Prisons & Probation
Ombudsman
Independent Investigations

Independent investigation into the death of Mr Martin Willis, a prisoner at HMP Stoke Heath, on 15 September 2022

A report by the Prisons and Probation Ombudsman

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

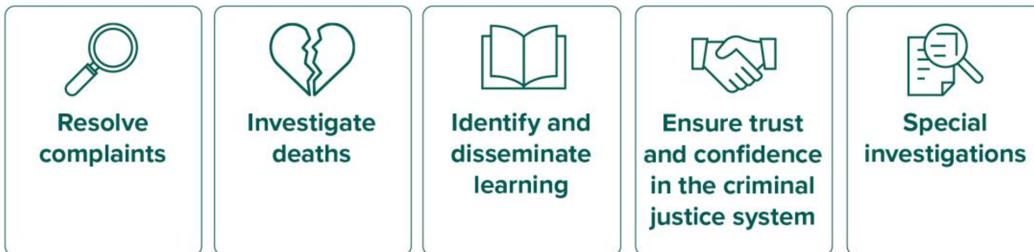
Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T I 020 7633 4100

OUR VISION

To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.

WHAT WE DO



WHAT WE VALUE

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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 Martin Willis died after he was found hanged in his cell at HMP Stoke Heath on 15 September 2022. He was 55 years old. I offer my condolences to his family and friends.

Staff monitored Mr Willis using suicide and self-harm prevention procedures when he was found with a ligature on 11 September. We found some deficiencies in the way staff managed those procedures and observations were not always completed as they should have been, including on the morning Mr Willis died.

We found that the key worker scheme at Stoke Heath was not implemented in line with Prison Service policy. This meant that Mr Willis did not have regular contact with a nominated member of prison staff after July 2022, despite the Exceptional Delivery Model (EDM) in operation during COVID-19 being stood down. The Head of Safety told us that Stoke Heath was still delivering the EDM due to staffing shortages and prioritising the most vulnerable prisoners for key work. We recognise the pressures caused by low staffing levels but are concerned that there is no clear strategy for identifying who is most vulnerable.

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

Kimberley Bingham
Acting Prisons and Probation Ombudsman **May 2023**

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Summary

Events

1. In October 2007, Mr Martin Willis was given an indeterminate public protection (IPP) sentence with a tariff of four years, for robbery. On 15 November 2021, Mr Willis was moved to Stoke Heath.

2. Mr Willis was diagnosed with schizophrenia in 2017. He experienced mental ill-health in prison and in the community when he was previously released on parole. Mr Willis also had a long history of substance misuse. He engaged with both the mental health team and substance misuse services at Stoke Heath and was on an opiate substitute programme.

3. On 6 September 2022, the Parole Board directed that Mr Willis should be released on 3 October and that he should reside at an Approved Premises. The decision to release him appears to have triggered a significant decline in Mr Willis' mental health. On 11 September Mr Willis was found with a ligature, and staff started suicide and self-harm prevention measures. Mr Willis was still subject to increased monitoring at the time of his death.

4. On 15 September, at around 8.38am, an officer went to unlock Mr Willis for his medication and found him hanging by a bed sheet attached to his bed. Staff radioed a code blue medical emergency, entered the cell and with the assistance of healthcare staff, including the prison GP, tried to resuscitate Mr Willis. Paramedics attended and resuscitation continued, but at 9.38am, the paramedics declared Mr Willis had died.

Findings

5. We found that Mr Willis had a history of struggling with the prospect of release, which impacted on his mental health. When the Parole Board directed his release on 6 September, staff put a supportive plan in place and tried to reassure Mr Willis but did not put additional monitoring in place because they did not consider that there was an increased risk of suicide or self-harm. We consider this reasonable, in the circumstances. On 11 September, staff found Mr Willis with a ligature and rightly started monitoring him using suicide and self-harm prevention procedures (known as ACCT).

6. However, ACCT procedures were not well managed. The pages within the ACCT document were not accurately completed, supervisor daily checks were not adequate, and observations did not always take place at the correct intervals. On the morning Mr Willis died he should have been checked at least hourly, but he was not.

7. On the morning Mr Willis died, the observation record on the ACCT document was altered. The prison conducted a disciplinary investigation into the actions of three members of staff. All three were given written warnings.

8. The clinical reviewer found Mr Willis received a good standard of care from both the mental health team and substance misuse services.

9. We found that the support and engagement provided through the key work model was satisfactory when it worked, but key work did not happen as often as it should have done. Mr Willis did not have a key work session after July. We found that while wing staff had a good rapport with Mr Willis and provided a good level of care, it is possible that a consistent point of contact, especially when he was subject to ACCT procedures and in the run up to his release, might have benefitted Mr Willis.

10. During the emergency response when Mr Willis was found hanged, the number of prison staff on the wing was unnecessary and the incident should have been better managed.

Recommendations

- **The Governor must ensure that staff are aware of their responsibilities for managing prisoners at risk of suicide and self-harm, in line with PSI 64/2011, in particular:**
  - **All sections of the ACCT document are completed and regularly updated**
  - **support actions are specific, meaningful and tailored to the individual to reduce their risk**
  - **support actions are completed and reviewed as appropriate**
  - **daily supervisor checks are completed.**

- **The Governor should ensure that ACCT observations are accurately recorded and completed as directed.**
- **The Governor should clarify the process for identifying and prioritising vulnerable prisoners for key work when staff shortages impact on delivery.**
- **The Governor should remind staff that medical emergencies should be appropriately managed and only members of staff required to support the process should remain at the scene**.

The Investigation Process

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

12. The investigator visited Stoke Heath on 22 September and obtained copies of relevant extracts from Mr Willis' prison and medical records.

13. NHS England commissioned a clinical reviewer to review Mr Willis' clinical care at the prison. The investigator and the clinical reviewer jointly interviewed healthcare and prison staff. The investigator also interviewed two prisoners and a prison manager during her visit to Stoke Heath.

14. We informed HM Coroner for Shropshire, Telford and Wrekin of the investigation. The Coroner provided us with the post-mortem report. We have sent the Coroner a copy of this report.

15. The Ombudsman's family liaison officer contacted Mr Willis' sister to explain the investigation and to ask if there were any matters she wanted us to consider. She wanted to know if Mr Willis received appropriate care for his mental health and if he was subject to additional monitoring before he died, which we address in this report.

16. Mr Willis's next of kin received a copy of the initial report. They did not identify any factual inaccuracies.

17. The prison also received a copy of the report. They did not identify any factual inaccuracies. An action plan for the recommendations is annexed to the report.

Background Information

HMP/YOI Stoke Heath

18. HMP/YOI Stoke Heath is a medium secure prison in Shropshire that holds up to 782 adults and young adult men on eight residential wings. Healthcare is provided by Shropshire Community Health NHS Trust. The Forward Trust provides services and support for prisoners with substance misuse issues.

HM Inspectorate of Prisons

19. The most recent full inspection of HMP/YOI Stoke Heath was in November 2018. Inspectors were concerned there had been a sharp increase in self-harm. Fortnightly complex case meetings and monthly strategic meetings were found to be not effective or attended consistently. Attendance at monthly strategic meetings was also inconsistent, and the meeting offered little analysis to understand the causes of self-harm at Stoke Heath.

20. Inspectors found the substance misuse team had appropriate throughcare arrangements to facilitate treatment continuation for prisoners on release.

Independent Monitoring Board

21. 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.

22. In its latest annual report for the year to 30 April 2022, the IMB found the prison was safe and positive environment. The IMB noted their concerns that the key worker provision had not been reintroduced quickly enough after its suspension due to Covid-19, which they deemed critical to a prisoner’s general well-being, mental health, safety and rehabilitation.

23. The IMB found incidents of self-harm were relatively low and were satisfied those at risk were proactively identified and supported by the ACCT process.

Previous deaths at HMP/YOI Stoke Heath

24. Mr Willis was the sixth prisoner to die at Stoke Heath since September 2020. Four previous deaths were from natural causes and one was self-inflicted. There has been one natural cause death since. We have previously identified issues with the management of ACCT procedures.

Assessment, Care in Custody and Teamwork

25. 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 support the prisoner. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011, *Management of prisoners at risk of harm to self, to others and from others (Safer Custody).*

26. 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, multidisciplinary review meetings involving the prisoner. As part of the process, support actions (a plan of care, support and intervention) are put in place. The ACCT plan should not be closed until all the support actions have been completed.

Approved Premises

27. Approved premises, formerly known as probation and bail hostels, mostly accommodate offenders released from prison on licence and those directed there by the courts as a condition of bail. Their purpose is to provide an enhanced level of residential supervision in the community, as well as a supportive and structured environment.

Indeterminate Public Protection Sentences (IPP)

28. Indeterminate public protection sentences were abolished in 2012. They were intended to protect the public from offenders whose crimes were not serious enough to merit a normal life sentence, but who could only be released once they had served their minimum tariff and had demonstrated to the satisfaction of the Parole Board that they had sufficiently reduced their risk.

Key worker scheme

29. The key worker scheme is a key part of HMPPS’s response to self-inflicted deaths, self-harm and violence in prisons. It is intended to improve safety by engaging with people, building better relationships between staff and prisoners and helping people settle into life in prison. Details of how the system should work are set out in HMPPS’s Manage the Custodial Sentence Policy Framework which says:

- All prisoners in the male closed estate must be allocated a key worker whose responsibility is to engage, motivate and support them through the custodial period.
- Key workers must have completed the required training.
- Governors in the male closed estate must ensure that time is made available for an average of 45 minutes per prisoner per week for delivery of the key worker role, which includes individual time with each prisoner.
- Within this allocated time, key workers can vary individual sessions to provide a responsive service, reflecting individual need and stage in the sentence. A key worker session can consist of a structured interview or a range of activities such as attending an ACCT review, meeting family during a visit or engaging in conversation during an activity to build relationships.

30. During the pandemic, key work was suspended across the prison estate under the Exceptional Delivery Model (EDM), except for prisoners identified as being most vulnerable. The EDM was stood down in April 2022 and prisons are now expected to be delivering key work for all prisoners.

Key Events

Background

31. On 29 October 2007, Mr Martin Willis was given an indeterminate public protection (IPP) sentence, with a tariff of four years for robbery (minus time on remand) and his tariff expiry date was 21 August 2011. He was released on 9 January 2017 to an approved premises (supervised hostel style accommodation for those released from prison on licence) but was recalled to prison later the same day when he did not comply with his licence conditions.

32. Mr Willis was released again in October 2020. He breached his licence conditions and was recalled to HMP Birmingham on 26 October 2021.

33. Mr Willis had a long history of substance misuse. He was also diagnosed with a range of mental health conditions including paranoid schizophrenia, dissociative personality disorder (a range of conditions that can cause physical and psychological problems and can mean a person feels disconnected from themselves or the world around them), anxiety and depression. Mr Willis was prescribed antipsychotic medication, an antidepressant and was on an opiate substitute plan (buprenorphine) at Birmingham. He was seen by a range of healthcare professionals for mental health and substance misuse assessments.

HMP Stoke Heath

34. On 15 November 2021, Mr Willis transferred to Stoke Heath. At his initial health screen, the nurse noted Mr Willis' mental and physical health history and referred him to the mental health and substance misuse teams. Mr Willis was assessed as a high risk to cellmates so required a single cell. Staff completed regular welfare checks on Mr Willis' first night and recorded no concerns.

35. The next day, Mr Willis was assessed by a prison doctor and the integrated drug treatment service (IDTS). His opiate substitute was continued, and he was accepted onto the IDTS team caseload, which meant he would be seen and reviewed regularly.

36. On 17 November, Mr Willis was also accepted onto the mental health team's caseload.

37. On 29 November, Mr Willis met with a recovery worker from the substance misuse team. Over the next few days, a recovery worker completed a full assessment of Mr Willis' needs and informed him that she would continue to provide regular support. The recovery worker met with Mr Willis regularly throughout his time at Stoke Heath.

38. On 1 December, Mr Willis met with his nominated key worker. Mr Willis said that he was familiar with the prison regime and had no specific issues.

39. On 2 December, Nurse A from the mental health team reviewed Mr Willis. He said he had stopped taking his medication in the community and his mental health declined. Mr Willis was hearing voices each day and asked for help to sleep. The nurse gave Mr Willis a distraction pack (a variety of quizzes, reading material and other activities to help distract during long periods of time spent alone) to help keep

him occupied and told him she would discuss his request for medication with colleagues. The nurse took Mr Willis' feedback to the multi-disciplinary team (MDT) meeting, attended by the forensic psychiatrist, and other mental health staff. They agreed his care should be discussed at the Safer Prescribing Meeting (SPM - a meeting of health professionals and pharmacy staff where medication issues are discussed and reviewed). On 10 December, Mr Willis was discussed at the SPM and it was agreed that his sleeping pattern would be monitored before prescribing any sleep medication.

40. On 15 December, Nurse A completed another review of Mr Willis. He said he still heard voices but was more settled on the wing. Mr Willis had no thoughts of suicide or self-harm.

2022

41. During January, Mr Willis remained settled on his wing. His key worker recorded that he kept himself occupied by watching the television and reading, and generally preferred his own company. Mr Willis met regularly with the mental health team and said he was getting more sleep.

42. On 1 February, Nurse A reviewed Mr Willis. He told her that he had started to hear voices and his sleep was disturbed. The nurse arranged to see Mr Willis again on 15 February, but he did not attend. She spoke with wing staff who said that Mr Willis was being supported by health and wellbeing champions (HAWCs - prisoners who are trained to support the healthcare team and their peers with health-related concerns). She wrote to Mr Willis to remind him of the importance of keeping his appointments and completed a detailed review of Mr Willis' risk history and risk management plan. She referred Mr Willis to the forensic psychiatrist for a review of his medications.

43. On 21 February, the forensic psychiatrist met Mr Willis and they discussed his medication. Mr Willis said that he was still hearing voices but felt stable. Mr Willis continued to be reviewed weekly by Nurse A and his care plan was reviewed and updated. Mr Willis reported feeling more stable since a change in his medication.

44. At the end of March, Mr Willis reported that although he still felt low at times, he had no thoughts of suicide or self-harm.

45. In April, Stoke Heath went into lockdown due to an outbreak of COVID-19. The mental health and substance misuse teams were unable to see Mr Willis in person but completed welfare checks via his in-cell telephone. On 27 April, Mr Willis told Nurse A that he was having problems sleeping again. She contacted Dr A, prison GP, who prescribed sleeping tablets for three nights (zopiclone). On 17 May, during a face-to-face meeting, Mr Willis told the nurse he felt well, and his sleep pattern was back to normal.

46. On 1 June, Nurse A contacted the Community Mental Health Team (CMHT) while completing a parole report for Mr Willis (CMHT had supported Mr Willis when he was last in the community). The CMHT confirmed that they would continue to support Mr Willis post release.

47. On 15 June, the Parole Board reviewed Mr Willis' suitability for release. Prison staff and his community offender manager proposed that he was suitable for release. They told the Parole Board there was a robust risk management plan in place for Mr Willis and a place had been secured at an Approved Premises from 3 October. The

Parole Board adjourned the hearing and asked for further assurance that sufficient support had been put in place for Mr Willis' release, based on the challenges he had experienced in the past.

48. During July, Officer A, a nominated key worker met with Mr Willis for his key work sessions. The officer recorded that staff suspected Mr Willis may be trading his medication but found no evidence to verify this. Mr Willis said he had been experiencing some mental health issues and he felt more comfortable staying in his cell, watching television. The officer was taken off key work duties soon after his last contact on 27 July, due to staffing issues in the prison, and was then on night duty, rest days and annual leave. Mr Willis did not have another key work session before he died.

49. Wing staff raised concerns with the mental health team that Mr Willis' mental health was declining. Mr Willis told Nurse A that his Parole Hearing had been adjourned and that when last released he had used illicit substances which had contributed to the relapse in his mental state. Mr Willis said he was hearing voices, was concerned that other prisoners had found out about his offence and feared for his safety. An appointment was arranged with the forensic psychiatrist. The mental health and substance misuse teams met to formulate a joint support plan for Mr Willis' release, to manage his substance misuse and mental health risks.

50. On 3 August, a substance misuse worker, reviewed Mr Willis' opiate substitute medication. She contacted Nurse A to raise concerns about his mental health. The nurse spoke with him and he said that he was worried about hearing voices again, but that was getting support from the HAWC service. Mr Willis said that the possibility of parole was worrying him and requested a change in antipsychotic medication. The nurse asked forensic psychiatrist to review Mr Willis' medication. The next day, the MDT discussed Mr Willis and scheduled a medication review for 18 August.

51. On 18 August, Mr Willis met with the forensic psychiatrist for his medication review. Mr Willis said he was not trading his medication or being bullied. He asked for a change in antipsychotic medication, which the forensic psychiatrist agreed. The forensic psychiatrist arranged for Mr Willis to gradually reduce his existing medication and introduce a new one on a low dose before building it up. He would monitor Mr Willis for side effects. Mr Willis asked for a move to HMP Dovegate, where they have 24-hour healthcare.

52. On 24 August, Nurse A asked the prison security team if there was any intelligence to suggest Mr Willis was trading or selling his medication and asked if a mandatory drug test had been completed. Security responded and said that no suspicions had been raised and as a result, a drug test had not been completed. Later, the nurse met with Mr Willis. He told her that he had met his community nurse earlier in the day and the meeting had gone well. Mr Willis said he felt well on his new medication and was not being bullied.

53. After meeting with Mr Willis, Nurse A emailed the forensic psychiatrist to ask if a 24-hour hospital wing placement would be appropriate for Mr Willis. The forensic psychiatrist said Mr Willis did not meet the criteria and was likely to be released soon, so a move would not be agreed.

September 2022

54. On 6 September, the Parole Board approved Mr Willis' release on 3 October, to Wharflane House Approved Premises.

55. On 9 September, Mr Willis told Officer A that he was hearing voices, thought someone was going to kill him and did not like being in his current cell. The officer moved Mr Willis to another cell, but he did not settle and used his emergency cell bell. Mr Willis told the officer A he wanted to speak to a Listener, which he arranged (Listeners are other prisoners trained by Samaritans to support their peers). The officer contacted the mental health team. Nurse A was on leave, so Nurse B went to see Mr Willis. He told her that he was due for release and was hearing voices that he was going to be killed and put in a body bag. Nurse B spoke to officers on the wing and reassured Mr Willis he had support. He did not report any thoughts of suicide or self-harm.

56. On 11 September, wing staff found Mr Willis trying to place a ligature around his neck; he told them voices were telling him to do so. At 11.45am, staff started suicide and self-harm prevention measures (known as ACCT) and implemented an immediate care plan. Staff observed Mr Willis hourly until he could be fully assessed.

57. The next day, Officer B completed Mr Willis' ACCT assessment. He noted that Mr Willis reported feeling better but would not elaborate on the voices he was hearing. Mr Willis said he had used a shoelace as a ligature, but said it was a cry for help, rather than an attempt to end his life. Mr Willis shared his self-harm history and said he was taking his medication as prescribed. He said he would engage with wing and healthcare staff when he needed support.

58. After the ACCT assessment, Custodial Manager (CM) chaired the first ACCT review. Nurse C, mental health team, the recovery worker and Mr Willis attended. Mr Willis said he was concerned about his release, that his new medication was making the voices worse and he believed someone was trying to harm him. Staff reassured Mr Willis that he had support on the wing and support measures would be in place when he was released. They reminded Mr Willis that he had appointments with Nurse A and the forensic psychiatrist later in the week, which he said he was aware of. Mr Willis was provided with distraction packs and said that he found reading and watching the television helpful. Observations remained hourly and the next ACCT review was scheduled for 15 September.

59. On 13 September, Mr Willis tried to force his way out of his cell when Officer C opened his door. The officer was opening the door so that the substance misuse workers, could speak to him. The officer pushed Mr Willis back into his cell and locked the door. He told Mr Willis to sit on his bed and calm down, which he did. A short while later his cell door was unlocked, and Mr Willis told one of the substance misuse workers that he heard voices saying someone was coming for him. The substance misuse worker noted Mr Willis looked agitated and confused and that he had apologised for his behaviour. Staff did not punish Mr Willis for his earlier aggressive behaviour.

60. Later, Nurse A met with Mr Willis. She noted that he was dishevelled, agitated and appeared to be responding to unseen stimuli. Mr Willis asked to leave the room and stand in the fresh air. He said he was not well and needed an increase in his medication. Mr Willis told the nurse he was glad he was not dead and had no

further thoughts to harm himself but wanted the voices to stop. The nurse told Mr Willis he had an appointment with the forensic psychiatrist on 15 September.

61. Nurse A spoke to wing staff to share her concerns about Mr Willis. An email referral was made for Mr Willis to be considered for management under a Challenge, Support and Intervention Plan (CSIP – violence reduction and victim protection measures) because staff were concerned he may have been selling or being bullied for his medication.

62. On 14 September, CM B noted that an ACCT review would be held early due to Mr Willis' behaviour. He noted the mental health team were concerned Mr Willis was not taking his prescribed medication and may have been using illicit substances.

63. Later, CM C chaired an ACCT review, attended by Nurse A, Supervising Officer (SO) A and Mr Willis. CM C noted Mr Willis remained distracted and was hearing voices, particularly at night. Mr Willis said he was taking his medication and knew that he had a medication review the following day, with the prison psychiatrist and the nurse. Mr Willis spoke about being released and that it had previously been a major cause of stress. The nurse reassured Mr Willis that there was a release plan, that he had somewhere to live (an Approved Premises, supervised by staff), and the community mental health team would support him. The CM continued hourly observations during the day, but increased observations to every thirty minutes during the night when Mr Willis felt most vulnerable (although the specific time frame for two checks an hour was not recorded). The next ACCT review was scheduled for 16 September.

64. At around 5.00pm, Mr Willis collected his evening meal and medication. Officer D spoke to him and did not raise any concerns. Mr Willis was locked in his cell for the night and his cell door observation panel was left open, at his request.

15 September

65. During the night, Operational Support Grade (OSG) A completed hourly checks on Mr Willis. The last check was completed at 6.47am. Checks should have been completed twice an hour, but the ACCT document had not been updated following the last review.

66. At around 7.00am, Officer D started the early morning roll check. She went to Mr Willis' cell and he smiled and waved when she said good morning. The officer recorded this in the ACCT 'ongoing record' section. It was the last time Mr Willis was checked before he died.

67. CCTV shows that at around 8.38am, Officer E went to Mr Willis' cell to unlock him to collect his medication. He looked through the observation panel and saw Mr Willis sitting on the floor with furniture behind the door. The officer then noticed a ligature around Mr Willis' neck and ran a short distance to the office to alert staff and request assistance. Officer D, Officer F and Officer G responded and one of them radioed a code blue medical emergency (used when a prisoner is unconscious or has breathing difficulties). The prison control room called for an emergency ambulance at 8.40am.

68. Officer E entered the cell. Mr Willis was hanging by a bed sheet attached to his bed. Officer E used an anti-ligature knife to cut the ligature and lowered Mr Willis to

the floor. Officer G started cardiopulmonary resuscitation (CPR) and a defibrillator was attached to Mr Willis which indicated he had no shockable heart rhythm.

69. Dr A, the prison GP, and three nurses also responded to the medical emergency and arrived at the cell. Prison and healthcare staff continued CPR until paramedics arrived at 8.54am. Mr Willis was declared dead at 9.38am.

Contact with Mr Willis' family

70. Stoke Heath appointed a prison manager, as the family liaison officer. Shortly after Mr Willis' death, she visited Mr Willis' sister to break the news and offer ongoing support. In line with Prison Service instructions, the prison paid the costs of Mr Willis' funeral, which was held on 7 October 2022.

Support for prisoners and staff

71. After Mr Willis' death, the Stoke Heath Governor, debriefed all staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team and the TRiM manager (trauma risk management for staff) also contacted prison staff.

72. The recovery worker said although she felt supported within her team, she did not feel supported by the prison as nobody from the prison care team or TRiM contacted her. The investigator raised this with managers, with her' permission, after she had been interviewed. They said they would make arrangements for the TRiM manager to contact her.

73. The prison posted notices informing other prisoners of Mr Willis' 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 Willis' death and a memorial service was held in the chapel. Prisoners who knew Mr Willis said they felt extremely well supported.

Post-mortem report

74. The post-mortem report concluded that Mr Willis' death was due to hanging. Toxicology results showed his prescribed medication and did not find any illicit substances.

Findings

Assessment of risk of suicide and self-harm

75. Prison Service Instruction (PSI) 64/2011, *Management of prisoners at risk of harm to self, to others and from others (Safer Custody),* sets out the procedures (known as ACCT) that staff must follow when they identify that a prisoner is at risk of suicide and self-harm. It says that ACCT case reviews should be multidisciplinary where possible, that a support plan 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. Support 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.

Decision to start ACCT procedures

76. On 6 September, Mr Willis received a letter from the Parole Board confirming that they were directing his release on 3 October. It was well documented that this was a significant trigger and risk factor for Mr Willis, whose mental health had declined when he had previously been granted release. It is clear from prison and healthcare records that Mr Willis was feeling anxious about his release, which he had mentioned to staff on a few occasions. Staff provided reassurance on the support systems that had been put in place to help him manage the process, and Mr Willis spoke to a community nurse in preparation for his release. Staff rightly monitored Mr Willis using ACCT procedures after he was found with a ligature on 11 September. We considered whether staff should have started ACCT procedures at an earlier stage, when Mr Willis' mental health started to decline, but we concluded that there were no obvious signs that his risk of suicide and self-harm had increased. In these circumstances, we do not make a recommendation.

Management of Mr Willis's ACCT document

77. We found issues with the ACCT documentation which impacted on risk management. The risks, triggers and protective factors page was not completed. While we are satisfied that staff had a good insight into these factors, it is important that they are recorded so that they can be effectively monitored by staff involved in case reviews, and so that staff less familiar with the prisoner are also aware. The supervisor's daily check was not always completed or completed properly, and the level of observations and conversations was not recorded on the first page of all daily ongoing records. Because the supervisor's checks were not completed as they should have been, these issues were not quickly identified or resolved. The case review completed on 14 September does not reference Mr Willis' impending release, or that the previous day an officer had to use force to stop him leaving his cell, which was unusual behaviour for him and a potential sign of increasing risk. We also found that the external contacts section in the ACCT was left blank and that staff did not consider involving Mr Willis' family in his care planning. This might have been a missed opportunity to reassure Mr Willis about support available in the community. There is little evidence that the support actions were reviewed, which meant there was no clear ongoing record of steps being taken to address the risks.

Observations

78. Our main concern is staff's failure to carry out hourly ACCT observations on the morning of Mr Willis' death. During the last ACCT review on 14 September, the

review increased observations to half hourly during the night (although the specific timeframe for the night period was not stated), but the ACCT document was not updated and officers completed only hourly checks. One observation was completed over an hour later. The last recorded observation was made by Officer D at 7.00am. Mr Willis was not checked again until 8.38am, when he was discovered hanging.

79. We are unable to measure the impact of these omissions on the outcome for Mr Willis, but we are concerned that staff did not comply with procedures which might impact on risk management and safety.

80. The Head of Safety during the time Mr Willis was at Stoke Heath, said that it was evident that despite staff training, leaflets, pocket guides and other literature on how to effectively manage an ACCT, this was not being implemented. She said that the Regional Safer Custody Team had been asked to review all the open ACCTs at Stoke Heath and meet with all case managers individually to identify how the process could be improved. She said if ACCTs are not implemented as they should be, case managers will now be held personally accountable (even though the ACCT is a shared document) and would be managed under poor performance measures to try and drive-up improvement. We welcome the proactive steps taken by Stoke Heath and hope our recommendations help guide this work.

- **The Governor must ensure that staff are aware of their responsibilities for managing prisoners at risk of suicide and self-harm, in line with PSI 64/2011, in particular:**
  - **all sections of the ACCT document are completed and regularly updated**
  - **support actions are specific, meaningful and tailored to the individual to reduce their risk**
  - **support actions are completed and reviewed as appropriate**
  - **daily supervisor checks are completed.**

- **The Governor should ensure that ACCT observations are accurately recorded and completed as directed**

81. After Mr Willis had been discovered, an entry was made on his ACCT document recording that he had been checked, as he should have been, before he was discovered. This entry was then crossed out. The Governor initiated a disciplinary investigation and suspended three members of staff, Officer D, Officer G and the CM. All three members of staff were allowed to return to duty once the investigation was completed. The Governor issued a five-year final warning to both Officer D and Officer G and a 12-month written warning to the CM. As the prison have already acted, we do not make a separate recommendation, which we would otherwise have done.

Clinical care

82. The clinical reviewer concluded that overall, the healthcare Mr Willis received was of a good standard, and equivalent to that which he could have expected to receive in the community.

Mental health

83. The clinical reviewer found that Mr Willis received comprehensive support from the mental health team, in particular from Nurse A. He had regular contact with the mental health team, he was reviewed by a consultant psychiatrist and care plans were updated.

84. Nurse A identified that Mr Willis' release was a trigger and risk factor for his mental ill-health. She liaised with the community mental health team to ensure that a support plan was in place to help Mr Willis manage the transition and access help in the community. The mental health team attended all of Mr Willis' ACCT reviews and liaised closely with prison colleagues and those in the substance misuse team to ensure support was co-ordinated.

85. The forensic psychiatrist reviewed and made changes to Mr Willis' antipsychotic medication as required and responded to Mr Willis' concerns when he was experiencing side effects. The forensic psychiatrist said that the change of medication could have affected Mr Willis' mental state during the transition but the dosage had been titrated (continuously measured and adjusted appropriately) by the time he died.

Substance misuse

86. The clinical reviewer found Mr Willis received comprehensive support and treatment from the substance misuse team.

87. We found that medication was a key concern for Mr Willis, particularly when he was experiencing symptoms like sleep disturbances and hearing voices, which impacted on his mental health. We are satisfied that clinical and prison staff responded effectively to Mr Willis' concerns and changes in his presentation, including via the ACCT process.

88. Some staff were concerned that Mr Willis may have been bullied for, selling, or trading his medication. Concerns were raised that he was not taking his medication as prescribed or using illicit substances. We found no evidence to verify these concerns during our investigation and nothing of note in the toxicology results.

Key Worker Scheme

89. Under the Offender Management in Custody (OMiC) model, every prisoner should have a dedicated key worker with whom they have weekly contact. The purpose of the model is to improve safety by building better relationships between staff and prisoners.

90. During 2022, Mr Willis had six key work sessions with nominated key worker (7 April, 1 and 30 May, 15 June, and 1 and 27 July). Between 27 July and Mr Willis' death, the nominated key work, was either not on duty or working nights and not allocated time to complete key work duties. This meant that Mr Willis did not have a key work session for over seven weeks before he died, during the period when he was informed of his release and when his mental health declined.

91. We found that the key worker scheme at Stoke Heath did not comply with the OMiC model, due to staffing shortages. In interview, the head of security told us that the prison was prioritising the most vulnerable prisoners, in line with the national Exceptional Delivery Model (EDM) in operation due to COVID-19. We are

concerned that Stoke Heath did not allocate an alternative key worker for Mr Willis in the nominated key worker's absence, despite him being subject to ACCT measures and identified as at increased risk. We were unable to clarify the process of how vulnerable prisoners were identified at Stoke Heath for key work. We cannot measure the impact on Mr Willis, but we know that regular key work sessions with a consistent officer can help to improve wellbeing and safety. We make the following recommendation:

The Governor should clarify the process for identifying and prioritising vulnerable prisoners for key work when staff shortages impact on delivery.

Management of incident

92. CCTV and body worn video camera (BWVC) footage shows that numerous prison staff responded to the medical emergency. Prisoners were locked back into their cells so that Mr Willis could receive treatment on the landing, where there was more space. However, staff not directly involved in the emergency response remained on the landing. Although there was no impact on Mr Willis' treatment, this was not appropriate and one of the managers on scene should have taken responsibility for managing the incident, as outlined in the Incident Management Manual 2022 (Annex A). We make the following recommendation:

The Governor should remind operational staff that medical emergencies should be appropriately managed and only members of staff required to support the process should remain at the scene.

Inquest

93. The inquest into Mr Willis' death concluded in November 2023. Mr Willis' death was suicide as a result of pressure on the neck caused by hanging.

Prisons &
Probation
Ombudsman
Independent Investigations

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T I 020 7633 4100