started using illicit methadone as well as heroin and had dropped out of treatment. The staff member gave Mr Johnson harm reduction advice, including the risk of mixing substances and using psychoactive substances (PS, also known as 'Spice'). Mr Johnson said he felt good emotionally and that he did not need support from DARS. (A member of the DARS team met with him again in August and noted that he remained stable on his methadone.)

44. On 18 June, a nurse from the substance misuse team (IDTS - integrated drug treatment services) met with Mr Johnson for his initial IDTS assessment. (Although Mr Johnson had been referred to DARS at reception, he was not referred to IDTS.) She noted that Mr Johnson said he was stable on 30mls of methadone, was not using illicit substances and had no cravings. The nurse provided advice and information about the risks of overdose and started a care plan, to be reviewed every three months.

45. On 2 July, an officer completed a Challenge, Support and Intervention Plan (CSIP – violence reduction measures) referral after Mr Johnson told him that he could not go to the workshop as he had been threatened by other prisoners. (He said this related to an issue outside the prison, but he was not clear about exactly what.) Mr Johnson said he was annoyed as he enjoyed his job. On 8 July, a Custodial Manager (CM) completed her CSIP investigation. Mr Johnson told her that he had not received any threats and did not want any action taken. The CM closed the referral and noted that the wing staff would look out for any ongoing issues.

46. On 12 July, a case administrator from the Offender Management Unit (OMU), noted in Mr Johnson's prison record that the Parole Board had deferred a decision

on his release and had requested further reports. (Mr Johnson had a release date of 23 July 2020 from his original sentence of 32 months for burglary, but was waiting for a parole review of his recall.)

47. On 13 August, an officer noted on Mr Johnson's prison record that he had 'issues' with another prisoner on the wing. Prison staff spoke to the other prisoner who said there had been problems with Mr Johnson outside the prison, and that he could not work in the same workshop and wanted to be moved.

48. During the Bank Holiday weekend of 24–26 August, Mr Johnson and at least eight other prisoners were suspected of being under the influence of drugs. Staff submitted an intelligence report, which noted that healthcare staff were not required and no action was taken.

49. On 27 August, Mr Johnson was removed from the tiling workshop after he made violent threats to the tutor. Mr Johnson was placed on a disciplinary charge. On 29 August, Mr Johnson pleaded guilty to the charge of using threatening, abusive or insulting words, and lost seven days privileges and 50% of his earnings as punishment.

50. On 5 September at 4.42pm, an officer recorded in Mr Johnson's prison record that she had introduced herself to Mr Johnson as his key worker and explained her role. (Key workers should 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 prisoners' records about their progress.) She noted that Mr Johnson did not want to talk as he had recently woken up and wanted to go back to sleep. (On 31 May, officer had noted in Mr Johnson's prison record that she had been appointed as his key worker and would introduce herself to him. There are no intervening entries to explain why she did not meet with him for over three months.)

51. On 12 September, a nurse completed Mr Johnson's IDTS review. She noted Mr Johnson looked 'run down' and spoke to him about self-care. Mr Johnson said he had lost his job in the tiling workshop due to 'a misunderstanding' and was upset as he enjoyed the work. Mr Johnson said he would like to be released drug free, as during a previous sentence he had spent £20,000 on PS. He agreed to attend the Turning Point group (a group facilitated by clinical staff from the substance misuse team which is aimed at prisoners who have an established history of drug use and have previously been through the recovery cycle). Mr Johnson's attendance was sporadic but he did attend sessions on 25 September and 30 October, and it was noted he engaged well.

52. On 13 September, an officer noted that she had not been to see Mr Johnson for his key work session because of an incident on C Wing. On 17 September at 9.59am, the officer recorded that she went to Mr Johnson's cell for his key work session and woke him up, but he did not want to talk.

53. On 2 October, a member of staff from the DARS team, introduced herself to Mr Johnson as his new case worker. She reviewed his care plan and noted that he was stable on 30mls of methadone. She told Mr Johnson she would refer him to the mental health team to address anxiety issues he had raised.

54. On 5 October, Mr Johnson was twice found under the influence of PS. A nurse noted in Mr Johnson's medical record that he was unable to speak, had glazed red eyes and was unsteady on his feet. She referred him to the substance misuse team. The next day, a CM downgraded Mr Johnson to the basic IEP level and placed him on a disciplinary charge. On 7 October, Mr Johnson pleaded guilty to being under the influence and was punished by having privileges removed for 42 days.

55. On 8 October, the member of staff from the DARS team met with Mr Johnson. He told her that his PS use on 5 October had been a 'one off' and he felt his mental health was okay. She provided Mr Johnson with information on the dangers of using PS and told him that she would review him as planned in December. She referred Mr Johnson to the mental health team for an assessment.

56. On 12 October, a CM reviewed Mr Johnson's IEP status and recorded there had been no issues. Mr Johnson remained on basic with four targets: remain warning and adjudication free; comply with all wing rules and regimes; remain in purposeful activity; and comply with targets set by OMU. There is no corresponding entry on Mr Johnson's prison record. The next day Mr Johnson was given a formal warning for wearing his dressing gown and pyjamas all day, despite being asked not to.

57. On 15 October, at 1.42pm, a nurse from the mental health in-reach team, met with Mr Johnson. Mr Johnson said he felt frustrated, fed up with the cycle of offending and being in prison and that he had been placed on the basic regime following his use of PS. Mr Johnson said this was a 'one off' and had placed his prison job in jeopardy. Mr Johnson said he did not sleep well and felt low and anxious, but had no thoughts of suicide or self-harm. The nurse concluded that there was no current need for Mr Johnson to continue meeting with the mental health team, but sent a task to the GP requesting medication to help him sleep. A prison GP replied to this task the next day saying that she would not prescribe medication. She did not suggest any alternative or follow up review of Mr Johnson.

58. On 16 October, an officer recorded in Mr Johnson's prison record that Mr Johnson became irate when he explained he could not be let out for association as he was on basic. He said Mr Johnson picked up a coffee jar and threw it with such force that it smashed against the back of the door, which he had quickly closed to avoid being hit. When he told Mr Johnson he would place him on a disciplinary charge, he made further violent threats towards him. (On 18 October, Mr Johnson pleaded not guilty to attempting to assault the officer but the charge was proven on 28 October. Mr Johnson lost privileges and 50% of his earnings for 28 days as punishment.)

59. On 19 October, a SO chaired a review board of Mr Johnson's IEP status, which a CM and Mr Johnson attended. The review board noted that Mr Johnson should remain on basic as he had received two negative entries. A 28-day review was scheduled for 2 November.

60. At 5.14pm, an officer recorded in Mr Johnson's prison record that she had visited him during education that afternoon. She noted that he was a little more talkative. He told her that he was on basic following an argument with an officer and had lost some privileges. Mr Johnson said he had had contact with the mental health team

and would benefit from further contact. She noted that she spoke to the mental health team immediately after seeing Mr Johnson and they told her that they had visited him on 15 October, but as he only reported not sleeping they did not need to visit him again. She told Mr Johnson to submit an application to healthcare if he wanted to see them again, explained the resources available for support and encouraged him to get off the basic regime. The next day Mr Johnson failed to attend his education class.

ACCT: 23 to 29 October

61. On 23 October, at 3.45pm, a nurse started suicide and self-harm prevention procedures (known as ACCT). On the Concern and Keep Safe form, she noted that during a Turning Point group session, Mr Johnson had talked about his impulsive behaviour, a previous suicide attempt in prison and that he feared there was 'no point'. Mr Johnson said his mental health was deteriorating and that he had made a ligature a few days before, which a friend had found.

62. A CM completed the ACCT immediate action plan at 4.40pm and set observations at two an hour. The CM referred Mr Johnson to the mental health team and made him aware of the support available from Listeners (prisoners trained by the Samaritans). The CM noted that Mr Johnson wanted to improve his recent poor behaviour and wanted to get a job.

63. On 24 October at 9.05am, an officer completed the ACCT assessment. The officer noted that Mr Johnson said his mental health was deteriorating, that he was hearing voices and not sleeping well. Mr Johnson told him that he had tried to hang himself at Leeds, but had luckily been found by his cellmate. Mr Johnson said he had not self-harmed recently and did not have any current thoughts of suicide or self-harm, but was not in a good place as he was not sleeping. He said he was also being placed on report for doing stupid things. Mr Johnson said he would like to move to a smaller wing and be referred to the mental health team.

64. At 2.25pm, a SO chaired the first ACCT review which was attended by, a mental health nurse and Mr Johnson. (Another SO had been allocated as the ACCT case manager, but was not on duty to hold the review.) The SO recorded that Mr Johnson said he was having trouble sleeping, which was causing him to hear voices and do silly things. He said he had been placed on the basic regime for being under the influence. He said he did not feel like self-harming but that this could change if he did not get some sleep. Mr Johnson said he had no problems on the wing, but he was locked in his cell for long periods as he did not have a job. Two issues were noted on the caremap: for the mental health nurse to arrange sleeping tablets and for Mr Johnson to attend the stress course (delivered by the mental health team). Staff assessed Mr Johnson's risk level as raised (out of low, raised and high) and set observations at one an hour.

65. At his disciplinary hearing on 25 October, Mr Johnson pleaded not guilty to being under the influence, but the charge was proved. He was punished by having his privileges removed for 14 days and 50% of his earnings for 21 days.

66. On 29 October at 4.13pm, a SO chaired the ACCT review which was attended by Mr Johnson. No one from the mental health team attended but the SO noted on the form that they had provided a report. The SO noted that he told Mr Johnson

that he had spoken to the mental health team about his medication and that he would be seeing the GP about getting medication to help him sleep, and that he was on the stress course. Mr Johnson told him that he had no thoughts of suicide or self-harm and had not had any since the one moment that had prompted the starting of ACCT procedures. The SO recorded that the two caremap actions had been completed and that they agreed to stop ACCT procedures.

67. On 31 October, Mr Johnson was found under the influence of PS. The next day, a nurse went to see Mr Johnson to discuss his drug use, but although he was walking and talking, she was not able to engage with him and suspected that he was still under the influence. At his disciplinary hearing on 2 November, Mr Johnson pleaded guilty to being under the influence. He was punished by having his privileges stopped for 21 days and 50% of his earnings for 42 days, but this punishment was suspended until 2 February 2020.

68. On 3 November, a SO reviewed Mr Johnson's IEP status. The SO recorded on Mr Johnson's prison record that he remained on the basic regime due to his recent drug use.

69. Staff at Wealstun hold a weekly Safety Intervention Meeting (SIM) to discuss managing the risks to prisoners and the prison. It is attended by heads of function, including security, safer custody and healthcare managers. On 5 November, Mr Johnson was listed as being one of eleven prisoners on the basic IEP regime for more than 28 days. An action was recorded for a CM to update at the next meeting about what actions had been taken to help each prisoner upgrade to standard.

70. On 5 November, a SO completed Mr Johnson's ACCT post-closure review. The SO noted that Mr Johnson said all his issues were resolved and that the two caremap actions had been completed.

71. At 3.30pm, the staff member from the DARS team met with Mr Johnson to review his substance misuse care plan. She had to speak to Mr Johnson through his door as he was locked up because he was on the basic regime. She noted that he was very quiet, difficult to engage and said that his main issue was not sleeping. Mr Johnson said he thought he was going to be prescribed mirtazapine (an antidepressant that can also help with sleep), but had not been and he did not know why. She said that it could have been due to his recent drug use, but that she would find out. Mr Johnson told her that he was willing to engage with the mental health team, but did not want to attend DARS groups. She scheduled Mr Johnson for a review in January 2020.

72. On 8 November, an officer went to visit Mr Johnson in the afternoon for his key work session. She noted that he appeared to be asleep but jumped up when she called his name. He said he was tired and not feeling well and wanted to try to sleep.

73. On 12 November, the SIM was held and Mr Johnson was again listed as a prisoner who had been on basic for more than 28 days. No update was given.

74. At 3.57pm, an officer recorded in Mr Johnson's prison record that he had not attended his afternoon English lessons. She noted that she had visited Mr

Johnson who said he had 'safer custody issues and had spoken to a CM and another officer. She noted that Mr Johnson was not subject to CSIP. She noted that wing staff had said Mr Johnson was probably self-isolating as he was in debt and she spoke to the CM for advice as Mr Johnson was reluctant to speak to her.

75. At 4.23pm, an officer recorded that she had gone to see Mr Johnson as he had not been attending his education class. She noted that he said he was tired as he struggled to sleep and that he had submitted an application to healthcare. Mr Johnson told the officer he was not going to education because 'he was safer custody', but was reluctant to expand. The officer noted that she concluded the session to allow Mr Johnson to sleep and that he was reluctant to talk about his problems.

76. On 15 November, a CM reviewed Mr Johnson's IEP status. He noted that Mr Johnson had complied with the rules of the basic regime and he upgraded him to the standard regime.

77. On 21 November, Mr Johnson did not attend the stress control group. The group facilitator tried to contact the wing to find out why he had not attended but did not get an answer. The group facilitator listed Mr Johnson for the group on 28 November, but he did not attend and was removed from the group.

78. On 23 November, an officer spoke to Mr Johnson during morning association when he was talking to other prisoners. Mr Johnson said he was off basic and intended to stay off. She asked Mr Johnson why he was not going to education and he said it was 'due to safer custody issues'. She noted he was reluctant to speak and asked to return to his conversation with the other prisoners. She recorded, 'Lewis is always very reluctant to talk during keyworker sessions.'

79. On 26 November, the officer went to see Mr Johnson for his key work session. The officer recorded that Mr Johnson had stayed in his cell and not attended education. Mr Johnson said there was trouble in education and he had told staff. She noted that Mr Johnson was reluctant to engage in conversation and went back to watching television.

80. All prisoners' telephone calls, except those that are legally privileged, are recorded, and prison staff listen to a random sample. The investigator listened to the calls Mr Johnson made from his in-cell telephone between 5 December and 10 December, when he made his last call. In total he made 13 calls to his mother (not all were answered), totalling over 30 minutes.

81. During a nine-minute call on 5 December, Mr Johnson discussed the possibility of parole and using his mother's address for release. He asked her to contact the Probation Service as they needed information by 6 December for his parole review. Mr Johnson sounded angry and frustrated. He then disclosed that other prisoners were having a go at him as he owed £50 and he said, 'They are doing my head in.'

82. The next day, Mr Johnson phoned his next of kin several times. On two occasions he left a message saying he needed to speak to her and sounded upset. At 1.17pm, Mr Johnson's next of kin answered the telephone, but told him that she could not speak as she was at work. During a six-minute call at 3.16pm, Mr

Johnson told his next of kin that he owed £25 and £100, that he was under pressure and hiding in his cell. Mr Johnson asked his next of kin to pay his debts for him. Mr Johnson sounded upset and frustrated and said that he needed to pay £125 in the next couple of hours. Mr Johnson was shouting, said he needed to get out of prison and that he would not finish his sentence because he was not mentally strong enough. Mr Johnson asked his next of kin again to pay the money, which she agreed to do and she asked him to call her back with the details.

83. At 3.45pm, Mr Johnson called his next of kin and provided bank details for the payments. He sounded much more subdued than in the earlier calls. At 5.10pm, Mr Johnson called his next of kin again. His speech was very slurred. Mr Johnson's next of kin confirmed that she had made the payments and asked why he was slurring. Mr Johnson said that he was watching television, had taken a sleeping tablet and more sleep meant he was closer to his release date. Mr Johnson said there was 'one other thing hanging over my head', but did not go into detail.

84. On 7 December, an officer went to see Mr Johnson during afternoon association but although he was polite, he did not want to speak and said he wanted to go out on the landing to associate with other prisoners.

85. On 8 December at 3.57pm, Mr Johnson called his next of kin. He thanked her for the £100, but said he had sent her a text about another £25.

86. On 9 December at around 3.50pm, a CM discovered Mr Johnson under the influence in his cell and he placed him on report. This was the last entry in Mr Johnson's prison record before he died. Staff downgraded Mr Johnson to the basic regime. A nurse responded to the code blue medical emergency. She noted that Mr Johnson was unable to confirm his name, his speech was slurred, he had bloodshot eyes and was under the influence of PS.

87. On 10 December at 11.33am, Mr Johnson telephoned his next of kin. He told her that he had not yet received a decision about his parole and that he thought he would not be released until July, as he did not have an address to go to, and had recently been in trouble. Mr Johnson sounded annoyed that his next of kin had not paid his debt. Mr Johnson said that he needed 'medicating' but the prison GP thought he was chasing drugs. At 3.07pm, Mr Johnson called his next of kin and asked her to pay a £30 debt. He said this debt was important and asked her to pay it as soon as possible.

88. At 3.19pm, a member of staff from DARS recorded in Mr Johnson's medical record that she went to see him in response to him being under the influence the previous day. Mr Johnson said he had smoked a cigarette but did not know it contained PS. Mr Johnson said he would like to re-engage with DARS. She gave Mr Johnson information on harm reduction and risk, some in cell worksheets to raise awareness about the dangers of using PS and referred him to the inclusion recovery programme (IRP).

89. On 11 December, Mr Johnson pleaded guilty to being under the influence on 9 December. He lost all privileges and had 50% of his earning stopped for 42 days as punishment, but the punishment was suspended until 11 February 2020.

90. At 3.25pm, Mr Johnson called his next of kin with bank details and again at 3.46pm, when his next of kin told him she had transferred the money to pay his debt. This was the last phone call he made.

91. At 7.11pm, closed circuit television (CCTV) shows Mr Johnson talking to other prisoners on the wing before he returned to his cell and closed his door. An officer told the investigator that he had observed Mr Johnson during association that day and did not notice anything of concern.

12 December

92. CCTV shows that at 1.49am, an operational support grade (OSG) and night patrol officer, went to Mr Johnson's cell. He told the investigator that he could not recall why.

93. At 3.28am, Mr Johnson activated his emergency cell bell. The OSG went to his cell at 3.30am, and Mr Johnson told him that he had tripped over, thought he had broken his ankle and wanted to go to hospital. The OSG said he could not see any swelling to Mr Johnson's ankle, although he was a little distance away and looking through the observation panel. He asked Mr Johnson to wiggle his toes, which he could do. He told Mr Johnson that there were no healthcare staff on duty, that he would check on him throughout the night and would tell day staff when the night shift ended. He said Mr Johnson accepted this.

94. CCTV shows the OSG returned to Mr Johnson's cell at 3.49am. He said he opened the observation panel on the cell door and saw that Mr Johnson was lying on his bed with his eyes closed and looked asleep. He said he quietly closed the flap, heard a noise so opened it again, but Mr Johnson had not stirred so he closed it again. He did not make an entry in the wing observation book about Mr Johnson's ankle or his request to go to hospital.

95. CCTV shows at 4.42am, the OSG went to check on Mr Johnson. He said he looked through the observation panel and thought Mr Johnson was standing at the back of his cell and he asked if he was alright. When he got no response, he shone his torch into the cell and could see Mr Johnson had a ligature around his neck so he used his radio to ask for assistance.

96. Two officers and a CM were close to C Wing and responded immediately. An officer said it was clear from the OSG's voice it was an emergency. Both officers' arrived first. CCTV shows at 4.45am, an officer unlocked the cell and they both entered.

97. Mr Johnson was found hanging by a dressing gown cord attached to the window frame. An officer supported Mr Johnson and used his anti-ligature knife to cut the cord and lowered Mr Johnson to the floor. An officer said he could not find a pulse and thought Mr Johnson looked dead. An officer used his radio to contact the control room. An OSG, recorded in the control room log that there was a call for assistance at 4.43am and at 4.45am, he received a request to call an ambulance.

98. When the CM arrived at the cell, he told both officers to leave as the cell was a potential crime scene. An officer said he left Mr Johnson in a sitting position with his head tilted back to keep his airway open. CCTV shows they locked the cell at

4.47am, and a third officer who had also responded to the call for assistance, was asked to wait outside the cell.

99. The CM returned to the wing office with two officers and contacted the control room to request an ambulance. An officer queried the decision not to start cardiopulmonary resuscitation (CPR). The CM agreed and asked the two officers to return to the cell and start CPR. CCTV shows the cell was opened again at 4.52am, and an officer started CPR, with the assistance of the third officer.

100. An officer who had responded to the request for assistance, returned to the gate so he could help open the vehicle lock to allow access for the ambulance. At 4.55am, an officer left the cell and used the wing office telephone to contact the control room, who had requested information for the ambulance service. The officer then went to find the defibrillator and returned to the cell with it at 5.01am and attached it to Mr Johnson. The defibrillator indicated Mr Johnson had no shockable rhythm. The officer left the cell and escorted the ambulance to the wing. An officer continued CPR until paramedics arrived.

101. The investigator listened to the telephone call made by the OSG to Yorkshire Ambulance Service. The OSG contacted an officer at the scene to obtain more details and he was told that Mr Johnson was dead. A few minutes later, the OSG said he had been told that Mr Johnson had been dead for some time as there was no pulse. Around six minutes into the call, the ambulance service operator asked for confirmation CPR had started and if it was a 'workable arrest' (potentially responsive to life saving procedures). The OSG spoke to someone and a couple of minutes later was told it was not a workable arrest, but Mr Johnson had been cut down and CPR was ongoing. A minute or so later the ambulance service operator asked for confirmation that a defibrillator was being used. The OSG checked with staff at the scene and was told they did not have a defibrillator, that Mr Johnson was stiff and in their opinion, he was dead. The ambulance service operator told the OSG to instruct staff to get the defibrillator, which he did. Nineteen minutes after the call was first made, the ambulance arrived at the gate and the call to the ambulance service operator ended.

102. Yorkshire Ambulance Service records show they received a request for an ambulance at 4.48am, six minutes after Mr Johnson was first discovered. Paramedics arrived at the gate at 5.06am, but were delayed entering as the electronic gate had failed and had to be hand-cranked open. The CM went to the gate to assist an officer as opening the gate in this way was physically hard work. Paramedics arrived at Mr Johnson's cell at 5.18am. They took over Mr Johnson's care and established a pulse. Mr Johnson was taken to hospital, unrestrained, and treated in intensive care. He did not regain consciousness and died at 10.56am.

Contact with Mr Johnson's family

103. The Governor contacted Mr Johnson's next of kin to inform her that he had been taken to hospital and was critically ill. She told her to go directly to hospital where staff from Wealstun would meet the family.

104. The prison appointed prison offender manager, as the family liaison officer (FLO) and an officer as her deputy. The deputy and a CM met Mr Johnson's family at

the hospital. They offered condolences and support. The prison contributed towards the costs of Mr Johnson's funeral, which was held on 17 January 2020, in line with national policy.

Support for prisoners and staff

105. The Governor held a debrief for all staff involved in the emergency response. The head of safety, and a CM, the TRiM manager (trauma risk management), also met with prison staff before they went off duty, including the hospital escort staff. A member of staff from the regional safety team, and head of safety facilitated a further debrief with all staff on 21 January 2020.

106. Staff involved in the response when Mr Johnson was discovered felt well supported and were provided with information on how to access specialist help. However, a SO, the ACCT case manager, and an officer, Mr Johnson's key worker, did not feel well supported. In addition, an officer said he felt upset that staff on the wing were telling prisoners that Mr Johnson was in hospital, after he had in fact died. He said that he was informed of Mr Johnson's death by another prisoner and felt staff should have been notified first to avoid prisoners on the wing accusing staff of lying.

107. Healthcare staff received support and clinical supervision from Care UK.

108. The prison posted notices informing other prisoners of Mr Johnson's death, and offering support. Staff reviewed all prisoners considered to be at risk of suicide and self-harm, in case they had been adversely affected by Mr Johnson's death. The prison held a memorial service for Mr Johnson on 29 January 2019.

Post-mortem report

109. A pathologist concluded that Mr Johnson died from hypoxic ischaemic encephalopathy (a lack of oxygen to the brain), as a result of hanging. Toxicology results showed Mr Johnson had used PS before he died.

Findings

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

ACCT procedures

110. Prison Service Instruction (PSI) 64/2011, Management of prisoners at risk to self, to others and from others (Safer Custody), sets out the procedures (known as ACCT) that staff must follow when managing prisoners at risk of suicide and self-harm. It says that ACCT case reviews should be multidisciplinary where possible, that a caremap should be completed at the first review, and that it must reflect the prisoner's needs, level of risk and the triggers of their distress. Caremap actions must be tailored to meet the individual needs of the prisoner, be aimed at reducing the prisoner's risk to themselves and be time bound.

111. A nurse appropriately started ACCT procedures on 23 October, when Mr Johnson disclosed during a discussion group that he had made a ligature. At the first case review on 24 October, a SO recorded two caremap actions: to arrange sleeping tablets and put Mr Johnson on the stress course. Despite Mr Johnson saying that he was on the basic regime and was finding it difficult being locked in his cell for most of the day after losing his job, no caremap actions were identified to address these issues.

112. Mr Johnson was added to the list for the stress course. However, Mr Johnson was never given sleeping tablets. After the first case review, a mental health nurse sent a task request for a prescription of mirtazapine to a member of staff in the dental team instead of the prison GP. The member of staff in the dental team sent this email back on 28 October, but the system shows the task was closed. The mental health nurse said that she had not realised her mistake and the task had probably been closed automatically.

113. At the second ACCT case review on 29 October, a SO recorded that both caremap actions had been completed, and he agreed with Mr Johnson to stop ACCT procedures. No one from the mental health team attended but the SO told the investigator that they had provided a verbal update that Mr Johnson would be seen by a GP about medication to help him sleep (this never happened). The SO said that it was common for mental health nurses to provide a verbal update because they were often too busy to attend in person.

114. We consider that the caremap was inadequate in terms of addressing Mr Johnson's risk. We are also very concerned that a key caremap action, to arrange sleeping tablets, was never completed. The SO stopped ACCT procedures on 29 October, with this action still outstanding. There was also no one from the mental health team present when the decision to stop ACCT procedures was made.

115. During the post-closure period Mr Johnson was twice found under the influence of PS. There is no evidence anyone reassessed Mr Johnson's risk or considered restarting ACCT procedures. At the ACCT post-closure review on 5 November, the SO made no reference to Mr Johnson's drug use. There were three reviews in total, including the post-closure review, each with a different case manager which resulted in a lack of continuity in Mr Johnson's care.

116. We consider that Mr Johnson's risk of suicide and self-harm should have been managed better. The variable management of ACCT procedures was an issue that HMIP inspectors identified during their inspection of Wealstun in October 2019. We make the following recommendation:

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

- **ensure case reviews are multidisciplinary, with healthcare staff in attendance where appropriate;**
- **set caremap actions that are specific, meaningful and tailored to the individual to reduce their risk;**
- **ensure all caremap actions are completed before stopping ACCT procedures; and**
- **reassess risk if a significant event occurs during the post-closure period and restart ACCT procedures if necessary.**

Violence Reduction – CSIP procedures

117. A Prisons and Probation Ombudsman (PPO) publication in October 2011, Violence reduction, bullying and safety, noted the links between bullying and violence and self-inflicted deaths of prisoners of all ages. In our PPO thematic report into self-inflicted deaths in 2013-2014, we found that reports or suspicions that a prisoner is being threatened or bullied need to be recorded, investigated and responded to robustly.

118. Wealstun has a Safer Custody strategy dated May 2018, which sets out the process for raising and investigating any identified or suspected acts of aggression, bullying, intimidation or violence, using the challenge, support and intervention plan (CSIP) model. Around a month before Mr Johnson died, he stopped going to his education class and told staff it was due to 'safer custody issues'. We are concerned that no one considered making a CSIP referral.

119. An officer was appointed as Mr Johnson's key worker on 31 May 2019, but did not meet with him until 5 September. The officer met with Mr Johnson regularly from September, but there was little meaningful interaction. While we acknowledge that the officer recorded that Mr Johnson was reluctant to speak to her, there is little evidence that the officer tried to explore his issues around his self-isolation, his refusal to attend education classes due to 'safer custody' and his substance misuse.

120. We consider that Wealstun made inadequate attempts to resolve Mr Johnson's concerns about his safety and did not follow their own violence reduction and safer custody strategies.

121. On 3 February 2020, The Head of Safety, issued a Notice to Staff (NTS 035/2020) – New CSIP Guide. This notice contained updated information on how to submit a CSIP referral and contained a link to a PowerPoint presentation explaining the process. In addition, on 24 February 2020, Wealstun held an anti-bullying week to raise staff awareness. She told the investigator that Wealstun is focusing on prisoners' non-attendance at work and key work as a priority. The safety team will

attend the weekly labour board (who assign jobs) and review all non-attendees and those unemployed due to safety, to prompt further investigation and discussion from residence, safety and activities functional heads. While we recognise that Wealstun have already taken steps to improve violence reduction measures, we make the following recommendation:

The Governor should ensure that staff identify and manage prisoners at risk of bullying, intimidation or violence in line with the prison's violence reduction policy, in particular all staff should:

- **receive training on CSIP and understand the referral process and expectations of their role;**
- **provide effective support and protection for apparent victims with meaningful objectives and long-term solutions, which address their individual situations; and**
- **consider whether apparent victims are at increased risk of suicide and self-harm.**

Incentives and Earned Privileges

122. Wealstun's Incentives and Earned Privileges Scheme Policy dated November 2018, says that prisoners on the basic regime should have realistic targets to assist them to progress to the standard level, which should be noted on the prisoner's prison record. Mr Johnson had four generic objectives, which were not recorded on his prison record, and there was no evidence of what, if anything, was done to support him to progress or achieve these objectives. The use of generic improvement targets that did not sufficiently address the issues that led to the prisoner's demotion to basic, was an issue identified by HMIP during its inspection of Wealstun.

123. The Head of Safety, told the investigator that all prisoners who have been on the basic IEP for 28 days or more are to be included in the daily reporting briefing, reported to the SIM and supported to progress back to standard and whether they should be supported to do so via CSIP, as set out in the IEP policy. Mr Johnson remained on the basic IEP for 41 days, and there was no evidence recorded at the SIM meeting of what was done to encourage him to engage and socialise and Wealstun did not follow their own protocol. Mr Johnson was placed on basic again three days before he died, but this was not recorded on his prison record. We therefore make the following recommendation:

The Governor should ensure prisoners on the basic IEP regime:

- **are given clear and realistic targets to help them progress to standard, and these are recorded on the prisoner's prison record; and**
- **are given appropriate support to help them progress where they have been identified as being at risk of suicide and self-harm.**

Clinical care

Mental health

124. The clinical reviewer concluded that the care Mr Johnson received for his mental health at Wealstun was not equivalent to that he could have expected to receive in the community.

125. Mr Johnson was not referred for a mental health assessment when he first arrived at Wealstun as he should have been, despite the reception nurse noting that she would make a referral. Mr Johnson was not seen by the mental health team until 15 October, after the DARS team referred him.

126. On 16 October, a prison GP refused to prescribe medication to help Mr Johnson sleep but did not suggest an alternative, or arrange a follow up review of Mr Johnson. Mr Johnson was never prescribed any medication to help him sleep, despite this being one of his ACCT caremap actions. The task sent by the mental health nurse after the first ACCT review was never actioned because she sent it to the wrong person and the task was closed automatically. We make the following recommendation:

The Head of Healthcare should ensure that:

- **reception staff make mental health referrals where appropriate;**
- **prison GPs work more proactively with the mental health service to ensure that other treatment options are considered if they feel a suggested medication is not appropriate;**
- **when prisoners have multiple services involved, such as DARS and mental health, they consider using a care co-ordinator or lead professional to coordinate care plans and interventions; and**
- **all users of the electronic medical record (SystmOne) are provided with training on how to check on the completion of tasks, to reduce the likelihood of missed tasks.**

Substance Misuse

127. When Mr Johnson arrived at Wealstun, a nurse appropriately referred him to DARS. The involvement of DARS was proactive, responsive when there was an escalation of risk following misuse of PS, and there were timely referrals to support groups, as well as regular reviews of Mr Johnson's person-centre care plans. Although his attendance at support groups was erratic, it was recorded that Mr Johnson contributed well when he did attend.

128. Methadone was prescribed when Mr Johnson arrived at Wealstun and maintenance was appropriately managed. The advanced practitioner for substance misuse, evidenced that Wealstun followed national drug misuse and dependence protocols, often known as 'orange guidelines', for prisoners with substance misuse issues. All interventions with the substance misuse team were well documented on Mr Johnson's medical record and there was evidence of good

joint work between primary healthcare and DARS in the running and facilitating of support groups.

129. The clinical reviewer concluded that the care Mr Johnson received for his substance misuse issues was equivalent to that he could have expected to receive in the community.

Emergency response

Communicating the emergency

130. PSI 03/2013, Medical Emergency Response Codes, sets out the actions staff should take in a medical emergency. It contains mandatory instructions for Governors to have a protocol to provide guidance on efficiently communicating the nature of a medical emergency, ensuring staff take the relevant equipment to the incident and that there are no delays in calling an ambulance. It says that if a medical emergency code is called over the radio, an ambulance must be called immediately.

131. When an OSG found Mr Johnson hanging at around 4.43am, he asked for assistance rather than calling a medical emergency code as he should have done. Two officers responded and after they had arrived at the cell, one officer contacted the control room to ask for an ambulance instead of calling a code blue as he should have done. The control room log shows that request was made at 4.45am. However, the ambulance service was not contacted until 4.48am. Overall, there was around a five minute delay between Mr Johnson being found and an ambulance being called. We do not know if this delay affected the outcome for Mr Johnson, but we know that in an emergency situation a delay of a few minutes could be critical.

132. During the investigation it became apparent that prison and healthcare staff did not understand the correct use of medical emergency codes. Many staff told the investigator that code blues were radioed whenever a prisoner was found under the influence of PS, regardless of whether or not it was a medical emergency. Experienced staff said that although they were familiar with the requirements of PSI 03/2013, they would always ask for 'assistance' so the control room knew it was an emergency.

133. On 16 October, The Head of Safety issued a Notice to Staff (NTS 373/2019), Emergency Response in Custody (E.R.I.C) Protocol, reiterating the medical emergency code procedures. In addition, E.R.I.C cards were distributed to staff, followed up by knowledge and awareness sessions on residential units. On 30 January 2020, The Head of Safety issued another Notice to Staff (NTS 032/202), Emergency Response Codes, reiterating that Wealstun should follow national guidance set out in PSI 03/2013. Wealstun also held a full staff meeting specifically about medial emergency protocol awareness, facilitated by Safer Custody, HMPPS, Care UK and a paramedic. We acknowledge that Wealstun has already taken steps to improve understanding about the need to use medical emergency codes, so we do not make a recommendation.

Resuscitation and medical emergency equipment

134. After staff discovered Mr Johnson hanging and cut him down, the CM told officers to leave the cell and they returned to the wing office. It was only when an officer said CPR should be started, that they returned to Mr Johnson's cell. There was a delay of at least seven minutes before CPR was started. There was a further delay of around nine minutes before a defibrillator was found and applied to Mr Johnson, in response to the direction from Yorkshire Ambulance Service.

135. An officer told the investigator that he thought the decision not start to CPR immediately was incorrect, but he followed the instruction given to him by a senior member of staff to leave the cell. He said in hindsight, he should have challenged this decision. The CM said that he had checked Mr Johnson and could not feel a pulse, that his hands were white, there were no signs of life and he concluded there was nothing that could be done. However, he accepted that he should not have told staff to leave the cell. The CM said it had been an extremely difficult and challenging night in the prison and he simply forgot the correct procedure.

136. We note that ambulance paramedics were subsequently able to establish a pulse when they took over Mr Johnson's care about 30 minutes after the officers left the cell. We cannot say if the outcome might have been different for Mr Johnson if CPR had been started earlier and the defibrillator had been used earlier. We make the following recommendation:

The Governor should ensure that all staff understand PSI 03/2013 and their responsibilities during medical emergencies, including that:

- **staff carry out basic life support without delay until healthcare or ambulance staff arrive; and**
- **all staff know where defibrillators are located.**

Ambulance delay at gate

137. PSI 03/2013 also contains mandatory instructions that prison staff should prevent unnecessary delay in escorting ambulances and paramedics to the patient. The ambulance service recorded that they were delayed entering the prison. The ambulance arrived at Wealstun at 5.06am, but it took around 12 minutes to reach Mr Johnson. Paramedics recorded that there was a mechanical fault with the gate.

138. The works department had been called to the gate on 11 December at 6.40pm, due to a problem with the electronic mechanism. They fixed the problem but on 12 December, the mechanism failed again. The CM said he received his handover for the night and was told that the main gate was broken, despite the works department trying to fix it during the day and the only way to allow access to emergency vehicles was to hand crank the front and back gates. The CM said there had been several incidents during the evening and night that required staff to escort prisoners outside of the establishment, so staff numbers were depleted when Mr Johnson was discovered and he was trying to coordinate the situation. When an ambulance was required for Mr Johnson, the CM went to assist an officer at the gate.

139. Wealstun have already arranged for additional contingency training, including for night OSGs, for when there is a mechanical gate failure and revised easy read guides which have been displayed prominently in the gate. We therefore make no recommendation.

Body-worn video camera (BWVC)

140. PSI 04/2017, Body-Worn Video Cameras, states it is mandatory for staff to use BWVCs at any reportable incident (as outlined in PSI 11/2012, Management and Security of the Incident Reporting System) and that staff should start recording at the earliest opportunity to maximise the material captured by the camera. None of the officers present when Mr Johnson was discovered used a BWVC. The CM said it was 'custom and practice' at Wealstun that nobody wore a BWVC during the night. He said incidents at night were rare and that if a BWVC was required, one could be obtained quickly.

141. The Head of Safety raised the issue of staff not wearing BWVC at the operations meeting on 23 January 2020. In response, The Head of Operations, issued a Notice to Staff 024/2020 on 27 January reiterating the need for all operational staff to wear a camera, including night staff. As Wealstun have already addressed this issue, we make no recommendation.

Learning from this report

142. We consider it important that staff should learn the lessons from this report. We therefore recommend:

The Governor should share this report with the CM and personally discuss the Ombudsman's findings with him.

The Governor should share this report with a SO and an Officer and arrange for a senior manager to discuss the Ombudsman's findings with them.

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