

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Trevor Oakley a prisoner at HMP Winchester on 22 October 2018

A report by the Prisons and Probation Ombudsman

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 Trevor Oakley was found hanged in his cell at HMP Winchester on 22 October 2018, the day his trial was due to start. He was 74 years old. I offer my condolences to Mr Oakley's family and friends.

Mr Oakley was supported by Prison Service suicide and self-harm prevention measures (known as ACCT) on three occasions at Winchester, but was not being supported under ACCT at the time he died. Although Mr Oakley had attempted to take his own life before his arrest, and had become unwell on several occasions when he was due to appear in court, staff at Winchester did not identify that the start of his trial might increase his risk of suicide. An opportunity to support him using ACCT procedures was missed.

Winchester does not have an effective staff support team, something we have identified in previous investigations and which the prison needs to address.

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

Sue McAllister CB
Prisons and Probation Ombudsman

May 2019

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Summary

Events

1. On 14 February 2018, Mr Trevor Oakley was remanded in prison custody, charged with sexual offences, and sent to HMP Winchester. This was his first time in prison.
2. Mr Oakley was supported using Prison Service suicide and self-harm prevention procedures (known as ACCT) on three occasions, on 16 February, from 9 to 19 March and from 8 to 9 August. On each occasion, his risk of suicide and self-harm increased when he either protested his innocence, was anxious about court proceedings or was due to appear in court.
3. Mr Oakley's trial was due to start on 22 October. That morning, when an officer arrived at Mr Oakley's cell during the early morning roll check, he could not see him. The officer tried to get a response by tapping the door and switching the light on and off but without success. He went to the wing office to check whether there was a prisoner in that cell and then returned with another officer. They entered the cell and found Mr Oakley hanging from the window. Staff radioed a code blue medical emergency at 6.27am and attempted resuscitation. However, paramedics pronounced Mr Oakley dead at 6.50am.

Findings

4. Staff failed to start ACCT procedures for Mr Oakley when he arrived at Winchester, despite having several risk factors for suicide and self-harm. We also found some deficiencies in the way the subsequent ACCT procedures were managed.
5. We are concerned that staff failed to identify that Mr Oakley's risk of suicide and self-harm might increase when he was due to appear in court at the start of his trial, despite prison and healthcare staff being aware that he had either become ill or had been supported by ACCT procedures on previous occasions.
6. There was a delay in staff entering Mr Oakley's cell. Although it made no difference in Mr Oakley's case, this could be critical in future cases.
7. Winchester still has no staff care team. We have made a recommendation on this previously.

Recommendations

- The Governor and Head of Healthcare should ensure that reception staff start ACCT procedures whenever a prisoner has significant risk factors, regardless of the prisoner's stated intentions.
- The Governor and Head of Healthcare should ensure that staff manage ACCT procedures in line with the guidance in PSI 64/2011, including that:
 - healthcare staff always attend the first case review; and

- staff hold post-closure reviews within seven days of the ACCT being closed, and complete the post-closure review paperwork fully and accurately.
- The Governor and Head of Healthcare should develop a system to identify and record dates that might be triggers for suicide and self-harm, such as court dates, and ensure wing and healthcare staff are made aware.
- The Governor and Head of Healthcare should ensure that prisoners passing through reception on return to the prison after a court appearance, or any other event that might increase their risk, are screened to assess their risk of suicide and self-harm and for potential health problems.
- The Governor should ensure that where a member of staff cannot see a prisoner in their cell, and they consider it unsafe to enter the cell alone to check on the prisoner, they request assistance immediately.
- The Governor should ensure all staff, irrespective of status, position or experience, are offered formal support from the prison, following a death in custody.

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 her. One prisoner responded.
9. The investigator visited Winchester on 25 October, and obtained copies of relevant extracts from Mr Oakley's prison and medical records and visited D Wing.
10. NHS England commissioned a clinical reviewer to review Mr Oakley's clinical care at the prison.
11. The investigator interviewed seven members of staff and two prisoners at Winchester on 20 November. She also conducted telephone interviews with two staff in January 2019.
12. We informed HM Coroner for Hampshire Central of the investigation. The coroner 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 investigators, contacted Mr Oakley's family to explain the investigation and to ask if they had any matters they wanted the investigation to consider. Mr Oakley's family raised no specific issues.
14. Mr Oakley's family received a copy of the initial report, but did not identify any factual inaccuracies.
15. The prison also received a copy of the report and identified a factual inaccuracy, which we have amended.

Background Information

HMP Winchester

16. 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.
17. Winchester is one of 11 prisons placed in Special Measures in June 2018. This means that HM Prison and Probation Service has determined the prison needs additional, specialist support to improve performance.

HM Inspectorate of Prisons

18. The most recent inspection of HMP Winchester was in July 2016. Inspectors noted that Winchester continued to face some big challenges to improve safety. There had been five self-inflicted deaths on the main site since the previous inspection. Inspectors found insufficient attention had been given to ensuring that action taken in response to Prisons and Probation Ombudsman (PPO) recommendations was embedded in practice. Although there was a healthcare improvement plan based on lessons learnt from the deaths in custody, there was no plan for the prison as a whole and some of the PPO concerns had not been fully addressed.
19. Inspectors found in too many cases there were significant weaknesses in the ACCT case management processes, with actions not being completed before closure, poor care planning and a lack of multidisciplinary attendance at reviews.
20. Reception processes were found to be comprehensive and included checks on vulnerability and the risk of self-harm. However, some of these interviews were rushed and too focused on completion of the cell sharing risk assessment, rather than exploring prisoners' history and risks of self-harm. Inspectors reported that they saw many staff engaging positively with prisoners. Even though relationships had improved, the restricted regime on the main site was having an impact on developing staff-prisoner relationships, limiting the amount of time that staff had to build rapport with prisoners and check on their wellbeing.

Independent Monitoring Board

21. 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 to May 2018, the IMB noted that Winchester was placed into Special Measures because of safety concerns, culture, leadership and lack of progress, and an action plan was produced. The Board reported that the Governor had tried hard to effect change and instil a culture of rehabilitation. However, staff shortages (including the loss of experienced staff), lack of resources and the diverse prison population had prevented significant improvement. Prisoners with a physical disability were found to be seriously disadvantaged because the only access to reception is via a flight of steps with no wheelchair facility.

Previous deaths at HMP Winchester

22. Mr Oakley was the 11th prisoner to die at Winchester since October 2015. Of the previous deaths, four were self-inflicted and six were from natural causes. There have been two deaths since, one self-inflicted and one from natural causes. We have previously made recommendations about improving staff's assessment of risk of suicide and self-harm and the need for them to consider all relevant risk factors when deciding whether to start ACCT procedures. We have also identified that there was no effective staff care team.

Assessment, Care in Custody and Teamwork

23. ACCT is the Prison Service care-planning system used to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk, how to reduce the risk and how best to monitor and supervise the prisoner.
24. After an initial assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. Checks should be irregular to prevent the prisoner anticipating when they will occur. There should be regular, multi-disciplinary review meetings involving the prisoner. As part of the process, a caremap (a plan of care, support and intervention) is put in place. The ACCT plan should not be closed until all the actions of the caremap have been completed.
25. All decisions made as part of the ACCT process and any relevant observations about the prisoner should be written in the ACCT booklet, which accompanies the prisoner as they move around the prison. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011, *Management of prisoners at risk of harm from self, from others and to others (Safer Custody)*.

Key Events

26. On 14 February 2018, Mr Trevor Oakley was remanded in prison custody, charged with sexual offences, and sent to HMP Winchester. This was his first time in prison.
27. Mr Oakley arrived at Winchester around 4.20pm. His Person Escort Record (PER - a document that accompanies all prisoners when they move between police stations, courts and prisons, which sets out the risks they pose) noted that on 6 February, prior to his arrest, he had made a serious suicide attempt by overdosing on his prescribed medication.
28. An officer completed Mr Oakley's first night induction and another officer recorded at 7.20pm that Mr Oakley had no thoughts of suicide or self-harm. A Supervising Officer (SO) completed the cell sharing risk assessment (CSRA) and recorded Mr Oakley had no thoughts of self-harm. A nurse also completed the CSRA and noted Mr Oakley should not share a cell, because he had reduced mobility, it was his first time in prison and that he needed be located 'flat' so he did not have to use stairs. There were no available beds in the healthcare inpatient unit and so Mr Oakley was moved to a room on C Wing, a standard residential wing, until a bed became available.
29. At 9.01pm, the nurse recorded in Mr Oakley's medical record that she could not complete a full initial health screen because Mr Oakley was unable to access the reception area due to his reduced mobility. The nurse recorded Mr Oakley's clinical observations, noted his medications and informed the night nurse. (the night nurse did not complete the health screen as there was an incident in the prison during the night shift.)
30. The next day at 8.35am, the nurse completed a full healthscreen. She noted Mr Oakley had several chronic physical health conditions including diabetes and heart and lung disease, and that he had limited mobility, as well as impaired hearing and sight. The nurse recorded that Mr Oakley should not have his medications in possession due to his recent overdose. She noted Mr Oakley had been diagnosed with possible psychosis, schizophrenia and bipolar affective disorder in 2007, but his symptoms had subsided when he stopped using cannabis in 2009. There was no recent history of illicit drug use.
31. At 9.08am, a mental health nurse recorded that she had received information from a hospital, where Mr Oakley had been admitted after his overdose. The hospital found no evidence he had a mental illness and there were no signs of psychosis. She informed the hospital that Mr Oakley would be assessed by the mental health team at Winchester. She incorrectly noted that Mr Oakley was being monitored under Prison Service suicide and self-harm procedures (known as ACCT).
32. A clinical team manager, assessed Mr Oakley at 9.54am and recorded that he should be moved to the inpatient unit. At 3.07pm, a GP examined Mr Oakley and agreed. At 3.56pm, a pharmacist reviewed Mr Oakley's medication and a GP prescribed it all. At 5.25pm, Mr Oakley was moved to into a shared cell on the ground level in D Wing, the vulnerable prisoner unit, as there was no space in the

- inpatient unit. Mr Oakley told staff that he was happy to move to a quieter wing and to have the company of a cellmate.
33. On 16 February, Mr Oakley told an officer that he was going to refuse food and his medication. The officer spoke to a Custodial Manager (CM) and a nurse. At 9.49am, a nurse and the officer tried to encourage Mr Oakley to eat and take his medication but, despite being advised of the risks of not doing so, he refused. The nurse started ACCT procedures at 10.00am and staff moved Mr Oakley to the inpatient unit.
 34. Mr Oakley told a SO during his ACCT assessment that he wanted to get out of prison and was frustrated that he did not know his solicitor's contact details. At 3.55pm, a SO held an ACCT case review with Mr Oakley and another SO. A SO recorded that Mr Oakley said he was protesting against false charges, but that he had no thoughts of suicide or self-harm and that he would start eating and taking his medication. Mr Oakley was given the contact details of his solicitor. Both SO's concluded that Mr Oakley's risk of suicide and self-harm was low and closed the ACCT. At 6.04pm, Mr Oakley apologised to a nurse and said that 'his head was all over the place' and accepted all his medications.
 35. On 21 February, two mental health nurses, reviewed Mr Oakley. A nurse recorded that Mr Oakley spoke at length about his innocence, but that there was no evidence that he was at increased risk of suicide or self-harm. She scheduled a mental health review for after his next court appearance in March.
 36. An ACCT post-closure review was scheduled for 23 February. However, while the form was dated 23 February, it was not signed until 26 February and the person completing the post-closure review did not record their name. (Post-closure reviews should take place within seven days of the ACCT being closed.) Mr Oakley is noted to have 'come to terms with why he is here' and said that he had no thoughts of suicide or self-harm.
 37. On 7 March, a nurse started a health and social care plan for Mr Oakley. He told the nurse that his previous suicide attempt was a mistake and that he had no thoughts of suicide or self-harm.
 38. At 10.35am on 9 March, a nurse started ACCT procedures. Mr Oakley had told wing staff that he felt suicidal and that he hoped he would die in his sleep in three days' time (his next court appearance was scheduled for 14 March). At 10.15am the next day, an officer completed the ACCT assessment, and recorded that Mr Oakley stated he had 'given up mentally and physically' and was not eating or taking his medication, but had no intention of killing himself. A CM held the ACCT review at 10.30am, which was attended by Mr Oakley, an officer and a nurse. The attendees concluded Mr Oakley's risk of suicide and self-harm was raised. The nurse assessed Mr Oakley to have the capacity to make the decision to refuse his medication and he was moved to the healthcare inpatient unit for observation.
 39. A CM held a further ACCT review on 11 March. Staff assessed Mr Oakley's risk as high as he was still refusing to eat or take his medication, but was drinking fluids. Mr Oakley said he felt well supported in the healthcare unit and he did not have any thoughts of harming himself. Staff held another ACCT review the next

day and noted that Mr Oakley had started to eat and take his medication, and had asked to return to D Wing. Mr Oakley remained in the healthcare unit for further assessment.

40. On 12 March, a consultant psychiatrist, assessed there was no evidence Mr Oakley had a mental disorder, recommended that he remain on ACCT procedures and that staff should continue to monitor his food, drink and medication. Mr Oakley appeared at Winchester Crown Court on 14 March. Staff held an ACCT was review the next day, and they assessed his risk as low. Mr Oakley was moved to D Wing the same day.
41. A SO held an ACCT review on 19 March, attended by Mr Oakley, another SO and a member of the mental health team. Mr Oakley said he felt settled on D Wing, that he had a good cellmate and was planning for his trial later in the year. The attendees assessed that his risk of suicide and self-harm remained low and closed the ACCT. The SO scheduled a post-closure review for 26 March.
42. On 26 March, a CM completed the post-closure ACCT review. Mr Oakley said that his problems had been resolved, that he was eating well and felt supported on the wing by staff and other prisoners.
43. On 2 and 9 April, Mr Oakley complained of chest pains. He also told healthcare staff that he was not sleeping due to a noisy cellmate and was anxious about his court case. Mr Oakley was assessed by prison and hospital doctors and was prescribed medication for angina.
44. On 28 April, an officer recorded in Mr Oakley's prison record that he was unhappy with his cellmate who he said was unhygienic and that he wanted to move back to the healthcare inpatient unit. The officer spoke with healthcare staff who arranged for Mr Oakley to be assessed for his social care needs. Mr Oakley twice met with a resettlement officer during May, who assisted him with financial issues. There are no entries in Mr Oakley's prison record during June and July. Healthcare records detail regular contact with Mr Oakley during this time, and that his diabetes was monitored with regular blood tests.
45. On 3 August, Mr Oakley had chest pains and was assessed by a nurse. She recorded that Mr Oakley's temperature was slightly raised and he had a bad cough. A GP reviewed Mr Oakley, who complained of continued chest pains. An ambulance was requested and paramedics assessed him and administered GTN spray (used to relieve angina) and pain relief.
46. On 6 August at 8.44am, a nurse examined Mr Oakley and assessed he was fit to attend court. There is no information in Mr Oakley's prison record, but the nurse recorded in his medical record at 7.19pm that Mr Oakley had spent time at hospital as he felt unwell at court. Mr Oakley said to the nurse that he might not feel strong enough to attend court the next day.
47. The next day at 6.46am, Mr Oakley told a nurse that he had chest pains. The nurse took his clinical observations which were all within the normal range. Mr Oakley was taken to the healthcare unit and a nurse examined him at 7.09am and recorded that his observations were within normal limits and advised him to have two puffs of his GTN spray. The nurse recorded that she told the court at

- 9.53am, that Mr Oakley was not fit to attend. At 10.53am, a GP examined Mr Oakley who said that he felt vulnerable. Mr Oakley became tearful, said that he was being bullied by his cellmate and that his chest pain was emotional rather than physical. The GP recorded that the results of an ECG were normal and contacted D Wing to arrange a cell move.
48. On 8 August at 3.00pm, an officer started ACCT procedures. The officer recorded that Mr Oakley had been self-isolating on the wing and was feeling down as he was being bullied. Nobody completed the ACCT immediate action plan. Mr Oakley was referred to the mental health team at 6.23pm by a pharmacy technician. Mr Oakley told him that he had chest pains, but was feeling low and wanted to talk to someone to relieve his anxiety. He recorded that Mr Oakley had no thoughts of suicide or self-harm.
 49. On 9 August at 8.55am, an officer completed the ACCT assessment. Mr Oakley said he felt bullied and intimidated by his cellmate who said he could not read after a certain time and could not use the toilet more than twice in the night. Mr Oakley said he had no thoughts of harming himself, was eating and taking his medication as prescribed but felt very low. Mr Oakley had already moved cells before his ACCT assessment and told the officer that he felt much happier, and safer now he had told staff and other prisoners about his situation. A SO held an ACCT review immediately after the assessment attended by Mr Oakley, the officer and a mental health nurse. The attendees assessed his risk of suicide and self-harm as low and closed the ACCT.
 50. On 14 August, a psychiatric nurse reviewed Mr Oakley and assessed that no further input from the mental health team was necessary. Mr Oakley told her that things had improved on the wing since his cell move and he was aware of how to contact the mental health team should he need further support.
 51. A post-closure ACCT review was scheduled for 16 August. The post-closure review was signed on 28 August, but the person completing the review did not record their name. Mr Oakley said he felt well supported and had no thoughts of suicide or self-harm.
 52. There are only a few entries on Mr Oakley's prison record during September, all entered by an offender supervisor. She ran the retirement club, for prisoners aged over 65 years, recorded that Mr Oakley attended on 5, 12 and 19 September and after a period of feeling unwell he attended on 17 October. This is the last entry on Mr Oakley's prison record. She said that even when Mr Oakley did not attend the retirement club, she would have contact with him once or twice a week.
 53. On 25 September and 1, 2 and 4 October, a nurse recorded on Mr Oakley's medical record that he was fit to attend court, but according to a manager of the offender management unit (OMU), Mr Oakley only appeared at Salisbury Magistrates' Court on 2 October. The PER notes his physical medical conditions, and that an ACCT was closed on 28 August (the date of the post-closure review), but gives no other information about his risk of suicide and self-harm. There was no corresponding record that Mr Oakley was assessed by healthcare staff when he returned from court, except a note of his blood sugar level.

54. On Saturday 20 October at 3.52pm, a nurse assessed Mr Oakley was medically fit to attend the Crown Court on 22 October, from information contained in his medical record. A nurse also noted that he had told reception that an accessible vehicle had been booked. The investigator was not provided with a PER for this court appearance because the prison said they could not find it.
55. Mr Oakley had no visitors during his time at Winchester and did not make any telephone calls, except to his solicitor.

Monday 22 October

56. Closed circuit television (CCTV) shows at 6.16am, an officer started the early morning roll check on D Wing. He started checking the cells along the left-hand side of the wing, and arrived at Mr Oakley's cell (D2-14) around a minute later. The officer put the light on, but could not see anyone. At 6.19am, he went back to Mr Oakley's cell. Although CCTV is not clear, the officer was standing outside the cell for just over a minute and he said he tapped on the door and switched the light on and off to try and get a response from Mr Oakley. The officer walked to the wing office around 6.21am, to check if there was meant to be a prisoner in cell D2-14, as he was not familiar with the prisoners on D Wing. CCTV shows the officer returned to Mr Oakley's cell at 6.24am, and returned to the wing office at 6.25am, when he asked another officer to check Mr Oakley's cell with him.
57. Both officers returned to Mr Oakley's cell. CCTV shows an officer had his keys in his hand, knocked on the door and entered the cell at 6.27am. There was a sheet obscuring the end of the cell and when he looked behind it, the officer discovered Mr Oakley hanging by a sheet attached to the window. He shouted to the other officer to radio a code blue medical emergency (used when a prisoner is unconscious or having breathing difficulties). He cut Mr Oakley down, lowered him to the floor and started cardiopulmonary resuscitation (CPR).
58. An officer responded to the code blue and assisted the officer. Mr Oakley's complexion was described as grey, his extremities were cold but his body was still warm and there were no signs of rigor mortis. Two nurses responded to the code blue. A nurse arrived first, at 6.30pm, and started preparing the defibrillator, and the other nurse arrived a short time after. They attached a defibrillator and staff continued resuscitation efforts until paramedics arrived.
59. South Central Ambulance Service records show that an ambulance was requested at 6.28am and paramedics arrived at Mr Oakley's cell at 6.47am. Paramedics pronounced Mr Oakley dead at 6.50am.

Information after Mr Oakley's death

60. A friend of Mr Oakley on D Wing, said that Mr Oakley's health had deteriorated in the months before his death, but he remained sociable. He said Mr Oakley was worried about his court appearance and travelling in a standard taxi and not a wheelchair vehicle, dying in prison if he got a long sentence and the fact he had no family support. However, Mr Oakley had never spoken directly about taking his own life. The friend said staff on D Wing were very supportive and if they had had an inkling Mr Oakley's risk had increased they would have provided support. He said in hindsight Mr Oakley had his cell cleaned the day before he died and

was possibly preparing for his suicide. He said Mr Oakley was very good at hiding his feelings and so there was very little anyone could have done to prevent his death.

61. Another friend from D Wing, said that he attended the retirement club with Mr Oakley, and that during their conversations over the weeks and months before he died, Mr Oakley had asked if people who take their own life go to heaven. He said Mr Oakley had spoken of having nothing left and the prospect of being sentenced weighed heavily. He said Mr Oakley never discussed how he would take his own life and never said directly that he intended to. He did not tell prison staff about their conversations and said, 'When a man means it, God bless you.' He said he was saddened to hear that Mr Oakley had died, although was a little surprised he took his own life when he did. He reflected that in hindsight, Mr Oakley had given away some possessions the day before, milk and biscuits, so believed that he had planned his death.
62. An offender supervisor said that during the retirement club meeting on 17 October all those attending, including Mr Oakley, had discussed plans for the Christmas retirement club on 27 December, and when she found out he had taken his own life she was shocked because he had been making future plans. She said she was aware that Mr Oakley was worried about his court appearance, but did not consider he was at heightened risk of suicide.
63. Mr Oakley had told his friends and the offender supervisor that he had cancer, but there is no medical evidence that he did.

Contact with Mr Oakley's family

64. The prison appointed a residential manager, as the family liaison officer (FLO) and a CM as her deputy. They met Mr Oakley's family at the Crown Court, where they informed them of his death. The FLO and her deputy provided ongoing support to the family. The prison contributed towards the costs of Mr Oakley's funeral, which took place on 20 November, in line with national policy.

Support for prisoners and staff

65. A deputy governor, debriefed the staff involved in the emergency response and offered her support. At the time of Mr Oakley's death, Winchester did not have a Staff Care Team to offer immediate and ongoing support to staff. Staff who required additional support were given the contact details for an external health and wellbeing support agency. The offender supervisor who had had regular contact with Mr Oakley, said she was not formally informed about his death and was provided with no support.
66. The prison posted notices informing other prisoners of Mr Oakley's death, and offering support. Staff reviewed all prisoners considered to be at risk of suicide and self-harm, in case they had been adversely affected by Mr Oakley's death.

Post-mortem report

67. A pathologist concluded that Mr Oakley had died from ligature suspension (hanging). A toxicology report shows there were no substances in Mr Oakley's blood at the time of his death, other than those prescribed.

Findings

Assessment and management of Mr Oakley's risk of suicide and self-harm

68. Prison Service Instruction (PSI) 64/2011 – *Management of prisoners at risk from self, from others and to others (Safer Custody)*, lists a number of risk factors and potential triggers for suicide and self-harm. The risk factors that applied to Mr Oakley were: it was his first time in prison, he had attempted suicide before his arrest, he had been charged with serious offences against a family member and he faced a lengthy sentence if convicted.
69. Despite Mr Oakley having these risk factors, reception staff did not start ACCT procedures when he arrived at Winchester. It was not until two days later, on 16 February, that staff started ACCT procedures when Mr Oakley refused food and medication. Staff stopped ACCT procedures later the same day, at the first case review. No healthcare staff were in attendance, despite this being a mandatory requirement. Although a post-closure review was held, it was held ten days after the ACCT was closed, rather than within seven days. Also, the person who completed it did not record their name or the reason for the delay.
70. Mr Oakley was supported under ACCT procedures on two further occasions, from 9 to 19 March, and 8 to 9 August. On 8 August, the immediate action plan, which should be completed within one hour, was not done. Also, the post-closure review was 12 days late and again, the person who completed it did not record their name or the reason for the delay.
71. A safer custody manager accepted that the ACCT process and documentation were not always completed as thoroughly as they should be, but he told the investigator that he was committed to improving standards. We make the following recommendations:
- The Governor and Head of Healthcare should ensure that reception staff start ACCT procedures whenever a prisoner has significant risk factors, regardless of the prisoner's stated intentions.**
- The Governor and Head of Healthcare should ensure that staff manage ACCT procedures in line with the guidance in PSI 64/2011, including that:**
- **healthcare staff always attend the first case review; and**
 - **staff hold post-closure reviews within seven days of the ACCT being closed, and complete the post-closure review paperwork fully and accurately.**
72. Mr Oakley's last period of ACCT monitoring ended on 9 August and his post-closure interview was completed on 28 August. He was not being monitored under ACCT when he died.
73. We are concerned that no one considered starting ACCT procedures before Mr Oakley's trial began on 22 October. PSI 64/2011 lists the start of a trial as a potential trigger for suicide and self-harm. Mr Oakley had expressed anxiety

about his court appearances previously, most notably in March when he said he hoped he would die before he was next due to appear.

74. There is no evidence that reception staff considered starting ACCT procedures when Mr Oakley returned from court on 2 October. Prison Service Order (PSO) 3050, *Continuity of healthcare for prisoners*, says that events such as attending court, sentencing at court, or being questioned by police, are factors that might have a significant impact on the health of a prisoner. For those prisoners passing through reception, prisons are required to have protocols in place for screening them to identify any potential healthcare or suicide and self-harm issues. PSI 07/2015, *Early Days in Custody*, states that the PER and any other available information must be examined by reception staff and the prisoner must be interviewed to assess their risk of suicide and self-harm. There is no record this was done.
75. A healthcare manager, said there was no mechanism to identify dates or situations that might be triggers for suicide and self-harm. She said that key dates, such as trials and sentencing, and the nature of certain offences that might increase risk were generally not shared by prison staff. The safer custody manager said Winchester 'struggled to do the very basics' due to low staffing levels, so there was no process for an effective alert protocol. He said greater personal officer work, on a consistent basis, should improve the identification of prisoners at risk and the process of sharing information. The investigator was told by the safer custody manager that the current personal officer scheme was ineffective at Winchester, and the new Offender Management in Custody (OMiC) model, part of a national roll-out where every prisoner has a keyworker as their first point of contact to assist with any difficulties, had yet to be fully implemented.
76. Given Mr Oakley had taken a significant overdose with the intent to take his own life shortly before he was remanded, stated that he wanted to die before a court appearance in March, was taken ill during court appearances in August, and told a prison doctor his chest pains were emotional rather than physical, staff should have considered starting ACCT procedures before his trial started on 22 October. While we cannot say with any certainty opening an ACCT or providing additional support would have made any difference to Mr Oakley, communication needs to improve to ensure that potential triggers and risks are better identified and proper consideration is given to starting ACCT procedures. We therefore make the following recommendations:

The Governor and Head of Healthcare should develop a system to identify and record dates that might be triggers for suicide and self-harm, such as court dates, and ensure wing and healthcare staff are made aware.

The Governor and Head of Healthcare should ensure that prisoners passing through reception on return to the prison after a court appearance, or any other event that might increase their risk, are screened to assess their risk of suicide and self-harm and for potential health problems.

Clinical care

77. PSO 3050 – *Continuity of healthcare*, states all prisoners that arrive in prison custody should have an initial healthscreen while in reception, and if appropriate, be referred to the doctor to assess their physical and mental health needs, including any medication they may be prescribed.
78. Mr Oakley was assessed by a nurse when he arrived at Winchester, but due to restricted access to reception, did not have a full healthscreen. The nurse flagged the need for him to be examined by the night nurse, but was called away to attend to other significant incidents during his night shift.
79. The clinical reviewer noted that Mr Oakley's medical records were detailed and of a good standard. During his time at Winchester there were no major concerns about Mr Oakley's physical or mental health, any new symptoms that he developed were always promptly addressed and treated by the appropriate healthcare professionals, and his case was discussed at multidisciplinary meetings. The clinical reviewer concluded the care Mr Oakley received was of a good standard and equivalent to that which he could have expected to receive in the community.

Delay entering Mr Oakley's cell

80. Winchester's local instructions (2.77 effective from 1 January 2016) for unlocking a prisoner during the night say that the preservation of life must take precedence over security concerns but night staff should not take action that they feel would put themselves or others in unnecessary danger. The instruction goes on to say:

"Under normal circumstances, authority to unlock a cell at night will be given by the Night Orderly Officer (NOO). Under normal circumstances, no cell will be opened unless two members of staff are present one of whom should be the NOO. Where there is, or appears to be, immediate danger to life, cells may be unlocked without the authority of the NOO. Where there is, or appears to be, immediate danger to life, cells may be unlocked with one member of staff. The Control Room **must** be informed before such action is taken".
81. An officer looked into Mr Oakley's cell around 6.17am, but could not see him. It was not until 6.25am that he asked another officer to check the cell with him and the medical emergency code was not called until 6.27am, ten minutes after the officer first had concerns that he could not see Mr Oakley. The officer said he was trained never to enter a cell alone, and did not consider using his radio earlier to ask for assistance.
82. We accept that the officer could not see Mr Oakley hanging when he looked into his cell and that he therefore did not know that it was a medical emergency. We accept that it was reasonable for him not to enter the cell alone in the circumstances. Nevertheless, we consider that he should have asked for staff assistance on his radio, which would have enabled him to enter the cell earlier than he did. Although earlier intervention would not have made a difference in Mr Oakley's case, it is critical that staff act quickly in situations such as this, where a prisoner's life could be at risk. We make the following recommendation:

The Governor should ensure that where a member of staff cannot see a prisoner in their cell, and they consider it unsafe to enter the cell alone to check on the prisoner, they request assistance immediately.

Support for staff

83. PSI 08/2010 – *Post Incident Care*, states: “The Governor must have a local policy to identify the staff responsible for ensuring access to post incident care.” The investigator was told by many staff that around 18-24 months before, the entire care team had resigned and had never been reinstated.
84. Most staff interviewed said that they had felt well supported by managers and their colleagues, and had been provided with information on how to access the external provider for wellbeing support. However, not all staff felt sufficiently valued or supported. An officer said that while less experienced and more evidently upset staff were supported immediately, he was not provided with the same care. The offender supervisor from the retirement club said that she was only told of Mr Oakley’s death by a colleague, and nobody had come to check on her or the other members of the retirement club to see if they needed support following Mr Oakley’s death.
85. We were told Winchester have identified staff to be trained with a view to reinstating the care team, which is welcome. However, an effective care team is crucial to ensuring staff are appropriately supported following significant events and reinstating a post incident care team should be made a priority. We therefore make the following recommendation:

The Governor should ensure all staff, irrespective of status, position or experience, are offered formal support from the prison, following a death in custody.

**Prisons &
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