Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Karl Quincey, a prisoner at HMP Wakefield, on 21 October 2023

A report by the Prisons and Probation Ombudsman

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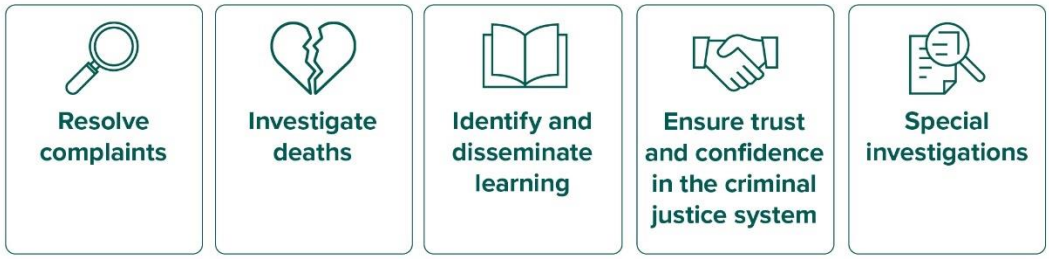
OUR VISION

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

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 Karl Quincey died in hospital of sepsis on 21 October 2023, after he inserted the arm of a pair of glasses into his chest in his cell at HMP Wakefield six days earlier. He was 48 years old. I offer my condolences to Mr Quincey's family and friends.

Mr Quincey was transferred to Wakefield around three months before he died, having spent the previous nine months in a high secure psychiatric hospital. He had an extensive history of self-harm and was monitored under constant supervision throughout his time at Wakefield.

Managing Mr Quincey's behaviour and risk was challenging for prison and healthcare staff and we found that they took positive actions to support him while at Wakefield. Suicide and self-harm procedures were generally well managed, with a consistent case co-ordinator and regular input from the mental health team. However, there was limited senior multidisciplinary input into managing and mitigating Mr Quincey's risk – particularly towards the end of his life when changes were made that should have been recognised as potential triggers for suicide and self-harm – and the Safety Intervention Meeting, which should provide this support, was often poorly attended and provided little guidance to the case review team.

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 **January 2025**

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Summary

Events

1. On 24 November 2010, Mr Karl Quincey received a life sentence with a minimum term of seventeen years for murder.

2. Mr Quincey had diagnoses of emotionally unstable and dissocial personality disorders. He had a substantial history of self-harm, which included cutting and inserting multiple objects into an open chest wound. While in prison, staff frequently monitored Mr Quincey under suicide and self-harm prevention procedures (known as ACCT).

3. On 22 September 2022, Mr Quincey transferred to Broadmoor Hospital (a high security psychiatric hospital), following events including an escalating pattern of serious self-harm.

4. Mr Quincey struggled to progress at Broadmoor and continued to seriously self-harm, including by inserting the arm of a pair of glasses and putting faeces into his chest wound. On 18 July 2023, Mr Quincey was transferred to HMP Wakefield.

5. Upon arrival at Wakefield, prison staff immediately began monitoring Mr Quincey under ACCT procedures, placing him under constant supervision in the healthcare inpatient unit. Mr Quincey was resistant to any suggested changes to his location and frequently threatened to harm others if staff moved him onto a standard residential unit. Over time, prison managers reduced the number of officers constantly supervising Mr Quincey and introduced short periods in which his cell door was closed.

6. On 9 October, staff moved Mr Quincey onto a different landing in the healthcare inpatient unit. On 11 October, the ACCT case review team told Mr Quincey that he needed to begin to engage in the prison regime or, at his next case review, they would review his incentive level.

7. On 12 October, Mr Quincey told a constant supervision officer that he had opened an old wound and was “waiting for the right moment”.

8. At around 5.50pm on 15 October, Mr Quincey approached a constant supervision officer and handed her a note which advised her to call the emergency response nurse. Mr Quincey then showed the constant supervision officer that he had inserted the arm of a pair of glasses into his open chest wound.

9. Paramedics took Mr Quincey to hospital. He was taken to hospital in double handcuffs with a four-officer escort.

10. While in hospital, Mr Quincey declined surgery to remove the arm of the glasses. He continued to deteriorate, and doctors confirmed his death at 5.15pm on 21 October.

Findings

11. Prison and healthcare staff took many positive actions to support Mr Quincey. They appropriately recognised that he was at high risk of suicide and self-harm and placed him under constant supervision. Case reviews were regular, multi-disciplinary and almost always included a mental health nurse. There was a consistent case co-ordinator, a manager in the safety team, who knew Mr Quincey well. Whenever possible, staff who Mr Quincey knew and was comfortable with were assigned to his constant supervision.

12. There were two significant events in Mr Quincey's last week at Wakefield: he moved cell and was told that his incentives level might be reduced (meaning he could lose access to things like in-cell television and his games console). Mr Quincey had been clear that he did not wish to move cells and that the benefits of his enhanced incentives level were significant protective factors, and it was recognised that these were both potential triggers for suicide and self-harm. There should have been wider and better quality senior multidisciplinary input – through the Safety Intervention Meeting or otherwise – to consider the potential impact of these changes and how to manage and mitigate the additional risks they presented.

13. Mr Quincey harmed himself in the days following these events and indicated that he might repeat or escalate this. This should have prompted an urgent case review.

14. Mr Quincey died while being restrained with an escort chain, after a period in which he was unconscious and recognised to be near the end of his life.

Recommendations

- The Governor should ensure that the Safety Intervention Meeting is chaired by an appropriate senior operational manager and attended by senior multidisciplinary staff, including from the Safety Team, and that complex prisoners, including those placed under constant supervision, are properly discussed with supported plans made to identify how to reduce their risk.

- The Governor should ensure that urgent case reviews take place when a prisoner monitored under ACCT procedures harms themselves or other indicators of increased risk emerge.

The Investigation Process

15. HMPPS notified us of Mr Quincey's death on 21 October 2023.

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

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

18. The investigator interviewed 18 members of staff in person and by video conference between 5 February and 1 March 2024. In May 2024, we reassigned the investigation to another investigator, who interviewed an additional member of staff in June.

19. NHS England commissioned a clinical reviewer to review Mr Quincey's clinical care at the prison. He attended joint interviews with healthcare staff.

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

21. The Ombudsman's office contacted Mr Quincey's friends, his next of kin, to explain the investigation and to ask if they had any matters they wanted us to consider. They did not have any questions.

22. We shared the initial report with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

23. We also shared the initial report with Mr Quincey's family. They did not make any comments.

Background Information

HMP Wakefield

24. HMP Wakefield is a high security prison for category A and B male prisoners. There are four main residential wings, a healthcare inpatient unit, a segregation unit and a close supervision centre (CSC). The healthcare inpatient unit can accommodate up to 14 prisoners and includes two constant supervision cells.

25. Practice Plus Group is commissioned by NHS England to provide the majority of healthcare services at Wakefield. Psychiatry, recovery and clinical psychology services are contracted to Midlands Partnership Foundation Trust. Forensic psychologists are employed by HMPPS.

HM Inspectorate of Prisons

26. The most recent inspection of HMP Wakefield was in November 2022. Inspectors found that healthcare outcomes required improvement and much of the delivery was undermined by a shortage of healthcare staff. There was lack of suitable mental health therapies and interventions, including for those in crisis.

27. Levels of self-harm were higher than at the previous inspection but had reduced over the last year. Inspectors found that oversight of suicide and self-harm prevention work was underdeveloped. They noted that minutes from safety intervention meetings showed good coordination between functions for individual prisoners, but inspectors found that there was no strategy and minimal interrogation of data to understand drivers and trends. Inspectors found that support for prisoners monitored under ACCT procedures was generally good but that in some cases care plans lacked meaningful targets for prisoners.

Independent Monitoring Board

28. 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 April 2023, the IMB reported that they remained concerned that too many prisoners were not engaged in education or work opportunities.

29. The IMB found that the quality of ACCT documents varied although they noted that managers were monitoring this and providing regular training for staff to continue to improve quality.

Previous deaths at HMP Wakefield

30. Mr Quincey was the twenty-seventh prisoner to die at Wakefield since October 2020. Of the previous deaths, three were self-inflicted and twenty-three were from natural causes. Up to the end of September 2024, there has been one more self-inflicted death and four deaths from natural causes. We have previously identified issues with the inappropriate use of restraints at Wakefield.

Assessment, Care in Custody and Teamwork

31. 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. After an initial assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm.

32. Part of the ACCT process involves assessing immediate needs and drawing up support actions to identify the prisoner's most urgent issues and how they will be met. Staff should hold regular multidisciplinary reviews and should not close the ACCT plan until all the support actions are completed. 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).

Key Events

33. On 24 November 2010, Mr Karl Quincey received a life sentence with a minimum term of seventeen years for murder. He was sent to HMP Winchester.

34. Mr Quincey had diagnoses of emotionally unstable and dissocial personality disorders. He had a substantial history of self-harm, which included cutting and inserting multiple objects into a chest wound. Between July 2008 and September 2022, prison staff monitored Mr Quincey under ACCT procedures on at least 25 occasions. Mr Quincey had a chronic open wound overlying his sternum which had been subject to repeated wound infections. He had a number of other physical health concerns, including self-induced ventricular septal defect (hole in the heart), mild right ventricular systolic dysfunction (heart failure) and chronic heart failure.

35. On 7 July 2022, a psychiatrist at HMP Whitemoor referred Mr Quincey to Broadmoor Hospital (high-security psychiatric hospital) under the Mental Health Act. He recorded that Mr Quincey had failed to progress in terms of his sentence plan, had disengaged with therapeutic work and was displaying an escalating pattern of self-harm that put him at high risk of serious injury or death.

36. During the eight months leading up this referral, Mr Quincey had repeatedly inserted metal spikes, aerials, and sharpened pieces of wood into his chest wound.

Broadmoor Hospital

37. On 22 September 2022, Mr Quincey transferred to Broadmoor Hospital.

38. On 5 January 2023, Mr Quincey inserted the arm of a pair of glasses into his existing chest wound. In a conversation following this incident, Mr Quincey shared that he felt that his glasses were a risk item.

39. From mid-June 2023, hospital staff noted a deterioration in Mr Quincey's behaviour and more frequent attempts to self-harm.

40. On 29 June, a consultant psychiatrist completed a remission to prison form. She recorded that Mr Quincey had struggled to progress, mainly due to being unable to tolerate the restriction of risk items. She noted that despite 24-hour support for several months, Mr Quincey's mental state had not improved, and his frustrations had led to an increase in risks to himself and others.

41. On 6 July, a consultant psychiatrist from Broadmoor chaired a multi-disciplinary meeting under Section 117 of the Mental Health Act, which hospital and prison staff attended to prepare for Mr Quincey's return to prison. The psychiatrist summarised Mr Quincey's care and stated that he had seriously self-harmed on several occasions. She provided an overview of these occasions and highlighted that a trigger for self-harm was often around decisions which Mr Quincey saw as punitive or not favourable to him.

HMP Wakefield

July-August 2023

42. On 18 July, Mr Quincey was transferred to HMP Wakefield. Prison staff immediately started monitoring Mr Quincey under ACCT procedures and noted that he was at high risk of suicide and self-harm. They made him subject to a three-officer constant supervision, to mirror the safeguarding arrangements that had been in place at Broadmoor. (Constant supervision is when one or more members of staff remain with and observe the prisoner at all times, usually sitting outside the cell door.)

43. Mr Quincey was allocated a constant supervision cell in the healthcare inpatient unit. He remained under constant supervision for the duration of his time at Wakefield. (A constant supervision cell has fewer ligature points than a standard prison cell. It also has a barred gate which can be used instead of a standard cell door, so that supervising staff can more easily see into the cell.)

44. Initially, staff placed Mr Quincey in double handcuffs when moving him outside of the cell. This was done to mirror the way in which Mr Quincey had been managed while at Broadmoor and to mitigate the risk to himself and other prisoners. On 24 July, a senior manager made the decision to remove the handcuffs.

45. During Mr Quincey's ACCT assessment, he shared that he had self-harmed at Broadmoor because of the way staff there had treated him. He identified that listening to music, playing on his Xbox and his artwork were protective factors. A Custodial Manager (CM) from the Safer Custody Team was allocated as Mr Quincey's case co-ordinator.

46. A member of the chaplaincy team visited Mr Quincey as part of his induction and recorded that he engaged well. He added that Mr Quincey expressed a wish to avoid self-harm. (Chaplaincy staff visited Mr Quincey over 35 times prior to his death and offered him advice and support.)

47. Mr Quincey told one of his allocated prison offender managers (POMs) that he had expected to return to the FENs unit (a specialist therapeutic unit at HMP Whitemoor for prisoners with personality disorders) and asked her to contact this unit to discuss why he had not returned there. She did so a few days later. Staff on the FENs unit told her that Mr Quincey would not be able to return as the service had changed since he had been there, and the current expectation was that prisoners would arrive treatment ready (which Mr Quincey was not considered to be).

48. On 19 July, the case co-ordinator chaired Mr Quincey's first ACCT case review. Attendees included a mental health nurse, a POM, an officer and a safer custody officer. The officer who had completed the ACCT assessment, was not present at this review.

49. The case co-ordinator recorded that Mr Quincey spoke about how the staff at Broadmoor had "stitched him up" and "caused him lots of problems". The case co-ordinator told Mr Quincey he would visit him the next day to go through the ACCT document in detail. He explained to the investigator that this first review was more of an introduction to go through Mr Quincey's regime, handcuffing arrangements and the risk assessment.

50. On 20 July, the case co-ordinator chaired an ACCT case review. Attendees included a mental health nurse, two prison offender managers and a custodial manager from the healthcare unit. Staff completed a care plan during this review. This included actions to maintain contact with next of kin (Mr Quincey had no contact with his family but was in touch with some friends who had visited him while in prison) and restart therapy. (The action plan was next updated at case review 12 in September.) Additional support actions included engaging in a gym induction, safe lifting course and maintaining contact with chaplaincy and his key worker.

51. The case co-ordinator reviewed the items that Mr Quincey could have in his cell with him and agreed that he could have access to paper and pencils. He could also have his glasses in his cell for reading but had to hand these back afterwards. The case co-ordinator reviewed this items list at subsequent ACCT case reviews and an up to date list of items allowed in Mr Quincey's possession was kept in the ACCT document, so that constant supervision staff could easily access and refer to this.

52. Upon arrival at Wakefield, Mr Quincey was referred to the mental health team and healthcare staff completed an initial mental health assessment the following day. On 22 July, Nurse A and the clinical lead for the mental health team were assigned to be Mr Quincey's mental health case workers and staff added him to the waiting list to see a psychiatrist.

53. On 24 July, Nurse A reviewed Mr Quincey's crisis plan, and the subsequent day completed a risk assessment for him. On 26 July, she completed a mental health care plan and noted that in the short term, the plan was to encourage and to support Mr Quincey to engage in the wing regime and associated activities. In the long term, the plan was to identify treatment within the Prison Service's personality disorder pathway. She saw Mr Quincey regularly by attending his ACCT reviews.

54. Over the following months, the case co-ordinator chaired regular ACCT case reviews. These were multidisciplinary, had consistent attendance and almost always included a member of the mental health team (usually Nurse A or Nurse B). Prison and healthcare staff also discussed Mr Quincey at the weekly safety intervention meeting (SIM).

55. During Mr Quincey's case reviews, staff gradually increased Mr Quincey's access to items. The case co-ordinator regularly recorded in case review records that Mr Quincey saw his Xbox and music as protective factors. Mr Quincey often expressed his frustration with the regime and not having access to particular items. He shared that he wished to go back to therapy and particularly to the FENs unit where he had been before.

56. Mr Quincey said to constant watch officers on several occasions that he "wished they would turn a blind eye" and often made comments suggesting he did not want live anymore.

57. Mr Quincey frequently said that he did not want to be located alongside sex offenders (a large proportion of prisoners at Wakefield have been convicted of sex offences). The case review team discussed with Mr Quincey about moving from the inpatients unit to a standard residential wing. He refused to discuss this on each occasion and made threats to kill a sex offender if he was moved.

58. Mr Quincey's regime included a shower, morning exercise (initially restrained by rigid bar handcuffs and escorted by four officers and later decreased to two officers and uncuffed) and an hour by himself in the recreation room in the afternoon. In early August, staff gave Mr Quincey the opportunity to come out for his meals with other prisoners and for a session during the evening association period. However, this was only permitted when another prisoner (a high-profile sex offender) declined to collect his meals or have his evening association.

59. Over the next few months, two POMs attempted to explore a number of avenues for progression, contacting the Support Transition and Enabling Progression Unit at Full Sutton (STEP, a national resource providing a small number of prisoners with the opportunity to leave long-term segregation), the Beacon Unit at Garth (offender personality disorder pathway) and the BRIDGE unit (a reintegration wing at HMP Whitemoor for prisoners leaving the segregation unit). They received responses that Mr Quincey was either clearly not treatment ready or his risk to men convicted of sex offences meant it was unlikely they would be able to manage him in these units.

60. Both POMs contacted other professionals, some of whom had worked with Mr Quincey previously, to get advice on how to work on stabilisation and relationship building. They also contacted the team responsible for provision of psychological services at HMP Wakefield, asking them to attend an ACCT review. The Head of the Assessment and Intervention Centre responded that they would have a senior registered psychologist for case consultation from an offender personality disorder (OPD) perspective. She explained that the team would not provide face-to-face work to Mr Quincey. At interview, she told the investigator that the Prison Service's Psychology Services Group (PSG) are not resourced to work with prisoners on a one-one basis, except in exceptional circumstances.

61. The senior registered psychologist produced a plan (completed for all individuals remitted from hospital back to prison) which included signs to indicate Mr Quincey's risk was increasing, as well as actions that made things worse or better for Mr Quincey. Actions to make things better included consistent and multi-disciplinary led care, gaming, transparency and being included in decision making where possible. Actions which made things worse included not feeling listened to, being challenged and a lack of autonomy. Signs that the risk was increasing included not eating, threats towards others and becoming more withdrawn. The case co-ordinator told us that this document was shared with the ACCT case review team and was stored in the ACCT document.

62. On 7 August, the case co-ordinator told Mr Quincey that he had reviewed the incentives level Mr Quincey that had been on before moving to Broadmoor and had confirmed that he had been on enhanced. (The Incentives Policy Framework (IPF) Scheme aims to encourage and reward responsible behaviour in prisons – enhanced is the highest level available.) Prison staff reinstated this and allowed Mr Quincey to have an Xbox in his cell. A constant supervision officer recorded that Mr Quincey was extremely happy after having gained his enhanced status.

63. On 12 August, Mr Quincey's constant supervision was reduced to two staff. When staff initially told Mr Quincey about this in a case review, he said he was "bubbling" and did not feel that this was the right time to reduce his staffing level. The case co-

ordinator informed Mr Quincey that this was a show of his progression and that he would still be supervised by regular staff, which he seemed happy about.

64. On 18 August, the case co-ordinator chaired an ACCT case review. A POM and constant supervision officer attended. Staff informed Mr Quincey that from 21 August, his constant supervision would reduce to one member of staff.

65. Later that day, a multi-disciplinary team meeting (MDT) was held to discuss Mr Quincey. They discussed that Mr Quincey's constant supervision would be reduced to one officer the following week. They discussed risks to himself and others if he was moved from the current location due to his previous threats to harm sex offenders. Another MDT was scheduled for 22 August (this did not go ahead due to key staff not being present).

66. On 21 August, Mr Quincey's constant supervision was reduced to one staff member.

67. At case reviews over the next few weeks, Mr Quincey continued to threaten to harm other prisoners if staff moved him to a standard residential wing. Staff informed him that the present situation could not continue indefinitely and that they would need to move him if they required the bed space in the healthcare inpatient unit.

September 2023

68. On 4 September, a psychiatrist reviewed Mr Quincey and noted that he said he would put another prisoner "in a body bag" should staff move him to a standard wing. Mr Quincey also said that he wanted to return to therapy but could not do it at Wakefield due to it taking place in a group-work setting. The psychiatrist recorded that Mr Quincey was at medium risk of suicide and self-harm as he had no plans but had daily thoughts that he would rather be dead.

69. On 8 September, the Head of Safer Custody chaired an ACCT case review in the case co-ordinator's absence. Staff explained to Mr Quincey that reducing observations after being on constant supervision would be hard and they would value his input into how they planned this. Mr Quincey said he would not come off constant supervision as it was too early. He then left the review and later expressed his frustration to the mental health nurse and his POMs.

70. Attendees decided to close Mr Quincey's outer cell door for an hour over lunch to see how he managed. They agreed that an officer would still sit outside his door and the observation hatch would be open so staff could still see him. On the first day this took place, an officer, who had a good rapport with Mr Quincey, sat outside the door and talked to Mr Quincey for the hour period. (Staff continued to close Mr Quincey's door every lunchtime when he was at Wakefield.) Initially, Mr Quincey was resistant to this change and a constant supervision officer recorded that he was very unsettled and pacing his cell.

71. Later the same day, a POM wrote to several senior members of staff, including the Governor, to provide them with an update on Mr Quincey. She noted that she and another POM had liaised with several specialist treatment units across the prison estate but had been told that Mr Quincey was not treatment ready and that they needed to keep working on stabilisation. She explained that they had been told that

the pre-PIPE unit (a psychologically informed planned environment) at HMP Long Lartin might be worth contacting but that they were aware the process for this could be very slow. She added that they had explored all options and felt like they had reached the limit of what they could do for Mr Quincey. She added that they would continue what they were doing but did not feel they had the skills to prepare Mr Quincey for treatment and felt that ongoing psychology input would be more beneficial but was not available at Wakefield.

72. On 11 September, the Head of Reducing Reoffending chaired an ACCT case review in the case co-ordinator's absence. She noted that Mr Quincey initially refused to engage if his POMs were present and was rude throughout the review. She recorded that although Mr Quincey had not self-harmed since arriving at Wakefield, his risk remained high. She added that having his environment changed was likely to invoke a reaction and cause him some fear. (This was not recorded as a trigger in the ACCT document.)

73. On 19 September, Mr Quincey met his keyworker. He explained that he did not like his door being shut at lunch time as he was scared he would be forgotten about and mentioned that this made him want to self-harm. (This was not recorded as a trigger in the ACCT document.) They discussed gaming and Mr Quincey said that he would really struggle without his Xbox as it "keeps him sane".

74. On 25 September, the case co-ordinator chaired an ACCT case review. Mr Quincey was asleep and therefore did not engage in the review. Staff on the unit told the case co-ordinator that he had been staying up all night playing on his games console, which was disrupting other patients. They said that over the weekend his attitude had been poor at times, including throwing a vape at the wall.

75. At this point, items which were allowed in Mr Quincey's possession included paper and pencils, a stereo and CDs, TV, Xbox and letters. Mr Quincey's glasses were allowed in his possession for reading but he had to hand them back when he was finished. This also applied to his vape, electric shaver, toothbrush and cutlery.

76. On 27 September, an MDT meeting was held. They discussed options for Mr Quincey's next move. They also spoke about potentially closing his cell door at certain intervals, as staff did not yet feel confident enough to take him off constant supervision. They discussed that the IPF system was not being used at the time with Mr Quincey as there was a concern that taking away his enhanced status could increase his risk of self-harm. (Prisoners would usually be expected to work or attend education to qualify for enhanced status.) They concluded that any changes needed should be in "tiny steps". These included introducing key work, managing the use of his games console, having consistent and confident staff on constant supervision and establishing boundaries by using the IPF.

77. On 28 September, the SIM referenced that they would discuss the outcome of the previous day's multidisciplinary meeting at their meeting the following week.

78. An officer recorded that Mr Quincey told her that he wanted to end his life as he could not see an end to his situation. She added that she tried to encourage him to see the positives, no matter how small they might have been, but Mr Quincey stated that he still held onto strong suicidal ideations.

79. Later that afternoon, the case co-ordinator chaired an ACCT case review. (This included prison offender managers. A mental health nurse joined at the end due to other clinical demands.) Mr Quincey told staff that he was "bubbling and on edge". However, he also said that he kept himself occupied by listening to music and playing his games console. The case co-ordinator spoke about Mr Quincey disrupting other prisoners with his games console at night. He told Mr Quincey that he should be considerate towards those around him.

80. Mr Quincey said that he had nothing to do during the day. The case review panel discussed that Mr Quincey had not been on the exercise yard due to poor weather and had not used his association period. The case co-ordinator asked Mr Quincey about attending chapel and if he would be interested in attending the library to get some books or CDs. Mr Quincey declined attending chapel but expressed interest in attending the library. They spoke about Mr Quincey's relationship with his POMs which had deteriorated in recent weeks. Mr Quincey explained he would like to speak to the case co-ordinator separately about this, and the case co-ordinator agreed to come back the following week and speak to him about this on a one to one basis. (We have not seen evidence of this conversation taking place.)

October

81. There was no weekly SIM on 5 October, due to staff training.

82. On 6 October, the case co-ordinator chaired an ACCT case review. Nurse B attended this review. The case co-ordinator recorded that Mr Quincey said he was "still bubbling and felt on edge" but continued to keep himself occupied with his games console and music. He said that he felt his POMs were not doing anything for him and the case co-ordinator advised him that he needed to work with them to progress. The case co-ordinator noted that there had been no incidents of self-harm (although it had been reported that Mr Quincey had self-harmed, this turned out to be false).

83. Nurse B noted in Mr Quincey's medical record that staff had told him at this review that he might be moved to another constant supervision cell due to clinical need and that he expressed unhappiness about this. Mr Quincey requested a separate appointment with his mental health worker. (Nurse A went to see Mr Quincey on 11 October, but he refused to engage with her).

84. Later that evening, Mr Quincey spoke to a constant supervision officer and explained that he had been told he may have to move cells. Mr Quincey told the officer that his "head would go" and his mental health would deteriorate if he was surrounded by the prisoners on the second landing due to them being disruptive. (At the time there was a particularly disruptive prisoner located on the second landing of the healthcare unit.)

85. On 7 October, a nurse recorded that Mr Quincey had said to an officer that he "would do something to himself" if staff moved him onto the second landing. She noted that the officer and orderly officer (the senior uniformed officer in charge of responding to incidents in the prison) discussed a plan should relocation go ahead. She noted that this would be discussed with the prison day team, but there is no evidence of this conversation taking place.

86. On 9 October, a nurse reviewed Mr Quincey and noted that he said he was not in a good place**.**

87. That afternoon, Mr Quincey moved to a constant supervision cell on the second landing in the healthcare inpatient unit. This move took place due to another prisoner needing the constant supervision cell on the third landing as this was closer to the nurse's office. (This prisoner was frequently harming himself and judged to be at significantly high risk of suicide.)

88. The case co-ordinator told the investigator that Mr Quincey agreed to the move with no argument. A nurse said that when she saw Mr Quincey moving cells he seemed quite enthusiastic about this.

89. At 3.00am on 10 October, Mr Quincey was woken by other prisoners banging and shouting. A constant supervision officer recorded that he was not happy about this and said it was "not doing his mental health any good". He told a constant supervision officer that he wanted to be moved off the landing due to not being able to sleep and said, "I'll be a bed watch soon if I stay on this floor". (Bed watch is the term used for a hospital inpatient escort. It is likely that Mr Quincey was indicating that he would harm himself.) Over the next few days, Mr Quincey regularly had trouble sleeping and spoke about issues with other prisoners on the landing.

90. On 10 October, a chaplain saw Mr Quincey for a welfare check and recorded that Mr Quincey said he had asked healthcare and mental health staff for help but did not feel he was getting support. Mr Quincey said he was "better to die". The chaplain recorded this in the ACCT ongoing record. Later, a staff member from education went to see Mr Quincey, who declined any courses.

91. On 11 October, the case co-ordinator and the Head of Safer Custody chaired an ACCT case review. Attendees included a POM and Nurse A. The case co-ordinator noted that Mr Quincey kept himself occupied with his games console and music, which he saw as a protective factor. He recorded that Mr Quincey was sleeping a bit more. (This contrasts to what staff had noted in the ACCT ongoing record, that Mr Quincey had had difficulty sleeping since moving cells.)

92. The Head of Safer Custody told Mr Quincey that he had been informed that Mr Quincey had declined to engage in his education induction. Mr Quincey responded that this was not the case and that he had spoken to them. Mr Quincey told the Head of Safer Custody that he had declined to engage in his gym induction for medical reasons (relating to his heart condition).

93. The Head of Safer Custody asked that Mr Quincey take part in the education and gym induction process before Friday 13 October. He said that if this was not completed by then they would review his IPF level his next ACCT case review, scheduled for 16 October. (This action had been discussed as a potential option at the MDT on 27 September.) At this point, Mr Quincey did not engage any further in the review.

94. Later that day, in the ACCT ongoing record, a constant supervision officer recorded that staff had serious concerns about the safety of Mr Quincey and other prisoners if "certain propositions" went ahead. The officer noted that "issues may need to be spoken about after conversations regarding serious self-harm if propositions were

to go ahead". (We understand the "propositions" to mean a review of Mr Quincey's IPF level.)

95. In the record of evening summary on the ACCT ongoing record, another constant supervision officer recorded that Mr Quincey was not happy about the Head of Safer Custody's "threats" to take away his enhanced status if he did not go to education or workshops. Mr Quincey also told the officer that he struggled to sleep due to his loud neighbours, which was affecting his mental health.

96. On 12 October, the SIM minutes identified that Mr Quincey had been directed to engage with education or work and that his incentives level would be affected if he did not engage. The Head of Safer Custody chaired this meeting, although there was no other senior manager present and no healthcare representative. There is no record that the potential impact on Mr Quincey's risk of a change to his incentives level was discussed.

97. An officer told Mr Quincey that he was required to attend education. Initially, Mr Quincey declined but changed his mind minutes later and said he would need four staff to take him and would require handcuffs. (Mr Quincey appeared to be referring to the arrangements when he first moved to Wakefield, which were no longer in place.) There appears to have been some confusion as a short while later, staff told Mr Quincey that he was not required for education and stayed in his cell.

98. That afternoon, a constant supervision officer identified a red mark on Mr Quincey's chest. A nurse reviewed him, but Mr Quincey refused to engage.

99. At around 7.00pm, an officer recorded in Mr Quincey's prison record, and in an intelligence report, that he had told her that he had opened an old wound and was "waiting for the right moment". Mr Quincey told her that Mr Brown was "playing a dangerous game" with him trying to get him to education or work. She noted that when Mr Quincey's cell door was closed he was "digging and digging" at his wound. She noted that she informed healthcare and emailed the Safer Custody team. There was no entry in the ACCT ongoing record of this conversation.

100. At 8.40pm, Mr Quincey told the constant supervision officer that he felt depressed and had a lot on his mind. He said that he found it difficult to dealt with these things.

101. At 10.30pm, a constant supervision officer submitted an intelligence report stating that Mr Quincey said that he was being made to go to education or a workshop and that he would "kill a [sex offender]".

102. At 12.50am on 13 October, a nurse reviewed Mr Quincey after he told a constant supervision officer that he had an open chest wound. She noted that the wound was open (indicating that Mr Quiney might have purposefully opened the wound).

103. On 13 October, a physical education instructor officer spoke to Mr Quincey regarding his gym induction. He told the officer that he was not allowed to attend gym due to instructions given by his cardiologist. (Mr Quincey had a history of heart failure and other cardiac abnormalities and had been under the care of cardiologists for some time but we do not know if he had been given this particular advice.)

104. A nurse visited Mr Quincey to conduct a wound and welfare check but recorded that he was extremely hostile towards her and refused to engage. In the afternoon, a GP

and a nurse visited Mr Quincey to review his chest wound. Mr Quincey refused to show them his wound or to take antibiotics.

105. On 14 October, an officer noted in the ACCT ongoing record that Mr Quincey had a settled morning and afternoon. No one made an entry in the ongoing record that evening.

Events of 15 October

106. There is no CCTV covering the second landing in the healthcare unit. The following account has been drawn from staff statements, interviews and ambulance records. In the morning, Mr Quincey spent time writing and did not engage in any meaningful conversation. At 12.10pm, a CM recorded in the daily review section of the constant supervision handover log that he saw Mr Quincey on his rounds and that there had been no change to his risk or circumstances.

107. In the afternoon, Mr Quincey took a shower and spent an hour in the recreation room. After returning from the recreation room, Mr Quincey had an argument with a prisoner in the opposite cell. Mr Quincey threatened that he would throw a cup of boiling water at this prisoner. Officer A told them to stop, after which Mr Quincey watched television.

108. At 5.05pm, Officer B took over from Officer A as Mr Quincey's constant supervision officer. Officer A handed over the events of the afternoon. After the officer left, Mr Quincey sat at his desk. Officer B said that Mr Quincey was writing and listening to music. She added that he kept getting up every so often and did not show any signs of distress.

109. At around 5.50pm, Mr Quincey approached Officer B and handed her a piece of paper which said, "Call Hotel 5 code red". (Hotel 5 is the call sign for the emergency response nurse and code red indicates a medical emergency involving loss of blood.) She asked Mr Quincey what he had done, and he opened his dressing gown. She saw that he had inserted something into his chest wound (which she later realised was the arm of his glasses). She radioed for Hotel 5 to attend, then called a medical emergency code red. The control room operator telephoned for an ambulance.

110. While waiting for staff to attend, Officer B asked Mr Quincey why he did this and he said, "it's been bubbling for a while now". She said that Mr Quincey appeared very calm and was still vaping as he walked around the cell.

111. At around 5.55pm, an officer arrived with healthcare staff. A Supervising Officer (SO) joined them shortly after. The staff went into the cell and healthcare staff conducted an assessment. They noted that Mr Quincey was alert but said he felt nauseated and lightheaded.

112. At 6.02pm, paramedics arrived at the prison and attended the scene at 6.16pm. Paramedics recorded that there was a long delay gaining entry to the prison due to security procedures.

113. At 7.35pm, paramedics took Mr Quincey to Leeds General Infirmary. While being escorted out of the ambulance, Mr Quincey managed to push the glasses arm further into his chest.

114. Prison and healthcare staff completed an escort risk assessment. A nurse recorded that there were no medical objections to the use of restraints but that they should be removed in the event of [cardiac] arrest. A security officer assessed that Mr Quincey was a high risk to the public and medium risk of escape. The authorising manager authorised that the escort should consist of four officers and that double handcuffs should be used. (Double cuffs is where two sets of handcuffs are used: one to handcuff the prisoner's hands together, and the other is attached to the prisoner's wrist and that of an officer.) The authorising manager recorded that this was agreed with paramedics.

115. The following day, prison staff found a note in Mr Quincey's cell suggesting that his actions were a deliberate attempt to take his life. (We do not know when this was written.)

Events between 16 and 20 October

116. While in hospital, Mr Quincey refused any surgery to remove the glasses arm from his chest and expressed a desire to die. As a result, he continued to deteriorate over the following days. The hospital mental health team reviewed Mr Quincey and assessed him as not having the mental capacity to make decisions about his own care and planned to undertake surgery under the Mental Health Act. A hearing to consider this was scheduled for 23 October.

117. Mr Quincey said during his time in hospital that his "tipping point" was being moved downstairs in the healthcare unit.

118. On 18 October, Mr Quincey shared that he was very uncomfortable in double cuffs. A custodial manager attended the hospital and completed a bedwatch management check. They noted that Mr Quincey was unable to stand or move and that the use of double cuffs should be discussed. The duty governor advised there should be no changes made to the restraints at this point.

119. On 19 October, a custodial manager noted in the bedwatch management check that double cuffing was appropriate as Mr Quincey was still conscious, communicative and had been obstructive with prison and nursing staff. The following day, a custodial manager noted that Mr Quincey was not communicating with staff but was still being obstructive with staff and nurses and therefore did not recommend any change to the cuffing arrangements.

Events on 21 October

120. In the afternoon, a hospital nurse told the bedwatch officer that she did not think Mr Quincey would make it until Monday (23 October) if he continued to refuse treatment and that his condition was deteriorating fast.

121. At around 2.00pm, hospital staff informed the officer in charge of the bedwatch that they were looking to move Mr Quincey to end-of-life care as they could not do anything further if he refused any treatment. He told the investigator that he asked

the nurse for a prognosis, and she explained that she could not give him one but thought Mr Quincey might die that Monday.

122. At this point, the officer in charge of the bedwatch checked the 'part 11' of the escort risk assessment (the part 11 gives authorisation for removal of all restraints) to see if it said anything about what to do if Mr Quincey's condition deteriorated. The part 11 only covered the scenario of Mr Quincey going into surgery. At around 2.30pm, the officer phoned the control room, who informed him that a CM would complete a management check soon so they would be able to do a joint assessment of the cuffing arrangements.

123. At around 4.00pm, a custodial manager arrived at the hospital to complete his management visit. He told the investigator that Mr Quincey looked very unwell and was not responsive. He spoke to the duty governor, who advised that they could reduce the cuffing arrangement to an escort chain only. He said that this would be reviewed at a later stage once he had spoken with the Governor about removing all restraints.

124. At around 4.20pm, bedwatch staff noticed that Mr Quincey's breathing had become laboured. The officer in charge of the bedwatch informed a nurse, who said that it was normal and expected. He said that at this point Mr Quincey appeared to be unconscious.

125. At around 4.45pm, bedwatch staff noticed that Mr Quincey's breathing became very shallow, before stopping completely. The officer in charge of the bedwatch immediately alerted a nurse, who found that Mr Quincey had died. He then contacted the prison, who advised him to remove the escort chain, which he did. At 5.15pm, a hospital doctor confirmed that Mr Quincey had died.

Contact with Mr Quincey's next of kin

126. On 20 October, hospital staff contacted Mr Quincey's friends, who he had nominated as his next of kin, and told them that he was very ill in hospital.

127. At 5.15pm on 21 October, a prison family liaison officer (FLO) telephoned Mr Quincey's friends, and told them that he had died. She explained that she did this over the phone as they lived a long way from Wakefield and were already aware of Mr Quincey's situation.

128. In line with his friends' wishes, the FLO arranged Mr Quincey's funeral, which Wakefield contributed to in line with national guidelines.

Support for prisoners and staff

129. Postvention is a joint HMPPS and Samaritans initiative that aims to ensure a consistent approach to providing staff and prisoners support following all deaths in custody. Postvention procedures should be initiated immediately after every self-inflicted death and on a case-by-case basis after all other types of death. Key elements of postvention care include a hot debrief for staff involved in the emergency response and engaging Listeners (prisoners trained by the Samaritans

to provide confidential peer-support) to identify prisoners most affected by the death.

130. After Mr Quincey was taken to hospital, there was no hot debrief for the prison or healthcare staff involved in the emergency response. Two of the prison staff involved in the emergency response went on to escort Mr Quincey to hospital. The care team offered support to prison staff. A member of healthcare staff who attended the emergency response told the investigator that she was not offered support by the care team.

131. After Mr Quincey died, the officer in charge of the bedwatch, under the instruction of the duty governor, conducted a hot debrief for the bedwatch staff. There was no collective debrief with all staff involved in Mr Quincey's care after his death.

132. The prison posted notices informing other prisoners of Mr Quincey's death and offering support. The prison also deployed Listeners to support prisoners on the healthcare inpatient unit.

Post-mortem report

133. A post-mortem examination showed that Mr Quincey died of sepsis caused by infection of foreign body in the heart.

Findings

Managing risk of suicide and self-harm

134. Prison Service Instruction (PSI) 64/2011 contains guidance and mandatory instructions on managing prisoners at risk of suicide and self-harm. It advises that prison staff should consider constant supervision when a prisoner has been identified to be at serious risk of carrying out acts of self-harm or other behaviours which could lead that prisoner to accidentally or intentionally killing themselves. It states that constant supervision must only be in place for the shortest time possible and used as a last resort, due to the distress it may cause to the prisoner. PSI 64/2011 also says that an urgent case review should take place as soon as possible if risk is likely to have increased between planned case reviews.

135. Mr Quincey was a very challenging prisoner for staff to manage, with an extensive history of serious self-harm and a complex mental health presentation. He was often hostile to staff and resisted any attempts to move location or encourage progression, threatening to harm other prisoners. Mr Quincey had been remitted from Broadmoor due to his lack of progression and had continued to seriously self-harm whilst there.

136. On arrival at Wakefield from Broadmoor, prison staff appropriately started monitoring Mr Quincey under ACCT procedures and placed him under a three-officer constant supervision, which mirrored Mr Quincey's observation level at Broadmoor. ACCT case reviews were regular, multi-disciplinary and almost always included a mental health nurse who knew Mr Quincey. There was a consistent ACCT case co-ordinator, who was a senior member of the Safer Custody Team. The team who supported Mr Quincey knew him well and were aware of the issues surrounding his care. Whenever possible, regular staff were assigned to Mr Quincey's constant supervision, who he knew and was comfortable with.

137. Given Mr Quincey's method of self-harm, staff put together a list of risk items which were allowed in his possession. This was regularly reviewed, and the protocol was updated as the multidisciplinary team got to know Mr Quincey.

138. Staff rightly recognised that Mr Quincey's risk of suicide and self-harm was high, and he remained under constant supervision during his three months at Wakefield. He resisted any proposed changes to his observations, and threatened to harm others if changes were made. The case co-ordinator told the investigator that Mr Quincey often stated he could kill himself in two minutes if he wanted. We found that prison staff reacted appropriately to this, taking a staged approach to constant supervision, incrementally reducing the number of officers down to one and implementing a period of an hour a day where Mr Quincey's door was closed. Mr Quincey's prison offender managers also made several attempts to identify a route for progression to another prison with a unit suitable for Mr Quincey's needs.

139. While there were many positive aspects to Mr Quincey's risk management, we found that there could have been more senior multidisciplinary input, particularly surrounding decisions that were made towards the end of his life.

140. PSI 64/2011 sets out that the Safety Intervention Meeting (SIM) is a multi-disciplinary safety risk management meeting, chaired by the Senior Management Team, to provide further support and guidance to case review teams for prisoners with particularly challenging needs or a significant level of risk. Prisoners placed on constant supervision are a mandatory referral to the SIM.

141. On a number of occasions throughout September and October, the SIM was chaired by a custodial manager rather than a senior operational manager. In addition, there were some meetings without any senior representation from safer custody, with the team represented by administrative staff only (including four consecutive meetings in late August and September). Some meetings did not have a healthcare representative present.

142. There was some positive input from the Head of Safer Custody, who attended some of Mr Quincey's ACCT reviews to support the multi-disciplinary team. He told us that that Mr Quincey was also discussed unofficially amongst the safety team on an almost daily basis.

143. At the same time, there is little evidence to suggest the most significant events towards the end of Mr Quincey's life – moving him to a different cell and the suggestion that his IPF level would be reduced (and with it the removal of protective factors, such as his Xbox and music) – were planned and discussed more widely by a senior multidisciplinary team, even though they were recognised as potential triggers for self-harm. While there was a multidisciplinary meeting on 27 September to discuss the next steps for Mr Quincey, including establishing boundaries through the IPF process, this did not have significant senior input and there was no discussion around how the potential impact on Mr Quincey's risk would be managed. These potential changes were also not fully discussed at the SIM before they were implemented.

144. Mr Quincey reopened his wound following these events, which he linked to the suggestion that his incentives level would be reduced. This escalation in Mr Quincey's behaviour did not prompt an urgent case review to discuss how to mitigate the potential increase to Mr Quincey's risk. This was the first time that Mr Quincey had harmed himself at Wakefield and should have been recognised as indicating an escalation in his level of risk.

145. Constant supervision should be used for the shortest possible time, and it is right that staff thought about what they might do to help Mr Quincey integrate better into prison life and reduce the need for constant supervision, even if these actions might initially prove unpopular with him. However, proper senior multidisciplinary discussion, through the SIM or otherwise, might have allowed staff to consider and provide wider support to Mr Quincey around these events and to consider how to mitigate any potential short-term increase in risk that these changes might initiate.

146. We make the following recommendations:

The Governor should ensure that the Safety Intervention Meeting is chaired by an appropriate senior operational manager and attended by senior multidisciplinary staff, including from the Safety Team, and that complex prisoners, including those placed under constant supervision, are properly discussed with supported plans made to identify how to reduce their risk.

The Governor should ensure that urgent case reviews take place when a prisoner monitored under ACCT procedures harms themselves or other indicators of increased risk emerge.

Governor to Note

147. Generally, Mr Quincey's ACCT ongoing record was filled out comprehensively, although there were occasions when no written entry was made, including the evening before he went to hospital. Constant supervision handover and daily visit logs were not always completed. Case review documents sometimes contained an incorrect date or were not numbered, making it hard to ensure continuity.

148. Significant events, such as when Mr Quincey told an officer he had opened an old wound, were not always recorded in the ongoing record. Even when these events are recorded elsewhere in the prison record, it is important that information relating to a prisoner's risk is recorded in the ACCT document to ensure that all others involved in a prisoner's care are made aware.

149. On 15 October, Mr Quincey harmed himself while under constant supervision. As there is no CCTV covering the second landing, we were unable to assure ourselves that Mr Quincey was appropriately supervised. However, staff should be aware that prisoners can covertly self-harm and understand the importance of remaining vigilant at all times.

Use of restraints

150. The Prison Service has a duty to protect the public when escorting prisoners outside prison, such as to hospital. It also has a responsibility to balance this by treating prisoners with humanity. The level of restraints used should be necessary in all the circumstances and based on a risk assessment, which considers the risk of escape, the risk to the public alongside the prisoner's health and mobility. A judgment in the High Court in 2007 made it clear that prison staff need to distinguish between a prisoner's risk of escape when fit (and the risk to the public in the event of an escape) and the prisoner's risk when he has a serious medical condition. The judgment indicated that medical opinion about the prisoner's ability to escape must be considered as part of the assessment process and kept under review as circumstances change.

151. Given Mr Quincey's history of unpredictable behaviour, staff assaults and risk of further self-harm, the initial risk assessment and decision made to use double handcuffs was appropriate. During the few days Mr Quincey was in hospital, he refused to undergo surgery to remove the glasses arm from his chest and his health slowly started to deteriorate.

152. By 21 October, Mr Quincey was only engaging very minimally, refusing to eat or drink and was incoherent. In the afternoon, he became unresponsive, and the escorting staff were told that he was nearing the end of his life. While his risk was reconsidered and the level of restraints reduced to an escort chain, his medical condition at the time should have resulted in the immediate removal of restraints. Even with his history, by this stage Mr Quincey's health meant that he presented little to no risk. Prison managers, including the duty governor who was consulted,

should have recognised this, and been emboldened to remove the restraints, rather than allowing Mr Quincey to die in handcuffs.

153. Notwithstanding this, when Mr Quincey died, the bedwatch staff should have removed the handcuffs immediately without the need to telephone the prison first to obtain permission.

154. Disappointingly, we have raised concerns about the use of restraints at Wakefield several times in recent reports. We welcome the work that the Operational Security Group Director has undertaken to review and amend the national risk assessment form, mandate its use, and provide additional guidance to staff responsible for making decisions about the use of restraints. We understand that there will be ongoing work to address issues and so we make no recommendation, but clearly, there remains an issue at Wakefield that the Governor should address.

Mental healthcare

155. The clinical reviewer concluded that the clinical care Mr Quincey received at Wakefield was of a good standard and was equivalent to that which he could have expected to receive in the community.

156. Mr Quincey had a mental health care plan and was jointly managed by two registered mental health nurses. Mr Quincey was also seen by a psychiatrist around a month and half after he arrived. The mental health team's approach was to try and build a therapeutic relationship with him, which they did by attending all his ACCT reviews.

157. While Mr Quincey did not always engage with mental health staff, we found a consistent approach was adopted and efforts made to re-engage with him. The clinical reviewer found that the healthcare contribution to the ACCT process was excellent.

158. The clinical reviewer highlighted that it is significant that a specialist high secure mental health service could not meet Mr Quincey's needs due to his non-engagement and that he was therefore returned to prison. This meant that managing him in a prison environment, without the specialist facilities that Broadmoor Hospital could provide, was particularly challenging.

Governor to note

Staff debriefs

159. There was no hot debrief conducted for any of those involved in the emergency response for Mr Quincey. Two of the officers involved in the emergency response were sent to escort Mr Quincey to hospital. While we understand that this incident occurred over the weekend where there was limited staffing, consideration could have been given to sending other staff, who had not been involved in the response, to the hospital, and providing immediate support for those staff who had been involved in an emotionally challenging incident.

160. When Mr Quincey subsequently died in hospital, a custodial manager held a debrief in the hospital for the bed watch officers. There were a large number of staff involved in Mr Quincey's care who knew him well. In cases such as this, the Governor will want to consider facilitating a wider debrief for prison and healthcare staff to attend.

Good practice

161. We wish to highlight the work which took place to prepare for Mr Quincey's arrival at Wakefield from Broadmoor Hospital. There was excellent attendance at the Section 117 meeting from across prison and healthcare staff and those who were closely involved with Mr Quincey's care were briefed before he arrived. Staff appropriately mirrored the observations from Broadmoor in order to aid his transition from hospital back into prison, and potential triggers and risk factors were clearly communicated.

Inquest

162. The inquest into Mr Quincey's death concluded on 5 November 2025, and recorded a verdict of suicide.

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