Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Bulent Sessacar, a prisoner at HMP Woodhill, on 21 January 2021

A report by the Prisons and Probation Ombudsman

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Our vision

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

Our values

We are:

Impartial: we do not take sides

Respectful: we are considerate and courteous

Inclusive: we value diversity

Dedicated: we are determined and focused

Fair: we are honest and act with integrity

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 Bulent Sessacar was found hanged in his cell at HMP Woodhill on 21 January 2021. He was 36 years old. I offer my condolences to his family and friends.

Mr Sessacar had been transferred from HMP Gartree to Woodhill at short notice two days before he died due to a serious security concern. He was a very challenging prisoner to manage safely. He had a history of serious mental health issues and attempted suicide and self-harm and was being monitored under ACCT procedures when he was transferred to Woodhill.

Staff at Woodhill continued to monitor Mr Sessacar under ACCT procedures. After he was found with a ligature round his neck on the evening of 20 January, they increased the frequency of his observations from once an hour to three times an hour. I am, however, concerned that they did not consider placing Mr Sessacar under constant supervision to give them an opportunity to get to know him better and make a more informed assessment of his risk to himself.

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 **July 2022**

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Summary

Events

1. Mr Bulent Sessacar was remanded into custody in December 2012, charged with the murder of his wife. He was subsequently transferred to a secure psychiatric hospital, where he was diagnosed with emotionally unstable and antisocial personality disorders and returned to prison in October 2013. In February 2014, he was convicted of manslaughter, with diminished responsibility, and received a life sentence, with a minimum tariff of ten years and eight months.

2. He also had a long history of self-harm and suicide attempts self-harm and he was monitored under suicide and self-harm prevention procedures, known as ACCT, in prison on several occasions.

3. In March 2015, Mr Sessacar was transferred to HMP Gartree. He remained under the care of the mental health team, he was prescribed psychiatric medication and was monitored under ACCT procedures several times.

4. In 2020, Mr Sessacar was diagnosed with attention deficit hyperactivity disorder (ADHD). He struggled to cope with the restricted regime due to the COVID-19 pandemic and was managed under ACCT for two periods.

5. On 14 January 2021, staff started ACCT procedures again as Mr Sessacar was not coping well with the restricted regime.

6. On 19 January, Mr Sessacar was transferred to HMP Woodhill at very short notice due to serious security concerns at Gartree. His ACCT observations were increased to hourly before he left Gartree. Staff at Woodhill completed an ACCT review when Mr Sessacar arrived, and decided to continue observing him hourly.

7. On the evening of 20 January, staff found Mr Sessacar in his cell with a ligature tied around his neck. He did not need medical treatment. Staff increased his ACCT observations to three an hour and made an appointment for him to see the mental health team the next morning.

8. On the morning of 21 January, staff completed ACCT checks and raised no concerns about Mr Sessacar. This was followed by an ACCT review, and a mental health nurse assessed Mr Sessacar. He said that he had harmed himself for most of his life and that he had thoughts of self-harm. An urgent appointment was made for him to see the prison psychiatrist.

9. At 12.54pm, a prison officer checked on Mr Sessacar as part of his ACCT monitoring and found him hanging from a ligature attached to a cell window bar. The officer radioed an emergency code. Staff responded, cut him down and tried to resuscitate him. Ambulance paramedics arrived but were unable to resuscitate him. At 2.30pm, they pronounced that Mr Sessacar had died.

Findings

Assessment and management of risk

10. Given his history, his mental health diagnoses, his impulsivity and unpredictability, and his difficulty coping with even minor changes to his routine, Mr Sessacar was an extremely challenging prisoner to manage safely, especially during the pandemic when prisoners were spending long periods locked in their cells. In these circumstances, we do not think it was possible to guarantee that Mr Sessacar would never take his own life. However, we consider that Gartree managed his risk well and provided him with a good level of support.

11. We accept that it was necessary to move Mr Sessacar to Woodhill at short notice

12. We are concerned that both prison and healthcare staff at Woodhill placed too much emphasis on what Mr Sessacar said and how he presented and did not pay sufficient attention to his numerous risk factors.

13. We are concerned in particular that there is no evidence that they considered placing Mr Sessacar under constant supervision on 20 January.

Clinical Care

14. The clinical reviewer concluded that Mr Sessacar's medical care was equivalent to that which he could have expected to receive in the community.

Recommendations

- The Governor and Head of Healthcare should ensure that prison, healthcare and mental health teams consider all risk factors and relevant information when deciding how best to manage a prisoner at risk, including considering whether constant supervision is suitable

The Investigation Process

15. The investigator issued notices to staff and prisoners at HMP Woodhill informing them of the investigation and asking anyone with relevant information to contact him. No one responded.

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

17. The investigator interviewed seven members of staff at Woodhill in March 2021. NHS England commissioned a clinical reviewer to review Mr Sessacar's clinical care at the prison, and the clinical reviewer joined him for the interviews. All the interviews were conducted by video link because of the COVID-19 restrictions in place.

18. We informed HM Coroner for Milton Keynes of the investigation. He gave us the results of the post-mortem examination. We have sent him a copy of this report.

19. The Ombudsman's family liaison officer contacted Mr Sessacar's family to explain the investigation and to ask if they had any matters they wanted us to consider. Mr Sessacar's family had no specific questions. However, his sister said that they had found things in Mr Sessacar's possessions showing that he had asked for help, but that staff had not listened. She also said that she had contacted safer custody at Gartree a few times in 2019 to express her concerns that Mr Sessacar was struggling, but not much was done. She said she considered, "This has been a failure with Gartree they have not supported him in any way".

20. Mr Sessacar's family received a copy of the initial report. They did not make any comments.

21. The initial report was shared with HM Prison and Probation Service (HMPPS). They identified no factual inaccuracies in the report. The recommendation was accepted.

Background Information

HMP Woodhill

22. HMP Woodhill is a training prison for long-term Category B prisoners, serving sentences of at least four years. Woodhill also holds a small number of Category A prisoners on remand and attending trial. Central and North-West London NHS Foundation Trust provides health services at the prison. There is an inpatient unit with 12 beds, which provides mental and physical healthcare.

HM Inspectorate of Prisons

23. The most recent inspection of HMP Woodhill was in February 2018 (when Woodhill was a local prison). Inspectors reported that the number of recorded self-harm incidents had increased and was much higher than at similar prisons. They noted that the number of prisoners being managed under ACCT procedures was very high, so staff struggled to give them the attention they needed. Inspectors found that there had been some good actions to improve suicide and self-harm prevention systems but, overall, the prison had failed to sustain this work. They noted that some aspects of the ACCT process had improved and were generally better than seen elsewhere.

24. Inspectors found that the mental health team was well integrated with the rest of the prison and was regularly involved in ACCT reviews and prison-wide meetings to support prisoners with complex needs. They found that referrals were received to a dedicated email box, reviewed and actioned appropriately.

Independent Monitoring Board

25. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report for the year to 31 May 2020, the IMB reported that from late March 2020, the COVID-19 pandemic caused severe restrictions to the prison regime. They also noted difficulties that there had been long delays in processing prisoners' property when they arrived at Woodhill.

Previous deaths at HMP Woodhill

26. In 2015 and 2016, a total of 12 prisoners took their lives at Woodhill, a much higher figure than at comparable prisons. There were no self-inflicted deaths in 2017 and one in 2018. In 2019, there were four self-inflicted deaths. Since then, there have been two self-inflicted deaths, including that of Mr Sessacar.

27. Previous PPO investigations identified deficiencies in ACCT management, notably the absence of healthcare staff from case reviews.

Assessment, Care in Custody and Teamwork

28. ACCT is the care planning system the Prison Service uses to support prisoners at risk of suicide or self-harm. The purpose of ACCT procedures is to determine the level of risk posed, the steps that staff might take to reduce this and the extent to which staff need to monitor and supervise the prisoner. Checks should be made at irregular intervals to prevent the prisoner anticipating when they will occur.

29. Part of the ACCT process involves assessing immediate needs and drawing up a caremap to identify and address a prisoner's most urgent issues. Staff should hold regular multidisciplinary reviews and should not close the ACCT plan until all the actions of the caremap are completed. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011 on safer custody.

Key Events

30. Mr Sessacar was remanded into custody to HMP Belmarsh in December 2012, charged with the manslaughter of his wife. It was not his first time in prison.

31. Mr Sessacar had a long history of involvement with mental health services in the community and in prison. He also had a history of substance misuse and self-harm. He had previously been admitted to a psychiatric hospital under the Mental Health Act, and he had been monitored under ACCT procedures in prison after harming himself.

32. In August 2013, Mr Sessacar was sectioned under the Mental Health Act and transferred to a medium secure psychiatric hospital, where he was diagnosed with emotionally unstable and antisocial personality disorders (EUPD and ASPD, conditions where the person can be impulsive and manipulative, have difficulty in forming relationships and may respond in an aggressive and unpredictable manner). On 1 October, he returned to Belmarsh.

33. In February 2014, Mr Sessacar was convicted of manslaughter with diminished responsibility and received a discretionary life sentence with a minimum tariff of ten years and eight months.

34. In March 2015, Mr Sessacar was transferred to HMP Gartree, where the mental health team continued to support him, and he was prescribed psychiatric medication. However, his contact with the mental health team was intermittent and his medical records showed a trend that he would request mental health support but then refuse treatment.

35. Staff monitored Mr Sessacar under ACCT procedures from 26 June to 29 October 2019 as he had poor mental health and said that he wanted to end his life.

2020

36. When a restricted regime was introduced in March 2020 in response to the COVID-19 pandemic, Mr Sessacar's mood and mental health fluctuated. He was prioritised for key work (which required his key worker to see him every week or two to check on his welfare and to address any problems).

37. Mr Sessacar was again monitored under ACCT procedures between 17 May and 2 June 2020 after he took an overdose and swallowed 20 paracetamol tablets. He said that he constantly had thoughts of taking his own life. His prescribed medication had also changed from sertraline to mirtazapine (both antidepressants). During this period, the prison's consultant psychiatrist assessed Mr Sessacar for Attention Deficit Hyperactivity Disorder (ADHD – a condition where the person is unable to concentrate and is constantly restless and overactive).

38. On 7 June, Mr Sessacar stopped taking his mirtazapine. A nurse spoke to him about the risks of stopping antidepressants suddenly. Mr Sessacar agreed but was concerned that having the medication at 4.30pm made him feel tired. He asked for sertraline again. This was agreed but stopped on 2 July because Mr Sessacar had not taken it for over a week.

39. On 7 July, staff started ACCT procedures after Mr Sessacar tried to hang himself. Mr Sessacar said that he felt hopeless and while he got on with everyday life at times, his desire to commit suicide was strong. He said that the lack of routine during the pandemic (when prisoners had considerably less time out of their cell for work, gym and association) was a main contributor.

40. On 23 July, the prison psychiatrist saw Mr Sessacar and confirmed that he had ADHD. He was prescribed medication for this.

41. On 1 August, staff had increased his ACCT observations after they found him with a noose around his neck. He was seen by a mental health nurse and said that he put the noose around his neck, set his time for an hour and fell asleep. He woke up when he heard staff opening his door. He said that his ADHD medication had helped him focus and not fidget. However, he said that he was experiencing hallucinations and felt depressed, paranoid, abnormal and suicidal.

42. Two days later, staff noted that Mr Sessacar was acting bizarrely. He had put water on the floor and was drinking it, saying that he was an animal. He had also tied a ligature and said that if he did not speak to Boris Johnson, he would kill himself. A healthcare multidisciplinary team (MDT) review took place, and it was agreed to increase Mr Sessacar's ADHD medication.

43. At an ACCT review on 10 August, Mr Sessacar discussed his ADHD medication. He said that it made him feel weird, depressed and suicidal. He admitted that he had been trying to commit suicide since the age of 17 and that his mood had always fluctuated. He said that speaking to staff was of no benefit to him and he felt better when he was out of his cell. He declined the use of a distraction pack to keep him mentally occupied in his cell. The nurse told Mr Sessacar that he should continue taking his medication. Mr Sessacar confirmed that he had felt some benefit as he had been able to watch a football match and had slept well for a few days.

44. At his ACCT review on 20 August, Mr Sessacar said that he still sometimes felt low, but his sleep had improved, and he felt calmer and less erratic.

45. While Mr Sessacar continued to be monitored under ACCT procedures, the mental health team adjusted his medication dosage to a therapeutic level at regular intervals. By September, the consultant psychiatrist noted that Mr Sessacar appeared less agitated but that he still had suicidal thoughts of tying a ligature around his neck.

46. At his key worker session on 6 September, Mr Sessacar said that his mood had been fluctuating. He said that his ADHD medication dosage had been increased twice but he was not sure whether or not it was working. He was in regular contact with his family and wanted to start a new life abroad with them when he was released. The key worker noted that Mr Sessacar's outlook was positive, and he was talking more.

47. Staff stopped ACCT monitoring on 14 September. Mr Sessacar reported that he felt much more settled and had no suicidal thoughts. His ADHD careplan noted that his mood and behaviour had improved while taking his medication.

48. On 10 November, healthcare staff reported that Mr Sessacar had threatened not to comply with his ADHD treatment and to stop taking his medication. When this was discussed at the weekly MDT meeting, Mr Sessacar said that he had not stopped his medication as he realised that doing so would lead to a deterioration in his mental health.

49. At a key worker meeting in November, Mr Sessacar talked about how he was managing during the COVID-19 restrictions. He said that he did not cope well with uncertainty and liked routine and purpose. His key worker noted that Mr Sessacar seemed fairly settled although he still had “the occasional hyper outburst”.

50. The consultant psychiatrist saw Mr Sessacar on 30 November and reviewed his treatment. During the review, he noted that Mr Sessacar’s mood was upbeat and positive. Mr Sessacar said that his concentration level, engagement with his family and sleep had improved. The consultant psychiatrist suggested that Mr Sessacar could try an increased dose of his ADHD medication. He discussed the potential side effects of doing so, and Mr Sessacar agreed to try it.

51. On 30 December, Mr Sessacar complained of feeling increasingly agitated and unable to sleep. A mental health nurse saw him the next day and noted that Mr Sessacar described having issues with wing staff. He thought that his ADHD treatment was having an impact. The nurse said that Mr Sessacar engaged well and had no suicidal thoughts. Mr Sessacar said that several minor issues were irritating him. Staff offered to help him, but he declined. He said his medication was helping him to some extent. He accepted that his mood fluctuations would probably continue but that his impulsivity had reduced, which lowered his suicide risk. The nurse said that she would discuss with the MDT whether zopiclone would help Mr Sessacar sleep. (Mr Sessacar later declined this medication.)

52. It was also noted that Mr Sessacar he had recently missed his metabolic monitoring appointment. He said he had been working on the wing at the time and although he knew about the appointment, he did not like to change his routine or to have 'things to be sprung on” him. The nurse said it would be rebooked.

2021

53. At a key worker session on 3 January 2021, Mr Sessacar said that he had struggled with his mental health over the past week due to a lack of sleep but was feeling a bit better as wing staff had arranged for him to get a mini disc player. He said he had kept in good contact with his family over Christmas and the New Year. His key worker noted that Mr Sessacar was coping much better than six months earlier.

54. On 5 January, prison staff phoned the mental health team as Mr Sessacar was struggling to cope with a change in regime. His mental health worker was away from the prison and no one visited him over the next few days as there was a lack of mental health resource (due to sick leave).

55. On 12 January, the security team completed a search of Mr Sessacar’s cell. Mr Sessacar said he was upset and stressed as his routine had been disrupted by the search. Wing staff spoke to Mr Sessacar and noted that he struggled when his routine was changed. After he had cleaned his cell, staff noted that Mr Sessacar had calmed down and appeared more relaxed by the evening. A security

intelligence report noted Mr Sessacar's history of suicidal thoughts and that his cell search, and the disruption it caused to his routine, may result in him wanting to kill himself.

56. On 13 January, a security intelligence report noted that Mr Sessacar had been shouting at someone during the day and previous night, although staff reported that no one was there. It suggested that he was hearing voices and noted that Mr Sessacar had been struggling with his mental health due to the COVID-19 restrictions. A nurse tried to review Mr Sessacar, but he did not attend his appointment.

57. On 14 January, Mr Sessacar complained that he had asked to see the mental health team over three weeks earlier and was not being supported. Healthcare staff told him that the mental health team had seen him several times in that period, the last time on 31 December. Mr Sessacar responded to this by threatening to kill himself. Staff decided to start ACCT procedures and noted that the effects of the continued restricted regime and lack of time out of his cell continued to have a negative impact on his mental health. They set hourly ACCT observations.

58. In the ACCT assessment that followed, Mr Sessacar said that he felt that the healthcare team had let him down and he was struggling with his mental health while locked in his cell. He said his mood fluctuated because of his ADHD. While he had no plans to take his own life, Mr Sessacar said he had suicidal thoughts that had got worse over the last three months. He was constantly thinking of new ways to kill himself. He said that his family was aware of his behaviour. He said he needed structure and routine throughout the day to cope better. His ACCT observations remained hourly.

59. A mental health nurse visited Mr Sessacar on the wing and spoke to staff. Mr Sessacar said that his mood was low. The nurse spoke to the MDT about prescribing Mr Sessacar antidepressants, and they booked an appointment for him to see the prison GP on 20 January.

60. Mr Sessacar became irritated and refused to answer questions at his first ACCT review on 15 January. The panel (which included a mental health nurse) assessed that his risk of self-harm was raised and increased his ACCT observations to three an hour (at irregular intervals). His ACCT caremap noted that the mental health team would continue to support Mr Sessacar.

61. A mental health nurse arranged to review Mr Sessacar after his ACCT review, but he declined as he said he had seen mental health staff in his ACCT review and the previous day.

62. The ACCT case manager held an ACCT review on 17 January while Mr Sessacar was in the exercise yard as he would not go to a meeting room. The review lasted around 45 minutes. Mr Sessacar said that he was feeling better as staff had worked with him and allowed him more time out of his cell to do cleaning jobs. However, he said that the high level of ACCT checks made him feel worse. The ACCT case manager discussed Mr Sessacar feelings with a member of the mental health team. They noted that Mr Sessacar said he had no active plans to harm himself. They agreed that his risk of self-harm had reduced to low and that his ACCT observations should be reduced to two conversations with Mr Sessacar each

day and hourly observations during periods when prisoners were locked in their cells. His next ACCT review was scheduled for 21 January.

Events from 19 January: Transfer to Woodhill

63. A security intelligence report on 19 January said that the recent search of Mr Sessacar's cell suggested that he may be involved in inappropriate activity with a member of staff.

64. As a result of the security intelligence, staff completed an interim ACCT review with Mr Sessacar at 10.15am and told him that he was to be transferred to HMP Woodhill immediately due to an alleged serious security breach. Mr Sessacar was very quiet during the review, packed his own property and complied with staff instructions. The case manager increased Mr Sessacar's ACCT observations to one an hour (day and night) as he was aware that he struggled with change. He noted that staff at Woodhill should conduct a further ACCT review when Mr Sessacar arrived.

65. About an hour later Mr Sessacar was taken to reception for his pending transfer to Woodhill. A nurse assessed him, confirmed that he was fit to travel and noted his current ADHD medication.

66. Mr Sessacar arrived at HMP Woodhill at around 2.00pm on 19 January. A Supervising Officer (SO) held an initial reception interview with him. He told us that Mr Sessacar openly answered all his initial questions about his mental health and risks.

67. The reception manager, a Custodial Manager (CM), completed an ACCT review, assisted by an officer from the safer custody team. The CM noted that Mr Sessacar talked about his medication and about having ADHD. He remained very quiet. The officer introduced herself to Mr Sessacar and explained her role in the safer custody team. Mr Sessacar said that he did not know why he had been transferred to Woodhill and that he had two years and seven months of his sentence to serve.

68. Mr Sessacar told the officer that he had a large family support network, he was not affiliated to any gangs and did not know anyone who wanted to harm him at Woodhill. He said that his last disciplinary hearing was for barricading his cell in 2019 and that he had no current substance misuse issues. Mr Sessacar denied that he had a history of self-harm but said that he had previously tried to take his life in prison by overdose and by hanging. She asked him how he would cope with the move to a new prison, and he gave vague responses. She reassured him that he would be supported and reminded him that he could speak to a Listener (prisoners trained by the Samaritans to support other prisoners) and also had access to the Samaritans phone 24 hours a day. Staff agreed to maintain hourly ACCT observations.

69. A nurse completed Mr Sessacar's reception health screen and reviewed his ACCT paperwork. She said that Mr Sessacar appeared settled, made good eye contact and answered all her questions. He said he had no thoughts of suicide or self-harm. She examined Mr Sessacar and noted no physical health concerns. She noted his history of substance misuse and that he had last used crack cocaine eight years ago. He said he had depression, ADHD, a personality disorder and bipolar

disorder and was prescribed ADHD medication. He said that he was being monitored under ACCT procedures as he had tried to harm himself at Gartree. She referred Mr Sessacar to the mental health team and to the prison GP to review his medication.

70. The prison GP continued Mr Sessacar's medication, and it was confirmed that the mental health team would see him the next day.

71. The CM handed over to an officer, who completed Mr Sessacar's induction interview. He explained to Mr Sessacar that he would stay on the induction unit for a maximum of two weeks due to the COVID-19 isolation restrictions. The officer noted that Mr Sessacar was quiet during the interview and said that he was unsure why he had been transferred to Woodhill. He was aware that Mr Sessacar was being monitored under ACCT procedures and noted his risk factors. Mr Sessacar said that he had no thoughts of suicide or self-harm but was still processing the fact that he had been transferred without any notice. He declined the offer of making a phone call.

20 January 2021

72. The following morning, a SO from the safer custody team completed Mr Sessacar's second ACCT review. A mental health nurse and another SO from the safer custody team attended. Mr Sessacar said that his first night at Woodhill had not been great. He said that he had been happy at Gartree. The SO discussed the COVID-19 restrictions at Woodhill, which were the same as Gartree.

73. The SO described Mr Sessacar as fidgety and unable to maintain any eye contact. Mr Sessacar explained that his ADHD made him unable to concentrate on a task for more than 20 minutes. He also said he had Obsessive Compulsive Disorder (OCD). Mr Sessacar told the panel that he had tried to kill himself a week earlier and that he always had thoughts of suicide and self-harm but tried to dismiss them. He said he never planned to harm himself and his actions were spontaneous and a consequence of his frustration. He said he would not tell staff if he intended to harm himself because he had trust issues. The panel told Mr Sessacar that the mental health team would support him, they maintained hourly ACCT observations and added that staff should have three conversations with him (in the morning, afternoon and evening).

74. The mental health nurse told us that she interviewed Mr Sessacar afterwards to complete his early days in custody interview. She referred him for a mental health assessment. Mr Sessacar's presentation had not changed from the earlier ACCT meeting. He said he was "pissed off" because he had been transferred and, that although he had no plans to take his life, he was impulsive and felt anxious. He said that he had not received his property following his transfer, and this contributed to his mood. Mr Sessacar described his property as a protective factor.

75. Around 5.40pm that evening, a CM from the safer custody team attended Mr Sessacar's wing as staff had reported that Mr Sessacar was acting "odd". During an ACCT check, he was found lying under his bed, was not responding to staff and his cell light was off. She went to see him, and when she arrived, she found that two staff had already unlocked and entered his cell. They told her that they had found Mr Sessacar with part of a bedsheet tied around his neck although it was not

tied to anything. He had used the bedsheet to strangle himself by tightening it and then letting it go. Mr Sessacar handed the ligature to staff when asked.

76. The CM noted that Mr Sessacar was initially reluctant to talk. However, he eventually sat up on the floor, spoke calmly and talked about why he was transferred from Gartree. He said that he had had good support from the mental health team at Gartree and had been waiting to see a psychiatrist. She reassured Mr Sessacar that she would arrange for the mental health team to see him the next morning.

77. Mr Sessacar said he wanted his property which was in the reception area. The CM explained to him that because of a unit move that was underway, there had been a shortage of staff to sort out prisoners' property. (The property of newly arrived prisoners is searched for security reasons before it is given to them.) Mr Sessacar said that he had no food and was eating couscous for breakfast. Reception staff had lent him a stereo, but he did not have any CDs.

78. A nurse arrived a few minutes later and examined Mr Sessacar. She recorded that Mr Sessacar said he felt like he had been dumped at Woodhill and "just feels he is done with everything and wants it all to be over". When she asked about the red marks on his neck, Mr Sessacar said he was not in any pain and he had just harmed himself because he felt like he had nothing and no possessions. He normally listened to his CDs to distract himself. The CM said she would try to resolve this for him.

79. The CM told us that Mr Sessacar did not appear to be at immediate at risk and was more interested in his property. Mr Sessacar apologised for his actions and said he should not have done it. Prison staff checked Mr Sessacar's cell for ligatures. None were found. Mr Sessacar said that his phone calls to his family were a supportive factor. He said that if he got his CDs that evening, he would be okay overnight. The CM noted her interaction with Mr Sessacar as an ad-hoc ACCT review. She assessed his risk as raised and increased his observations to three an hour.

80. The CM and a colleague left Mr Sessacar's cell and went to the reception area. She found his CDs and some food. She gave him the items within 30 minutes. Mr Sessacar appeared surprised and thanked the CM.

81. At 7.00pm, Mr Sessacar telephoned a female relative. He told her that he wanted to leave the wing, that no one had been allowed out and he wanted his music. He also talked about the visiting procedures and told her not to worry.

Events on 21 January

82. At 8.05am on 21 January, staff unlocked Mr Sessacar and offered him a shower and exercise. He declined exercise and said he would shower once he received his toiletries. He collected his medication from the medication hatch on the wing.

83. During the ACCT check at 9.15am, staff observed Mr Sessacar exercising in his cell. During further ACCT checks staff recorded that Mr Sessacar cleaning his cell and exercising. When they asked Mr Sessacar if he was okay, he gave them a thumbs up.

84. A SO completed an ACCT review at 10.00am. A mental health nurse attended. The SO noted that Mr Sessacar was fidgeting and made no eye contact with them. Mr Sessacar said he had tied a ligature the previous night because he had struggled over the past few weeks. He said his actions were triggered by not receiving his property at Woodhill.

85. The panel noted that Mr Sessacar showed signs of paranoia. He said he believed staff at Woodhill were colluding with staff at Gartree and were playing games with him. When the SO agreed to check the status of Mr Sessacar's property, Mr Sessacar told him not to ask the reception staff as they would then label him as a demanding prisoner and "mess" with his property. Mr Sessacar said that he had been given some of his property the previous night. He explained that the current regime was not conducive to his mental health and admitted to having thoughts of self-harm but refused to disclose further details. He said he had had hallucinations at Gartree. He said that he disliked prison food and ate items bought from the prison shop. He said that although he kept in contact with his mother, she was expecting him to die.

86. The SO maintained Mr Sessacar's observation level at three an hour. He then escorted Mr Sessacar to a private room so that the nurse could assess his mental health. He also spoke to reception staff, who agreed that Mr Sessacar could visit the reception area the following morning to collect more of his property. The next ACCT review was scheduled for 25 January.

87. The nurse told us that Mr Sessacar was very forthcoming in talking about his mental health issues during the mental health assessment. She concluded that Mr Sessacar showed no overt signs of mental illness. Mr Sessacar told her that self-harm had been an issue for most of his life. She arranged for an urgent appointment with a consultant psychiatrist on 25 January and suggested that Mr Sessacar should be assessed in the prison's Clinical Assessment Unit (CAU) when a bed became available there. She said that Mr Sessacar did not present with any immediate risks and did not warrant being placed under constant supervision in her view.

88. Later that morning, a psychiatrist emailed the consultant psychiatrist and asked for Mr Sessacar to be reviewed before his medication prescription was renewed, particularly as he had tried to harm himself.

89. Staff completed ACCT checks on Mr Sessacar at 11.30am and 11.50am. He had collected his lunch and staff recorded that he appeared to be in a good mood. When Officer A completed his ACCT checks at 12.15pm and 12.35pm, Mr Sessacar was standing by the cell window, looking at his television. The officer said he tried to talk to him and asked if his PIN phone account had been activated. Mr Sessacar responded positively about this but made no further conversation.

90. When Officer A went to do his ACCT check at 12.54pm, he looked through Mr Sessacar's observation panel and saw him hanging from a ligature, tied to the window bar of the cell. He radioed a medical emergency code blue (used to indicate a prisoner is unconscious or having difficulty breathing.) The control room log recorded that this was at 12.54pm. Staff in the control room called an ambulance immediately.

91. Officer B was on the same landing and got to the cell within seconds. As he arrived, Officer A unlocked and went into the cell, followed by Officer B. Officer A cut down Mr Sessacar with his anti-ligature knife while Officer B supported his weight and lowered him to the floor. Officer A started cardiopulmonary resuscitation (CPR).

92. A nurse arrived at Mr Sessacar's cell within two minutes. Prison staff continued to administer CPR. Other prison staff had had already retrieved the defibrillator and other medical equipment. The nurse attached the defibrillator and administered oxygen to assess Mr Sessacar. It instructed that CPR (chest compressions) should continue. The nurse and a colleague continued resuscitation attempts. A prison GP arrived and also assisted.

93. Paramedics arrived at the main prison gate at 1.00pm and arrived at Mr Sessacar's cell at 1.02pm. They took over his care but were unable to resuscitate him. At 2.42pm, they declared that Mr Sessacar had died.

94. After his death, staff found notes addressed to family members in Mr Sessacar's cell, along with two post-it notes on the cell wall that listed the advantages and disadvantages of his current prison placement. In these notes, Mr Sessacar complained about the conditions at Woodhill, the regime restrictions, the quality of the food and not being allowed to shower/exercise. He wrote that prison staff had treated him well and his cell was spacious. He made references to the allegation that he had had an inappropriate relationship with a member of staff at his previous prison, and said it was false. He wrote that staff had tried to manipulate him into admitting to something he had not done and had threatened to make the rest of his sentence harder for him if he denied it.

Contact with Mr Sessacar's family

95. A senior manager and a CM were appointed as family liaison officers. They visited Mr Sessacar's father that afternoon and broke the news of Mr Sessacar's death. In line with Prison Service policy, Woodhill offered a financial contribution to Mr Sessacar's funeral.

Support for prisoners and staff

96. After Mr Sessacar's death, a senior manager 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. All staff involved in the emergency response told the investigator they felt well supported.

97. The prison posted notices informing other prisoners of Mr Sessacar'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 Sessacar's death.

Post-mortem report

98. The post-mortem report found that Mr Sessacar died from hanging. The toxicology results show that he had used amphetamine before he died.

Findings

Assessment and management of Mr Sessacar's risk

99. PSI 64/2011 on safer custody sets out risk factors for suicide and self-harm. Mr Sessacar had a number of these: a significant and long history of self-harm and attempted suicide, substance misuse issues and mental health issues, including personality disorders and ADHD (which meant he was likely to behave impulsively and unpredictably), and he had previously been admitted to a psychiatric hospital. He was also known to cope badly with change and to be struggling with the very restricted COVID-19 regime.

100. This made Mr Sessacar an extremely challenging prisoner to manage safely, and we do not consider that it was ever possible to guarantee that Mr Sessacar would not take his own life at some point. However, we consider that prison and healthcare staff at Gartree managed his risk well and consistently provided him with a good level of support.

101. On 19 January 2021, Mr Sessacar was transferred to Woodhill due to a serious security risk. We accept that this was a necessary and reasonable decision. We are also satisfied that, before he transferred, Gartree took reasonable measures to assess his increased risk of suicide and self-harm, acknowledged a change to his risk and altered the frequency of his ACCT observations to hourly to cover his transition to a new prison. They also highlighted that Woodhill would need to review this.

102. Woodhill reviewed and maintained Mr Sessacar's level of observations at hourly when he arrived. We are surprised that there is no evidence that they considered increasing the frequency of observations. We consider that they focussed too much on Mr Sessacar's assertions that he had no thoughts of self-harming and that they did not give enough consideration to his risk factors and the fact that he transferred to a new prison so suddenly. This was a very significant change for a man who struggled to cope with change of any kind and who was known to be impulsive and unpredictable.

Constant supervision

103. When Mr Sessacar was found with a ligature around his neck on the evening of 20 January, staff increased his ACCT observations to three an hour. In addition to Mr Sessacar's static risk factors and long history of suicide attempts, he had had a sudden and unexpected transfer to a new prison, the reason for his transfer appeared to have played on his mind, and he had been removed from his usual environment and his usual routine had been disrupted. And he had now tied a ligature around his neck, showed signs of paranoia and expressed suicidal thoughts to a nurse.

104. PSI 64/2011 says that staff should consider placing prisoners under constant supervision for the following reasons:

- Serious attempts and/or compelling preparations for suicide, e.g. making a ligature, hoarding medication and/or writing a suicide note.

- A credible expression of a wish to die.

- A recent and credible attempt by a prisoner to take her own life e.g. in prison and before admission to prison.

105. We consider that these criteria applied to Mr Sessacar. While we recognise that three observations an hour is a high level of ACCT monitoring, we are concerned that there is no evidence that staff considered placing him under constant supervision.

106. We recognise that constant supervision should only be used during acute crises, and that being under constant supervision can, in itself, add to a prisoner's stress. However, we believe that staff should have at least considered this level of monitoring given Mr Sessacar's static and new risk factors, especially as he was a new prisoner to Woodhill who staff did not yet know. A short period under constant supervision - at least until Mr Sessacar could be further assessed the following morning or until his urgent psychiatric appointment and/or move to the Clinical Assessment Unit - would have given staff the opportunity to learn more about him and make a more informed assessment of his risk. It would also have given Mr Sessacar the opportunity to settle and develop new routines at Woodhill.

107. We make the following recommendation:

The Governor and Head of Healthcare should ensure that prison, healthcare and mental health teams consider all risk factors and relevant information when deciding how best to manage a prisoner at risk, including considering whether constant supervision is suitable.

Clinical care

108. The clinical reviewer concluded that Mr Sessacar's clinical care was equivalent to that which he could have expected to receive in the community.

Mental healthcare

109. It is evident from Mr Sessacar's medical record that he was impulsive and reactive. The clinical reviewer noted that this was in line with Mr Sessacar's diagnosis of personality disorders and ADHD. The clinical reviewer considered that mental health staff at Woodhill responded and engaged appropriately with Mr Sessacar through the ACCT process.

110. However, reception healthcare staff missed that Mr Sessacar had an outstanding appointment to see the prison GP about whether he should be prescribed antidepressants. This may have been identified during Mr Sessacar's secondary health screen, but he died before this took place.

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