Investigation into the circumstances surrounding the death of a man in March 2008 at Royal Hampshire County Hospital whilst in the custody of HMP Winchester

Report by the Prisons and Probation Ombudsman for England and Wales

July 2010

This is the report of an investigation into the circumstances surrounding the death of a man on 18 March 2008 at a Royal Hampshire County Hospital whilst he was in the custody of HMP Winchester. The man had been found hanging in his cell on 14 March.

I offer my sincere sympathy and condolences to the man's family and all those affected by his passing.

The investigation was carried out by two investigators from my office. I must apologise for the delay in issuing this report. This was due to the necessity to commission from Hampshire PCT a clinical review that took into account the mental health issues arising from the man's death in addition to his primary medical care.

I am grateful to the Clinical Reviewer and his team at Hampshire PCT who reviewed the primary care that the man received whilst in custody, and to a member of staff from the Hampshire Partnership NHS Trust and her team who conducted a mental health critical incident review. The primary care review team makes six recommendations, and endorses the four actions identified in the mental health team's critical incident review.

I would like to thank the former Governor and his staff and prisoners at HMP Winchester for their full and ready cooperation during the course of the investigation. I am particularly grateful to the Liaison Officer for her assistance to my investigators.

Prior to the man's death there had been eight deaths at Winchester since I began investigating all deaths in prison custody in 2004. Seven of these were as a result of natural causes, and one was apparently self-inflicted.

The man was serving an indeterminate sentence for public protection (IPP). He had complained of feeling frustrated at the lack of progress through his sentence and the delay in transferring him to HMP Parkhurst.

This report makes eleven recommendations. I am pleased to see that ten of the recommendations have been accepted. I have made a number of changes in this version of the report (at paragraphs 37, 91, 99,103,108 and 127) in response to observations made by the man's family after they had studied the draft report I issued last year.

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.

Jane Webb
Acting Prisons and Probation Ombudsman **July 2010**

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SUMMARY

The man was sentenced to an indeterminate sentence for public protection in October 2006. He spent time at HMP Parkhurst before being transferred to HMP Winchester on 11 December 2006.

The man had a long history of mental health issues, substance misuse problems and deliberate self harm. He had a diagnosis of personality disorder. He was at serious risk of self harm and suicide, and during his time in custody there were numerous incidents of deliberate self harm which included serious cutting and hanging attempts. He was frequently monitored under the ACCT (Assessment, Care in Custody and Teamwork) procedures, a system used by the Prison Service to monitor and support those prisoners deemed at risk or self harm and/or suicide through a period of crisis. He also spent much time located in the healthcare centre where he could be monitored more closely.

When the man arrived at Winchester he was already well known to mental health services both in the community and prisons. He had a significant risk history of deliberate self harm. The psychiatrist at Parkhurst had fully briefed the psychiatrist and community mental health team at Winchester before the man's transfer there.

In 2006 and early 2007, the man self harmed on over 30 occasions. However, towards the end of 2007 he made real progress. He seemed to come to terms with his sentence and settled down to prison life at Winchester. The man earned the respect of both staff and other prisoners. Although a quiet man he was known for being helpful and cooperative with both staff and prisoners. He secured a job first as wing painter then as wing cleaner on B wing, and became an enhanced prisoner under the Incentives and Earned Privileges (IEP) scheme.

The man's mental health seemed stable during 2007 and into 2008. His self harming reduced significantly to the point where there were no further incidents of deliberate self harm and he was no longer monitored on an open ACCT. He also seemed to be over his substance misuse problems and had volunteered to be subject to the voluntary drug testing programme.

On the morning of 14 March 2008 at 8.46am, he was found hanging in his cell on B wing by a fellow prisoner, who was located in the adjoining cell. The prisoner called for help and a PE Officer, (physical education officer) who was on the landing at the time, immediately entered the man's cell. The PE Officer then shouted for assistance from his colleague who then arrived. With the prisoner's help, the man was cut down and the officers began resuscitation. The second Officer to arrive radioed for medical assistance and healthcare staff quickly arrived. Cardio pulmonary resuscitation (CPR) was continued with the aid of a defibrillator. Despite the staff's efforts and medical intervention from a visiting psychiatrist, the man did not start to breathe again. An ambulance crew arrived quickly, but they were ambulance technicians rather than trained paramedics so a second ambulance was dispatched to the

prison. (There is no evidence that this had a negative impact on the care the man received or his chance of survival.)

The man was taken in an evacuation chair to the ambulance and transferred to the intensive care unit at the Royal Hampshire County Hospital. Sadly, he did not recover and died four days later.

I include four specific recommendations to the PCT and the Governor which seek to address improvements in standards of emergency response:

- the Governor and Head of Healthcare, in collaboration with the PCT, should review the standards of training relating to life support for healthcare and substance misuse staff.

- the Governor and Head of Healthcare, in collaboration with the PCT, should review the emergency medical response code system with a view to introducing a colour coded system.

- the Governor and Head of Healthcare, in collaboration with the PCT, should review the content and location of the emergency bags to ensure they are accessible at the point of use and are fit for purpose.

- the Governor and Head of Healthcare, in collaboration with the PCT, should raise with Hampshire Ambulance Service the delays due to attendance by an unqualified crew.

THE INVESTIGATION PROCESS

1. I was notified of the man's death on 18 March 2008. The case was allocated to two Investigators on the same day. The investigation was formally opened on 1 May 2008 when my investigators issued notices announcing the investigation to the staff and prisoners of HMP Winchester. The notices included an invitation to those who wished to contribute to the investigation to make themselves known to my investigators. Three prisoners came forward to speak to the Investigators.

2. The investigators visited the prison during the third week of May 2008. They met the governing Governor, the chair of the local branch of the Prison Officers' Association, the chair of the Independent Monitoring Board (IMB), and the Safer Custody Officer who assisted my investigators as their liaison officer.

3. My investigators reviewed the man's core custodial record, his clinical record, and a number of other documents including F213 reports (medical report of injury to a prisoner) and ACCT documents from his time in custody at HMP Parkhurst and Winchester. My investigators compiled a time-line of events and identified prison staff and prisoners at Winchester who they interviewed over a number of days during May and June 2008. The Governor was kept updated and given full verbal and written feedback by my investigators after they had concluded the interviews and made their initial findings.

4. A clinical review of the man's primary medical care whilst in Winchester was commissioned from Hampshire Primary Care Trust (PCT). There was a delay in issuing my report because I judged it necessary to commission from Hampshire PCT a clinical review that took into account the crucial mental health component arising from the man's death in addition to his primary care. The Clinical Reviewer and his team at Hampshire PCT reviewed the primary medical care that the man received whilst in custody. A member of staff from Hampshire Partnership NHS Trust and her team conducted a mental health critical incident review.

5. One of my family liaison officers, contacted the man's sister to explain the investigation process and offer the opportunity for the family to be involved. One of the Investigators and the Family Liaison Officer met with the man's sister and his daughter in June 2008. The man's family raised a number of issues which this report has aimed to address as fully as possible. Their questions concerned the following issues:

    - the mental healthcare, substance misuse care and general healthcare which the man received whilst in custody at Winchester
    - the prison's response following the discovery of the man hanging in his cell

- the prison's response when the man was at Royal Hampshire Hospital
- the prison's liaison with the family following the man's death
- concerns about IPP sentencing and prisoners' difficulties in progressing through the prison system generally
- concerns about the level of care that the prison could realistically provide for individuals such as the man
- the lack of follow-up to an ongoing urology problem.

HMP WINCHESTER

6. HMP Winchester is a category B local prison built in 1846 to a Victorian radial design. Winchester is currently undergoing major refurbishment with a build programme lasting five years. Work which has already been completed includes safer custody changes to the healthcare centre, first night centre and detoxification unit, a new electrical system, renewal of the fire and general alarms, a new visits complex and pedestrian access at the main gate.

7. The rebuild of C wing is well underway to improve the accommodation for prisoners. The accommodation is mostly double cells. Transfers into Winchester are only by prior approval from the Governor. Winchester holds both remanded and convicted prisoners.

HM Chief Inspector of Prisons' inspection 2007

8. HM Chief Inspector of Prisons, last inspected Winchester in April 2007. She published her report in June 2007 and commented:

> "Like all local prisons it faces considerable pressures and increased demands. There was some evidence, at this inspection, that this combination was testing the prison's ability to sustain and continue improvements. Winchester remains a reasonably well performing local prison, in spite of the pressures in the prison system as a whole. However, there are some warning signs – the lack of sufficient activity spaces in the main prison, the somewhat dislocated resettlement places and, in particular, the fact that residential staff are not fully engaged in the support and rehabilitation of prisoners. These are all matters that prison managers, and the National Offender Management Service, will need to monitor closely."

Indeterminate sentences for public protection (IPP)

9. In her report on Winchester, HM Chief Inspector of Prisons wrote:

> "There were 24 prisoners serving indeterminate sentences for public protection (IPP) and 23 mandatory and discretionary lifers, of whom seven were recalls. Multi agency lifer risk assessment panels were organised after sentence and were well attended and documented. The lifer systems were good but communication with prisoners was poor. Lifers were concerned about the length of time they waited at Winchester before moving to a first stage lifer prison. This took an average of 12 months but some spent two years at Winchester before transfer. Indeterminate prisoners spent too long at the prison. Offender supervisors reported difficulty in forging positive links with offender managers in the community. Communication links

could have been improved by the involvement of probation staff working in the prisons.

IPP prisoners frequently did not understand the implications of this type of sentence and were not issued with any relevant information. Three prison staff had completed the relevant lifer training, although only the lifer officer presently had any ongoing contact with lifer prisoners.

Life-sentenced prisoners and those subject to indeterminate public protection sentences should be assigned lifer officers who have received appropriate training.

Arrangements for clinical information-sharing within the prison and the guardianship of confidentiality were unclear and there were no appropriate policies and some evidence of inconsistent practice."

10. HM Chief Inspector of Prisons and HM Chief Inspector of Probation published a review on indeterminate sentences for public protection in September 2008. In the introduction to their review, the Chief Inspector's comment:

> "By 2007, the Parole Board's caseload had increased by nearly a third since 2005-6, and it faced considerable delay in listing and hearing cases, not least because only 38% of the dossiers it needed were arriving on time from NOMS.
>
> This was a perfect storm. It led to IPP prisoners languishing in local prisons for months and years, unable to access the interventions they would need before the expiry of their often short tariffs. A belated decision to move them to training prisons, without any additional resources and sometimes to one which did not offer relevant programmes, merely transferred the problem. By December 2007, when there were 3,700 IPP prisoners, it was estimated that 13% were over tariff. As a consequence, the Court of Appeal found that the Secretary of State had acted unlawfully, and that there had been 'a systemic failure to put in place the resources necessary to implement the scheme of rehabilitation necessary to enable the relevant provisions of the 2003 Act to function as intended'. Rather more pithily, a prison lifer governor told us: 'It is as though the government went out and did its shopping without first buying a fridge'. This report chronicles clearly the problems and confusion that this caused for prisons and prisoners up to the end of 2007. As this report shows, these are prisoners with many and complex needs, including mental health, learning disability and a risk of self harm, as well as criminogenic needs."

The Independent Monitoring Board (IMB) Annual Report 2007/08

11. The Prisons Act 1952 requires every prison to be monitored by an independent board appointed by the Secretary of State for Justice from members of the community in which the prison is situated. The Board must satisfy itself as to the humane and just treatment of those held in the prison it monitors.

12. The Winchester IMB's most recent annual report was published in May 2008. The section on Safer Custody says:

> "Over the past year, the prison has taken a number of positive steps forward in terms of safer custody. There was a noticeable increase in 'ownership' of this aspect of prison management, much of it owed to the efforts of a new Suicide Prevention Coordinator, and the close interest taken by the supervising Governor. A much more 'joined up' approach was taken, with a weekly meeting to discuss individual prisoners on ACCT providing a very effective focus. There has been an average of 29 ACCTs opened each month, compared with 25 for the previous year. More emphasis has been put on an anti-bullying strategy, and documentation has been more closely scrutinised in order to ensure better ACCT monitoring. The part played by the Listeners should not be underestimated, though there has been a continued shortage, which puts extra pressure on those already in post. Again, the Samaritans' role in training the Listeners deserves considerable credit.
>
> The new National Order concerning safer custody is a welcome step forward and has been embraced enthusiastically by Winchester; the prison has produced a comprehensive draft 'Suicide Prevention and Self-Harm Management Policy and Strategy Document'. Nevertheless, concerns over safer custody still remain. For example, whilst C Wing is being rebuilt, it is not easy to keep vulnerable prisoners on D Wing separated from remand prisoners. Winchester remains fairly safe overall, though regrettably there have been two deaths in custody during the year."

13. Under the heading 'Lifers and Indeterminate Sentence Prisoners', the IMB Chair says:

> "There has been little change in the number of lifer prisoners at HMP Winchester. At the end of May 2008 there were 18 men serving life sentences compared with 21 in May 2007. Whilst there has been some movement, there remain 5 prisoners who have been in Winchester since May 2007; this is of some concern given the lack of available resources for lifers at Winchester. The Board does recognise however the difficulties in transferring life prisoners, given that 50% have vulnerable

prisoner status. At the end of May 2008 there were 29 prisoners subject to an indeterminate sentence of Imprisonment for Public Protection (IPP) under CJA2003. Ten are Cat B (tariff more than three years) and 19 are Cat C (tariff less than three years). Of these, 5 prisoners have now exceeded their minimum tariff."

Previous deaths in custody at Winchester

14. Since I was given responsibility for investigating all deaths in prisons in April 2004 there have been eight previous deaths at Winchester, one apparently self-inflicted and seven from natural causes.

Prison Family Liaison Officer

15. My report following the death of a prisoner at Winchester in June 2007 made the following recommendation to the Governor:

> "The Governor should consider implementing a local policy on the role of Family Liaison Officer in accordance with Chapter 4 of Prison Service Order 2710."

The Prison Service accepted the recommendation. In response, they said: Policy drafted and implemented. I also recommended:

> "The Governor should consider placing suitable volunteers on the Family Liaison Officer training course waiting list as soon as practicable to ensure that there are dedicated staff available to carry out the role when a local policy is implemented."

The Prison Service also accepted this recommendation. In response, they said: Volunteers are being sought to fill the role. Training to commence in the New Year."

THE EVENTS LEADING UP TO THE MAN'S DEATH

16. When the man was received at HMP Parkhurst on 12 May 2006, he was settled and said he had no feelings to self harm. He was convicted of false imprisonment, making threats to kill and common assault and battery and was sentenced at a local Crown Court in October 2006 to an Indeterminate Sentence for Public Protection (IPP). The judge set the tariff at 1 year 11 months and 18 days, which took account of time spent in custody whilst on remand.

17. The man had a history of mental health problems and deliberate self harm so an Assessment, Care in Custody and Teamwork (ACCT) document was opened on his reception at Parkhurst. His ACCT was reviewed on 14 May and a care plan agreed. However, two days later he cut his arm and was taken to the accident and emergency department at St Mary's Hospital for treatment.

18. The man had a psychiatric assessment in prison by Doctor A, a visiting psychiatrist, on 16 May. He complained of 'hearing voices' which he described as 'mostly his own thoughts'. Doctor A reported that:

> "These auditory hallucinations did not appear symptomatic of schizophrenia and were transitory in nature especially appearing in times of stress. Affect was mildly flat; there was no formal thought disorder and no overt psychotic symptoms. The perceptual disturbances (auditory hallucinations) did not appear to be symptomatic of a psychotic illness."

19. Doctor A concluded that the man:

> "Appeared to have features of emotionally unstable personality disorder (both borderline and impulsive features) and also dissocial personality disorder and that the evidence for a mental illness was slight."

20. Doctor A said that the man:

> "May be transferred to the wing as he is not subject to a mental illness, but staff will need to be aware of his risk of harm to self and others and manage his behaviour accordingly."

21. The man was also referred to the community mental health team for support. He was prescribed a number of medications in May. These were: trifluoperazine - a medication prescribed for a number of reasons which include agitation for patients with behavioural problems and mental disorder such as schizophrenia; citalopram - a medication prescribed for depression associated with mood disorders; and diazepam - a medication to reduce tension and anxiety. The man's medications were all prescribed as 'not in possession'. This meant that he went to the healthcare treatment room every day where his

medication was administered directly to him by the nurse, and he took it there and then.

22. The man was seen by the Counselling, Assessment, Referral, Advice, Throughcare (CARAT) team on 15 May and his substance misuse problems assessed. He said that heroin was his main problem drug. He was initially treated with Subutex, a drug used to help patients with substance detoxification needs. This helped him to manage his drug problems and to feel calmer.

23. The man cut his arm again on 18 May. He was due to appear in court the following day. The man's ACCT care plan was reviewed and levels of observation increased due to the heightened risk of further self harm. He self harmed on 20 May by opening up a previous wound. He was treated by healthcare staff.

24. During May 2006, the man's treatment and response to treatment were closely monitored by the visiting psychiatrist and community mental health team at Parkhurst. His medication was reviewed and adjusted but his self harming behaviour continued.

25. On 5 June, the man refused to eat, but healthcare staff managed to persuade him to start eating again before he suffered serious health problems. These problems continued on and off during June when he was not eating properly; healthcare staff continued to monitor his weight and the community mental health team continued to monitor his mental health. Healthcare staff noted that there were times during June when he refused to eat altogether and staff would need not only to monitor his weight but ensure he was drinking. He was kept under review by both clinical teams throughout the summer of 2006.

26. The man was seen by the prison doctor on 13 June and referred to a urologist. He was subsequently seen by Doctor B, Associate Specialist in Urology at the Urology Department of St Mary's Hospital on 22 August. Doctor B diagnosed the man's urology problems and arranged urgent cystoscopy (a procedure whereby the doctor sees inside of the bladder and urethra) in the first instance to rule out specific problems. He also arranged a further appointment to follow-up the man's urology treatment.

27. The man was more settled during the first two weeks of June but on 16 June he was observed cutting his arm. Healthcare staff treated the wound and offered support. He said he used cutting as a coping mechanism and stress relief.

28. On 20 June, he cut his left arm once more, and this was treated by healthcare staff. The man was reviewed by Doctor C a visiting psychiatrist, and prescribed medication. A week later, he cut his arm and chest and was again treated by healthcare staff. The following day he cut himself yet again.

29. The man cut his testicles on 2 July and was treated by healthcare staff. He talked about his low self esteem but agreed to hand over the small piece of metal he had used to cut himself. The following day he cut his testicles again but this time made a deeper cut in his scrotum. Healthcare staff treated and dressed the wound.

30. The man self harmed on numerous occasions during the summer of 2006 with incidents recorded on 5, 8, 9, 10, 12, 21, 28 July and 6, 10, 11, 18, 21, 24, 25 August. He self harmed by either cutting his arms or re-opening wounds from previous self harm incidents. The man's wounds were treated by healthcare staff on every occasion.

31. The community mental health team and healthcare staff continued to offer the man support and he remained under their supervision throughout the summer. Whilst at Parkhurst during 2006 there were 27 recorded incidents of deliberate self harm. The man was closely monitored and supported by the community mental health team and continued to be kept under review by the visiting psychiatrist. The management plan was that he should remain on ordinary location as the community mental health team were of the view that he did not require inpatient care at the time. They considered the most appropriate approach would be to continue to monitor him on ordinary location and that admission to the inpatients' unit would not have been helpful at this point.

32. The man's self harming behaviour had improved by the autumn of 2006 and he seemed to be coping much better. He seemed less anxious and said he had started to come to terms with spending many years in prison. He also appeared less worried following his appointment with the urology specialist.

33. Doctor D a visiting psychiatrist at Parkhurst, wrote to Doctor E the visiting psychiatrist at Winchester, on 16 November. She outlined the man's diagnosis of emotionally unstable personality disorder as well as dissocial personality disorder, and described his difficulties, particularly his problems with his mood, his impulsive behaviour, problems maintaining stable relationships and his deliberate self harm.

34. The man was refused a place at Winchester initially because of his medical needs, but a few months later he was transferred there. He was received at Winchester on 11 December 2006 and was seen by the prison doctor who noted his medical and psychiatric history and his history of substance misuse, self harming and previous suicide attempts, including an overdose of prescribed medication ten years earlier. He was on an open ACCT at that time, and was referred to the community mental health team following reception at Winchester partly because of the previous contact he had with the community mental health team at Parkhurst.

35. On 14 December, the prison healthcare team discussed with Urology Admissions at his local hospital the man's follow-up appointment for a procedure which had originally been booked for 22 November 2006 but had been cancelled by Parkhurst on 17 November 2006 because of his pending transfer to Winchester. A GP appointment was then made for the following Monday so that the man could be seen by the prison doctor and re-referred for urology - but this time to another local hospital. There is no written note in the clinical record that he was subsequently seen and referred by the prison doctor for a follow-up urology appointment.

36. The prison mental health service at Winchester is provided by the Adult Mental Health Directorate of Hampshire Partnership NHS Trust. The service is based on a community mental health team (CMHT) approach. A community psychiatric nurse (CPN) from the community mental health team undertook an initial assessment of the man's mental health on 14 December. The man and the Nurse discussed how he would manage the risks and that he would alert staff and ask to see a Listener (a prisoner trained by the Samaritans). However, he conceded that he was impulsive and this strategy would not work. He felt that the risk was not high at that time and his main concern was that his medication should not be changed as he felt it was helping him. He talked about his future plans, which included a desire to return to his local area.

37. He saw Doctor F, a visiting psychiatrist, on 19 December. Doctor F assessed the man's problems as dissocial personality disorder, borderline personality disorder, deliberate self harm, and high risk of suicide. Doctor F agreed a treatment plan with the man which included an increase of his medication and the continuance of other medication. Doctor F wrote to the man's prison doctor and informed him of his diagnosis and treatment plan and that he considered the man to be at high risk of suicide. Follow-up appointments were scheduled but on some occasions the man failed to attend.

38. Regular appointments for psychiatric review were scheduled. The man was due to attend a follow-up appointment on 27 December but he did not attend. (It is not known why he did not keep his appointment.) The man was reviewed by the community psychiatric nurse two days later on 29 December and said that he wished to return to Parkhurst.

39. By using an elastic band and extra strong mints as a distraction, and with the support of his cell mate, the man managed to cope with his feeling of self harm during this time. He also complained that his sleep was erratic but he considered this to be normal for him so he was not over concerned. He still experienced feelings of paranoia and said these feelings upset him. His mental health care plan was to continue to receive support on ordinary location with regular visits from the community mental health team a further review in two weeks' time.

40. The community psychiatric nurse completed a risk assessment on 29 December and ensured both prison and healthcare staff were aware of the risks that the man presented. He had a significant and lengthy history of self harm which included serious cutting to his arms, over dosing on prescribed medication and attempted hanging whilst in custody over a number of years. He continued to be subject to an open ACCT into 2007. In early 2007 the man told staff that he had no strong thoughts of suicide.

41. The man was treated with a number of different medications which had been initially prescribed for his mental health problems when he was at Parkhurst. He told staff at Winchester that he was anxious that his medications should not be changed. He felt they were helping him cope better with his mental health problems and feelings of self harm. The man's initial care plan identified the need for psychiatric review followed by regular follow-up by the prison's community mental health team. The man's care plan specified that he should be managed on ordinary location wherever possible, but that if he found he could not cope with ordinary location he would be re-located in healthcare.

42. The clinical management plan in place during 2007 stipulated that the man's medication regime was to be reviewed on a regular basis. Doctor F advised the prison teams that there should be frequent risk assessments undertaken, with subsequent levels of observation guided by the risk assessments. The multi-disciplinary team decided that the man should be kept under review by Nurse A on a frequent and regular basis.

43. The multi-agency risk assessment planning (MARAP) meeting held on 17 January 2007 identified concerns about the man's risk of self-harm or suicide. A risk management plan was agreed with the prison community mental health team to continue contact with the man in order to provide support when required. There was an expectation that he would remain compliant with prescribed medication.

44. The man remained frustrated at his perceived lack of progress through the prison system and his IPP sentence. Along with a number of other IPP prisoners, the man attended an IPP meeting on 21 January where the Head of Offender Management explained to the prisoners the current Prison Service policy for those with indeterminate sentences. She told my investigators:

> "The man obviously attended with loads of others. Of course, the assessments and things had been done, his Sentence Plan had been written and we were as far as we could go with him."

45. A multidisciplinary team meeting in January agreed that the man would continue to be reviewed by the community mental health team and would be referred to the visiting psychiatrist if required. At the

community mental health team review on 26 January, the man repeated his wish to be transferred back to Parkhurst.

46. During early 2007, the man continued to miss some of his mental health review appointments but would send a message to the healthcare staff to say he was fine. The community psychiatric nurse saw him on 27 January when he seemed to be coping well.

47. On 7 February, the man's care plan was reviewed again to enable access to the prison Listeners as he had expressed some anxiety about his possible move back to Parkhurst. He had requested to move back to Parkhurst but he still felt anxious about the pending change of prison. At this time he was located in the healthcare centre so he could be more closely supported and his mental health monitored because he complained that his mood was low and he felt anxious. He was monitored on an open ACCT although he had no current thoughts to harm himself. He said that a previous self-harm incident had not been a suicide attempt but because of feeling frustrated with his situation.

48. He was seen by the community psychiatric nurse on 15 February. He told her that he had no current thoughts of self harm. However, on 1 March he cut his wrist with a razor. Healthcare staff were called and treated the wound.

49. On 21 February, the man submitted an application to be moved to West Hill, which is the category C wing of the main prison at Winchester. The Governor's reply was that they were awaiting instructions from Population Management Section as to where Winchester would allocate IPP prisoners, and then they would start the transfer process.

50. On 2 March, the man was seen for a mental health review at the request of healthcare staff following an incident of self harm which he had reported as an attempted suicide. The man said he was having constant thoughts of self harm by either cutting or hanging himself, and that he had plans and intent to kill himself. He added that part of him wanted help although he was unable to identify specific triggers for his thoughts of self harm and suicide. He was admitted to the healthcare centre on an open ACCT and seen by the community psychiatric nurse.

51. The man was reviewed again on 6 March by the community mental health team. He had self harmed the week before and said he had done this to relieve tension but then had gone on to cut his arm deeper because he had thoughts about ending his life. At the mental health review the man said that he still struggled with thoughts of suicide. He said that he wanted to go to Parkhurst but had told staff that he had found out his appeal against sentence had been turned down. He understood and that he would serve at least five years. This news had distressed him and he was finding it difficult to cope.

52. The man saw Doctor G, the visiting psychiatrist, following the incident of self harm the previous week. He told Doctor G that initially he had self-harmed by cutting his wrist with a razor in order to relieve tension. During the episode he said he felt more disinhibited and, following thoughts of ending his life, he had cut deeper, sustaining significant lacerations. The man described how his mood had dipped with poor energy levels and loss of interest and enjoyment of things. He said his sleep was poor and he described reduced appetite with ongoing fleeting ideas of suicide. Doctor G's management plan was to increase the man's anti-depressant medication with ongoing input from the healthcare centre in the short-term whilst his mood and sleep pattern improved. Doctor G felt it was important to transfer the man back to the main wing as soon as his symptoms started to improve. The community mental health team arranged to follow-up the man to monitor his response to the change in medication. Doctor G considered that there was an ongoing risk of deliberate self harm in the context of maladaptive coping strategy.

53. The man was moved back to the wing on 22 March. He was initially compliant with the move back to ordinary location, but once he had returned to his cell he refused to eat and drink. He said he was not going to eat or drink and not take his medication until he was moved to Parkhurst. However, within a few days his mood lifted and he was compliant with medication and was eating and drinking properly.

54. The man settled on the wing during the end of March. He reported to staff feeling happier and much brighter in mood. He was now compliant with his medication regime and continued to maintain positive relationships with staff and prisoners.

55. The man's personal officer told my investigators:

> "Yes, generally he was quite a reserved character. I made sure that I spoke to him as often as possible. Not specifically because I was his personal officer but partly because he was a cleaner and partly because he was a long-term resident of B wing. He was a reasonable, a mature and sensible fellow, worked hard. He never asked me for anything, from time to time when people need things for example, if something happens in their personal life they might need an office phone call and they'll ask. But he never, he never asked me any of that."

56. During April, the man had a number of appointments, some of which he failed to attend, with the community mental health team. There is no clear evidence that this was rigorously followed up by the community mental health team, although he was monitored by healthcare staff on a day-to-day basis. He was reviewed in late April and reported that his mood had improved. He felt stable on his current medication and was generally coping with prison life.

57. The man spent a lot of time in his cell during the spring and summer of 2007 and complained that his urinary problems were preventing him from going to education. At that time, the man's main aim was to get back to his local area so that he could receive treatment. He reported that he had no current thoughts of self harm or suicide. The man's probation officer visited him to discuss how he could facilitate a move back to Parkhurst.

58. On 30 May, the man participated in the CARAT harm minimisation programme, which he completed successfully. A Nurse from the Substance Misuse team told my investigators:

> "Yes, he was quiet but he was also a very pleasant prisoner. He was not one that, because of who and the type of people we deal with, they can be very frustrated individuals and express themselves in such a way, whereas he never done that."

59. During May and June of 2007, he continued to submit further applications for a transfer to Parkhurst. On 26 June, he was told that he would be transferred to Parkhurst in the coming three to five months. The housing support officer arranged to visit him to start to make plans in anticipation of his eventual release from custody. The community mental health team reviewed him on 28 June and noted the progress he was making. His application for a transfer to Parkhurst was supported and again he was told that he would be transferred within three to six months.

60. The man expressed no further thoughts or feelings of self harm or suicide at this time. The community mental health team noted that he was very positive about his future and demonstrated insight into his mood swings. The man told the community mental health team that he would contact them if he felt he needed to.

61. The man cut his arm with a razor on 18 July, causing a deep wound that required sutures. The following day an ACCT was opened to manage the man's increased risk of self harm. He was seen by healthcare staff and was admitted to the healthcare centre after he complained of hearing voices and not being able to cope on the wing.

62. At the mental health review on 20 July, he admitted that he had stopped taking his medication about three weeks earlier to see if he could cope without it. There appears to have been a breakdown in communication as this was not picked up and adequately responded to by the clinical teams. The man said that very quickly his sleep, appetite and concentration began to deteriorate and he experienced upsetting thoughts and voices telling him to harm himself. The man was to remain in the healthcare centre for a short term stay and then the plan was that he should return to the wing. The following day, he complained of pain in his arm from when he cut his arm and was

treated with pain relief medication. On 23 July, he badly cut his arm which needed suturing by healthcare staff.

63. The mental health review team decided on 24 July that the man would remain in the healthcare centre for the time being and be reviewed at the end of the week. Doctor E reviewed the man and recommenced his medication regime. The man conceded that it had been a 'big mistake' to stop taking his medication and indicated that he would now comply properly with his treatment regime.

64. The man complained to healthcare staff on 26 July that he was experiencing symptoms of tardive dyskinesia (a condition resulting from the side effects of neuroleptic medication with the uncontrollable trembling of limbs and excessive salivation). He was given procyclidine, a medication to help reduce the side effects of neuroleptic medication.

65. The next day the man's ACCT was reviewed and kept open. He said he felt much better and did not see the point of harming himself. He remained compliant with medication.

66. The mental health review noted on 31 July that the man appeared more settled and reported fewer thoughts of self harm. His mood had improved but he still remained low and felt it would be beneficial if he stayed in the healthcare centre for a while longer. The plan was that the man's anti-depressant medication would be increased and he would remain in the healthcare centre to ensure he made consistent progress.

67. The man continued to make good progress in the healthcare centre and his mood seemed to become more stable with fewer thoughts of self harm or suicide. He was reviewed by the community mental health team on 3 August. The man reported that he was not experiencing any current thoughts of self harm or suicide and was keen to return to the wing. Doctor E saw the man on 7 August with a view to discharging him back to ordinary location. Doctor E increased the man's anti-depressant medication but continued his anti-psychotic medication at the same level.

68. The medication Doctor E prescribed was diazepam (prescribed for depression associated with mood disorders), procyclidine (to reduce the side effects of other medication for mental disorder), citalopram (prescribed for depression associated with mood disorder), and olanzapine (for mental disorder associated with depressive episodes and mood swings or for schizophrenia). The plan was to continue to monitor the man's mood and the effect of his prescribed medication on his mood and mental state before returning him to the main wing. Doctor E wrote to the prison doctor outlining the man's discharge plan from the healthcare centre, which included follow-up with the

community mental health team and follow-up psychiatric review with Doctor E in four weeks time.

69. The man's ACCT was reviewed on 10 August. Due to the progress he had made, it was closed. The multidisciplinary team considered that he did not present a high risk any longer. His mood was much brighter and his mental state appeared stable. He was subsequently relocated back to the wing.

70. The man was seen by the community mental health team on the wing on 17 August. He said that he had no problems and no thoughts of suicide or self harm. The plan was to review him again in two weeks time.

71. During September, the man maintained progress. The mental health review on 13 September noted that he was positive about his future and awaiting transfer back to Parkhurst. His medication was reviewed but not changed. The man did not complain of any persistent thoughts of self harm or suicide at that time.

72. The man continued to make good progress during October. Nurse A visited him on the wing on 11 October and found his mood and mental health stable with no thoughts of self harm or suicide. However, on 31 October he was seen by healthcare staff after complaining of experiencing a panic attack. The man had been to a funeral that day and the nurse who saw him felt that this might have triggered his panic. Despite this, he said that he had no thoughts or intention to self harm. On 1 November, he applied for a job as wing painter, which he started later that month.

73. The man's progress continued and he was reviewed by the mental health team on 15 November. He reported no thoughts of self harm or suicide and that his mood was stable. The man complained of some anxieties but felt that he was generally coping well and was positive about the future. He had settled down to life at Winchester and developed a number of positive relationships with both staff and other prisoners. He had secured a job as the wing cleaner on B wing, which he was especially proud of, and on 25 November he was made an enhanced prisoner under the IEP scheme.

74. The Officer who was later to be second on the scene when the man was found hanging recalled:

> "When he first came to Winchester he was on an ACCT, but that had been closed for a long time because, I think if I remember rightly, when I first put him forward for the painter's job he had just had the ACCT closed or it was almost closed when we gave him the job, and that was months prior to him being given the cleaner's job."

75. The man's personal officer, recalled:

> "The man was already a cleaner by the time I joined the wing, as far as I can remember, and nice guy so no problems with him at all. So yes, trusted yes, and rightly so in his case."

76. The man was seen by the community psychiatric nurse on the wing on 2 December. He reported no concerns about his mental health and said that he had no thoughts of suicide or self harm. He was keeping busy as a wing cleaner and had a few friends whom he associated with. The man was working as a wing cleaner on the 4s of B wing at the time.

77. Wing staff recorded in the Wing Observation book that he had given:

> "101% commitment to his job role and complied in full with staff requests, and an excellent choice for cleaner, an excellent attitude towards staff and prisoners and even takes time out to help fellow prisoners with problems or shoulder to cry on, and fully complies to wing regime."

78. On 13 December, the man was referred to Winchester's drug and alcohol treatment unit because he had complained of some substance misuse issues, although the healthcare team could not identify any specific issues at the time. My investigators were told by a prisoner whom they interviewed during the course of their investigation, that the man had on occasions, albeit rarely, taken non-prescribed or illicit drugs.

79. The man signed-up to B wing's voluntary drug testing compact on 20 December. The first two weeks would be on a trial basis. The man signed to say that he understood the implications of agreeing to the compact.

80. The man complained to healthcare staff on 31 December that he was not happy with a recent medication change. He was due to see Doctor E for psychiatric review but failed to attend his appointment.

81. The man responded positively to the substance misuse team's interventions and no further problems were reported by either him or staff. The man was subject to Winchester's frequent voluntary drug testing programme and was subject to frequent testing throughout January, February and March 2008 with negative results for benzodiazepine but positive for opiate Subutex on 8 January.

82. On 18 January, the man was seen by healthcare staff and the community mental health team following a telephone call from an 'external agency' who suspected that he might have taken an overdose of medication.

83. A member of staff made an entry in the clinical information system dated 18 January 2008 which records:

> "Telephone call from the community psychiatric nurse, saying external agency concerned that the man had overdosed. The man was seen on the wing. All stable and well. No issues of concern. Given a telephone call to his family to reassure them. Have re-spoken to the community psychiatric nurse and informed her that there appeared to be no concerns."

84. There is no further information contained in the clinical record about this issue. The man was seen on the wing by healthcare staff and was found to be stable in his mental health with no particular issues of concern. The entry in the clinical IT system states that the man's family was informed of the situation, but his family say this was not the case.

85. The community mental health team saw the man on the wing on 22 January for his regular review. His probation officer asked for a psychological assessment to assist the man's sentence planning. During January and into February, he continued to make good progress and reported no significant concerns. He submitted an application to ask if he could have his medication in possession, and on 15 February he was seen by the community mental health team. The outcome was that he was not allowed to have his medication (prescribed for mental health problems) in possession.

86. The man's sister had raised concerns about a 'psychiatric report which he needed to assist his transfer to Parkhurst'. The man's sister told my family liaison officer, that after months of indecision this was eventually refused in Feb 2008 'due to a lack of funding'. My investigators could not find any evidence to substantiate this.

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87. The community psychiatric nurse saw the man on 5 March. He complained of low mood and feeling stressed and wanted a review of his medication. He said he still wanted to move to another prison where he felt he would have a better opportunity to access relevant courses so that he could progress through his sentence. The man's medication regime was diazepam, procyclidine, citalopram and olanzapine.

88. On 7 March, he attended his sentence planning and review meeting where his risk assessment was reviewed and updated. No changes were made to the level of risk the man presented. Planning for the

next 12 months included the identified risks that still needed to be worked on. These were domestic abuse and offending behaviour, substance misuse and victim empathy. The sentence planning and review meeting noted that the man had no IEP warnings or adjudications for poor behaviour and that he was on the enhanced regime. The man was employed in a trusted position and had been working as a wing cleaner for six months at that point.

89. The man's perspective was that he was keen to progress and attend programmes in order to achieve release at the first opportunity. The man's identified needs included his emotional well-being, specifically that he needed to remain in contact with his CMHT worker, Nurse A, and remain compliant with his medication; and purposeful activity, in that he needed to remain in employment and undertake duties to keep him active and that he would also benefit from gaining some vocational skills to assist him in gaining employment upon release.

14 March 2008

90. On the morning of 14 March just before 8.30am, the man's cell (B4-39) was unlocked by the officer who would later be second on the scene when the man was found hanging. He was always one of the first to be unlocked because he was a wing cleaner. The man went downstairs to the treatment room where the nurse administered his daily morning medication. The medication administration record chart records that he accepted his three prescribed medications: olanzapine 5mg, procyclidine 5mg and citalopram 20mg. The man then returned to his cell.

91. A PE officer, was walking along the 4s landing on B wing to see which prisoners wanted to go to the gym. At 8.46am a prisoner, shouted to the PE Officer that a prisoner was hanging in the cell adjoining his own. The Prisoner and the PE Officer immediately ran into B4-39 and found the man hanging from a ligature made from shoelaces attached to a window bar.

92. The Prisoner supported the man's body weight while the PE Officer went to call for assistance by shouting down from the 4s landing to another Officer who was on the 2s landing at the time. The Officer ran up the stairs and went into the cell to help. The PE Officer and the Prisoner lifted the man down from the bars and the PE Officer cut the ligature from the bar whilst a third Officer cut the ligature from around the man's neck. In interview, the Officer that cut the ligature said the man appeared "sort of limp and lifeless". Within a few seconds another Officer, who had also responded to the third officer's shouts for assistance, joined them in the cell. The three officers placed the man on the bed and another Officer started cardio pulmonary resuscitation (CPR). A Senior Officer came into the cell got a face mask out of his pack and performed mouth to mouth resuscitation. The Officer who

had cut the ligature shouted out a Code 1 over the radio (the call sign for a medical emergency).

93. At 8.50am, nurses from the substance misuse team heard the calls for assistance and arrived to assist. The substance misuse nurses had the ambu bag (a hand-held device used to provide positive pressure ventilation to a patient who is not breathing or who is breathing inadequately) to assist respiration and another Senior Liaison Officer took over on chest massage. The officers pulled the bed out from the side of the cell so that staff had more room to intervene. A Nurse arrived a few minutes later at 8.56am and inserted a Guedal airway (used to maintain a patient's airway) into the man's mouth and administered oxygen via the ambu bag to try to get him to start breathing. The Nurse could not detect a heartbeat. At 9.00am, staff applied the defibrillator paddles but the defibrillator advised that no shock was needed. (Note: it is critical that staff do as instructed by the defibrillator – to 'shock' when indicated otherwise is at best ineffectual, and at worst can be harmful to the patient). An officer in Control had already called 999 for an ambulance at 8.55am.

94. Visiting psychiatrist, Doctor C, had arrived on the wing at 9.00am and immediately assisted. Doctor C felt for the carotid pulse and noted that the man's pupils were fixed and dilated. Doctor C detected a pulse at this point. He then administered intravenous adrenaline. The man still did not breathe so oxygen therapy via the mask and ambu bag was continued. Staff continued to perform CPR until the ambulance crew arrived.

95. The first ambulance crew arrived a few minutes later on B4 at 9.02am. The man's carotid pulse was still palpable with a strong output but he was not breathing on his own. Staff continued to use the defibrillator to analyse the man's vital signs but no shock was needed throughout the process. Doctor C attached a collar to support the man's neck and inserted a cannula (a tube inserted into the body to deliver fluids) with saline flush.

96. The man's personal Officer was deployed to ensure an accurate log of events was recorded. A Governor told my investigators:

> "There was no orderly officer actually at the scene. The co-ordination of people going to and from the scene was actually being dealt with by the staff that was actually up there. There was no one designated person that was dealing with it."

97. The first ambulance team to arrive consisted of ambulance technicians and were not trained paramedic personnel. A second ambulance team with paramedics was subsequently despatched. The community mental health team in their clinical review has committed to raise this incident with South Central Ambulance Service regarding the delays experienced due to the initial attendance by an unqualified crew. I

have also written formally to South Central Ambulance Service for their response.

98. The second ambulance team arrived at 9.16am and paramedics took over the man's care from prison staff. He was put in an evacuation chair to take him to the ambulance. He was still not breathing so ambulance staff continued to administer oxygen all the way down the stairs from the 4s landing. The second ambulance crew arrived at 9.15am. The man was transferred to the ambulance in the evacuation chair at 9.32am and taken to a hospital near the prision. He was admitted to the intensive care unit (ICU).

99. The man's family were notified of his admission to hospital, but unfortunately this did not happen in a satisfactory way and caused the family considerable distress. The prison-based probation officer, had spoken to the man's offender manager in the community, as part of the prison protocol in such circumstances, and told his offender manager that the man was in hospital. The offender manager assumed that the man's family had been informed of his condition and spoke of him being seriously ill in hospital when he rang the man's sister. This news came as a shock to her as she had not at that point been made aware by prison management that her brother had been found hanging.

100. That afternoon, a Governor visited the Royal Hampshire County Hospital where he met the man's mother and sister and told them of what had taken place. He continued to visit the man in the hospital each day and to see his family. When healthcare staff from the prison visited the man on 17 March they were told that he remained critical and a CT scan was scheduled for that afternoon.

101. Although the prison has a canteen, it is common practice for staff to use the facilities at the hospital across the road. Members of the man's family have told my investigation team that they were upset when they overheard prison staff laughing and joking in the hospital canteen during the time the man was in intensive care. The family members felt that the prison staff had shown a lack of sensitivity to their feelings at that distressing time. The family were also upset about some of the comments they heard from the escort and bedwatch staff looking after the man in the hospital.

102. The next day (18 March 2008), the ICU team informed the prison that the man's condition had not improved so the ventilator would be turned off later that day as there was no sign of brain activity. The Governor says that he talked to the man's family that morning about what to expect as it was clear that the man was going to die. The man's family, however, disputed this part of the Governor's account when they read my draft report. That afternoon the ventilator was switched off and the man died at about 6.20pm.

THE EVENTS FOLLOWING THE MAN'S DEATH

103. The next day (19 March), the man's sister telephoned the Governor grade she had met at the hospital. The Governing Governor had wanted to send letters of condolence to the family but, as the relationship between the prison and the family had been quite strained, the Governor that the man's sister telephoned wished to talk to her first. An offer of a financial contribution towards the funeral costs was also made.

104. A few days later on 25 March, the man's sister called the same Governor Grade she had previously spoke to and told him that some members of the family would like to receive condolence letters from the Governing Governor. However, she said that the family did not wish any prison representation at the funeral or for a floral tribute to be sent.

KEY FINDINGS AND CONCLUSIONS

First on the scene and emergency response

105. My investigators found that prison staff acted in a professional and caring manner when they attended the man's cell. The prisoner had found the man hanging in his cell, promptly supported his body weight while The PE Officer summoned help from his colleagues. The prisoner and the PE Officer acted in a caring manner to do their best for the man. The prisoner's prompt action is to be commended (if he is still in custody, I hope that the current Governor can share that commendation with him).

106. Healthcare staff were called to the man's cell and were quick to respond. Doctor C visiting psychiatrist, working in the prison that day, also responded to the emergency and administered emergency medical treatment. The regular prison doctor had not yet arrived in the establishment as he was not due to start duty until 9.00am.

107. When the man was found hanging in his cell the prison's response was timely and efficient. I judge that all staff performed well in trying to try to save the man's life, but sadly they were not successful. The clinical review team endorse my finding in their report.

Cardio Pulmonary Resuscitation (CPR)

108. Prison officers and healthcare staff performed Cardio Pulmonary Resuscitation (CPR) to try to save the man's life. The man was placed on the bed after the ligature was cut and, because of the need for spontaneous and urgent action and limited space in the cell, staff performed the CPR on the bed.

109. I understand it was of great concern to the man's family that CPR was carried out on the bed and not the floor, as is widely recommended. Indeed, Prison Service Order 2700 Suicide Prevention and Self-harm Management Annex 13A Action Following Self-harm: Emergency Procedures states, "Place the prisoner on his/ her back on a flat, solid surface." There is no question but that CPR is most efficient when carried out on a firm surface. However, my investigators found that the healthcare staff present were satisfied that the CPR carried out was professional and competent. The Officer who initially started the CPR, is also a trained auxiliary fire officer with additional training and experience in carrying out CPR. Other staff and prisoners commented on how well CPR had been carried out by the healthcare and prison staff. In the circumstances, I do not believe that staff should be criticised for the decision to carry out CPR on the bed. However, the Governor may wish to remind staff of best practice.

110. Doctor C, who gave medical intervention, including the administration of adrenaline, had recently undertaken refresher medical emergency training. Fortunately, his own medical bag contained a cannula which he used to administer the adrenaline. My investigation highlighted the need for low cost items such as cannulas to be stocked and easily accessible to trained staff.

111. The critical incident review by Hampshire Partnership NHS Trust has recommended that appropriately equipped emergency bags should be available on each wing for prison healthcare teams, and that the standards of training relating to life support for both healthcare and substance misuse staff groups should be reviewed.

The Governor and Head of Healthcare, in collaboration with the PCT, should review the standards of training relating to life support for healthcare and substance misuse staff.

Medical emergency bags

112. My investigators found that healthcare staff were unclear as to what the emergency bags should contain and where they were located in the establishment. Healthcare staff complained that equipment was sometimes missing from the emergency bags and that the bags were heavy when they had to be carried to an emergency.

The Governor and Head of Healthcare, in collaboration with the PCT, should review the content and location of the emergency bags to ensure they are accessible at the point of use and are fit for purpose.

Medical emergency code system

113. The prison has a code system to alert healthcare and discipline staff to medical emergencies. The current system is:

- Code 1 – which indicates a life threatening situation, for example a prisoner found hanging or having a heart attack
- Code 2 – which indicates serious but not life threatening situations, for example a prisoner having an epileptic fit or self harm
- Code 3 – less serious incidents, for example feeling very ill

114. My investigators found that the code system in place at Winchester for medical emergencies is unclear, not based on best clinical practice, and is not properly understood by all healthcare and discipline staff. The discipline and healthcare staff my investigators interviewed described different meanings to each code as they perceived it.

115. Many establishments use a colour code system which helps to identify the type of emergency the staff are required to respond to and in turn allows the correct equipment to be taken. For instance a 'code red' indicates an emergency involving the loss of blood, 'code blue' breathing problems.

The Governor and Head of Healthcare, in collaboration with the PCT, should review the emergency medical response code system with a view to introducing a colour coded system.

Ambulance response

116. The first ambulance team to arrive consisted of ambulance technicians who were not trained paramedic personnel. The community mental health team in their Clinical Incident Review Report has committed to raise this incident with South Central Ambulance Service regarding the delays experienced due to the attendance of an unqualified crew. I must stress though that there is no evidence that this had a negative impact on the care the man received or diminished his chance of survival.

The Governor and Head of Healthcare, in collaboration with the PCT, should raise this incident with Hampshire Ambulance Service regarding the delays due to attendance by an unqualified crew.

Imprisonment for Public Protection (IPP)

117. My investigators reviewed previous Inspectorate and IMB reports on Winchester which contained concerns about the establishment's ability to provide access to suitable offending behaviour courses for IPP prisoners trying to progress.

118. The man's offender manager from the community, and Winchester's head of offender management, both expressed their concerns about the prison's ability to provide access to suitable courses and about IPP generally.

119. The lack of access to courses for IPP prisoners may mean that they are not able to make meaningful progress through their sentences. However, some courses are offered at Winchester: for example, the domestic violence programme.

120. The man, had wanted to return to HMP Parkhurst so that he would have better access to the relevant courses and also to attend an outstanding hospital appointment.

121. Prisoners who knew the man that had felt frustrated at the delay in transferring him from Winchester to Parkhurst. He was eager to progress through his IPP sentence and to eventual release. Equally,

the man's family were also frustrated and angry that the Prison Service had not moved him back to Parkhurst despite his clear desire for such a transfer.

122. My investigators spoke to the man's community offender manager. He said that a high risk housing assessment and a risk assessment of self harm and harm to others had been carried out by himself and a specialist housing officer to support the man's eventual return back into the community.

123. The man told his community offender manager that he would have preferred a ten year sentence to an IPP sentence. The community offender manager described how the man had "seemed very flat" the last time he had seen him in December 2007, which "was very different to previous visits during 2006", although the man's self harming behaviour seemed to have abated.

External hospital appointments

124. The man had been receiving treatment for a urology problem which caused him some anxiety and embarrassment. He was keen to resume his medical treatment. My investigators found that this did bother the man a great deal and very likely affected his low self esteem and poor mental health on occasions.

125. There was some confusion over arranging follow-up urology appointments. This was compounded by the man's pending transfer to Winchester before his first follow-up appointment.

The Governor and Head of Healthcare, in collaboration with the PCT, should have mechanisms in place to ensure that any outstanding hospital appointments are acted upon when prisoners transfer between establishments. Healthcare staff should ensure that all entries in the medical records and appointment systems contain the date and time, particularly for multiple entries on the same day.

Sharing of information and risk assessment

126. The community mental health team's initial assessment at Winchester in December 2006 noted the man's long history of self harm and that he was previously known to mental health services at Parkhurst. The man's diagnosis was personality disorder. The man said he felt stable at that time with the medication he was taking. This assessment was comprehensive and covered several areas which included the man's view of problems, past and current psychiatric problems, current mental health presentation, substance misuse issues, and risk of self harm and suicide. The community mental health team carried out an enhanced assessment which looked at specific areas of mental health, including the man's behavioural issues and personal history.

127. From the initial mental health assessment a comprehensive and enhanced risk assessment and management plan was developed on 14 December 2006. The risk screen identified the man's risk areas as history of suicide, current risk of deliberate self harm, and a history of and current risk of violence towards others. The risk assessment identified that the man had a long history of self harm which he used as a coping strategy and that he did not always recognise a trigger to self harm and described a rapid variation in mood. It also identified a history of suicide attempts with the man's last suicide attempt having occurred whilst he was on remand at Parkhurst. The man described himself as intolerant towards others especially when he felt stressed and said he had a history of violence towards other people.

128. The risk management plan set out that the man was to be located on the wing wherever possible at Winchester so that he could adjust to the prison regime with support from Listeners. He was monitored on an open ACCT when this was necessary with healthcare and wing staff aware of his problems. The community mental health team ensured he was kept under regular review and, when he experienced a crisis, admission to the healthcare centre was an option.

129. The man was also registered under the care programme approach (CPA) on the enhanced level. The man's CPA care plan included a risk management plan which specified that he would try to alert staff when he had the urge to cut himself, that the community mental health team would follow-up as appropriate and that he would request a listener if he needed support. The contingency plan was that the man could be admitted to the healthcare centre if need be but, if possible, he would be managed on the wing. The CPA care plan was developed from the community mental health team's initial risk assessment and risk management plan following the man's reception to Winchester.

130. A cell sharing risk assessment undertaken in December 2006 when the man was received at Winchester identified he was on an open ACCT. This had been open since 13 May 2006 with numerous incidents of deliberate self harm during 2006, although on reception to Winchester he denied any thoughts of self harm. The man's risk was assessed at 'medium' which meant no immediate risk but the situation would need to be reviewed regularly. Concerns about the risk of self harm were then communicated to the wing team.

131. Healthcare staff did not always contribute towards the ACCT process. The majority of ACCT cases will involve prisoners with some kind of mental health problem, and healthcare involvement is imperative to inform risk assessment and aid effective decision making. Local procedures for ACCT should be reviewed to ensure that healthcare staff are involved in the decision to close the case.

132. The cell sharing risk assessment was followed up and reviewed in March 2007 and the assessment of risk deemed to be low risk (no current indication or evidence of risk and suitable for multi-cell location). He told staff that he had no problems and got on well with other prisoners.

133. The multi-agency risk assessment planning (MARAP) meeting held in January 2007 identified concerns about the man's risk of self-harm or suicide. A risk management plan was agreed which specified that the prison community mental health team would continue to maintain contact with him to provide support. He was expected to remain compliant with his prescribed medication for mental health problems.

134. The man was monitored on a number of open ACCTs during 2006 and 2007. These were 12 May to 27 December 2006, 6 to 12 February 2007, 1 to 30 March 2007 and 18 July to 1 September 2007. There did not appear to be great input from healthcare staff to contribute to the decisions to close the ACCTs. If healthcare staff did contribute, this was not detailed in the ACCT documents

135. In March 2008, the man attended his sentence planning and review meeting where his risk assessment was reviewed and updated and progress reviewed. No changes were made to the level of risk he presented. Planning for the next 12 months included the identified risks that still needed to be worked on: domestic abuse and offending behaviour, substance misuse and victim empathy. The sentence planning and review meeting noted that the man had no IEP warnings or adjudications for misbehaviour and that he was on the enhanced regime and had been working as a wing cleaner.

136. The man's perspective on his time in custody during 2008 was that he was keen to progress and attend programmes in order to achieve release at the first opportunity. The man's care plan addressed his emotional well-being, specifically that he would remain in contact with his community mental health team worker, and remain compliant with his medication. He was to continue to engage in purposeful activity so he needed to remain in employment. His care plan also suggested that he would benefit from gaining vocational skills to assist him in getting a job on release.

137. Staff and prisoners who knew the man have described him as being "a complex individual with issues" who had a history of mental health, drug problems and self harm. The community mental health team saw the man on a regular basis as he was subject to the Care Programme Approach. He was being treated with medication prescribed by Doctor C, visiting psychiatrist, and was kept under regular psychiatric review both by Doctor C and by the manager of the prison's community mental health team.

138. My investigators found that the man had been a prolific self harmer during 2006 and 2007 with over 30 incidents of self harm recorded at Parkhurst and latterly at Winchester. He had been a patient in the inpatients unit at Winchester on an open ACCT but this was closed in September 2007. From then until his death there were no self harm incidents and he appeared to be generally coping well.

139. The man had been a substance misuser and was treated by the prison's detoxification team. There was no evidence that he misused drugs whilst in prison and in the time leading up to his death, other than one incident of a positive result for Subutex. Mandatory drug tests were negative, although a prisoner told my investigators that he thought the man was using illicit drugs purchased within the prison to 'get by' day to day.

140. My investigators found a general lack of multidisciplinary team working and sharing of prisoner information between the teams of healthcare, drug detoxification, CARATS, community mental health team, probation, offender management and wing staff. There were inadequate shared risk assessment and care planning processes across these teams to address risk issues in terms of the man's risk of self harm, drug problems and mental health. Improved multidisciplinary team working and shared communication would have improved the quality of joined-up and integrated care that he received whilst at Winchester.

141. My investigators found that staff from the different disciplines and teams did not communicate in a formal way to share relevant information to inform the man's care management. For example, his history sheets were not written in by staff from the different teams, thereby missing an opportunity to share important information about him.

142. In the introduction by the Head of Offender Management Partnerships, National Offender Management Service to 'Safe and Secure': Guidance for prison healthcare staff on information sharing' (2007), he wrote:

> "Although staff from all organisations involved with justice and secure care systems have always been willing to cooperate with and assist each other where possible, concerns over unlawful disclosure of sensitive and personal data have constrained sharing of information with, at times, tragic results. Whilst concerns to stay within the laws and guidance governing disclosure of information are justified and laudable, they have at times been misplaced."

143. A clear policy for the obtaining of consent and disclosure of prisoners' confidential medical information should be implemented to meet the requirements of Prison Service Order 2700, Suicide Prevention and Self Harm Management. Chapter 8, Planning and providing care for prisoners at risk of suicide and/or self harm, says:

> "Good care can only be achieved through effective communication and teamwork".

The Governor and Head of Healthcare, in collaboration with the PCT, should review the management arrangements for sharing appropriate information about vulnerable prisoners, to include shared assessment and care planning arrangements on a multi-professional basis across healthcare, discipline, CARATS, drug detoxification and mental health team. This should include a procedure to implement a clear policy for the obtaining of consent and the subsequent disclosure of prisoners' confidential medical information to realise the requirements of Prison Service Order 2700. The effectiveness of the new arrangements should be formally reviewed within six months of their introduction.

The Governor and Head of Healthcare, in collaboration with the PCT, should undertake a local review of ACCT procedures to assure healthcare input into the ACCT process to inform risk assessment and aid decision making

Personal officer scheme

144. Winchester has a personal officer scheme running on the wings where each prisoner is allocated an officer to support him on a day-to-day basis. The man's personal officer was very upset when he learned that the man had died. However, he had not been fully aware of the man's history of self harm and had had a limited understanding of his mental health and drug problems. I fear this may illustrate the lack of information sharing between the teams working in Winchester who were involved in the man's care.

Prison staff

145. Some staff at Winchester regularly use the canteen of the hospital across the road from the prison. As I have reported, members of the man's family were upset when they overheard prison staff laughing and joking in the canteen when the man was in the intensive care unit.

146. There is no evidence that the prison staff were aware that members of the man's family were nearby, but this unfortunate incident does highlight the need for prison staff to remember that they represent their prison and the Prison Service as a whole at all times.

147. The family were also upset about some of the comments from the prison escort and bedwatch staff looking after the man in the hospital. I have not investigated this issue further, but staff should be especially mindful of what they say to family members during a bedwatch.

The Governor should remind staff of the need to be professional and sensitive at all times, especially when outside the prison, where staff may come into contact with distressed and bereaved relatives and friends.

The memorial service

148. HMP Winchester organised a memorial service for the man's family and friends, which included prisoners who had known him.

149. Family and prisoners who attended felt that the memorial service was poorly conducted and should have been more sensitively handled by prison managers and the chaplaincy team. When prisoners at the service were asked by the man's family to share their contact details, the service was prematurely terminated by the chaplain, because he did not know whether security allowed this. Not surprisingly, this added to the family's distress.

150. My investigators could not find a Prison Service Order or Prison Service Instruction which specifically prohibits prisoners giving their contact details to family in these circumstances.

151. The family were also unhappy that the Governor, or his representative, did not attend the memorial service. This situation arose due to a misunderstanding about whether the family wanted prison managers to attend the memorial service or not.

The Governor should ensure that consistent management arrangements are in place when a memorial service, or similar occasion, is organised, and these arrangements should include proper staff and prisoner briefings to ensure that services are conducted in a sensitive manner.

Family Liaison Officer and notifying the family

152. The family were very distressed by the way in which they were notified of the man's condition. My investigators found that the process for informing the man's family that he was seriously ill in hospital did not happen as the prison had initially planned. As I have shown, the prison-based probation officer, spoke to the man's offender manager in the community, and told him that the man was in hospital. The man's offender manager assumed that his family had already been told and so contacted the man's sister.

153. Meanwhile, the Governor acting as family liaison officer for the establishment was planning to drive to the man's sister's home to tell her that he was seriously ill in hospital.

154. The man's family feel strongly that, given his critical condition, the prison should have rung them as a priority and by doing so allowed them as much time as possible with him. The family believe it was not appropriate in this situation to have wasted valuable time arranging a car when the family do not live near the prison.

155. Prison Service Order 2710, Follow up to deaths in custody, includes guidance for liaison with bereaved families. This sets out the functions of a family liaison officer and the recommended options of breaking news to the family in the event of death. This guidance represents best practice following a death.

156. The prison made strenuous efforts to act in accordance with the guidance for liaison with bereaved families and it appears they were anxious that I would be critical if someone from the prison did not visit the family in person. However, I actually think it is one thing for the prison to deploy a family liaison officer to visit the family to break news of a death and something quite different when a death has not occurred, but may be imminent, and time is of the essence.

157. In this, and indeed in all other situations, common sense should be applied with the prison responding in an appropriate and sensitive way depending on the specific circumstances.

158. I understand that a delay in returning the man's property to his family added to their distress.

159. My investigators found that despite my recommendation in a previous investigation, Winchester had not trained an adequate number of family liaison officers and an effective system was still not in place.

I repeat the recommendation from my previous investigation in 2007: the Governor should consider placing suitable volunteers on the Family Liaison Officer training course waiting list as soon as practicable to ensure that there are dedicated staff available to carry out the role when a local policy is implemented.

Conclusions

160. I recognise that the man was willing to engage with mental health and prison staff and that, to a large degree, he was compliant with the care plans devised by those teams, especially during the last year of his life. However, he continued over many years to commit serious acts of self harm. The indications are that, despite his progress in recent months, he apparently decided to end his life on 14 March 2008.

161. After the man was found hanging, the prison's response was generally timely and efficient. However, I have criticised aspects of Winchester's preparedness and this is reflected in my recommendations.

162. The man had felt frustrated at his perceived lack of progress through his indeterminate sentence for public protection and the prison's apparent inability to afford him access to the relevant offending behaviour courses. I have made a recommendation that the prison's capacity and capability to improve access to suitable courses for IPP prisoners whilst they await transfer to next stage prisons should be reviewed.

163. The level and comprehensiveness of risk assessment and risk management processes and their application to the man's care and risk were well developed. However, I have found a general lack of multidisciplinary team working and sharing of prisoner information between the teams across HMP Winchester. For example, I found scant evidence that healthcare staff were fully engaged and contributed to the ACCT process.

164. Chapter 8.11 of Prison Service Order 2700 says: "Good care can only be achieved through effective communication and teamwork". Annex 8V of that Prison Service Order goes further:

> "Failures of communication of all kinds are one of the commonest contributory factors found in investigations into self-inflicted deaths, in prisons and in the NHS. Lack of communication between healthcare and residential staff was specifically identified as a significant problem in the evaluation of the F2052SH (the predecessor of ACCT) … Teamwork requires respect of and from each other and between our different disciplines, a willingness to work together, and above all, professionalism and trust so that information can be shared with those who need it. Working in teams helps to share the anxieties associated with caring for those at risk."

RECOMMENDATIONS

The Governor and Director of Offender Management for South West have accepted ten of these recommendations. Below each recommendation is their response contained in an action plan provided to me on 3 August 2009. A further progress report was issued to me in April 2010. The additional information from this update is recorded in italics below each relevant recommendation.

To the PCT and Governor

1. The Governor and Head of Healthcare, in collaboration with the PCT, should review the standards of training relating to life support for healthcare and substance misuse staff.

   All Portsmouth City PCT staff have now received life support training. The Hampshire Partnership Trust will ensure that Substance Misuse staff working at Winchester Prison receive training in Life Support. The target date for completion was September 2009.

2. The Governor and Head of Healthcare, in collaboration with the PCT, should review the emergency medical response code system with a recommendation to introduce a colour coded system.

   The Prison Service asked that this recommendation be amended to reflect that there is no mandatory national requirement to operate an emergency code system and therefore no obligation for an establishment to introduce a colour coded system.

3. The Governor and Head of Healthcare, in collaboration with the PCT, should review the content and location of the emergency bags to ensure they are accessible at the point of use and are fit for purpose.

   A multi disciplinary review of the location and impact of the location of emergency bags will be carried out. This will be accompanied by a risk assessment process that will ensure the optimum coverage for the prison is achieved. The target date for completion was July 2009.
   The content of the emergency bags will be assessed as part of the review and guidance sought from the PCT Training Department. The target date for completion was July 2009.

   These checks are now carried out by the Health and Safety Department. These matters are discussed at a monthly meeting.

4. The Governor and Head of Healthcare, in collaboration with the PCT, should raise this incident with Hampshire Ambulance Service regarding the delays due to attendance by an unqualified crew.

The Governor, in liaison with the Head of Healthcare, to formulate a letter to the Hampshire Ambulance Service highlighting the concerns raised and ways to prevent re-occurrence. This subject to also be raised at Clinical Governance and Partnership Board meetings. The target date for completion was July 2009.

The Head of Healthcare has written to all parties concerned.

5. The Governor and Head of Healthcare, in collaboration with the PCT, should review the management arrangements for sharing appropriate information about vulnerable prisoners, to include shared assessment and care planning arrangements on a multi-professional basis across healthcare, discipline, carats, drug detoxification and mental health teams. This should include a procedure to implement a clear policy for the obtaining of consent and the subsequent disclosure of prisoners' confidential medical information to realise the requirements of Prison Service Order 2700. The effectiveness of the new arrangements should be formally reviewed within six months of their introduction.

   An information sharing meeting was arranged for 22 July 2009. The target date for completion was September 2009.
   An information sharing protocol will also be implemented to give clear understanding to all parties with regards to sharing appropriate information. The target date for completion was September 2009.
   This protocol will be reviewed in line with the recommendations at six months or before if the need arises. The target date for completion was September 2009.

   These actions have all been completed.

6. The Governor and Head of Healthcare, in collaboration with the PCT, should undertake a local review of ACCT procedures to assure healthcare input into the ACCT process to inform risk assessment and aid decision making.

   A meeting is to be arranged between the Safer Custody Lead and Healthcare staff. This meeting will put in place a review system which will ensure joined up working between prison and PCT. This process will be subject to review at Partnership Board. The target date for completion was July 2009.

   This review was carried out. A further review is due to take place in May 2010.

7. The Governor and Head of Healthcare, in collaboration with the PCT, should have mechanisms in place to ensure that any outstanding hospital appointments are acted upon when prisoners transfer between establishments. Healthcare staff should ensure that all entries in the medical records and appointment systems contain the date and time, particularly for multiple entries on the same day.

IT records now provide an audit trail to record date and time of entries so this recommendation has been completed.
With reference to transfers and appointments, a management check is now in place to review all new Reception records. This will ensure that regardless of transfer, appointments and medical issues are shared appropriately. Check in place as from June 2009.

Check in place as from June 2009.

To the Governor

8. The Governor should remind prison staff for the need to be professional and sensitive at all times, especially when outside of the prison, where staff may come into contact with distressed and bereaved relatives and friends.

   The Prison Service Code of Conduct covers staff behaviour in public areas. However at times when distressed or bereaved relatives are present a protocol will be developed to ensure all staff working in the prison are aware of the increased tension and standards of behaviour are reinforced. The target date for completion was August 2009.

   Notice to Staff has been issued and staff have been advised that they face possible disciplinary action should they breach any aspect of the COD [Code of Discipline].

9. The Governor should ensure that consistent management arrangements are in place when a memorial service, or similar occasion, is organised, and these arrangements should include proper staff and prisoner briefings to ensure that services are conducted in a sensitive manner.

   Our local follow up to death in custody procedures will be amended to include a section on full staff and prisoner briefings prior to bereaved family members attending the prison. The target date for completion was September 2009.

   Local protocol would now include appropriate briefings.

10. I repeat the recommendation from my previous investigation in 2007: the Governor should consider placing suitable volunteers on the Family Liaison Officer training course waiting list as soon as practicable to ensure that there are dedicated staff available to carry out the role when a local policy is implemented.

    There are currently two Family Liaison Officers at HMP Winchester. The Governor will continue to recruit Family Liaison Officers so as to ensure appropriate coverage is achieved. The target date for completion was December 2009.

A local policy document for Family Liaison Officers will be drawn up and added to Winchester's Death In Custody local policy document. The target date for completion was December 2009.

Continuing to recruit FLO's. FLO policy now in place.

11. Arrangements for how and when a prisoner's family is contacted following a serious incident or when the prisoner is taken seriously ill should be reviewed.

    Duty Governor's are in negotiation with PCT staff to assess the condition and prognosis of the prisoner and decide on contacting the family of the prisoner when seriously ill or with a life threatening condition. The target date for completion was December 2009.

    Decision now taken on a case by case basis following multi-disciplinary review.