

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Michael Folley a prisoner at HMP Winchester on 18 September 2017

A report by the Prisons and Probation Ombudsman

PO Box 70769
London, SE1P 4XY

Email: mail@ppo.gsi.gov.uk
Web: www.ppo.gov.uk

T | 020 7633 4100
F | 020 7633 4141

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.

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

Mr Folley died in hospital on 18 September 2017, having been found hanging in his cell two days earlier at HMP Winchester. He was 25 years old. We offer our condolences to Mr Folley's family and friends.

Mr Folley had only been at Winchester for one night when he was found hanging. Our investigation found that reception staff failed to properly assess the documentation that accompanied Mr Folley from court, which indicated that he was at heightened risk of suicide and self-harm. Consequently, they missed an opportunity to start suicide and self-harm prevention monitoring when Mr Folley first arrived at Winchester.

We also found deficiencies in Winchester's emergency response procedures and repeat a recommendation we have made previously.

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

Elizabeth Moody
Acting Prisons and Probation Ombudsman

April 2018

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Summary

Events

1. Mr Michael Folley was remanded to HMP Winchester on charges of theft. He arrived during the evening of 15 September 2017. His Person Escort Record (PER) (a document that accompanies prisoners during transfers between police custody, court and prisons, which sets out the risks they pose), included a completed 'red flag page', which indicated that he was at heightened risk of suicide and self-harm.
2. When Mr Folley arrived at Winchester, he was assessed by two prison officers followed by a nurse. The first officer to assess Mr Folley had access to his PER but did not pass this to the other officer or to the nurse. Mr Folley told all three members of staff that he had no thoughts of suicide or self-harm. None of them started suicide and self-harm prevention procedures. Mr Folley disclosed to the nurse that he had spent time in a psychiatric hospital and the nurse made an urgent referral for a mental health assessment (although Mr Folley was not seen before he died).
3. Mr Folley's cellmate said he had caused him no concern that evening. The next morning, Mr Folley's cellmate left their cell early to go to work. When he returned later that morning, he was unable to get in because Mr Folley had barricaded the door. On gaining entry to the cell, staff saw Mr Folley hanging from the cell window bars. Mr Folley was taken to hospital but he failed to regain consciousness. He died on 18 September after his life support was switched off.

Findings

4. We found no evidence that the first officer to assess Mr Folley in reception considered the information in his PER, particularly the 'red flag page', which indicated that he was at heightened risk of suicide and self-harm. The officer did not pass the PER to the other officer or to the nurse. Consequently, no one considered starting suicide and self-harm prevention procedures as they should have done. We consider that the nurse in particular should have had sight of the PER so that he could have made a better informed decision about Mr Folley's risk of suicide and self-harm.
5. We also found that staff did not use the designated emergency code after they found Mr Folley hanging in his cell. We repeat a recommendation we have previously made to Winchester about its emergency response procedures.

Recommendations

- The Governor should ensure reception staff identify prisoners at risk of suicide and self-harm, and manage them appropriately, by ensuring they:
 - have a clear understanding of their responsibilities;
 - read all documentation accompanying a prisoner so that they can make an informed assessment of a prisoner's risk of suicide and self-harm;

- consider and record all known risk factors of prisoners when determining their risk of suicide and self-harm;
 - alert other reception staff responsible for assessing risk of suicide and self-harm, particularly the reception nurse, to potential risk factors and pass on relevant documentation; and
 - open an ACCT whenever a prisoner has significant risk factors, irrespective of their stated intentions.
- The Governor should ensure that all prison staff are aware of, and understand PSI 03/2013 and their responsibilities during a medical emergency, including efficient communication of the nature of the emergency and ensuring there are no delays in calling an emergency ambulance.

The Investigation Process

6. The investigator issued notices to staff and prisoners at HMP Winchester informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
7. The investigator visited Winchester on 21 September. She obtained copies of relevant extracts from Mr Folley's prison and medical records and interviewed Mr Folley's cellmate.
8. NHS England commissioned a clinical reviewer to review Mr Folley's clinical care at the prison. The investigator interviewed four members of staff at Winchester on 11 October and five on 24 October, jointly with the clinical reviewer.
9. We informed HM Coroner for Hampshire Central of the investigation. We have sent the coroner a copy of this report.
10. One of the Ombudsman's family liaison officers contacted Mr Folley's next of kin, his father, to explain the investigation and to ask if he had any matters he wanted the investigation to consider. He did not have any questions or concerns. Mr Folley was informed the initial report was available, but did not wish to receive a copy or make any comment.
11. The report was shared with the Prison Service. The Prison Service did not find any factual inaccuracies.

Background Information

HMP Winchester

12. HMP Winchester is a local prison, serving courts in Hampshire. It holds around 700 adult remanded and sentenced men. It includes a separate lower security unit for up to 129 sentenced men nearing the end of their sentence, known as West Hill. Central and North West London NHS Foundation Trust provides healthcare at the prison and 24 hour healthcare cover.

HM Inspectorate of Prisons

13. The most recent inspection of HMP Winchester was in July 2016. Inspectors reported that new prisoners were treated well, although they were let down by some weak first night arrangements, especially for those at risk of self-harm.
14. Inspectors said that the prison's reception area was particularly busy, especially in the evenings. Staff welcomed all new arrivals, and prisoners had the opportunity to disclose concerns about their vulnerability and thoughts of self-harm. Inspectors recommended that all new prisoners should receive comprehensive first night support, including a thorough assessment of how they are feeling and their risk of self-harm. However, first night support for many new prisoners was limited by their late arrival from court, which meant they did not have the opportunity to meet wing staff, settle in, or receive additional support before being locked up for their first night.
15. Inspectors noted that the level of self-harm had increased at the prison, but there was little analysis of data or trends to inform a local strategy. There had been five self-inflicted deaths since their previous inspection and inspectors found that insufficient attention was given to previous PPO recommendations.

Independent Monitoring Board

16. 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, covering June 2016 to May 2017, the IMB reported that healthcare services at the prison had been barely adequate the previous year, but were now failing to safeguard the basic needs of prisoners.
17. The IMB reported that there was often a bottleneck of prisoners waiting to be seen in reception, which resulted in lengthy delays in processing prisoners and moving them onto wings. Also, poor availability of healthcare staff in reception had added delays to an already slow process.
18. The IMB found that ACCT training had increased, and the number of self-harm incidents had dropped slightly during the first half of the reporting year.

Previous deaths at HMP Winchester

19. Mr Folley was the ninth prisoner to take his life at Winchester since 2014. We have previously made recommendations about the prison's emergency response procedures, a recommendation we repeat in this report.

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 the ACCT is to try to determine the level of risk posed, the steps that staff might take to reduce this and the extent to which staff need to monitor and supervise the prisoner. Part of the ACCT process involves assessing immediate needs and drawing up a caremap to identify the prisoner's most urgent issues and how they will be met. Staff should hold regular multidisciplinary reviews and should not close the ACCT until all the actions are completed.

Key Events

21. On 15 August 2017, police found Mr Michael Folley walking near electrified railway tracks in an agitated state and took him to a mental health unit in a hospital. He told doctors there that he had no thoughts of suicide, but he felt bored and wanted attention. Mr Folley was discharged on 16 August and given an appointment with the Crisis Community Team for the following day, but he did not attend.
22. During the afternoon of 17 August, Mr Folley went to Havant Police Station and told the police he had stolen various goods and that he felt paranoid. Police contacted Solent East Mental Health Services (SEMHS) the next day who told them about recent events and that they should contact the Crisis Community Team. There is no record this happened. Mr Folley appeared in court on 19 August on charges of theft and was remanded to custody at Winchester prison, Mr Folley had been in prison custody a number of times previously.
23. On 25 August, a worker for prisoner resettlement started suicide and self-harm prevention monitoring (known as ACCT) after Mr Folley told her he intended to take an overdose. The ACCT was closed the next day. Mr Folley was released on 1 September.
24. On 3 September, Mr Folley was found distressed in a public toilet in Canterbury, having cut off part of his ear and some of his hair. Police took him to Canterbury police station using section 136 of the Mental Health Act (a section 136 order allows police to remove a person from a public place to a place of safety for up to 72 hours, if they consider the person is at risk to themselves or others). He appeared angry, paranoid and anxious, and flooded his room. He was placed on hourly observations and continued to be disruptive. He told staff he was hearing voices and was contemplating harming himself. Staff arranged for Mr Folley to be admitted to a psychiatric intensive care unit in Portsmouth, where he was monitored at 15-minute intervals. He was discharged on 11 September, after a doctor concluded there was no evidence of an enduring mental illness and that he potentially had an antisocial personality disorder or factitious disorder (a condition in which a person acts as if they have an illness by deliberately feigning or exaggerating symptoms so they receive clinical attention).
25. On 13 September, Mr Folley attended a mental health walk-in centre in Reading. He appeared intoxicated, tried to bite staff and spat at them. Police again detained him under section 136. Mr Folley said he had committed the offence in the hope he would be sectioned or detained in custody. Mr Folley was returned to mental health unit. While there, he smashed windows, broke furniture and wrote, "Satan has arrived", in his blood on the wall. He was arrested and taken into police custody.
26. Police spoke to Hampshire's Liaison and Diversion Service (a service to support vulnerable people through the criminal justice system). They said that Mr Folley posed a potentially escalating risk to himself and others, but did not think readmission to hospital would help. They assessed that his reported paranoia was likely to be due to use of cocaine and new psychoactive substances (NPS), rather than a symptom of an underlying mental illness.

15 September 2017

27. Mr Folley appeared at Portsmouth Magistrates' Court on 15 September, and was remanded in custody at Winchester later that day. His remand warrant said that he had not been granted bail for his alleged offence because, among other reasons, he had threatened to harm himself and had harmed himself in the past. The investigator spoke to staff at the court who said Mr Folley had given them no cause for concern while in their custody.
28. A supervising officer (SO) saw Mr Folley in reception at Winchester. He was one of 16 new receptions that evening. The SO had access to Mr Folley's remand warrant and PER. Within the PER, the suicide and self-harm warning form (SASH form) had been left blank but a 'red flag page' had been completed, which stated, "He has a history of self-harm, some of which is recent. He has been displaying signs of paranoia (March 2017). He has a marker saying he may attempt suicide on the railway (May 2017). Also attended a hospital in March this year saying he was suicidal. He says he has no current thoughts of self-harm." The front page of the PER had not been ticked to indicate that a 'red flag page' had been completed.
29. The SO completed the first part of the Cell Sharing Risk Assessment (CSRA). Mr Folley told him he had an antisocial personality disorder and paranoia, but no thoughts of suicide or self-harm. The SO concluded he was able to share a cell. Mr Folley said he was only willing to live on D Wing, for vulnerable prisoners, but was told there were no spaces on that wing.
30. An officer then interviewed Mr Folley as part of the reception process. She was only given Mr Folley's CSRA. She remembered Mr Folley was angry that there was no space for him on D Wing, as he said he would be under threat from prisoners if he were elsewhere in the prison, but did not elaborate. Mr Folley also told her he had some mental health issues, including antisocial personality disorder and paranoia. As a result, she referred Mr Folley to the mental health team. She asked Mr Folley if he had any thoughts of suicide or self-harm, and he said he did not.
31. Mr Folley next saw a nurse. The nurse said that there is a standard operating procedure for healthcare screening in reception. The nurse is given a prisoner's CSRA to complete and any additional relevant documentation from escorting staff is passed to the nurse by reception staff. He said he was only given the CSRA form and not the warrant or PER. He completed the second part of Mr Folley's CSRA, noting he was able to share a cell.
32. The nurse remembered Mr Folley from his previous time at Winchester, and when he entered his name on the healthcare records system, his previous prison healthcare records appeared. The nurse said he was not able to view any community medical records at that stage, so he would not have seen that Mr Folley had been detained in a psychiatric hospital.
33. The nurse recalled having a positive rapport with Mr Folley and said he did not seem anxious or depressed. Mr Folley was adamant that he should be given a cell on D Wing, and was not willing to be located elsewhere in the prison. Mr Folley told the nurse that he had been a patient in a psychiatric unit, but

attributed this to his NPS use and said he had discharged himself. Mr Folley said he had no thoughts of suicide or self-harm. Because of his drug use and hospital admission, the nurse made an urgent mental health referral, hoping that Mr Folley might be seen the next morning (Saturday) but if not, on Monday morning. The nurse was not aware of any referral timescales. By the end of their meeting a space had become available for Mr Folley on D Wing.

34. Mr Folley shared a cell. The cellmate told the investigator that Mr Folley arrived in the cell at about 8pm, while he was in bed watching television. Mr Folley ate a meal, washed, made his bed and got into it. He said Mr Folley did not mention any issues and seemed 'okay'.
35. An operational support grade (OSG), was on duty on D Wing overnight. She recalled checking Mr Folley's cell four times, when he was either talking to his cellmate, or asleep.

16 September

36. The next morning, 16 September, an officer unlocked the cellmate at approximately 9am, to collect his medication. She said Mr Folley was still in bed and looked up briefly. She escorted the cellmate back to the cell a little later, and Mr Folley was still in bed.
37. Later that morning, an officer unlocked the cellmate so he could go to work as a kit orderly on the wing. Mr Folley was standing at the back of the cell washing his face. He looked at the officer through the mirror, but did not speak to her. After this, all prisoners were unlocked for association, but Mr Folley stayed in his cell.
38. At approximately 11am, the cellmate asked an officer to unlock his cell, as the door was closed. She was unable to unlock the door and saw the observation panel was obscured. She called another officer to try to open the door. The other officer could not open it either, and knocked and pushed the door trying to get a response, assuming Mr Folley was inside. The first officer went to find a senior member of staff to assist them. The second officer asked a prisoner to alert another officer, who had the cell inundation key, so she could put her arm through the inundation point (a removable bung) to try to remove the toilet tissue that was obstructing the observation panel.
39. In the meantime, a manager arrived at the cell with an emergency entry box (called MOE, mode of entry) which would allow him to take the lock off the door and open it outwards. The manager who was responsible for the day to day running of the prison that morning, and another manager, also arrived at the cell and tried to help open the door. It became clear that the cell door had also been barricaded with objects (mirrors and cutlery) which made this difficult. Eventually, they managed to dislodge the door enough for one of them to see that Mr Folley was hanging by a ligature, made from a bedsheet, from the cell window bars.
40. Two of the managers and an officer managed to squeeze into the cell. One of the managers cut the ligature and they laid Mr Folley onto his bed, while trying to make room on the floor. The mirrors and cutlery obstructing the door were removed. An officer started cardiopulmonary resuscitation (CPR) on Mr Folley

on the bed, until there was room to move him onto the floor. Once on the floor, a manager continued CPR while the officer attempted to keep Mr Folley's airway open. Another officer then took over chest compressions and attached a defibrillator (a life saving device that gives the heart an electric shock in some cases of cardiac arrest). The machine advised not to shock Mr Folley. A manager radioed for an ambulance to be called and for further assistance.

41. A nurse heard a manager calling for assistance on the radio and went to Mr Folley's cell. She saw staff carrying out CPR and radioed for a member of healthcare to bring an emergency bag to the cell, which a nurse did. A nurse and a prison GP (who had also responded to the call for assistance) took over CPR with a nurse. A nurse said Mr Folley's skin looked very grey when they started CPR, but his colour improved and by the time the paramedics arrived, he had recordable blood pressure and a pulse.
42. Paramedics arrived at Mr Folley's cell at 11.20am, and took him to the hospital. He was admitted to the high dependency unit and placed on a life support machine.
43. Mr Folley's life support was switched off at 4.35pm on 18 September, and he was pronounced dead at 4.43pm.

Contact with Mr Folley's family

44. Mr Folley's father was seriously ill in a different hospital when he was told that his son had been taken to hospital. The prison arranged for Mr Folley's father to visit his son, and he was with him when he died. The prison contributed to Mr Folley's funeral, in line with national guidance.

Support for prisoners and staff

45. After Mr Folley's death, a 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, although a manager and an officer, who were both involved in this incident, were the only members of the team on duty.
46. The prison posted notices informing other prisoners of Mr Folley's death, and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Folley's death.

Post-mortem report

47. The post-mortem and toxicology report were outstanding at the time of issuing this report.

Findings

Assessment of risk

48. Prison Service Instruction (PSI) 64/2011, which covers safer custody, lists a number of risk factors and triggers that might increase a prisoner's risk of suicide and self-harm. Mr Folley presented with several risk factors including early days in custody, previous self-harm, recent contact with psychiatric services, and substance misuse.
49. In February 2016, the PPO published a Learning Lessons Bulletin entitled, 'Early days and weeks in custody'. It is widely acknowledged that the early days and weeks of custody are often a difficult time for prisoners and periods of particular vulnerability for those at risk of suicide. Our bulletin highlighted the importance of carrying out an effective risk assessment in reception so that risks are identified and recorded when a prisoner first arrives.
50. We found that too often, staff in prison receptions miss obvious signs of risk and make decisions based on their perceptions of a prisoner's presentation and the prisoner's own statements that they have no thoughts of suicide and self-harm. We highlighted a particular case where not all staff in reception saw all the information they needed to assess a prisoner's risk, information was not shared and no one recorded the prisoner's risk factors or the reasons why they had decided not to start ACCT procedures. We have the same concerns about Mr Folley's reception to Winchester.
51. A SO was the first officer to assess Mr Folley during the initial reception process. He had access to his warrant (which noted that he had self-harmed in the past) and to his PER. Within the PER, a 'red flag page' had been completed to indicate that Mr Folley had a heightened risk of suicide and self-harm. It noted that Mr Folley had a history of self-harm, some of which was recent. Even though the front page of the PER had not been ticked to indicate that a 'red flag page' had been completed, we would still expect reception staff to look through the PER in its entirety. There is no evidence that a SO assessed the contents of Mr Folley's PER or that he flagged the concerns raised in the PER to the reception nurse, who did not have sight of this document.
52. We consider that given Mr Folley's recent history of self-harm and suicidal thoughts, reception staff should have considered opening an ACCT. We also consider that reception staff should share relevant documentation about a prisoner's risk of suicide and self-harm with other staff who are responsible for assessing risk, particularly the reception nurse. We make the following recommendation:

The Governor should ensure reception staff identify prisoners at risk of suicide and self-harm, and manage them appropriately, by ensuring they:

- **have a clear understanding of their responsibilities;**
- **read all documentation accompanying a prisoner so that they can make an informed assessment of a prisoner's risk of suicide and self-harm;**

- **consider and record all known risk factors of prisoners when determining their risk of suicide and self-harm;**
 - **alert other reception staff responsible for assessing risk of suicide and self-harm, particularly the reception nurse, to potential risk factors and pass on relevant documentation; and**
 - **open an ACCT whenever a prisoner has significant risk factors, irrespective of their stated intentions.**
53. Mr Folley requested vulnerable prisoner status as he felt he would be under threat from other prisoners. There is no evidence that anyone discussed this more fully with him, but neither is there any record that Mr Folley had been threatened when he was in custody at Winchester before. He was given a cell on the VP wing as requested.

Emergency response

54. Prison Service Instruction 03/2013 requires governors to have a two-code medical emergency response system that ensures an ambulance is called immediately when staff have serious concerns about the health of a prisoner. Winchester's medical emergency response protocol requires staff to call either a code blue (when a prisoner is unconscious or having difficulty breathing) or a code red (when a prisoner has severe bleeding or burns), which should trigger the control room to call an ambulance immediately.
55. On 16 September, Mr Folley obscured the observation panel and barricaded his cell door. Once the door was open and Mr Folley was seen hanging, a manager requested assistance and an ambulance, but she did not use an emergency code blue. Staff told the investigator that they do not routinely call an emergency code or request an ambulance when a cell door is barricaded, which is reasonable, but once they saw Mr Folley hanging, they should have called a code blue immediately. We make the following recommendation:

The Governor should ensure that all prison staff are aware of, and understand PSI 03/2013 and their responsibilities during a medical emergency, including efficient communication of the nature of the emergency and ensuring there are no delays in calling an emergency ambulance.

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