Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Nigel Coomber, a prisoner at HMP Winchester, on 17 March 2019

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 Nigel Coomber died on 17 March 2019, having been found hanging in his cell at HMP Winchester on 13 March. He was 55 years old. I offer my condolences to Mr Coomber's family and friends.

Mr Coomber was a vulnerable prisoner who frequently self-harmed and threatened to self-harm. He was subject to Prison Service suicide and self-harm procedures (known as ACCT) for his entire three months at Winchester, apart from one week. He experienced severe mood swings from being extremely negative to being relatively positive.

In December 2018, he was convicted and received a long prison sentence. Although he had pleaded guilty, he maintained his innocence. He had made allegations to the police that he believed would affect his conviction, but on the afternoon of 13 March he was told that the police were not taking his allegations any further. Within an hour, he was found hanging in his cell.

I recognise that it is difficult to manage the risks posed by very emotionally volatile prisoners, like Mr Coomber. However, I found that although staff at Winchester did recognise Mr Coomber's risk, they underestimated it at times, particularly on 13 March, and did not give sufficient weight to his unpredictable moods and behaviour. I am also concerned that after delivering bad news to Mr Coomber and assessing him as high risk, staff then left him alone in his cell for 41 minutes, during which time he hanged himself.

Although many aspects of Mr Coomber's healthcare were good, I am concerned that prison staff did not receive sufficient support from healthcare staff on the management and risk assessment of such an unstable prisoner.

This is not the first time we have expressed concerns about risk management at Winchester and I am therefore escalating this case to the Prison Group Director.

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 2021**

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Summary

Events

1. In July 2018, Mr Nigel Coomber was remanded to HMP High Down charged with violent and sexual offences against his wife. It was his first time in prison. When he was arrested, he suspended himself with a ligature around his neck and, while in police custody, he tried to choke himself with a paper cup. He had a history of depression, diabetes and asthma, and had limited mobility.

2. When he arrived in prison, staff started ACCT procedures after Mr Coomber said that he wanted to be dead. He was assessed and judged not to need the support of the mental health team. Over the next few months he self-harmed several times, sometimes requiring hospital treatment. ACCT procedures were closed on 19 October.

3. In early December, Mr Coomber pleaded guilty and was sentenced to 12 years in prison. He was taken to HMP Winchester. He was distressed and said that he wanted to die, and staff again opened ACCT procedures.

4. Throughout his three months at Winchester, Mr Coomber claimed he was innocent and said that he had only pleaded guilty on bad advice from his legal advisers. He harmed himself on several occasions, while also repeatedly saying that he had no intention to harm himself.

5. In January 2019, Mr Coomber told staff that he did not want to harm himself but wanted to fight his conviction. ACCT procedures were closed on 21 January. On 29 January, Mr Coomber tied a ligature around his neck and ACCT procedures were reopened.

6. On 21 February, police interviewed Mr Coomber about allegations he had made against his wife which he believed would affect his conviction. He was very pleased that his claims were being investigated.

7. On 13 March, prison staff told Mr Coomber at an ACCT review that the police had decided they were not going to pursue his allegations. He was very upset and said that he had nothing to live for. Staff advised him to think positively about the future and by the end of the review they considered that he seemed happier. They raised his risk to 'high' and his ACCT observation levels from three times per day to once per hour. Mr Coomber was then left alone in his cell.

8. Approximately 40 minutes later, a prison officer found Mr Coomber hanging in his cell. Staff tried to resuscitate him, paramedics took over his care and Mr Coomber was transferred to hospital. He did not regain consciousness and died on 17 March.

Findings

ACCT management and assessment of risk

9. Mr Coomber was under ACCT management for all but one week of the three months he spent at Winchester. Reviews were multidisciplinary, which was good

practice. However, healthcare staff sometimes attended ACCT reviews without having familiarised themselves with Mr Coomber's background.

10. We are also concerned that, given Mr Coomber's frequent self-harm attempts and his possible personality disorder, healthcare staff did not provide prison staff with sufficient support and advice on how best to manage the risk he posed to himself.

11. We are also concerned that the complex case meetings at which Mr Coomber was discussed seem to have taken place in isolation and that what was discussed was poorly minuted and communicated.

12. We consider that staff underestimated the risk Mr Coomber posed to himself. This was particularly the case at the ACCT case review on 13 March, the day Mr Coomber hanged himself.

13. Although we agree that it was appropriate to tell Mr Coomber in person that the police were not going to pursue the allegations he had made, we do not think that sufficient thought was given to how and when to give him such devastating news or to the effect this was likely to have on his risk to himself.

14. We are concerned that Mr Coomber was left alone in his cell only a few minutes after being given the bad news, and that, despite assessing his risk as 'high', staff only raised his observations to one per hour. We do not consider that this was sufficient in the circumstances.

Emergency response

15. The emergency response when Mr Coomber was found hanging was generally good. We are, though, concerned that several staff attended before one of them called the emergency medical code. Although this did not result in a significant delay in this instance, it could do so in future.

Clinical care

16. The clinical reviewer noted that the clinical care provided to Mr Coomber was generally of a good standard and equivalent to that which he could have expected in the community. He did, however, have some concerns which we have reflected in this report.

Recommendations

- The Head of Healthcare should ensure that healthcare staff attending ACCT reviews have familiarised themselves with the prisoners' relevant medical history prior to attending.

- The Head of Healthcare should ensure that:

    - where it is suspected that a prisoner has a personality disorder, a full assessment is undertaken and a care plan put in place. Healthcare staff should consider whether to pursue a diagnosis and, where necessary, record their reasons for not doing so;

    - the risks associated with certain mental health conditions, such as EUPD, should be shared with prison staff and taken into account in risk assessments.
- The Governor and Head of Healthcare should ensure that:
    - complex case meetings are made aware when a prisoner is being managed under ACCT;
    - complex case meeting discussions are clearly recorded; and
    - all information relating to risk that is discussed at such meetings is made available to relevant staff.
- The Governor should ensure that staff manage prisoners at risk of suicide and self-harm in line with national guidelines, in particular that evidence of risk should be fully considered and balanced against how the prisoner presents himself.
- The Governor should remind staff of the importance of using the correct medical emergency codes as soon as possible in an emergency, and the potential consequences of not doing so.
- The Prison Group Director for South Central should write personally to the Ombudsman to set out what he is doing to achieve improvements in risk assessment at Winchester.

The Investigation Process

17. 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. One prisoner wrote to him.

18. The investigator visited Winchester in March and June 2019. He obtained copies of relevant extracts from Mr Coomber's prison and medical records. He contacted the police officer in charge of the police investigation and exchanged information.

19. The investigator interviewed five members of staff and four prisoners at Winchester in March and June 2019.

20. NHS England commissioned a clinical reviewer to review Mr Coomber's clinical care at the prison. He joined the investigator for interviews of staff.

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

22. One of our office's family liaison officers contacted Mr Coomber's mother to explain the investigation and to ask if she had any matters she wanted the investigation to consider. She did not have any specific questions. Mr Coomber's mother received a copy of our initial report and did not make any comments.

Background Information

HMP Winchester

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

24. HM Prison and Probation Service placed Winchester in 'special measures' in December 2017, meaning it was assessed as needing additional specialist support to improve to an acceptable level. The special measures were ended in November 2019.

HM Inspectorate of Prisons

25. The most recent inspection of HMP Winchester was conducted in June and July 2019. Inspectors concluded that the inspection overall was "disappointing".

26. They said lack of improvement in work to reduce self-harm remained a significant concern: the recorded incidents had doubled since the last inspection in 2016, leading to levels higher than any other local prison in the country. Seven prisoners had also taken their own lives, three in the previous 12 months. The prison's response to recommendations made by the Prisons and Probation Ombudsman following investigations was not robust and many actions were not well embedded. A considerable number of prisoners were subject to suicide and self-harm interventions (known as ACCT), with the risk that arrangements could become almost unmanageable. The ACCT case management that inspectors reviewed was applied inconsistently, and care was too often insufficient. Many of those in crisis spent too long locked up without distraction, further increasing their risk.

Independent Monitoring Board

27. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to May 2019, the IMB said that Winchester had made progress from the previous year. Staffing levels had improved, though there were still problems for prisoners with mental health issues and with the high levels of self-harm.

Previous deaths at HMP Winchester

28. Mr Coomber was the ninth prisoner to have died at Winchester since May 2017, and the sixth prisoner to take his own life in this period. Since Mr Coomber's death, two other prisoners have died of natural causes.

29. We have previously made recommendations about the prison's emergency response procedures, and the management of prisoners under ACCT procedures. These are issues that we also raise in this report.

Assessment, Care in Custody and Teamwork

30. Assessment, Care in Custody and Teamwork (ACCT) is the care planning system the Prison Service uses for supporting and monitoring prisoners assessed as at risk of suicide and self-harm. The purpose of the ACCT process is to try to determine the level of risk posed, the steps that might be taken to reduce this and the extent to which staff need to monitor and supervise the prisoner. Levels of supervision and interactions are set according to the perceived risk of harm. There should be regular multidisciplinary case reviews involving the prisoner. Checks made on prisoners should be at irregular intervals to prevent the prisoner anticipating when they will occur.

31. 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. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

Key Events

32. On 16 July 2018, Mr Nigel Coomber was remanded to HMP High Down charged with violent and sexual offences, including rape, against his wife. This was Mr Coomber's first time in prison.

33. Police records showed that when his wife reported the assault to the police, Mr Coomber had suspended himself with a ligature around his neck and when police arrived, they had had to cut the ligature. A memorandum from hospital showed bruising and abrasion to his neck, but no evidence of significant injury. While in police custody, Mr Coomber tried to choke himself with a paper cup. Escort papers that arrived with him in prison noted that he was "highly suicidal".

34. Mr Coomber had a history of depression, for which he had been treated by his GP. He had been diagnosed as having Type 2 diabetes and asthma, and he suffered from back pain.

35. When Mr Coomber arrived at High Down, staff started Prison Service suicide and self-harm monitoring procedures (known as ACCT). During a cell-sharing risk assessment, Mr Coomber said that he wanted to be dead. In a reception health screening, Mr Coomber again said that he wanted to be dead. He said that he had reduced mobility due to leg pain and had used a wheelchair and a mobility scooter in the community. Some days, he needed help dressing. He said that had been abused as a child, and again as an adult by his wife.

36. He was admitted to High Down's healthcare centre because of his thoughts of self-harm. On arrival in the centre, he said that he always had thoughts of self-harm but had no plan to take his life at that time. He was referred to the mental health team and to the psychiatrist, and a note was added to his file that he was not to be discharged to a standard prison wing until his mental state had stabilised.

37. The following day, a psychiatrist assessed Mr Coomber. He said that he had been treated for depression, as well as being prescribed medication to ease his pain, and to help him sleep. The psychiatrist prescribed an antidepressant and referred him to the GP for pain relief.

38. On 19 July, Mr Coomber handed in a piece of glass that he said he had intended to swallow. He was moved from the healthcare centre to a standard wing on 26 July but remained under ACCT management.

39. In a mental health assessment on 30 July, Mr Coomber spoke at length about the reasons he was in prison, denying his guilt. He said that he did not feel life was worth living, was ashamed to face his family, and was struggling to cope with many stressors. He heard voices at night telling him to harm himself and said that he had made cuts to his arms and wrists the previous night with two razor blades. These were taken from him. He was due to see his solicitor to discuss his trial, at which he intended to plead not guilty. Later that day he told officers that he would kill himself that night. They found that he had written a suicide note addressed to his family. He was admitted to the healthcare centre.

40. Mr Coomber told staff that because of his mobility issues he was having trouble collecting his meals while using a walking stick and had suffered falls getting in and out of bed and trying to use the toilet. He was referred to occupational therapy.

41. On 13 August, staff ended ACCT monitoring. Mr Coomber had been visiting the chaplaincy and found his faith supportive. He had also received written support from his mother, and said he no longer wanted to die. On 15 August, Mr Coomber was discharged from the mental health team's caseload.

42. On 6 September, Mr Coomber pressed his cell bell. Staff responded and found that he had cut his wrists and tied a ligature around his neck. Staff called an ambulance, but Mr Coomber refused to go to hospital. Having recently returned to a standard prison wing, he was relocated to the healthcare centre. Staff started ACCT monitoring and referred Mr Coomber to the psychiatrist. The psychiatrist suspected that he was suffering from Emotionally Unstable Personality Disorder (EUPD, also known as Borderline Personality Disorder) which can include traits of impulsive behaviour, difficulty in forming and maintaining relationships, and fluctuating mood. Mr Coomber said that he no longer felt like self-harming and felt better for having been listened to.

43. On 14 September, Mr Coomber was found in bed unconscious. He later said that he had wanted to kill himself and had taken an overdose of his painkillers. He had also made deep cuts to his scrotum, which required stitches in hospital.

44. On 18 September, Mr Coomber said he would decline medication, food, and drink and refuse to come out of his cell until he had seen the police about an alleged assault on him by his wife. He saw the doctor and agreed to accept his medication and food, but was angry about the legal process.

45. On 28 September, Mr Coomber was unhappy about being warned for his behaviour and threw himself out of his wheelchair and down the stairs, injuring his head. He refused to attend the healthcare centre. A note on his medical records stated that nurses and prison officers had seem him walking unaided, sometimes fairly quickly, but he insisted he needed his wheelchair.

46. Staff stopped ACCT monitoring on 19 October. Through October and November, Mr Coomber attended hospital several times for various health issues.

HMP Winchester

47. On 10 December 2018, Mr Coomber went from High Down to court for his trial. During the day he was tearful and said that he would rather kill himself than be found guilty. He told court staff that he had tried to hang himself the previous week. Mr Coomber then pleaded guilty and was told to return the following day for sentencing. He was taken to HMP Winchester. Mr Coomber was tearful and told a nurse that he was expecting to receive a long sentence the next day. ACCT procedures were re-opened.

48. On 11 December, Mr Coomber was sentenced to 12 years in prison. He returned to Winchester. That evening he reported pain and on assessment was thought to have been suffering a panic attack.

49. On 12 December, Mr Coomber attended an ACCT review. Staff assessed his risk of self-harm as low. He also saw a member of the mental health team and was referred to the psychiatrist for a review of his medication.

50. The next morning, he saw a prison GP. He was prescribed insulin for his diabetes and inhalers for asthma. The doctor noted that Mr Coomber had decreased mobility but could walk short distances with the aid of two walking sticks. The doctor noted previous diagnoses of depression, lung problems and erectile dysfunction. Mr Coomber was distressed during the consultation, protesting his innocence and saying that his legal team had pushed him to plead guilty to something he did not do. He told the doctor he had thoughts of self-harm but did not think he would act on them.

51. On 14 December, a psychiatrist assessed Mr Coomber. The psychiatrist recorded that Mr Coomber had traits of EUPD and a possible depressive disorder. He noted that Mr Coomber's problems were not of a kind that could be addressed by the mental health team, although they should attend his ACCT reviews.

52. On 15 December, Mr Coomber made a cut to the shaft of his penis and punctured his left wrist. He was taken to hospital for treatment. The next day, he said that he felt less distressed and more positive and had no thoughts of harming himself. Staff reduced the level of observations to one observation every two hours.

53. A note on Mr Coomber's medical record on 17 December summarised his history and needs. It noted that he tended to give unnecessarily explicit details of his alleged sexual abuse at times. A risk trigger for self-harm was when he thought that people did not believe his version of events about his offence.

54. On 18 December, staff found Mr Coomber slumped on his bed with a ligature around his neck. He was breathing and conscious, but agitated and distressed, saying that he intended to take his own life because he had been pressured into pleading guilty and now had a 12-year sentence. Ambulance staff assessed him as not requiring hospital treatment, so he was taken to the prison's healthcare centre as an inpatient and placed on constant watch. A multi-disciplinary team including prison and healthcare staff assessed him. He remained tearful, saying that he wanted to end his life. He said he was lonely, having no contact with his family. He agreed to seek a meeting with the police in relation to allegations he wanted to make about his wife which he thought might affect his sentence. Staff agreed he should remain on constant watch for at least 48 hours and issued him with anti-ligature clothing.

55. On 20 December, an offender supervisor introduced herself to Mr Coomber. He told her that he had felt suicidal as nobody was listening to him, but now he felt supported. He asked her if she could help him arrange to speak to the police, and to a different solicitor. He said that he felt a renewed sense of purpose, wanting to see if he could change his sentence.

56. Mr Coomber remained on constant watch but was allowed his own clothing. A physiotherapist examined Mr Coomber and diagnosed instability of a joint in his left leg and advised Mr Coomber on exercises he could do in his cell.

57. On 27 December, Mr Coomber said that he had made contact with his family and had begun to put a case together about being coerced into pleading guilty. On 28 December he saw a counsellor and told her that he denied his offence and could now prove his sexual dysfunction to the court.

58. On 3 January 2019, the psychiatrist assessed Mr Coomber. The psychiatrist noted that although he spent a lot of time protesting his innocence and that he was the victim of an abusive relationship, there were no abnormalities of thought or any suggestion of psychosis. Staff stopped Mr Coomber's constant watch. He was added to the waiting list for psychological group therapy.

59. On 15 January, Mr Coomber moved to D wing, the Vulnerable Prisoners Unit (for prisoners who may be vulnerable either because of the nature of their offence, or for other reasons such as debt).

60. Prisoners on D wing told the investigator that Mr Coomber continually spoke about his innocence, saying that he had been given bad advice by his solicitors and had pleaded guilty to something he did not do. Prisoners said that it was difficult to have a normal conversation with him without him bringing up these issues and discussing them at great length.

61. On 21 January, Mr Coomber said that he was settled and did not want to harm himself. Staff closed the ACCT.

62. On 29 January, Mr Coomber tied a ligature around his neck. A nurse attended, and he was conscious and talking. There were no visible injuries. He said he had been stressed following a telephone call but had no intention of harming himself now. His ACCT was reopened.

63. At an ACCT review the following morning, Mr Coomber appeared in crisis. He said that he had been upset after a telephone call with his mother the previous day and had then had a recurring bad dream about an incident when he said he had been sexually assaulted by other men at his wife's instigation. He said he had reported this alleged assault and was awaiting a visit from the police. He said that he was settled on D wing, was on medication to help him, and usually managed his thoughts of self-harm. That night they had just been too overwhelming. Observation levels were set at a quality conversation twice per day, with at least two observations per hour at night.

64. On 4 February, Mr Coomber told staff that he was pleased that the police were going to come and see him about his allegations. A note on his electronic record said that he was worried they might not take him seriously, which could be a trigger for him. He said that he had no desire to harm himself. Staff decided that the ACCT should remain open until he had given his evidence to the police.

65. The Safer Custody department held complex case meetings on a weekly basis, attended by discipline and healthcare staff. On the morning of 6 February Mr Coomber was one of the prisoners discussed. The note of the meeting showed that he had contacted the police to make an allegation about being abused by his wife, and that if he received a negative response it could have a detrimental impact on him. A psychologist, who was at the meeting, asked all staff to be vigilant.

66. At an ACCT review on 14 February, Mr Coomber was in good spirits as he had a date for an interview with the police. He said he was enjoying his work in Workshop 5 and was sleeping better. His risk was judged to be low, but the ACCT would remain in place until he had had his police interview.

67. The complex case meeting notes for 20 February noted that all present agreed that he would be removed from the complex case management list.

The police interview

68. On 21 February, Mr Coomber was interviewed by the police. Staff held an ACCT review afterwards. Mr Coomber said the police interview had been emotional but productive. It had only lasted 30 minutes, and he had not been able to complete his statement as he felt he could not talk any more, but the police had said they would return to allow him to do so. Staff recorded that Mr Coomber was upbeat and that the police interview had been "a massive relief" for him and "a positive step forward in his mental health".

69. However, on 26 February, staff noted in his ACCT ongoing record that he was feeling very down. Within the space of half an hour he said that he had thoughts of ending his life, then promised that he would not self-harm. On 27 February, his offender supervisor recorded that Mr Coomber said he was having "a bad day". He told her he had only been able to speak to the police for half an hour and did not know when/if they would return. He wanted to 'vacate' his guilty plea but had not contacted a solicitor. He said he did not think he could manage without the support of the ACCT.

70. At a further ACCT review on 28 February Mr Coomber said that he still had occasional thoughts of self-harm but would talk to staff when necessary.

71. On 5 March, the ACCT ongoing record noted that Mr Coomber said that he had received some bad news and felt like giving up. His mood was low, and his observation level was raised to at least once every 30 minutes. He had received a letter from the police about his case, and it had upset him. He said that he had no intention of taking his own life but wanted to go to sleep and not wake up.

72. On 6 March, Mr Coomber was referred back to the complex case meeting for discussion after concerns about his erratic behaviour. The notes of the meeting record that he had had an emotional outburst in the workshop and said that he wanted to end his life, and that he had stabbed his genitals with a pen to prove that he had no feeling there. (No dates were given for these events.)

73. On the afternoon of 6 March, a Custodial Manager (CM) chaired an ACCT review. She recorded that Mr Coomber engaged well but that when he started talking again about his case and his sexual dysfunction, she stopped him saying that he had been over this several times and that he now needed to start focussing on positive thinking for the future. She noted that they "eventually" managed to do this and made some small steps. Staff reduced ACCT observations to one conversation in the morning, one in the afternoon and at least hourly checks during the night.

74. On 7 March, Mr Coomber had a visit from a friend. He said that the visit went well. That afternoon he moved to a new cell. He told staff he was pleased with the move and liked his new cellmate.

The events of 13 March

75. On the morning of 13 March, Mr Coomber was discussed again at the complex case meeting. The notes said, "Mr Coomber is now self-strangulating but is in full control when he does it. Very erratic behaviour". The note does not indicate where this information came from.

76. A prisoner wrote to the investigator and said that on 13 March, Mr Coomber told him that he was going to kill himself that afternoon. He said that Mr Coomber habitually talked too much and said that he wanted to die every day. The prisoner thought he was saying the same thing again, as he always did, and he did not take it seriously.

77. Also, on 13 March, the police contacted Winchester and said that they were not going to pursue Mr Coomber's allegations against his wife. They were planning to write to him, but the senior offender supervisor and Head of Offender Delivery, said that the news should be given to Mr Coomber in person.

78. After lunch, Mr Coomber did not return to the workshop but remained on D wing for his ACCT review. This was chaired by a CM (who was on secondment from HMP Erlestoke to provide Winchester with extra support while it was in 'special measures'), and was attended by the senior offender supervisor, a mental health nurse, and a new member of the team shadowing the nurse. The review was held in Mr Coomber's cell because there were standard prisoners out on association on the wing and the CM did not want to walk Mr Coomber, a Vulnerable Prisoner, past them. (Mr Coomber's cellmate was at work.) CCTV records show that the review started at 3.34pm.

79. The mental health nurse told the investigator that the senior offender supervisor had wanted to attend Mr Coomber's ACCT review so he could tell him the police would not be taking any action about his allegations. The CM told the investigator that the senior offender supervisor spoke to him before the ACCT review and asked him to give Mr Coomber the news during the review, but that he said he thought it would be better for the senior offender supervisor to do it himself. The senior offender supervisor said at interview that he had not originally intended to tell Mr Coomber the news during the ACCT review, but that, when Mr Coomber continued to say that he did not want to move to another prison because he was still intending to challenge his conviction, he decided that this was "the ideal opportunity" to tell Mr Coomber and try to get him to put his allegations aside and focus on the positive actions he needed to take to help him progress through his sentence.

80. When Mr Coomber was told that the police were not going to pursue his allegations, he became angry and tearful and said that, in that case, he had nothing to live for. Staff tried to get Mr Coomber to focus on the future and look at positive ways to proceed. They discussed how he could challenge the legal advice he had received from his solicitors at his trial. They discussed how he could appeal against the police decision not to proceed with his allegations.

They discussed a move to HMP Isle of Wight, a specialist prison for sex offenders, where Mr Coomber could advance through his sentence. They encouraged him to think about his children, and the recent visit he had had from a friend who had indicated that she would continue to visit. The senior offender supervisor recorded that Mr Coomber "appeared more happy at the end of the meeting".

81. In interview, the CM, the mental health nurse and the senior offender supervisor all said that Mr Coomber was very upset and angry when he was first told that the police would be taking no action, but by the end of the review Mr Coomber seemed to be less despondent and was thinking about his next steps. He said that he would not harm himself.

82. The CM noted on the ACCT document that Mr Coomber's risk level was high. They agreed that his level of observation should rise from three times daily with hourly checks at night, to hourly checks throughout the day and night.

83. The CM and mental health nurse told the investigator that they discussed outside the cell whether Mr Coomber should be put on constant observation and decided against it as they though once an hour was already a big step up from the previous level of observations. The nurse said she also considered whether he would benefit from spending some time in the healthcare department, but she concluded that he would be isolated and have less support there.

84. The staff left the cell at 3.46pm, leaving Mr Coomber inside.

85. Shortly before 4.30pm, staff began to unlock prisoners to collect their evening meals. An officer arrived at Mr Coomber's cell at 4.27pm. She opened the observation panel and saw Mr Coomber hanging. She screamed. Another officer was nearby and ran to her, using her radio to call for staff assistance as she did so. The officer opened the cell door and the officers went in and tried to support Mr Coomber's weight. Other staff joined them, cut the ligature and lowered Mr Coomber to the floor.

86. A Supervising Officer (SO) radioed a code blue medical emergency (meaning a prisoner not breathing). CCTV footage indicates that this was approximately 30 seconds after both officers went into the cell. This prompted the control room to request an ambulance. This request was made at 4.27pm.

87. Staff moved Mr Coomber out of the cell onto the landing and began to perform cardiopulmonary resuscitation (CPR). Medical staff had responded to the code blue and nurses and officers continued to provide first aid to Mr Coomber until paramedics arrived. They provided further medical treatment and Mr Coomber was taken by ambulance to Southampton General Hospital. Mr Coomber was not subject to physical restraints, though prison officers were present with him during his time in hospital.

88. Mr Coomber did not regain consciousness and was pronounced dead at 4.43pm on 17 March.

Post-mortem report

89. The post-mortem report said that Mr Coomber's cause of death was hanging.

Contact with Mr Coomber's family

90. Winchester appointed an officer as family liaison officer when Mr Coomber was taken to hospital. He identified Mr Coomber's mother as his next of kin and went to her address to tell her what had happened. She and other members of the family went to the hospital through the following days and were with Mr Coomber when he died.

91. In line with Prison Service guidance, Winchester offered a contribution to the cost of Mr Coomber's funeral.

Support for prisoners and staff

92. After Mr Coomber was taken to hospital, the prison's Deputy Governor debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

93. The prison posted notices informing other prisoners of Mr Coomber's death and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Coomber's death.

After Mr Coomber's death

94. Staff found a note that Mr Coomber had left in his cell, saying that he could not live with the pain of his situation. They also found what appeared to be another ligature, made from a torn bed sheet and a parcel strap, under his pillow.

Findings

Risk assessment and management of ACCT

95. Apart from one week in January 2019, Mr Coomber was continually monitored under ACCT throughout his time in Winchester. Although we agree that this was appropriate, we have identified a number of shortcomings in the assessment of Mr Coomber's risk to himself.

96. Throughout his three months at Winchester, Mr Coomber's mood fluctuated significantly between despair, with episodes of self-harm, to more positive and settled periods when he seemed to be planning for the future and assured staff he would no longer self-harm. We recognise that this made it very difficult to manage his risk, particularly as his assurances that he would not self-harm could not always be relied upon.

97. Both staff and prisoners told us that, although Mr Coomber had pleaded guilty, he was not reconciled to his imprisonment and continued to maintain his innocence. He talked about this continually and obsessively and the possibility of over-turning his conviction or reducing his sentence was his main focus in life. A key element of this was the allegations of abuse he made against his wife which he saw as proving that he was the victim not the offender. At the ACCT review on 21 February, he told staff that being interviewed by the police about his allegations that morning had been "a massive relief" for him.

98. It was clear to prison and healthcare staff who knew Mr Coomber, that his mood relied heavily upon how he felt about his conviction at any given time. When he felt that he had something to look forward to, to help him challenge his conviction or improve his circumstances, he was more positive and denied any intention of harming himself. When he felt that all avenues were closed, he became very low and, on several occasions, harmed himself.

99. His medical record contained a note on 17 December that feeling that his version of events was not believed could be a trigger for self-harm. His electronic prison record also contained a note on 4 February warning that if he felt police did not take his allegations against his wife seriously, this could be a trigger for self-harm, and that staff should be vigilant.

100. Within a few days of seeing the police on 21 February, it is clear from the records that his mood dropped again as he started to worry that the police would not come back to enable him to finish his account.

The role of healthcare

101. Mr Coomber clearly had complex mental health issues. We are concerned that healthcare staff did not always provide prison staff with adequate support and advice on how best to manage the risk he posed to himself.

102. Most of Mr Coomber's ACCT reviews were attended by members of the mental health team, which was good practice. However, we share the clinical reviewer's concern that healthcare staff did not always attend reviews with a full knowledge

of Mr Coomber's history. This made their input much less useful than it could have been. We make the following recommendation:

The Head of Healthcare should ensure that healthcare staff attending ACCT reviews have familiarised themselves with the prisoner's relevant medical history prior to attending.

103. We are also concerned that insufficient weight was given to the possibility that Mr Coomber suffered from an Emotionally Unstable Personality Disorder (EUPD). Two psychiatrists suspected that this might be the case in September and December 2019, but no formal diagnosis was made. Characteristics of EUPD can include impulsive behaviour, intense negative emotions and severe mood swings from negative to positive over a short period, and a significantly heightened risk of self-harm and suicide. A mental health nurse said in interview that Mr Coomber presented with these traits.

104. However, because Mr Coomber was not formally diagnosed, there were no management strategies in place to address this condition, and we have seen no evidence that prison or healthcare staff were aware that the traits of EUPD significantly raised Mr Coomber's risk to himself.

105. We recognise that prisoners who repeatedly self-harm and/or threaten to kill themselves, like Mr Coomber, can be exceptionally difficult to manage, and that staff can come to think that there is an element of 'crying wolf'. We share the clinical reviewer's view that suggestions of a relevant mental health condition should be fully explored and strategies for the prisoner's care, including strategies to reduce risk, should be developed and shared with prison staff.

106. We make the following recommendation:

The Head of Healthcare should ensure that:

- **where it is suspected that a prisoner has a personality disorder, a full assessment is undertaken, and a care plan put in place. Healthcare staff should consider whether to pursue a diagnosis and, where necessary, record their reasons for not doing so;**
- **the risks associated with certain mental health conditions, such as EUPD, should be shared with prison staff and taken into account in risk assessments.**

Complex case meetings

107. The notes of Winchester's complex case meetings do not specify who attended and generally provide an inadequate record of what was discussed. We are also concerned that these meeting seem to have taken place in isolation and that what was discussed was very poorly communicated.

108. For example, the notes of the meeting on 20 February 2019 show that Mr Coomber was removed from the complex case management list the day before he was due to have his police interview. There is no indication of why this was thought appropriate.

109. The notes of the meeting on the morning of 13 March, the day Mr Coomber hanged himself, say, "Mr Coomber is *now* self-strangulating but is in full control when he does it" [our italics]. There is nothing to say where this information about self-strangulation came from, and nothing to indicate what 'now' meant in this context. The clear implication of the word was that this was current behaviour which had been occurring since Mr Coomber had last been discussed at the complex case meeting on 6 March. However, there is no reference to Mr Coomber tying ligatures at this time in his ACCT document, his prison record, in any intelligence reports, in the wing observation book, or in his medical record. The last record of such behaviour was 29 January.

110. The psychologist was at the meeting, but in interview she said that she did not remember this being discussed. We have been unable to identify who took the minutes. It seems most likely that the reference to 'self strangulation' referred to previous behaviour and that the minutes were simply badly written, but we cannot be sure of this.

111. The psychologist told us that those attending complex case meetings would not necessarily know if the prisoner being discussed was under ACCT management, nor when the next ACCT review was due. We find it difficult to understand how the complex case meeting could have a full discussion without knowing this key information.

112. There is no reference to the complex case meeting on 13 March in Mr Coomber's electronic prison record. The CM and mental health nurse both said they were not aware of the complex case meeting when they attended Mr Coomber's ACCT review that afternoon.

113. We are concerned that this indicates that potentially key information was not being shared and that prison staff were largely left to manage Mr Coomber's complex psychological needs without specialist advice on how best to proceed.

114. Another example of this occurred on 6 March, when Mr Coomber was discussed at a complex case meeting in the morning. Later that day a CM chaired an ACCT review and refused to allow Mr Coomber to talk about his sentence and his sexual dysfunction again. We cannot say whether her approach was appropriate or not, but we have seen no evidence that it was anything other than her own idea or that it was informed by any guidance from the complex case meeting, as we would have expected.

115. We make the following recommendations:

The Governor and Head of Healthcare should ensure that:

- **complex case meetings are made aware when a prisoner is being managed under ACCT;**
- **complex case meetings are clearly recorded; and**
- **all information relating to risk that is discussed at such meetings is made available to relevant staff.**

Risk assessment

116. We are also concerned at what we consider to be poor judgements shown in some of the risk assessments.

117. For example, on 15 December, Mr Coomber made a cut to his penis and his wrist which required hospital treatment. Despite this, his observation levels were reduced at his ACCT review the next day when he said he felt better. We do not consider that the decision to reduce the observations took full account of Mr Coomber's current risk. We note that two days later an ambulance had to be called after Mr Coomber tied a ligature round his neck.

118. A further example occurred on 6 March. On 5 March, Mr Coomber said that he had received some bad news from the police, his mood was "low", he felt like "giving up" and, although he had no suicidal intentions, he "wanted to go to sleep and not wake up". His observations were increased to at least once every 30 minutes. Despite this, at the ACCT review the following day, his observations were reduced to one conversation in the morning, one in the afternoon and hourly observations at night on the basis that he had made some "small steps" in thinking more positively about the future. We consider that such a dramatic reduction in observations was inappropriate on the basis of so little evidence that Mr Coomber's risk had changed significantly.

119. We are also concerned about the risk assessment decisions made on 13 March, the day Mr Coomber hanged himself.

120. We consider that the senior offender supervisor's decision that Mr Coomber should be told in person that the police were not going to pursue his allegations was a good one. However, we are concerned that very little thought seems to have been given to when and how he should be given this very significant news.

121. The senior offender supervisor said at interview that he was well aware of Mr Coomber's issues because he had spoken to him on the wing and discussed his case with the offender supervisor, and that he was aware he was a frequent self-harmer who was maintaining his innocence and having difficulty accepting his sentence. However, he did not know Mr Coomber well and in interview he did not appear to be aware of the overwhelming weight Mr Coomber was placing on having his allegations investigated by the police.

122. The CM and mental health nurse told us that the senior offender supervisor had always intended to give Mr Coomber the news that the police would not be investigating at the ACCT review. However, the senior offender supervisor said this had not been his original intention and that he only decided to do so during the review because he judged it to be "the ideal opportunity". Given the crucial importance to Mr Coomber's mental state and the fact that he did not know Mr Coomber well, we consider that it would have been advisable for him to have sought advice from healthcare specialists about the best way to break the news.

123. We are also concerned that none of three staff present at the ACCT review that afternoon was aware of the notes in Mr Coomber's records that feeling that his version of events was not believed could be a trigger for self-harm and that staff

should be vigilant. These concerns had not been documented in his ACCT paperwork, as they should have been.

124. Staff at the ACCT review recognised that Mr Coomber was very upset and angry that his allegations were not going to be pursued, and that he said he had nothing left to live for. However, we are concerned that they do not appear to have appreciated the extent to which this was a devastating blow for Mr Coomber, the end of all his hopes, and that he would now be forced to face up to the reality of his long sentence. Instead they focussed on trying to persuade him to become more forward-looking and to consider his next steps. They all told us that Mr Coomber was more positive by the end of the review and that he said he had no intention of suicide or self-harm.

125. The CM told us at interview that he thought the review lasted about 25 to 30 minutes and was surprised to be told that CCTV shows it lasted only 12 minutes. This was a very short time in which to give such important news, allow Mr Coomber to process it and discuss it, persuade him to start thinking about the future, and decide on his level of risk and observations. We do not consider that it was long enough.

126. Those present assessed Mr Coomber's risk to be "high" and increased his observations from three checks during the day and hourly checks at night, to at least one per hour. We do not consider that this level of observations was sufficient in the circumstances and we are concerned that Mr Coomber was not subject to a higher level of checks. Although it was understandable that they wanted to start Mr Coomber thinking about the future, we consider that they underestimated the impact the news was likely to have on him and that they should have recognised that he would need more than a few minutes to process the information and what it meant for him. They should also have appreciated that previous experience showed that no reliance could be placed on Mr Coomber's assertions that he would not self-harm, and that while he might present as reasonably positive during the review, he might well feel very differently once he was alone in the cell reflecting on what he had been told. As we have said many times, when assessing risk, staff need to balance a prisoner's presentation against his risk factors and, in this case, Mr Coomber had just received bad news and was known to have a history of self-harm and to be impulsive and subject to intense mood swings.

127. The CM scheduled the next ACCT review for 5 days' time. He told us that he probably set a date that he knew he could make himself to ensure continuity. However, we consider that this was too long a gap given the devastating news they had imparted and the fact that Mr Coomber had said he saw no point in living in the light of it. It reinforces our concern that those present simply did not appreciate that the news was likely to have significantly increased Mr Coomber's risk to himself.

128. We are also concerned that although staff had apparently identified various positive steps Mr Coomber could take, the CM did not update Mr Coomber's care plan with any actions to support him.

129. After the review the staff then left Mr Coomber locked alone in his cell. Nobody checked on him until an officer was unlocking prisoners for dinner 41 minutes

later. While this was within the stipulated time for ACCT checks, it was a long time to leave him alone after giving him such bad news and we consider that it again shows that staff had underestimated his risk.

130. We make the following recommendation:

The Governor should ensure that staff manage prisoners at risk of suicide and self-harm in line with national guidelines, in particular that evidence of risk should be fully considered and balanced against how the prisoner presents himself.

131. As this is not the first time, we have expressed concerns about the adequacy of risk assessment at Winchester, we are escalating our concerns to the Prison Group Director. We recommend:

The Prison Group Director for South Central should write personally to the Ombudsman to set out what he is doing to achieve improvements in risk assessment at Winchester.

Emergency response

132. When the officer found Mr Coomber hanging, she screamed. This alerted another officer to go to her aid. At that point the other officer did not know what the issue was, just that a colleague needed help, so she radioed for staff assistance, which was a reasonable response. A SO called the code blue emergency when he arrived. CCTV footage indicates that this was only 30 seconds or so after the officers entered the cell, so the delay in this case was minimal and unlikely to have affected the outcome. Nevertheless, several staff were at the cell before the SO and none called a code blue. In emergencies, seconds can be vital, and in another situation, such a delay could have serious consequences. We make the following recommendation:

The Governor should remind staff of the importance of using the correct codes as soon as possible in an emergency, and the potential consequences of not doing so.

133. The clinical reviewer noted that the medical response to the emergency call was prompt and comprehensive.

Clinical care

134. The clinical reviewer concluded that overall the clinical care Mr Coomber received was of a good standard and equivalent to that which he could have expected in the community.

135. The clinical reviewer noted that Mr Coomber presented with several physical health problems. These were appropriately investigated and managed. The clinical reviewer also noted that there were no issues raised with regards to Mr Coomber's mental capacity.

136. The clinical reviewer stated that Mr Coomber was well-supported by mental health staff through his time in prison. He was seen several times by psychiatrists when referred. Mental health staff attended most of his ACCT

reviews and always saw him promptly when changes in mood or episodes of self-harm were reported. When he died, Mr Coomber was on the waiting list for psychological therapy.

137. The clinical reviewer did, however, raise concerns about healthcare staff attending ACCT reviews unprepared; about the failure to address Mr Coomber's possible EUPD; and about the recording and communication of complex case meeting discussions. We have reflected these concerns in the section on Risk Assessment above.

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