Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Daryl Hargrave a prisoner at HMP Winchester on 19 July 2015

A report by the Prisons and Probation Ombudsman
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Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

Our Values

We are:

Impartial: *we do not take sides*
Respectful: *we are considerate and courteous*
Inclusive: *we value diversity*
Dedicated: *we are determined and focused*
Fair: *we are honest and act with integrity*

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The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out **independent** investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

My office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Hargrave was found hanged in his cell at HMP Winchester on 19 July 2015. He was 22 years old. I offer my condolences to Mr Hargrave's family and friends.

I am concerned that Mr Hargrave's risk of suicide was not properly considered when he first arrived at Winchester, although this risk was subsequently identified. However, staff at Winchester did not operate Prison Service suicide and self-harm prevention procedures properly, and in line with national instructions, to support Mr Hargrave and keep him safe. I am also concerned about GP provision and prescribing at Winchester, which meant that Mr Hargrave did not receive all his medication for several days after he arrived.

It is worrying that I have identified a number of these deficiencies before in previous investigations into deaths at Winchester, including that of a prisoner who died the day before Mr Hargrave. The Governor and senior Prison Service managers need to assure themselves that safer custody systems at Winchester operate appropriately to safeguard prisoners.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman **April 2016**

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Summary

Events

1. On 13 July 2015, Mr Daryl Hargrave was remanded to HMP Winchester. He had a history of suicide attempts and contact with mental health services. He had previously served a prison sentence. At an initial health screen, he told a nurse that he suffered from depression, anxiety and post-traumatic stress disorder. He said he had taken an overdose four months earlier, drank very heavily and had substance misuse problems. His escort record documented his mental health problems and previous suicide attempts but no one in reception assessed him as at risk or began Prison Service suicide and self-harm prevention procedures (known as ACCT). The next day, a substance misuse doctor prescribed medication for drug and alcohol withdrawal. He did not prescribe other medication for mental health as Mr Hargrave's community GP records had not been received.

2. On 15 July, a healthcare support worker began ACCT procedures when Mr Hargrave said he had suicidal thoughts. At an ACCT case review that evening, he was referred for a mental health assessment and medication review. The case review assessed that Mr Hargrave was at raised risk of suicide and self-harm and staff were required to observe him hourly.

3. On 16 July, a doctor prescribed Mr Hargrave's medication for mental health problems, as his GP records had arrived. A mental health nurse assessed him and arranged for someone from the prison community mental health team to see him on 20 July. On 18 July, Mr Hargrave cut himself and appeared suicidal. A mental health nurse assessed him. A manager increased the frequency of observations to twice an hour and moved him to the prison's healthcare inpatient unit for observation. There was no formal ACCT case review. The next day, Sunday 19 July, Mr Hargrave repeatedly expressed his frustration at being in the impatient unit where he was not allowed to smoke. A custodial manager went to hold an ACCT case review just after 3.00pm and found Mr Hargrave hanged in his cell. Staff gave emergency treatment and paramedics took him to hospital but Mr Hargrave was pronounced dead, shortly afterwards.

Findings

4. We are concerned that Winchester did not operate Prison Service suicide and self-harm prevention procedures effectively. Reception staff appear to have relied too much on Mr Hargrave's statements that he did not intend to harm himself and did not identify and consider his risk factors. When staff began ACCT procedures, the level of observations did not reflect the level of risk of suicide and self-harm and the first case review was not multidisciplinary. Despite Mr Hargrave's mental health and substance misuse problems, no healthcare staff were invited to either ACCT case review.

5. We consider that when Mr Hargrave cut himself on 18 March and was moved to the inpatient unit, staff should have held an immediate case review to address his risk factors. They did not increase the frequency of checks sufficiently to reflect his increased risk. The move to a bare cell in the inpatient unit was unsuitable

for a suicidal prisoner. It left Mr Hargrave isolated, with no distractions and unable to smoke which was a major issue for him. The half hourly checks were all at predictable intervals. A nurse did not record her final interaction with Mr Hargrave because she was told that her contact did not count as an official check.

6. There were also a number of deficiencies in Mr Hargrave's clinical care. The reception nurse did not make a mental health referral, despite his recorded mental health problems. Mr Hargrave's GP records were not processed for two days, which meant that he did not receive medication he had been prescribed in the community for three days. When he was admitted to the healthcare inpatient unit, nurses were not allowed to give Mr Hargrave nicotine patches and he became agitated. The unit ran out of medication to treat his depression and post-traumatic stress disorder. The clinical reviewer considered there was insufficient GP cover at the prison and systemic problems with medication management. Inspectors identified similar issues about staff shortages and the provision of medication during an inspection in 2014.

7. The duty governor informed Mr Hargrave's mother that her son had been taken to hospital in a critical condition, but left it to the hospital to break the news of his death. We consider that this was not in line with national instructions.

Recommendations

- The Governor should introduce clear and effective reception operating procedures so that all staff understand and follow the procedures for identifying prisoners at risk of suicide and self-harm. In particular, staff should:

    - Have a clear understanding of responsibilities and the need to share all relevant information about risk.
    - Consider and record all the known risk factors of a newly arrived prisoner when determining their risk of suicide or self-harm, including information from suicide and self-harm warning forms, PERs and other records.
    - Open an ACCT whenever a prisoner has recently self-harmed or expressed suicidal intent.

- The Governor and Head of Healthcare should ensure that prison staff manage prisoners at risk of suicide or self-harm in line with national guidance, including in particular:

    - All case reviews should be multidisciplinary where possible and a member of healthcare staff should attend all first case reviews.
    - Care map actions should be set, which address all identified issues and ACCT monitoring should continue until all care map actions have been completed.
    - Setting levels of observations which reflect the prisoner's actual risk.
    - All staff, including healthcare staff, recording every interaction with a prisoner in the correct ACCT document.
    - Conducting checks at irregular intervals within the specified frequency.

- Holding a case review whenever an event occurs which indicates an increase in risk.
    - Documenting any decision to relocate a prisoner.
    - Providing the prisoner with sufficient distractions such as a radio, television and books.

- The Head of Healthcare should ensure that:

    - Reception nurses identify and record mental health concerns and make necessary referrals;
    - There is adequate primary care GP provision;
    - There is adequate primary mental health provision;
    - Patient Group Directions are updated to allow healthcare staff to issue patients with nicotine replacement therapy;
    - Prescriptions are started and continued without interruption.

- The Governor should ensure that in the event of a death in custody, the prisoner's next of kin are informed in line with Prison Service Instruction 64/2011.

The Investigation Process

8. The investigator issued notices to staff and prisoners at HMP Winchester informing them of the investigation and asking anyone with relevant information to contact him. No one responded.

9. The investigator visited Winchester on 23 July. He obtained copies of relevant extracts from Mr Hargrave's prison and medical records and interviewed a prisoner.

10. The investigator interviewed twelve members of staff at Winchester on 26 and 28 August and 8 and 10 September. He subsequently interviewed two other members of staff by telephone and one by videolink.

11. NHS England commissioned a clinical reviewer to review Mr Hargrave's clinical care at the prison. He joined the investigator for the interviews with healthcare staff.

12. We informed HM Coroner for Hampshire Central of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

13. One of the Ombudsman's family liaison officers contacted Mr Hargrave's mother to explain the investigation and to ask if she had any matters she wanted the investigation to consider. She wanted to know how her son had managed to take his own life.

14. Mr Hargrave's mother received a copy of the initial report. Her solicitor wrote to us raising a number of questions that do not impact on the factual accuracy of this report. We have provided clarification by way of separate correspondence to the solicitor.

Background Information

HMP Winchester

15. HMP Winchester is a local prison, serving the courts in Hampshire. It holds around 700 adult remanded and sentenced men. Central and North West London NHS Foundation Trust provide healthcare services. There is a primary care team, a substance misuse team and a community mental health team providing secondary mental healthcare on weekdays. There is a member of primary care staff on duty 24 hours a day, seven days a week. There is a healthcare inpatient unit with space for 18 prisoners.

HM Inspectorate of Prisons

16. The most recent inspection of Winchester was in February 2014. Inspectors found that progress, after a very critical inspection in 2012, had been slow and described the main prison as insufficiently safe. Support for prisoners at risk of suicide and self-harm was reasonable with good attendance at case reviews. The quality of ACCT documents was generally good. Listeners complained that staff were slow to take them to prisoners who needed their support. As at the previous inspection, inspectors found that Listeners' suites were not properly furnished to provide an appropriate, supportive environment. The inspection found there were no procedures to monitor and challenge bullies and support victims.

17. Healthcare services had begun to improve, but staff shortages had had an adverse effect on service delivery. Too many prisoners did not receive their medication on time.

Independent Monitoring Board

18. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to May 2015, the IMB reported that officer supervision was highly stretched on some wings and was barely enough to cover routine operations. The IMB was concerned that many of the staff were new and inexperienced and reported an increase in violent incidents and bullying at the prison.

Previous deaths at HMP Winchester

19. Since 2013, we have investigated eleven deaths at Winchester. Three of these were self-inflicted deaths and seven were from natural causes. In our investigation reports of the self-inflicted deaths, we were concerned about failures to identify the risk of suicide and self-harm in reception, the poor quality of ACCT procedures, prescribing of medication and advising next of kin when ill prisoners are taken to hospital.

Assessment, Care in Custody and Teamwork

20. Assessment, Care in Custody and Teamwork (ACCT) is the care planning system the Prison Service uses to support prisoners at risk of suicide or self-harm. 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. Checks should be irregular to prevent the prisoner anticipating when they will occur. Part of the ACCT process involves drawing up a care map to identify the prisoner’s most urgent issues and how they will be met. Regular multi-disciplinary reviews should be held. The ACCT plan should not be closed until all of the actions on the care map have been completed. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

Key Events

21. Mr Daryl Hargrave had frequent contact with social services and mental health services during his childhood. In 2013, he took an overdose and was admitted to hospital for his own safety under section 136 of the Mental Health Act. Hospital staff found no evidence of a mental illness and discharged him.

22. Later in 2013, Mr Hargrave was arrested and charged with wounding. He cut himself in police custody. On 2 September, he was remanded to HMYOI Feltham and initially admitted to the mental health inpatient unit and monitored under ACCT procedures for a month. He said he needed antipsychotics and antidepressants, but a psychiatrist obtained his community records, assessed him and decided that he did not need them. Mr Hargrave was discharged to a standard wing.

23. On 21 March 2014, Mr Hargrave moved to HMP Pentonville. Another mental health assessment found that he was distressed and anxious. Although he still asked for antipsychotic medication, he had no psychotic symptoms.

24. On 26 March, Mr Hargrave was sentenced to 21 months in prison sentence and, on 3 April, he returned to Feltham. Another mental health assessment found no signs of psychosis or depression. He was released on 18 July 2014.

25. A large amount of documentation and correspondence was scanned into Mr Hargrave's prison medical record during this sentence, including:

    - A diagnosis of attention hyperactivity deficit disorder (ADHD).
    - A diagnosis of impulsive behaviour and conduct disorder (antisocial behaviour displayed in adolescence).
    - Symptoms of severe anxiety and post traumatic stress disorder (PTSD).
    - A possible diagnosis of emotionally unstable personality disorder.

Monday 13 July 2015

26. On Monday 13 July 2015, Mr Hargrave was remanded to HMP Winchester, charged with grievous bodily harm. He arrived at the prison at 4.00pm. His Person Escort Record (PER) (a document which accompanies all prisoners escorted between police stations, courts and prisons) noted that Mr Hargrave had a history of depression, PTSD, schizophrenia and anxiety. It said that he had harmed himself in custody in 2013 and methods of self-harm included taking overdoses and biting his wrist.

27. An officer interviewed Mr Hargrave in reception and said he interacted well. He was hobbling and thought it unfair that he was in prison, while the people who had assaulted him were not. She noted that he had mental health problems, but Mr Hargrave said he had no current suicidal thoughts. She told the investigator that she had had no concerns about him and did not think that he needed ACCT monitoring.

28. The officer gave Mr Hargrave a smoker's pack (an advance supply of tobacco) and £1 credit to make a telephone call. He gave his mother's name and telephone number, as his next of kin.

29. A nurse assessed Mr Hargrave in reception. She did not look at his medical record from his last period in prison and told us that she did not normally look at prisoners' previous records. Mr Hargrave said that he had no current thoughts of suicide or self-harm but had overdosed four months earlier, as he had had relationship problems. He said he had mental health problems including anxiety, depression and PTSD and mentioned his previous hospital admission. He said he was prescribed fluoxetine (an antidepressant), pregabalin (for anxiety) and propranolol (for PTSD). Mr Hargrave told her that he drank four bottles of wine and half a bottle of vodka daily and misused benzodiazepines. He had two black eyes after an assault.

30. The nurse referred Mr Hargrave to the substance misuse team for alcohol and benzodiazepine misuse. She did not make a mental health referral. She told the investigator that she did not think that Mr Hargrave was at risk of suicide and self-harm and that his main issue was his facial injuries, from the assault before he came to prison.

31. Mr Hargrave was assessed as suitable to share a cell. The nurse noted in the healthcare section of the assessment form that the community mental health team (who provide secondary mental healthcare in the prison) should assess Mr Hargrave before a final decision about cell sharing was made. However, she did not refer this to the community mental health team. She could not remember why she had not done this.

32. The duty governor spoke to Mr Hargrave in reception. He said that Mr Hargrave seemed confident and jovial. He did not consider he appeared vulnerable and had no concerns about him.

33. Mr Hargrave shared a cell on the third landing of B Wing, with a cellmate. The cellmate said that, over the next few days, Mr Hargrave read the bible a lot. He never mentioned harming himself or suicidal thoughts. They talked about what they would do when they were released.

Tuesday 14 July

34. On Tuesday 14 July, Mr Hargrave attended an induction session with an officer. He then went to the substance misuse clinic and tested positive for benzodiazepines. He told the substance misuse doctor that he was a heavy drinker, misused benzodiazepines and had recently been to a residential rehabilitation clinic. He said his community GP had prescribed him fluoxetine and pregabalin, for depression and anxiety. He seemed calm and had no obvious withdrawal symptoms.

35. The substance misuse doctor prescribed a reducing dose of diazepam (a benzodiazepine) and thiamine and vitamin B to relieve symptoms of alcohol withdrawal. He prescribed pain relief for Mr Hargrave's injuries but decided to wait for his community records before prescribing any medication for his mental health. Healthcare staff received his community records the same day but these

were not scanned in or reviewed by a GP and Mr Hargrave did not receive any mental health medication that day.

36. That afternoon, the daily substance misuse team meeting discussed new arrivals. They decided to continue observing and assessing Mr Hargrave for withdrawal symptoms. A nurse from the substance misuse team recorded two care plans for alcohol and buprenorphine withdrawal. (The latter should have been a care plan for withdrawal from benzodiazepines.)

37. Later that day, a nurse checked Mr Hargrave and he showed no signs of withdrawal. He told her that he had taken a paracetamol overdose three months previously and had been taken to a place of safety under the Mental Health Act. He said he was not going to harm himself at the time, but had thoughts of self-harm 'going around in his head'. She did not explore these thoughts with him or begin ACCT procedures.

Wednesday 15 July

38. At 8.30am on Wednesday 15 July, a healthcare support worker (HCA) checked Mr Hargrave and found he had no withdrawal symptoms. At 10.00am that morning, another prisoner on B Wing was found hanged in his cell and was taken to hospital.

39. At lunchtime, substance misuse staff discussed Mr Hargrave at their daily meeting and decided that he no longer needed to be monitored as there were no signs of withdrawal. They planned to review him again after five days (19 July), 13 days and 28 days.

40. At 3.20pm, a HCA began ACCT procedures during Mr Hargrave's secondary health screening as his mood was very low and he said he had suicidal thoughts. He said he had made numerous attempts at suicide in the past, had overdosed three months earlier and had 'meant it'. He appeared to be 'spaced out', made poor eye contact and was slow to answer questions. He told the HCA that he was unable to cope and sometimes he did not want to live. He asked to see the mental health team and described hearing voices. He spoke about a 'sadness inside'. He was anxious that his cellmate was going to attack him.

41. At 3.40pm, a Supervising Officer (SO) completed the ACCT immediate action plan and decided that staff should observe Mr Hargrave once an hour until the first ACCT case review.

42. At 7.10pm, a SO assessed Mr Hargrave as part of ACCT procedures. Mr Hargrave seemed quite low and kept looking at the floor. He said that he suffered from depression and anxiety and was psychotic. He asked for antidepressants and to see a mental health nurse. He had scratches on his arms and said he had taken many overdoses since the age of 14. He had taken an overdose of paracetamol three months earlier, after which he had been taken to a place of safety under the Mental Health Act.

43. Mr Hargrave said that he thought about suicide and ways to take his own life. He had not made any definite plans but said that he could be impulsive. He said that he would not be getting any visits but could telephone his mother. He said that he misused benzodiazepines and alcohol in the community. Mr Hargrave said

that he had not taken anything, but the SO suspected that he had obtained illicit medication or other substances in prison because his speech was slurred and his behaviour was strange.

44. The SO thought that Mr Hargrave might need detoxification treatment for any substances he might have taken. Because she had not met him before, she was unsure whether he was genuinely low in mood or if substance misuse was causing it. She recorded 'depression / mental illness' as a trigger for a further case review at the front of the ACCT document. She noted that ACCT procedures should continue until the mental health team assessed him.

45. At 7.20pm, a custodial manager chaired the first ACCT case review with a SO and Mr Hargrave. A member of healthcare staff should attend the first case review, but the custodial manager could not remember if he had asked a nurse to attend. He said that managers had told him to prioritise case reviews after the prisoner had hanged himself earlier that day, rather than wait for the next morning when more nurses would be on duty.

46. The custodial manager thought that Mr Hargrave seemed distant, calm, and vacant. Mr Hargrave complained that he had not been given his medication. He said he was having thoughts about killing himself but his Christian beliefs were helping him. He talked about hearing demons and voices and sometimes lost eye contact, seemingly looking at something elsewhere in the room.

47. The custodial manager assessed Mr Hargrave's risk of harm to himself and the likelihood of further risk behaviours as raised. He kept the frequency of observations at hourly. Staff were also required to have three conversations with Mr Hargrave, although the custodial manager did not record how often or when. He told the investigator that he had intended these conversations to happen in the morning, afternoon and early evening. He scheduled the next case review for 22 July and planned to invite healthcare staff and the mental health team.

48. The custodial manager added two issues to the ACCT care map: mental health issues and a medication review. Both actions were marked as ongoing. He and the SO telephoned the healthcare unit after the case review and asked for Mr Hargrave's medication to be reviewed and for him to see the mental health team. At 8.00pm, a nurse made a high priority mental health referral to the primary care team.

Thursday 16 July

49. At 10.45am, the substance misuse doctor (who was helping out in the absence of a primary care GP) started Mr Hargrave's prescriptions for fluoxetine, pregabalin and propranolol after checking his community records, which had been scanned into the clinical record that morning. He did not see Mr Hargrave.

50. At 3.30pm, a nurse from the primary care team assessed Mr Hargrave. (Winchester does not have a dedicated primary mental health team. Assessments are completed each Thursday by a nurse from the primary care team with appropriate mental health training.) She read his clinical record before she saw him. Mr Hargrave remained very low in mood. His eye contact was poor and his speech was slow. He was paranoid, thought that everyone was

talking about him and was hearing voices telling him to harm himself. He had bizarre ideas and talked about a demon taking him over and tormenting him. He said that he did not want to die but would kill himself ‘to stop the demons’ and was being ‘tortured internally’.

51. Mr Hargrave cried quite a lot during the assessment. He said that he had harmed himself deliberately in the past, that he felt vulnerable on the wing, and had been staying in his cell. He said he had been self-medicating with benzodiazepines since he was 16. He reported suffering from schizophrenia, PTSD and severe depression, and said he had seen mental health crisis teams in the community. He asked for antipsychotic medication.

52. The nurse wrote in the ACCT document and referred Mr Hargrave to the community mental health team for a full mental health assessment and medication review. The referral would not normally have been considered until the team’s next meeting on 23 July, but she asked for the referral to be prioritised and the team’s manager booked an appointment for Monday 20 July. (Community mental health team staff do not work at the weekend.) The nurse told the investigator that she would have admitted Mr Hargrave to the inpatient unit for monitoring, but there was no bed available. Mr Hargrave collected his first doses of fluoxetine, pregabalin and propranolol that evening.

Friday 17 July

53. At 10.20am on 17 July, a nurse saw Mr Hargrave for a urine test. He was feeling depressed and suicidal and said he was unable to cope or sleep. She referred Mr Hargrave back to the daily lunchtime multidisciplinary meeting, who decided that no additional input was needed.

54. Mr Hargrave had tried to call his mother on 16 and 17 July but did not get through. At 2.30pm, he told an officer that he had no phone credit and wanted to call his mother. He seemed very flat. She told Mr Hargrave to complete an application for emergency phone credit.

Saturday 18 July

55. Early in the morning, the prisoner who had hanged himself on B Wing on 15 July died in hospital. Prisoners were notified during the day but this did not result in Mr Hargrave’s ACCT being reviewed.

56. During the night, Mr Hargrave cut his arms with a razor blade, while his cellmate was asleep. The cellmate said that, when he woke up and realised what had happened, Mr Hargrave said, ‘You have to go to extremes to get things done’. At about 11.00am, staff took Mr Hargrave to a treatment room where a nurse cleaned and dressed his injuries. She was worried that he might harm himself again. Mr Hargrave said he felt ignored and wanted to die.

57. Later, a nurse from the primary care team spoke to Mr Hargrave in his cell. He seemed agitated and depressed, his eye contact was poor and he mumbled while looking at the floor. He said there was no point in going on and that he thought he was possessed by devils in his bloodstream. He said that the only way to exorcise them was to cut himself or take his own life. He liked his

cellmate but was terrified that he could not control himself and that he might harm him. He was not tearful or hysterical, but articulate and clear.

58. The nurse felt that Mr Hargrave urgently needed help. She spoke to the Acting SO, who was in charge of B Wing. They went to see the orderly officer in charge of the prison. She said she was very concerned about what Mr Hargrave was saying and his risk of suicide. She thought that he had a serious plan to harm himself or his cellmate. She said that she asked the orderly officer to move Mr Hargrave to the inpatient unit and place him under constant supervision, but he said that no staff or cells were available as both constant supervision cells in the inpatient unit were full.

59. The nurse in charge of the primary care team that day was walking past and overheard. She decided that a mental health nurse should assess Mr Hargrave. The orderly officer told the healthcare staff and the SO to resolve the issue between them. He did not see Mr Hargrave or ask for an ACCT case review.

60. Shortly after midday, the nurse asked an agency nurse with mental health training who also works at a medium secure unit, to assess Mr Hargrave. Mr Hargrave was very low and anxious, but stayed calm and talked freely. He said the voices of demons were telling him he was worthless and should kill himself. He thought that life was not worth living. He said that he had cut himself because he was not getting the help he needed and that he had tried to kill himself in the community a year earlier, but could not go through with it because of his family. He said he had suicidal thoughts but no definite plans. He was finding it hard to cope and said that he might end his life if things continued. He said that antipsychotic medication and inpatient admission had helped in the past.

61. The agency nurse suspected either drug induced psychosis or a personality disorder. He decided to move Mr Hargrave to the inpatient unit for monitoring. He wanted the community mental health team to see him first thing on Monday to assess whether he needed antipsychotic medication. She recommended to the SO that ACCT observations should increase to every half hour. He did not think that constant supervision was necessary.

62. At 12.45pm, the agency nurse took Mr Hargrave back to his cell. He telephoned the nurse in charge of the primary care team but there was no bed available in the healthcare unit at that time. On the agency nurse's recommendation, the SO Johnson increased the frequency of ACCT observations, and recorded this on the front cover. He did not hold an ACCT case review.

63. At about 4.00pm, a bed in the inpatient unit became available and Mr Hargrave was moved to cell H1-17. This is classed as a reduced risk cell. The furniture is made of moulded plastic and bolted down. Mr Hargrave had no television or radio. He had no cellmate and no neighbour, as the cell next door was out of commission. The cell is situated on its own in the far corner of the unit, down a corridor and around the corner from the staff office.

64. No one consulted the duty governor or the orderly officer about the move. When he arrived, Mr Hargrave told the nurse in charge of the primary care team that he was not happy about the move, as there was no television in his cell. At 4.30pm, Mr Hargrave seemed to be in a better mood and collected books from the library.

At about 5.00pm, he collected his tea and ate it in his cell. At 8.10pm, he asked the officer performing an ACCT check about his medication, which he should have had at 6.00pm. There is no record of whether or not he was given this medication. Before finishing her shift, the nurse left a message for a colleague to see Mr Hargrave the next day, because she was concerned about his mental health.

Sunday 19 July

65. At 7.00am, a nurse checked Mr Hargrave, who said he had had a settled night. At about 10.30am, Mr Hargrave told a nurse and an officer Ward that he was still thinking about trying to kill himself to get rid of the demons but had no definite plans. He felt that nobody was trying to help him. He was unhappy in the healthcare unit and asked to return to B Wing so he could smoke. (Prisoners are not allowed to smoke anywhere in the healthcare unit, including on the exercise yard.)

66. A nurse considered that Mr Hargrave's mood improved when she spoke to him. She told him he needed to stay in the unit until he saw the community mental health team the next day. Mr Hargrave said he was struggling with substance withdrawal and she promised to contact the substance misuse team. An officer asked Mr Hargrave if he would like to go outside in the exercise yard during the afternoon and Mr Hargrave said he would. At 11.00am, Mr Hargrave declined a shower until he got his medication, which he had still not received.

67. At 12.25pm, the senior nurse in charge of the primary care team that day checked Mr Hargrave. He seemed very bored but brighter than the day before. He had not received his prescribed fluoxetine or propranolol because they were out of stock. He was in a very bad mood because he could not smoke in the inpatient unit. She said that only a doctor could prescribe nicotine patches and she offered to ask the smoking cessation team to see him the next day.

68. The senior nurse remained very concerned about Mr Hargrave, and she asked a prison chaplain to visit him. The chaplain went to his cell but he seemed to be asleep, so she planned to see him later that afternoon.

69. The ACCT record indicates that an officer checked Mr Hargrave every half hour at 2.00pm, 2.30pm and 3.00pm. The officer told the investigator that he had made the final entry in error as he should have written this in another prisoner's ACCT document.

70. The last member of staff to see Mr Hargrave alive was the senior nurse at 2.50pm. She stood at the observation panel to speak to him. He was more agitated than before and was still frustrated that he could not smoke. He asked for nicotine patches or gum but she said that she could not give him these. He said that he wanted to go back to B Wing and was not interested in seeing the smoking cessation team. When she left the cell, Mr Hargrave was still preoccupied about not being able to smoke. He did not mention any suicidal thoughts.

71. The orderly officer in charge of the prison that day had checked the daily briefing sheet and noted that Mr Hargrave was due to have an ACCT review. Nobody

had told him of any additional concerns about Mr Hargrave during the day. At 2.30pm, a senior officer went to the inpatient unit to help take a patient with serious mental health problems to the exercise yard. While the prisoner was outside, he went back to his office. When he went back to the inpatient unit at 3.00pm to take the prisoner back to his cell, the orderly officer asked him to hold Mr Hargrave's ACCT case review.

72. When the senior officer looked at Mr Hargrave's ACCT document he was confused, as the front cover indicated that the next review was not due until 22 July. He telephoned the orderly officer to ask why he was holding a review. Neither realised that Mr Hargrave was the prisoner who had self-harmed the day before. The senior officer then recalled that the senior nurse had been concerned about him the day before and decided that a case review was a sensible precaution. The nurse said that she had offered to attend the case review, but the senior officer had said that this would not be necessary.

73. At 3.11pm, the senior officer went to Mr Hargrave's cell and saw a bed sheet stretched from the medicines hatch in the door to the door frame. Mr Hargrave had fed the sheet through the hatch and back through the door frame into the cell to create a ligature point. As soon as he saw the sheet across the door, he shouted, 'Code blue' twice to an officer who was nearby, constantly supervising another prisoner at risk, and asked him to get help.

74. The senior officer looked through the hatch and saw Mr Hargrave slumped behind the door, suspended by the sheet, which was tied around his neck. He unlocked the cell and pushed hard to get inside as Mr Hargrave's weight was against the door. The officer followed him into the cell. Another officer arrived a few seconds later.

75. An officer cut the sheet from the door and then removed the rest from around Mr Hargrave's neck. Mr Hargrave was unresponsive and not breathing. As the officer was removing the sheet, just before 3.12pm, the senior officer radioed the control room and called a code blue emergency in healthcare. He said that a young adult was hanging and that an ambulance was required. Fifteen seconds later, control room staff radioed all healthcare staff to attend the scene, and they telephoned the ambulance service within 45 seconds.

76. The senior officer began chest compressions to try to resuscitate Mr Hargrave. An officer prepared his airway and then the senior nurse arrived and took over. Another nurse collected the emergency response bag containing a defibrillator, oxygen and adrenaline from the treatment room. More healthcare staff also attended.

77. The senior manager was trained in emergency response procedures and inserted a plastic airway and attached the bag valve mask. The senior nurse took over chest compressions from him while a colleague gave oxygen. The nurses attached the defibrillator, which found no shockable rhythm and they continued resuscitation. After discussion with her colleagues, the senior nurse gave Mr Hargrave adrenaline.

78. An ambulance arrived at the prison gates at 3.16pm and was taken to the inpatient unit. At 3.25pm, a rapid response car arrived. The paramedics also

gave adrenaline intravenously and a defibrillator recorded a heart rhythm. At 3.43pm, Mr Hargrave was taken to hospital. He did not recover and was pronounced dead at 3.59pm.

Contact with Mr Hargrave's family

79. At about 3.45pm, the duty governor telephoned Mr Hargrave's mother to tell her that her son had tried to take his life and was on his way to hospital in a critical condition. He gave her details of the hospital and she said that she would visit her son.

80. At about 4.00pm, the ward sister at the hospital telephoned the prison and told the duty governor that Mr Hargrave had died. He said that Mr Hargrave's mother was on the way to the hospital and the ward sister said that she would break the news to her when she arrived. He told the investigator that he was reluctant to telephone Mr Hargrave's mother himself to break the news of her son's death while she was travelling.

81. The duty governor did not telephone Mr Hargrave's mother again and there is no evidence that anybody from the prison had any further contact with her that day, either by telephone, face-to-face or via the police. The only trained family liaison officer was on leave and a family liaison officer was not appointed until the next day. The next entry in the family liaison log is dated 20 July, when an officer telephoned Mr Hargrave's mother to discuss her son's funeral arrangements. Mr Hargrave's funeral took place on 7 August. In line with Prison Service instructions, the prison contributed to the cost.

Support for prisoners and staff

82. At 4.30pm on 19 July, the duty governor debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

83. On the evening of 19 July, the duty governor and the orderly officer checked prisoners on ACCTs throughout the prison. An officer told Mr Hargrave's former cellmate on B Wing of Mr Hargrave's death and offered him support.

Post-mortem report

84. The post-mortem examination found that Mr Hargrave died as a result of ligature suspension. The results of a toxicology test showed a substantial amount of a designer benzodiazepine similar to diazepam which Mr Hargrave might have ingested since his imprisonment. However, the pathologist did not consider that this would not have made any discernable contribution to his death.

Findings

Assessment of risk in reception

85. Neither an officer nor a nurse began ACCT procedures for Mr Hargrave in reception. PSI 64/2011 (Safer Custody) lists risk factors and potential triggers for suicide and self-harm. It states that 'all staff who have contact with prisoners must be aware of the triggers that may increase the risk of suicide, self-harm or violence and take appropriate action'. Mr Hargrave had a number of these risk factors, including a history of self-harm, mental health issues (including schizophrenia – reports suggest that people with schizophrenia are up to twelve times more likely to kill themselves) and alcohol abuse. The concerns were noted on the escort record, in an alert on Mr Hargrave's prison record and in his medical records.

86. In a thematic report about risk factors in self-inflicted deaths published by the Prisons and Probation Ombudsman in April 2014, we identified that too often assessments place insufficient weight on known risk factors and too much on staff perceptions of the prisoner. We are concerned that the reception staff relied too heavily on Mr Hargrave's presentation rather than his risk factors.

87. There is no evidence that anyone in reception considered that these factors increased Mr Hargrave's risk of suicide or self-harm and no one began ACCT procedures. We do not know what weight the staff attached to his risk factors (if any) as opposed to his statements that he did not intend to harm himself. We identified the need to take full account of risk factors for newly arrived prisoners in the investigation report into the death of a prisoner at Winchester in 2014. The prison accepted our recommendation and said that they had taken action to ensure that reception staff were aware of all risk factors and took into account all information from external sources when assessing a newly arrived prisoner's risk. However, we found similar failures in the investigation into subsequent deaths at the prison in March and July 2015. We make the following recommendation:

    The Governor should introduce clear and effective reception operating procedures so that all staff understand and follow the procedures for identifying prisoners at risk of suicide and self-harm. In particular, staff should:

    - **Have a clear understanding of responsibilities and the need to share all relevant information about risk.**
    - **Consider and record all the known risk factors of a newly arrived prisoner when determining their risk of suicide or self-harm, including information from suicide and self-harm warning forms, PERs and other records.**
    - **Open an ACCT whenever a prisoner has recently self-harmed or expressed suicidal intent.**

ACCT procedures

88. PSI 64/2011 notes that 'The ACCT process is necessarily prescriptive and it is vital that all stages are followed in the timescales prescribed'. The investigation identified a need for improvements in a number of aspects of the operation of ACCT procedures, which we outline below.

89. PSI 64/2011 requires any member of staff to begin ACCT procedures if they receive information which might indicate a risk of suicide or self-harm. When a nurse saw Mr Hargrave on 14 July, he said that he had recently taken an overdose and been detained under the Mental Health Act. He said he was not going to harm himself but had thoughts in his head. She did not ask him about these thoughts. This was another missed opportunity to support Mr Hargrave using ACCT.

90. A HCA began ACCT procedures on 15 July after Mr Hargrave expressed clear suicidal thoughts. There was no member of healthcare staff present at the first ACCT case review, contrary to a mandatory instruction in PSI 64/2011. After another prisoner hanged himself earlier the same day without having an ACCT case review within the required timescales, the case manager said he was told by his managers to prioritise case reviews, which was why he decided to proceed, even though he knew about the mandatory requirement. This meant that there was no one at the review to give insight into Mr Hargrave's mental health issues and how they might affect his risk of suicide and self-harm.

91. PSI 64/2011 states that ACCT case reviews must be multidisciplinary where possible. The senior manager did not invite a nurse to the planned second case review on 19 July. The senior nurse said that she offered to attend but that he declined and took an officer instead. Given Mr Hargrave's apparently deteriorating mental state and the previous failure to include a nurse at the first case review, the second case review should certainly have been multidisciplinary, particularly as he was on a unit staffed by nurses.

92. The panel at the first case review set an hourly frequency of observations. We consider that this was too low, given that they assessed Mr Hargrave as a raised risk of suicide or self-harm and that the following information was available:

- Mr Hargrave had not yet had a mental health assessment.
- His prescriptions for mental health medication had not yet been started.
- He reported a recent detention under the Mental Health Act.
- He reported a history of multiple suicide attempts and a recent overdose.
- He had been misusing alcohol and drugs and appeared to be under the influence of an unknown substance during the assessment interview.
- He said that he tended to act impulsively.
- He said that he thought about suicide and ways to do it, although he had no current plan.

93. PSI 64/2011 requires that the ACCT care map should aim to address the issues identified in the assessment interview. The ACCT assessor thought that Mr Hargrave had taken an unknown substance and might need to complete detoxification treatment. However, a custodial manager did not add this to the

care map and with no nurse at the case review the substance misuse team, who had stopped monitoring Mr Hargrave, were not alerted to this potential relapse. Mr Hargrave received no further input from substance misuse staff even though he complained about substance withdrawal to Nurse Town on 19 July, who promised to refer him back to them.

94. PSI 64/2011 instructs staff to hold a new ACCT case review whenever a trigger is activated. A SO recorded 'depression / mental illness' as a trigger in the ACCT document. There were three occasions when healthcare staff received risk information that should have prompted a further ACCT review. On 16 July, Mr Hargrave told a nurse about demons tormenting him and voices telling him to harm himself. He talked about killing himself to stop the demons. On 17 July, he told a nurse that he was feeling depressed, suicidal and unable to cope. On 19 July, Mr Hargrave told a nurse and an officer Ward that he would continue to try to kill himself to get rid of the demons but had no definite plans. None of these incidents prompted an ACCT case review or an increase in the level of observations.

95. PSI 64/2011 requires staff to hold a new ACCT case review if there is an increase in lethality. On 18 July, Mr Hargrave cut himself for the first time and moved to the inpatient unit. At this stage, managers should have arranged an immediate ACCT case review to update the care map and address his deteriorating mood. It would have been appropriate for B Wing staff, who knew him, to have held this review before handing over to the inpatient staff. A SO, who was temporarily promoted and has since returned to officer grade, increased the frequency of observations, but did not hold an ACCT case review. He is trained as an ACCT case manager. A nurse did not arrange for a case review when Mr Hargrave arrived on the inpatient unit.

96. We consider that the increase in the frequency of observations to every half hour was insufficient. Mr Hargrave had told an agency nurse that he was hearing the voices of demons telling him to kill himself. He had not seen the community mental health team, had actively self-harmed and had moved to the inpatient unit, where he was in a cell on his own for the first time. A senior nurse was so worried about Mr Hargrave that she had advocated constant supervision. While the agency nurse disagreed, the senior nurse's concerns suggest that half-hourly checks were not commensurate with the risk of suicide.

97. PSI 64/2011 requires staff locating an at-risk prisoner to weigh up the benefits the new cell might afford and the risk he presents to himself. We consider that staff located Mr Hargrave in an inappropriate cell on the inpatient unit. The senior nurse described this cell as dismal and not suitable for someone fragile and very vulnerable. The move was intended to support Mr Hargrave but, in our view, may have made his situation worse. There were a number of reasons the cell was unsuitable:

- There were no television, books or radio (we were told that there are only a few radios and they are mostly broken) to distract Mr Hargrave.
- The cell was in an isolated location in the far corner of unit with no staff passing by.
- He had no cellmate or neighbour.

- He was unable to smoke anywhere on the inpatient unit, which was a significant issue for him.

98. PSI 64/2011 requires staff to check prisoners at unpredictable times. However, throughout the morning and afternoon of 19 July, staff recorded Mr Hargrave's ACCT observations precisely on the hour and half hour.

99. An officer made the final entry in Mr Hargrave's ACCT ongoing record at 3.00pm. However, he told the investigator that this was not a true account of events and he had accidentally recorded a check on a different prisoner in Mr Hargrave's ACCT document. He alerted managers to his error immediately after Mr Hargrave died and informed the investigator at interview.

100. The senior nurse was the last member of staff to see Mr Hargrave. She spoke to him at 2.50pm but did not write her check in the ACCT ongoing record. She said that she had been told by officers not to write in the ongoing record because her visits did not count as official ACCT checks. This is at odds with the multidisciplinary approach of the ACCT process.

101. We do not consider that the prison operated ACCT procedures effectively, in line with national instructions, to keep Mr Hargrave safe. There was a failure to involve healthcare staff in the ACCT process, even though their input can be critical and a HCA and a senior nurse demonstrated insight into Mr Hargrave's serious risk of suicide. There was also a failure to act on or properly review new risk information, including not holding case reviews following an increase in risky behaviour or setting an appropriate level of observations. Finally, Mr Hargrave's move to an inappropriate cell only increased his risk. We make the following recommendation:

The Governor and Head of Healthcare should ensure that prison staff manage prisoners at risk of suicide or self-harm in line with national guidance, including in particular:

- **All case reviews should be multidisciplinary where possible and a member of healthcare staff should attend all first case reviews.**
- **Care map actions should be set, which address all identified issues and ACCT monitoring should continue until all care map actions have been completed.**
- **Setting levels of observations which reflect the prisoner's actual risk.**
- **All staff, including healthcare staff, recording every interaction with a prisoner in the correct ACCT document.**
- **Conducting checks at irregular intervals within the specified frequency.**
- **Holding a case review whenever an event occurs which indicates an increase in risk.**
- **Documenting any decision to relocate a prisoner.**
- **Providing the prisoner with sufficient distractions such as a radio, television and books.**

Clinical care

102. In a thematic report about the self-inflicted deaths of prisoners published by this office in March 2015, we found that mental health referrals should be made and acted on promptly. We also stressed the importance of continuity of mental health care from the community into prison.

103. Mr Hargrave's mental health issues were highlighted on the PER. He told a nurse in reception that he had previously been admitted to hospital under the Mental Health Act and was currently prescribed a number of mental health medications. There was also a large amount of risk information in his clinical record. We consider that there was enough information available to the reception nurse for her to have made an immediate mental health referral. Although she wrote on the cell sharing risk assessment that he would need to see the community mental health team, she did not make the necessary referral, and Mr Hargrave only had a mental health assessment three days later after an ACCT review.

104. The clinical reviewer found that the system for obtaining and acting on a patient's community records was inefficient and led to a delay of three days before Mr Hargrave was prescribed medication for his mental health problems. He identified a progressive deterioration in Mr Hargrave's mental health, so any delay in treatment was unhelpful.

105. The substance misuse doctor prescribed the mental health medication, as no primary care GP was available. The clinical reviewer found that the provision of primary care GPs at Winchester was not equivalent with that in the community. He said that he has often had to compensate for the absence of a primary care GP to ensure that prisoners get their medication. During their most recent inspection, HMIP found that chronic healthcare staff shortages had had an adverse effect on service delivery.

106. The clinical reviewer also found that there was no full time, dedicated primary mental health provision, which is very unusual in a local prison. Instead, a nurse from the primary care team with a mental health background was allocated time one day a week to assess new referrals. We are aware that, since Mr Hargrave's death, there is now one full time primary mental health nurse at Winchester, but we remain concerned at the paucity of cover.

107. Mr Hargrave repeatedly expressed his frustration at being unable to smoke on the inpatients unit. The unit has a strict no smoking policy, even in the exercise yard. With no other distractions, he became increasingly agitated, mentioning this issue in his final conversation with a senior nurse. The clinical reviewer found that acute nicotine withdrawal might well have had an adverse effect on his mood. Because it was a weekend, nursing staff were unable to help Mr Hargrave, as they could not issue nicotine patches without a doctor's authorisation. We agree with the clinical reviewer's recommendation that the nurse in charge should be allowed to issue nicotine replacement therapy.

108. During their most recent inspection, HMIP found that too many prisoners did not receive their medication on time. They recommended that the reordering of medicines should be managed effectively to ensure continuity of care. On 19

July, nursing staff could not issue Mr Hargrave with fluoxetine and propranolol because they were not in stock. The senior nurse said that healthcare staff often ran out of prescription medication, which they obtain form a local pharmacy. The clinical reviewer found that the prescription was inefficient, unreliable and unsatisfactory, and that access to medication was not equivalent to that expected in the community. We make the following recommendation:

The Head of Healthcare should ensure that:

- **Reception nurses identify and record mental health concerns and make necessary referrals**
- **There is adequate primary care GP provision**
- **There is adequate primary mental health provision**
- **Patient Group Directions are updated to allow healthcare staff to issue patients with nicotine replacement therapy**
- **Prescriptions are started and continued without interruption**

Family liaison

109. Prison Rule 22 requires that when a prisoner becomes seriously ill, the Governor should "at once inform the prisoner's spouse or next of kin, and also any person who the prisoner may reasonably have asked should be informed". The duty governor telephoned Mr Hargrave's mother immediately to tell her that her son had been rushed to hospital in a critical condition. However, when the hospital informed him 15 minutes later that Mr Hargrave had died, he agreed that the ward sister would inform Mr Hargrave's mother.

110. PSI 64/2011 sets out the requirements for liaison with families after a death in custody. Prison staff have a responsibility to break the news of a prisoner's death to their next of kin in person if at all possible. Mr Hargrave had been taken to a hospital opposite the prison, and we consider that someone form Winchester should have broken the news of Mr Hargrave's death to his family in person. We are also concerned that the prison did not speak to Mr Hargrave's mother until the following morning after a family liaison officer was appointed. We have made several recommendations to Winchester about similar issues since 2013 and it is with disappointment that we do so again.

The Governor should ensure that in the event of a death in custody, the prisoner's next of kin are informed in line with Prison Service Instruction 64/2011.

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