Prisons & Probation
Ombudsman
Independent Investigations

Independent investigation into the death of Mr Stephen Hillsden, a prisoner at HMP Wymott, on 15 August 2022

A report by the Prisons and Probation Ombudsman

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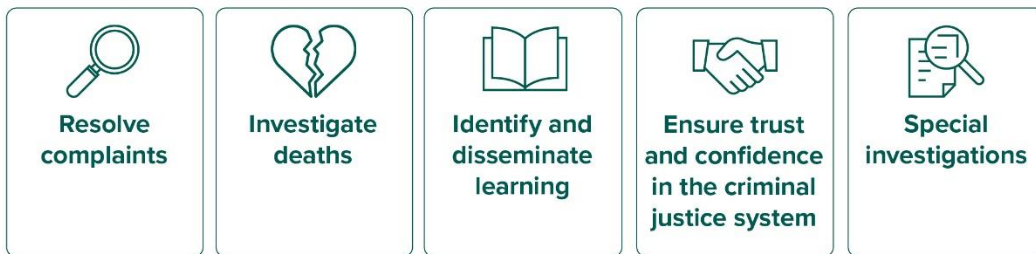
OUR VISION

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.

If my office is to best assist His Majesty's Prison and Probation Service (HMPPS) in ensuring the standard of care received by those within service remit is appropriate, our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.

Mr Stephen Hillsden died on 15 August 2022, after taking an overdose of prescription medication in his cell at HMP Wymott. He was 51 years old. I offer my condolences to Mr Hillsden's family and friends.

Mr Hillsden was experiencing increasing paranoia and anxiety in the period before his death and the reasons for this were unclear. His engagement with staff was mixed, he withdrew from the regime, threatened to harm himself and barricaded his cell door. On 13 August, staff rightly put additional monitoring in place to manage the risk of suicide and self-harm.

When Mr Hillsden's mental health declined and he said he felt under threat, we found that staff were supportive. Beyond suicide and self-harm monitoring procedures, they offered a flexible regime to help reduce Mr Hillsden's anxiety. This included delivering medication to his door and the offer of separate showering and exercise from other prisoners. Staff supported his requests to move to a different wing and helped him complete the relevant paperwork.

However, once staff became concerned about his risk of suicide and self-harm, there were missed opportunities to review whether it was still appropriate for him to hold quantities of medication in his cell. It is particularly concerning that staff did not search Mr Hillsden's cell when they had reasons to suspect he might be misusing medications. We also found some issues in the delivery of suicide and self-harm risk reduction processes, which did not directly impact on the outcome for Mr Hillsden but should be addressed to prevent an impact on future care.

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

Adrian Usher
Prisons and Probation Ombudsman **October 2023**

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Summary

Events

1. Mr Stephen Hillsden had been in prison since 2012 and was serving an indeterminate sentence with a minimum tariff of two years and 181 days. He had significant mental health needs including depression, anxiety and post-traumatic stress disorder (PTSD). He had previously attempted suicide in the community. Mr Hillsden was prescribed a range of mental health medications which he kept in his cell and was responsible for taking the correct doses. He also engaged with therapy. Staff put additional monitoring in place on a few occasions during Mr Hillsden's sentence, when they assessed that his risk of suicide and self-harm had increased. Mr Hillsden also had a history of substance misuse, but there is no evidence that he used substances at Wymott.

2. Mr Hillsden moved onto Wymott's specialist unit for personality disorders in May 2022. In June, a prison psychiatrist assessed that he was experiencing anxiety and paranoia but appeared to be stable overall. In July, staff noted a change in Mr Hillsden's mental health. He said that he had been having flashback dreams and felt under threat. In August, Mr Hillsden refused to meet his therapist. When staff expressed concern at his mood, he said that he had had some items stolen from his cell and felt at threat from other prisoners. He was thinking of leaving the unit.

3. On 13 August, Mr Hillsden barricaded his cell door and told staff he would cut himself with a razor blade. They encouraged him to remove the barricade and hand over the blade, which he did. Mr Hillsden said that he wanted to move to a different unit, which staff said they would consider after the weekend. In the meantime, they put Assessment, Care in Custody, and Teamwork (ACCT) procedures in place to monitor Mr Hillsden and manage the risk of suicide and self-harm.

4. The following day, Mr Hillsden did not engage with the ACCT review process. He was asked to hand over his medication and when he did, some were missing. A prison nurse advised that there were no risks associated with the medications that were missing. That evening, Mr Hillsden handed over more of his medication and said he had taken a large quantity two days earlier. Healthcare organised urgent blood tests. Mr Hillsden barricaded his door again and said he had taken more medication, but then denied this. A nurse found no signs of overdose, and the results of the blood test were normal.

5. On 15 August, Mr Hillsden told staff he had been threatened by another prisoner, but the name he gave did not match anyone living at Wymott at the time. He wanted to apply for vulnerable prisoner status (living in a separate part of the prison for his own protection) and staff agreed to help him apply. He said he had no more thoughts of harming himself.

6. That night, an officer saw Mr Hillsden with a quantity of medication strips and boxes. These were removed and nurses assessed Mr Hillsden's health. His observations were all normal, but nurses advised that Mr Hillsden should be transferred to hospital for further tests. They increased ACCT observations while awaiting the Ambulance Service. Soon after, Mr Hillsden became unresponsive. When staff went into his cell he woke up, but his behaviour was erratic. He then

become unconscious. Nursing staff updated the Ambulance Service and continued to monitor Mr Hillsden, but at around 9.55pm he stopped breathing. They attempted CPR and were then joined by paramedics. Mr Hillsden was pronounced dead at 11.11pm.

Findings

Assessment of suicide and self-harm risk

7. Healthcare staff assessed that Mr Hillsden could safely hold a quantity of his various medication in his cell. When Mr Hillsden said that some of his medication had been stolen, officers did not tell healthcare staff, so they did not review the appropriateness of the risk assessment.

8. On 13 August, Mr Hillsden threatened to cut himself with a razor blade and staff rightly opened ACCT procedures. Officers did not notify the healthcare department and there was a lack of clarity on how the process should work over the weekend.

9. When Mr Hillsden refused to participate in the first ACCT case review, staff did not hold one in his absence. While they offered him support, they did not record a meaningful discussion of Mr Hillsden's risks and how they should be managed.

10. The following day, staff asked Mr Hillsden to hand in the medications he had in his cell, to reduce the risks further. When Mr Hillsden did not return all his tablets, healthcare advised that there were no risks presented by those that were missing (they were for stomach issues), so no cell search was undertaken. We consider this reasonable. However, Mr Hillsden later handed further medications in and said that he had taken a large quantity two days prior. The next day, he was seen with medication in his cell. Only then did officers conduct a search and clear Mr Hillsden's cell of any medications they found. The cell should have been searched on 14 August when he handed further medications in and said he had taken a large quantity of them.

11. When Mr Hillsden told a nurse that he had taken a large quantity of medication two days previously, this was not reflected in his ACCT document.

Mr Hillsden's healthcare

12. The clinical reviewer concluded that the care Mr Hillsden received was partially equivalent to that which he could have expected to receive in the community. There were gaps in the risk assessment when staff removed Mr Hillsden's permission to hold his own medication, and the review makes recommendations to improve wider care planning processes.

Recommendations

- The Governor should ensure that any information relating to the possible mis-use of in possession medication is shared with healthcare staff so that relevant risk assessments can be completed.

- The Governor and Head of Healthcare should ensure that cell searches are completed wherever there is disclosure or reasonable suspicion of misuse of medication, to ensure that risks are effectively managed.
- The Head of Healthcare should remind staff of the importance of recording all relevant risk information in ACCT documents, to ensure that risks can be effectively managed.
- The Governor and Head of Healthcare should clarify the process for notifying healthcare in the event of an ACCT being opened over a weekend, to ensure care planning has multidisciplinary input.
- The Governor should ensure that when prisoners do not engage, staff continue to hold ACCT reviews in line with HMPPS guidance, to ensure that risks are effectively managed.

The Investigation Process

13. HMPPS notified us of Mr Hillsden's death on 16 August 2022. The investigator issued notices to staff and prisoners at HMP Wymott informing them of the investigation and asking anyone with relevant information to contact him. He received one response from a prisoner, who he later interviewed.

14. The investigator visited Wymott in November 2022. He obtained copies of relevant extracts from Mr Hillsden's prison and medical records.

15. The investigator interviewed nine members of staff at Wymott.

16. NHS England commissioned a clinical reviewer to review Mr Hillsden's clinical care at the prison. The investigator and clinical reviewer jointly interviewed healthcare staff.

17. We informed HM Coroner for Lancashire and Blackburn with Darwen of the investigation. The Coroner gave us the results of an initial post-mortem examination. We have sent the Coroner a copy of this report.

18. Wymott did not have any next of kin recorded for Mr Hillsden and were unable to locate a contact following his death. We therefore did not speak to Mr Hillsden's family or friends as part of our investigation.

19. We shared our initial report with HM Prison and Probation Service (HMPPS). They asked for some minor amendments and provided an action plan.

Background Information

HMP Wymott

20. HMP Wymott is a medium security prison in Lancashire with capacity to hold 1,176 adult men. Most prisoners are serving sentences of four years or longer. Specialist wings include two psychologically informed planned environment (PIPE) units for prisoners with personality disorders.

21. Healthcare services are provided by Greater Manchester Mental Health NHS Trust. There is 24-hour nursing cover, although between 9pm and 7am there is one nurse on duty.

HM Inspectorate of Prisons

22. The most recent inspection of HMP Wymott was a short scrutiny visit in August 2020. Inspectors reported that there was a misconception among staff that levels of self-harm had fallen. A poor pharmacy working environment resulted in delays in delivering medications to prisoners. They also noted that prisoners had no access to evidence-based psychological treatment. Prisoners under ACCT management received an acceptable level of support and care.

Independent Monitoring Board

23. 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 31 May 2022, the IMB reported that levels of self-harm were higher than the previous year. There were significant weaknesses in the provision of primary healthcare services. The Board also noted a chronic shortage of staff in offender management.

Previous deaths at HMP Wymott

24. Mr Hillsden was the fifteenth prisoner at Wymott to die since September 2020. The previous deaths were all due to natural causes and there are no similarities in our findings across these investigations.

Assessment, Care in Custody and Teamwork (ACCT)

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 supervise the prisoner.

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 multi-disciplinary review meetings involving the prisoner. 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.

27. 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.

Challenge, Support and Intervention Planning (CSIP)

28. CSIP is a Prison Service scheme designed to address factors contributing to violence in prisons by managing the most violent prisoners and supporting the most vulnerable prisoners. Prisoners who are perpetrators of violence or who are vulnerable to violence or bullying are managed and supported on a plan with individualised targets and regular reviews.

Key Events

Background

29. Mr Stephen Hillsden was remanded to prison on 31 August 2012, charged with wounding with intent to do grievous bodily harm. He said that he had a history of self-harm, linked to a diagnosis of antisocial personality disorder, and had attempted suicide. Mr Hillsden also had a diagnosis of Post-Traumatic Stress Disorder (PTSD) stemming from a sexual assault, and a history of substance misuse.

30. On 31 October, Mr Hillsden was convicted and given an indeterminate sentence for public protection (IPP - for individuals who pose a significant risk of harm and must serve a minimum term of imprisonment before they can be considered for release by the Parole Board), with a minimum tariff of two years and 181 days. It was not his first time in prison.

31. In 2013, Mr Hillsden transferred to the therapeutic community in HMP Grendon. He said that the treatment stirred up painful memories, and in January 2014 he was managed under Prison Service suicide and self-harm monitoring procedures (Assessment, Care in Custody and Teamwork - ACCT). He was monitored under ACCT procedures several times before leaving the therapeutic community. He returned to a standard prison in 2017. Mr Hillsden showed signs of paranoia, saying he felt under threat.

32. In March 2020, Mr Hillsden transferred to HMP Wymott with the aim of undertaking trauma therapy.

HMP Wymott

33. Mr Hillsden was referred to the mental health team on arrival at Wymott and was managed under the Care Programme Approach (CPA), a package used to plan a patient’s mental health care. Mr Hillsden was prescribed various medications.

34. The Parole Board was due to consider Mr Hillsden’s release in 2022. In April 2022, Mr Hillsden’s solicitor told the Board that he was not seeking release because he wanted to complete further trauma therapy. The solicitor asked the Board to reconsider Mr Hillsden’s release after he had completed the course.

35. In May 2022, Mr Hillsden moved to the prison’s psychologically informed planned environment or ‘PIPE’ unit to begin psychological therapy. PIPEs provide specialist intervention for prisoners with personality disorders.

36. On 10 June, the Parole Board wrote to Mr Hillsden and confirmed that they agreed he was not ready for release but could be reconsidered once he had completed his trauma therapy. Mr Hillsden had a right to appeal the decision but did not.

37. On 16 June, a psychiatrist reviewed Mr Hillsden’s progress. Mr Hillsden said that he experienced anxiety and paranoia during the day. While his medication helped him to get to sleep, he woke up frequently and had nightmares. Mr Hillsden was being prescribed tamsulosin (used to treat prostate problems), omeprazole (for indigestion

and heartburn), meloxicam (used to treat ulcers and stomach problems), ezetimibe (used to treat cholesterol), folic acid (a vitamin dietary supplement), propranolol (used to treat anxiety and heart problems), quetiapine (a mental health medication), and prednisolone (a steroid used for many conditions including for its anti-inflammatory properties). He asked for his medication to be changed, which the psychiatrist arranged. Overall, the psychiatrist thought that Mr Hillsden appeared to be stable, and not significantly anxious or distressed.

38. In July, Mr Hillsden began a new job caring for the prison's animals. He settled into the job well and said he enjoyed the fresh air.

39. On 5 July, Mr Hillsden was assessed as suitable to hold seven-day supplies of his medication in his cell, instead of them being dispensed daily by healthcare.

40. On 11 July, healthcare completed an assessment of whether Mr Hillsden could be allowed to hold 28-day supplies of his medication. This was agreed.

41. On 19 July, Mr Hillsden told the forensic psychologist providing his trauma-focused therapy that he thought a prisoner was going to attack him. He did not give any more information.

42. On 26 July, it was noted in Mr Hillsden's electronic prison records that his mood had changed. That day, he told the forensic psychologist that he had experienced a bad flashback on the night of 21 July. The psychologist discussed this with the Senior Forensic Psychologist and Clinical Lead in the PIPE unit and another psychologist on the unit. They both told him that staff had noticed a decline in Mr Hillsden's mood and mental wellbeing. They said that staff would monitor him and offer support if necessary.

43. On 28 July, Mr Hillsden's prison offender manager went to see him, but he did not want to talk. She wrote to him to say that he could contact her if he needed anything.

44. On 2 August, Mr Hillsden told the forensic psychologist that he felt much better. She asked him if he still felt under threat, and he said that he had not thought about it anymore. He still got flashbacks, which was normal for him, but that they were not particularly distressing.

45. The Senior Forensic Psychologist and Clinical Lead spoke to Mr Hillsden about his night terrors. He told her that he had experienced them for many years and just managed the feelings and let them fade. He said he did not need any additional support.

46. On 9 August, Mr Hillsden would not meet the forensic psychologist for his psychological therapy. He decided to remain in his cell and told staff that he felt unable to take up the support they offered. Unit staff told the psychologist that Mr Hillsden had not left his cell for a few days. They agreed to continue to monitor him and offer support, including the opportunity to shower alone in case that would be helpful.

47. On 11 August, officers on Mr Hillsden's unit told a Custodial Manager (CM) that they were concerned at his lack of engagement. The CM went to see Mr Hillsden. He said that medication and food had been stolen from his cell at some point during

the previous week. The CM told Mr Hillsden that because he had not reported it at the time and could not be specific about the timings, he was unable to check CCTV footage. Mr Hillsden said that he understood but said that he was under threat from prisoners on the third landing. The CM asked for more details, but Mr Hillsden was unable to provide names or descriptions, just that they had been calling him names through the window. There is no evidence that the CM told healthcare staff that Mr Hillsden's medication might have been stolen, and so there was no review of the risk of him holding medication in his cell.

48. Mr Hillsden said he was thinking about leaving the PIPE unit and applying for vulnerable prisoner (VP) status (living in a separate part of the prison for his own protection). The CM submitted an intelligence report and opened Challenge Support and Intervention Planning (CSIP) procedures. He also sent an email to the Senior Forensic Psychologist and Clinical Lead, asking her to speak to Mr Hillsden to discuss his options if he did decide to leave the unit. The CM noted on Mr Hillsden's record that a self-isolation regime would be offered. (Wymott has a policy to support prisoners who are self-isolating, encouraging them to partake in the prison regime. This can include, for example, offering a move to a different wing, or arranging for them to shower or take exercise when other prisoners are not present.)

49. The Senior Forensic Psychologist and Clinical Lead spoke to Mr Hillsden on 12 August. He confirmed that he was thinking of applying for vulnerable prisoner status. She explained that there was a PIPE unit on G wing, which was also a Vulnerable Prisoner Unit (VPU). Mr Hillsden said that he would be happy to consider it.

Saturday 13 August

50. On the morning of Saturday 13 August, Mr Hillsden pressed his cell bell. When officers responded, they found that he had barricaded his door and was threatening to cut himself with a razor blade. Staff talked to Mr Hillsden about how he was feeling and encouraged him to remove the barricade and hand over the blade, which he did. Mr Hillsden told a CM that he could hear prisoners calling him names. He said that a previous CM and the Senior Forensic Psychologist and Clinical Lead had told him that he could move to the PIPE unit on G wing. The CM said that he would speak to them on Monday, and Mr Hillsden seemed content with that. He said he wanted to self-isolate until then. The CM began ACCT monitoring, which included checking on Mr Hillsden at least once an hour. The healthcare department was not informed.

51. An officer conducted an ACCT assessment interview that afternoon. Mr Hillsden's main concern was that some items had been stolen from his cell recently. Staff told Mr Hillsden that they were looking into his request for VP status and a move to the PIPE unit on G wing.

Sunday 14 August

52. Mr Hillsden was due to have an ACCT review on the morning of 14 August. A nurse from the mental health team had been asked to attend. In her statement, she said that when she was preparing for the review, she checked Mr Hillsden's medical record and saw that he had last been given his in possession medication on 9

August. She shared the information with a nurse in the primary care team, who said they had not been informed that an ACCT had been opened for Mr Hillsden. As a result, healthcare staff had not considered whether Mr Hillsden should still be able to keep his medication in his cell.

53. Mr Hillsden did not want to come out of his cell to attend his ACCT review and told staff to leave him alone. The duty governor spoke to Mr Hillsden, and he agreed that she could talk to him in his cell. A CM, a nurse and an officer joined the conversation. Mr Hillsden was anxious and said that he could hear prisoners outside his cell calling him names. The CM said that this was not the case; staff were positioned nearby and had not witnessed anything. He reassured Mr Hillsden that staff would intervene if they saw any such behaviour. Mr Hillsden was offered a different cell on the opposite side of the landing, but he said he wanted to move to the PIPE unit on G wing. The CM explained that the request could not be addressed on a Sunday, but that staff would look into it on Monday. Mr Hillsden said he had no further thoughts of harming himself.

54. The nurse was concerned about Mr Hillsden maintaining possession of his medications, given he was on an ACCT and not engaging with staff. She asked him to hand back his medications and attend the treatment hatch to collect them. Mr Hillsden threw some boxes of medication onto the floor and said that he would not come to the treatment hatch to collect medication. Staff agreed that they would take his medication to his cell at the appropriate times. The nurse had a list of the medication that Mr Hillsden should have had in his possession. She checked the medication he had handed over and identified that some was missing. Mr Hillsden said he had used them. She described what was missing (omeprazole, and tamsulosin). When asked for an explanation, Mr Hillsden told her that he had not taken them for some time and did not have them, despite saying he had used all of them earlier on. In their statements, the CM and the duty governor said that the nurse advised that the missing medication was for stomach-related issues and there were no major risks. Body worn video camera footage shows the duty governor ask the nurse if she was content with the medication handed over, and the nurse confirmed that she was.

55. In interview, the CM said that he agreed with colleagues that he would write up the conversation as an ACCT review, although it did not meet the criteria of a formal ACCT review. They agreed that Mr Hillsden was very anxious and increased observation levels to once every 30 minutes.

56. The care plan in Mr Hillsden's ACCT noted that in light of Mr Hillsden's concerns about theft, he had been given a privacy cell key. (Privacy cell keys allow a prisoner to lock their cell door to prevent access by other prisoners. Prison officers have an override key.) As he was self-isolating, staff would arrange for Mr Hillsden to shower and exercise on his own. The care plan also noted that Mr Hillsden's medication should be removed and dispensed to him at his cell door. The care plan did not include any instruction that Mr Hillsden's cell should be searched to ensure he had no medication in his possession.

57. After the ACCT review, the nurse completed another review of the medication Mr Hillsden had handed in. He had handed in more quetiapine than he should have had left, less venlafaxine, more propranolol, and no omeprazole, meloxicam or tamsulosin when he should have had two weeks' prescription of each. She went to

the wing and spoke to the CM, the duty governor and officer. They speculated that Mr Hillsden's paranoia might have been due to a debt. She documented the conversation, sent an electronic update to Mr Hillsden's mental health nurse, updated his medications risk assessment and informed the pharmacy team. She then spoke to a colleague to ensure that Mr Hillsden's medication would be taken to his cell at the appropriate times.

58. At 6.37pm, the colleague took Mr Hillsden's medication to his cell. She asked him if he had any left in his possession, and he handed over a box of meloxicam tablets. She also asked about the missing venlafaxine. Mr Hillsden said that he had taken a large amount of venlafaxine two days earlier, to help him sleep. He had not told anyone but said he had no intention to harm himself. She took Mr Hillsden's medical observations and gave him an electrocardiogram (electronic test of the heart's function), which provided results within the normal range. She noted that he was coherent and engaged well. She also took a blood sample and sent it for urgent testing.

59. At 9.14pm, Mr Hillsden pressed his cell bell. When staff arrived, they found that he had barricaded his door again. Mr Hillsden said that he had taken all of the medication he had not previously handed over and staff requested an ambulance. Officers negotiated with Mr Hillsden and encouraged him to remove the barricade, which he did at 9.43pm. Mr Hillsden retracted his statement and said he had not taken any medication. A nurse assessed Mr Hillsden and found that he was tearful, anxious, sweating, and had an increased heart rate. He said that he had taken a quantity of dihydrocodeine and codeine (which had not apparently been prescribed to him). She noted that his blood test results were normal and found no signs of opiate overdose. She asked for the ambulance to be stood down. A CM increased Mr Hillsden's observation levels to at least once every 15 minutes. In interview, the CM said that he did not consider a search of Mr Hillsden's cell because he believed that any medications had already been handed in.

15 August

60. Staff checked on Mr Hillsden during the night. At 5.56am, they found that he had blocked the observation panel in his door. An operational support grade officer (OSG) tried to open the door, but Mr Hillsden had barricaded it shut. The OSG asked him to remove the blockages, which he did.

61. At 10.00am, a CM chaired an ACCT review for Mr Hillsden. The review was attended by a prison manager, the Prison Offender Manager, a nurse, and the Senior Forensic Psychologist and Clinical Lead. Mr Hillsden engaged well. He said that he had been threatened by a prisoner in the Care and Separation Unit (CSU), which was below his wing. Staff confirmed that there was nobody with that surname living in the CSU. Mr Hillsden said that his "head was all over the place" and the reassurance had made him feel better. He had continued to self-isolate though he had left his cell for a shower.

62. Staff offered to help Mr Hillsden apply for VP status and if approved, he could then apply for the PIPE unit on G wing. He discussed his trauma therapy and said that he had no thoughts of suicide or self-harm. He was still having difficulty sleeping, so the nurse said she would speak to the GP. She told him that he would need to

attend the medication hatch for his medication, and Mr Hillsden asked if he could do so at the beginning or end of the medication round to avoid other prisoners. He said he had not been eating his meals, but officers on the wing confirmed that he had been eating items ordered from the canteen. Staff agreed that the level of observations could be reduced to at least once per hour.

63. Staff encouraged Mr Hillsden to try to take some fresh air, and he agreed to exercise in the garden. An officer completed ACCT checks and Mr Hillsden asked her for some help with his VP application. At 5.30pm, when other prisoners had been locked into their cells, she let Mr Hillsden out of his cell and helped him complete the application.

64. At 7.58pm, Officer A went to Mr Hillsden’s cell to complete an ACCT check and asked how he was. Mr Hillsden did not reply but pointed to a quantity of medication strips and boxes on his bed. He took a tablet and swallowed it. The officer went to the office and asked other officers and healthcare staff to come to F wing. Officer B, the assistant orderly officer (responsible for the day to day running of the prison), and two nurses went to Mr Hillsden’s cell. Mr Hillsden was agitated, and the nurses assessed him while the officers removed the medication from his bed and his locker as well as removing a razor blade. Mr Hillsden’s observations were all within the normal range, but nursing staff agreed that he should be transferred to hospital for further tests.

65. Officer B contacted a CM, the night orderly officer, and told her what had happened. She arranged for an ambulance to be requested. The Ambulance Service assessed the request as a category two call, which meant they could not give an estimated time of arrival. The CM increased Mr Hillsden’s observations to a minimum of three per hour.

66. At 8.45pm Officer B returned to check on Mr Hillsden, and he appeared to be asleep. He knocked on his door and called to him but got no response. He radioed a code blue emergency (meaning a prisoner is unconscious or having difficulty breathing). Colleagues responded and, as they entered the cell, Mr Hillsden woke up, startled, and started to behave erratically. He was ashen and sweating but would not allow the nurse to take his observations. She encouraged Mr Hillsden to let her complete them, but he would not agree. Mr Hillsden was sitting in his chair when staff left the cell. The CM asked an OSG to update the Ambulance Service that Mr Hillsden’s condition had deteriorated. The Ambulance Service said that it remained a category 2 call.

67. The OSG checked on Mr Hillsden at 9.00pm and 9.25pm and found him sitting in his chair talking to himself on both occasions. She completed a further check at 9.36pm and thought that he was asleep; she noted movement. When she checked him again at 9.55pm, he had slumped down the chair and she could not see any movement. She called to Mr Hillsden, but he did not respond. She went to the wing office and told Officer A that she was concerned. They contacted Officer B, and he and the CM went to the cell. Because of Mr Hillsden’s previous erratic behaviour, three officers were present when opening his cell. In his statement, Officer B said that this took about one minute to arrange. In the meantime, he called a code blue emergency.

68. When officers opened Mr Hillsden's door they found him unresponsive. They laid him on the floor and could not detect any breathing so began to perform cardiopulmonary resuscitation (CPR). The CM radioed the control room asking them to tell the Ambulance Service what had happened. The control room said that the ambulance had already arrived, and paramedics were on their way. The officers applied a defibrillator (a machine that in some cases can restart the heart) but it recommended that they continue with CPR. Paramedics arrived at the cell at 10.03pm and continued to try to resuscitate Mr Hillsden but at 11.11pm said that he had died.

Contact with Mr Hillsden's family

69. A family liaison officer (FLO) was appointed. Mr Hillsden did not have any contact with family and no nominated next of kin. The FLO contacted Mr Hillsden's solicitor, the Coroner's office, the police and the Probation Service to identify a potential next of kin but was unable to locate one. Wymott arranged and paid for Mr Hillsden's funeral.

Support for prisoners and staff

70. After Mr Hillsden's death, the duty governor debriefed the 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 also offered support.

71. The prison posted notices informing other prisoners of Mr Hillsden'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 Hillsden's death.

Post-mortem report

72. Initial post-mortem tests showed that Mr Hillsden had high levels of venlafaxine in his system when he died, within the range that could cause death. Mr Hillsden also had high levels of propranolol (one of his prescribed medications) in his system, but not at a level that could cause death. The examination also found traces (that were unlikely to have contributed to Mr Hillsden's death) of meloxicam, which had been prescribed to him, and sertraline, citalopram and fluoxetine which had not been prescribed to him for several years.

73. No invasive post-mortem examination was completed. Mr Hillsden's exact cause of death is to be determined at inquest.

Findings

Assessment of risk

Medication

74. Mr Hillsden was prescribed a number of different medications to treat his physical and mental health conditions. In July, healthcare staff assessed that Mr Hillsden could safely keep 28 days' worth of medication in his cell. We have considered whether that was reasonable in the circumstances, and whether there were any missed opportunities to review the risk assessment.

75. The clinical reviewer concluded that the decision to allow Mr Hillsden to keep his medication in his cell was reasonable. However, on 11 August, Mr Hillsden told officers that some medication and other items had been stolen from his cell. This information was not shared with healthcare staff and so they did not review whether it was still appropriate for Mr Hillsden to keep the medication in his cell. We make the following recommendation:

    The Governor should ensure that any information relating to the possible mis-use of in possession medication is shared with healthcare staff so that relevant risk assessments can be completed.

76. On 14 August, in preparation for Mr Hillsden's first ACCT review, a nurse looked at his health records and noticed he had last been given his stock of in possession medication on 9 August. She decided there was sufficient risk that he might misuse his medication that it was appropriate to remove all medication he had in his possession. Mr Hillsden handed in some of his medication, but some of it was missing. In interview, a CM told us that the nurse had advised the medications were not dangerous, so the cell was not searched.

77. That evening, Mr Hillsden handed over a further box of medication to a nurse and told her that he had taken a large amount of venlafaxine two days previously. The nurse told officers, but no cell search was completed. Later in the evening, Mr Hillsden told staff that he had taken all of his medication. His cell was still not searched.

78. On the evening of 15 August, Officer A saw a quantity of medication strips and boxes on Mr Hillsden's bed. His cell was searched, and his medication locker was emptied by staff.

79. We are concerned that when Mr Hillsden admitted to taking large quantities of his medications and was given medical attention for this, officers failed to complete cell searches to remove any further medication. A cell search took place twenty-four hours later, after he was seen with more medication. We do not know when he took the medication that caused his death, but post-mortem toxicology tests showed the presence of medication that had not been prescribed to Mr Hillsden. This is in addition to potentially fatal amounts of two drugs that had been prescribed and were known to be in his possession. We make the following recommendation:

The Governor and Head of Healthcare should ensure that cell searches are completed wherever there is disclosure or reasonable suspicion of misuse of medication, to ensure that risks are effectively managed.

ACCT procedures

80. Prison Service Instruction (PSI) 64/2011 Managing Prisoners Safety in Custody contains national requirements on the assessment and management of suicide and self-harm risks in prisons. The instruction lists risk factors and potential triggers that staff should be alert to and act appropriately to address. Any prisoner identified as at risk of suicide and self-harm must be managed under ACCT procedures and an Immediate Action Plan (IAP) should be drawn up and regularly reviewed by a multidisciplinary team, in consultation with the individual. The PSI also states that wherever possible, staff opening an ACCT must inform healthcare and request any information relevant to supporting the prisoner, to help inform the content of the IAP. If opened when there is no healthcare cover in the prison, then healthcare must be informed at the earliest opportunity.

81. Mr Hillsden presented several of the risk factors for suicide and self-harm listed in PSI 64/2011, including active PTSD, depression and a history of attempted suicide. When Mr Hillsden threatened to harm himself with a blade on 13 August, staff rightly opened ACCT measures. We have considered whether, once Mr Hillsden was considered a risk of suicide and self-harm, staff took appropriate steps to support him and keep him safe.

82. When Mr Hillsden told a nurse that he had taken a large quantity of medication two days previously and handed over more tablets, this was not reflected in his ACCT document. Important information such as this must be reflected so that staff assessing risk are fully aware of all relevant factors. We make the following recommendation:

    The Head of Healthcare should remind staff of the importance of recording all relevant risk information in ACCT documents, to ensure that risks can be effectively managed.

82. When ACCT measures were opened, nobody notified the healthcare team. In interview, a CM said that he would not normally make any arrangements to inform healthcare if he opened an ACCT. He said that there was an administrative team responsible for notifying healthcare, but they were off work because it was a Saturday. A nurse in the mental health team told us that the mental health team would usually be informed, but the CM said that there were no mental health nurses available at the time. When we looked at Wymott's internal process, we found that it was only in place from Monday to Friday. At weekends, prison staff are expected to liaise with whoever is covering healthcare, directly.

83. On Sunday 14 August, a nurse was on Mr Hillsden's wing attending another prisoner's ACCT review. A CM asked her if she could attend Mr Hillsden's review later the same day, which she agreed to. She notified the main healthcare team that an ACCT had been opened for Mr Hillsden, which they were unaware of as they had not received a communication from wing staff. They were able to discuss medication risks and take action, which we discuss later in this report. While this meant that the ACCT process was appropriately supported by healthcare, who

attended the first review in line with policy, this was due the proactive approach of the nurse and not a clearly defined process. We found a lack of clarity on the process for notifying healthcare when an ACCT is opened over a weekend, that could impact on future care and should be addressed. We make the following recommendation:

The Governor and Head of Healthcare should clarify the process for notifying healthcare in the event of an ACCT being opened over a weekend, to ensure care planning has multidisciplinary input.

84. PSI 64/2011 states that prisoners must attend ACCT case reviews unless unwilling or unable, and that they should be encouraged to engage with the process. The first case review meeting should consider the initial assessment content in detail, including all identified risks and triggers. It should also involve discussion around risk information and support actions in place, with documented decisions and reasoning. If possessions are to be removed this should be documented as a defensible decision.

85. On 14 August, a CM attempted to hold an ACCT review with Mr Hillsden. He did not want to leave his cell or engage with the process. Staff tried to hold a meaningful discussion but were unable to discuss how Mr Hillsden was feeling and his risk factors. The CM recorded the ACCT review but did not reflect the limitations on the conversation.

86. We recognise that Mr Hillsden’s lack of engagement created a challenge for staff who were trying to manage his risk, and we recognise that they did spend time talking with him to try and support him. However, when they did not secure Mr Hillsden’s engagement, they did not have a meaningful conversation about risk. They could have held a case review in his absence, and this might have provided an opportunity to further consider the risks Mr Hillsden presented, including his medications status and whether his cell should have been searched. We make the following recommendation:

The Governor should ensure that when prisoners do not engage, staff continue to hold ACCT reviews in line with HMPPS guidance, to ensure that risks are effectively managed.

87. On 13 and 15 August, Mr Hillsden told staff he felt under threat by other prisoners and asked to move to a different unit. However, he did not specify who had threatened him and why. Some prison officers speculated that he might have been in debt. We found no specific evidence to suggest this was the case, although it seems he was accessing medication that was not prescribed to him. Mr Hillsden was managed under Challenge, Support and Intervention Planning (CSIP), supported to apply for vulnerable prisoner (VP) status and given reassurance that staff would address any specific concerns he had with individuals. Staff were due to discuss a move to a different wing on Monday 16 August, the day after Mr Hillsden died. We are content that Mr Hillsden’s concerns about other prisoners and the safety of his location were dealt with appropriately.

88. When staff called a code blue emergency on the evening of 15 August, a CM raised Mr Hillsden’s observation levels to a minimum of three times per hour. When there was a further code blue, she kept the observations at that level. The clinical

reviewer said that there was no clinical need for Mr Hillsden to be under more frequent observation at that stage.

Mr Hillsden's healthcare

89. The clinical reviewer concluded that the physical healthcare Mr Hillsden received was equivalent to that he could have expected in the community. The clinical review contains recommendations to improve care processes including medication risk assessments.

Inquest

90. The inquest, held from 4 to 8 September 2023, concluded that Mr Hillsden died by misadventure.

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