

**Investigation into the death of a man at the
Royal Hampshire County Hospital in July 2012,
while a prisoner at HMP Winchester**

**Report by the Prisons and Probation Ombudsman
for England and Wales**

March 2013

This is the report of the investigation into the death of a man who died at the Royal Hampshire County Hospital in July 2012. He had collapsed in his cell at HMP Winchester two days earlier and it was later discovered that he had obstructed his airway with food, including a whole hard boiled egg in its shell. The post-mortem report gave his cause of death as cerebral hypoxia (reduced oxygen to the brain) as a result of choking. I offer my condolences to the man's family.

The investigation was carried out by one of my investigators. A clinical reviewer was appointed to conduct a review of the clinical care the man received at Winchester. Winchester cooperated fully with the investigation.

The man had been in prison on remand since 28 May, and at Winchester since 29 May, charged with the murder of his wife. Throughout his time in prison he was considered to be a high suicide risk and he was monitored under suicide and self-harm prevention measures. At the time of his death he was being constantly supervised by a prison officer.

The investigation found that much of the work done to support and protect the man was of a good standard. Mental health specialists frequently reviewed the man and did not think that he showed any clear signs of a mental illness. The clinical reviewer concludes that the healthcare the man received was equivalent to community standards.

In order to protect the man, the prison removed many items that he might use to harm himself. The circumstances of the man's death are exceedingly rare, and it did not occur to staff that the man might use food apparently to take his own life. Nevertheless, the investigation has identified some areas for procedural improvement at Winchester, including better liaison with the families of those who are at risk of self-harm. I also make a national recommendation about guidance to prisons about assessing the risk of food for those at high risk of self-harm.

Overall, while the man's death at his own hand was foreseeable (and recognised to be so by the prison), the method he apparently used could not reasonably have been foreseen and staff took reasonable steps to prevent his death.

We are grateful to the man's family for considering the report at the draft stage. This final version of the report reflects some of their views and includes the National Offender Management Service response to the recommendations made.

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

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SUMMARY

1. On 25 May 2012, the man was arrested and later charged with the murder of his wife. He was considered to be at risk of suicide and was monitored accordingly in police custody. He appeared in court on 28 May and was remanded into the custody of HMP Isle of Wight. On his arrival, suicide and self-harm monitoring procedures were started and he was checked several times every hour.
2. The man appeared at Winchester Crown Court on 29 May, and from there was remanded into the custody of HMP Winchester. It was known that the man had harmed himself a number of years earlier and had received some mental health treatment at the time. However, his community medical record, which contained more detail, was never requested. The man was given a cell in the healthcare inpatient unit, for a period of close monitoring and assessment. He was referred to the prison mental health team and was quickly assessed by the prison psychiatrist and the mental health team leader.
3. The man was reviewed regularly during his first days at Winchester and it was noted that he was subdued and shocked by events. On 1 June, the man's daughter wrote to the prison healthcare department concerned about her father's state of mind and sought reassurance that he was receiving appropriate treatment. Healthcare staff replied and assured her that the man was receiving regular input from mental health specialists. The psychiatrist and mental health team leader continued to assess the man. The man sometimes spoke of wishing he was dead, at times had trouble sleeping and was low in mood, but he was not considered to have a mental illness. He was not prescribed any medication for his mental health while at Winchester.
4. On 25 June, the man asked for a letter to be posted. An officer read the letter which suggested that the man intended to kill himself after his wife's funeral the next day. His cell was searched and another letter to his children was found in which he tried to explain events leading to his wife's death. Elements of the letter suggest that the man might have been experiencing some kind of mental disturbance at the time of the murder. Prison staff decided that the man was a very high suicide risk and he was placed under constant supervision. (When a prisoner is constantly supervised, a member of staff remains on watch outside their cell at all times and accompanies him to any activity. The purpose is to engage with the prisoner and try to help him through a period of crisis while also preventing him from harming himself.)
5. On 26 June, the man's spent time in the prison chapel while his wife's funeral took place. On 27 June, the constant supervision was ended because the man said that he found it very stressful. However, some items were removed from his cell in case he used them to harm himself.
6. On 1 July, the man tried to persuade officers to allow him time to kill himself. As a result, the constant supervision was reinstated. Most items were removed from his cell in case he used them to harm himself and he was placed in special clothing which cannot easily be torn or used as a ligature to

tie around the neck. The man spoke very little to the staff monitoring him. He was given a cold dinner, including a whole hard boiled egg in its shell, potato and lettuce. He did not eat it all that night and was allowed to keep it in his cell overnight. He did not sleep.

7. At 7.00am on 2 July, an officer who had never before been responsible for the constant supervision of a prisoner took over monitoring the man. The officer did not fully understand what was required and had a book of number puzzles with him, which he worked on from time to time. He and the man did not speak during the morning.
8. At around 11.40am, the man appeared to be eating some of the previous evening's dinner. Seconds later he collapsed in the cell. Staff responded quickly and an ambulance was called. Officers, prison nurses and the paramedics tried to resuscitate the man. Once at hospital, doctors discovered that the man's airway was obstructed by the whole hard boiled egg and other food. The man was placed on life support but had suffered irreversible brain damage. His family requested that his organs be donated for transplant and, this having been arranged, the life support was withdrawn on 3 July and he died that evening.
9. Throughout his time at Winchester, the man was considered to be at risk of suicide. We conclude that officers and healthcare staff worked hard to support him and keep him safe. At the time of his death, almost everything that he could use to self-harm had been removed from his cell. His is only the third death we have investigated in which the prisoner apparently deliberately blocked his own airway with food. It is a very rare occurrence. Many years previously, we understand that the man had tried to swallow a sock in an act of self-harm. Staff were apparently unaware of this, but said that even had they known, they would not have considered removing the food from the man's cell.
10. We have made seven recommendations as a result of our investigation. While we conclude that the suicide monitoring procedures in the man's case were generally good, we have identified areas for improvements, such as involving the family in the process and ensuring that checks are made in line with national policy. We have also recommended providing staff with clearer guidance about carrying out constant supervision duties. We have made a national recommendation to ensure that prisons across England and Wales learn from the man's death and risk assess food in the same way as other items.

THE INVESTIGATION PROCESS

11. The Ombudsman's office was informed of the man's death in July 2012. The investigator issued notices to staff and prisoners at HMP Winchester to inform them of the investigation and asking anyone with relevant information to contact her. No responses were received.
12. On 12 July, the investigator visited HMP Winchester and met the Governor, the prison family liaison officer, the head of healthcare, the head of safer custody and other staff. She also met a member of the Independent Monitoring Board (IMB) and a representative of the Prison Officers' Association. The investigator obtained copies of the man's prison and medical records.
13. A clinical reviewer was appointed to review the clinical care the man received at Winchester. The clinical reviewer was also given a copy of the man's prison medical record.
14. The investigator and the clinical reviewer carried out interviews at Winchester in August and September. The Governor was given verbal and written feedback after the interviews. A further interview with a member of staff at Winchester was carried out by telephone in October.
15. The clinical reviewer and the investigator had sight of internal investigations carried out by Solent NHS Trust and the PCT.
16. The Coroner for Hampshire Central was informed of the investigation and provided the investigator with the result of the post-mortem report. A copy of this report will be sent to him.
17. One of the Ombudsman's family liaison officers contacted the man's family outlining the purpose of the investigation. In November, the Ombudsman's family liaison officer and the investigator visited the man's family. They identified a number of concerns and questions, summarised as follows:
 - That the man was able to kill himself despite his family raising concerns about his risk of suicide with staff at Winchester on several occasions, including telling them that he had previously tried to kill himself by swallowing a sock.
 - That his family had not been consulted about or involved in the care provided to the man, despite being eager to support and help him. They felt that, as they knew him best, they would have been able to provide additional information to prison staff about his history and changes to his appearance and behaviour in prison. They thought that they should have been more closely involved because the man had signed a power of attorney giving his brother responsibility for handling his affairs.
 - That the man was able to kill himself while being constantly supervised by officers and deemed to be a very high suicide risk.
 - That the prison did not adequately manage the man's risk to himself. They asked us to consider whether the cell the man was being constantly

supervised in at the time of his death had a blind spot, why food was left in his cell, why he had been allowed plastic cutlery, which they believed he had concealed, and why there were plans to move him to a normal wing when he was at high risk of suicide.

- That healthcare staff did not seek to obtain the man's community medical record, which would have given them further information about the mental healthcare he received in 1992.
- Whether the man was being prescribed any medication for mental health problems, and if so, whether he was taking it.
- That the care the man received in prison compared unfavourably with the care afforded by the police.
- That the man should have been transferred to a secure hospital for treatment of mental health problems, rather than remaining in prison.
- That aspects of the liaison between the prison and the family after the man's death had not been appropriate. They felt that there had been a delay in informing them of the man's collapse and said that prison staff had initially tried to prevent the man's children from visiting him in hospital. They were also upset that, during a meeting after the man's death, they caught sight of letters written by the man which they had not seen before and which had not been returned to them with his property.

18. We hope this report gives the man's family a better understanding of his time in prison and the circumstances surrounding his death.
19. The man's family considered the report at the draft stage. The man's brother remains concerned about some aspects of the care provided to the man at Winchester. He is concerned that, although he made numerous telephone calls to the prison to express his fears about the man, only one member of staff recorded details of the conversation in the man's file or passed on his concerns. He also remains concerned that the constant supervision cell is not suitable because staff do not have a clear view of the prisoner at all times without moving position.

HMP WINCHESTER

20. HMP Winchester is a local prison receiving prisoners from courts in Hampshire. It holds up to 706 category B and C adult male prisoners on remand or sentenced, including up to 129 category C adult male sentenced prisoners in a separate resettlement unit.
21. Twenty-four hour primary general and mental healthcare services are provided by Solent NHS Trust, including an 18 bed inpatient unit. Community mental health services are provided by Southern Health NHS Foundation Trust.

HM Inspectorate of Prisons (HMIP)

22. HMIP carried out an unannounced short follow up inspection at Winchester in September 2010, following a full inspection in 2007. The Inspectorate found that suicide and self-harm prevention procedures were reasonable and had improved since the last inspection. Care plans were comprehensive and there was evidence of a multi-disciplinary approach. HMIP was satisfied that the evidence demonstrated that staff had engaged with the individual at risk.
23. The full inspection in 2007 raised concerns about the attitudes of some staff towards prisoners. In 2010, HMIP reported that the prison had worked on improving relationships between staff and prisoners and that senior staff were taking the lead in engaging appropriately with prisoners. HMIP found that prisoners were mostly positive about staff, but that while some staff had relaxed relationships with prisoners, some were still unnecessarily rude and dismissive.
24. Health services were also found to have improved. HMIP reported that secondary mental health care was good; however, primary mental health care provision was judged inadequate for the needs of the population.

Independent Monitoring Board (IMB)

25. Each prison has an Independent Monitoring Board of unpaid volunteers from the local community who monitor all aspects of prison life to help ensure that proper standards of care and decency are maintained. The most recent IMB annual report for Winchester covers the year 2010/2011.
26. The IMB noted that the recruitment of a modern matron (who acts as the head of healthcare) had led to improvements in the running of the healthcare unit. The safer custody team had also benefited from consistent management. The weekly multi-disciplinary meeting held to discuss prisoners at risk of suicide or self harm was praised for offering a reliable platform for discussion and support.

Previous deaths at Winchester

27. In the last three years, we have investigated seven deaths at Winchester, two of which were self inflicted. There are no similarities between these and the death of the man.

Assessment, Care in Custody and Teamwork (ACCT)

28. ACCT, the Prison Service process for supporting and monitoring those prisoners thought to be at risk of harming themselves, was introduced in 2007. An ACCT plan can be opened by anyone working in the prison if they have any concerns that a prisoner might have tried, or, in the future, might try to harm himself. The purpose of ACCT is to try to determine the level of risk posed, the steps that might be taken to reduce this and the extent to which staff need to monitor and supervise the prisoner. Levels of observations (where staff must check the prisoner) and interactions (where staff must have a conversation with the prisoner) are flexible and can be set according to the perceived risk of harm. If staff perceive the risk of harm to be very high, the prisoner may be constantly observed, with a member of staff positioned outside their cell at all times. Where the perceived risk is lower, the level of observations may be several times an hour or day. Observations also take place during the night.
29. Part of the ACCT process involves drawing up a caremap. A good caremap will identify the prisoner's most urgent and pressing issues, set achievable goals to help resolve the issues and identify who is responsible for resolving each goal. The ACCT plan should not be closed until all of the actions on the caremap have been completed.

KEY EVENTS

30. In 1992, the man was treated for mental health problems. As part of this investigation, the clinical reviewer obtained the man's community medical records. According to the records, the man had twice been voluntarily admitted for psychiatric care, in October and November 1992. The admissions followed an incident of domestic violence and a serious act of self-harm in which he cut both arms near the elbows, injuring nerves and arteries on both sides. On the first occasion, in October 1992, the man remained an inpatient for 12 days and was diagnosed with depression, with secondary paranoid psychosis. He was initially prescribed chlorpromazine (used to treat a variety of psychiatric illnesses). Several days later, when the man was no longer feeling paranoid, the medication was changed to remoxipride (then prescribed as an anti-psychotic medication). The records show that a few weeks later, in November, the man was admitted to the psychiatric hospital again, where he remained for less than 24 hours. By February 1993, the man had stopped taking remoxipride. According to the community medical records, the man did not complain of any further episodes of paranoia or depression and was not prescribed any medication to treat mental health problems after 1993.
31. The man's family told us that the man had twice been sectioned under the Mental Health Act (under which someone can be detained, admitted and treated for mental illness against their wishes). They were also certain that, at the time, he was diagnosed with paranoid schizophrenia with psychotic tendencies. According to his family, at around this time, the man tried to swallow a sock in an act of self-harm. This is not mentioned in his community medical record.
32. On Friday 25 May 2012, the man was arrested and charged with the murder of his wife. The offence occurred on the Isle of Wight and the man was taken into police custody there. He was assessed by a doctor who concluded that there were no signs that the man had any acute mental health problems although he was in a state of shock. The doctor instructed police officers to give the man paracetamol if required and prescribed diazepam (a sedative medication) to be given at night. The man was constantly observed by police officers while in custody because of the nature of the offence and his state of shock. The doctor considered the man to pose a medium risk of self-harm.
33. The man appeared at the magistrates' court on the Isle of Wight on Monday 28 May. While at court, escort staff (who are responsible for looking after defendants at court) completed a suicide and self-harm warning form noting that the man was unpredictable and at high risk of self-harm. They noted that the man seemed unable to believe that his wife was dead. He continued to be monitored constantly while at court.
34. Escort staff also noted that the man had harmed himself 15 years earlier and been sectioned. The form does not specify from where escort staff got this information, but it does not accord with his community medical record.

35. At court, the man was remanded into the custody of HMP Isle of Wight. As soon as he arrived, an ACCT plan was opened which noted that the man might pose an increasing risk to himself as he began to realise the consequences of his actions. Staff completing the plan noted the man's history of self-harm. He was given a single cell and officers were initially instructed to check him at least once an hour during the day and twice an hour over night.
36. Nurse A carried out the man's reception healthscreen at 2.58pm. (The purpose of the healthscreen is to identify any immediate mental or physical health problems requiring treatment or referral to another service.) The nurse recorded that the man was on an ACCT plan, was withdrawn and made no direct eye contact. She made an urgent referral to the prison mental health team. The nurse recorded that the man said he did not drink very much alcohol. She noted that he had been prescribed diazepam while in police custody (often used for alcohol detoxification) and that she would discuss this with the prison doctor. There is nothing in the medical record to confirm that she did so and it seems that the man was not prescribed any further diazepam while in prison.
37. At 4.30pm, Officer A carried out the ACCT assessment interview. The man said that he felt low but not suicidal. He said that he was managing to eat and, while in police custody, was given medication to help him sleep. He said that he was feeling okay and had support from his brother and children. The man said that he understood he could access support from the Samaritans by telephone, or from Listeners (prisoners trained and supported by the Samaritans to offer confidential emotional support to fellow prisoners in distress).
38. Shortly after, the first ACCT case review took place chaired by Senior Officer (SO) A, with Officer A and the man present. No-one from healthcare attended. SO A noted that the man was stunned and struggling to take in the situation. The man said that he had no thoughts of suicide or self-harm and, when reminded about the different avenues of support open to him, said he would talk to staff if he needed support. He was assessed as a raised risk of self-harm (the options being low, raised and high). SO A began the ACCT caremap noting that the man was struggling to come to terms with the situation and would need to discuss it openly with staff. The SO also recorded that the man needed to be referred to the mental health team and a referral was made that day. The level of observations remained unchanged at one an hour during the day and twice an hour at night.
39. At 7.10pm, once the man had moved to the wing where he would spend his first night, the wing senior officer chaired an ACCT case review attended by the man, the most senior officer on duty, a wing officer and the man's personal officer. (Personal officers are usually assigned a small number of prisoners and should get to know their personal circumstances, provide individual support and act as the prisoner's first point of contact for questions or concerns.) Again there was no-one present from healthcare or other disciplines. The staff checked that the man understood the purpose of the

ACCT process and raised the level of observations to four checks an hour at irregular intervals and at least one recorded conversation each hour. The man was given a single cell.

40. On 29 May, the prison's community mental health team (CMHT) noted that they would work with the man. However, that day, he appeared at Winchester Crown Court and from there, was remanded into the custody of HMP Winchester. The open ACCT plan accompanied him to court and on to Winchester.
41. A community psychiatric nurse and the CMHT team leader at Winchester, saw the man in reception, having been advised of his transfer by the Isle of Wight CMHT. The man told her that he had last had contact with mental health services about 20 years earlier, but that he had suffered a breakdown caused by stress and had harmed himself 15 years earlier. (As noted, the man's last recorded mental ill health and contact with mental health services was in 1992). The CMHT team leader recorded that the man had been in prison 30 years previously. The man denied any use of illicit drugs and said that he only drank alcohol socially. He said that he did not have any thoughts of suicide or self-harm. The man asked her how his family could visit him and said that he would like to telephone his brother to let him know he had moved prison. The CMHT team leader recorded that the man was not currently prescribed any medication. She concluded that he should be given a cell in the healthcare inpatient unit, where he could be more closely monitored, because events were only just beginning to sink in.
42. At 5.05pm, SO B, Principal Officer (PO) A (both from the safer custody team), a psychiatric nurse and the man met for an ACCT case review. The man said that he was feeling progressively worse as he realised what had happened, however, he continued to say he had no thoughts of suicide or self-harm. The staff told the man that he would initially be given a cell in the healthcare unit and would stay at Winchester at least until the end of legal proceedings at the Crown Court. They considered that the man posed a raised risk to himself and the observations were set at three an hour with three conversations to be recorded each day. No new entries were made on the caremap.
43. Once the man had moved to the healthcare unit, Officer B carried out the first night induction interview. The officer gave the man a smokers' pack (which contains an amount of tobacco) and put £1.00 on the man's pin phone account. (Each prisoner is issued with a personal identification number (pin) which they must enter before dialling the number they wish to call. Prisoners can only make calls to agreed specified numbers. Prisoners are required to buy phone credit using their own money.)
44. In the afternoon of 30 May, the man was assessed by Dr A, the prison psychiatrist. At interview, the doctor explained that the man was placed on his caseload because of the concerns about his risk of self-harm. The doctor recorded that the man was not currently prescribed any medication and had not had any recent mental health problems. Both the CMHT team leader and the doctor told the investigator that the man's community medical records

should have been requested from his doctor, but that had not been done. The CMHT team leader said that this was an oversight. It meant that full information about the man's previous mental health and treatment was not known.

45. The psychiatrist recorded that the man was cooperative and engaged in conversation but seemed subdued. The man said that he was in shock but had no thoughts of suicide or self-harm. Dr A concluded that the man was showing no signs of any abnormality of thought or perception (one of the symptoms of psychosis) although he noted that the man said he was being followed before the offence occurred. Dr A concluded that there was currently no evidence that the man was suffering a mental disorder but that his mental state and behaviour should be monitored. At interview, the doctor explained that his practice with prisoners arriving who were charged with murder, was to continue to assess their mental health over an extended period of time. He said that it was not uncommon for the mental health of such prisoners to deteriorate. The psychiatrist suggested that the man might move to a standard prison wing the next week.
46. At 3.40pm, another ACCT case review was held chaired by SO B, attended by the man, community psychiatric nurse A and Officer C. SO B wrote that the man still seemed shocked and overwhelmed by events. The man said that his family had been present at court but that he was not sure whether they supported him and he was encouraged to write to his brother. The man continued to deny any thoughts of suicide or self-harm and the frequency of observations was reduced to twice an hour. The Caremap was updated noting that the man was not sure of the contact details for different members of his family and would write to his brother for the information. Later that day, SO B recorded that the man had written to his brother (he received a reply on 31 May).
47. The next ACCT case review was held at 10.15am on 1 June, attended by the man, SO B, community psychiatric nurse A and Officer D. The man said that he was still feeling numb but was pleased to have heard from his brother and daughter. The man could not remember his pin phone code and the SO arranged for it to be reissued. He had also run out of tobacco and was not due to receive any more for several days, so the SO noted that she would arrange for him to be given some. Both issues were entered on the caremap and recorded as resolved later that day. The man said that he was not eating or sleeping very much. The staff agreed that he still posed a raised risk, partly because it was very difficult to interpret how he was feeling. The frequency of observations remained at two an hour. Both the prison electronic record (P-Nomis) and the electronic medical record system (SystemOne) were updated appropriately after each ACCT case review.
48. The man's brother visited him on 1 June. After the visit, the man's daughter wrote to the prison healthcare department concerned about her father's mental health and that he would try to harm himself. She wrote that her uncle had been shocked at the man's appearance and state of mind and thought that he was displaying multiple personalities. The healthcare department

recorded that they received the letter on 7 June and details of the contents were entered onto the man's medical record. The community psychiatric nurse and the primary care team leader, replied on 8 June reassuring she man's daughter that he was an inpatient in the healthcare unit and was being seen regularly by mental health staff. They wrote that the man had told them that he was feeling slightly better and that he had been treated in a positive and respectful manner by all staff.

49. On 6 June, SO B, Nurse B from the CMHT and the man met for another case review. The man said that although he wished he was dead, he had no plans to harm himself. The nurse recorded that the man was tearful at times during the review. The man said that his daughter had sent him money at HMP Isle of Wight which had not been transferred to Winchester and the SO agreed to investigate. This was resolved the next day. SO B and Nurse B agreed that the risk remained raised and that the frequency of observations should remain unchanged. The nurse recorded that there were some signs that the man was planning for the future.
50. The man saw Dr A again on 7 June. He told the psychiatrist that he spent all of his time in his cell, did not mix with other prisoners and did not watch television. He said that his appetite was okay but that he was only sleeping fitfully. The man told the psychiatrist that he wished he was dead and would take a lethal pill if one was available, but would not try to take his life unless he knew he would succeed. He said that he would not cut himself again. The doctor recorded that he did not think that the man was suffering with a depressive disorder although his mood was subdued, but that he might have an adjustment disorder. (This is when the individual is unable to cope with a particular situation or event and experiences symptoms similar to depression. However, unlike major depression, the symptoms normally resolve once the individual adapts to the situation.) The doctor wrote that staff needed to encourage the man to mix and exercise and that thought should be given to moving him to a normal prison wing where he could benefit from a wider range of activities.
51. Dr A told the investigator that the symptoms of a depressive disorder are normally low mood, low energy levels, poor appetite and concentration and problems sleeping. People suffering depression may also have suicidal thoughts, although the psychiatrist explained that it is possible to have suicidal thoughts without being depressed. Both the doctor and the CMHT team leader told us that the CMHT at Winchester does not use any of the standardised tools developed for use in primary care (such as by general practitioners) to help diagnose depression. They said that, given their specialist knowledge of mental illness, they preferred to use their clinical experience and judgement when assessing patients. The doctor said that he remained open minded and continued to monitor the man for signs of depression or a deterioration in his mood. In the absence of a diagnosis of depression, the doctor did not think it appropriate to prescribe the man anti-depressant medication.

52. Dr A said that he was aware of the letter the man's daughter had written and her concern that the man was displaying multiple personalities. He said:

"I must say it's very clear that the daughter was very concerned that her father had a mental health problem and needed mental health care. Now as far as I was concerned he was getting mental health care which was quite frequent, daily contact with our team and ... I hadn't identified an illness for instance, that required medication nor did I establish any basis for transferring him to hospital."

At interview, the CMHT team leader said that she and her colleagues were already concerned about the man, but she did not think he was displaying multiple personalities.

53. SO B chaired another ACCT case review at 10.00am on 8 June, attended by the man, the CMHT team leader, Nurse C and Officer D. The man said that he was feeling a little better and his appetite was returning. The group discussed his daughter's letter to the healthcare department and the man said that he was glad she had written. He said that he knew he would have to move to a normal prison wing at some point, but that he did not want to do so until he felt settled. He agreed to start mixing with other prisoners to prepare himself. Once again, the man denied any thoughts of suicide or self-harm and the frequency of observations was reduced to once each hour. Staff were also instructed to record details of every conversation they had with the man in his ACCT plan. Over the following days, a number of ACCT entries give basic information about officers' verbal exchanges with the man, however none detail more in-depth conversations.
54. Entries in the man's ACCT plan note that he spent most of each day in his cell asleep or reading books. Staff wrote that he did not mix with other prisoners or exercise, but collected his meals regularly, showered and cleaned his cell. They noted that he was cooperative and would talk to staff but kept to himself and rarely asked any questions.
55. On 12 June, the man received a visit from his solicitor. The next morning SO B, the CMHT team leader, Officer D and the man met for another ACCT case review. The man said that the legal visit had been difficult but had gone okay. He said that he was enjoying reading books for the first time in some years and was able to concentrate. At interview, the CMHT team leader said that she looked for signs that the man was depressed. She explained that he sometimes had some of the core symptoms of depression and sometimes did not and so staff continued to monitor him. Dr A agreed, and described the man's mood as fluctuating.
56. The man told the staff that he wanted to spend some time in the chapel on the day of his wife's funeral, but did not yet know when that would be. This information was entered onto the ACCT caremap and SO B contacted the chaplaincy department to arrange this later that day. The man said that he did not want to move to a normal prison wing until after the funeral. The staff

considered that the man remained at a raised risk of self-harm and the frequency of observations was unchanged.

57. Dr A saw the man again at 11.00am on 15 June. The psychiatrist noted that the man was tearful but that there was no evidence he was suffering with depression. The doctor wrote that the man said that he had no specific suicidal intent and no means to kill himself. The doctor explained to the investigator how he assessed suicidal intent:

“... when assessing suicide I would be asking whether or not someone has ideas of trying to kill themselves ... and then if they do whether or not those are fleeting and things which they dismiss, or is it something which is very much on their mind and is there an indication that they really intend to carry that out, and further if that is the case, is there a plan, have they got the means, and so it's really a three sectioned assessment ...”

Dr A was asked whether he felt that the man was suicidal. He explained that he remained concerned that the man was under a great deal of stress because he was facing a murder charge and had lost his wife. However, he said that the man's thoughts of suicide were not constant. The psychiatrist explained that part of the purpose of his sessions with the man was to explore whether he had worked out a lethal method of suicide, which the man denied. The psychiatrist said that all of the information he gathered and his clinical judgements fed into decisions about the most appropriate levels of observation.

58. On 19 June, the man was discussed at the healthcare morning meeting. The staff present agreed that his mood seemed much improved and he was interacting better with others. They agreed that he should remain in the healthcare unit until after his wife's funeral.
59. The following day, the man, the CMHT team leader and SO B met for an ACCT case review. The man said that he had heard from both of his children and had written them a letter to try to explain events. The man said that his brother had been unable to visit the previous week but might visit that afternoon and might be able to give him information about his wife's funeral. The staff decided that the risk that the man might harm himself remained raised and the frequency of observations remained the same.
60. The man's brother visited on the afternoon of 20 June. During the visit, the man signed a general power of attorney, which was witnessed by a prison officer. In a general power of attorney, an individual authorises another to act on his behalf in private matters, such as property or business affairs, while he is unable or does not wish to. We have seen this document. The general power of attorney the man and his brother signed did not extend to decisions about the man's health and welfare.
61. The CMHT team leader met the man on 21 June. He told her that his wife's funeral would take place on 26 June and she passed the information to the

chaplaincy and recorded it in the ACCT. The man said that, after the funeral, he would concentrate on his criminal case.

62. On 23 June, the man's brother telephoned the prison to inform them of the man's wife's funeral. Officer E spoke to the man's brother. She told us that he was very concerned that the man might try to harm himself before the funeral. He also told the officer that the man's daughter had written asking him why he had killed his wife and that this might also increase the risk. The officer told the investigator that she tried to reassure the man's brother. She said that he told her that the man had previously tried to kill himself, but she did not recall him giving any specific information about the methods he had used. She did not remember being told that the man had tried to swallow a sock before. She told the investigator that she was quite sure that had she been given such information, she would have included it in the email she immediately sent to the safer custody team (and which was shared with the investigator). The email set out the man's brother's concerns, what the officer had told him about the support being offered to the man and the action that she had already taken to make sure that other staff were aware.
63. After the telephone call ended, as well as sending the email, Officer E telephoned the healthcare unit and spoke to Officer F who updated the ACCT plan and alerted staff in healthcare to the concerns. Officer E said that she also spoke to the orderly officer (the most senior officer on duty) to discuss whether any further action was necessary, and they agreed that she had taken sufficient steps.
64. On 25 June, the modern matron in charge of healthcare, PO A, the Salvation Army chaplain, and other staff based in the healthcare unit discussed the man at the healthcare morning meeting and recorded details of the meeting in his medical record. The man had asked staff to post a letter he had written to his mother, which staff had read and been concerned about. In prison, a proportion of all incoming and outgoing mail is read. Sometimes, post is selected for monitoring because of intelligence, on other occasions, post is randomly selected. The PO explained that an officer read the man's letter because he had told her that he felt suicidal. As a result of the contents of his letter, the man's cell was searched and a letter he had written to his daughter was found which suggested that he planned to take his life.
65. The investigator and clinical reviewer obtained copies of the letters found in the man's cell. One of them, addressed to his daughter, details the events that led to his wife's death. In the clinical reviewer's opinion, the man's account suggests that he might have been suffering from some kind of mental disturbance with elements of paranoia at the time of the murder.
66. In the meeting minutes, staff wrote that the man had told them that he wanted to be left alone and would need all of his energy to get through the next day. They thought that he seemed motivated by his wish to spend time in the chapel at the time of the funeral, but recognised that this could also be an integral part of a suicide plan. The staff decided that he should be placed under constant supervision immediately after his wife's funeral. (In such

cases, the prisoner is normally placed in a cell with a barred gate, rather than a solid door. A member of staff is positioned outside the cell at all times. The purpose of constant supervision is to offer continuous support to the prisoner during a period of crisis and to prevent any acts of self harm.) It was decided that the constant supervision would be brought forward if there were any further developments or concerns. An ACCT case review was planned for later that day and the group agreed to discuss the man at the morning meeting the following day.

67. Later that morning, Nurse D made an entry in the man's medical record, noting that he was a very high suicide risk. She wrote that he was not talking about self-harm but was maintaining a "veneer of normality". The frequency of ACCT observations was increased to two per hour and staff were warned to be vigilant. Officers, healthcare staff, the CMHT and chaplaincy department were made aware of the new level of risk.
68. At 1.45pm, primary care mental health nurse A introduced herself to the man. The man admitted that he would find the day of his wife's funeral difficult but denied any plans to harm himself. The nurse told him that staff knew the following day would be very stressful for him and that it was likely he would be placed under constant supervision. The man said that he did not want this. He said that he did not want to mix with other prisoners or talk to staff, but wanted to be given time to cry. He acknowledged the staff support available to him. The nurse recorded that she would discuss her thoughts with the CMHT and officers.
69. PO A chaired the ACCT case review at 3.00pm attended by the man, community psychiatric nurse B, the modern matron, mental health nurse B, a student nurse and head of residence. The man said that he had written the letter to his daughter when he first came into prison and did not plan to send it, but the staff believed it had been written recently and that the man intended to send it after his wife's funeral. They challenged the man about not being open with his feelings after which they recorded that he became tearful and opened up a little. The PO noted that staff needed to build relationships with the man to help manage the risk better.
70. The group decided that the man should be placed under constant supervision immediately. PO A told the investigator that staff were concerned that the man was unnaturally fixated on his cutlery and they decided that it should be removed from his cell. He said that other items would be removed from the cell if staff thought the man might use them to self-harm. The man said that placing him under constant supervision would not help him and he did not want to be watched. The man was considered to pose a high risk to himself. Another review was scheduled to take place after his wife's funeral. Appropriate entries detailing staff's concerns were made on P-Nomis and SystemOne.
71. Officer G based in the healthcare unit, was responsible for constantly supervising the man immediately after the case review meeting. She noted that he thought the decision to constantly supervise him was unfair. He told

her that he would not kill himself because he was happy that he was now in contact with his daughter. The officer said that he understood that staff were concerned about him because of his wife's funeral.

72. The man spent some of the morning of 26 June in the chapel with a member of the chaplaincy team. The member of the chaplaincy team made an entry in the ACCT plan noting that he and the man had prayed and talked. He wrote that the man understood that his children had lost their mother and needed not to lose him too. He wrote that the man said he had written about taking his life the previous week and did not feel that way any longer.
73. The ACCT review was held at 2.15pm attended by PO A, the man, the head of residence, the community psychiatric nurse A, the modern matron in charge of the healthcare and the student nurse. The man said that he was relieved that the funeral had taken place and that he had spent time in the chapel. He brushed off any suggestions that he might harm himself but staff recorded that he made poor eye contact with them and his mood seemed flat. The prison staff involved agreed that he remained at high risk of suicide and that the constant supervision should continue, at least until the man had seen Dr A the next day. The man's cutlery was removed from his cell after he had eaten his dinner.
74. Dr A assessed the man again in the afternoon of 27 June. The man denied ever having had a specific plan to kill himself but said he had wanted to be with his wife. He maintained that he did not have an intention or plan to kill himself and that he would not know how to kill himself with any of the items remaining in his cell. The man said that he found the constant supervision stressful and was unable to use the toilet while being watched. The psychiatrist concluded that there were no signs that the man was depressed.
75. The investigator asked Dr A about the letters found in the man's cell. He said that he had been shown them all and said:

“... there are some statements [in the letter detailing events leading to his wife's death] which, in retrospect, could be the basis of delusional thinking or mental illness. Now when I interviewed the man he was quite plausible ... with hindsight, it may be that I made an error of judgement in judging that that was not the basis of mental illness ... looking specifically at the letter he wrote, he does make a number of statements which would suggest that there was something going on ... I interviewed him on the basis of having read the letter and my observations were, for instance, that he did not appear paranoid, there was no evidence he was hallucinating ...”
76. Later that afternoon, Dr A attended an ACCT case review chaired by PO A. The man and the duty governor were also present. The duty governor told the investigator that they talked for some time about the impact of the man's actions on his family. He said that he understood it would take time to repair relationships, if they could be repaired at all. The man told the staff that he did not want to kill himself because he knew how much this would upset his

family. He said that he wanted to work with his family and to contact his mother. The duty governor described him as someone who engaged with the staff and seemed to answer their questions honestly.

77. Although the man was still considered to pose a raised risk to himself, the staff involved agreed that the constant supervision could be reduced to three observations an hour with three recorded conversations each day. Because the duty governor still had concerns about the man, she suggested that his television be removed each night (because parts of it could be used to self-harm) and he was given anti-ligature bedding, which is difficult to tear. She explained that decisions to remove items from an at-risk prisoner's cell are usually made on the basis of specific information about the individual (for example, previous acts of self-harm) or knowledge of the most common methods of self-harm (tying things around the neck or cutting with sharp objects).
78. The duty governor and PO A both said that, from their non-clinical perspective, they did not see any signs of mental illness at the ACCT reviews they chaired. The duty governor described the man as articulate, intelligent and calm and collected. She said that she had read the letters found in the man's cell, but during the review she chaired saw no signs of paranoia. PO A told the investigator that he had worked with a number of prisoners with mental health problems and thought that he could recognise the signs of mental distress. He said that he thought some of the man's letter was strange and said that, on one occasion, the man said that he had been followed in the days leading to his wife's death. He thought this seemed a bit paranoid, but was not overly concerned by what the man said.
79. On 29 June, PO A chaired an ACCT case review attended by the man and Dr A. The man said that he felt edgy and anxious but had no thoughts of suicide or self-harm. He said that he was forcing himself to eat and was trying to read books, although he was struggling to concentrate. The staff concluded that the man now posed a low risk to himself and the frequency of observations was reduced to two an hour.
80. At 9.23am on 30 June, the man saw the primary care team leader complaining that he had had a headache for the last two days. She recorded that he had no history of recurrent headaches and prescribed him two paracetamol tablets. The man also said that he was having trouble sleeping because he was stressed. The primary care team leader said that she would discuss this with the CMHT. He was given more paracetamol that afternoon and the next morning.
81. Shortly before 1.00pm, Nurse E prescribed another two paracetamol. Officer G spoke to the man, who she thought seemed a bit "out of sorts". The man said that he did not feel well and still had a headache despite having taken paracetamol. The officer noted in the ACCT plan that the man seemed lower in mood than previously. The man was prescribed a further two paracetamol at about 9.30pm and again at 7.10am on 1 July. The modern matron in charge of healthcare told the investigator that prisoners on ACCT plans must

be observed when they take any medication and that the nurse administering it should check the prisoner's mouth to see, as far as possible, that he has swallowed it. This reduces the risk that the prisoner is hoarding medication to overdose. Although the nurses who dispensed paracetamol to the man recorded that they had done so in the medical record, none of entries showed that any consideration had been given to his risk, or that they had observed him swallowing the tablets. That said, there is no evidence to suggest that the man was hoarding medication.

Sunday 1 July

82. Officer G was on duty again on the morning of 1 July and noted that the man seemed very low in mood and was sitting on a chair, staring at the floor. She told the investigator that the man's mood seemed a lot worse than the previous day. At 11.50am, the duty governor spoke to the man because staff were concerned about him. She wrote in his ACCT plan that he seemed very low in mood and had not eaten lunch. The man told her that he felt a bit down, but had felt worse the day before. He said that he was worried that he had not had any letters from his family. He said he had no thoughts of self-harm and asked to make a telephone call. He tried to make a call but does not appear to have spoken to anyone. The duty governor concluded that no further action was necessary for the time being and that an ACCT case review was scheduled to take place the next day.
83. At 2.35pm, Officer G wrote that the man seemed paranoid and he was convinced that an officer had been talking about him to another prisoner. Officer G told the investigator that the officer was talking to one of the unit cleaners in the kitchen, near the man's cell. She recalled that they were talking about holidays but the man believed that they were talking about his case. Officer G reassured him that they were not talking about him and said that he seemed to accept what she said. He was given another chance to telephone his brother, but said that the number had been deactivated from his pin phone account (which was not the case).
84. Officer G offered him another telephone call at 3.00pm. The man replied "If I do, will you let me go?" and said that he wanted to speak to his brother to thank him. When the officer asked him to explain what he meant by letting him go, he refused to talk. The officer reminded him that he could speak to Listeners or the Samaritans but the man asked that he be given five minutes to think. At 3.45pm, Officer G and another officer went into the man's cell. Officer G told the investigator that the man was standing behind the privacy screen (a waist high panel which gives the prisoner some privacy when using the toilet) "doing something" with his plastic knife. The two officers thought that he might have been trying to sharpen it so that he could use it to self-harm.
85. The man tried to convince the officers to give him five minutes to kill himself, telling them that he wanted to be with his wife. The man's television, lighters and all plastic items he could use to harm himself were removed from his cell

and the duty governor was contacted. Officer G said that she was very concerned about him and thought that he seriously intended to take his life.

86. The duty governor decided that the man should be moved from his cell for a while because it was dirty and messy. Staff began to clean it for him and, as a result had further concerns. The duty governor told the investigator that a pool of drying liquid was found on his mattress, which could have been blood. She said that it looked like the man had tried to clear the liquid up. The duty governor said that there was some water and a white flannel in the cell sink and there were traces of apparent blood in the water and on the flannel. Officer G told the investigator that she had not seen the man using the flannel and, as far as she knew, neither had any colleagues. The duty governor said that the man was searched when he was taken from his cell, to make sure that he did not have any items, such as hidden razor blades, which he could use to harm himself. She told the investigator that staff did not see any injuries which might account for the blood.
87. While cleaning the cell, staff lifted the man's mattress and found he had placed a large number of cigarette ends under it. The duty governor said that the man had also been hoarding food and had breakfast packs, fruit and other food that he had not eaten.
88. At 4.00pm, the duty governor convened an ACCT case review, attended by a healthcare officer, Nurse F and the man. The staff questioned the man about his behaviour. The man said that he did not want to harm himself but had thought about it earlier that day. The man said that he had asked for five minutes alone to "get his head together". He said that he had suffered a nosebleed and had used the flannel to stem the bleeding, which is why it had blood on it. The duty governor wrote in the ACCT plan that the man was behaving oddly. While he answered her questions, he did not make any eye contact and his answers seemed rehearsed. The duty governor concluded that the man should be constantly supervised again because he posed a high risk to himself. She also decided that he should be placed in anti-ligature clothing (made from fabric that cannot easily be torn or used to create a noose).
89. At 4.17pm, the man spoke to his brother on the telephone for five minutes. (The investigator was given recordings of the telephone calls the man made between 27 May and his death. She listened to those that took place on 30 June and 1 July. It does not appear that prison staff listened to any of the man's telephone calls while he was at Winchester.) During the conversation, the man told his brother that "the whole prison" was saying that he was in prison for sexual offences against children. (There is no evidence to suggest that this was the case). He seemed worried that information about him might be circulating on the internet. The man's brother was clearly concerned about him and asked if he should contact the prison to alert someone. The man told him not to. At the end of the conversation, the man's brother urged him to ask to see a doctor and said that he was going to telephone the prison when they had finished speaking. He urged the man not to "do anything stupid". The man's brother told the investigator that he thought the man was displaying

signs of paranoia during the conversation and that he was very worried about him. After the call, the man was moved to the gated constant supervision cell.

90. The man's brother told us that he telephoned the prison on numerous occasions because he was worried about the man's wellbeing. He was able to provide the names of two members of staff whom he spoke to (one being Officer E, whose contact with him we have already described). There is no mention of the other calls in the man's prison record. The man's brother said that he telephoned the prison again on the afternoon of 1 July and spoke to SO C, who was the orderly officer that day. He said that he warned the SO that the man had previously tried to swallow socks to self-harm. The SO told the investigator that he could not remember all of the details of the call but said that the man's brother was worried that the man was going to harm himself. The SO knew that the man was on an ACCT in healthcare and reassured his brother that staff were already monitoring him. The SO told the investigator that he could not remember the man's brother mentioning the previous attempt to swallow socks. He said that because he knew that the man was already on an ACCT, he did not take any further action, such as to contact the healthcare unit, ask that the ACCT plan be updated, record details of the telephone conversation on P-NOMIS or inform the safer custody team.
91. The duty governor told the investigator that she did not know that the man had ever tried to swallow socks to self-harm. However, she had already decided that his socks should be removed in case he used them to make a noose.
92. The man was given his evening meal at about 5.00pm. Prisoners order their food several days in advance from a set menu. That evening, he had ordered a cold salad which included a hard boiled egg, whole and in its shell, potatoes and lettuce. Staff noted that he was picking at it during the course of the evening. The man's television (which he apparently never watched) and cutlery were removed from his cell that night.
93. The man did not eat all of his evening meal and he was allowed to keep it in his cell. When asked whether they had ever thought that food might be used to self-harm, PO A, Dr A, the CMHT team leader and the duty governor all said that, before the man's death, they had never heard of someone intentionally choking on food in an attempt to kill themselves. The duty governor said that she was more concerned that the man might stop eating because his mood was low. There was no policy about how long a prisoner might keep cold food in his cell.
94. Between 7.30pm and 9.00am, Officer H and Officer I were responsible for the constant supervision. The log they completed indicates that the man did not talk to them and did not sleep all night, but sat or lay on his bed smoking. At 8.40pm, Officer H wrote that the man told him his brother was due to visit the next day. When the officer remarked that would be nice, the man replied "it would have been" but would not explain what he meant. At 5.00am on 2 July, Officer H wrote that the man was very hard to engage in conversation and seemed very low in mood.

Monday 2 July

95. Officer J took over responsibility for the constant supervision at 7.00am and was due to finish at 12.30pm. The front cover of the ACCT plan suggests that, on 2 July, the man' level of supervision was reduced to two observations an hour and three conversations a day. It seems that this was an incorrect entry as the man remained constantly supervised that day.
96. Officer J told the investigator that although he had been an officer at Winchester for nine years, he had never carried out a constant supervision before. PO A explained that often constant supervision duties are carried out by staff who volunteer for extra shifts on over-time. When they cannot be covered by volunteers, officers are moved from other tasks. The PO told the investigator that, while some officers are naturally more suited to constant supervisions than others, all are expected to undertake them if necessary.
97. When he arrived in the healthcare unit, Officer J was briefed by the two officers monitoring the man. He said that they told him the man had not slept all night. The officer was told that he would need to make coffee for the man if requested and also light his cigarettes because his lighter had been removed from the cell. The officer said that the man was in anti-ligature clothing and his television had been removed overnight. The officer was told that the man had in his possession a polystyrene container with some of the previous evening's dinner in it. The officers who had been on duty overnight told Officer J that the man had not talked to them.
98. Officer J explained that he sat on one of the chairs outside the cell (which are positioned about six feet away from the cell gate). He told the investigator that he knew he had to make regular entries in the constant supervision log. He thought that he was allowed to read a book or paper or similar while covering the constant supervision and told the investigator that he had a book of number puzzles with him, which he worked on from time to time during the morning. The officer said that he did not introduce himself to the man (whom he had never met before) or try to make any conversation with him.
99. Later that morning, the man declined an offer to clean his cell or shower and remained quiet. His only interaction with staff was apparently to ask Officer J for a light for his cigarette, which he did about every twenty minutes.
100. At 10.30am, the CMHT team leader went to the man's cell and tried to talk to him but she said that he was irritable and made it clear he did not want to speak to her. She told him that she would see him later in any case because another ACCT review was scheduled.
101. Between 11.10am and 11.40am, the man stood at the cell gate watching staff and prisoners in the healthcare unit. Officer J told the investigator that the man's food was on a table on the right hand wall of the cell. The officer said

that the table was positioned in such a way that he could not see it if he remained sitting on the chair. Some staff described this as a blind spot in the cell, however, the investigator checked and found that it was possible to see the area by standing at the cell gate. The officer said that shortly after 11.40am, the man moved to the table and the officer thought he was eating his food, which did not concern him. The officer described the sequence of events:

“He then moved away from the gate towards his salad, which didn’t cause me any great concern because I assumed, because he hadn’t eaten all night and hadn’t had breakfast, that he wanted something to eat. He wasn’t there for very long, seconds really. He’d been out of my eyesight so I immediately stood up, moved round to see if was eating because I then wanted to make an entry to say I’ve witnessed him eating. He then staggered, which is what immediately threw me into concern that he was staggering towards the back of the cell ... I then moved right up to the gate ... and he then slumped onto his knees and there was no movement. I immediately called for assistance. I unlocked the gate. I ran straight to him ...”

102. Officer J told the investigator that it was a matter of about 30 seconds between the man turning his back on the officer at the table and his collapse. He said that he did not hear the man make any noise and did not see him retch, gag or cough. The officer, who said that he had been a trained first aider for some 30 years, said that there were no indications that the man was choking and it did not occur to him that this might be the case. He laid the man down on the cell floor and noticed blood around his mouth. The officer tried to rouse the man but he did not respond and then began to convulse. The officer placed the man in the recovery position (which helps to facilitate breathing) and tried to check that his airway was open. He described the man’s jaw as locked firmly closed and he could not open his mouth.
103. Officer K who was working on the healthcare unit that day, said she was walking past the man’s cell when Officer J shouted for help. She said that she, rather than Officer J, unlocked the man’s cell and the two of them went into the cell together. She described the man as slumped with his back to the cell gate, and from the movements he was making she thought that he was being sick.
104. Officer K said that she walked past the man’s cell several times that morning and did not see Officer J doing number puzzles. She stated that she was telling the truth and was not covering for him. She felt that he, and all of the staff involved that day, could not have done any more to keep the man safe. Officer K told the investigator that she happened to be walking past the man’s cell when Officer J shouted for help. She said that she was sure she had unlocked the gate, but was aware that Officer J was sure that he had done so. She thought that both of them had their keys ready, which might account for why they both felt they had unlocked the gate. The officer described seeing the man’s shoulders moving in such a way that she thought he was being

sick. She said that it did not occur to her that he might have anything blocking his airway. She thought he might be having a heart attack.

105. Nurse D was in the healthcare unit office with a colleague when Officer F rushed into the office and asked them to help a patient who had collapsed. The nurse said that an emergency code system (red, amber and green) is in place at Winchester which is used to establish the seriousness of a medical emergency and helps healthcare staff take the right equipment to the scene. On this occasion, staff did not use the code system.
106. The healthcare office is very close to the man's cell and so Nurse D reached him quickly. She examined the man and found that he was floppy and his skin colour was poor and so she got the emergency medical bag from the treatment room, which was almost opposite the man's cell. The nurse told the investigator that she checked the man for a pulse and could not find one. His pupils were dilated and he was gasping for breath. She also thought that the man might be having a heart attack. She and some of the staff who had arrived began to administer cardiopulmonary resuscitation (CPR, the delivery of rescue breaths and chest compressions to artificially circulate oxygen around the body). The control room log records that an emergency ambulance was requested at 11.41am.
107. Nurse D told the investigator that the staff present managed to open the man's mouth and she looked into it and then used her finger to feel for any foreign objects. She said that she saw and felt nothing and was able to insert a Guedel airway (a plastic tube which is placed over an unconscious person's tongue and into the throat to maintain a clear airway during resuscitation). The nurse and the modern matron in charge of healthcare (who arrived at the cell while CPR was being carried out) told the investigator that there was no immediate evidence to suggest that the man's airway was blocked. The automated external defibrillator (AED, a machine which can deliver an electric shock to re-establish a normal heart rhythm) was attached to the man and instructed that staff continue CPR because he did not have a shockable heart beat. Dr B, a doctor working at the prison that day, also arrived to help. The doctor did not know the man but knew that he was on an ACCT and so thought that his collapse could possibly have been caused by an overdose of either opiate medication or insulin. She injected him with glucagon, which raises blood sugar levels, and nalaxone, which reverses the effects of an opiate overdose.
108. The ambulance arrived at Winchester at 11.44am and the paramedics had reached the man's cell by 11.50am. Nurse D told the investigator that they took over the man's care. The man was transferred to the ambulance which left the prison at midday. At 12.19pm, a hospital doctor discovered that there was something blocking the man's airway and was able to extract an amount of food (including the whole hard boiled egg, potato and lettuce) from it. He was placed on a life support machine.

Contact with the man's family

109. SO B, the appointed family liaison officer, telephoned the man's brother at 1.00pm. She explained that the man was in hospital and that he was in a serious condition.
110. The man's brother arrived at the hospital later that afternoon and met SO B and the member of the chaplaincy team there. Both of the man's adult children also arrived at the hospital later that evening. His family told us that, when his children arrived at the hospital, prison staff initially tried to prevent them from going to see the man, who was unconscious and on a life support machine. They were understandably very upset and said that, eventually, a doctor intervened and allowed them to see their father. SO B was not at the hospital when the man's children arrived and was unaware of their complaint. After we raised the issue with her, she spoke to SO D, the escort officer on duty and the only prison representative present at the time. SO D was also unaware that his children had initially been told they could not see their father. He told SO B that he had definitely not given any such instruction. We do not know who tried to prevent the man's children from visiting him.
111. The man's family decided that they would like to donate his organs for transplant. At 6.40pm on the day the man died, hospital doctors carried out two brain stem tests and concluded that the man had no brain activity. After some of his organs had been donated the life support machine was turned off and the man died.
112. In line with national guidance, the prison offered to make a contribution to the costs of the man's funeral. SO B attended the funeral and returned the man's property to his brother. During the course of the various investigations that were carried out after the man's death, his family became aware of the letters the man wrote and which had been found in his cell on 26 June. They were upset that they had not been given the letters when the man's property was returned to them. SO B told the investigator that, when they were originally found in his cell, the letters were photocopied because they formed part of the evidence for instigating the first constant supervision. They were then returned to the man so that he could send them if he still wished to. They were not found in his property after his collapse, suggesting that he had disposed of them. The copies of the letters formed part of the man's prison file, which is not immediately disclosed.

Support for prisoners and staff

113. A Governor's notice was issued informing all prisoners that the man had died. All prisoners on ACCT plans at Winchester were reviewed and offered support.
114. Staff interviewed as part of this investigation said that they had been offered sufficient support by their managers and from the prison's care and support team.

ISSUES

Assessing the man's mental health

115. In 1992, after assaulting his wife, the man made a determined attempt on his life. In the following weeks, he was twice treated as an inpatient in a psychiatric hospital. As we have already documented, there are discrepancies between the man's community medical records and his family's recollection of his diagnosis and treatment at that time. The medical records show that, in 1992, the man was diagnosed with depression and paranoid psychosis and was prescribed anti-psychotic medication, which he took for four months. There is no evidence to suggest that he complained of any further mental health problems or received any mental health treatment in the intervening years.
116. The man's family told us that his behaviour in the days leading to and straight after his wife's death strongly suggested that he was experiencing a similar mental health crisis to that he suffered in 1992. Because of the similarities between events in 1992 and 2012, the man's family are very concerned that the man was not diagnosed with a mental illness or prescribed any suitable medication in the aftermath of his wife's murder. They believe that in 1992, treatment in a psychiatric hospital with appropriate medication prevented the man from making any further attempts on his life. As a result, they feel strongly that, had he been prescribed medication on this occasion, he might well not have taken his life. They also consider that the man should have been held in a psychiatric hospital rather than prison. We have given careful consideration to the mental healthcare the man received at Winchester and the assessments of his mental health.
117. When he arrived at Winchester, the man was referred to the Community Mental Health Team (CMHT). He was frequently seen by the prison's consultant psychiatrist, Dr A and the CMHT leader. They accepted that a copy of the man's community medical record should have been requested and that there was no good reason for this failure. The clinical reviewer concludes that the community records probably did not contain any information which would have helped healthcare staff to reduce the man's risk to himself. However, they would have provided further information on which to base assessments. Paragraph 2.1 of Prison Service Order (PSO) 3050 'Continuity of Healthcare for Prisoners' notes that "[e]fforts should be made to retrieve any information required from the prisoner's GP ...". We make the following recommendation:

The Head of Healthcare should ensure that community GP records are routinely requested for all prisoners to ensure continuity of healthcare.

118. While in police custody, the man was prescribed sedative medication (although we do not know the strength of the doses he received, or how much). He was not prescribed any medication at HMP Isle of Wight and only paracetamol at Winchester. Both Dr A and the CMHT team leader said that their role was to assess the man's mental health on an ongoing basis. They

had read the letters found in the man's cell (which in the clinical reviewer's opinion showed some signs of disordered thinking, flitting ideas and a degree of paranoia). Both Dr A and the CMHT team leader said that they did not think the man was showing the symptoms of psychosis or paranoia. They considered that he might be suffering with adjustment disorder and shortly before his death, thought that he might be becoming depressed. They intended to continue to monitor him. In the absence of clear signs of a mental illness, the man was not prescribed medication.

119. The clinical reviewer concludes that the man was seen and assessed regularly by experienced specialists. He notes that patients who are not depressed do not benefit from taking anti-depressants "just in case". We appreciate that the man's family might well have been able to offer further insights into his mental health and we discuss the failure to involve his family. However, Dr A and the CMHT team leader (and non-clinical but experienced prison staff) were quite clear that, in their view, the man did not display clear symptoms of mental illness. Prisoners can only be transferred to a secure psychiatric hospital where there are genuine concerns about their mental health. In the absence of such concerns, the man was not deemed suitable for transfer.

Assessing the man's risk of suicide

120. The man was identified as at risk of self-harm and suicide on 25 May 2012 when he was arrested, and was constantly monitored while in police custody. Escort staff responsible for his welfare at court on 28 May continued to constantly monitor him. They also completed a suicide/self-harm warning form which noted the man's history of self-harm and his struggle to come to terms with events. He was monitored on an ACCT plan from his arrival at HMP Isle of Wight until his death five weeks later.
121. Prison Service Instruction (PSI) 64/2011, 'Management of prisoners at risk of harm to self, to others and from others (Safer Custody)' sets out a number of factors which can help to identify those prisoners most at risk of self-harm and suicide. They include factors such as having been charged with or convicted of a violent offence against a family member, a history of self-harm or suicide attempts, a history of mental illness and being in the early days of custody. Some of the factors in the PSI were highly relevant to the man. During his time in prison, the man gave further cause for concern by speaking openly about wishing he was dead, writing letters which suggested that he planned to kill himself and behaving strangely. His family were very concerned that he would attempt suicide and made their concerns clear to the prison. It was clearly quite right that the man was considered at high risk of suicide.

The ACCT process

122. The man's ACCT plan is a very detailed and comprehensive document which gives a good account of his demeanour and behaviour during his time at Winchester. The case reviews were held frequently and attendance was consistent. Either SO B or PO A chaired all but one of the 12 case reviews

that took place at Winchester. Consistent case management helps the case manager assess the individual's risk on an ongoing basis. It can also help the prisoner at risk to speak honestly about his thoughts and feelings without having to repeat his circumstances to a new person each time.

123. According to PSI 64/2011, case review teams must be multi-disciplinary where possible. Each of the case reviews carried out at Winchester was multi-disciplinary. The CMHT team leader and Dr A attended a number of reviews, and where they were unable to, other members of the mental health team or general healthcare staff were present. We are pleased that mental health specialists, who had regular contact with the man, were involved in the process.

Levels of observation and the constant supervision

124. The man's perceived level of risk was assessed at each ACCT case review. On some occasions, he was considered high risk and on others, raised risk. The levels of observations and conversations were altered accordingly. On 29 June, PO A and Dr A judged that the man posed a low risk to himself. This was the only occasion on which staff considered the man to be low risk. We are surprised that two experienced members of staff made this assessment. There was no evidence that the man's situation had changed or that any of the risk factors had been resolved. However, the man's overall ACCT plan shows that staff generally made considered decisions.
125. PSI 64/2011 instructs that observations must be at unpredictable times, for example twice an hour, rather than at half hourly intervals. Although the levels set in the man's ACCT reflect this guidance, the entries staff made in the ongoing record suggest that they conducted the checks at regular intervals. We make the following recommendation:

The Governor should ensure that staff conduct ACCT observations at irregular intervals.

126. On two occasions, from 25 to 27 June and from 1 July, the man was placed under constant supervision because staff were very concerned that he intended to take his life. The man was being constantly supervised when he died and so we have considered the quality of the supervision on the morning of 2 July. Officer J was responsible for the constant supervision from 7.00am that morning. He told the investigator that he had never carried out a constant supervision duty before. He thought that he was entitled to bring reading material or similar with him and said that, during the course of his duty, he completed some number puzzles. The officer said that he did not introduce himself or attempt to make any conversation with the man.
127. PSI 64/2011 instructs that "*[the member of staff conducting supervision must actively engage with the prisoner, encouraging them to talk and participate in activities where appropriate]*". The PSI does not make any reference to whether or not staff conducting supervision should be reading or otherwise occupied during the duty. In our view, it is self-evident that constant

supervision requires staff's full attention and concentration. It should not need saying that being otherwise distracted by a newspaper, puzzle book or television (unless the officer and the prisoner are reading or watching together) will adversely impact on the quality of the supervision.

128. We think it unlikely that Officer J is the only officer at Winchester to misunderstand the role of the constant supervision officer. His evidence is indicative of wider training needs at Winchester. Since the man's death, the prison has compiled new guidance about constant supervision. Amongst other things, it highlights that "the emphasis must be on interaction and not supervision" (the word is underlined in the document). However, little other specific guidance about how to conduct the supervision is given. For example, it does not offer any suggestions on what staff can and cannot do or how best to engage the prisoner. It is also not clear how this guidance is shared with staff. It would seem most appropriate for it to be attached to the ACCT plan for any prisoner placed on a constant supervision. In this way, all staff conducting the constant supervision could refer to it. Staff new to such duties need to be fully briefed about what is expected of them.

The Governor should ensure that all staff undertaking constant supervision duties are fully briefed beforehand about what is expected of them. The constant supervision guidance should be expanded to fully reflect the role and responsibilities and attached to the ACCT plan of every prisoner placed on a constant supervision.

Assessing items of risk

129. On 1 July, when the constant supervision was put in place, staff decided that, due to their concerns about him, almost everything should be removed from the man's cell. He was wearing anti-tear clothing, his television and cutlery had been removed, as had his lighter. The man apparently killed himself by blocking his airway with a whole hard boiled egg in its shell and other food which he had been allowed to keep from the previous evening.
130. Staff were asked whether they had ever considered food to be a risk item. Although some were aware of other items, such as toilet paper or tampons being used to deliberately block the airway, none of them had ever heard of food being used in such a way. This office has been responsible for investigating all deaths in prisons since 2004. In that time, two other prisoners have died as a result of apparently deliberately blocking their airways with food. We think it was fully understandable that staff did not consider that the man might use the food to kill himself. It is highly likely that staff at other prisons in England and Wales are similarly unaware of the risks and so we make the following national recommendation:

The Chief Executive of the National Offender Management Service (NOMS) should ensure that all prisons in England and Wales are made aware of the method by which the man took his life and that food should be risk assessed in the same way as any other item a prisoner at risk has access to.

Involving the man's family

131. The man's family were disappointed that they were not more closely involved in and consulted about the care provided to the man. Both his brother and daughter had contacted the prison to raise concerns about him. In so doing, they demonstrated their willingness to support the man and to engage with prison and healthcare staff. Their knowledge of the man could have helped staff make better informed decisions about him. For example, they knew which aspects of what he said or wrote displayed paranoid tendencies, they could tell whether his demeanour and appearance were normal and they had information about his previous medical history.
132. PSI 64/2011 instructs that "*consideration must be given to inviting the prisoner's family/next of kin where this is thought to be beneficial ...*" (the use of italics in the PSI denotes a mandatory action). Staff are instructed that they must note clearly any decisions relating to involving the family in the ACCT plan. PO A told the investigator it was not always easy to involve families in the ACCT process, particularly when the prisoner's offence was against a family member. However, he acknowledged that no one had considered involving the man's family in the ACCT process. The man's brother visited him at Winchester and could have been invited to an ACCT review. He could also have been invited to participate by telephone or in writing. The man's ACCT plan makes no reference to involving his family. We make the following recommendation:

The Governor should ensure that ACCT case managers give proper consideration to involving the prisoner's family in the ACCT process and record this in the ACCT plan.

133. The man's brother told us that he telephoned the prison on a number of occasions because he was worried about the man. He said that several times, he told staff that the man had previously tried to swallow a sock. Only one of the calls the man's brother made to the prison was logged (by Officer E). The man's brother gave the names of two members of staff he spoke to by telephone and both were interviewed. Both Officer E and SO C had no recollection of being told that the man had previously tried to swallow a sock. External telephone calls into the prison are not recorded and so we do not know the content of staff's conversations with the man's brother. We can only repeat the differing accounts. Shortly after speaking to the man's brother, Officer E informed the healthcare department and arranged for the ACCT plan to be updated. She also emailed the safer custody team with details of the contents of the conversation and spoke to the most senior officer on duty, all of which were appropriate actions. SO C said that he knew the man was already on an ACCT and so did not think that he needed to take any further

action. He did not make any note of the telephone call. It is important that staff are made aware when a prisoner's family raise concerns, even when the prisoner has already been identified as at risk, that a note should be taken, the ACCT plan should be updated and the safer custody team informed, as a minimum. We make the following recommendation:

The Governor should ensure that telephone calls from families expressing concern about the wellbeing of a prisoner are noted and logged and dealt with appropriately.

134. Staff were asked whether, had they known that the man had previously tried to swallow a sock, they would have made different risk assessments of the items left in the man's cell. While we understand it will be little comfort to the man's family, they said that it would ultimately not have made a difference. None of the staff involved said that they had ever considered food to be a risk item. When the duty governor began the second period of constant supervision, she decided that the man's socks should be removed, because she was worried he might use them to create a ligature to tie around his neck.
135. The man's family thought that, because a general power of attorney was in place, they would be able to make decisions about his treatment. In particular, they thought that they should have been able to insist that he was medicated. As noted earlier, the power of attorney the man and his brother signed did not give the family such control. The Mental Health Act 2005 introduced two lasting powers of attorney (LPAs). The LPA (Health and Welfare) allows the appointed attorney to make decisions about the individual's health and personal welfare if the individual loses mental capacity. The appointed attorney can only make such decisions once the LPA had been registered with the Office of the Public Guardian, and when the individual in question can no longer make decisions for himself. At no time did healthcare professionals consider the man to be unable to make decisions for himself. It seems that, in the given circumstances, no matter which power of attorney had been signed, the man's family could not have made decisions on his behalf.
136. The man's family felt that there was a delay in informing them of the man's collapse. SO B, who was appointed to act as the prison family liaison officer on 1 July, telephoned the man's appointed next of kin, his brother, at 1.00pm. This was an hour after he had been taken to hospital. We do not consider this was an inordinate delay, but it is worth bearing in mind that Prison Rule 22 requires governors to contact the prisoner's spouse or next of kin "at once" when a prisoner is seriously ill.

The Governor should ensure that families are informed as soon as possible when a seriously ill prisoner is taken to hospital.

The emergency response

137. The man collapsed in his cell at about 11.40am. Both Officer J and Officer K described a sequence of events which took 20 to 30 seconds to unfold. There is no CCTV footage covering the incident, but on the basis of the available evidence, we are satisfied that the staff response to the man's collapse was not delayed. It seems that Officer J was watching the man at the time of the collapse and was not otherwise distracted.
138. The ambulance was requested quickly and arrived at the prison within four minutes of the call. Paramedics reached the man within ten minutes of his collapse.
139. None of those who were involved in the emergency response realised that the man had a blocked airway. Nurse D checked the man's mouth for signs of an obstruction and found nothing. She was also able to fit a Guedal airway. After the draft report was published, the clinical reviewer confirmed that, in his view, the man was treated appropriately given the circumstances – CPR was commenced and the prison doctor gave him injections to reverse the effects of a possible overdose. It was only when the man arrived at the hospital and staff were able to examine him using more advanced equipment that they discovered that items of food were lodged some way down his airway. Sadly, by this time, the man had suffered irreversible brain damage.

CONCLUSION

140. The man took his life five weeks after being remanded into custody for the murder of his wife. He was considered to be a high suicide risk and was consequently monitored under suicide prevention measures for the entirety of his time at Winchester. He was being constantly supervised when he apparently deliberately blocked his airway with food. In our experience, this was a very rare set of circumstances.
141. We are satisfied that the mental health care the man received at Winchester was appropriate, although we appreciate his family's concerns that he had not been diagnosed with or treated for a mental illness. We conclude that, generally, staff worked hard to keep the man safe. While the man's death was foreseeable, we do not think that more could reasonably have been done to prevent it.

RECOMMENDATIONS

The NOMS response is given in italics beneath each recommendation.

1. The Head of Healthcare should ensure that community GP records are routinely requested for all prisoners to ensure continuity of healthcare.

This recommendation was accepted. NOMS confirmed that “Healthcare will request health records of ALL new prisoners to HMP Winchester. Urgent requests will be within 24 hours and routine 48 hours.”

2. The Governor should ensure that staff conduct ACCT observations at irregular intervals.

This recommendation was accepted: “Governors order to be issued stating that all ACCT observations should be conducted at irregular intervals. Local Safer Custody policy to be updated to include guidance.”

3. The Governor should ensure that all staff undertaking constant supervision duties are fully briefed beforehand about what is expected of them. The constant supervision guidance should be expanded to fully reflect the role and responsibilities and attached to the ACCT plan of every prisoner placed on a constant supervision.

This recommendation was accepted: “Review and publish Constant Supervision Guidance for staff undertaking those duties. These to include what is expected of staff. Introduce a protocol to ensure that all staff undertaking Constant Supervision Duties sign to say they have read and understood the role and responsibilities. To introduce a system to ensure that a copy of the Guidance is attached to each ACCT document of all prisoners subject to Constant Supervision.”

4. The Chief Executive of the National Offender Management Service (NOMS) should ensure that all prisons in England and Wales are made aware of the method by which the man took his life and that food should be risk assessed in the same way as any other item a prisoner at risk has access to.

This recommendation was accepted. The Offender Safety, Rights and Responsibilities Group (within NOMS) will circulate the details through the regional safer custody forums.

5. The Governor should ensure that ACCT case managers give proper consideration to involving the prisoner’s family in the ACCT process and record this in the ACCT plan.

This recommendation was accepted: “A protocol will be written to instruct that an entry will be made in the ACCT document at the “First Review” that consideration has been given to the inclusion of the prisoner’s family in the ACCT process. Notice to Staff to be issued to inform all staff of the new protocol.”

6. The Governor should ensure that telephone calls from families expressing concern about the wellbeing of a prisoner are noted and logged and dealt with appropriately.

This recommendation was accepted: "A local protocol to be written on what actions should be taken by any member of staff receiving a telephone call from anyone expressing concern for a prisoner's wellbeing. Notice to staff to be issued advising all staff of the new protocol."

7. The Governor should ensure that families are informed as soon as possible when a seriously ill prisoner is taken to hospital.

This recommendation was accepted: "Protocol to be written for Duty Governors and Orderly Officers as an Aide Memoire to consider contacting the next of kin when any seriously ill prisoner is sent to outside hospital."