PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent Investigations

Investigation into the death of a man at HMP Winchester in September 2011

Report by the Prisons and Probation Ombudsman for England and Wales

May 2013

This is the report of an investigation into the death of a man, a prisoner at HMP Winchester. He was discovered hanging in his cell in September 2011. He was 44 years old. I offer my condolences to the man's family and friends.

The investigation was carried out by one of my investigators. Hampshire Primary Care Trust (PCT) appointed a clinical reviewer to review the man's clinical care. Staff at HMP Winchester cooperated with this investigation. I apologise for the delay in issuing this draft report.

The man was a prisoner for just over three months before his death. He had a number of chronic health conditions, which were managed satisfactorily but I am concerned that he was not provided with equipment to help manage his sleep apnoea. He had made a clear statement of intent to friends and prison staff that he intended to take his own life and he was monitored under suicide and self-harm prevention procedures. Winchester correctly identified times when he was at increased risk and reviewed the management plan accordingly. Monitoring stopped on 16 August, when the man presented as more settled and positive and had no stated thoughts of suicide.

The man had extensive support and was closely monitored when he was identified as high risk to himself. While the investigation found some room for improvement in the management of the suicide and self-harm procedures I do not consider this contributed to his death, which would have been very difficult to prevent.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman **May 2013**

CONTENTS

SUMMARY

1. The man, a French national, was convicted of sexual offences on 16 June 2011 and was remanded in custody at HMP Winchester. He was sentenced on 5 August to 15 years imprisonment and remained at Winchester. He told prison staff he had a number of chronic health problems, including diabetes, sleep apnoea (abnormal pauses in breathing during sleep) and angina (pain in the heart).

2. The man was a complex and sometimes difficult man to manage. From his first day in prison custody and at court, he made his intention to kill himself known and made a number of unsuccessful attempts on his life. He was monitored through the prison's suicide and self-harm monitoring process. There are extensive records covering the period he was monitored and appropriate actions and decisions were taken to keep him safe. There was a great deal of contact with mental health services and good support from a consultant psychiatrist and his team.

3. In addition to the support from the professional medical services, prison officers went to great lengths to engage with the man. A number of the interventions by prison and medical staff appeared to help keep him stable and assisted in him being able to move from the healthcare centre to accommodation on D wing. Once on D wing, the man appeared to settle and his risk was considered sufficiently reduced so that monitoring could end. A post-closure review was not carried out at that time although it should have been.

4. The man suffered from sleep apnoea and he had been issued with equipment before he was imprisoned to aid his breathing. Healthcare staff and prison managers were aware at an early stage that he required this specialist equipment but no one took responsibility to ensure that he was given access to the machine while at Winchester. We do not know whether the lack of this equipment had any bearing on the man's state of mind.

5. On a day in September 2011, staff discovered the man hanging from the window bars in his cell. He was cut down immediately and staff began resuscitation. Healthcare staff attended quickly and took over resuscitation attempts. Paramedics arrived and declared that the man had died at 8.22am.

6. We make four recommendations about the provision of CPAP machines for prisoners diagnosed with sleep apnoea, checks and provision of emergency medical equipment and timely post-closure reviews for suicide and self-harm monitoring.

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THE INVESTIGATION PROCESS

7. The Ombudsman's office was informed of the man's death on 27 September 2011. The investigator issued notices to staff and prisoners informing them of the investigation and inviting anyone with any relevant information to contact him. No one came forward.

8. The investigator visited Winchester on 18 and 19 October 2011 and met the deputy governor, head of healthcare, members of the management team and a representative from the Independent Monitoring Board (IMB). The investigator was given all of the man's prison records including his medical records.

9. Hampshire Primary Care Trust (PCT) asked a clinical reviewer to review the man's clinical care at the prison. The clinical reviewer received copies of all the relevant documentation to assist this review.

10. In December 2011 and February 2012, the investigator interviewed prison staff and prisoners. Feedback was provided to the deputy governor and this was followed up in writing.

11. Her Majesty's Coroner for Hampshire was informed of the investigation and provided the results of the post-mortem. The Coroner has been sent a copy of this investigation report.

12. One of the Ombudsman's family liaison officers contacted the man's friend, his nominated next of kin. She explained the purpose of the investigation and gave him the opportunity to identify matters she wanted the investigation to consider. He said that his friend had felt well supported by Winchester, but wanted the investigation to consider:

    - Why his friend did not have his breathing apparatus (CPAP machine) for sleep apnoea?
    - Was his diabetes managed properly and did he receive appropriate dental treatment?
    - Was his friend encouraged to attend to his personal hygiene?
    - Did his friend sufficiently understand prison processes, as he was a French national?
    - The man's friend said that she contacted Winchester on a number of occasions about her friend's physical and mental health, but felt her concerns were not taken seriously.

13. We are sorry the draft of this report was delayed for so long; this is due to a backlog of work at the Ombudsman's office which we are striving to clear.

14. The draft report was shared with two of the man's friends. One friend did not make any comments. The other friend raised some points that do not require this report to be amended in any way.

15. The draft report was also shared with the service, who did not raise any factual inaccuracies. Their response to the recommendations is included on page 27.

HMP WINCHESTER

16. HMP Winchester is a local prison (a prison that sends and receives prisoners directly to and from the courts) and holds up to 707 men. Healthcare is provided by Solent Primary Care Trust. Secondary mental health services are provided by Winchester Community Mental Health from the Hampshire Partnership Trust. There is an inpatient healthcare unit providing 24 hour medical care.

Her Majesty's Inspectorate of Prisons (HMIP)

17. HMIP last inspected Winchester in September 2010. The Inspectorate commented:

> "On our previous visit, we found the prison to be performing reasonably well, although suffering all the typical pressures of a crowded local prison. On our return for this unannounced follow-up inspection, we were pleased that - despite ongoing pressures - there had been progress on a number of our recommendations. However, there remained plenty still to do".

18. The Inspectorate went on to say that the prison remained reasonably safe and that there had been some improvements to the management of early days in custody. Suicide prevention arrangements were reasonable but measures to reduce violence and bullying were inadequate and required improvement.

Independent Monitoring Board (IMB)

19. Each prison has an Independent Monitoring Board of unpaid volunteers from the local community, who monitor all aspects of prison life to help ensure that proper standards of care and decency are maintained. The IMB report for Winchester for the year until 31 May 2012 said:

> "The weekly multi‑disciplinary ACCT [suicide and prevention measures] meeting (Assessment, Care in Custody and Teamwork) provides a reliable platform for both review and support from a broad cross section of disciplines involved with opening, reviewing and appropriate closure of ACCTs."

20. The Board noted that there was a growing number of prisoner officers that related well to prisoners, particularly those on ACCT. However the IMB was concerned that the number of ACCTs opened remained a high.

Assessment, Care in Custody and Teamwork (ACCT)

21. ACCT is the Prison Service process for supporting and monitoring prisoners thought to be at risk of harming themselves. The purpose of ACCT is to try to determine the level of risk posed, the steps that might be taken to reduce this and the extent to which staff need to monitor and supervise the prisoner. Levels of observations (where staff must check the prisoner) and interactions

(where staff must have a conversation with the prisoner) are flexible and can be set according to the perceived risk of harm. If staff perceive the risk of harm to be very high, the prisoner may be constantly observed. Where the perceived risk is lower, the level of observations may be several times an hour or day. Checks should be irregular to prevent the prisoner anticipating when they will occur.

22. Part of the ACCT process involves drawing up a caremap. A good caremap will identify the prisoner's most urgent and pressing issues, set achievable goals to help resolve the issues and identify who is responsible for resolving each goal. Regular multi-disciplinary reviews should be held. The ACCT plan should not be closed until all of the actions on the caremap have been completed. When an ACCT is closed, a post-closure review should be held at an agreed interval to check there are no further concerns.

Previous deaths at Winchester

23. Since 2008 there have been five self-inflicted deaths at Winchester, including this man. The only similarity between these deaths is that all were through hanging (the most common form of self-inflicted death we investigate). There has been one self-inflicted death since.

KEY EVENTS

24. The man was born in March 1967 and was a French national. At the time of his arrest he lived in Hampshire. He moved back to France and returned for his court hearing. On 16 June 2011, he was convicted of serious sexual offences at a Crown court.

25. The man was taken to Winchester and told escort staff that if he was found guilty, he would take his own life. An escort officer placed him under constant supervision and completed a suicide and self-harm warning form which accompanied the man to Winchester.

26. At the reception healthcare screening (which is to identify any immediate physical or mental health concerns) a nurse was concerned about the man's mental health. He had read the concerns in the suicide self-harm warning form, and decided that the man should be admitted to the prison healthcare centre for observation and assessment.

27. At 8.00pm, an ACCT plan was opened by a nurse in the healthcare centre. She wrote that the man had been under constant supervision in court and his mood was very low. She said that he had declined to engage fully in the reception healthcare screening and had been convicted of a serious offence.

28. The immediate action section of the ACCT plan completed soon after, shows that the man was placed on 15 minute observations pending a full ACCT assessment (which should take place within 24 hours). He was admitted to the healthcare centre and offered the use of the phone. He was also given reception information in French, which included information about visits, the telephone system, how to use the prison shop and some basic expectations of prisoners. As a precaution, his shoe laces, belt and television were removed until the assessment was completed.

29. The man was checked every 15 minutes overnight. At about 2.45am on 17 June, a nurse noticed that he was sitting on his bed with a sheet around his neck. Prison staff went into his cell and removed the sheet from him. He did not resist the intervention and the 15 minute checks continued.

30. Later that day, at about 9.50am, an officer conducted an ACCT assessment with the man. She recorded that he had been found by staff with a sheet round his neck and that he was refusing to engage with anyone. He would not speak to her so she decided to refer him for further assessment to the healthcare manager and Community Mental Health Team (CMHT). She also asked a French speaking officer to come to talk to the man in case he could not understand English well. He refused to speak to the officer.

31. The ACCT assessment was then considered as part of a review meeting and the 'action following assessment' section was completed by a senior officer (SO). The man, an officer and a member from the CMHT were also present at the review. The ACCT case summary notes show that the man would only

shake his head when asked questions, after which he stopped all communication.

32. During an ACCT check at 4.00am on 18 June, an officer saw that the man had put something around his neck and was experiencing difficulty breathing. The officer called for assistance and went into his cell using his emergency key. (At night only the night orderly officer carries standard keys. Other staff have a cell key in a sealed pouch for use in emergencies.) He found that the man had placed a plastic bag around his neck and had twisted the bag with a spoon to tighten it. Officers removed the bag and asked him why he had tied it around his neck; he said "I just want to die". After removing the bag, officers left the cell and went to an office to discuss the level of observations needed. A noise was then heard from the man's cell and staff returned and found he had placed a sweatshirt around his neck and had twisted it tightly. Staff removed the sweatshirt and increased his observation to constant supervision. This meant that a member of staff was outside the man's cell and able to watch him constantly.

33. A case review was held at 10.30am that day, chaired by the duty governor. He wrote in the summary section of the ACCT review that the man would not speak to the review team, but shook his head when asked questions. Over the next three days further case reviews were held daily. There was no change in the man's behaviour, other than he told the review panel that he would refuse all medical treatment and said he wanted to die. He continued to be subject to constant supervision. While he was constantly supervised the enhanced case reviews were held chaired by a senior manager or doctor.

34. In the meantime the prison had contacted the man's own doctor who confirmed his patient had diabetes which had been treated using tablets and injections.

35. On 22 June, a consultant psychiatrist assessed the man for the first time. In a report he prepared for our investigation, the consultant psychiatrist said he had told the man that he was carrying out a "Capacity Act assessment" to judge his ability to refuse interventions needed to keep him alive should he lose consciousness, due to lack of food and fluids, in case he decided to refuse these. He said the man gave brief responses to his questions. He said that on two occasions he began to cry and had shown him a note in which he had said his daughter had made false allegations against him, but added that he loved her and wanted her and his ex-wife to visit him. The consultant psychiatrist said he told the man that medical staff would intervene if he lost consciousness and attempt to resuscitate him. The doctor said the man told him he would not let that happen. He interpreted this to mean that the man would kill himself by a different method, other than refusing food. He said he could not explore the man's thinking any further because of what he described as "poor cooperation". The doctor's conclusion was that the man lacked capacity to make decisions about refusing life sustaining treatment. He devised a care plan as follows:

- Offer basic nursing to keep the man comfortable

- Offer food and fluids on a regular basis
- Record the man's consumption of food and fluids
- Continue to attempt to take observations, including pulse, blood pressure and blood sugar
- Intervene and transfer to outside hospital if necessary, if the man's condition should deteriorate.

36. The consultant psychiatrist advised that medical staff should resuscitate with all appropriate interventions if the man lost consciousness. He also noted that the man had made statements about killing himself and written two notes to say he would kill himself, one of which said he would end his life on Saturday that week.

37. Later on 22 June, another case review was held, chaired by the CMHT team leader. The record shows that the man did not attend the meeting but he had spoken to the consultant psychiatrist before the meeting had taken place. The review noted that the man told the doctor he wanted to die and that he had been told that he would not be allowed to die. The man said his death could not be prevented.

38. The medical record indicates that the man had complained of headache on 22 June and that his speech was slurred. He refused to have his observations taken and refused pain relief, but asked for oxygen which was given to him by a nurse.

39. On 23 June at about 4.00am, the man reported having chest and right sided abdominal pain. A nurse assessed him and he was taken to outside hospital's accident and emergency department, adjacent to the prison. At the hospital he was examined by a doctor. A blood sugar test was conducted and the results were normal.

40. The man returned to prison later that morning. An ACCT case review meeting took place at 10.30am chaired by the CMHT team leader. This time the man engaged with the review panel. It was noted that he was low in mood and still intent on dying. He told the panel that he had lost his family and was expecting a ten year prison sentence. It was noted that he had written to a female friend and had sent her a visiting order and was hoping to see her on the Saturday. He said he had been discussing with this friend for some time, his intention to end his life. He would not say how he would do this. He agreed to have a shower and have books from the library. It was decided he should remain constantly supervised.

41. An operational manager at the prison attended the case review meeting and wrote a comprehensive note of the meeting, which she placed in the ACCT plan. She wrote:

> "This morning was the first time that [the man] engaged with the review. He showed many high risk indications of a man who is intent on suicide. Whilst it is positive that he has begun to talk to us, have a shower and have his clothes laundered I must be clear that all of his

actions could be those of a man who is at peace with the decisions he has made.

He was quite clear that although he has sent a VO [Visiting order] out to a friend – this is with the intention of saying goodbye. He says he has discussed ending his life with her already and she is well aware of his intentions. Clearly, if this visit takes place the risk level is increased…

He is appreciative of our efforts and kindness, but does not wish us to "waste our time on him". Indeed he admitted his reluctance to converse since his arrival was to protect staff from any guilt when he passed away.

…I cannot stress enough that all the signs show [the man] to be extremely high risk. Staff need to be alert at all time whilst detailed to his constant supervision, that means not having their attention diverted by other goings on with the unit and/or other distractions … think about tactics such as pulling covers up to interrupt your view."

42. On 24 June, the man learned that his friend could not visit him the next Saturday as she was going on holiday for two weeks and would not see him until his court date scheduled for the following month. The ACCT case review notes show that he was said to have been "crushed" by the news. However, he had been pleased to learn that another friend was going to be visiting instead. Due to his disappointment, the case review panel agreed to allow him a telephone call to his friend who was going on holiday. It was also arranged that the duty governor would meet the man's other visitor when he arrived.

43. The CMHT team leader sat with him when he phoned his friend and the man agreed to allow the CMHT team leader to speak to her. The friend told her that the man had had a fixed plan for three years that he would kill himself if he was convicted of the offence. The friend told her that the man had given her a letter and photographs which he wanted her to give to his daughter when she was older.

44. The next day, 25 June, the man had a visit from a different friend. The visit took place in the healthcare centre and his friend was invited to join the ACCT case review after the visit, which he did. The man was described as tearful at the review but said he had found it useful. He told the review panel that he still had thoughts of self-harm and of ending his life. It would appear from the notes that the meeting ended on a positive note. The level of observations was to remain as constant.

45. The clinical reviewer in his report said the man suffered from sleep apnoea (a sleep disorder resulting in abnormal pauses in breathing or low breathing during sleep.) Before his imprisonment the man had been issued with a Continuous Positive Airway Pressure (CPAP) machine, which he kept at home, to help his breathing while asleep. The clinical reviewer adds that the

man had asked a friend to take the CPAP machine to the prison and that one of the nurses was going to try and arrange for it to be allowed in the prison.

46. At interview a nurse said the man did not speak to her about wanting a CPAP machine. She said that in her opinion the man did not present symptoms to suggest he required the machine, as he slept well.

47. During a case review on 26 June, the man continued to say he would kill himself and said he had had three years to consider what he would do. The case manager noted that the man spoke calmly and quietly and assured the panel that he would kill himself. It was agreed that the constant supervision would continue.

48. An officer who regularly watched the man on constant supervision told the investigator that there were long periods when he did not engage with prison staff much and unless the staff spoke to him he would not communicate. The officer said that when he did respond it was quite often just a grunt or a whisper but that changed over time. He said that at first he had not taken care of his personal hygiene but then began to shower regularly.

49. Although he did not communicate much, the officer said the man told him that he had been a chef and talked about meals he had cooked. He said he had worked at Disneyland Paris and had cooked meals for the G4 summit in Paris. He said the man used to write down recipes for him and he spoke and understood English well.

50. The man told the officer he was annoyed that he was not allowed to communicate with his daughter. The officer added that the man's animosity was directed towards his ex-wife. He said the man often spoke of ending his life and blamed his ex-wife for his situation. The officer said he used to say he would not end his life while being monitored on ACCT, because he "did not want to get the staff into trouble".

51. The ACCT review on 27 June was chaired by the duty governor. Also present were two members of the Community Mental Health Team. In the case review notes the chair summarised the meeting:

> "[The man] had a good visit on Saturday with his friend, but he does not feel that he wants to "inconvenience" his friend as [he] has a family to look after. We tried to encourage [the man] to maintain contact; he seems more proactive in maintaining contact with [his other friend]. [He] still feels he wants to die though he is showering daily and has been taking his medication for the last three days… [He] states he intends to take his life and has a plan … We spoke about the appeal process against his conviction but he was despondent about this."

52. On 28 June at about 11.30pm, the man complained again that he was experiencing chest pain. As a precaution he was taken to outside hospital and admitted onto a medical ward. He was discharged from hospital after tests and returned to the prison on 29 June.

53. Two ACCT reviews were held on 29 June. The first one at 11.00am was a normal routine review. The case manager noted that the man had not engaged with the ACCT process or with the consultant psychiatrist. He went on to note that the man had been writing letters saying he would take his own life but would not discuss them with the review team. It was also noted that he was taking his medication for his diabetes condition and he had been eating and drinking. The review decided to reduce the level of observations from constant to three irregular observations hourly.

54. Shortly afterwards the man was found lying on the floor with a jumper tied loosely around his neck. Another case review was held at 2.00pm. The case manager wrote that although the man had a "ligature" around his neck he was not convinced that it was a "credible suicide attempt". However, he recognised that it was an indication of raised risk and so observations were raised back to constant supervision.

55. The consultant psychiatrist saw the man in his cell on 30 June, but he would not respond to his questions. He said there were a number of written documents in the cell and he asked the man if he could read them. He did not answer and so the doctor took this as an indication that the man had no objections. The doctor said the first letter was a nine page document written to the Prime Minister in which the man complained about the injustice he said he had suffered and that he intended to take his own life. The second note related to his plans to stop eating, drinking and taking medication. The final letter had been written to his daughter in which he said goodbye and told her that he loved her.

July 2011

56. The man remained on constant supervision until 4 July. He had daily ACCT reviews chaired by governors but did not communicate with staff. On 2 July, he ate some toilet roll in what was described as an attempt to choke himself and had undressed completely. He was also reported to have "modified a plastic spoon to unscrew an electric socket".

57. As part of the summary the duty governor said "the board feels [the man] needs firm boundaries with consequences for his actions. I will explain to [him] that he will be reported the next time he tampers with or damages prison property. I will also require him to get dressed for decency reasons". The attendees agreed that the level of risk remained high and constant supervision continued.

58. Later on 2 July, the man was taken to hospital after complaining of chest pain again. He was given glyceryl trinitrate (GTN) which is a treatment for angina given either as a spray or tablet placed underneath the tongue. The doctor at the hospital concluded the man had acid reflux and he was taken back to the prison.

59. On 4 July, the case manager at the ACCT review in his summary note said the man had “no feelings” and was not communicating. He went on to say that when he asked him if it was necessary to have an officer permanently outside his cell (constant supervision) he said he did not care. He was also asked whether he would attend the court for sentencing later that month, but he refused to answer the question. Despite the man’s non-cooperation the review decided to reduce the level of observation to three times an hour. It was agreed that his cell should be cleared of items which could be used to harm himself, including bed sheets and cutlery and that he should be supervised when he showered.

60. On 5 July, the man attended the ACCT case review. He asked if the duty governor would be present and was told that there would be no governor grade attending as he was no longer under the enhanced case review process. A senior officer recorded that the man became agitated and was abusive to an officer who was at the review. The man decided to take no further part and left the room. The level of observation remained the same.

61. The man complained of dizziness and abdominal pain and was seen by a doctor on 5 July. He went to hospital for further tests and after examination, the hospital arranged for a computerised tomography (CT) scan to be carried out the next day. In the meantime he was prescribed medication for abdominal pain. On 6 July the CT scan showed a small stone in the man’s left kidney. He was advised to continue taking diclofenac (anti- inflammatory treatment).

62. On 7 July, an operational manager at the prison and the CMHT team leader managed the ACCT review. The man was said to interact more positively than at other recent reviews. The operational manager noted that he was making positive plans, had sent a visiting order to a friend, and had written to his solicitor. He was taking his medication properly and eating normally. The outcome of that meeting was that he was allowed to have bed sheets and toilet roll in his cell. The level of observations was reduced to two each hour.

63. The next ACCT review was on 11 July, but the man refused to attend as there were no senior managers there The senior officer noted that the man stood in the corridor and initially refused to return to his cell. He was confrontational and abusive towards staff, but eventually went back to his cell with no further problems. A further case review meeting was scheduled for 13 July, the day before he was due to return to court for sentencing.

64. On 13 July, a nurse made an entry in the man’s medical record that he had been “rude” when she offered him his medication. Later that same day the consultant psychiatrist visited the man in his cell. He said that the man was lying on his bed under a blanket but sat up and spoke to him in a quiet voice and that his mood was “euthymic”. (Euthymia is a word used to indicate a normal non-depressed and reasonable positive mood.) He went on to say that the man continued to talk of ending his life but would not discuss how as he said he did not want the doctor to “frustrate his attempts”. He was eating and drinking normally.

65. At 2.30pm on 13 July, a case review noted that the man was “belligerent and arrogant”. He was asked how the next day’s court appearance and sentence would affect him and whether he felt strong enough to deal with the situation but his response is not recorded. On 14 July, he was taken to court but sentencing was adjourned for further reports.

66. In the meantime on 14 July, members of the CMHT had discussed the man’s management and recommended that he could be managed and monitored on D wing. (D wing is a dedicated unit for those regarded as vulnerable usually because of their offence.) No decision was made that day.

67. At the ACCT review on 15 July, the case manager noted that the man’s mood had been low and that he had been upset because he had been unable to get in contact with his solicitor or friend. It appears that he could not find the telephone numbers and the case manager arranged to find them and pass them to him. The level of observations was set to hourly.

68. At 3.57am on 17 July, the man was found with a towel and plastic bag wrapped around his neck. At 9.20am a further ACCT review was held. The case manager noted that the man said nothing had changed since the first day and that no one listened to him. He said he was innocent of the offence. He was reported to be “angry and belligerent” when challenged. The case manager noted that in his opinion the man was trying to “manipulate things to go his way”. The level of observation was amended to every half hour.

69. On 19 July, the man was taken to hospital for an appointment at the Rapid Access Chest Pain Assessment Service. He was unable to do a treadmill test and had to return at a later date when he was physically and emotionally able to do a perfusion test. A treadmill test or cardiac stress test is used to measure the heart’s ability to respond to external stress in a controlled environment. Perfusion tests produce an image of the heart muscles.

70. The man did not go to the ACCT review on 21 July, which went ahead with three prison managers, a prison officer, the CMHT team leader and the consultant psychiatrist. The review was to discuss the proposal that he move to D Wing. It was agreed that his healthcare needs could be properly managed on D wing. A care plan to ensure his blood sugar level was monitored would be established to ensure his diabetes was appropriately treated. It was also agreed that he would be allowed to have a GTN spray. The use of an epipen to deliver insulin would be supervised. He moved to D wing later that day, where he shared a cell with a fellow prisoner.

71. The man seemed to settle well and mix with other prisoners. His cellmate told the investigator that he shared the cell for about two weeks. He described the man as a “nice guy”. He said he told him he would not be able to cope with a prison sentence but appeared to settle down and be much happier. He said the man talked about killing himself but he did not take the comments seriously.

72. On 22 July, as part of the ongoing support, the CMHT team leader saw the man on D Wing. In her report, she said the man had been talking to another prisoner and was animated and smiling. She said he told her he was feeling better and said "I can't die because that would mean I would do nothing and I want to see my daughter again, I will not die". She said he had become tearful saying he could not understand the law in England because in France evidence was needed to put someone in prison. She said he asked for some form of activity as he wanted something to do.

73. A senior officer chaired an ACCT review on 25 July and noted that the man was interested in joining an education class and that arrangements were being made for him to be offered a suitable course. The review which included the CMHT team leader and a member of healthcare staff also discussed the man's pending court appearance and decided it was appropriate to keep the ACCT open. The senior officer noted that the man thanked staff for their kindness and had said he did not want to be a problem. His level of observations was reduced to one each shift (morning, afternoon and evening) and four random checks during the night.

74. From then on prison records show that the man was far more settled and joined in with normal prison routines. He communicated well with prison staff and other prisoners and caused no specific concerns.

August 2011

75. On 4 August, the man was prescribed tramadol (a pain killer for moderate to severe pain) to help relieve the pain caused by his kidney stone. The next day, 5 August, he appeared at a Crown court and was sentenced to 15 years imprisonment.

76. When he arrived back at Winchester, another ACCT review was held, chaired by a senior officer. The man attended the meeting with three officers and a nurse from the CMHT. The man said he felt "low but not suicidal". He asked to be allowed to telephone his family, although the records do not indicate whether this was done. As a precaution the man was re-admitted to the healthcare centre, although he asked to return to D wing. The level of observations was raised to one each hour.

77. In the consultant psychiatrist's report for the investigation he said that when the man returned from court, he had spoken to a nurse and "told the nurse he knows what he is going to do and what he needs to do, but would not be more specific". The consultant psychiatrist said the nurse had noted poor eye contact during the ACCT case review and that he had spoken softly. He said that although the man had told the meeting he would not kill himself, the nurse said "some risks remain".

78. On 6 August, the duty governor told the man that he would stay in healthcare over the weekend, and then they would review it. He was offered items from his cell on D wing but was unhappy at the decision to keep him in healthcare and refused to speak.

79. A senior officer chaired an ACCT review on 8 August. The man attended with the wing manager, a nurse and a prison chaplain. The senior officer wrote: "[The man] is keen to return to the wing where he has a good network of peer support, and states that he is enjoying the time out of cell which is greater on the main wing". The SO added that the man said he did not want to die, as he was "keen to move forward". He returned to D wing around lunchtime that day.

80. When the man returned to D wing, he now shared a cell with a new cellmate. His cellmate told the investigator that initially he and the man spent time talking and that he spoke very good English. He said he often talked about his experience as a chef. He said that the man often talked about ending his life and had shown him a number of "ropes" which he had made from bed sheets. The man's cellmate said he did not tell staff about the ropes and he did not take the man seriously, as he believed it was "just talk".

81. There were few meaningful entries in the ongoing ACCT record between 8 and 16 August. A senior officer chaired the ACCT review on 16 August attended by the man and a nurse from the CMHT. The senior officer wrote: "[The man] presented as extremely positive today. He was articulate throughout. Due to the length of his sentence, peer support has been very much appreciated by him and he is very hopeful for the future…" The man had asked to be allowed his exenatide pen (for diabetic medication) and CPAP machine in cell. It was agreed to follow this up.

82. It was decided to close the ACCT and a post-closure review was arranged for 24 August. Post-closure reviews are held to check there are no ongoing issues for the prisoner that warrant consideration under ACCT procedures. A review should take place within seven days of closing the ACCT.

83. At Winchester, when a post-closure interview is arranged the time and date is entered onto a computer diary system. Wing managers are expected to check whether any reviews are due for prisoners on their wing. The post-closure review was correctly entered on the computer diary system, but the scheduled review did not take place.

84. After the ACCT was closed, the nurse from the CMHT noted in the clinical record that the man was aware that a post-closure review had been arranged and that he had advised him he could speak to prison staff if he had any concerns. He noted that he had agreed to continue to support the man who had seemed pleased by that.

85. On 19 August, the man had an appointment with one of the locum doctors. He had asked to see an osteopath and had been upset when told the service was not available in prison. He was told he could be referred to a physiotherapist, which he refused. The locum doctor referred the man for the coronary perfusion test which had been postponed earlier and that he also made a referral to a respiratory clinic for a CPAP machine.

86. On 24 August, the man was given his exenatide pen and a needle to take his diabetic medication. He then refused to return them to the nurse and so his cell was searched by prison officers. During the search pieces of glass, a needle and spring were recovered. The man later apologised for his behaviour and asked to have the pen in his possession again, but this was not allowed.

September

87. On 1 September, the man went to the treatment hatch on D wing and asked for mouthwash which he said the dentist had recommended. He became angry with the nurse as she would not give him mouthwash as it had not been prescribed. He did not collect his lunchtime and evening medication that day.

88. On 5 September, an operational manager at the prison wrote to the man's friend in response to some concerns she had raised. The operational manager said she had spoken to the man and that he had agreed she could share the detail of that meeting with her. The operational manager said the man was "now aware" how he could access the details of his telephone account and that he had done so. She said that he was attending education classes three times each week and was on the waiting list for other courses. (He attended classes on Monday, Tuesday and Wednesday mornings from 5 September. He was studying Level 1 Numeracy, which he successfully completed on 19 September, and had been attending an IT course.)

89. On 9 September, the post-closure review originally scheduled for 24 August, took place. The senior officer noted that a prison officer and the man attended. He recorded, "Medication issues have been sorted. He is in education and remedial gymnasium. He is much more accepting of his sentence now. He is not having thoughts of DSH [Deliberate Self harm] at present".

90. On 13 September, the man received an appointment for the respiratory clinic for 11 October.

91. The next day the man complained of severe toothache. A nurse gave him ibuprofen and made an appointment for him to see the dentist. On 22 September, he was examined by the dentist and given a filling. She noted the tooth would require extraction if the filling did not control the symptoms.

92. At about 10.30am on 24 September, an officer went to the man's cell as she heard him and his cellmate having an argument. To resolve the problem, she moved the man to another cell. The officer said that the reason for moving the man and not his cellmate was that his cellmate had an extra long bed due to his height, so it would not have been practical to move him.

93. His cellmate told the investigator that he and the man had been getting on well, but over time, the relationship deteriorated to the point where they were not speaking. He said the man had begun gradually to take over the cell space and had spread his own property around the cell, leaving his cellmate

with only a small area for his items. He said when the officer told the man he would have to move to another cell, he had not been happy.

94. The man was moved to a double cell, but did not have a cell mate. After he moved, the consultant psychiatrist said he was asked to speak to the man as his mood had dropped. He said the man was uncommunicative but complained about lack of dental treatment and analgesia. He told the doctor he would not be eating or taking his medication. The doctor said he offered him the opportunity of meeting him the following morning to address his concerns, but the man refused.

95. On a day in September, another prisoner on D wing said the man came to see him and was apparently upset. He said that the man wrongly believed that by being on his own in a cell, he would not have access to education classes or a telephone. He said the man did not mention ending his life or give him any reason to believe he would do so.

96. At about 5.00pm, a nurse went to the man's cell as a follow up to the consultant psychiatrist's meeting the previous day. The man would not speak to him so the nurse arranged to see him the next day. He had eaten but had not collected his medication that day.

97. An officer who was on night duty on D wing that day conducted a roll check shortly after she arrived at 7.45pm to check all prisoners were in their cells. She recalled that the man was sitting on his bed watching television. He looked at her but did not speak to her, which she said was normal for him. She told the investigator she had no reason to be concerned about him. She told us that the man did not use his cell alarm bell during the night. She therefore had no reason to see him again until the following morning roll check.

Morning of man's death

98. At about 6.00am on a day in September, an officer began the early morning roll check. At interview she said she recalled looking into the man's cell and saw his feet and lower legs behind the privacy screen of the toilet. She believed he was using the toilet, so continued the roll check and confirmed to the night manager that the roll on D wing was correct. She said that the man was usually up early.

99. An officer started duty on D wing at about 6.50am and at about 7.00am also conducted a further roll check. He too remembered seeing the man in the toilet area of the cell and assumed he was using the toilet.

100. At about 8.00am, all staff on duty in D wing attended a morning briefing and then started their daily duties. An officer said that after the meeting he went to the third floor landing and started unlocking prisoners' cells. When he arrived at the man's cell he looked into the cell and because he could not see him clearly, he turned the cell light on. He said it appeared that the man was sitting on the toilet, as he could see his knees outside the privacy screen.

101. The officer called the man's name but got no response. He therefore unlocked the cell door, but was unable to get in as a bed had been placed against the door. He called for help from two colleagues who were nearby. One of them radioed a code red (for urgent medical assistance) and an ambulance and blew his whistle to get more staff to help.

102. Two officers forced the door open and found the man was hanging by a bed sheet tied to the cell window bars. One of the officers cut through the sheet with his anti-ligature knife and at the same time his colleague supported the weight of the man's body.

103. The man was placed on his back on the cell floor. One of the officers said he saw what he believed to be froth coming from the man's mouth, but found it was compressed toilet paper. The officer removed the paper and after checking for signs of life, he and his colleague began cardiopulmonary resuscitation (CPR – a mixture of rescue breaths and chest compressions to keep blood and oxygen circulating around the body). One of the officers asked if there were any mouth guards available but was told there were not. He began mouth to mouth resuscitation anyway and as a result ingested some fluid from the man's mouth. Despite this he continued with resuscitation until healthcare staff arrived and took over. He said that during the CPR process he noticed the man's eyes open and initially thought they had been successful in resuscitating him. The officer said the man's body was "floppy".

104. The other officer carrying out CPR said the man's skin colour was not normal and that his body was cold. He said he did not detect any signs of life and that once healthcare staff arrived he withdrew from the cell to allow the nurses more room to work.

105. Two nurses were in an adjacent wing (C wing) issuing medication to prisoners, when they heard a whistle being blown. In response to the whistle, the two nurses left the treatment room and ran to D wing which one of them said took a few seconds. When they arrived on the wing they were joined by a further nurse who had heard the radio message. She brought an emergency equipment bag which contained airway and blood pressure monitoring equipment.

106. One of the nurses who attended the emergency said they arrived at the cell at about 8.10am. The two other nurses inserted an airway and they took over CPR from the officers. A defibrillator was attached to the man (A defibrillator can restart the heart in some cases of cardiac arrest by giving an electric shock. It detects the electrical activity in the heart and gives automated instructions to the rescuer.) The equipment instructed them to continue CPR. One of the nurses said the defibrillator had completed three cycles and on each occasion it had instructed them to continue CPR. She said there was no pulse or cardiac output and that the man's body was cold and grey. The nurses continued CPR until the paramedics arrived.

107. The South Central Ambulance Service NHS Trust record shows that the ambulance was called at 8.10am. Paramedics arrived at the prison at 8.16am and were with the man four minutes later. The record shows that death was confirmed at 8.22am.

108. One of the nurses said that during the rescue attempt an automated suction machine was tried to ensure the man's airway was clear, but that it was faulty. The equipment has since been replaced.

Events after the man's death

109. A family liaison officer was appointed from the prison. She said that she and a prison chaplain went to see the man's nominated next of kin, a friend, that morning to break the news of his death. She noted in the family liaison log that she offered additional support, including accompanying the man's friend to the funeral directors to view his body and assistance with the cost of the funeral.

110. At 11.00am on the day of the man's death a hot de-brief meeting was held chaired by the deputy governor to support the staff involved in the incident.

111. All prisoners subject to ACCT monitoring were reviewed and the news was broken to prisoners on D wing.

112. After his death, letters and notes were found in the man's cell, most of which were undated. These indicated that he was committed to ending his life and that he continued to maintain his innocence. Although we cannot be certain, there is one letter prison staff believed to be a final suicide note. In this note he wrote that he had loved his life but was unable to let others run it when he had done nothing wrong. He thanked prison staff for their professionalism and criticised the legal system. He expressed his love for his daughter and thanked his friends for their support and for the support of three prisoners on D wing.

ISSUES

Clinical care

113. The clinical reviewer concludes that the man had received a prompt reception screening after which he was admitted into healthcare under close observation. He was assessed frequently by the mental health team and this was clearly documented.

114. The man's medical history was obtained from his own doctor and hospital and it had been confirmed that he was being treated for diabetes.

115. Between June and early August, the prison did not have a regular doctor and that the work was being carried out by a series of visiting locums. The clinical reviewer said the lack of continuity meant it was difficult to form a therapeutic relationship with a familiar doctor. By the end of August, there were regular doctors employed at the prison, but as the man appeared more settled, he had less contact with the doctors.

116. When the man complained of chest pains, it was taken seriously and medical investigations identified a kidney stone. He had also complained of some dental problems. The clinical reviewer said the man was seen and assessed promptly by the dentist and that the dentist had appropriately involved the man in the proposed treatment.

117. The clinical reviewer said it was established that the man suffered from sleep apnoea and that he had been issued with a CPAP machine before being imprisoned. It was not clear why the machine was never allowed into the prison. He said there were conflicting opinions offered by healthcare and prison staff. Healthcare staff believed it had not been allowed due to "security concerns". Prison staff told him they believed it was healthcare staff who said he did not require it. There does not appear to have been any policy objection to the provision of a CPAP machine as another prisoner in the healthcare centre had one in his cell.

118. It is clear that the man had been issued with a CPAP machine for health reasons before coming into prison. A number of managers and healthcare staff were aware of this, but little appears to have been done to provide one for him. His friend raised this matter in two letters in August, but her concerns appear not to have been acted upon.

The Head of Healthcare and Governor should ensure CPAP machines are available if required for prisoners diagnosed with sleep apnoea.

119. Suction equipment taken to the man's cell during the resuscitation attempt, was faulty. This did not affect the outcome for the man. Although we have been assured the suction equipment has been replaced, the clinical reviewer was concerned that better regular and recorded checks of emergency equipment were required.

The Head of Healthcare should ensure that all emergency equipment is checked regularly and that the checks are fully documented.

Assessment Care in Custody and Teamwork

120. The man was appropriately monitored under ACCT procedures when he arrived at Winchester and this continued until 16 August. He had several periods of constant supervision and enhanced case reviews. Sometimes he engaged with the process but this was not always the case, and this was not easy to manage. Overall there is evidence of multi disciplinary reviews and consideration of the man's needs. One of his friends was included at least once in the process. However, there are some areas that require improvement.

121. The man's cell location was not always clearly marked on the ACCT documents, and the level of observations was not always clearly written on the front cover of the ACCT.

122. There were 26 case reviews held as part of the man's ACCT plan, however these were chaired by 12 different managers. Prison service guidance states that the ACCT process will operate more effectively if there is continuity in the attendance. We consider that consistency of case management is particularly important for effective risk assessment and judgement of progress over time. It helps the prisoner at risk build a relationship and speak honestly about his thoughts and feelings without having to repeat his circumstances to a new person each time.

123. The man said he was more settled on D wing. After a court appearance on 4 August, he was held in the healthcare centre over the weekend for his own safety. He wanted to return to the wing, and it is not clearly recorded on the ACCT document why it was considered that he would be safer in the healthcare centre, away from friends and a cellmate. He eventually returned to D wing on 8 August.

124. There were no entries demonstrating meaningful interaction with the man between 8 and 16 August. However the level of observations and interactions had been gradually reduced over a period of time and the caremap was reviewed and updated frequently. The ACCT was closed on 16 August and all actions of the caremap had been completed.

125. A senior officer arranged a post-closure meeting for 24 August. This was particularly important as the man had been on an ACCT for a long time with periods of crisis. Prison records show the post-closure meeting was correctly entered on the computer diary. Unfortunately, the review did not take place until 9 September, three weeks after the ACCT had been closed. A post-closure review is an essential part of the ACCT process and helps ensure that the decision to close the ACCT was correct and that there are no ongoing issues or vulnerabilities for the prisoner concerned.

The Governor should ensure that ACCT procedures are followed correctly, including that the level of observations and significant events are properly recorded on the ACCT document, that there is continuity of case management in ACCT case reviews and that timely post-closure reviews are held.

126. The man had made clear his intent to take his own life, which he had stated to friends and staff on a number of occasions. He had made several attempts before finally taking his life. The letters found in his cell after his death also made it clear that this was something he had intended to do for some time. When assessing someone's risk to themselves a wide range of risk factors should be taken into account. We are satisfied that, overall, the prison appropriately considered the man's risk throughout his time at Winchester and raised the level of observations when it appeared his risk had increased. His level of observations were gradually reduced as he began to appear to settle more in the prison and participate in activity. At the time his ACCT was closed on 16 August, he gave no sign at that stage that he continued to have suicidal thoughts. Although with hindsight it appears that he continued to maintain his plan to end his life, we accept it would have been difficult to prevent someone determined to end their own life from doing so. We are satisfied that he received the appropriate support to help him when he needed it. Although we will never know, it is possible that he decided to present himself as more settled in order to ensure the ACCT was closed. He had previously said he would not kill himself when on an open ACCT as he would not wish staff to be blamed.

Emergency response

127. After the man was found hanging, an officer checked for signs of life and began mouth to mouth resuscitation. He had not been provided with a mouth shield, however he continued the resuscitation attempt. Unfortunately during the procedure he ingested some fluid. Commendably the officer continued with mouth to mouth breathing.

128. In the most recent instruction issued 17 February 2012 (Prison Service Instruction 64/2011) by the National Offender Management Service "Management of prisoners at risk of harm to self, to others and from others" there is a section which deals directly with emergency response kits. At chapter one the Service has issued the following mandatory instruction:

> "Emergency response kits must be available in all residential areas. Prisons, in consultation with their healthcare provider, must determine what items need to be included in them."

129. Although the instruction came into effect after the man's death, it is important these emergency kits are readily available in all areas of the prison, and contain mouth shields.

The Governor should ensure that emergency kits are provided on all wings, which include mouth shields for safe mouth-to-mouth resuscitation.

RECOMMENDATIONS *(Service response in italics)*

1. The Head of Healthcare and Governor should ensure CPAP machines are available if required for prisoners diagnosed with sleep apnoea.
   Accepted: *Healthcare will liaise with the security department regarding individuals who require use of a CPAP machine.*

2. The Head of Healthcare should ensure that all emergency equipment is checked regularly and that the checks are fully documented.
   Accepted: *All emergency bags are checked each morning and after each incident; the nurse carrying out the check will sign the log book that accompanies each bag.*

3. The Governor should ensure that ACCT procedures are followed correctly, including that the level of observations and significant events are properly recorded on the ACCT document, that there is continuity of case management in ACCT case reviews and that timely post-closure reviews are held.
   Accepted: *Management checks have been introduced that include both the level and quality and frequency of observations. Guidance to be sent to all managers to include the important of continuity. NTS to be published – list of post closure reviews is published on Z drive on Daily ACCT List – functional heads to oversee.*

4. The Governor should ensure that emergency kits are provided on all wings, which include mouth shields for safe mouth-to-mouth resuscitation.
   Accepted: *Emergency kits are provided on each wing. These are examined daily to ensure that the security seals are intact and they have not been used. The checks are recorded in the wing diary. Each kit contains a mouth shield.*