Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Frazer Williams, a prisoner at HMP Guys Marsh, on 7 March 2022

A report by the Prisons and Probation Ombudsman

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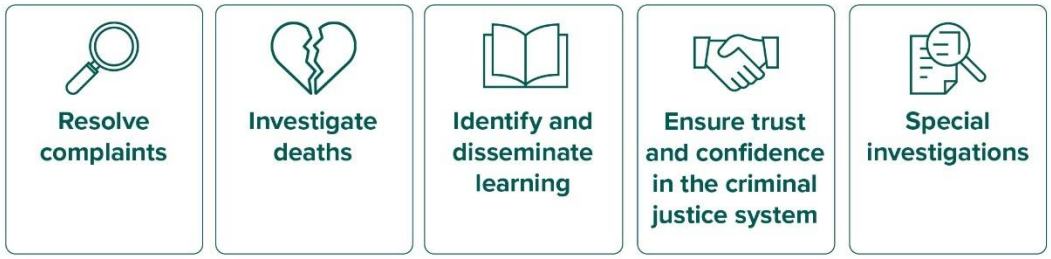
OUR VISION

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

WHAT WE DO



WHAT WE VALUE

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 Frazer Williams died on 7 March 2022, after he was found hanged in his cell at HMP Guys Marsh. He was 28 years old. I offer my condolences to his family and friends.

Mr Williams was transferred to Guys Marsh on 14 January 2022. He had a history of self-harm, emotionally unstable personality disorder (EUPD) and drug-induced psychosis, for which he was prescribed antipsychotic medication.

Mr Williams was a very challenging prisoner. He refused to engage with staff and spent much of his time living in a dirty cell that smelt of faeces as he refused to flush his toilet. Mr Williams was under the care of the mental health team and was managed under suicide and self-harm monitoring procedures (known as ACCT) throughout his time at Guys Marsh.

He needed additional support, but staff did not consistently address his risk factors holistically, and his complex issues warranted better case management. There were deficiencies in the management of ACCT procedures. Although there is evidence of discussion about Mr Williams' issues, I am not satisfied that specific actions were identified that might have helped to resolve these problems.

In particular, there was a lack of effective care planning to help address Mr Williams' risk, and there was a lack of input when his circumstances changed (when Mr Williams was considered not to have mental capacity in regard to his needs). We found that HM Prison and Probation Service had no self-neglect guidance in place to help to support prisoners such as Mr Williams.

Ten days before his death, Mr Williams was assaulted, as a direct result of his dirty living conditions. I am not satisfied that staff properly assessed the risk or impact this might have had on him.

Four days before Mr Williams' death, he was informed that he would soon be transferred to a secure mental health hospital. I am concerned that his risk of suicide and self-harm was not assessed in light of this.

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 **June 2022**

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Summary

Events

1. In October 2021, Mr Frazer Williams was remanded in custody to HMP Winchester. On 10 November, he was sentenced to nine months in prison. It was not his first time in prison. He had a history of self-harm, substance misuse and mental health problems, including emotionally unstable personality disorder, drug-induced psychosis, attention deficit hyperactive disorder (ADHD), anxiety and depression. Mr Williams was supported by the mental health team and prescribed antipsychotic medication.

2. On 14 January 2022, Mr Williams was transferred to HMP Guys Marsh, where his behaviour deteriorated. He rarely engaged with staff and did not take care of his personal hygiene. Mr Williams said that he heard voices and refused to flush his toilet because he believed that his family would be made to eat the contents. As a result, he lived in dirty conditions. Prison staff managed him under suicide and self-harm procedures, known as ACCT, for the majority of his six weeks at Guys Marsh.

3. Mr Williams spent long periods of time in his cell, which smelt of faeces, and did not always collect his medication. Staff tried to conduct 12 ACCT case reviews. Of these, Mr Williams only attended two and refused to attend or showed limited engagement at all others.

4. On 9 February, a consultant psychiatrist concluded that Mr Williams had a psychotic disorder and started the process to transfer him to a secure mental health hospital. He noted that Mr Williams did not have mental capacity to make decisions about his needs. There was no evidence that staff had taken action to improve his living conditions.

5. On 25 February, Mr Williams was assaulted in his cell by another prisoner because he had thrown a plastic bag containing his faeces out of his cell window and it had landed in the cell below.

6. On 3 March, a mental health nurse told Mr Williams that he was to move to a secure hospital. The date of his transfer (7 March) was withheld from him for security reasons. After this point, no one assessed Mr Williams' risk of suicide and self-harm or considered how the news of this transfer might have affected him.

7. At 3.15am on 7 March, an officer found Mr Williams hanging from the inside of his cell door. The officer radioed a medical emergency code blue and staff responded quickly. Staff tried to resuscitate Mr Williams until paramedics arrived and took over. At 3.48am, they confirmed that he had died.

Findings

Management of Mr Williams' risk of suicide and self-harm

8. Mr Williams had a number of risk factors when he arrived at Guys Marsh: he had a history of self-harm, substance misuse, mental health problems and was prescribed antipsychotic medication. Staff appropriately started ACCT procedures.

9. We are concerned that staff underestimated Mr Williams' level of risk. They placed too much emphasis on his behaviour and did not give sufficient weight to his underlying risk factors, including recognising that his self-neglect was a form of self-harm.

10. We found some deficiencies in the prison's management of the ACCT procedures. These included a lack of a consistent case co-ordinator, not identifying risks or setting appropriate care plan actions and not correctly recording the outcomes of those care plan actions which were identified. Staff failed to assess Mr Williams' risk after he was informed that he would be transferring to a secure hospital setting.

11. We are concerned there was a lack of leadership and planned action in relation to unusual or complex cases and the Safety Intervention Meeting (SIM) did not create a proper management plan to address Mr Williams' risks.

Mr Williams' location

12. While Mr Williams' lived in dirty living conditions, staff did not monitor him more closely and did not consider moving him to another cell or wing.

Key work

13. Prison staff did not have sufficient meaningful interaction with Mr Williams through key work sessions.

Clinical care

14. The clinical reviewer found that the clinical care at Guys Marsh was partially equivalent to that which Mr Williams could expect to receive in the community. There was a lack of safeguarding oversight in managing Mr Williams' self-neglect. No one reviewed Mr Williams after he was told that he would be moving to a mental health hospital.

Recommendations

- The Governor and Head of Healthcare should ensure that all Reception and First Night staff have a clear understanding of their responsibilities to identify prisoners at risk of suicide and self-harm in line with national instructions and in particular, the need to record, share and consider all relevant information about risk, and start ACCT procedures when indicated.

- The Governor should ensure that staff manage prisoners at risk of suicide and self-harm in line with national instructions, including that:

    - a case co-ordinator is appointed at the first case review, who should lead all subsequent case reviews wherever possible;

    - case review teams assess risk and set levels of observations based on the prisoner's risk;

  - prisoners with challenging needs or significant complexity are referred to the Safety Intervention Meeting, who identify meaningful action points to address the key issues;
  - ACCT care plans are completed that are specific and meaningful and include all of the issues identified during the assessment interview and at case reviews;
  - urgent case reviews are held when information is received that indicates increased risk; and
  - ACCT entries are completed accurately, legibly and in a timely manner and are signed and correctly dated.
- The Governor should ensure that when a prisoner's cell is uninhabitable or damaged to the extent it impacts on his basic needs, prison staff should:
  - move him to another cell as quickly as possible; and
  - record the damage, monitor the wellbeing of the prisoner while he remains in the cell and escalate the situation to managers to resolve promptly.
- The Governor should ensure that there is an effective key worker scheme which provides meaningful and ongoing support to prisoners.
- The Heads of Healthcare at HMP Winchester and HMP Guys Marsh should ensure that effective liaison between prisons takes place when prisoners with a history of severe and enduring mental illness are transferred between the prisons, with the outcome fully documented in the prisoner's medical records.
- HM Prisons and Probation Service's national adult safeguarding lead should develop a self-neglect strategy and formal guidance to be used in the prison environment.
- The Head of Healthcare should ensure that any information about secreted medication is recorded, communicated and considered appropriately.
- The Governor and Head of Healthcare should ensure that a copy of this report is shared with the staff named in this report and that a senior manager discusses the Ombudsman's findings with them.

The Investigation Process

15. The investigator issued notices to staff and prisoners at HMP Guys Marsh informing them of the investigation and asking anyone with relevant information to contact him. Two prisoners contacted the investigator.

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

17. NHS England commissioned a clinical reviewer to review Mr Williams' clinical care at the prison.

18. The investigator and clinical reviewer jointly interviewed nine members of staff and three prisoners at Guys Marsh between 4 and 17 May 2022.

19. We informed HM Coroner for the County of Dorset of the investigation. She gave us the results of the post-mortem examination report. We have sent her a copy of this report.

20. The Ombudsman's family liaison officer contacted Mr Williams' mother to explain the investigation and to ask if she had any matters she wanted us to consider. Mr Williams' mother asked the following questions about the circumstances leading to Mr Williams' death:

    - Was Mr Williams being monitored by suicide and self-harm prevention procedures?
    - Did Mr Williams receive any healthcare or psychological support?
    - Did Mr Williams have the mental capacity to make decisions and what safeguarding interventions were put in place to support him?
    - What were the circumstances which led to Mr Williams being referred to a secure mental health hospital?

    We have addressed these questions in this report.

21. Mr Williams' mother received a copy of the initial report. She did not make any comments.

22. The initial report was shared with HM Prison and Probation Service (HMPPS). They identified three factual inaccuracies which have been amended in the final report. All recommendations were accepted.

Background Information

HMP Guys Marsh

23. HMP Guys Marsh is a medium security prison that holds up to 491 men. Practice Plus Group (formerly Care UK) provides primary and secondary mental healthcare and has commissioned another agency, EDP, to provide integrated substance misuse services. Healthcare services are available on weekdays and at weekends from 8.30am to 6.00pm and there is a doctor on duty on Saturday mornings.

HM Inspectorate of Prisons

24. The most recent full inspection of HMP Guys Marsh was in January 2019. Inspectors reported that the prison had started to make progress after successive poor inspections. However, they remained concerned about safety and purposeful activity. Levels of violence, driven by drug use and debt, were higher than at similar prisons. and the prison had been slow to formulate improvement strategies. New measures to combat illicit drug use were untested, and several deaths had been related to the use of illegal psychoactive substances. There remained a problem with increased self-harm among prisoners. Inspectors found that a significant amount of work had been done to try to improve the situation and support for those in crisis seemed good.

25. In October 2019, HMIP carried out an Independent Review of Progress to look at progress against key recommendations from the earlier inspection. Inspectors reported that, overall, progress had been disappointing. There had been many incidents, and some deaths, relating to the use of illicit drugs, debt and intimidation arising from the trade of drugs. Work to prevent drug use and debt prevention work was developing well, and the number of positive drug tests had dropped markedly. A wide range of security measures had been taken to cut the supply of drugs, but more work was needed in light of continuing poor outcomes. Inspectors found that the response to the drugs problem was undermined by the fact that intelligence was not always processed promptly or analysed systematically to identify trends and patterns, and target searching often did not take place. They recommended that coordinated action should be taken to make the prison safer, in particular, developing effective responses to drug misuse and debt.

Independent Monitoring Board

26. 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, covering the year to November 2021, the IMB reported that the availability of illicit substances continued to be a concern, most commonly psychoactive substances. There were concerns about the number of prisoners who had severe mental health issues. Key working was notably absent over the year and impacted on prisoners' wellbeing. There was still a reluctance among staff to wear body-worn cameras.

27. The number of prisoners subject to ACCT monitoring averaged 15 throughout the year. On routine examination of ACCT documents, the IMB found that there was an

improvement in entries since more staff had been trained in the ACCT process but entries with minimal content were seen, especially when officers were stretched by monitoring multiple prisoners who were subject to ACCT procedures and who had high observation demands.

Previous deaths at HMP Guys Marsh

28. Mr Williams was the third prisoner to die at Guys Marsh since 1 January 2019, and the first to have taken his life. Of the previous two deaths, one prisoner died from natural causes and the other was drug-related. Our report into the death of a prisoner in July 2021 found that the prisoner did not receive appropriate support through the key worker scheme.

Assessment, Care in Custody and Teamwork

29. 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. Checks should be carried out at irregular intervals to prevent the prisoner anticipating when they will occur. Regular multidisciplinary review meetings involving the prisoner should be held.

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

Key worker scheme

31. The key worker scheme aims to improve safer custody by engaging with prisoners, building better relationships between staff and prisoners and helping prisoners settle into life in prison. It provides that all adult male prisoners will be allocated a dedicated key worker who will spend an average of 45 minutes a week on key work activities, including having meaningful conversation which each of their allocated prisoners.

32. The key worker scheme was suspended across the prison estate on 24 March 2020 due to the COVID-19 pandemic. To ensure that meaningful interaction continued for priority prisoners, such as those who were at risk of suicide or self-harm, the Prison Service introduced the Exceptional Delivery Model for key work in May 2020. This provides that an officer will have a weekly conversation with prisoners identified as vulnerable.

Transfers of prisoners to hospital under the Mental Health Act

33. When a prisoner has a mental illness that requires detention in a hospital for medical treatment, and the prisoner urgently needs that treatment, the prison can arrange for them to be transferred to a secure hospital under section 47, 48 or 49 of the Mental Health Act 1983.

Self-neglect

34. Self-neglect is an extreme lack of self-care and is a category of neglect which falls under the adult safeguarding procedures in the Care Act 2014. It can be challenging for professionals to work with someone who self-neglects and it requires a complex and multifaceted approach.

Key Events

35. On 4 June 2021, Mr Frazer Williams was remanded in custody to HMP Lewes, charged with having an article with a blade or point in a public place. He was subsequently sentenced to four months in prison.

36. From July, Mr Williams was monitored under suicide and self-harm prevention procedures, known as ACCT, and located in the healthcare inpatient unit due to concerns over his declining mental health. He had a history of poor engagement, self-harm, substance misuse and self-neglect. Mr Williams had ADHD, emotionally unstable personality disorder and drug-induced psychosis.

37. On 4 October, Mr Williams was released on licence from Lewes. He was monitored under ACCT procedures until his release.

HMP Winchester

38. On 7 October, Mr Williams, was recalled to HMP Winchester, charged with possession of an offensive weapon in a public place.

39. Reception staff recorded that Mr Williams was experiencing the effects of withdrawal from drugs. He refused the support of the substance misuse team. No concerns were recorded about his risk of suicide and self-harm. The reception nurse recorded Mr Williams' substance misuse history. She noted that he had anxiety and depression but was mentally stable.

40. The next day, the healthcare team reviewed Mr Williams' medical record and completed a medicine reconciliation. They noted that his prescribed medication included amitriptyline (used to treat depression), naproxen (used to treat pain) and olanzapine (an antipsychotic). He was not allowed to keep his medication in his cell and had to collect it in person each day and take it in front of a nurse.

41. On 18 October, a mental health nurse saw Mr Williams in his cell after it was reported that he was living in dirty conditions. Mr Williams was in bed and declined to be assessed. The nurse recorded that his cell was full of rubbish and decaying food and that his personal belongings were on the floor and his cell smelt of urine. The nurse informed wing staff to monitor Mr Williams and for the mental health team to complete welfare checks on him.

42. That day, wing staff notified the healthcare and substance misuse teams that Mr Williams had been observed trying to divert his medication. From a review of his medical record, it was noted that he had an extensive history of diversion.

43. On 19 October, Mr Williams again declined to be assessed by a mental health nurse.

44. On 10 November, Mr Williams was sentenced to nine months in prison. (His release date from prison was 25 March 2022.)

45. On 5 December, healthcare staff noted that Mr Williams had not collected his medication for two days. A member of the pharmacy team spoke to him. Mr

Williams said that he was okay but did not feel like taking his medication. Staff noted that Mr Williams' medication compliance would be monitored and informed the mental health team.

46. On 22 December, a consultant forensic psychiatrist assessed Mr Williams who refused to talk about his mental health but was happy to discuss his medication (olanzapine). He wanted the dose to be increased, which was agreed. The psychiatrist noted that Mr Williams displayed no acute signs of psychosis at the time and would be reviewed in approximately two weeks to check for signs of deterioration to his mental health. The psychiatrist noted that Mr Williams' medical records showed that when he was previously in custody, his mental health and self-care had simultaneously deteriorated. This included that his cell was in a state of neglect, with flies in the toilet.

47. On 5 January 2022, a mental health nurse tried to review Mr Williams, who said that he did not need mental health support.

48. On 14 January, Winchester arranged for Mr Williams to transfer to HMP Guys Marsh. Healthcare staff recorded in Mr Williams' medical record that they had emailed a handover note to the healthcare team at Guys Marsh. The handover noted that Mr Williams had emotionally unstable personality disorder and drug-induced psychosis and was prescribed olanzapine. It noted that his engagement with mental health services was poor.

HMP Guys Marsh

49. Mr Williams arrived at Guys Marsh that afternoon. His Person Escort Record (PER, a document that provides information about a person's risk and is used as they move between police custody, court and prison) noted that he had health issues and was prescribed olanzapine.

50. An officer recorded that Mr Williams had no history of substance misuse or self-harm and had not previously been monitored under ACCT procedures. She noted that he was not taking any prescribed medication and had no physical or mental health problems. This information was incorrect.

51. A nurse conducted a health screen and noted Mr Williams' mental health diagnoses and history of substance misuse. Mr Williams said that he had no thoughts of suicide or self-harm. The nurse referred Mr Williams for a mental health assessment.

52. Mr Williams was allocated a single cell on the Reverse Cohorting Unit (where prisoners are usually isolated on arrival in prison under COVID-19 restrictions), due to his mental health concerns.

53. On 15 January, a member of the substance misuse team visited Mr Williams at his cell to conduct an assessment. Mr Williams declined to engage. He was given information about how to minimise the harm from drugs.

54. That day, a mental health nurse and the mental health team leader saw Mr Williams in his cell and completed a triage assessment. This followed concerns from wing staff that Mr Williams had refused to engage, had isolated himself in his cell and

declined his meals and medication. Mr Williams refused to engage with the nurses, although when the nurse told him that she intended to start ACCT procedures, he stated that he would kill himself if this happened. She started ACCT procedures, with monitoring initially set at four observations per hour.

55. As he was being monitored under ACCT procedures, Mr Williams fell under Guys Marsh's criteria to have daily wellbeing checks. (A wellbeing check is when an officer interacts with a prisoner face-to-face to check on his health and wellbeing.)

56. That evening, staff completed a wellbeing check on Mr Williams. They noted that he still did not engage and had not left his cell or collected his evening medication.

57. On 16 January, Mr Williams refused to attend his ACCT assessment and first case review. A Supervising Officer (SO), the case co-ordinator, reported that Mr Williams had started to engage with staff, had left his cell and was seen interacting with other prisoners. Mr Williams had told staff he had no thoughts of self-harm, had a year left of his sentence and was making plans for his release from prison. She and a Custodial Manager (CM) (the ACCT assessor) agreed to reduce Mr Williams ACCT observations so that they were less intrusive for him. Observations were changed to one per hour, with staff having two conversations each day with him. His ACCT case review was rescheduled for 17 January.

58. A nurse saw Mr Williams that evening. Mr Williams said that he had eaten and was now willing to engage with the mental health team. He asked for his medication to be reviewed. The nurse noted that another prisoner (a long-term friend of Mr Williams) had reported that Mr Williams was hearing voices.

59. An officer completed a wellbeing check that evening. She saw Mr Williams coming out of his cell and talking with his friend. He had also collected his meals and medication.

60. Another SO was now named as the case co-ordinator and completed an ACCT case review on 17 January, assisted by the Head of Healthcare. Mr Williams attended and was supported by his friend. Mr Williams said that he was struggling but had no thoughts of self-harm. He said that his medication (olanzapine) had an adverse impact on his mental health. He said that he had difficulty sleeping and heard voices which distracted him and made him laugh. Mr Williams refused to talk about his family. His friend told the panel that he believed that Mr Williams' mental health issues were due to him misusing drugs. The Head of Healthcare told Mr Williams that a full medication review would be completed after a psychiatrist had assessed him. The panel noted that Mr Williams had left his cell more than once and collected his medication and meals. They noted a slight change in ACCT observations to one conversation per day but continued with hourly observations.

61. The case co-ordinator recorded three issues in Mr Williams' ACCT support plan: his lack of sleep due to his medication not working; for him to see the psychiatrist due to hearing voices (an appointment had been made for 20 January); and for consideration to be given to his friend living on the same wing as Mr Williams when they were moved from the Reverse Cohorting Unit. (Despite further ACCT reviews noted later in this report, no further support plan actions were recorded.)

62. On 18 January, an officer completed a wellbeing check. He recorded that Mr Williams had remained in bed all day (other than to collect his meals) and had not engaged with staff. Wing staff completed frequent wellbeing checks during the rest of the month and recorded similar behaviour from Mr Williams each time. He rarely left his cell, other than to collect meals (which he also sometimes missed) and engaged little with staff.

63. On 20 January, a consultant psychiatrist assessed Mr Williams in his cell. (Mr Williams' friend was also present to support him.) He noted that Mr Williams presented as distressed and guarded. Mr Williams said that if he flushed the toilet in his cell, his family would be made to eat the contents (faeces). He also believed that if he watched television, his family would be tortured. He no longer wanted to take olanzapine and said that he wanted medication to help him sleep. Mr Williams denied substance misuse or an intent to harm himself. His friend told the psychiatrist that he had known Mr Williams for a long time and had not seen him like this before. The psychiatrist noted that Mr Williams had a possible psychotic disorder and would need further assessment. He prescribed an alternative antipsychotic, quetiapine.

64. The next day, the case co-ordinator chaired an ACCT case review. A member of the substance misuse team, a nurse and Mr Williams' friend attended. Mr Williams was initially reluctant to attend but his friend persuaded him to. Mr Williams said that he heard voices and did not want to be at the case review or be monitored by ACCT procedures. He said that he "could not be bothered" to collect his new medication from the medication hatch. The nurse reminded him of the importance of taking his prescribed medication. Mr Williams refused to discuss why he would not flush his toilet. Due to his lack of engagement, ACCT monitoring remained in place, with no change to the level of observations.

65. On 22 January, a nurse reviewed Mr Williams in his cell. Mr Williams was lying in bed in the dark. She noted that he did not want to speak to her for long. He expressed his fears of flushing his toilet and said that he had no thoughts of self-harm. She noted that staff should regularly encourage Mr Williams to engage.

66. On 24 January, Guys Marsh became a COVID outbreak site, and the prison remained an outbreak site until after Mr Williams died. The outbreak affected staff attendance, reducing the consistency of available staff on residential wings.

67. That day, Mr Williams moved to Saxon Wing. Contrary to the ACCT support plan action, his friend was moved to a different wing.

68. On 26 January, a CM, now listed as the ACCT case co-ordinator, tried to conduct an ACCT case review. Mr Williams refused to attend. The CM rescheduled the case review for the following day in the hope that Mr Williams would want to engage. ACCT observations remained unchanged.

69. On 27 January, another CM, listed as the case co-ordinator, chaired an ACCT case review. A mental health nurse attended, and a previous case co-ordinator provided a verbal contribution. After much persuasion, Mr Williams agreed to attend. However, he made no eye contact with the panel, kept his head bowed and the conversation with him was limited. Mr Williams asked more than once if he could stop the meeting and return to his cell. He said that he had no thoughts of self-

harm. The CM noted that Mr Williams "played down his poor mental health" and stated that he was okay and no longer heard voices. The nurse recorded that the panel had discussed whether ACCT monitoring needed to continue as Mr Williams had not harmed himself and had no thoughts to do so. Her recommendation was that the ACCT should remain open because Mr Williams' poor engagement meant his risks could not be properly assessed. She made an urgent appointment for Mr Williams to see the psychiatrist (on 1 February) as he continued to present with psychotic symptoms. The CM noted in the ACCT record that Mr Williams observations had been reduced to one conversation a day (and no observations). In contrast, the nurse recorded that his observations were to remain hourly. (Staff applied the CM's monitoring instruction.) Mr Williams' next ACCT review was scheduled for 1 February, if he had had his appointment with the psychiatrist, and otherwise it would be completed on 2 February.

70. Over the next few days, Mr Williams behaviour remained unchanged.

71. On 31 January, Mr Williams broke the fire detector in his cell, which activated the fire alarm several times in the evening. Mr Williams was relocated overnight onto Anglia Wing, so that a member of the maintenance team could fix the fire detector in the morning.

72. On 1 February, a CM completed an ACCT case review. An officer and a nurse also attended. Mr Williams declined to engage in the meeting, although stated that he had not harmed himself and did not want to be monitored under ACCT procedures. He had not left his cell on Anglia Wing since his temporary move. The CM told Mr Williams that his cell had now been repaired and that he would return to Saxon Wing soon. Mr Williams' response was that he had no intention to return to his former cell. He then refused to engage further with the panel. The nurse noted that Mr Williams looked unkempt, refused to answer any of the CM's questions and kept shaking his head. He did not respond when asked if he had any thoughts or intention to harm himself or end his life. The CM increased Mr Williams' ACCT observation level to two conversations a day (with no observations).

73. Mr Williams was sent back to his cell on Saxon Wing that afternoon. Staff reported no concerns about him.

74. Shortly afterwards, the psychiatrist assessed Mr Williams at his cell. He observed that Mr Williams looked dishevelled and that his room smelt due to him not flushing the toilet. Mr Williams refused to engage in any conversation and just shook or nodded his head when asked any questions. Mr Williams' medical records noted that he had refused to take his quetiapine on four occasions since 20 January. The psychiatrist believed that Mr Williams may have a psychotic disorder and noted that he would review him in a week.

75. On 2 February, a multidisciplinary mental healthcare meeting discussed Mr Williams. Attendees included the psychiatrist and two nurses. It was agreed that when the psychiatrist returned from his forthcoming annual leave, the team would discuss whether Mr Williams should be assessed for hospital admission under the Mental Health Act (MHA). A nurse was assigned as his case worker.

76. That day, staff opened a food refusal log after Mr Williams declined to eat.

77. Over the coming days, there was no change in Mr Williams' behaviour. He occasionally collected food from the servery and also purchased food through his canteen orders. The food refusal log was therefore closed on 7 February.

78. On 8 February, a CM tried to complete an ACCT case review. A nurse assisted him and an officer contributed verbally. When the CM and the nurse went to collect Mr Williams, he was in bed in the dark, with the bed sheet pulled over his head. He declined to engage or leave his cell, which had an "extremely offensive" smell of faeces due to the toilet not being flushed. The nurse noted that staff were struggling to work in such conditions and that it was difficult to assess Mr Williams' risk of suicide and self-harm. She sent an urgent email to the senior healthcare manager and to the covering psychiatrist (the other psychiatrist was on leave) to seek an urgent review. The CM noted that Mr Williams' observations would remain at two conversations a day.

79. The CM told us at interview that the smell from Mr Williams' cell was abhorrent and that staff had taken to flushing his toilet themselves during the daily fabric checks of his cell. Other prisoners on the wing had also apparently tried to encourage Mr Williams to clean his cell. We found no consistent recorded information to support this.

80. On 9 February, Mr Williams' case was referred to the Safety Intervention Meeting (SIM), a weekly multidisciplinary meeting which discussed prisoners with complex needs in order to create care plans to support them. The SIM minutes noted that an emergency referral had been made for Mr Williams to see a psychiatrist. No other information was recorded.

81. That day, the duty consultant psychiatrist assessed Mr Williams. A nurse and Mr Williams' friend were also present. The psychiatrist noted that Mr Williams' presentation was unkempt and that he was withdrawn and extremely guarded when he tried to discuss his self-care/hygiene and toilet issues. He concluded that Mr Williams had a psychotic disorder and would benefit from further assessment in a mental health hospital. He made a first recommendation for a transfer to hospital under section 47 of the MHA and explained this to Mr Williams. Mr Williams responded, "I'm not mad, I don't want to go anywhere". The psychiatrist recorded that Mr Williams was vulnerable and noted his level of self-neglect and poor engagement. He noted that Mr Williams had a poor insight into his mental health and did not have mental capacity to make decisions about his needs. He also increased Mr Williams' quetiapine dose.

82. That evening, an officer completed a wellbeing check. She noted that Mr Williams had not engaged in any conversation with staff that day. He had collected his lunch, evening meal and canteen, and left his cell during association time (when prisoners socialise with each other).

83. On 10 February, an officer completed a key work session. Mr Williams did not engage in conversation although occasionally responded with 'yes' or 'no'. The officer noted that he appeared to be socialising more with other prisoners, collecting his food and that he now had a television.

84. Later, a nurse created Mr Williams' mental health care plan. It noted that Mr Williams continued to present with psychotic symptoms and fixed delusional beliefs

about flushing his toilet. He also had intermittent compliance with his antipsychotic medication, a deteriorating mental state and poor self-care. While he had a long history of substance misuse, there was no evidence that he had recently used illicit substances at Guys Marsh. The plan remained to continue with the recommendations required for section 47 of the MHA and for Mr Williams to be transferred to a secure mental health hospital. In the meantime, staff were to monitor him for any change in behaviour.

85. That day, a prison GP completed a second recommendation for section 47 of the MHA. She noted Mr Williams' poor mental health and engagement and concluded that he did not have mental capacity to make decisions about his health and wellbeing.

86. A member of the substance misuse team tried twice to call Mr Williams' in-cell telephone. Mr Williams did not answer so a self-referral form was sent to him to complete and report any issues.

87. On 15 February, a CM, listed as the ACCT case co-ordinator, and a nurse tried to complete an ACCT case review. Mr Williams refused to engage with the staff or leave his cell. The CM noted that his cell "reeked so much of excrement" that he almost vomited. He noted that he disliked that he had to work in such conditions and believed it compromised his health and safety. The nurse noted that Mr Williams remained in bed, with his head under the blanket and his light on. His cell had a "very malodorous smell of urine" and was unkempt. The nurse noted that two section 47 recommendations had been made, and that Mr Williams was waiting to be assessed by the local psychiatric hospital (Ravenswood Unit). His ACCT observations remained the same.

88. That afternoon, the nurse noted that it had been difficult to assess Mr Williams because of his lack of engagement. Mr Williams failed to acknowledge the need for a risk assessment and would not give staff permission to contact his family. She recorded that he lacked capacity and insight into his mental health. She also recorded that prison staff remained concerned that Mr Williams continued to live in an unpleasant environment and to neglect his personal self-care. She commented that prison staff had to clean Mr Williams' cell due to the offensive odour. We have been unable to find any evidence in Mr Williams' prison records to confirm when or how many times staff helped to clean his cell.

89. Later that afternoon, an administering nurse reported to the nurse who had attended the ACCT that Mr Williams had been caught secreting his medication the previous day.

90. On 16 February, a SO, listed as the case co-ordinator, and a nurse attended Mr Williams' cell to conduct an ACCT case review. Mr Williams was in bed and refused to engage. The SO noted that the cell had a stench of human waste from the toilet and rubbish was strewn over the floor. He queried whether ACCT monitoring was appropriate as Mr Williams had not harmed himself and said that he had no intention to do so. The nurse said that Mr Williams had a history of serious self-harm, and, in view of his current mental health state, it would be prudent for some form of monitoring to continue. The SO asked for Mr Williams' case be referred to the morning SIM. He recommended that Mr Williams' lack of engagement and the concerns about his mental health meant that a higher

multidisciplinary approach needed to be considered. The observation level remained the same.

91. The SIM meeting which took place later that day acknowledged that Mr Williams had been referred due to his "bizarre behaviour" and that he was waiting for a psychiatric appointment. There is no record that any other action or action plan was considered.

92. On 17 and 18 February, staff noted that Mr Williams had spent a lot of time out of his cell interacting with other prisoners and had collected his meals.

93. On 18 February, a CM, listed as case co-ordinator, and a nurse tried to conduct an ACCT case review. When they arrived at Mr Williams' cell, he again refused to engage. He lay in bed in the dark. The staff recorded that they were unable to assess Mr Williams' risk and presentation due to his non-engagement. They recorded that there were suspicions that Mr Williams may be secreting his medication.

94. On 20 February, an officer completed a key work session. The officer noted that he felt that he was slowly getting more of a response from Mr Williams as opposed to his normal "no" or monosyllabic responses he gave other wing staff.

95. The next day, prison records noted that Mr Williams had a broken sink in his cell. Mr Williams spent most of the morning in his cell due to the COVID regime. He did not collect his lunch or engage with staff, but he collected his medication.

96. On 23 February, the psychiatrist tried to review Mr Williams, but he refused to engage. He noted that Mr Williams' cell remained in a poor state, and that he was experiencing a psychotic disorder that could not be adequately treated in a prison setting.

97. That evening, an officer noted that Mr Williams had been "pretty chatty" with staff during the day, had collected his medication and meals and was seen on the landing during association.

98. On 24 February, a CM and a nurse tried to conduct an ACCT case review. Mr Williams refused to engage with them. The CM noted that considerations were underway for Mr Williams to be transferred to a psychiatric hospital. He scheduled the next review for 28 February.

99. On 25 February, the maintenance repair team attended Mr Williams' cell to fix the broken sink pipe. The repair team noted that they were unable to conduct the work as the cell was "too dirty" to work in and needed to be bio-cleaned (cleaned to remove harmful bacteria) before the work could be completed.

100. Later that morning, Mr Williams had a fight in his cell with Prisoner A. Staff intervened quickly and separated both prisoners, who were given disciplinary warnings. The prisoner told us that he had confronted Mr Williams because he had thrown faeces out of his cell window and it had entered his cell, which was directly below Mr Williams' cell. No ACCT review took place to assess Mr Williams' risk after this incident.

101. A nurse and a consultant psychiatrist from Ravenswood Unit (a secure mental health unit) arrived on the wing shortly after Mr Williams' fight with Prisoner A, to complete an assessment. When they attended his cell, Mr Williams refused to engage. He said that he was okay, that he did not want to talk and asked staff to go away and close his cell door. The nurse recorded that Mr Williams appeared very unkempt, his cell was in an unhygienic state and had an offensive smell. She noted her concern that other prisoners on the wing had targeted Mr Williams by saying offensive things about the smell from his cell. At interview, she told us that prisoners had also put incense sticks outside Mr Williams' cell door and burnt them to stop the smell. Having raised her concerns with a wing manager, she told us that she was informed that consideration was being given to moving Mr Williams to a different wing. We found no evidence in prison records to suggest what, if any action, was considered.

102. Following the assessment, the psychiatrist told the nurse that he would contact her once he knew of an available bed space at Ravenswood Unit.

103. The next day, Mr Williams' disciplinary hearing (for fighting) was adjourned. That evening, an officer completed a wellbeing check. She noted that Mr Williams and Prisoner A had apologised to each other for the fight. Mr Williams had not collected his lunch but had collected his medication. She noted that his cell was still "a mess".

104. Prisoner A told us that he became friends with Mr Williams. He said that they would often smoke psychoactive substances (PS) together and get "stoned". He said that Mr Williams did not talk a lot. He was aware that Mr Williams had mental health problems and encouraged him to collect his dinner. He was also aware that Mr Williams was selling his medication for nicotine caps. Another prisoner told us that he believed Mr Williams was struggling with his mental health and that staff and prisoners gave him less attention because of the smell from his cell and called him names.

105. On 27 February, an officer noted in her wellbeing check that Mr Williams' cell smelt very foul. His engagement with staff was still very limited and he remained in his cell for most of the day. Mr Williams was scheduled to have an ACCT case review on 28 February. There is no record that this took place.

106. On 1 March, a CM tried to conduct an ACCT case review. An officer assisted and a nurse from the mental health team contributed verbally. Mr Williams refused to engage with the staff.

107. That day, a warrant was received for Mr Williams to be transferred to hospital under section 47 of the MHA. Healthcare staff were told that a bed space was available for Mr Williams to transfer to Ravenswood Unit on Thursday 3 March. During interviews, however, we were told that on that day, the prison could not facilitate any transport vehicles to take Mr Williams. In response, the hospital indicated they could not accept Mr Williams on Friday 4 March, as they had reduced staffing levels over the weekend. It was then agreed and confirmed that Mr Williams would be transferred to Ravenswood Unit on Monday 7 March, accompanied by a nurse.

108. An officer completed a wellbeing check that evening (1 March). He noted Mr Williams had left his cell during the day but remained uncommunicative with staff.

109. On 2 March, a CM chaired the SIM. The panel discussed Mr Williams' need for ACCT support. It was agreed that it would remain open and noted that Mr Williams' transfer to a psychiatric hospital had been delayed to 7 March.

110. On 3 March, a nurse saw Mr Williams. She explained to him that he would be moving to a secure psychiatric hospital for further assessment. She added that she could not advise him when this would be due to security reasons. Mr Williams said that the move was "not happening" and he would not go. While trying to explain the process to him, she said that Mr Williams got up and walked out of the meeting room. She told us that Mr Williams' presentation appeared no different after hearing the news.

111. The nurse recorded in Mr Williams medical record that she was unable to assess his risk associated with the news of his transfer to hospital. She asked staff to monitor him for any change in his presentation and to increase his observations if necessary. She told us that she also recorded her concerns in Mr Williams' ACCT document and informed wing staff. The ACCT documents contained no information about an ACCT review that day or about the events that occurred when Mr Williams was informed of his transfer.

112. After this, healthcare staff only saw Mr Williams when he collected his medication between 3 and 5 March.

113. On 4 March, an officer conducted a wellbeing check of Mr Williams and noted no real change. Mr Williams collected his food and medication during the day and generally kept to himself.

114. On 6 March, Mr Williams did not attend for his medication.

Events of 6-7 March 2022

115. CCTV footage shows that Mr Williams collected his lunch and left his cell for short periods on three occasions. While he had little interaction with staff, he spoke to some prisoners.

116. Two prisoners told us that they saw two unknown prisoners enter Mr Williams cell while he was not in his cell and flush his toilet. They speculated that this happened because the other prisoners were unhappy with the smell from Mr Williams' cell.

117. At 8.38pm, CCTV footage shows that an Operational Support Grade (OSG) A completed a roll check, which consisted of her looking through Mr Williams' cell door observation panel. At interview, she told us that Mr Williams' observation panel was open and the main cell light was on. Mr Williams was on his bed and appeared to be asleep. As she had noticed on previous occasions, Mr Williams' cell was very untidy. She left his observation panel open, as she found it.

118. At 9.35pm, OSG A patrolled the wing landing. She told us that she heard nothing untoward as she walked past Mr Williams' cell.

119. At 3.12am on 7 March, OSG A completed an ACCT check on another prisoner, whose cell was on the opposite side of the landing to Mr Williams' cell. As she did

this, she noticed a silhouette through Mr Williams' observation panel. The cell light was still on. She went to check.

120. When OSG A arrived at the cell, she saw Mr Williams standing with his back to the cell door, slightly left of the observation panel. She thought that, based on his height, his feet appeared to be on the floor. Mr Williams' chin was resting on his chest. Mr Williams did not respond when she called his name. She noticed what looked like a ligature around Mr Williams' neck, although she told us that it was so tight that it was almost obscure. She was unable to see what the ligature was attached to. She radioed a medical emergency code blue. The control room log recorded that this occurred at 3.15am and that they called an ambulance immediately.

121. OSG A continued to try and gain a response from Mr Williams. CCTV footage shows that OSG B responded to the emergency alarm and arrived at Mr Williams' cell within a minute. Mr Williams still had not responded. OSG B looked through the observation panel and noticed a green cord running up the back of Mr Williams's neck and up to the top left corner of the cell door. He unlocked the cell door and found that Mr Williams' body was wedged behind it, making it difficult to open. A CM, followed by officers, arrived to assist and helped OSG B to push the door slightly open so that he could squeeze through. OSG B cut the ligature from behind the door and Mr Williams fell onto his bed. This allowed staff entry to the cell.

122. OSG B placed Mr Williams on the floor and removed the ligature from around his neck. Mr Williams showed no signs of life and was cold. The CM started cardiopulmonary resuscitation (CPR). In the meantime, OSG A collected the defibrillator from the office, which advised that CPR should continue. An officer also collected the red medical emergency bag (containing oxygen and other monitoring equipment). Staff continued CPR efforts.

123. Paramedics arrived at 3.30am and took over Mr Williams' care. At 3.48am, they confirmed that he had died.

Information received after Mr Williams' death

124. In his statement, an officer who also responded to the emergency, said he saw what looked like PS paraphernalia on a shelf in Mr Williams' cell. He said that the cell had a pungent smell, and the sink was hanging off the wall.

125. After Mr Williams' death, a number of prisoners came forward with information to suggest that Mr Williams was being bullied and "tortured" because of the state of his cell. They alleged that some prisoners, fed up with the smell of his cell, had entered his cell and flushed his toilet the day before his death. Another prisoner reported that Mr Williams was being bullied for his medication.

Contact with Mr Williams' family

126. After Mr Williams died, it was noted that he had not identified any next of kin. Staff located his mother's contact details from the probation database.

127. The family liaison officer and the Governor visited Mr Williams' mother to inform her and Mr Williams' sister of his death. Mr Williams' family said that they were not aware that he had been transferred from Winchester to Guys Marsh.

128. The prison provided ongoing support and contributed towards the costs of Mr Williams' funeral in line with national instructions.

Support for prisoners and staff

129. The Head of Safety debriefed the prison staff involved in the emergency response. All staff were offered the support of the prison's care team. The Governor posted notices informing other prisoners of Mr Williams' death and offering support in case they had been adversely affected.

Post-mortem report

130. A post-mortem examination identified Mr Williams' cause of death as ligature suspension. Post-mortem toxicology tests found quetiapine and olanzapine present in Mr Williams' system. No other drugs or illicit substances were detected. The amount of quetiapine present was at a subtherapeutic level and therefore may have been consistent with non-recent use.

Findings

Management of Mr Williams' risk of suicide and self-harm

131. Prison Service Instruction (PSI) 64/2011 on safer custody contains guidance and mandatory instructions on managing prisoners at risk of suicide and self-harm. We are satisfied that prison and healthcare staff appropriately started ACCT procedures on 15 January 2022.

132. Managing Mr Williams was challenging for prison staff, and he had several factors that increased his risk of suicide and self-harm. He was diagnosed with ADHD, emotionally unstable personality disorder and drug-induced psychosis (for which he was prescribed antipsychotic medication). Mr Williams had a history of poor engagement, self-harm, substance misuse and self-neglect. His behaviour was very challenging and made it difficult for staff to manage him due to his lack of engagement, lack of personal hygiene and unhygienic living conditions. Mr Williams' behaviour prompted multiple referrals to the mental health team.

133. Some positive, supportive actions were taken, and it was apparent from our interviews that staff were aware of the issues surrounding Mr Williams' care. However, there were some aspects of ACCT procedures that might have been improved. In particular, we are concerned that staff underestimated Mr Williams' risk of suicide and self-harm and did not give enough thought to addressing and resolving his risk factors. We identified a number of concerns about the management of ACCT procedures.

Reception

134. When Mr Williams arrived at Guys Marsh, his PER noted he had health issues and was prescribed antipsychotic medication. His electronic prison record identified a history of self-harm and that he had been monitored by ACCT procedures in prison more than once. Despite this, reception staff recorded that Mr Williams had no risks. We are concerned that staff did not properly review and consider his risk factors as they should have and consider whether starting ACCT procedures was appropriate.

Management of ACCT procedures

135. During his time at Guys Marsh, staff conducted 12 ACCT case reviews, including those in which Mr Williams refused to participate or his engagement was limited. An additional case review scheduled to take place on 28 February did not happen and no reason was recorded for this. All of the reviews were multidisciplinary and had input from the mental health team.

Appointment of a case co-ordinator

136. PSI 64/2011 instructs that ACCT reviews are led by a consistent ACCT case co-ordinator, appointed at the first case review. A SO was initially named as case co-ordinator on the front cover of the ACCT document but did not participate in this role thereafter. Indeed, Mr Williams had nine different case co-ordinators for 12 ACCT reviews. HM Prison and Probation Service (HMPPS) guidance states that it is good practice to consider which case co-ordinator is best placed to oversee the ACCT

procedures as the individual may feel more comfortable with engaging with the process if a member of staff they know and trust is co-ordinating them. The lack of a clear case co-ordinator meant there was little managerial ownership of Mr Williams' case, and it is likely that this contributed to the lack of care planning.

Assessing the risk of suicide and self-harm

137. Mr Williams' lack of engagement meant that it was difficult for staff to assess his risk. However, we are concerned that some aspects of his behaviour were not given sufficient weight or recognised as factors that increased his risk.

138. On 8 February, staff made an urgent referral for Mr Williams to see the psychiatrist, where it was assessed that he had poor insight into his mental health and did not have mental capacity to make decisions about his needs and increased his antipsychotic medication. This might have indicated that his risk level had heightened and there is no evidence that a change to the level of observations was considered at the case review held that day. There is also no evidence that the case review team considered what additional support could be provided.

139. PSI 64/2011 instructs that an urgent case review should take place as soon as possible if risk is likely to have increased between planned case reviews. It gives examples of when this might happen, including when information is received to suggest increased risks.

140. We found that no ACCT case review took place after Mr Williams was assaulted by another prisoner (on 25 February), to assess and review his risk and the impact that this altercation might have had on him. There was no evidence that the assault was considered or discussed at Mr Williams' next case review, several days later.

141. On 3 March, Mr Williams was told that he was to be transferred to a secure psychiatric hospital. He was adamant that he did not want to make this move. Mr Williams did not have an ACCT case review after this and there is no evidence that anyone considered the impact this may have on his risk of suicide and self-harm.

142. At the same time, Mr Williams' poor living conditions were not recognised in the ACCT support plan. There is no evidence that staff considered that Mr Williams' neglect for his personal hygiene and the cleanliness of his cell may be an additional risk factor. Indeed, on more than one occasion, staff appeared to question the use of ACCT monitoring to support Mr Williams, indicating that they did not recognise that he was harming himself through poor self-care and living in poor conditions. Our Fatal Incidents Learning Lessons Bulletin, published in August 2014, identified that challenging behaviour can mask vulnerability and that managing the risk of suicide and self-harm, treating mental ill health and managing behaviour needs to be better integrated to ensure a balanced, holistic and consistent approach.

143. PSI 64/2011 identifies that some prisoners supported through ACCT procedures may have particularly challenging needs or a significant level of complexity. It says that such prisoners should be referred to the SIM. PSI 64/2011 gives two specific instances where prisoners must be referred to the SIM (neither of which applied to Mr Williams) but says that it is largely up to ACCT case review teams to decide whether a case requires a referral for discussion at a SIM.

144. Mr Williams was appropriately referred to the SIM on 9 February. However, we found that the SIM minutes simply recorded that Mr Williams was to see a psychiatrist with a view to moving to a secure psychiatric hospital. They did not create any action points to address his self-neglect and dirty living conditions, lack of engagement and other issues. While hospital admission was clearly important, in the interim, a meaningful care plan might have helped address Mr Williams' issues to improve his quality of life and reduce his vulnerability.

Setting ACCT observations

145. PSI 64/2011 instructs that ACCT case review teams must set appropriate levels of observations and conversations, which need to be tailored to reflect the assessed risk and needs of the prisoner. Mr Williams' ACCT observations were initially set at hourly. On 27 January, they were reduced to one conversation per day and, on 1 February, increased to two conversations a day. They remained at this level for the remainder of Mr Williams' life.

146. We are concerned that Mr Williams' observations were reduced so significantly while he still presented with several risk factors, including ongoing mental health problems, isolating behaviour, and minimal engagement with staff. Furthermore, at this same time, the outcome of an urgent planned appointment with the psychiatrist was unknown, which should have at least given staff more reason for concern about his mental health and possibly raised his risk. While we cannot know if maintaining an increased level of ACCT observations at the case review on 27 January would have affected the eventual outcome for Mr Williams, it would have provided an additional level of monitoring and support for someone whose risk was not easy to assess.

147. We also note that a CM and a nurse both recorded contradictory information about the level of observations that Mr Williams was subject to at the ACCT case review on 27 January.

148. As noted, no one considered whether Mr Williams' risk of suicide and self-harm had increased when he was told that he was to be transferred to a secure hospital. This might also have led to an increase in ACCT observations.

ACCT care plan

149. PSI 64/2011 states that support actions must be set at the first case review to mitigate and lower risk for all prisoners subject to ACCT monitoring. These should be completed as part of a care plan in the ACCT document, identifying action points required to reduce risk, who is responsible for completing these actions points and when they should be completed. They should be reviewed at each subsequent case review, with additional support actions added as required.

150. Staff did not include some important issues in Mr Williams' care plan. While a care plan was started at Mr Williams' case review on 17 January, it was not further completed or updated. It therefore contained no additional support actions. It did not reference Mr Williams' complex needs that were not therefore addressed in his ACCT care plan. This included his deteriorating mental health, the unhygienic conditions he lived in, any measures put in place to keep him safe from violence or the outcome of any of the urgent referrals to the psychiatrists or identified support

measures. The care plan might also have been used to identify how Mr Williams might have been able to receive support from his long-term friend once they moved to different locations.

151. These were major omissions. As well as being a mandatory requirement, the care plan is a key tool in planning how to address a prisoner's issues and it is hard to see how prison staff could have made any coherent plan for Mr Williams without being able to identify, progress and manage his risks effectively.

ACCT quality

152. PSI 64/2011 states that staff must follow the level of conversations stated on the ACCT document and must record these immediately or as soon as is practical. It states that conversations with prisoners should be meaningful, and that staff must be aware of what is in a prisoner's care plan to understand the context of any conversation. It also notes that the written summaries should be meaningful and sufficiently detailed to convey the key details of what was discussed.

153. From the ACCT document provided to the investigator, we found that the administration and qualitative content of the ACCT document was poor. As well as the lack of a properly completed care plan, the ACCT ongoing record was only partially completed. We noted a number of blank spaces which should have been completed with staff summaries detailing conversation updates with Mr Williams, noting his behaviour and presentation. Some entries that were completed were not signed, dated or time-stamped. Some ACCT reviews were signed with the wrong date and noted incorrect planned review dates.

154. We consider that the management of the ACCT was inadequate in terms of addressing Mr Williams' risk and that his risk of suicide and self-harm should have been better managed. We make the following recommendations:

The Governor and Head of Healthcare should ensure that all Reception and First Night staff have a clear understanding of their responsibilities to identify prisoners at risk of suicide and self-harm in line with national instructions and in particular, the need to record, share and consider all relevant information about risk, and start ACCT procedures when indicated.

The Governor should ensure that staff manage prisoners at risk of suicide and self-harm in line with national instructions, including that:

- **a case co-ordinator is appointed at the first case review, who should lead all subsequent case reviews wherever possible;**
- **case review teams assess risk and set levels of observations based on the prisoner's risk;**
- **prisoners with challenging needs or significant complexity are referred to the Safety Intervention Meeting, who identify meaningful action points to address the key issues;**

- **ACCT care plans are completed that are specific and meaningful and include all of the issues identified during the assessment interview and at case reviews;**

- **urgent case reviews are held when information is received that indicates increased risk; and**

- **ACCT entries are completed accurately, legibly and in a timely manner and are signed and correctly dated.**

Mr Williams' environment and location

155. Mr Williams' living conditions affected those who lived and worked around him and led to him being bullied (verbally and physically) because of his behaviour. A CM described the smell in Mr Williams' cell as so bad that it made him want to vomit and said that it was a health and safety issue. We were also told that prisoners placed incense sticks outside Mr Williams' cell to diffuse the smell.

156. A nurse said that she had advised prison staff to move Mr Williams because of these conditions and believed he was vulnerable to abuse from others. There was little recognition in the ACCT document or elsewhere of how staff planned to manage this and the impact Mr Williams' living conditions might have on him, other prisoners or staff.

157. Moving Mr Williams to a different location within the prison may have averted friction from other prisoners and staff from the incidents we have described. However, it seems unlikely that it would have changed his behaviour given that there was no change when he was moved to Saxon Wing. That said, we found no evidence that prison staff discussed in any detail or considered moving Mr Williams to a different location. A CM told us that the only other location available would have been the Segregation Unit. However, they considered that living on this unit would further isolate him because of the already restricted regime and it was therefore not deemed suitable. We agree with this. Prison research into the mental health of prisoners held in solitary confinement indicates that, for most prisoners, there is a negative effect on their mental wellbeing and that in some cases, the effects can be serious. Such a move might therefore have exacerbated Mr Williams' already declining mental health.

158. However, we are concerned that there was no plan to try to improve Mr Williams' living conditions, especially as it was considered that he lacked the mental insight into his care needs. We appreciate that addressing the condition of the cell with Mr Williams would have been difficult due to his poor engagement. However, it appeared that staff became complacent and accepting of the conditions he lived in, rather than proactively trying to improve the environment.

159. We saw no evidence that staff had tried to assess the impact of, for example, relocating Mr Williams to a different cell temporarily so that his cell could be bio-cleaned, and his toilet flushed. We noted that the prison maintenance team had refused to work in Mr Williams' cell to fix a broken sink until it was bio-cleaned. There was no consideration given to cleaning of Mr Williams' cell when he was moved temporarily overnight due to a defective fire detector. We make the following recommendation:

The Governor should ensure that when a prisoner's cell is uninhabitable or damaged to the extent it impacts on his basic needs, prison staff should:

- **move him to another cell as quickly as possible; and**
- **record the damage, monitor the wellbeing of the prisoner while he remains in the cell, and escalate the situation to managers to resolve promptly.**

Key worker scheme and wellbeing checks

160. Under the Offender Management in Custody model, each prison officer is a named key worker for five or six prisoners and should be allocated an average of 45 minutes per week to spend on key work duties with each prisoner, including having regular meaningful conversations. In March 2020, HMPPS suspended key work due to the COVID-19 pandemic. On 12 May 2020, key work was reintroduced but delivered in a more limited way in line with an Exceptional Delivery Model, where priority prisoners received key work.

161. Mr Williams was monitored under ACCT procedures for most of his time at Guys Marsh, which meant that he was a priority prisoner for key work sessions and regular wellbeing checks. Despite this and his complex mental health needs, he only received two key work sessions on 10 and 20 February.

162. We acknowledge that Guys Marsh had become a COVID-19 outbreak site during parts of January and February 2022. This impacted on staff attendance, reduced the consistency of available staff on residential wings and affected their ability to conduct weekly key work sessions. We also appreciate that the delivery of key work was accompanied by the use of wellbeing checks, which Mr Williams received most days.

163. However, the key work meeting can have a far greater input into building a relationship with a prisoner, especially one with engagement and mental health issues like Mr Williams and this should have been prioritised as an important part of his support plan. Mr Williams' key worker stated that he had started to build a rapport with him. Their meetings, however, were not consistent enough to build a trusting relationship. The regular, supportive contact between prisoners and their key workers is likely to be a significant protective factor and an important source of information to those managing and caring for such prisoners. We make the following recommendation:

The Governor should ensure that there is an effective key worker scheme which provides meaningful and ongoing support to prisoners.

Clinical care

164. The clinical reviewer found that the clinical care Mr Williams received at Guys Marsh was of the standard reasonably expected, and was partially equivalent to that which he could have expected to receive in the community.

165. While there were examples of good practice on the part of the mental health team, notably the speed of Mr Williams' referral for an assessment under the Mental Health Act, the clinical reviewer highlighted areas in which the clinical care could

have been improved. This centred specifically around the management of his self-neglect from a safeguarding perspective, and a lack of input when Mr Williams' circumstances changed (when he was told he would be moving to a mental health hospital).

Handover from HMP Winchester to HMP Guys Marsh

166. We were told that a nurse at Winchester emailed the mental health team at Guys Marsh to provide a handover about Mr Williams' care before his transfer. We have not seen this email but were told that it provided an impression of Mr Williams' mental health and confirmed his prescribed medication. We have been unable to identify what action was taken at Guys Marsh on receipt of the email. What was evidenced, however, was a handover note recorded on Mr Williams' medical record which stated that he had emotionally unstable personality disorder and drug-induced psychosis, was prescribed antipsychotic medication and that his engagement with the mental health services was poor.

167. Prison Service Order (PSO 3050) on the continuity of healthcare for prisoners states that prisoners with more complex health needs may need detailed care planning with the receiving healthcare team in advance of a transfer. We are concerned that the handover between prisons was poor before Mr Williams' transfer and that the note made in his medical record did not have the level of impact expected for someone with his history and diagnoses. We share the clinical reviewer's concerns that it would have been good practice for a formal handover, at least in the form of a phone call, to have taken place, especially as the transfer may well have exacerbated his risks. We make the following recommendation:

The Heads of Healthcare at HMP Winchester and HMP Guys Marsh should ensure that effective liaison between prisons takes place when prisoners with a history of severe and enduring mental illness are transferred between prisons, with the outcome fully documented in the prisoner's medical records.

Mental capacity, safeguarding and self-neglect

168. Mr Williams had a history of self-neglect when his mental health deteriorated, and this was identified early on in his time at Guys Marsh. Both prison and healthcare staff had reported his poor self-care and poor living conditions. However, this did not translate into staff raising the issue of self-neglect as a specific safeguarding concern. The SIM forum appeared not to recognise or consider that Mr Williams' self-neglect was fundamentally also a safeguarding matter.

169. Within a prison setting, the overall responsibility for safeguarding adults falls to prison staff. At Guys Marsh, the responsibility for safeguarding is with the Offender Management Unit but there is also a healthcare safeguarding lead who works as a Health and Wellbeing Co-ordinator, and who also attends the SIM. All healthcare staff have a responsibility to report safeguarding concerns to the prison.

170. We found that Guys Marsh had no self-neglect strategy in place. While there are a number of guidance materials available to prison and healthcare staff at Guys Marsh, including HMPPS' policy on safeguarding adults and children (2020), PSI

16/2015 on adult safeguarding in prison, and Practice Plus Group's safeguarding policy' (October 2020), they lacked details about how to support people who neglect themselves. The clinical reviewer noted that Mr Williams' case exposed a gap that needed to be addressed and identified that a self-neglect strategy/policy should include:

- the interdisciplinary support available from prison and healthcare services to the approach of supporting a prisoner who neglects himself;
- a collaborative personalised support plan on how to manage self-neglect in prison settings;
- identification of a lead person to build a trusting relationship with the prisoner and understand what they would like as an outcome;
- a risk assessment, with frequent review and monitoring of the risks;
- a positive risk-taking approach to managing self-neglect risks and understanding that risks will reduce slowly;
- the interface with the Mental Capacity Act (2005), including when best interest decisions should be made; and
- specific training for staff to understand that self-neglect is a safeguarding category and approaches that help support the prisoner who is neglecting himself.

171. Almost all of the elements described above were identified in Mr Williams' case and should be contained in a self-neglect healthcare strategy. The clinical reviewer notes that supporting people who neglect themselves is challenging, and they often find it hard to engage with others, as was evident with Mr Williams. The need to build relationships is even more important and we have already highlighted the value of Mr Williams' trusted friend and his key worker in building trusting relationships to change behaviour. We agree with the clinical reviewer that a strategy should have been developed to address Mr Williams' self-neglect.

172. We also note that Mr Williams' mental capacity was assessed not to have capacity to make decisions about his health, wellbeing and self-neglect risks. However, the clinical reviewer noted that while it was good practice that Mr Williams' capacity was assessed, staff did not have a meaningful discussion about how best to support him in the areas in which he did not have the mental capacity to make decisions. It was not clear if information about Mr Williams' mental capacity needs were shared with prison staff as there is no reference in his ACCT document or prison records. We make the following recommendation:

HM Prisons and Probation Service's national adult safeguarding lead should develop a self-neglect strategy and formal guidance to be used in the prison environment.

Hospital transfers

173. The process of assessing Mr Williams under section 47 of the Mental Health Act, and the subsequent process of transferring him to a hospital setting, was done quickly and efficiently. However, we share the concerns of the clinical reviewer that when a nurse informed Mr Williams (on 3 March) that he would be moving to a secure hospital setting, no plans were made to review or monitor him. As well as the impending change in Mr Williams' circumstances, his reaction to the news meant that timely follow-up was important. The nurse told us that she advised prison staff to monitor Mr Williams and noted this in his ACCT document. We did not see any record in the ACCT document of this. There should also have been a more formal mental health interim plan to review Mr Williams. We make the following recommendation:

The Head of Healthcare should ensure that there is a formal care plan in place when a prisoner is waiting for transfer to a mental health hospital bed.

Prescribed medication

174. It is unclear how compliant Mr Williams was with his prescribed medication (quetiapine). According to the medication administration records, he did not attend for his medication on one occasion in February 2022 and again, the day before he died on 6 March 2022. This would not have triggered an omitted medication process (which would only have been initiated after three consecutive omitted doses).

175. The post-mortem toxicology reports noted that, while quetiapine was present in Mr Williams' system, it was of a sub-therapeutic level, which suggests that he was not taking his medication regularly. While healthcare staff had suspicions that Mr Williams was secreting medication, it was not clear what action was taken about this as the documentary evidence is poor. The Head of Healthcare told us that even though Mr Williams may have been secreting some of his medication, as it was a critical medication for his mental health, it would have still been given to him on a balance of risks. After Mr Williams' death, another prisoner told us that Mr Williams was being bullied for his medication and that he also traded his prescribed medication for other medications or PS. We found no evidence to suggest that prison or healthcare staff were aware of this before Mr Williams' death.

The Head of Healthcare should ensure that any information about secreted medication is recorded, communicated and considered appropriately.

Learning lessons

176. We have identified a number of concerns in this report. We consider that it is important that staff learn from our findings. We recommend:

The Governor and Head of Healthcare should ensure that a copy of this report is shared with the staff named in this report and that a senior manager discusses the Ombudsman's findings with them.

Inquest

177. An inquest was concluded on 17 May 2024, that the cause of Mr Williams' death was ligature suspension. The coroner found that Mr Williams died by suicide in circumstances where there was inadequate assessment and monitoring of his risks of self-harm and suicide prior to his death.

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