Circumstances surrounding the death of a male prisoner from HMP Winchester, at the Royal Hampshire Hospital in November 2005

Report by the Prisons and Probation Ombudsman for England and Wales

March 2006

This is the report of an investigation into the circumstances surrounding the death of a male prisoner at the Royal Hampshire Hospital, Winchester, on 29 November 2005. At 2.55pm the previous day, the prisoner had been found hanging in his prison cell. At the time of his death, he was serving a prison sentence at HM Prison Winchester.

A post mortem examination conducted on 2 December found that the prisoner's death was caused by hanging. The prisoner was 37 years of age.

The investigation was carried out by my colleagues. I also commissioned an independent clinical review of the management of the prisoner's health needs while he was in custody. This was conducted by a representative of the Mid-Hampshire Primary Care Trust (PCT). I am most grateful to the PCT for their work.

I should also like to thank the Governor and staff at Winchester for their help and co-operation during the course of this investigation.

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Prisons and Probation Ombudsman **March 2006**

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Summary

The prisoner was arrested on suspicion of wounding in the early hours of 30 May 2005. He was taken to a police station near Southampton, where he was assessed by a Forensic Medical Examiner who considered that he was at risk of self-harm. The prisoner was taken to Southampton Magistrates' Court the following day. He was remanded in custody and taken to Winchester prison, arriving at 3pm.

During the reception procedures at Winchester, no formal health screen was completed. However, the nurse who saw him noticed that the prisoner was extremely withdrawn, uncommunicative and, at times, tearful. He was therefore admitted to the healthcare centre and made subject to formal self-harm monitoring procedures through the ACCT system (Assessment, Care in Custody and Teamwork). Initially, he was placed on a constant watch.

The prisoner remained in the healthcare centre for nearly three months. Whilst there, he twice attempted to harm himself. On the first occasion, he made indentations in his abdomen with a plastic knife. On the second occasion, he attempted to hang himself in his cell using a television cable. Frequent and regular ACCT case reviews were convened in order to monitor the prisoner's risk. Observation levels were varied in keeping with his fluctuating mood and behaviour. The prisoner was also regularly reviewed by the prison doctor, by a psychiatrist, and by a Community Psychiatric Nurse (CPN).

On 20 August, it was considered that the prisoner's mental state was such that it was safe for him to be discharged from the healthcare centre to a wing where unconvicted prisoners are normally held. Here, the prisoner shared a cell. As a precaution, the formal self-harm monitoring procedures were continued for two more weeks. The prisoner's ACCT form was closed on 6 September. His mental state remained under observation by the CPN until 13 September, when he told her that he felt no need for further consultations. The CPN nevertheless planned to review the prisoner again once his trial had ended.

In October, the prisoner joined a sports injuries course in the prison's gymnasium. By all accounts, he enjoyed the course and made good progress.

On 21 November, the prisoner's trial commenced at Southampton Crown Court. Two days later, he was sentenced to two years imprisonment. The CPN was not told of this and did not see him as she had intended.

During the weekend of 26 and 27 November, the media published details of the offences the prisoner had committed. According to a friend, this was the cause of much humiliation and embarrassment to him. During the weekend, he stopped eating and hardly left his cell. His cellmate reported his concerns to an officer who initiated fresh self-harm monitoring procedures.

On the afternoon of Tuesday 28 November, the prisoner declined an opportunity to take exercise. Instead, he remained in his cell alone. At about 2:55pm, an

officer found him hanging from the bars of his cell window. No suicide note was found.

Prolonged attempts were made by prison staff and by a paramedic crew to revive him. As a result, a slight pulse was detected. The prisoner was therefore transferred to the Royal Hampshire Hospital adjacent to the prison, where he died at 4:30pm the next day.

The investigation found that the care afforded to the prisoner in Winchester was appropriate. The attempts made by staff to revive him are commendable.

I make nine recommendations and draw attention to a number of examples of good practice.

2. Investigation methodology

The investigation began on Friday 2 December when my investigators met with the Governor, the chairman of the Independent Monitoring Board (IMB) and the chairman of the local branch of the Prison Officers' Association (POA) at Winchester. My investigators explained to them the nature and scope of the investigation and the report handling process.

On the same day, notices were issued to staff and to prisoners announcing the investigation and inviting anyone with concerns or information relating to the prisoner's death to make themselves known to my investigators.

During the course of the investigation, the prisoner's former girlfriend was contacted by one of my Family Liaison Officers. The woman said that she was in touch with the prisoner's family and would make sure that they were given the contact details for my office. She later expressed a number of concerns but neither she, nor the prisoner's family, wished to meet with my colleagues at that stage. The concerns she expressed have been addressed in this report.

A wide range of nursing, medical, and discipline staff were formally interviewed. Informal discussions were held with other prison staff, the CPN and a prisoner.

On 14 December, my investigator wrote to the prisoner's former cellmate at his home address to invite him to be interviewed. Although the cellmate confirmed in writing that he was willing to be interviewed, he did not respond to any further communications from my investigator. It has therefore not been possible to interview him.

3. The deceased

The deceased prisoner was born in 1968. He left school with a number of 'O' levels and then attended college where he completed a City and Guilds qualification in Mechanical Engineering.

After the age of 26, he lost all contact with his parents and siblings.

In March 2004, when he and his then girlfriend were asked to leave their accommodation, he planned to go abroad with her to work. Four days before they were due to leave, his girlfriend told him that she did not want to join him and that she wanted their relationship to end. Shortly afterwards, the prisoner became depressed and attempted suicide by running a hose-pipe from the exhaust pipe of his car through the car window. Later, he travelled to Greece where he remained in deep despair. After five weeks, he returned to England.

On 30 May, the prisoner broke into his then girlfriend's flat. He intended to see her and then to commit suicide. He lay under her bed and, when she returned to the flat with her new boyfriend, assaulted her. The prisoner was later arrested.

On 31 May 2005, he appeared at Southampton Magistrates' Court where he was remanded in custody.

At HMP Winchester, he became involved in projects for 'Children in Need' and undertook a course in Basic Sporting Injuries.

He was 37 years old when he died.

4. HMP Winchester

HMP Winchester is a Victorian local prison that can hold up to 695 adult male remand and sentenced prisoners. One of its units, Westhill, operates as a resettlement unit.

At the time of the investigation, healthcare was provided by the Prison Service under arrangements made by the Mid-Hampshire Primary Care Trust. These arrangements were about to be reviewed. The healthcare centre provides 24 hour medical and nursing cover and has inpatient facilities for up to 22 prisoners.

The prison was last inspected by Her Majesty's Chief Inspector of Prisons in December 2004. The report of that inspection commented that training in self-harm monitoring procedures was a high priority at Winchester. The investigation found that all staff had been trained in ACCT (Assessment, Care in Custody and Teamwork) procedures.

The inspection report also drew attention to the need to ensure that all ACCT care plan and review boards comprise a multi-disciplinary team. This investigation found evidence that this was still not being implemented consistently.

The death of this prisoner was the first self-inflicted death I have investigated at Winchester. In September 2003, another prisoner died by his own hand at the establishment. All recommendations stemming from the investigation conducted by the Prison Service into that death have been implemented. My investigators found that, although local contingency plans for handling a death in custody were in place, there were none for managing a life-threatening situation.

5. Events prior to 28 November 2005

At about 1:25am on 30 May 2005, the prisoner was arrested in Southampton on suspicion of wounding. He was taken into police custody at Lyndhurst Police Station at about 3am. He was seen in police cells by a Forensic Medical Examiner (FME) from 5:10am until 5:50am. The FME made the following comments on a Detained Person's Medical Form:

> "Very low since split with girlfriend 8 weeks ago after 5 years. Girlfriend started seeing someone else recently. Poor sleep and appetite. Made bankrupt recently. Previous medical history. Cut wrists aged 20s. Seen by psychiatrist. No illicit drugs recently. Cannabis years ago. Not in contact with his family.
>
> "On examination, tearful, low mood, few words. Wishes to kill himself. Also just wants his life back. Tried tonight to stab himself. Minor nicks to abdomen. Plan: need to be psychiatrically assessed."

The FME ticked a box on the form indicating that the prisoner's risk of self-harm was high.

The Hampshire Constabulary custody log shows that the prisoner was kept in police cells for the remainder of 30 May. He slept until about 1pm. At 3pm, he underwent a mental health assessment. This concluded that, although he was very distressed at times, he was fit to be interviewed. A recommendation was made that, in the event of his release from custody, he should receive support from a Community Mental Health Team.

On 31 May, the prisoner was taken to Southampton Magistrates' Court from Lyndhurst Police Station. The escorting staff noted on a Prisoner Escort Record (PER) that he was at risk of self-harm or suicide. The escort record was passed to officials at the court. As the prisoner was considered likely to commit further offences, he was remanded in custody. He was taken to HMP Winchester later that day by Reliance, a private security company. He arrived at Winchester at 3pm.

During the reception procedures, the prisoner was completely withdrawn and unresponsive. The reception officer on duty noticed that he had already been assessed as being at risk of self-harm by the escorting staff who had brought him to the prison. This information was recorded on a self-harm warning form that the officer read and signed. The form showed that the prisoner had made statements of intent to self-harm or commit suicide, and that he seemed very depressed. The source of this information was the prisoner's solicitor.

There is no evidence that the prisoner was subject to any formal health screen during the reception procedures. The nurse who saw the prisoner in reception told my investigators that she could not remember whether she completed a first or a secondary screen but that she would be very surprised if one was not done. However, she recalled that she was so concerned about the prisoner's mental state

that she decided he should be admitted straightaway to the healthcare centre. The nurse made the following entry in the prisoner's medical record:

> "16.40. Admitted to healthcare on constant watch.
> Very tearful on admission. States we don't understand.
> Proceeded to lie on bed and go to sleep. Pulse 84.
> Pupils reacting. Reflex reaction good. ACCT opened."

The ACCT form is used as a tool by which those prisoners who are considered to be at risk of self-harm or suicide can be appropriately observed, monitored and managed. In the form, the nurse wrote,

> "Came into reception tearful and non communicative.
> Has stated he would like to kill himself and wants his life back. Girlfriend left him eight weeks ago, made bankrupt recently. Has cut his wrist in past."

The prison doctor also saw the prisoner. The doctor decided to place him on a constant watch in a single, ligature-free, cell (H1-16) because he appeared to be severely depressed.

The establishment's Suicide Prevention Co-ordinator completed an ACCT Action Plan the same day. The action plan included the following:

> "Location: In conjunction with the doctor who expressed severe concerns recommends going in to a gated cell.
>
> Frequency of staff support: Level 1 obs until at least tomorrow's case review.
>
> Phone access: offer declined.
>
> Listener access: available.
>
> Other immediate interventions: Medical obs and test to see if o/d (overdose)."

The Suicide Prevention Co-ordinator told my investigators he vaguely recollected that the prisoner suggested he might have taken an overdose and was concerned that this possibility should be further examined. There is no evidence in the medical record to show whether any action was taken to follow up the Suicide Prevention Co-ordinator's remarks.

On 1 June, an entry was made in the prisoner's medical record showing that he was tearful and making wailing noises. Also recorded was the fact that he had secreted a plastic knife and had used it to try to inflict stab wounds to his chest. A form F213SH (the report of a self-harm injury sustained by a prisoner) was completed after this incident by a healthcare officer (HCO). The form showed that the prisoner had moderate indentation marks, but that his skin had not been punctured. The HCO also made an entry in the medical record to record this incident. As a result of

his attempt to self-harm, the prisoner was moved to a gated cell (H1-17). This type of cell is designed to enable staff to observe the occupant at all times.

At 3.25pm on 2 June, an ACCT assessment interview was carried out by a Prison Officer. The purpose of this interview was to assess the prisoner's mental state and risk of self-harm prior to the first multi-disciplinary case review that was to be held later that day. There is a requirement for such a review to be completed within 24 hours of the ACCT form being opened. My investigators were told that an attempt was made on 1 June to hold the review but, on that day, the prisoner was totally unresponsive to staff. The review was therefore delayed for 24 hours. The review was conducted by the Head of Healthcare, a Prison Officer who was the case manager for the prisoner at the time, and a prison doctor. The prisoner was present. The case review summary recorded that he was still feeling very upset, although he said that he felt better than he had two days earlier. He told the panel that he preferred to be in prison and seemed anxious when talking about release. A routine referral was made to the Community Mental Health Team (CMHT) with the prisoner's agreement. He also said he did not feel that he needed to be watched constantly. The case review concluded that the frequency of observations of the prisoner was to be reduced from a constant watch to level two (five times each hour) despite his attempt at self-harm the day before. At interview, the Head of Healthcare told my investigators that she could not remember at the time whether she knew of the prisoner's self-harm the previous day.

On 4 June, a further case review was held. This review was attended by a nurse, two Prison Officers and the prisoner. The case review summary recorded that the prisoner appeared brighter and more positive. It was noted that he had engaged in out-of-cell activities and that he had tried to establish contact with friends and solicitors. A decision was made to reduce the frequency of observations further, from level two to level three (twice per hour). The next case review was scheduled to take place on 14 June. In fact, it was held on 16 June.

On 7 June, the prisoner appeared at court. He was remanded in custody for a further week. The escort record for his court appearance noted that he was at risk of self-harm.

On 10 June, a student nurse compiled an initial Care Plan Approach (CPA) assessment in the presence of CPN. After recording details of the prisoner's psychiatric history, the nurse wrote:

> "Current presentation/mental state examination:
>
> Good eye contact, good engagement, though due to content of information given, was extremely tearful and emotional. Sleep pattern disturbed, but utilising sleep as a coping skill. Now accepting drinks and meals. Mental state not stable, can change rapidly dependent upon how he is thinking about events, situation etc."

The nurse added:

> "The prisoner is still at significant risk of further attempts at suicide. This is supported by his labile depressive state and the hopelessness he feels if he is not bailed. Has a number of unresolved issues ranging from child abuse and relationship difficulties."

The care plan recommended that the ACCT form should remain open, and that once bail had been agreed, and once the prisoner had arrived at his bail address, he should register with his GP. He should then access counselling and consider the use of anti-depressants. The risk management plan suggested he should continue with CMHT input and have access to Listeners (prisoners trained by the Samaritans to support other prisoners in crisis).

On 13 June, the prisoner's bail application was refused. He reacted badly to this decision. An entry made in the medical record shows that he was very depressed, quiet and withdrawn. The signature of the person who made the entry is illegible. In view of the prisoner's mental state, it was decided that he should be observed at level two (five times per hour) overnight.

At 10:30pm the following entry was made in the prisoner's ACCT form:

> "Looked in at 22:20 hours. The prisoner was writing a letter. At 22:30 hours, he was lying on the floor in the right hand side (FRONT) (sic) of his cell. We could not see his face and he did not respond to our calls. S.O was called over. He is now on level 2 obs."

At 10:45pm, the following entry was made in his medical record:

> "Officer informed that he can't see the prisoner. Laying on floor with head on side ... very depressed ... not talking, just lying there ... Put on level 2 obs for overnight observation … saying that the only way is to end it all."

At 11pm, the prisoner was seen still lying on the floor of his cell. However, at 11:20pm, he had moved onto his bed and was asleep. Regular observations were recorded in his ACCT form throughout the night. These show that he remained in his bed, either asleep or unresponsive, throughout the whole of the night and well into the next day.

At 11:40am on 14 June, the prisoner declined lunch. An entry made in his ACCT form at 1:20pm that day shows that he told a member of staff that there was "nothing to go on for".

An entry made in the medical record by a doctor on the following day records that the prisoner was "very morose and non-communicative, much as before." In view of the fact that the prisoner ate only one meal each day, the doctor noted his concern that his intake of food and fluids should be monitored. He also prescribed Fluoxetine, an anti-depressant drug.

On the same day, the prisoner compiled his own “get better plan”. In it, he wrote that he needed to understand why he was suffering from depression and that he wanted to stop his physical symptoms such as shaking, loss of appetite, and crying. He also wanted to rid himself of thoughts of self-harm. The prisoner wrote that he wanted to accept any help even if it involved the use of medication. He said he had intended to start counselling at his bail address but that this had not materialised as he had been refused bail. He said he wanted “to get off the hospital wing as soon as items like razor blades are only thought of as shaving implements”. He wanted to be “strong enough to not have irrational fear in social situations” and to prove that he was not going back to the same state that led him in to prison. He also wanted to forge links with his former girlfriend and her family so that the end of a loving relationship did not mean the end of his life. His concluding remarks in his “get better plan” were:

> “I need to discuss the way forward with someone who can give positive goals to attain and how to avoid pitfalls, since the time I had my breakdown and have had to talk with no input from anyone else. I am struggling on my own.”

A reference to the “get better plan” was made in the prisoner’s medical record after he had been seen that day during the doctor’s ward round. The doctor wrote that the prisoner was more positive and that he had discussed his depression with him. The prisoner agreed to taking Fluoxetine.

The review on 16 June was attended only by a Healthcare Senior Officer in his capacity as the prisoner’s case manager, and by the prisoner himself. The review summary described the prisoner as remaining low, but talking in a positive manner. Also noted was the fact that he was awaiting a visit from his legal adviser. Records show that the prisoner was visited by his legal adviser twice in June, twice in August and once in November, shortly before he was sentenced.

The next review was set for 30 June.

On 17 June, a Staff Nurse wrote in the prisoner’s medical record:

> “The prisoner is brighter in mood than previous meeting, despite bail being refused. Making a lot of self-motivated moves in understanding what has caused his depression and led him to his present situation. Has thoughts of self-harm but are not so frequent or severe. Refuses to use a razor currently. Is still dealing with low mood by sleeping but has improved mood by tea time, where he eats his one meal of the day. Will see again next week.”

This entry was countersigned by the CPN.

On 21 June, a doctor wrote in the medical record:

> “Has accepted anti-depressant and has much more positive attitude.”

The prisoner was seen again later that day by the CPN, who noted that his mood was deteriorating once again. The prisoner, she said, felt hopeless about the future and could not see anything but pain and loneliness. He was sleeping for a few hours at night, and had a poor appetite. At times, he was very low and tearful. The prisoner told the doctor that the only reason he had not killed himself was that he did not have the means to do so. He saw suicide as the only way to stop his pain. The doctor added that the prisoner was terrified that his lack of sexual feelings might become permanent. He felt that he was deteriorating. His sleep was becoming worse and his thoughts were becoming "like they were on the night of his offence". The CPN recorded that she advised the prisoner "to take things slowly and to try to do more in short bursts". She planned to see him again on 24 June. The CPN also made a record of this consultation in the ACCT form and added, "as his energy increases, he will be at increased risk of suicide".

At about 9.15pm on 22 June, the prisoner attempted to hang himself with a TV cable in a ligature free cell. This was recorded in both his medical record and the ACCT form. The entry made in the ACCT form said that the prisoner was

> "… found on the floor with a noose/cable around the outside of the cell door snapped. Prisoner on floor, opened cell door with officers and SO, put on bed. Small graze on neck."

A F213SH (report of a self-harm injury sustained by a prisoner) was completed by a Senior Officer who also noted that there was a small graze on the prisoner's neck. An entry made in the ACCT form shows that a decision was made to place the prisoner on a constant watch and that this decision was to be reviewed after 24 hours. The prisoner had an undisturbed night.

The following day, a case review was held. This review was conducted by two nurses. The prisoner was also present. The record of that review shows that his desire to die was still present. He told the panel that "just because it's a new day, it doesn't alter anything". He was very reluctant to engage in conversation. As he was already in a cell that was designated as ligature-free, it was decided that the frequency of observations could be reduced to level two. This level of observation required that the prisoner was to be observed five times in every hour. A record of each observation was to be made at the same frequency and, at times when he was awake, staff were required to record their conversations with him hourly. The record shows that this was done.

On 24 June, the prisoner was seen again by the CPN. She wrote in the medical record as follows:

> "The prisoner came to interview reluctantly, appeared extremely low, made no eye contact at all. Initially only monosyllabic responses, mumbled. Stated nothing to live for, feels dead, nothing good in life, no confidence can't trust anyone, no faith and no-one to love him. Feels it is getting worse. When asked about the hanging attempt, stated he had seen how to make a noose on TV. When it broke, he woke and 'felt pissed off'. He found the hanging experience pleasant. The phone call he made afterwards was to his partner

> whom he has asked to visit. He is expecting her today and wants to ask her why she doesn't like him any more. He is also going to ask her to stop seeing her new partner.
>
> I am concerned that this feels like a repeat of the circumstances of his index offence and would consider him to be HIGH RISK (sic) during and after the visit.
>
> Plan-ask the psychiatrist to see him as urgent on Tuesday 28/6."

The CPN also recorded these details in the ACCT form.

The records show that the prisoner's girlfriend did not visit him that day. However, she did visit him once in September, twice in October and once in November.

At 8:50am on Saturday 25 June, a further ACCT case review was held. This was chaired by a Healthcare Senior Officer and attended by a Healthcare Officer. The prisoner was again present. The review was summarised as follows:

> "The prisoner is refusing to eat or drink at present but is spending all his time lying on his bed and is making no physical effort to do anything. Will reduce level to three with the proviso level can be raised if required."

A doctor also saw the prisoner that day. The doctor wrote the following notes in the medical record:

> "Asked to see today. Has not been eating properly again, perhaps for several days. Has been seen to be drinking water and milk. He should be transferred to hospital for all care. I think his depression makes him not competent to choose to refuse food and drink to the death. We had a long chat and he told me that the anti-depressants had made him feel well enough to really hate himself and to try to kill himself. He has agreed with me and shook hands on it to treatments to get him well enough to be able to tell his story in court, that he was already low and depressed and thinking of death when he broke into his girlfriend's place to kill himself. In my presence, he went on to drink a pint of orange squash and has agreed to restart his anti-depressants. I have told him that he is ill with depression and that he cannot rationalise or explain it. But he has to accept that it exists and can be made better. I have also told him that because he is ill, I will not allow him to kill himself by neglect or by actions of his own hand. Plan was restart Fluoxetine, can have sleeping tablets at night. Encourage to be active throughout the day. Maintain level two observations."

The medical record does not make clear what time the doctor saw the prisoner or what time he made the above entry. At interview, the doctor told my investigators that he saw the prisoner during the morning. He made a corresponding entry in his

ACCT form against a time of 3:30pm in which he repeated the gist of his consultation but did not mention the need to maintain level 2 observations.
The level of observations instructed by the doctor differed from that recommended by the Healthcare Senior Officer. The record of observations maintained within the ACCT form show that staff made entries in the ongoing record at the following times that day:

Morning:	Afternoon:		Evening:	Night:
7:30	3:30	(Doctor's entry)	6:30	9:45
8:30	3:35		7:10	10:50
9:30			8:05	Midnight
10:40			8:25	
			8:50	

The frequency of these observations conforms neither to level two nor to level three. The entries suggest that staff may have been confused as to which level of observations applied.

The next review was scheduled to take place on 4 July.

On 28 June, the prisoner was assessed by a psychiatrist. The prisoner was tearful during the interview and expressed feelings of worthlessness and hopelessness. The psychiatrist diagnosed a depressive episode of moderate severity. He suggested that the prisoner should continue to take Fluoxetine. He also recorded his view that the prisoner continued to present as a high risk of self-harm and suicide.

On 4 July, a further case review took place as planned. This was attended by a Healthcare Senior Officer, a Prison Officer and the prisoner. The review was summarised as follows:

> "Remains unpredictable in mood. When coaxed becomes interactive and communicates. No real change in progress long term and just needs constantly encouraging."

A further case review was planned for 18 July.

On 8 July, the CPN saw the prisoner. Afterwards, she wrote in the ACCT form:

> "Continues to feel low and has no enthusiasm to do anything. Won't go on exercise as doesn't like sitting with people as he doesn't know what to say - this is very unusual for him. Sleeps lots day and night. Concentration poor. S/H (self harm) thoughts still there but not as often - feels he would not be safe *(sic)* on main wings as he would find any way to try to kill himself. Has plans but would not tell me what. Finds it extremely hard being inside when weather is fine - reminds him of what he would be doing.
> Plan: discussed gym, would like to go but knows will need to be told what to do and when to go. To be referred (to gym). To be reviewed in 7 days."

On 9 July, it was noted in the ACCT form that the prisoner refused exercise. On 11 July, the following entry was made:

> "Enjoyed education session - has decided on a course he will study. Was much happier, laughing, than last time. Talked about how he can occupy his time by reading and studying."

Thereafter, for a short time, the prisoner began to show signs of improvement. A number of entries made in his ACCT form show that, although, when his mood dropped, he continued to experience suicidal ideation, he nevertheless felt generally more settled. Entries made in both the medical record and the ACCT form variously recorded that he was "doing well", was in a "good mood", and was "predominately cheerful".

On 15 July, the CPN saw the prisoner again as planned. She wrote in the medical record:

> "At his brightest since coming into prison, though aware that he still experiences low moods at times which increase his suicidal ideation. Any transfer to wings should be considered with input from mental health team in respect of monitoring his mental state".

Further entries made in the ACCT form during the latter half of July show that the prisoner's mood continued to vary. On 19 July, the psychiatrist wrote:

> "Mood variable, low for two days (16/17). Less tearful. Ambivalent about self-harm when low. Bail application - will be at increased risk of self-harm if doesn't get bailed."

The next ACCT case review took place, as planned, on 18 July. This time, only the Healthcare Senior Officer and the prisoner were present. The Healthcare Senior Officer wrote the following remarks in the case review summary:

> "Still has his ups and downs in moods, but generally feels more settled with situation. Discussed future hurdles and how possibly to deal with them."

A further case review was to take place on 2 August.

Between 19 and 26 July, there were no further notations of any significance in the ACCT form. However, on 26 July, the CPN wrote:

> "States has struggled over past week and a half. Thought of how would kill himself but didn't make any attempts - feels good weather made him feel bad as he is unable to go out walking in it. Mood has lifted since and currently has no thoughts of suicide. Be aware, if he does not get released on bail on Monday (1 August) he will be a very high risk of suicide attempts. I will review on Tuesday."

During the following week, the prisoner remained in a stable, though passive, mood. At 9:30pm on 31 July, the eve of his court appearance, a member of staff in the healthcare centre made the following entry in the ACCT form:

> "Spoken to the prisoner, asked if okay. Said no not really. Asked if I could help. Said no. No-one can any more. Asked if he would like Listener. Said no thanks."

At 6:50am the next day, the Head of Healthcare wrote in the ACCT form:

> "In court today. 2nd bail application. Review if returns - at higher risk of self-harm. See trigger points."

Later that day (1 August), the prisoner appeared at Southampton Magistrates' Court. His application for bail was again refused. Upon his arrival back in the healthcare centre at 6pm, it was noted that he "was not happy with today's day at court". At 8:15pm, it was further noted that the prisoner was having a "quiet, settled evening", and that he was "responsive and appeared to be dealing with his day".

The prisoner was observed regularly through the night. After sleeping normally, he woke at 5:30am the next day. He then read for a while and fell asleep again. At 10am, he cleaned his cell and was described as "happy to interact" although "a bit fed up". At 4pm, he was seen by the psychiatrist who wrote in the ACCT form:

> "Mood better. No tearfulness. Thoughts self-harm at times. No current wish to act on thoughts."

The case review held on 2 August was attended only by the Healthcare Senior Officer and the prisoner. The case review summary described the prisoner as "rather down as was expected. Generally cheerful and philosophical in manner and looking positively at next court appearance."

On 16 August, the prisoner was seen again by the CPN, who made the following entry in the ACCT form:

> "Remains very angry re situation, determined to have revenge if he gets sentenced. Willing to start looking at his thinking and how it affects his mood and behaviour. Review in 2 weeks."

On 18 August, another review was held, this time attended by a nurse, a healthcare officer and the prisoner. One of the nurses summarised the review as follows:

> "Remains insular, spending majority of his time asleep as this makes time pass. Mood generally quite angry. Is spending time with CMHT, who are endeavouring to focus on positive approaches to his thoughts."

2 September was set as the date for the next case review. However, on 19 August, the Healthcare Senior Officer convened a review at which he and the prisoner were the only people present. My investigator was unable to establish

why this review followed so quickly after the review held the previous day. The Healthcare Senior Officer wrote in the review summary:

> "Sounds more positive and wants to go to the main prison as wants more to do. Discussed issues re coping and mixing with the main prison population, which he realises will be a challenge. Appears a lot more settled in mood."

As the Healthcare Senior Officer was not available for interview during the course of the investigation, my investigators were unable to discuss with him why the decision to consider the prisoner's discharge from the healthcare centre followed so quickly after the review on the previous day during which the subject of discharge was not mentioned. However, it is clear from an entry made in the medical record on 20 August that the Healthcare Senior Officer had discussed the prisoner's case with the CPN the previous day. The entry, made at 9am, reads as follows:

> "Discussed the prisoner's request to go to the main prison with the CPN yesterday. Agreed will follow up on the wing. Have had long discussion with the prisoner about issues on the main prison, i.e. feeling like self-harming and addressing those issues. Wants to do more as getting frustrated in HCC. Wants he says to go to gym and access library as examples. I voiced my concerns re manipulative behaviour (wanting to go to main prison and act inappropriately). Told if there were any concerns he would be moved back to HCC. Doctor involved in decision and aware of issues discussed."

A discharge care plan was made out by the Healthcare Senior Officer who wrote:

> "**Summary of inpatient stay:**
>
> Admitted initially for observation due to being withdrawn and self-harm issues. Has over time improved and now fit and has requested to go to the main prison. On ACCT which has been handed over to C Wing staff with briefing.
>
> **Discharge agreed by:**
> CPN
> Doctor
> Healthcare Senior Officer
>
> **Care plan whilst on ordinary location:**
> Will be reviewed by doctor and CPN within 7 days of discharge. Is aware of help from wing staff and Listeners. Continue and review ACCT."

The doctor told my investigators that, although he continued to have informal contact with the prisoner, he had no further formal consultations with him after his discharge from the healthcare centre.

At 10.45am on 20 August, the prisoner was transferred to C Wing where unconvicted prisoners are normally held. He was located in a shared cell (3-28). The ACCT form remained open. Regular entries were made in the ongoing record, although few of those entries reflect the level of interaction between staff and the prisoner. They paint a picture of a man who seemed to be content to remain in his cell reading or watching television rather than engaging in other activities. However, they do show that the prisoner's mental state did not deteriorate in the immediate aftermath of his discharge from the healthcare centre.

On 6 September, after the prisoner had ceased to show signs of suicidal ideation, a final ACCT case review was convened. At this review, a decision was made that the self-harm monitoring procedures to which he had been subject since his arrival at Winchester in May were no longer necessary. The ACCT form was therefore closed by a Senior Officer in the prisoner's presence. No other members of staff were present. A post-closure interview was to be held the following day. The investigation found no evidence that the post-closure review took place. The local suicide prevention policy requires that, following the closure of an ACCT form, prisoners should be interviewed every 14 days in order to measure the extent to which they are coping and that details of the interviews are recorded in their core prison file. Although the F2050A (Record of Events) contains a number of entries about this prisoner, none refers to post-closure ACCT interviews. My investigators could find no evidence that such interviews took place.

On 9 September, after a further appearance at court, the prisoner refused to change into prison clothing. He was charged under the prison disciplinary code. At the ensuing disciplinary hearing, he was given three days cellular confinement and stoppage of half his prison earnings for five days.

On 12 September, the prisoner appeared again at court. Once again, bail was refused. He was due to return to court on 17 November. The escort record noted no known risk of self-harm.

On 13 September, the prisoner was seen for the last time by the CPN. He made it clear that he wished to have no further input from her. The CPN told my investigators that this was a positive response from the prisoner. He said that he felt so much better that he did not require further help from her. Nevertheless, the CPN told the prisoner how to contact her should he change his mind, and told him that she intended to review his case after his trial. This was due to commence at Southampton Crown Court on 21 November.

In early October, the prisoner joined a Basic Sports Injuries course in the gym. This required his attendance every weekday for five weeks. My investigators were told by the PE staff that he was an able and enthusiastic student. They considered that his attitude during his time in the gym was consistently positive.

On 28 October, the prisoner was placed on a second disciplinary report for fighting. At the ensuing disciplinary hearing, he pleaded guilty to the charge. He was given stoppage of half his prison earnings for 10 days and loss of canteen (use of the prison shop) for seven days.

On 21 November, the prisoner’s trial began at Southampton Crown Court. On 23 November, he was sentenced to two years imprisonment. Staff at Winchester thought that the length of the custodial sentence was a pleasant surprise to him.

The CPN told my investigators that she was not informed by staff in the prison that the prisoner had been sentenced, and that she was disappointed that she could not therefore review his case as she had intended.

During the weekend of 26 and 27 November, following his sentencing, details of the prisoner’s trial were reported in the national and local media. A fellow prisoner told my investigators that this was a source of significant distress to him. That prisoner said that, during the latter half of October and the whole of November, they spent many hours in the gymnasium together as students on the Sports Injuries course. Apparently, the prisoner enjoyed his participation in the course and, although he often talked about his domestic circumstances, he did not display any signs of depression or suicidal thoughts. The prisoner’s friend knew there had been widespread publicity over the weekend which had given lurid accounts of his offence. The friend said he tried to prevent the prisoner seeing any newspapers. However, he told my investigators that another prisoner, whom he did not wish to identify, passed a press cutting underneath the deceased prisoner’s cell door. The friend said that, immediately after seeing the article, the prisoner suddenly changed. He did not leave his cell, did not eat and did not engage with anyone. The friend blamed the media coverage for the prisoner’s death.

On 27 November, a Prison Officer was told by the prisoner’ cell mate that the prisoner was not eating. When the officer spoke to the prisoner, he explained that he was not on a hunger strike and was drinking regularly. As the officer knew that the prisoner had already been subject to self-harm monitoring procedures, he decided to open a further ACCT form. The prisoner was to be placed on level three observations. An immediate ACCT action plan further required that he should be kept in a shared cell, and that he should be given access to telephones and to Listeners as required. He was also to have his meals delivered to his cell each day so that his eating pattern could be closely monitored. The prisoner was to be seen by someone in the healthcare centre as soon as possible. There is no evidence in the ACCT form or the medical record to show whether he was seen the next morning by anyone from the healthcare centre.

The first entry in the new ACCT form was made at 5:45pm on 27 November, when a Prison Officer recorded that the prisoner said that he “was ok”. Later that evening, a note was made in the record that he was seen lying on his bed watching television and that, at about 10pm, he appeared to be asleep. Further entries were made in the record at hourly intervals throughout the night. Each entry shows that the prisoner was observed as being asleep.

At 6:35am on Monday 28 November, the last entry was made for that night. It recorded that the prisoner appeared asleep on his back and that there were “no problems at staff handover”.

6. Events on and after 28 November 2005

No further entries were made in the record until 9:40am on 28 November when the Duty Governor recorded his management check of the ACCT form. He commented that a review date was to be set. The first review would have been due that day. An entry made in the ACCT form by the establishment's Suicide Prevention Co-ordinator shows that he was planning to convene a case review on the prisoner that afternoon.

An entry made at 12:10pm that day by a Prison Officer shows that the prisoner was "laid in bed. When asked if he was ok, said 'yes, marvellous pasta and potato put in his cell'."

It is normal practice at Winchester for officers to be deployed from one wing to carry out a task in another. This was the case when, at 2pm, the time came for prisoners in C Wing to be unlocked for exercise. The task of staffing the exercise yard fell to those officers available in C Wing. Once they were in place on the exercise yard, officers from A Wing unlocked C Wing prisoners for exercise. One of those officers was responsible for unlocking the prisoner's landing. However, the officer told my investigators that he could not specifically recall unlocking the cell in which the prisoner and his cellmate were located. However, it is clear that the cellmate left for exercise, and that the prisoner declined. He therefore remained locked in his cell, alone. The officer who unlocked him did not know that he was subject to an ACCT form.

At about 2:50pm, the cellmate decided he wanted to leave the exercise yard early. A Prison Officer offered to take him back to his wing as she wanted to see someone else on C wing. On returning the cellmate to his cell, the officer looked through the observation panel in the door and saw the prisoner hanging from the cell window by a ligature made from his bed sheet. The cellmate was immediately located elsewhere in the wing. As my investigators were unable to interview him, it has not been possible to establish what level of care he was given.

The Prison Officer immediately blew her whistle to alert other staff. She entered the cell, approached the prisoner and supported his body weight. Two other officers arrived soon after and together they helped to lift the prisoner so that the ligature could be removed. One of the officers told my investigators that he took about 20 seconds to untie the ligature. The prisoner was then laid on the floor of the cell in the recovery position.

Although there was no contingency plan in place to guide staff as to what procedures to follow when a life threatening situation is discovered, the Orderly Officer of the day nevertheless cordoned off the area and controlled access into, and egress from, the prisoner's cell. The Orderly Officer also appointed a log keeper who recorded events as they occurred.

Very soon after, two nurses arrived. They found that the prisoner was heavily incontinent of urine and was warm to the touch. No vital signs were evident. One nurse also said that the prisoner was heavily marked around his neck. She noticed some dried blood but no evidence of a major wound. The two nurses began to apply

cardio-pulmonary resuscitation (CPR) with the help of a Prison Officer. One of the nurses also alerted the communications room by radio to the need for the prison doctor and an ambulance to be called. She told my investigators that she asked three times for the doctor to come to C Wing and that, on the third occasion, she became cross because no-one had arrived.

At interview, the doctor concerned told my investigators that he was in Westhill Unit when he received a telephone call asking him to go to C Wing. He therefore terminated his consultation and left for C Wing. He said that he probably took about five minutes to reach the wing. It was only upon his arrival in the wing that he realised that the prisoner had been found hanging. He said that the person who called him merely said words to the effect, "the nurses would like you to attend C Wing. There's a problem there." The doctor was clear that he was not told that a prisoner had been found hanging.

A Prison Officer was in the communications room and in charge of the radio net at the time. Also on duty in the room were two further members of staff who were responsible for carrying out other tasks. The officer told my investigators that he received the nurse's radio call at about 3pm. He said that her call made it clear that there was a life-threatening situation in C Wing and that a doctor and an ambulance were required. The officer confirmed that one of the other members of staff in the communications room called an ambulance and made a telephone call to the healthcare centre asking for immediate assistance from the duty doctor. He said that, a few minutes later, the nurse asked again over the radio for the doctor to attend. The officer said that a further call was then made to the healthcare centre. It was then confirmed that the doctor was on his way.

The log shows the following:

3:00pm	Initial radio call made by the nurse requesting the presence of the prison doctor and an ambulance
3:01pm	Ambulance called
3:05pm	Ambulance arrived
3:07 pm	Doctor called again
3:09pm	Ambulance staff arrive on C wing
3.40pm	Ambulance leaves prison

Although the log does not show the time the doctor arrived at the cell, there is no reason to doubt that he went to C Wing as quickly as he could after receiving the telephone call in Westhill Unit. Any difficulties in contacting him were likely to be due to the fact that he did not carry either a pager or a radio.

While they were waiting for the ambulance to arrive, the staff in the cell continued to apply CPR to the prisoner. According to one of the nurses, an oxygen cylinder that had been brought to the cell appeared to be empty. Another cylinder was therefore requested. It was later confirmed that the original cylinder was fully serviceable but that it had not been turned on correctly. A defibrillator was also brought to the cell at the nurse's request. She later told my investigators that this could not easily be used on the floor because of the presence of so many body fluids. She therefore placed the

defibrillator on top of a cupboard but this too became problematic because the leads were not long enough for the pads to be attached to the prisoner's chest.

The resuscitation attempts therefore continued without the defibrillator. Two Prison Officers helped to apply oxygen while chest compressions were applied by the nurses. The nurses told my investigators that they thought that the prisoner was not likely to be successfully resuscitated. Nevertheless, they persevered until a paramedic crew arrived at the cell. Before they could use their defibrillator, the prisoner's bed had to be lifted and placed against the cell wall. The paramedic crew applied Adrenalin and then connected their own defibrillator to the prisoner's chest. They managed to achieve a slight cardiac output. They therefore decided to transfer the prisoner to the Accident and Emergency Department at the Royal Hampshire Hospital immediately adjacent to the prison. The prisoner had to be carried out of the wing to the ambulance in a "casevac chair". This difficult task was controlled by one of the Prison Officers.

The ambulance left the prison at 3:40pm and arrived at the hospital a few minutes later. When he arrived at the hospital, the prisoner's heart stopped beating but a cardiac output was soon restored.

The same day, the Governor chaired a debrief of the staff involved in the discovery of the prisoner and in the attempts to revive him. Those staff interviewed as part of the investigation said that they were satisfied with the level of care offered to them by the Governor, his senior managers and the establishment's care team.

As no next of kin details were given by the prisoner when he was initially received at Winchester in May, the Duty Governor in the prison at the time telephoned the prisoner's solicitors to find out if they were aware of any next of kin. They were not. The Duty Governor therefore used the prison's record of telephone calls made by the prisoner through his phone card to establish an appropriate contact number. By this means, the Duty Governor was able to contact the prisoner's former girlfriend at about 4pm to inform her of what had happened. She arrived at the hospital later that day.

At about 5:40pm, the prisoner was transferred from the Accident and Emergency Department to the intensive care unit where he was placed on a life support machine. During the night, his condition began to deteriorate. He died in the hospital at 4:30pm the next day. Following his death, his former girlfriend was invited to the prison where she spent time talking to staff and to the prisoner's friend.

The Duty Governor informed the prisoner's solicitor of his death on 30 November and asked him to take on the role of next of kin if no family members could be traced. At 10:45pm that day, the prisoner's sister-in-law called the prison. The next day, during a telephone conversation with the Duty Governor, she confirmed that the prisoner's parents and three siblings were aware of his death and that they wanted to be involved in arranging his funeral. She passed the Duty Governor their contact numbers. Some time later, the prisoner's parents made contact with the Duty Governor.

The prisoner's funeral took place on 13 December. A representative of the Governor attended. The funeral costs were met by the Governor.

Examination of the care given to the prisoner

Here I examine:

- the assessment and treatment of the prisoner's mental health needs.
- the assessment, monitoring and management of his risk of self-harm or suicide.
- the response after he was discovered hanging.

The assessment and treatment of the prisoner's mental health needs

- *Formal health screening*

Upon his arrival at Winchester on 31 May, the prisoner was immediately admitted to the healthcare centre. He was also made subject to formal self-harm monitoring procedures, through the use of the ACCT form, after the nurse who saw him in reception noticed that he was totally withdrawn and unresponsive. I consider that the decision to admit the prisoner to the healthcare centre was entirely appropriate. However, the decision was not based on any formal assessment of the prisoner's physical or mental health needs. Prisons are required to conduct a first, and then a secondary, reception health screen on all prisoners as soon as they arrive. In the case of this prisoner, no first or secondary health screen was carried out. This is likely to have been the result of the fact that the prisoner was withdrawn and unresponsive during the reception procedures.

I take the view that, in such circumstances, formal health screening should take place at the first available opportunity after the remaining reception procedures have been completed.

- *Follow up action on remarks made in ACCT form*

The Suicide Prevention Co-ordinator at Winchester drew up an Action Plan as soon as the ACCT was opened on 31 May. In it, he drew attention to the need for a medical check to be made in order to verify whether the prisoner had taken an overdose of drugs in the recent past. There is no evidence that this recommendation was followed up. The credibility of ACCT action plans will be eroded if their recommendations are not taken seriously and acted upon**.**

The Governor should remind his staff of the need to check that ACCT action plans are appropriately followed up and that management checks are carried out to ensure that this is done.

- *Mental health assessment, monitoring and review*

The prisoner was seen by a doctor in the healthcare centre immediately upon his admission. The doctor decided that the prisoner should initially be placed on a constant watch as his risk of self-harm was considered to be high. The first ACCT action plan assessment was carried out by the Head of Healthcare and the prison doctor. One of the outcomes of this assessment was that the prisoner was referred to

a Community Psychiatric Nurse (CPN) from the Community Mental Health Team (CMHT). On 10 June, a Care Plan Approach assessment was carried out by a student nurse under the supervision of the CPN. On 14 June, the prisoner made out his own "get better plan" in which he articulated his own worries as well as a number of possible solutions for dealing with them. The prisoner's plan was discussed with him by the doctor.

The prisoner remained in the healthcare centre for nearly three months. During that period, and indeed after his discharge to the main prison, his mental state fluctuated. His care was underpinned by a Care Plan Approach assessment, an ongoing nursing care plan, ACCT procedures and by frequent and comprehensive reviews by three different specialists - the prison doctor, a psychiatrist and the CPN. Regular ACCT case reviews were held, with the prisoner present at each. Comprehensive notes were made in the prisoner's medical record each time he was seen. With the exception of one occasion, when an entry made in the ACCT form did not refer to the level of observations mentioned in the medical record, corresponding information was logged in each document. By this means, there was effective cross-communication between those who were engaged in assessing, monitoring and managing the prisoner's general mental health and those who were responsible for monitoring his risk of self-harm. When he was discharged from the healthcare centre to the main prison in August, a proper discharge plan was made out, the aim of which was to structure his post-discharge care in the wing.

In July, the CPN notified the PE staff at Winchester of the prisoner's desire to use the gym. As a result, he later joined a Basic Sports Injuries course, perhaps the most positive and stimulating activities he undertook in prison. While he was on this course, he demonstrated few signs of depression.

The monitoring of the prisoner's mental health by the CPN continued until 13 September when the prisoner told her that he felt no need to see her again. The CPN regarded this as a positive development, but nevertheless made a plan to see the prisoner again as soon as his trial had been concluded. This began on 21 November and ended two days later when the prisoner was sentenced to two years imprisonment. Unfortunately, the CPN was not informed that he had been sentenced. She told my investigators that, had she been so informed, she would have seen him again as planned.

- *The treatment of the prisoner's depression*

The need for the prisoner to consider the use of anti-depressant medication was first mooted on 10 June, when a student nurse conducted a Care Plan Approach assessment of his mental health needs. On 14 June, the prison doctor decided to prescribe Fluoxetine, an anti-depressant drug. Although entries made in the medical record refer to the fact that the prisoner occasionally declined his medication, no such clarity is evident in the prescription charts.

On 25 June, the doctor wrote in the medical record that the prisoner told him that the anti-depressants had made him well enough to hate himself and to try to kill himself. The doctor reassured the prisoner that the treatments he prescribed would "make him well enough to be able to tell his story in court that he was already low and depressed

and thinking of death when he broke into his girlfriend's place to kill himself." As a result, the prisoner agreed to restart his anti-depressants.

The doctor told my investigators that he regarded the prisoner as a man "who did not have a 'doctor culture'. Rather, he had a 'sort-yourself-out' culture." The doctor understood that the prisoner was the sort of man who would have resisted medication. He agreed that Fluoxetine can increase the risk of self-harm or suicide as it starts to work. He persuaded the prisoner of the importance of working through the initial period. By explaining to him that he had to accept that he was ill with depression rather than trying to rationalise it, the doctor thought that he had succeeded in restoring his belief that the treatment was appropriate and that he could be made better.

I conclude that the individual and combined efforts of the doctor, the psychiatrist and the CPN, together with the nursing staff, to assess, monitor, review and manage the prisoner's health needs were entirely appropriate. They should be commended for their efforts.

However, the Governor should ensure that accurate details are recorded on prescription charts of any drugs prescribed, the dates when they are administered and the dates when they are not taken.

The assessment, monitoring and management of the prisoner's risk of self-harm or suicide

- *Opening of first ACCT form*

Formal self-harm monitoring procedures were invoked for the prisoner upon his arrival at Winchester on 31 May. The concerns expressed in the escort record prior to his appearance at court the previous day were properly passed from the police to the court officials, and onwards to Reliance, the private security company that took the prisoner to the prison. The reception officer on duty at the prison noted that a self harm warning form had been raised.

- *Case reviews*

Upon his admission to the healthcare centre during the evening of 31 May, the prisoner was placed on a constant watch. The first ACCT case review should have taken place within 24 hours of the form being opened. However, as the prisoner was completely withdrawn and unresponsive on 1 June, the case review was justifiably delayed until the next day.

Thereafter, regular and timely ACCT case reviews were held, the summary of each of which was appropriately recorded. The prisoner was present at every review and was therefore given an opportunity to be actively involved in decisions that affected him.

At the case reviews held on 18 July, 2 August, and 19 August, the panels were comprised of only one member of staff. The review held on 6 September, at which the decision to close the ACCT form was made, was also attended by only one

member of staff. The establishment's own suicide prevention policy requires that case reviews should be attended by the Case Manager, the prisoner, unit staff and representatives of any other departments that work closely with the prisoner. The local policy does not state how many staff should be present when an ACCT form is to be closed. My investigators were told that it was not always possible for more than one member of staff to attend because of other demands on staff time. I accept that, in a busy local prison such as Winchester, staffing levels and other operating difficulties can obstruct the achievement of the required standards. However, I believe that in an area as important as suicide prevention, standards must not be allowed to erode and that the multi-disciplinary approach to ACCT (where 'T' stands for teamwork) must be preserved.

The Governor should take steps to ensure that his policy for the operation of the ACCT system sets out a clear minimum attendance standard for all types of case review. The Governor should also ensure that the agreed standard should be audited routinely in management checks.

- *Post-closure ACCT reviews and interviews*

On 6 September, after the prisoner's ACCT form was closed, it was determined that a post-closure review was to take place the following day. The investigation found no evidence that this review took place. Furthermore, the local suicide prevention policy requires that, following the closure of an ACCT form, the prisoner should be interviewed every 14 days in order to measure the extent to which he is coping and that details of the interviews are recorded in the prisoner's core prison file. None of the entries made in the prisoner's F2050A (record of events) refers to post-closure ACCT reviews or interviews. My investigators could find no evidence that such interviews took place.

The failure to carry out post closure reviews and interviews could, I believe, have potentially serious consequences. Whilst I accept that there can never be a guarantee that the conduct of post-closure reviews and interviews will prevent a prisoner's suicide, a failure to carry them out will deny staff an opportunity to measure any changes in the mental state of a prisoner once the closely structured support of the ACCT system has been removed. In the case of this prisoner, the fact that no such reviews and interviews were carried out was mitigated, for a short while, by the CPN's continuing interest in him. However, this does not reduce the significance I attach to the need for staff to follow the post-closure procedures that are already explicit in the establishment's suicide prevention policy document.

The Governor should take urgent steps to ensure that post-closure reviews and interviews take place as a matter of routine. Checks carried out by managers should incorporate regular audits of this function.

- *Self harm attempts*

On 1 June, the prisoner's first full day in the healthcare centre, he made moderate indentations in his abdomen with a plastic knife issued to him for use at meal times. He did so while he was on a constant watch. It is clear that this was a minor act of self-harm rather than an attempt on his own life. Plastic cutlery is legitimately issued

to prisoners to enable them to eat their meals. Tempting as it is to suggest that prisoners who are considered to be at risk of self-harm should not have such implements in their possession, to deny them their use would be disproportionate and not in the interests of basic decency. I also believe that to restrict the issue of plastic cutlery to meal times would carry no guarantee that prisoners would not use them inappropriately. However, the fact that the prisoner was able to harm himself in this way at a time when he was on a constant watch is a cause for concern. The door of the cell in which he was located was fitted with a large observation hatch that afforded some observation into the cell. The officer who was watching the prisoner discovered the act immediately and reacted appropriately. After he had self-harmed, the prisoner was moved to a "gated cell". This was fitted with a metal grill-gate instead of a solid door, thereby affording optimum observation.

It would be sensible for the Governor to consider whether more gated cells should be provided in the healthcare centre so that no prisoner in need of constant watch is observed only through an observation hatch in a solid cell door.

A case review took place the day after the prisoner's self-harm attempt. At this review, a decision was made to reduce the level of observations from constant watch to five times per hour. The case review summary does not make mention of the events of the previous day. At first glance, the decision to reduce the frequency of observations the day after the prisoner had tried to harm himself seems inappropriate. However, at the review, he articulated his concerns clearly and said that he felt better than he had two days before. He told the review panel that he appreciated the support he was receiving, that he was willing to see someone from the Community Mental Health Team and that he did not feel that it was necessary for staff to watch him constantly. I am satisfied that, given the prisoner's improved demeanour that day, the decision to reduce the level of observations was understandable.

However, staff need to be careful to read previous entries in the ACCT form when conducting case reviews so that their decisions are based on the best and most up to date information.

At 9:15pm on 22 June, the prisoner was found on the floor of his cell in the healthcare centre with a snapped television cable around his neck after trying to hang himself. Although his life was not endangered, he nevertheless sustained a graze on his neck. He was immediately placed on a constant watch in a ligature-free cell. He then had an undisturbed night. The next day, a case review was convened. The panel decided that, as the prisoner was in a ligature-free cell, his level of observations could be reduced from a constant watch to level 2 (five times per hour).

There must be concern that television cables in prisoners' cells (particularly in healthcare) are of such a length that they can be fashioned into ligatures. I am also concerned that the prisoner was able to try to hang himself by this means when located in a cell described as ligature-free. The decision to reduce the level of observations after his self-harm attempt was driven by this same factor. At interview, my investigators suggested to the doctor that it was inappropriate

for television cables to be available as ligatures. He understandably took the view that the television set, with its connection to the mains electricity supply, was a much more dangerous self-harm implement than the television cable because prisoners could electrocute themselves by smashing the screen and touching the electrical circuitry inside the set. My investigators discussed this issue with the Deputy Governor at Winchester who put forward the view that it was possible to place selected television sets behind a perspex screen and to shorten the cables. I agree with the Deputy Governor's suggestion.

The Governor, in conjunction with the NOMS Safer Custody Group should consider the benefits of this suggestion.

- *Record keeping*

On 25 June, the doctor saw the prisoner at the request of healthcare staff who were concerned that he was not eating properly. The doctor made a record of his consultation in both the medical record and the ACCT form. The medical record does not make clear what time the doctor saw the prisoner. At interview, the doctor told my investigators that he saw him during the morning. The entry he made in the ACCT form was made against the time of 3:30pm. In the medical record, the doctor recorded that level 2 observations were to continue, but he did not mention this in the ACCT form. On the same day, a case review was held at 8:50am, chaired by the Healthcare Senior Officer, who decided that the prisoner should be observed at level 3. This conflicted with the doctor's instructions in the medical record. The actual observations made of the prisoner that day do not properly match the requirement for either level 2 or level 3 and suggest that staff may have been confused as to the which level of observation applied.

The Governor, in conjunction with the prison doctor, should ensure that entries made in medical records are accurately reflected in ACCT forms, within the bounds of medical confidentiality, so that no confusion arises about the level of observation to be adopted.

- *The prisoner's deterioration after his trial*

On 21 November, the prisoner's trial began at Southampton Crown Court. Two days later, he was sentenced to two years imprisonment.

The CPN told my investigators that no-one from the prison informed her of the fact that the prisoner had been sentenced. She was disappointed that she was therefore unable to review him as planned.

The Governor, in conjunction with the prison doctor, should ensure that such important details as the sentencing of a prisoner whose mental state is under review by the Community Mental Health Team and by psychiatrists is promptly communicated to all the agencies involved in his care.

Staff thought the prisoner's relatively short sentence came as a pleasant surprise to him. Although his mood had varied in recent weeks, his mental state had improved a little prior to being sentenced. However, over the weekend of 26/27 November the

details of his offence were publicised in the local and national media. Another prisoner, who undertook the Basic Sports Injuries course with the prisoner, and who became his close friend, told my investigators that he had tried to prevent the prisoner from hearing or seeing the publicity. The friend said that another prisoner, whom he did not name, pushed a newspaper containing an article about the prisoner's trial under his cell door. The friend said that the prisoner reacted very badly. He stopped eating and did not leave his cell. The friend blamed the media coverage for the prisoner's death.

On Sunday 27 November, a Prison Officer was told by the prisoner's cellmate that the prisoner was not eating. The prisoner explained to the officer that he was not on a hunger strike and that he was drinking regularly. As he knew that the prisoner had already been subject to self-harm monitoring procedures, the officer nevertheless took the precaution of opening a new ACCT form there and then. The prisoner was to be placed on level 3 observations. This required staff to make a written record of any conversations with the prisoner once per shift and at hourly intervals during patrol states (i.e. when prisoners are locked in their cells and minimum staff are on duty). I regard this as appropriate in the circumstances. An immediate ACCT action plan further required that the prisoner should be kept in a shared cell, and that he should be given access to telephones and to Listeners as required. He was also to have his meals delivered to his cell each day so that his eating pattern could be closely monitored. Furthermore, he was to be seen by someone in the healthcare centre as soon as possible. There was no evidence in the medical record or in the ACCT form that anyone from the healthcare centre saw him the next morning. At first glance this seems unfortunate. However, at the time the ACCT was opened, the prisoner was not actively suicidal. The reason for recommending that he should be seen by the healthcare staff was because he had not been eating. I therefore raise no criticisms about the fact that he was not seen the following morning.

By the time the investigation commenced, the cellmate had been released from prison. My investigators wrote to him at his home address to invite him to be interviewed. The cellmate later replied, saying that he was willing to be interviewed and was happy to receive a telephone call, on a given number, to discuss where and when the interview might take place. However, he failed to respond to the numerous calls my investigators made. As a result, it was not possible to interview him.

The evidence provided by the prisoner's friend suggests that the prisoner was devastated more by the publicity surrounding his trial than by the sentence he received. The friend had the presence of mind to report his concerns about the prisoner to an officer. This was a responsible and commendable act. The officer opened an ACCT form as a precaution against the possibility that the prisoner had commenced a hunger strike and because he knew that he had been the subject of formal self-harm monitoring procedures earlier.

The actions of that officer were commendable.

Observations were recorded in the prisoner's ACCT form throughout the remainder of the evening of 27 November, the following night and the morning of Monday 28 November. At 12:10 pm, a Prison Officer took the prisoner's lunch meal to him in his cell and asked him if he was alright. He said, "Yes, marvellous."

At about 2pm on 28 November, the prisoner declined exercise and remained in his cell alone. He was found hanging by an officer an hour later, towards the end of the exercise period. At interview, that officer told my investigators that, when she delivered the prisoner's lunch meal to him just after midday, he gave no signs that he was contemplating suicide.

I have considered whether, given the fact that he was the subject of formal self-harm monitoring procedures, it was appropriate for the prisoner to be left alone in his cell during the exercise period. With the benefit of hindsight, he may well have been planning to commit suicide, but the presenting risk indicators at 2pm that day were not suggestive of an imminent attempt on his own life.

I conclude that nobody was at fault for allowing the prisoner to remain alone during the exercise period. However, as a precaution, the Governor should consider the merits of ensuring that any prisoner subject to an ACCT form and left alone in his cell (during exercise for example) is observed five times an hour for that period.

The investigation found that it is not unusual for staff from one wing to unlock prisoners in another wing for activities such as exercise. This was the case where this prisoner is concerned: his cell in C Wing was unlocked at about 2pm by an officer from A Wing. This practice gives rise to the possibility that prisoners considered to be at risk of self-harm or suicide are not known by the staff who unlock them.

Indeed, the officer who unlocked the prisoner told my investigators at interview that he did not know that he was subject to ACCT procedures. This issue was discussed with the Deputy Governor, who takes the lead in setting and reviewing suicide prevention policy at Winchester. He told my investigators that, irrespective of which wing they work in, staff are expected to familiarise themselves with the names and cell locations of those prisoners subject to ACCT procedures - the details of whom are listed on a white board in each wing office. The officer who unlocked the prisoner for exercise on 28 November told my investigators that he was not aware of any such policy.

The Governor should remind his staff of the requirement to familiarise themselves with the names and cell locations of prisoners subject to ACCT procedures

The response after the prisoner was discovered hanging

The prisoner's former girlfriend told one of my Family Liaison Officers that she had been told, on one occasion, that 20 minutes had elapsed before any attempts to revive the prisoner were initiated. She said that, on another occasion, she was told that 40 minutes had elapsed. My investigators found no evidence to suggest this was the case at all. As soon as the officer discovered the prisoner hanging, she blew here whistle to alert other staff to the emergency. Within seconds, she was joined by other wing staff. Two nurses also arrived at the cell within a very short space of time.

My investigators found that, when the nurse asked the communications room to ask the prison doctor to come to the prisoner's cell, the request was relayed to the healthcare centre by telephone. At the time, the doctor was engaged in a consultation in Westhill Unit. There was therefore a slight delay in finding him. The doctor told my investigators that when he received the call for help he was not told that the prisoner had been found hanging.

In order to minimise the possibility of such difficulties in the future, the Governor should consider what better arrangements might be put in place for contacting duty doctors in emergencies, such as issuing them with a pager or requiring them to carry a radio. Local contingency plans for the management of life threatening situations should set out the procedures to be followed, including clear instructions for contacting the duty doctor, and should ensure that the type of emergency is communicated straightaway to those required to respond.

- *Attempts to revive the prisoner*

In spite of their view that it was unlikely that the prisoner could be successfully resuscitated, discipline staff, nursing staff, and the paramedic crew persevered. As a result, a slight cardiac output was achieved.

The efforts of those staff who were involved in the discovery of the prisoner and in attempts to revive him are worthy of praise.

- *Contacting the next of kin*

When the prisoner was received at Winchester on 31 May he volunteered no information as to who was his next of kin. This was probably due to the fact that, at the time, he was completely withdrawn and unresponsive. After his admission to hospital on 28 November, efforts to contact his next of kin were seriously hampered by the fact that no details were available in his core file.

The Governor should ensure that if, during the initial reception procedures, it is not possible to record next of kin details in prisoner's core records, this is done as soon as possible afterwards.

7. Good practice and Recommendations

Good practice

- The individual and combined contributions of the doctor, the psychiatrist and the CPN in the care of the prisoner at Winchester are worthy of praise.

- Those staff who were involved in the discovery of the prisoner hanging should be commended for their rapid response and for their perseverance in trying to revive him in very harrowing circumstances.

- The cellmate should be commended for bringing his concerns about the prisoner to the attention of a Prison Officer on 27 November.

- That Prison Officer should be commended for taking the initiative in opening a new ACCT form.

Recommendations

I make the following recommendations: (responses from the Prison Service are shown in italics and in brackets after each recommendation)

1. *Reception health screening*

- The Governor should ensure that, on the rare occasions when, because of a prisoner's behaviour, reception health screening cannot take place during the reception procedures, arrangements are made for the screening to take place at the first available opportunity after the remaining reception procedures have been completed. (*Accepted.)*
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2. *Record keeping*

- The Governor should ensure that entries in the medical record are legible and that the author of each entry is clearly identifiable. *(Accepted.)*

- The Governor, in conjunction with the prison doctor, should ensure that entries made in medical records are accurately reflected in ACCT forms within the bounds of medical confidentiality so that no confusion arises about the level of observation to be adopted. *(Partially accepted- the Prison Service stated that this was the responsibility of the doctor, not the Governor - but that a local protocol would be produced and guidance issued to advise all healthcare staff that entries in the IMR are reflected in the ACCT within bounds of medical confidentiality.)*

- The Governor should ensure that accurate details are recorded on prescription charts of any drugs prescribed, the dates when they are administered and the dates when they are not taken. *(Accepted.)*

- The Governor should ensure that if, during the initial reception procedures, it is not possible to record next of kin details in prisoner's core records, this is done as soon as possible afterwards. *(Accepted.)*

3. *Observation of prisoners at risk*

- The Governor should consider whether more gated cells should be provided in the healthcare centre so that no prisoner in need of constant watch is observed through an observation hatch in a solid cell door.*(Partially accepted- a needs analysis will be carried out by the Healthcare Manager.)*

- As a precaution, the Governor should consider the merits of ensuring that any prisoner subject to an ACCT form and left alone in his cell (during exercise for example) is observed five times an hour for that period. *(Partially accepted- This should be considered on an individual basis and will be incorporated in the Care Map and on all ACCT reviews.)*

4. *Local contingency plans for the management of a life-threatening situation*

- The Governor should ensure that local contingency plans are issued for the management of a life-threatening situation. *(Accepted.)*

- The Governor should consider issuing duty doctors with a pager or requiring them to carry a radio whilst in the prison. The arrangements for contacting duty doctors in an emergency should be reflected in local contingency plans. *(Accepted.)*

5. *ACCT procedures*

- The Governor should take steps to ensure that his policy for the operation of the ACCT system sets out a clear minimum attendance standard for all types of case review. The Governor should also ensure that the agreed standard should be audited routinely in management checks. *(Accepted.)*

- The Governor should remind staff of the need to be careful to read previous entries in the ACCT form when conducting case reviews, so that their decisions are based on the best and most up to date information. *(Accepted.)*

- The Governor should remind his staff of the need to check that ACCT action plans are appropriately followed up and that management checks are carried out to ensure that this is done. *(Accepted.)*

- The Governor should take urgent steps to ensure that post-closure interviews take place as a matter of routine. Checks carried out by managers should incorporate regular audits of this function. *(Accepted.)*

- The Governor should remind his staff of the requirement to familiarise themselves with the names and cell locations of prisoners subject to ACCT procedures. *(Accepted.)*

6. Television sets

- The Governor, in conjunction with the NOMS Safer Custody Group should consider the benefits of placing selected television sets behind perspex screens and shortening television cables. *(Partially accepted- Installation of perspex boxes can lead to the introduction of additional ligature points. There are no plans to do this. Television cables can be shortened if required. This would be risk assessed on an individual basis.)*

7. Inter-agency communications

- The Governor, in conjunction with the prison doctor, should ensure that such important details as the sentencing of a prisoner whose mental state is under review by the Community Mental Health Team and psychiatrists is promptly communicated to all the agencies involved in his care. *(Partially accepted- This is not the doctor's role - doctors are not always in a position to know this information immediately. However, procedures are in place to ensure that any change of status of any prisoner will be highlighted at reception/induction. A mechanism for improving the cascading of change of status information to relevant agencies will be considered by the Safer Custody Committee.)*

8. Use of oxygen cylinders

- The Governor, in conjunction with the doctor, should ensure that appropriate staff receive initial and refresher training in the operation of oxygen cylinders. (*Accepted.)*

9. The Governor should consider the following points made in the Clinical Review:

- *Defibrillators*

As a matter of urgency the Governor and PCT should ensure that **all** staff in the prison, from the most junior to the most senior should know how to get hold of and use the semi automatic defibrillators that the prison has bought at considerable expense. They are designed for use by untutored laymen and they will save lives, but only if used immediately a cardiac collapse occurs.

Consideration as to how to deal with defibrillation in a wet environment would make dealing with hangings not only safer but also more pleasant. I wonder if it might be useful to discuss with the ambulance service what they do in such circumstances.

(Partially accepted. A training needs analysis is currently being carried out to determine who requires this training. It would prove impractical to give all staff this training. Priority will be placed on healthcare staff and all first aid trained staff.)

- *Health screening*

A random check should be made of at least 20 prisoners' records (10 in healthcare and 10 on the wings) to ensure that the Reception Medical Screen has been scrupulously completed in every case. If any are found to have been inadequately completed, then all prisoners' IMRs should be checked to ensure that the Reception Medical Screen has been scrupulously completed in every case. This applies to the Secondary Health Assessment too. Without it, the simplest of audits will be impossible as there will be no record of prisoners' height and weight, blood pressure, smoking habits etc. The importance of completing the Reception Medical Screen properly needs to be reinforced to Reception Staff frequently. Now that doctors do not meet each prisoner on arrival it is the only mechanism whereby they are alerted to a new person's health needs.
(Accepted.)