

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

**Independent investigation into  
the death of Anthony McNally,  
a prisoner at HMP/YOI  
Aylesbury, on 8 January 2021**

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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

**OGL**

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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 Anthony McNally died on 8 January 2021 in Stoke Mandeville Hospital, having been found hanging in his cell in HMYOI Aylesbury that morning. Mr McNally was 18 years old. I offer my condolences to Mr McNally's family and friends.

Mr McNally was arrested in January 2020. He was subsequently convicted and sentenced to four years in custody. He had a history of self-harm. In September, he turned 18, and the following month he was transferred to Aylesbury. Staff monitored him under self-harm prevention procedures and worked to build relationships with him. Although Mr McNally continued to self-harm in minor ways, he began to come out of his cell and engage with parts of the prison's regime.

We found that both prison and healthcare staff in Aylesbury tried to form relationships of trust with Mr McNally, and to encourage him out of his social isolation. Although he remained at risk of harming himself, we found no evidence to suggest that anyone could have foreseen that he was an imminent risk of killing himself before his death. We commend staff for the care and support they provided.

When the night officer found Mr McNally hanging, he had difficulty in using the emergency cell key. We were also concerned that there was a short delay in calling for an ambulance, an issue we have raised with Aylesbury before.

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**

**March 2022**

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# Summary

## Events

1. In February 2020 Mr Anthony McNally was remanded to Oakhill Secure Training Centre. He had problems mixing with other detainees and threatened violence against staff. He had a history of drug and alcohol misuse as well as self-harm. He continued superficial self-harm in Oakhill and was managed through a safety plan. A psychiatric report noted a complex mental health history. He said that he intended to take his own life once he was released from custody.
2. In October, Mr McNally transferred to HMYOI Aylesbury as he had turned 18. Staff opened ACCT monitoring procedures, noting that his self-harm risk increased under stress. Mr McNally was nervous of Aylesbury's reputation, and reluctant to engage with either staff or prisoners. Mr McNally explained in ACCT reviews that he was anxious and used self-harm as a coping mechanism. He said he had no plans to end his life. Staff ensured that ACCT reviews were attended by people that Mr McNally knew.
3. Mr McNally did not want to mix with other prisoners and rarely left his cell. He self-harmed but was willing to work with the Psychology Department. In December, another prisoner gave him some 'Spice' (an illicit psychoactive substance), which he said he did not take.
4. On 4 January 2021, Mr McNally was worried about an exchange with another prisoner, but later told staff that he had been pleased at how he had dealt with the situation. The note of an ACCT review on 6 January recorded that Mr McNally felt supported by officers and staff from intervention services.
5. A night officer found Mr McNally hanging in his cell just before 6.30am on 8 January. He raised the alarm and, after some initial difficulty, went into the cell and lowered Mr McNally to the floor. There was a slight delay calling an ambulance. Other staff arrived and provided first aid until ambulance paramedics arrived and took over. They transferred Mr McNally to hospital, where he died at 1.50pm.

## Findings

### Assessment of risk of suicide and self-harm

6. Mr McNally arrived at Aylesbury on frequent observations because of his risk of self-harm and staff appropriately opened ACCT procedures. Reviews were multi-disciplinary and with continuity of attendees. When Mr McNally did not attend reviews, staff reported back to him. Decisions on observation levels were made by people familiar with Mr McNally, with him as a full participant. Mr McNally harmed himself on several occasions, which did not always lead to an immediate ACCT case review, as efforts were made to ensure that case reviews were attended by staff who knew Mr McNally well. Triggers were not obvious, and staff were not able to foresee when he would self-harm.
7. We considered that Mr McNally's complex risk was well managed, by staff who made efforts to form relationships with him and ensure continuity of care. We do

not consider that staff could have identified that Mr McNally was at imminent risk of suicide before he died.

### **Emergency response**

8. We are concerned that the night officer had difficulty using the emergency key because he could not break the sealed pouch. There was also a short delay in calling an ambulance when a medical emergency code was called.

### **Substance misuse**

9. Mr McNally had a history of substance misuse. He declined to engage with the drug and alcohol rehabilitation team but aside from one incident, there is no evidence that drug use was an issue for Mr McNally during his time in Aylesbury.

### **Mr McNally's healthcare**

10. The clinical reviewer noted that the healthcare that Mr McNally received in custody was equivalent to that which he could have expected in the community. His mental health was assessed on an ongoing basis with appropriate referrals.

### **Recommendations**

- The Director of Oakhill should ensure that any information about a prisoner's risk is effectively communicated to those who are responsible for their care following a transfer.
- The Governor of Aylesbury should ensure that all staff who may need to open sealed key pouches have received training in how to do so.
- The Governor of Aylesbury should monitor the response to emergency codes and report his findings to the Ombudsman after three months.

## The Investigation Process

11. The investigator issued notices to staff and prisoners at HMYOI Aylesbury informing them of the investigation and asking anyone with relevant information to contact him. No one responded.
12. The investigator obtained copies of relevant extracts from Mr McNally's prison and medical records.
13. The investigator interviewed nine members of staff and a prisoner at Aylesbury. NHS England commissioned a clinical reviewer to review Mr McNally's clinical care at Aylesbury. The investigator and clinical reviewer jointly interviewed healthcare staff.
14. We informed HM Coroner for Buckinghamshire of the investigation. He gave us a copy of the post-mortem toxicology report. We have sent the coroner a copy of this report.
15. One of the Ombudsman's family liaison officers contacted Mr McNally's mother to explain the investigation and to ask if she had any matters she wanted the investigation to consider. Mr McNally's mother asked why Mr McNally's observations were reduced when he moved to Aylesbury.

## **Background Information**

### **HM Young Offender Institution (YOI) Aylesbury**

16. HMYOI Aylesbury has capacity for up to 440 young adult men aged 18-20, who are serving the longest sentences for their age group in the country. Since May 2019, the prison has been operating at a reduced capacity, holding up to 209 young men, after it was placed in special measures by HM Prisons and Probation Service (HMPPS) due to serious concerns about safety at the prison.
17. Care UK provide physical health services and Barnet, Enfield and Haringey Mental Health Trust provide mental health services. Nursing staff are in the prison from 7.30am to 8.00pm Monday to Thursday, 7.30am to 6.30pm Friday, and 8.00am to 5.30pm at weekends.

### **HM Inspectorate of Prisons**

18. The most recent inspection of HMYOI Aylesbury was in October 2019. Inspectors reported that reception and first night processes were reasonably good, although induction was not always timely, and prisoners frequently missed sessions. Inspectors also found that 27 per cent of prisoners currently felt unsafe at Aylesbury, and 53 per cent had felt unsafe at some time at the prison. The rate of assaults was higher than at their previous inspection, although Inspectors noted that they were generally less serious in nature.
19. Inspectors reported that levels of self-harm had reduced since their last inspection and was lower than at comparable prisons. They found that the mental health team was skilled and had built a good rapport and trust with prisoners. Mental health referrals were triaged and assessed promptly.

### **Independent Monitoring Board**

20. 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 March 2020, the IMB reported improvements since Aylesbury had been put into special measures in 2019. The Board commended the embedding of the key worker scheme.

### **Previous deaths at HMYOI Aylesbury**

21. Mr McNally was the third prisoner at Aylesbury to take his own life in the last two years. We have previously made recommendations about resuscitation and calling ambulances promptly in a medical emergency.

### **Assessment, Care in Custody and Teamwork (ACCT)**

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

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

23. As part of the process, a caremap (plan of care, support and intervention) is put in place. The ACCT plan should not be closed until all the actions of the caremap have been completed. All decisions made as part of the ACCT process and any relevant observations about the prisoner should be written in the ACCT booklet, which accompanies the prisoner as they move around the prison. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

## **Psychoactive substances (PS)**

24. PS (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.
25. In July 2015, we published a Learning Lessons Bulletin about the use of PS 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.
26. HM Prison and Probation Service (HMPPS) now has in place provisions that enable prisoners to be tested for specified non-controlled PS as part of established mandatory drugs testing arrangements.

## Key Events

### Oakhill Secure Training Centre

27. In February 2020 Mr Anthony McNally was remanded on charges of attempted murder. It was his first time in custody. He was taken to Oakhill Secure Training Centre. On 28 August, he was convicted of wounding with intent and sentenced to four years imprisonment. He was 17 years old. Reports at the time noted that he was pleased that his sentence was not as long as he had expected.
28. Reports in Oakhill showed that he had problems mixing with other young people. He threatened violence against members of staff, including sexual violence against female staff. He made racist and misogynistic comments. He had a history of drug and alcohol misuse and he had self-harmed since the age of 14, including taking overdoses. He committed many acts of self-harm in Oakhill, mainly by scratching himself or by head-butting walls. He was managed through a safety and wellbeing plan (the process for managing residents at risk of self-harm).
29. A psychiatric report in August noted that Mr McNally had a complex mental health history. He had traits of emotionally unstable personality disorder and some features of post-traumatic stress disorder, but his age made it difficult to give a firm diagnosis. He had anxiety, and provoked reactions from people as a defence mechanism. The report noted that he should receive mental health support in prison and his risk of self-harming behaviour should be monitored. He reported a history of emotional, sexual and physical abuse, and also had a history of substance misuse. He said that he intended to take his own life once he was released from custody, but not while detained.

### HMYOI Aylesbury

30. In September, Mr McNally turned 18 and on 15 October he transferred to HMYOI Aylesbury. Before leaving Oakhill, he wrote letters to several members of staff, thanking them for their care.
31. Mr McNally had an induction interview at Aylesbury, and avenues of support were explained to him. In Oakhill, he had been under frequent self-harm monitoring (at least once every five minutes) so staff opened ACCT monitoring procedures. Staff were to check on Mr McNally at least five times per hour. His record noted that he had been judged a risk to females so was to have no lone contact with female staff. Alerts were added that he had displayed racist attitudes, and that his prolific self-harm risk was raised when he was under stress.
32. At his reception health screening, Mr McNally appeared anxious and admitted that he was nervous about transferring to Aylesbury but had no thoughts of suicide. He had no symptoms of COVID-19, but isolated for two weeks after his transfer, in line with national guidelines.
33. Cells in Aylesbury have in-cell telephones, and staff used these to contact prisoners during COVID-19 restrictions. A member of the drug and alcohol rehabilitation team (DART) telephoned Mr McNally to complete an induction, but he did not answer. Prison officers confirmed that he was well.

34. At his ACCT assessment interview, Mr McNally was nervous but engaged well. He said he was anxious but had no thoughts of self-harm. He said he often harmed himself superficially but had no plans to die. He sought a feeling of control, although if he did plan to take his own life, he said he would hide it. He was anxious in new surroundings as he said he took time to adjust. His sentence was shorter than he expected, and he was looking forward to being released, but wanted to be proactive in prison, working with the mental health team and the psychology department. He had regular contact with his mother, which he found supportive. The interviewing officer explained the ACCT process, and avenues of support available including the Samaritans' phone, the chaplaincy, Listeners (prisoners trained by the Samaritans to provide peer support), as well as talking to staff and to others. Mr McNally said he did not think he would use this support as he found it hard to trust others.
35. Mr McNally then had an ACCT review. A Custodial Manager (CM) was the unit manager and said that she would be his case manager. A nurse attended, along with a member of the Chaplaincy. Mr McNally was initially reluctant to engage, saying it was difficult for him to talk to people he did not know, especially men. He said he was scared of being assaulted or stabbed, based on what he had heard about Aylesbury. They discussed support, Mr McNally began to engage more, and they encouraged him to talk if he needed support.
36. Mr McNally's Offender Supervisor had tried to contact him by telephone, but Mr McNally had not answered. On 19 October, she went to see him. He told her that he did not like answering his telephone. She noted that he seemed to be 'okay', and his wing manager told her that he did not seem to have any problems. He was quiet and had not been mixing with other prisoners but was talking to staff. She gave him a letter with her details, asking him to contact her if he had any issues. A note on Mr McNally's medical record showed that he had been referred to the Mental Health In-Reach Team (MHIRT), but that they would probably use a multidisciplinary approach because of his complex mental health needs.
37. Mr McNally wrote a letter to an officer at Oakhill. The letter was undated but arrived in Oakhill on 21 October. In it, Mr McNally said that he was nervous about being in Aylesbury and did not like it there. When the officer collected the letter from Oakhill's security department it had already been opened, so she assumed that the content had been noted and, if necessary, dealt with. The security department at Oakhill, however, said that they did not have a record of the content of the letter. The information in the letter was not passed on to Aylesbury.
38. On 20 October, an officer introduced himself to Mr McNally as his key worker as part of his induction. Mr McNally was nervous but engaged well and asked a number of questions about how the prison operated. He said he had no concerns. The same day, a nurse from the MHIRT went to see Mr McNally. He said that he did not want to see anyone that day but would engage the next time.
39. A CM chaired an ACCT review on 22 October with a Supervising Officer (SO), a psychologist, and representatives from healthcare and the chaplaincy. Mr McNally refused to attend, saying nobody wanted to help him. He had not been engaging with staff or the regime, declining exercise and showers even though staff continued to offer these every day. The psychologist said that this fitted with Mr McNally's recorded previous behaviour pattern of rejecting before he could be rejected,

though he was also wary of Aylesbury's reputation. His risk was noted to be raised, but with no immediate risk of taking his own life. The level of observation was reduced to two per hour, but the number of meaningful conversations was raised to five per day to try to encourage him to engage. It was noted that staff could try contacting him on his in-cell phone in case he found that an easier way to talk. Other departments would be asked to inform wing staff if they telephoned him, whether he answered or not, so it could be noted on his ACCT document. After the review, staff told Mr McNally what they had discussed and agreed. Mr McNally admitted he was very stubborn.

40. That day, an officer tried to conduct a welfare check with Mr McNally, but he did not want to engage.
41. A nurse from the mental health team saw Mr McNally on the wing. He told her that he would not engage with men for therapeutic treatment but would see mental health staff and a clinical psychologist to address past trauma. He said he would not take any medication for mental health issues. She explained the Pathways service for people with traits of personality disorders. Mr McNally said he was anxious when hearing loud noises but was otherwise okay and had no thoughts of harming himself.
42. On 27 October, the key worker held a key worker session with Mr McNally, who admitted he had been anxious and had scratched his arms with staples the previous night. The key worker said that he would give him extra support and would visit him weekly. Mr McNally was appreciative, and they spoke for an hour. Mr McNally was happy that his observations had been reduced to two per hour but did not want to attend ACCT reviews. The key worker explained that it was a good opportunity to raise any issues he had. Mr McNally said that he had trust issues but would attend ACCT reviews if the key worker was there. That day, his offender supervisor telephoned, but Mr McNally did not answer. He also refused to speak to a mental health nurse.
43. On 28 October, Mr McNally threatened a prison officer. That day he saw a doctor from the mental health team. He was anxious and cautious about engaging. The doctor gave him some anxiety management techniques and noted that assessment should continue.
44. At an ACCT review on 30 October, Mr McNally said he was still reluctant to leave his cell. He did not like answering his in-cell telephone, feeling that it invaded his personal space, so he often unplugged it. He was willing to work with the mental health team but needed to take small steps to build his confidence. He said that when his reverse cohorting (initial isolation period) had ended, he had been moved to a cell that had multiple self-harm triggers. He had told a member of staff and they moved him to a cell he liked. He said he had no thoughts of self-harm and had some staff he was happy to talk to. Mr McNally said that he wanted to have the level of observation set at twice hourly, but after discussion agreed that meaningful conversations were more important so observations would be hourly.
45. That day, a nurse from the mental health team spoke to him and encouraged him to take small steps to trust people and to build his confidence to come out of his cell.

46. The key worker saw Mr McNally for a key work session on 31 October. Mr McNally had moved to a new cell on G Wing and said he was doing better since the move. He was still anxious but had been talking to other prisoners. Later that day, he scratched his arm. A nurse went to see him, but he had already cleaned the scratches and did not need further treatment. A mental health nurse saw him for a therapeutic session and Mr McNally said he had been thinking about past trauma. Harming himself helped relieve the pressure, and he had been doing it since he was a child. He said that he would end his life one day but not until he was out of prison and that he had no thoughts of harming himself again soon. He agreed to work with the psychology and mental health teams, and to try to engage with wing staff.
47. Because Mr McNally had self-harmed, staff held an ACCT review on 1 November. Mr McNally refused to engage, so staff raised the level of observation to three per hour with five conversations per day. Staff had found a piece of paper on which Mr McNally had written lots of slogans, including "I want to die". The key worker went to see Mr McNally and explained what had happened at the review. Mr McNally said that he was getting on better with staff but that there were still some he would not engage with.
48. On 2 November, Mr McNally declined his PE induction. He did, however, go out for exercise. Staff noted him engaging with other prisoners, including making rap rhymes with them.
49. At an ACCT review on 4 November, Mr McNally engaged well. He had started to come out of his cell for exercise and to collect his food. He said he liked the way staff had been flexible with encouraging him to engage. They discussed the paper with written slogans that staff had found. Mr McNally asked for it back, saying it was a thought diary that helped him process his feelings. After discussion, this was agreed. Staff suggested reducing observations to once per hour, but at Mr McNally's request agreed for it to remain twice hourly with five conversations per day.
50. Mr McNally had not responded to his offender supervisor's phone calls or letters, so on 6 November, she introduced herself to him in the exercise yard. Mr McNally told her to "fuck off". She noted that she would try to contact him again soon. That night, Mr McNally scratched his arm. He told staff that he had been frustrated that his vape had run out of battery.
51. On 9 November, at a multi-professional complex case clinic (MPCCC) meeting staff agreed that although Mr McNally was not autistic, he had autistic traits and a possible learning disability.
52. At an ACCT review on 12 November, Mr McNally said he had been engaging with the regime, agreed to see the mental health team weekly, and asked if his daily ACCT conversations could be longer and in more depth. Those present explained the pressures on staff, which he accepted. When they suggested reducing his observations to hourly, he said that he might self-harm. The review decided to err on the side of caution and retain the level he requested.
53. On 13 November, Mr McNally gave the psychologist the "About Me" introductory form he had completed as a first step into the Pathways intervention. At a

multidisciplinary healthcare meeting on 16 November, staff agreed that Mr McNally would probably be suitable for Pathways. The psychologist would see him weekly to talk about areas he would like to work on while in prison.

54. On 16 November, Mr McNally deliberately hit his head against a wall. Healthcare staff attended but he refused any treatment. He was open with staff about what he had done and said that he was 'okay'. Staff agreed that his observation level did not need amendment.
55. DART services had tried to contact Mr McNally several times during October and November, both by telephone and letter, but without response. On 16 November, Mr McNally said that he did not want to engage with DART services. The DART manager agreed to close his file.
56. On 19 November, staff held an ACCT review, and though Mr McNally refused to attend he said that he was not in a low mood and had no thoughts of harming himself. He had felt upset by a comment from a prisoner on the exercise yard. He was looking forward to his appointment with the psychologist the following day and working with Pathways. His observation level remained unchanged. Later that day Mr McNally cut his arm with a piece of plastic. He did not need treatment. The following day he told the psychologist that he had always wanted to take his own life but would do so outside prison. He said that he had no motivation and no goals in life. He said that he had harmed himself after being taunted about a family member abusing him. He had also hit his head against the sink but said he would not self-harm again now. His observations were raised to at least three per hour.
57. During the night of 23 November, Mr McNally scratched his arm again. At an ACCT review on 26 November, he said that the frequency of night checks was causing him stress and left him too tired to engage with the regime. Checks were reduced to at least one per hour during the night, twice hourly during the day. He liked the cell he was in and did not want to move, but it was near a wooden doorway and he was disturbed by the door banging. Mr McNally was planning to buy a stereo because he found music therapeutic, and it would cover the noise of the door.
58. On 30 November, a doctor noted on Mr McNally's record that there was no evidence of him having a learning disability or attention deficit hyperactivity disorder. He would remain under the mental health team's care and on the Pathways intervention list.
59. On 3 December, Mr McNally cut his arm, and said that he had taken 36 of his prescription lansoprazole (used to treat stomach acid). Medical staff took his clinical observations, but he did not need any further treatment. At an ACCT review the following day, he said that he had been made anxious by the wooden door banging. He was offered a cell move and said he would consider this.
60. On 12 December, Mr McNally refused to attend his ACCT review. The staff who attended spoke to him individually. He said that he felt 'okay' and did not need further support. If he felt that he did, he would ask his key worker. His observation level remained unchanged. Later that day he opened an existing wound on his arm. Observations were raised to two per hour. At an ACCT review the following day, Mr McNally was open, and said he was anxious about being around people he did not know. It was noted on his electronic record that one of Mr McNally's triggers

for self-harm was being checked on too frequently, but he understood that staff needed to keep him safe. Observations were reduced to hourly.

61. On 14 December, Mr McNally told the psychologist that he wanted to address some difficult issues in the next session. She suggested that they wait until after the Christmas break.
62. Staff had to persuade Mr McNally to attend his ACCT review on 15 December. He said that some prisoners had stopped talking to him, and he did not know why. Also, a prisoner had arrived from Oakhill and had been shouting to him. He had not responded and was relieved when staff said the prisoner would soon be moving off the wing. Mr McNally said that he would like to reduce the number of discussions with staff so each one could be more meaningful. He liked the cell he was in, though would still consider a move if he felt he needed to.
63. On 18 December, Mr McNally told the psychologist and his key worker that another prisoner had offered him some paper treated with 'Spice' (an illicit psychoactive substance) to test how good it was. An intelligence report said that he had accepted and swallowed it, though his key worker noted on Mr McNally's record that he said that he had declined. The psychologist explained the dangers of 'Spice' and told wing staff to be aware if the other prisoner approached Mr McNally's door again.
64. At an ACCT review on 21 December, Mr McNally engaged well. He talked about when he had been offered 'Spice' and said that, although he had refused, it had made him uncomfortable. He said he had not used drugs since arriving at Aylesbury and was concerned about meeting the prisoner who he said offered drugs at mealtimes. It was agreed that he could come out for meals alone to avoid this prisoner.
65. On 26 December, Mr McNally admitted that he had harmed himself the previous day. He refused to see healthcare staff. On 28 December, he agitated an existing wound on his leg. On both occasions, the ACCT panel agreed to leave his observation levels as they were, because there was a pattern of self-harm escalating with more frequent checks.
66. At an ACCT review on 29 December, Mr McNally said he had been settled over Christmas. He said he stayed up late and slept late, which allowed him to be alone and to stay out of "wing dramas". He said he did not want any visits but would not say anything further on the subject. He said that he got on well with his key worker and would speak to him if he needed support. He asked for the daily conversations to be removed from his ACCT process as he felt that he did not need them. After discussion it was agreed that they would be reduced to two per day as long as Mr McNally participated. Observations were left at one per hour.
67. On 30 December, a note on Mr McNally's medical record said that there was no evidence of psychosis or depression. His care was passed to the primary care mental health team. The same day, an officer introduced himself to Mr McNally as his new key worker. Mr McNally agreed to have a key work session. He said that he was okay but had not showered since arriving as he did not feel comfortable doing so in front of other people. The key worker offered the option of showering alone, and Mr McNally said he would consider this. The key worker said that they

would set small, achievable goals that Mr McNally was comfortable with to move forward. Mr McNally said that he had no other issues.

68. On 4 January 2021, the psychologist wrote to Mr McNally explaining that she could not see him for their usual sessions because of new COVID-19 lockdown restrictions. She would instead call him on his in-cell telephone at pre-arranged times, starting that Friday. When the key worker delivered the letter to Mr McNally, he said he was anxious about knowing who called him, so he kept the phone unplugged. He said that things would get worse if he had reduced contact with the psychologist. Mr McNally then said that while out on exercise he had had a rap battle with another prisoner. (A rap battle is when two rappers go head to head to test their creative sharpness against each other. Rap battles are competitive and include bragging and insults.) It had got personal, the other prisoner had taken offence, and Mr McNally was concerned about repercussions. The key worker said that he would tell officers so they could monitor the situation. He encouraged Mr McNally to use the in-cell phone because it would be an important means of communication in lockdown. He agreed he would have it ready to speak to the psychologist on Friday. The key worker said that he had some annual leave coming up, so Mr McNally might have someone different offering key work sessions in the following weeks, which Mr McNally accepted.
69. At an ACCT review on 6 January, the chair recorded that Mr McNally seemed bright and open. He was still sleeping during the day, as he preferred to be left alone, although it could be noisy. He talked at length about his rap battle and said that his opponent had become angry and had to be placated by other prisoners. Mr McNally was pleased at how he had remained calm and dealt with this, and that he had gone out of his cell the following day. He had also been going out to collect his meals. He was looking forward to getting his stereo but was worried that his money would not be in the right account to pay for it. Staff present promised that they would ensure that the transaction went through.
70. Mr McNally said that he no longer wanted to engage with psychology sessions, so did not want to see the psychologist again. He admitted that this might be a defence mechanism to avoid difficult topics, and that he was reluctant to have telephone sessions. After discussion, staff persuaded him to continue with his sessions. The note of the review said that he felt that he had good positive engagement from wing staff and lots of support from intervention services. Overall, it was recorded that Mr McNally had been open and reflective. Observation and conversation levels remained at once per hour and twice per day respectively. Mr McNally told his first key worker that he wanted to write a letter to a woman who had been an on/off girlfriend, which he would read to her over the telephone. His key worker agreed to read it over before he did so.

## **7 January 2021**

71. On 7 January, Mr McNally's brother's telephone number was removed from his allowed list. Mr McNally, who was barred from contact with children, had telephoned the number in December and spoken to a young female. The call was referred to the security department and the number was removed from his call list. Mr McNally dialled the number several times on 7 January, unaware that he was no

longer allowed to call it. He did not connect. He did not attempt to call any other numbers and did not raise the issue with staff.

72. An Operational Support Grade (OSG) was the night officer on G Wing and began his shift at 8.00pm that evening. He checked Mr McNally, who gave a thumbs-up gesture and said he was 'okay'. He checked him hourly through the night. As had often been the case on previous shifts, Mr McNally was awake for many of the checks, snacking or watching television. The OSG noted in the ACCT document and confirmed in interview that there were no causes for concern.

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73. When the OSG checked Mr McNally at 5.50am, Mr McNally's light was on and he was sitting at the end of the bed. At 6.20am, he was passing Mr McNally's cell and Mr McNally was putting on a t-shirt. He checked other cells on the landing and went back to Mr McNally's cell at 6.29am. He looked through the observation panel and saw Mr McNally suspended from the window bars by a ligature made from a bed sheet.
74. OSGs on night duty carry cell keys in a sealed pouch. The OSG said in interview that he tried to open the pouch but had not had to do so previously and had difficulty in the dim light. He stepped away from Mr McNally's cell door and into the office next door where the light was better. While doing so he used his radio to call a code blue emergency (meaning a prisoner is not, or is having difficulty, breathing). Records showed that this radio call was made at 6.29am. Having opened the pouch and got the key, the OSG opened the cell door and went in.
75. The OSG supported Mr McNally's body and used his anti-ligature knife to cut the sheet. At this point other staff responding to the emergency call arrived. (CCTV footage showed that this was one minute after he went into the cell.) They laid Mr McNally on the cell floor, and a CM radioed the control room to call an ambulance. This call was made at 6.33am, and the control room responded, "Yes, will do". (Ambulance service records show that the request for an ambulance was received at 6.32am.) An officer, who like the CM is first aid trained, checked Mr McNally for a pulse. Unable to find one, he applied a defibrillator (a machine that, in some instances, can restart the heart). The machine recommended no shock, so staff began to perform cardiopulmonary resuscitation (CPR). Healthcare cover is not 24-hour at Aylesbury, so no medical staff were on duty at the time. The prison staff continued to provide first aid until ambulance staff arrived and took over. At 7.40am they transferred Mr McNally to the ambulance and took him to hospital.
76. One of the prison's senior managers was appointed as family liaison officer. He contacted Mr McNally's mother and arranged for a taxi to take her to the hospital. Mr McNally was transferred to the intensive care unit and his mother went with him. At 1.50pm, Mr McNally died.
77. In line with Prison Service guidance, Aylesbury offered to contribute to the cost of Mr McNally's funeral.

## **Support for prisoners and staff**

78. Because Mr McNally was alive when he left the prison, an immediate debrief was not held, though managers spoke to staff involved in the emergency response and the staff care team offered support. Although staff told us they felt supported, the Governor will want to consider holding a debrief following any future life-threatening incident.
79. The prison posted notices informing other prisoners of Mr McNally'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 McNally's death. The psychology department contacted all prisoners on Mr McNally's wing to check on wellbeing and to offer support.

## **Post-mortem report**

80. Stoke Mandeville Hospital noted that on the balance of probabilities Mr McNally died from hypoxic brain injury resulting from hanging. The Coroner and Mr McNally's family accepted this so no post-mortem examination was held. Toxicology tests did not detect any illicit drugs in Mr McNally's system.

# Findings

## Assessment of risk of suicide and self-harm

### *Mr McNally's ACCT*

81. We found no evidence to suggest that staff could have predicted Mr McNally's actions on 8 January.
82. Prison Service Instruction (PSI) 64/2011 sets out the procedures for managing prisoners assessed as at risk of suicide or self-harm. Mr McNally arrived at Aylesbury on very frequent observations because of his risk of self-harm. Staff identified this and appropriately opened ACCT procedures, which were still in place when Mr McNally died.
83. ACCT reviews were multi-disciplinary and, because of Mr McNally's complex needs, they were case managed by a Custodial Manager, a higher grade than usual and an individual with whom Mr McNally had a good relationship. Mr McNally found it difficult to engage with new people, so staff worked to ensure continuity of those who attended reviews. This meant that case reviews were not always carried out immediately after Mr McNally self-harmed, as the PSI suggests. We are satisfied that officers and healthcare staff assessed Mr McNally after each act of self-harm and rightly prioritised continuity of staff at his case reviews to secure his engagement.
84. In January, Mr McNally's ACCT case manager was going to be unable to carry out the role for a short period. He discussed this with Mr McNally and explained that the role would be taken on by a manager with whom Mr McNally had a good relationship. Mr McNally was content with this, and we are pleased that staff took appropriate measures to ensure continuity of care.
85. In line with the requirements of the PSI, when Mr McNally was reluctant to attend reviews, staff encouraged him. When this was unsuccessful, they reported back to him after the reviews. Observations were carried out as directed.
86. When Mr McNally complained about the frequency of observations, staff were sympathetic and made adjustments while explaining to him the necessity of maintaining observations to try to ensure his safety. Decisions about the frequency of observations were made by multi-disciplinary teams who were familiar with Mr McNally, with him as a full participant in discussion. We consider that this was an appropriately flexible approach to managing Mr McNally's risk.
87. When staff were encouraged to try to engage with Mr McNally via his in-cell telephone, other departments were asked to inform the wing office when they did so, whether Mr McNally answered or not, so that it could be recorded. This is good practice, as was moving Mr McNally to a different cell when he felt unsafe in the one he moved to after his reverse cohorting period ended.
88. Mr McNally had harmed himself on several occasions. These incidents did not seem to be presaged by particular triggers in the present, and we consider that it would have been difficult for staff to have predicted when he would be vulnerable.

Moreover, the self-harm tended to be superficial. While Mr McNally did sometimes say that he thought he would take his own life, he consistently said this would not be in prison.

89. We found nothing to suggest that staff could have predicted a serious escalation and that Mr McNally's risk of suicide was imminent before he died, and we commend the staff involved for the care and support they provided him during the two and half months he spent at Aylesbury before his death.

#### *Mr McNally's relationships with others*

90. Mr McNally was reluctant to trust new people and had a history of not engaging. In Aylesbury he declined to deal with substance misuse services, or with the chaplaincy (though he did engage with one member). Staff worked hard to forge relationships with him and, to a fair degree, were successful. Mr McNally did not like using his in-cell telephone as he found it intrusive, so various members of staff made efforts to ensure that he had plenty of contact and this did not lead to him being isolated. He was concerned about Aylesbury's reputation and was reluctant to come out of his cell. There is no evidence to suggest that he had any issues with individual prisoners. Staff were patient and encouraging and worked with him to help him develop confidence in stages, such as arranging for him to shower alone or accompanying him to collect his meals. His confidence increased, and he began to come out of his cell for association and mix with other prisoners. When he was concerned about relationships with other prisoners, staff monitored the situation proportionately.

#### **Mr McNally's letter to Oakhill**

91. Shortly after arriving at Aylesbury, Mr McNally wrote to an officer in Oakhill. He wrote that he did not like Aylesbury and was not mixing. She said that when the letter arrived in Oakhill it was opened in the security department before she saw it. The security department in Oakhill, however, do not have a record of the content of the letter.
92. There is no evidence that staff at Aylesbury saw the letter that Mr McNally wrote to the officer. A nurse noted on his medical record that a letter was discussed before an ACCT review on 1 November. The nurse confirmed that it was only a passing comment about the security implications for that member of staff. Those at the review did not see a copy of the letter or discuss its contents and might have been speaking about the letters Mr McNally wrote when he left Oakhill.
93. Staff at Aylesbury had already identified the issues Mr McNally raised in his letter and were trying to help him address them. That they did not see his letter did not affect the care they provided. Nonetheless, Oakhill should have made Aylesbury aware of the contents of the letter. We make the following recommendation:

**The Director of Oakhill should ensure that any information about a prisoner's risk is effectively communicated to those who are responsible for their care following a transfer.**

## Emergency response

94. When the OSG tried to open the sealed key pouch to unlock Mr McNally's cell door, he struggled to do so. He said in interview that it was the first time he had had to break the seal on the pouch. We cannot say whether the short delay in entering the cell affected the outcome for Mr McNally, but delays could be critical in other life-threatening situations.
95. Prison Service Instruction (PSI) 03/2013 says that governors must have a medical emergency response code protocol to ensure that prisons call an ambulance immediately in a life-threatening medical emergency. The PSI explicitly says that control room staff should automatically call an ambulance whenever there is an emergency code.
96. The OSG called a code blue at 6.29am. Although it is not recorded when the ambulance was called, when the CM radioed the control room at 6.33am to call an ambulance, their response was "Yes, will do", indicating that they had not already done so. Ambulance service records showed that the call was received at 6.32am. It would seem that there was a delay of around four minutes between the code blue call and an ambulance being requested. Again, we cannot say if this delay affected the outcome for Mr McNally, but we do know that even a short delay can make a significant difference in a medical emergency.
97. In a previous investigation into a death at Aylesbury in May 2020, we found that control room staff did not immediately call an ambulance in response to a medical emergency code. The YOI recognised that this had occurred and on 12 January a notice was issued to all staff pointing out that such a delay is not acceptable. Nevertheless, it is disappointing to have to raise the issue again and the Governor will want to ensure that the system is working correctly. We make the following recommendations:

**The Governor should ensure that all staff who may need to open sealed key pouches have received training in how to do so.**

**The Governor should monitor the response to emergency codes and report on his findings to the Ombudsman after three months.**

## Substance misuse

98. Mr McNally had a history of substance misuse. Although the drug and alcohol rehabilitation team at Aylesbury tried to engage with him on several occasions, Mr McNally declined to do so. When another prisoner offered Mr McNally drugs, he openly discussed it with staff, and they responded appropriately. There is no evidence to suggest that drug use was an issue for Mr McNally during his time in Aylesbury.

## Mr McNally's healthcare

99. The clinical reviewer noted that the healthcare that Mr McNally received in custody was equivalent to that which he could have expected in the community. There was planning in advance of his arrival in Aylesbury. He was in good physical health.

His mental health was assessed on an ongoing basis with appropriate referrals. There was evidence of good communication between different branches of healthcare, and the department was represented in ACCT reviews. Staff worked to form relationships of trust with Mr McNally, sometimes in challenging circumstances.

**Prisons &  
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