Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Adam Basford a prisoner at HMP Winchester on 18 June 2018

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*

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 Adam Basford died in hospital on 18 June 2018 after he was found hanged in his cell on 11 June at HMP Winchester. He was 34 years old. I offer my condolences to his family and friends.

Staff at Winchester managed Mr Basford under self-harm and suicide prevention measures (known as ACCT) in the ten hours before he hanged himself. He had not self-harmed for three years, and I am satisfied that he gave staff no indication that he was at imminent risk of suicide before his death.

Our investigation has, however, identified a number of missed opportunities to identify Mr Basford's needs and provide him with the support he needed.

I am concerned that he did not have a secondary healthscreen or an adequate mental health assessment and as a result healthcare and prison staff were not aware that he had been diagnosed with either autism or a personality disorder.

Mr Basford's behaviour towards female staff was extremely inappropriate and it was difficult for staff to manage him. Staff took a purely punitive approach which meant that Mr Basford spent most of his time at Winchester on a basic regime, with two periods in the segregation unit. This had no effect on his behaviour. I am very concerned that staff did not consider whether there was an underlying cause for his inappropriate behaviour and that, as a result, he was not referred for a mental health assessment and his needs and vulnerability went unrecognised.

I am also very concerned that, in the two hours before he was found hanging, Mr Basford was not checked every half hour, as he should have been, and that he had not been checked for more than 45 minutes when he was found.

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 **March 2019**

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Summary

Events

1. On 4 April 2018, Mr Adam Basford was recalled to HMP Winchester, charged with public disorder and sexual offences and having broken the terms of his licence. He had been released from prison a week earlier.

2. At Winchester, Mr Basford's behaviour was improper and unacceptable. He repeatedly made inappropriate sexual remarks to and about female staff and misused his cell bell. He inappropriately touched female staff on more than one occasion. Staff placed him on a number of disciplinary charges and warnings under the Incentives and Earned Privileges (IEP) scheme (designed to reward good behaviour and challenge misbehaviour) for his poor behaviour. In April 2018, Mr Basford spent two periods in the segregation unit and in May 2018, eight days were added to his prison sentence. Both sanctions were imposed as punishments for his inappropriate sexual behaviour.

3. At approximately 2.00am on 11 June, staff started ACCT procedures after Mr Basford made cuts to his left arm. Staff agreed that Mr Basford should be checked at least every 30 minutes under ACCT procedures.

4. Later that day, staff unlocked Mr Basford's cell at 10.22am and found him hanging from a ligature made from bedsheets. Staff radioed a medical emergency code, and the control room called an ambulance. Healthcare and prison staff tried to resuscitate Mr Basford.

5. When the paramedics arrived, they took over his care and transferred him to hospital. On 18 June, the hospital doctor pronounced that he had died.

Findings

Management of risk of suicide and self-harm

6. When Mr Basford arrived at Winchester, staff appropriately assessed that he was not at immediate risk of suicide and self-harm.

7. Although staff later monitored Mr Basford under ACCT procedures, there were some deficiencies in the way they did so which were not in line with national instructions. Although staff were meant to check on Mr Basford at least every 30 minutes, they failed to do so on two occasions in the two hours before he was found hanging, and he had not been checked for 45 minutes before he was found. This was a missed opportunity to check on his wellbeing and, possibly, intervene.

8. Despite Mr Basford's diagnosis of a personality disorder or autism, prison and healthcare staff failed to consider whether his poor and inappropriate behaviour stemmed from these conditions. No one referred Mr Basford to the mental health team for support or referred his case for discussion at the Men's Complex Needs Meeting.

9. Winchester did not have a Staff Care Team to offer immediate support in person to staff after serious incidents.

Clinical care

10. Although the clinical reviewer found that Mr Basford's clinical care was equivalent to that which he could have expected to receive in the community, there were some concerns. Staff failed to complete Mr Basford's secondary health screen and refer him to the prison GP to prescribe antidepressants. Despite numerous concerns about Mr Basford's mental health, staff failed to make proper and timely mental health referrals. While Mr Basford was in the segregation unit, there was more than one occasion when healthcare staff failed to record significant contact with him in his medical records.

Recommendations

- The Governor should ensure that all staff undertake ACCT observations as directed, actively engage with prisoners being monitored and record their engagement promptly.
- The Governor and Head of Healthcare should ensure that staff are appropriately trained to understand when to refer prisoners who display challenging behaviour to the mental health team and when to create a care plan for prisoners with complex needs.
- The Head of Healthcare should ensure that when there are concerns about a prisoner's mental health, staff should review the prisoner's mental health history, including all available psychiatric information.
- The Head of Healthcare should ensure that healthcare staff record and action all GP referrals.
- The Governor and Head of Healthcare should ensure that staff working with prisoners with a personality disorder or an autistic spectrum disorder are briefed about their risks and needs and how to manage them.
- The Governor and Head of Healthcare should ensure that healthcare staff assess all prisoners in the segregation unit, and that all relevant mental health concerns are shared with staff and recorded in the prisoner's medical record.
- The Governor should ensure that a Staff Care Team is created to give staff the opportunity to discuss their involvement in a serious incident confidentially.

The Investigation Process

11. 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.

12. The investigator obtained copies of relevant extracts from Mr Basford's prison and medical records.

13. NHS England commissioned a clinical reviewer to review Mr Basford's clinical care at the prison.

14. The investigator interviewed 15 members of staff and two prisoners at Winchester, jointly with the clinical reviewer.

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

16. The investigator contacted Mr Basford's aunt to explain the investigation and to ask if she had any matters that she wanted us to consider. Mr Basford's aunt wanted to know as much as possible about the circumstances leading to Mr Basford's death.

17. Mr Basford's aunt received a copy of the initial report. She did not make any comments.

Background Information

HMP Winchester

18. 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

19. The most recent inspection of HMP Winchester was conducted in July 2016. Inspectors noted that Winchester continued to have some big challenges to improve safety. They found that the limited access to time out of cell for prisoners was undermining much that the prison could offer. The recently integrated mental health service provided both primary and secondary mental health services, with one referral pathway. Those with enduring mental health problems were managed using the care programme approach, with good liaison with community mental health teams.

Independent Monitoring Board

20. 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 reported that the living and working conditions in HMP Winchester were extremely poor. They noted that staff shortages meant that a restricted regime was offered. They said that there were many prisoners with mental health problems who required ongoing and/or emergency care. They noted a lack of effective healthcare provision for prisoners with a personality disorder, which currently fell outside the remit of the mental health and primary care team. They noted that this meant that too many men were left to navigate their sentences without appropriate support, despite the availability of a psychologist. Illicit drugs, such as ‘spice’, were also a significant problem.

Previous deaths at HMP Winchester

21. Since June 2015, Mr Basford was the fourteenth prisoner to have died at Winchester. Mr Basford was the seventh prisoner to take his own life during this period and two further prisoners have since taken their own lives.

Assessment, Care in Custody and Teamwork

22. 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

23. Mr Adam Basford had a significant medical history. He had depression and a psychiatric report completed in 2012 noted that he had characteristics of a schizoid personality disorder or an autistic spectrum disorder. In 2013, a prison psychiatrist noted that Mr Basford did not present as an individual with features of a mental illness, but as an inadequate individual with a schizoid-type personality style, in the context of a deprived psychosocial upbringing. (Someone with a schizoid personality disorder will typically show an indifference to social relationships and have a limited range of emotional expression. There is evidence indicating the disorder may be the start of schizophrenia, or just a very mild form of it.)

24. Mr Basford misused alcohol and drugs, including heroin and cocaine. He had tried to take his life in the community and had self-harmed during a previous prison sentence, both in 2015.

Events from October 2017

25. In October 2017, Mr Basford was remanded to HMP Winchester, charged with sexual assault on a female stranger and possession of a Class A drug. He later received a 20-week sentence and was added to the Sex Offender Register.

26. During his reception health screen, Mr Basford told the nurse that he had had heroin, cocaine and three cans of cider daily in the community. He said that he had depression and a personality disorder. A drugs screen was completed and Mr Basford tested positive for buprenorphine (Subutex, medication to treat opiate addiction) and opiates. The nurse referred Mr Basford to the substance misuse team and the prison GP started him on drug detoxification medication (a reducing dose of methadone).

27. On 16 November, a female officer recorded in Mr Basford's prison records that he had made an inappropriate sexual remark to her while she was working on the wing landing. Mr Basford had said that he wanted to have sex with her. The officer gave him an Incentives and Earned Privileges (IEP) warning. She recorded that "FEMALE STAFF should be aware as I understand that this parallels Adam's behaviour from the community".

28. On 12 December, staff submitted an intelligence report, which noted that Mr Basford had pressed his cell bell, which should only be used in an emergency, during the night. Mr Basford had stated that he wanted to be let out of his cell. After staff refused his request, Mr Basford repeatedly asked to have sex. The intelligence team noted that Mr Basford's behaviour was not a one-off incident and the wing manager should speak to him to address his behaviour.

29. On 27 December, Mr Basford was released from prison on licence. As part of his licence conditions, he was required to attend weekly supervised meetings with his probation offender manager until March 2018 and to attend and register (on a weekly basis) at his local police station.

HMP Exeter

30. On 15 January 2018, Mr Basford was recalled to HMP Exeter for breaching his licence conditions (by failing to attend appointments with the police and his probation offender manager) and for possession of a Class A drug. Staff raised no concerns about Mr Basford during his reception screen and recorded that he was suitable to share a cell with another prisoner. Mr Basford said that he had no thoughts of suicide or self-harm and had last harmed himself ten years ago. Because of his previous sexual offence, staff offered to locate Mr Basford in the Vulnerable Prisoners' Unit.

31. A nurse completed Mr Basford's initial health screen. Mr Basford told the reception nurse that he drank 140 units of alcohol per week. He tested positive for cocaine, opiates and benzodiazepines (tranquilisers). The nurse referred Mr Basford to the substance misuse team and the prison GP who prescribed a detoxification treatment plan of methadone.

32. On 5 February, Mr Basford appeared in court, after which he was transferred to HMP Bullingdon. On 29 March, Mr Basford was released from Bullingdon on a new licence which was scheduled to end on 27 May 2018. As part of the conditions of his licence, he had to live at an approved premises in Bournemouth. A restraining order was also in force which banned him from contacting three named female individuals.

33. Within days of living at the approved premises, staff reported that Mr Basford had damaged property and was verbally abusive. On 2 April, Mr Basford was charged with further public disorder and sexual offences.

HMP Winchester

34. On 4 April, Mr Basford appeared in court. The person escort record (PER) that travelled with him recorded that he was charged with indecent exposure, criminal damage, being drunk and disorderly and assault by beating. It was noted that he was a risk to females and vulnerable people and that he was violent. Mr Basford was recalled to HMP Winchester.

35. An officer completed Mr Basford's first night interview. He said that Mr Basford had engaged well, had no thoughts of suicide or self-harm and that he had agreed to comply with prison rules. Mr Basford said that he did not need any drug detoxification medication.

36. A nurse completed Mr Basford's reception health screen and recorded details on SystmOne, the electronic medical database. Mr Basford said that he had no history or thoughts of suicide or self-harm and that he had no mental health problems.

37. Afterwards, a nurse, who was a substance misuse nurse, interviewed Mr Basford. Mr Basford said that he was released from Bullingdon on 28 March. He said that he had been prescribed methadone and had last taken a dose on 31 March. He admitted that he had misused pregabalin (a prescription-only painkiller that may be misused because of its euphoric effects) and heroin (on 31 March) and had smoked crack/cocaine daily since his release from prison. He said that he had also drunk heavily and felt anxious.

38. The nurse noted that Mr Basford displayed no signs of drug or alcohol withdrawal symptoms and tested negative for opiates. She prescribed Mr Basford a five-day methadone detoxification treatment plan (which he later completed successfully). Staff raised no concerns about Mr Basford over his first night in custody.

39. On 5 April, intelligence reports recorded that Mr Basford rang his cell bell at 4.00am and asked to speak to a named female officer. When another female officer responded and told him that no officer by that name worked at Winchester, Mr Basford said that he wanted to have sex. The female officer told Mr Basford that this was not possible. Mr Basford repeated his actions ten minutes later. An intelligence report noted that there were concerns that Mr Basford may try to manipulate female staff and his inappropriate behaviour should be challenged.

40. At 8.55am, a member of the Offender Management Unit (OMU) tried to interview Mr Basford to complete his basic custody screening. However, after wing staff unlocked his cell door, Mr Basford tried to hug her. She turned her back and rejected his advances but he refused to listen. Mr Basford was locked back into his cell. The member of OMU submitted an intelligence report, which noted Mr Basford's inappropriate behaviour. Intelligence noted that this was the second incident reported about Mr Basford's inappropriate behaviour.

41. At 10.10am on 7 April, an officer went to Mr Basford's cell to escort him to collect his detoxification medication. When he left his cell, he tried to hug and touch the officer. She told him repeatedly to stop but he refused to do so. She reported the incident to a male officer and Mr Basford was escorted back to his cell. Staff submitted an intelligence report, placed Mr Basford on a disciplinary charge and gave him an IEP warning. Staff recorded in the wing observation book that Mr Basford had inappropriately touched a female officer.

42. On 8 April, Mr Basford moved to D Wing, a wing for vulnerable prisoners.

43. On 9 April, a Supervising Officer (SO) chaired an IEP review which downgraded Mr Basford's IEP level to basic (for a minimum 28 days) because of his inappropriate behaviour on 7 April. Staff took Mr Basford to the segregation unit under good order and discipline procedures, and it was noted in his prison records that he was a risk to female staff.

44. In the segregation unit, a prison manager chaired a disciplinary hearing and found Mr Basford guilty of common assault, use of threatening and abusive language and disobeying a lawful order. He noted that Mr Basford failed to give any assurances that his behaviour would improve. He noted that Mr Basford should remain in the segregation unit until at least 11 April, and he referred the incident to the police to investigate. (After Mr Basford's death, the police stopped their investigation.)

45. A nurse assessed Mr Basford as fit to be segregated but did not record this on SystmOne.

46. At 11.50am, a nurse, a substance misuse nurse, and a social care support worker, visited Mr Basford to complete his five-day detoxification review. The social care support worker was informed at the morning staff briefing meeting that Mr Basford had inappropriately tried to touch a female member of staff and

caution should be applied when dealing with him. She noted that although she was able to assess Mr Basford, he kept trying to move into her personal space. Mr Basford was locked back into his cell. It was noted that Mr Basford had now completed his detoxification programme and was not prescribed any medication.

47. In the afternoon, a nurse from the mental health team saw Mr Basford for a routine mental health screen (which is offered to all new prisoners). She spoke to him through the cell door due to his inappropriate behaviour with female staff. She told us that she did not ask Mr Basford why he had behaved inappropriately towards female staff. She said that she had only briefly reviewed Mr Basford's medical history before speaking to him.

48. Mr Basford was co-operative throughout their discussion and the nurse recorded that he had had previous contact with the mental health services. Mr Basford said that he had no thoughts of suicide or self-harm and was making plans for his release from prison. He said that he felt stressed, had anxiety and wanted antidepressants to help him manage his feelings. He asked for some self-help information. A nurse assessed that Mr Basford did not indicate that he needed mental health intervention. She noted in his medical records that she referred Mr Basford to a prison GP (to consider whether antidepressants were suitable), but this was not done.

49. On 10 April, during the segregation rounds, a nurse recorded in Mr Basford's medical record that he appeared fit and well. She noted that he should not be seen alone because of the recent incidents. Staff later gave Mr Basford some self-help booklets on how to manage stress and anxiety.

50. On 11 April, a prison doctor saw Mr Basford during the segregation rounds on 11 April and recorded that he had no concerns.

51. On the afternoon of 13 April, a prison manager reviewed Mr Basford's segregation. He recorded that a prison GP had not yet seen Mr Basford as part of his mental health intervention and that he was waiting for "professional guidance" from the mental health team. A segregation review was scheduled for 17 April.

52. On 14 April, an officer recorded that Mr Basford's behaviour had generally been 'okay'. Mr Basford said he wanted nicotine patches. The officer contacted the healthcare team and was told that this matter would be dealt with at his secondary health screen. However, there were around 120 outstanding secondary health screens.

53. When a nurse saw Mr Basford the next day, she told him that nicotine patches would be issued when he completed his secondary health screen. No secondary health screen took place.

54. On the evening of 17 April, Mr Basford returned to D Wing.

55. On 20 April, Mr Basford attended an education class, where he inappropriately touched the teacher. She immediately reported the incident to prison staff and the police. Staff placed Mr Basford on a disciplinary charge and took him to the segregation unit. A nurse assessed Mr Basford as fit to be segregated. (She did not record her contact on SystmOne.)

56. An intelligence report submitted that day noted that Mr Basford appeared not to understand boundaries and was deemed a “Risk to Females” after a similar incident when he had laid his hands on a female member of staff.

57. On the same day, healthcare staff recorded in Mr Basford’s medical record that they were unable to complete his secondary health screen.

58. On 21 April, a prison manager chaired a disciplinary hearing. He referred Mr Basford’s case to the independent adjudicator and adjourned the hearing to assess Mr Basford’s health. It was agreed that Mr Basford would remain in the segregation unit until 25 April and that staff would consider whether to transfer him to another prison for a fresh start. (There is no evidence that a full health assessment took place.)

59. On 23 April, there were intelligence reports that Mr Basford had again behaved inappropriately. Staff reported that while escorting Mr Basford to the shower area, he told the officers to bring him a drunk female to join him in the shower. He then masturbated.

60. On 24 April, Mr Basford returned to D Wing. An officer recorded in the wing observation book that female staff should not to deal with Mr Basford alone. A custodial manager (CM) recorded a similar warning in Mr Basford’s prison records. The officer told us that she recalled one weekend in April when Mr Basford had continuously pressed his cell bell and made derogatory and inappropriate sexual remarks towards her. (She could not recall the exact date.) She said that it became so bad that she refused to answer his cell bell and reported Mr Basford to the CM. He spoke to Mr Basford about misusing the cell bell system and his inappropriate behaviour and reminded him of the expected standards of behaviour.

61. On 2 May, staff again recorded that Mr Basford was misusing his cell bell. When staff responded, Mr Basford repeatedly asked to be let out of his cell to have sex. A SO gave Mr Basford an IEP warning.

62. On the same day, Mr Basford’s offender supervisor introduced himself to Mr Basford. He said that Mr Basford looked dishevelled and uninterested and gave limited and monosyllabic answers to his questions. When asked about his plans for his release from prison, Mr Basford said that he intended to live in an approved premises and do nothing.

63. On 3 May, a SO and an officer submitted intelligence reports and recorded in the wing observation book that they had had to respond to Mr Basford’s cell bell a number of times. Each time, Mr Basford made inappropriate comments of a sexual nature towards them. Shortly afterwards, at his request, staff gave Mr Basford the Samaritans phone. Intelligence reports noted that Mr Basford’s behaviour continued to be of concern and staff continue to note his high risk to females.

64. Later that morning, staff gave Mr Basford an IEP warning for persistently misusing his cell bell.

65. At 5.00am on 7 May, Mr Basford pressed his cell bell and asked the female officer who responded to have sex with him. The officer told Mr Basford to go

back to sleep. Later, an officer reviewed Mr Basford's IEP and decided that he would remain on basic IEP level until at least 17 May. This meant that he would serve the full 28 days he was given for his inappropriate behaviour which stemmed from assaulting a female member of the education staff. Mr Basford's next IEP review was scheduled for 11 May.

66. On 8 May, healthcare staff recorded that they had received a copy of Mr Basford's medical records from his community GP.

67. Staff recorded on 10 May that Mr Basford had continuously misused his cell bell between 5.00am and 7.00am. Mr Basford repeatedly asked staff to let him out of his cell for "something better". Staff gave Mr Basford an IEP warning.

68. When an officer responded to Mr Basford's cell bell at 10.15am, he asked if he could have sex with her. She challenged his inappropriate remark and told him he would be placed on a disciplinary charge.

69. That morning, staff submitted intelligence reports about Mr Basford's behaviour and constant misuse of his cell bell. Staff said that when a male officer answered his cell bell, Mr Basford would say, "I don't want you. Fuck off". When a female officer responded, he would make inappropriate sexual remarks that included, "Will you have sex with me?" or "I want to screw you." The intelligence report noted that only one member of staff had placed Mr Basford on a disciplinary charge, and that a wing manager should speak to him about his behaviour.

70. On 13 May, a SO reviewed Mr Basford's IEP level. She recorded that he should remain on basic for a further seven days because of his continued poor behaviour.

71. On 14 and 15 May, Mr Basford continued to misuse his cell bell and make inappropriate sexual demands and remarks to female staff. Staff gave him an IEP warning and reminded him of the behaviour standards they expected from him. An officer recorded that, despite this, Mr Basford had continuously pressed his cell bell and asked to speak to a female officer. When staff refused his request, Mr Basford asked to be let out of his cell to have sex. Staff placed Mr Basford on a disciplinary charge.

72. An intelligence report noted that Mr Basford's inappropriate behaviour was becoming more frequent and only male staff should attend his cell door. Female staff were warned not to deal with Mr Basford, where possible, because of his risky behaviour. Staff were reminded to update the wing observation book with incidents involving Mr Basford. The intelligence report added that staff should consider referring Mr Basford to the mental health team because of his inappropriate behaviour. (There is no evidence that this happened.)

73. Staff reported that Mr Basford misused his cell bell on 19 May, again asking to have sex with female officers.

74. On 22 May, a SO reviewed Mr Basford's IEP level. She noted that Mr Basford's behaviour had not improved during the last week and he had received two more IEP warnings for inappropriate comments to female staff and there were negative entries about him in the wing observation book. Staff decided that Mr Basford

should remain on basic IEP level for a further 14 days and his next review was scheduled for 5 June.

75. On 24 May, Mr Basford was convicted of criminal damage, assault by beating and damage to property.

76. On 25 May, the independent adjudicator added eight days to Mr Basford's sentence for his inappropriate behaviour in the education class.

77. From 27 May, a prisoner shared a cell with Mr Basford. The cellmate told the investigator that he believed that Mr Basford had learning difficulties. He explained that as time went on, he became frustrated at Mr Basford's behaviour and for continually misusing the cell bell. He said that Mr Basford was frustrated that he was on basic IEP and had limited time out of his cell. However, when Mr Basford was allowed out of his cell, he said that Mr Basford just stood in the doorway.

78. A prisoner who lived in the cell next door told the investigator that Mr Basford was timid, often upset and preferred to remain in his cell most of the time. He believed that Mr Basford was sometimes scared to leave his cell. He said that he had talked to Mr Basford to reassure him that everything was okay. The prisoner said that the cellmate and Mr Basford did not get along, mainly because of Mr Basford's inappropriate behaviour.

79. On 6 June, a SO chaired an IEP review. She noted that in the last fortnight, Mr Basford had shown that he could maintain a period of acceptable behaviour. She restored Mr Basford's IEP level to standard and reminded him that any further instances of inappropriate behaviour would result in an immediate downgrade of his IEP level to basic.

80. On the same day, a community offender manager and his offender supervisor interviewed Mr Basford as part of a Channel 4 documentary about the criminal justice system. (The interview was filmed by a television production team crew, working on behalf of Channel 4.)

81. The community offender manager believed Mr Basford displayed some indicators of autism because he had difficulties communicating with others and struggled to see others' perspectives. Mr Basford was not talkative during the interview. He said that he had no thoughts of suicide or self-harm and had not taken any illicit drugs for two months. He said that other prisoners called him names. She was aware that Mr Basford was due for release from prison on 12 July. She planned to refer him to a community autism specialist worker. She referred him to community accommodation and drug misuse services and for counselling.

82. On 9 June at 7.30pm, a CM and two officers unlocked Mr Basford, at his request, to see a Listener (a prisoner trained by the Samaritans to provide confidential emotional support to other prisoners). Mr Basford said that he no longer wanted a Listener but instead wanted sex with an officer. Staff locked Mr Basford back in his cell, and he was placed on a disciplinary charge for making another inappropriate sexual remark.

83. Some D Wing staff told us that Mr Basford regularly asked to speak to a named female officer and made inappropriate remarks about her. A SO, the D Wing

manager, said that he had talked to Mr Basford about his inappropriate behaviour. He said that sometimes Mr Basford was apologetic but at other times he said he believed that the female staff were there to satisfy his sexual needs. He said that Mr Basford did not appear to understand the effects of his behaviour on staff. Staff confirmed that Mr Basford did not have a formal care plan, other than that only male staff should deal with Mr Basford, and where possible, two members of staff.

84. His cellmate said that other prisoners were aware of Mr Basford's inappropriate behaviour towards female staff and he had witnessed them shouting abuse at him through his cell door on a number of occasions. He said that he believed Mr Basford was occasionally bullied for his canteen (purchases of toiletries and food), which he had traded for 'spice', a psychoactive substance. The prisoner said that Mr Basford sometimes cut his arms.

Events on 10 June

85. CCTV footage shows that at 11.51am on 10 June, Mr Basford's cell was unlocked at lunchtime to allow Mr Basford and his cellmate to collect their lunch. The cellmate then had an issue with another prisoner and refused to collect his food. He returned to his cell. A female officer was the only officer present and stood near to Mr Basford, outside his cell. Another officer, who was working on the landing, had had to leave the landing briefly to deal with another prisoner. She told Mr Basford to get his plate from the cell. Mr Basford tried to engage in conversation with her. He kept apologising to her and tried to put his arm around her and touch her. By this time, other officers, including the officer working on the landing, arrived to help, and put Mr Basford back in his cell. The officers tried to calm Mr Basford, but he started crying and would not comply with staff instructions so staff restrained him. An officer said that Mr Basford behaved hysterically while being put back in his cell. He was upset and was shouting that "the voices were telling him to do it".

86. Staff placed Mr Basford on a disciplinary charge. A SO from the Safer Custody Team was present and referred Mr Basford's case for discussion at the Men's Complex Needs Meeting group, with a view to learning how to manage and help him.

87. The cellmate refused to share a cell with Mr Basford. Staff subsequently moved him to another cell.

88. From about 12.30pm, staff locked all prisoners into their cells for the lunch period. Staff recorded that Mr Basford repeatedly misused his cell bell that day. Each time that staff responded, Mr Basford said that he wanted to be let out of his cell. Staff recorded Mr Basford's actions in the wing observation book and intelligence reports. Mr Basford did not listen to staff when they tried to talk to him and this resulted in further IEP warnings. Staff said that they heard other prisoners shouting abuse at Mr Basford because of his inappropriate behaviour.

89. An officer told us that Mr Basford missed his evening meal because he failed to follow staff instructions when they tried to come into his cell. Mr Basford continued to ask to speak to an officer.

90. A SO later reviewed Mr Basford's IEP level and downgraded him to basic for at least 28 days because of his poor behaviour.

91. At around 6.00pm, staff gave Mr Basford notice of a disciplinary hearing on 11 June for his inappropriate behaviour and told him that he would remain in his cell until then.

92. An officer recorded that when she responded to Mr Basford's cell bell that evening, he asked to have sex with her. She told him that he should stop making inappropriate remarks and gave him an IEP warning.

93. At 10.00pm, an officer noted that Mr Basford had repeatedly pressed his cell bell all evening. When she visited him, he told her that he was hearing voices, that there was someone in the yard shouting at him, and that he had to get out of his cell to have sex. She submitted an intelligence report.

94. That evening, Mr Basford again asked to speak to a Listener who went to the cell and tried to speak to him through the cell door. However, Mr Basford only wanted to be let out of his cell. When this request was denied, he continued to misuse his cell bell. An officer noted that Mr Basford continued to try to talk to her about having sex.

95. At 11.00pm, an officer made a record in the wing observation book and submitted an intelligence report. He noted that Mr Basford had repeatedly misused his cell bell for the last two and a half hours and asked to be let out of his cell. Mr Basford's behaviour had annoyed some of the other prisoners on the wing, who had threatened him with physical harm. The officer stated that staff should be aware of this situation when unlocking prisoners from their cells the next day.

96. The investigator found that between 8.00am and midnight, Mr Basford pressed his cell bell at least 90 times.

Events on 11 June

97. An officer responded to Mr Basford's cell bell at 1.59am and found that he had made cuts to his left arm. She started suicide and self-harm prevention procedures, known as ACCT. A CM, an officer and a nurse attended Mr Basford's cell. While the nurse treated and dressed Mr Basford's wounds, he repeatedly made inappropriate sexual remarks towards the CM and refused to stop when asked.

98. After the nurse had treated Mr Basford, he pulled open the cell door and tried to leave the cell. He stopped complying with staff instructions. The officer had to push Mr Basford back into the cell and he slipped during the process. The nurse visually checked that Mr Basford was okay once his cell door was locked.

99. The CM completed an ACCT immediate action plan. She noted that Mr Basford should remain in his cell and that staff should monitor him at least every 30 minutes. He was reminded that he could speak to a Listener or the Samaritans. She told us that Mr Basford's behaviour was "odd" and that he was agitated. She was concerned at the repeated nature of his inappropriate requests and referred him to the mental health team. She was aware that Mr Basford was shortly due

for release from prison and was concerned about the level of risk he posed to females. She emailed the Offender Management Unit about her concerns.

100. An officer completed half hourly ACCT checks on Mr Basford throughout the night.

101. At around 7.45am, a SO attended the prison's morning briefing, where he heard that Mr Basford had assaulted a member of staff the previous day and would remain locked in his cell until his disciplinary hearing, and that he was also subject to ACCT monitoring.

102. At 7.46am, an officer responded to Mr Basford's cell bell. Mr Basford said that he was concerned that he had upset staff the previous day. He said he felt hopeless and was worried that staff would not help him because of his inappropriate behaviour. The officer said that he reassured Mr Basford that everything would be okay and he could start afresh.

103. At 8.15am, an officer completed an ACCT check on Mr Basford. He noted that Mr Basford was standing up in his cell. At 8.17am, staff started to unlock some cell doors on the wing for prisoners to participate in the morning's association period. Mr Basford's cell door was not unlocked.

104. At 8.40am, an officer recorded in the ACCT log that he checked on Mr Basford who was standing up, looking out of the cell window. However, CCTV footage does not show that this check took place. The officer said that he may have recorded this check at a different time to when he completed it. Nonetheless, he recalled that when he checked Mr Basford, he was standing at the sink, looking out of the window.

105. At 8.44am, CCTV footage shows a prisoner talking to Mr Basford through his cell door, and that at 9.10am, an officer completed an ACCT check. (This is likely to be the check that he recorded as at 8.40am.)

106. CCTV footage also shows that a prisoner and former cellmate visited Mr Basford that morning and talked to him from outside his cell door. The prisoner said that the former cellmate demanded that Mr Basford pass some legal paperwork that belonged to him, underneath the cell door. An officer was standing on the landing nearby.

107. At 9.36, CCTV footage shows that an officer completed an ACCT check on Mr Basford. He noted in the ACCT record that Mr Basford was still looking out of the window. Shortly afterwards, CCTV shows a prisoner talking to Mr Basford through his cell door.

108. An officer recorded that she completed an ACCT check on Mr Basford at 10.00am, and that he was looking out of his window. She told us however that she had not actually completed a formal check but had glanced into Mr Basford's observation panel while walking down the opposite side of the landing. She added that in the morning, some prisoners had raised concerns about Mr Basford. They said Mr Basford had been screaming an officer's name during the night and repeatedly said he was sorry.

Emergency response

109. Around 10.22am, two officers went to D Wing to collect Mr Basford for his disciplinary hearing. A SO was standing nearby to help in case Mr Basford did not comply with instructions. The officers unlocked Mr Basford's cell door and found him hanging from a ligature, tied to the window. The radio network was extremely busy at that time and an officer used her whistle to alert staff to the incident.

110. The SO radioed the control room (recorded as at 10.22am) to alert them to an emergency on D Wing. CCTV shows that the SO and two officers responded to Mr Basford's cell within eight seconds. An officer supported Mr Basford's weight and untied the ligature as it was too thick to cut. An officer and the SO laid him on the floor. An officer radioed for healthcare assistance. (This was recorded in the control room as at 10.22am).

111. A SO checked Mr Basford for signs of life but found none. He started cardiopulmonary resuscitation (CPR). At 10.23am, the control room asked for an update and were told that staff were conducting CPR. An officer told us that he radioed a medical emergency code blue (which indicates that a prisoner is unconscious or has breathing difficulties). This is not recorded in the control room log. The control room called an ambulance (recorded in the control room as at 10.24am). An officer removed furniture from the cell to make more space.

112. Three nurses heard the whistle alarm and a radio request for healthcare assistance on D Wing. CCTV shows that nurses arrived at Mr Basford's cell within two minutes with the medical emergency equipment. A nurse saw that Mr Basford was pale in colour and lifeless. The nurses administered oxygen to Mr Basford and a nurse took over chest compressions from the SO. A healthcare assistant attached a defibrillator (a device that monitors heart rhythms and administers an electric shock if required) and it advised to continue CPR. The prison GP also helped with CPR.

113. The paramedics arrived at the cell at 10.43am and took over the care of Mr Basford and established a pulse. They transferred Mr Basford to hospital at 6.43pm, where he died on 18 June.

Contact with Mr Basford's family

114. Two prison managers were appointed as the prison's family liaison officers (FLO). Mr Basford did not provide any next of kin details when he arrived at Winchester. From historic records and extensive searching, the police identified an aunt, who was abroad. When she returned to the UK on 13 June, Mr Basford's aunt called the prison. A FLO broke the news of Mr Basford's death to her, offered his condolences and support, and met her at the hospital.

115. Winchester maintained contact with Mr Basford's family, and contributed to the costs of the funeral in line with national instructions.

Support for staff and prisoners

116. The duty governor debriefed the staff involved in the emergency response and offered her support.

117. At the time of the incident, Winchester did not have an active Staff Care Team to offer immediate and ongoing support to staff. Staff who required additional support were given the contact details for an external occupational health and wellbeing support agency.

118. Staff checked and reviewed prisoners assessed as at risk of suicide or self-harm, in case they had been affected by Mr Basford's death.

Other information

119. On 22 June, a prison psychologist submitted an intelligence report. She noted that two prisoners reported that Mr Basford had been bullied and harassed on the wing by other prisoners in the week before he took his life. They reported that Mr Basford was scared to come out of his cell, barely left his cell for showers and meals and apparently felt threatened. The prisoners said that they had heard death threats and insults made by other prisoners to Mr Basford which included "Kill yourself, hang yourself". The prisoners said that they did not report this to prison staff.

Post-mortem report

120. The post-mortem report noted that Mr Basford's death was caused by the delayed effects of ligature suspension. No toxicology examination was conducted because of the time lapse between Mr Basford's admission to hospital and his death. The pathologist added that consideration of Mr Basford's psychiatric history was of importance in determining how he died.

Findings

Assessment of risk

121. Prison Service Instruction (PSI) 64/2011 on safer custody and PSI 07/2015 on early days in custody list some risk factors and potential triggers for suicide and self-harm. Mr Basford had a number of these risk factors when he arrived at Winchester. He had been recalled to prison, had a history of self-harm and attempted suicide, and he had mental health, personality disorder and illicit substance misuse issues. However, during his reception screen, staff did not identify any of these risk triggers as raising Mr Basford's risk of suicide or self-harm. The substance misuse team addressed Mr Basford's substance misuse problems. He had last self-harmed in 2015 and was not subject to ACCT procedures until 11 June. While at Winchester, he had not expressed any thoughts that he wanted to take his life.

122. When Mr Basford cut his arm in the early hours of 11 June, staff appropriately started ACCT procedures and placed him under regular observations until they could assess him and hold his first ACCT case review to identify and address his risks and needs.

123. At 10.22am that morning, staff found Mr Basford hanging in his cell when they went to collect him for his disciplinary hearing. They had not yet completed the ACCT assessment and case review, and, while the outcome would not have changed for Mr Basford as he was found hanging when staff went to his cell, they should have prioritised completing the ACCT assessment and review before the disciplinary hearing.

124. In previous investigations, we have identified that challenging behaviour can mask vulnerability mental health issues, and that managing the risk of suicide and self-harm, treating mental health and managing behaviour needs to be integrated to ensure a balanced, holistic and consistent approach.

125. Prisons have the discretion to manage the most severely disruptive, volatile and difficult to manage prisoners using an enhanced ACCT case review process. Mr Basford might have benefitted from such a process, which brings a higher level of co-ordination between the different teams involved in a prisoner's care. However, he displayed no risk to himself throughout most of his time at Winchester, and we consider it reasonable that staff did not start ACCT procedures sooner or that they did not place him under enhanced ACCT measures immediately that they started ACCT procedures.

126. Based on the available evidence, we are satisfied that staff could not reasonably have known that Mr Basford was at an imminent risk of suicide before his death. However, we have significant concerns about the management of his complex behaviour and mental health, which we discuss later in this report.

ACCT checks

127. Staff should have checked on Mr Basford at least every 30 minutes under ACCT procedures. This did not happen in the period immediately before he was found hanging in his cell.

128. Although an officer recorded in the ACCT log that he had checked on Mr Basford at 8.40am, CCTV shows that he did not do so and did not in fact check him until 9.10am, 55 minutes after the previous check. The officer then checked him again at 9.36am and shortly afterwards CCTV shows a prisoner talking to Mr Basford through his cell door.

129. An officer recorded that she completed an ACCT check on Mr Basford at 10.00am. However, she did not do so but said that she glanced into Mr Basford's observation panel while walking down the opposite side of the landing. We do not consider that this amounted to an acceptable ACCT check. It means that no one had checked on Mr Basford for over 45 minutes before he was found hanging. If he had been checked as he should have been, it is possible that he would have been found earlier or that staff may have had an opportunity to intervene.

130. We note that Winchester has started an investigation into two officer's actions.

131. ACCT observations are intended to ensure the wellbeing of prisoners and offer them support, as needed. Staff should comply with the agreed level of observations in line with a prisoner's level of risk. PSI 64/2011 states that that conversations and observations must be recorded immediately or as soon as possible afterwards. We make the following recommendation:

The Governor should ensure that all staff undertake ACCT observations as directed, actively engage with prisoners being monitored and record their engagement promptly.

Prison staff's reaction to Mr Basford's difficult behaviour

132. We recognise that Mr Basford was a challenging prisoner to manage. He repeatedly made inappropriate use of his cell bell and his language and sexual behaviour towards female staff was inappropriate and unacceptable. This was dealt with by means of the disciplinary and IEP systems and Mr Basford spent much of his time at Winchester on the basic IEP level and had two periods in the segregation unit. However, his behaviour remained unchanged.

133. Despite the significant and detailed records of Mr Basford's inappropriate behaviour, staff did not put in place a strategy and care plan to manage him which should have included a mental health referral. Mr Basford was only referred to the mental health team after he self-harmed in the hours before he hanged himself. Staff missed a number of opportunities to refer Mr Basford to the mental health team when he repeatedly behaved inappropriately, during segregation reviews, after intelligence reports raised concerns about his mental health and when he said he heard voices the day before he was found hanging.

134. The most recent IMB report for Winchester highlighted staff shortages and said that there were many prisoners with mental health problems who needed ongoing and/or emergency care. It added that the lack of effective healthcare provision for prisoners with a personality disorder, which currently fell outside the remit of mental healthcare or primary care, meant that too many men were left to navigate their sentences without appropriate support. We consider that this was the case for Mr Basford.

135. A Learning Lessons Bulletin we published on prisoners' mental health in 2016 found that difficult or challenging behaviour may sometimes be the only way that distressed people with mental health problems are able to communicate when they need help. We concluded that there are no easy solutions to managing prisoners in such situations and that staff's ability to do so effectively is largely dependent on the training that they receive. We are aware that prison staff receive basic mental health awareness training but it is important that they understand the link between poor mental and emotional health and difficult and complex behaviour so that they support and manage prisoners appropriately and help them access appropriate support services.

136. There was evidence that Mr Basford either had a personality disorder or was on the autism spectrum. Yet no one appeared to link his repeatedly inappropriate behaviour to the possibility that he needed psychological intervention. Staff dealt with Mr Basford's behavioural issues punitively as they arose, rather than trying to identify and address the underlying cause.

137. We make the following recommendation:

The Governor and Head of Healthcare should ensure that staff are appropriately trained to understand when to refer prisoners who display challenging behaviour to the mental health team and when to create a care plan for prisoners with complex needs.

Clinical care

138. The clinical reviewer found that overall, the clinical care that Mr Basford received was equivalent to that which he could have expected in the community. However, like the clinical reviewer we are concerned about the failure to complete Mr Basford's secondary health screen and to refer him earlier to the mental health team because of his poor behaviour.

Health screens

139. Prison Service Order (PSO) 3050 on the continuity of healthcare for prisoners instructs staff to offer prisoners a general health assessment during their first week in prison. Although Mr Basford was assessed in reception, he never received a more in-depth secondary health screen. This was a missed opportunity for healthcare staff to review his physical and mental health history and identify how to support his needs. We make the following recommendation:

The Head of Healthcare should ensure that healthcare staff offer all prisoners a full general health assessment within a week of their arrival.

Mental healthcare intervention

140. Mr Basford's medical records indicated that he had a complex mental health history, and that he had either a personality disorder or was on the autism spectrum.

141. The mental health team only assessed Mr Basford once on 9 April as part of his initial health screen. The assessment was completed through his cell door in the segregation unit. While we appreciate that Mr Basford's behaviour had been

poor, this was not an acceptable way to assess his mental health. There is no evidence that healthcare staff reviewed Mr Basford's medical records in detail or that they were aware of his historic psychiatric assessment, which may have affected their decisions.

142. When Mr Basford said that he had anxiety and wanted antidepressants, the nurse failed to refer him to the prison GP to consider a prescription. This was a missed opportunity for healthcare staff to have assessed whether Mr Basford required any further support.

143. Mr Basford's unacceptable behaviour towards female staff got worse over time, and staff repeatedly reported their concerns about his behaviour. Records of Mr Basford's segregation review on 13 April noted concerns about Mr Basford's mental health and that some form of assessment and intervention was needed. Despite healthcare's daily presence in the segregation unit, there is no evidence that the mental health team assessed him or discussed his behaviour with prison staff. Healthcare staff failed to record in Mr Basford's medical record that they had completed segregation healthcare algorithms on 11 April and 20 April. They also failed to record that Mr Basford spent time in the segregation unit between 20 April and 23 April or whether a healthcare professional had seen or assessed him while he was segregated. This is extremely poor practice; especially as segregated prisoners often have greater needs and are more at risk than prisoners on standard wings.

144. There were many missed opportunities for prison and healthcare staff to identify and address Mr Basford's mental health needs in the context of his challenging behaviour. We agree with the clinical reviewer that Mr Basford should have been referred to the mental health team and the Men's Complex Needs Meeting before 10 June 2018, considering the number of incidents of inappropriate behaviour. We make the following recommendations:

The Head of Healthcare should ensure that when there are concerns about a prisoner's mental health, staff should review the prisoner's mental health history, including all available psychiatric information.

The Head of Healthcare should ensure that healthcare staff record and action all GP referrals.

The Governor and Head of Healthcare should ensure that staff working with prisoners with a personality disorder or an autistic spectrum disorder are briefed about their risks, needs and how to manage them.

The Governor and Head of Healthcare should ensure that healthcare staff assess all prisoners in the segregation unit, that all relevant mental health concerns are shared with staff and recorded in the prisoner's medical record.

Post incident support

145. PSI 64/2011 requires a senior member of staff immediately to debrief all staff directly involved in an incident when a prisoner dies in custody and says that a member of the staff care team must attend. Although the Governor, supported by a member of the chaplaincy team, had debriefed almost all the staff we spoke

to during the investigation, some members of staff told us that they were adversely affected by Mr Basford's behaviour and his subsequent death. However, Winchester did not have a staff care team to support staff individually afterwards, where necessary. One member of staff was offered access to an external confidential support service but this has not been delivered, some months after Mr Basford's death. We make the following recommendation:

The Governor should ensure that a Staff Care Team is created to give staff the opportunity to discuss their involvement in a serious incident confidentially.

Bullying and intimidation

146. After his death, his cellmate told us that other prisoners bullied Mr Basford for his canteen. We found no evidence to support this. However, there is evidence that other prisoners shouted abuse and threats at Mr Bashford and that staff were aware of this on occasions. We are concerned that no one considered whether Mr Basford was being bullied.

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