

**Prisons &
Probation**

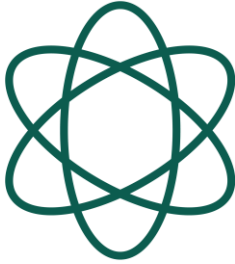
Ombudsman
Independent Investigations

**Independent investigation into
the death of Mr Conan Walton
on 27 September 2021,
following his release from
HMP Winchester**



Our vision

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



Our values

We are:

Impartial: we do not take sides

Respectful: we are considerate and courteous

Inclusive: we value diversity

Dedicated: we are determined and focused

Fair: we are honest and act with integrity

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Summary

1. 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.
2. From 6 September 2021, the PPO has been investigating post-release deaths that occur within 14 days of release from prison. Mr Conan Walton died 28 days after his release from prison and we have exercised the discretion we have to investigate his death so that we can identify any learning from this case.
3. Mr Walton died on 27 September 2021, having been found hanging in a local park, following his release from HMP Winchester on 31 August. He was 47 years old. I offer my condolences to his family and friends.
4. Mr Walton's risk of harm to himself was well documented. We are content that his community offender manager had fully considered his risk of suicide and self-harm and housing needs in her pre-release plans. However, we are concerned that there is no record of any communication from the prison to probation regarding Mr Walton's ongoing risk to himself immediately before he was released. We are also concerned that Mr Walton was not referred to alcohol services on release, in line with his licence condition, or that the reason for not doing this referral was not clearly recorded. We have made recommendations accordingly.
5. Despite efforts made by both the prison and community probation officer, Mr Walton remained homeless following his release. It seems likely that this, along with his alcohol misuse, exacerbated his feelings of suicide. We are surprised that the local authority did not consider Mr Walton a priority for emergency housing although we note that the provision of accommodation and mental health for people leaving prison is an issue that extends beyond the remit of HMP Winchester or local probation services.

Recommendations

- The Governor of HMP Winchester should ensure that concerns about a prisoner's risk of suicide and self-harm are shared with community probation staff before they are released.
- The Local Delivery Unit manager of Brighton and Hove probation should ensure that offender managers clearly record in nDelius decisions about sentence plan objectives relating to licence conditions.

The Investigation Process

6. The PPO investigator obtained copies of relevant extracts from prison and probation records and a summary of community mental health and medical records.
7. The investigator had a video conference with the community offender manager and their line manager to introduce the investigation process.
8. We informed HM Coroner for Brighton and Hove of the investigation. The Coroner accepted the cause of death as hanging and no post-mortem was carried out. We have sent them a copy of this report.
9. The Ombudsman's family liaison officer contacted Mr Walton's family to explain the investigation and to ask if they had any matters they wanted the investigation to consider. They had no questions but asked for a copy of our report.
10. Mr Walton's family received a copy of the draft report. They did not make any further comments.
11. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out some factual inaccuracies and this report has been amended accordingly. The action plan has been annexed to this report.

Background Information

HMP Winchester

12. HMP Winchester is a local prison for men and young adults, serving courts in Hampshire. It has the capacity to hold around 700 remanded and sentenced men. It includes a separate low security training unit for up to 129 men nearing the end of their sentence.
13. Practice Plus Group Health has provided 24-hour healthcare cover at the prison since July 2020. Mental health and substance misuse services are provided by Central and North West London NHS Foundation Trust and psychosocial interventions by Phoenix Futures. Catch22 is commissioned to provide accommodation support as part of the Integrated through-the-gate (ITTG) service. The most recent inspection report concluded that most prisoners were seen by resettlement before release, but there was a lack of help for prisoners who had poor records of involvement with housing providers in the past.

Probation Service

14. The National Probation Service supervises individuals serving community orders, provides offenders with resettlement services while they are in prison (in preparation for their release) and supervises all individuals on a for a minimum of 12 months after they are released from prison.

Key Events

15. On 21 July 2021, Mr Conan Walton was convicted of breaching a restraining order and was sentenced to three months in prison. He was taken to HMP Lewes.
16. Mr Walton had a well-documented history of mental health issues. He had an emotionally unstable personality disorder (this can cause intense and fluctuating emotions and a propensity to act without thinking) and a history of misuse of alcohol. Mr Walton was prescribed anti-psychotic and anti-depressant medications.
17. Mr Walton had been known to the Probation Service since 2003 due to previous community orders and periods in custody. Mr Walton's current community offender manager (COM) had managed his case since July 2019. Before he was taken to prison, she had assessed that he posed a high risk of harm to himself and had a history of contemplating suicide. She also noted that alcohol consumption was associated with his risk of suicide. She contacted HMP Lewes about Mr Walton's risk to himself on the day that he was taken to prison. She also updated Mr Walton's community mental health worker of his whereabouts.
18. During his induction at Lewes, Mr Walton told an officer that he felt low and that he had tried to take an overdose and hang himself the previous day. She started Prison Service suicide and self-harm monitoring procedures (known as ACCT) and his risk was such that staff assessed he needed to be constantly observed. HMP Lewes could not facilitate this so he was transferred to HMP Winchester that afternoon.
19. On 27 July, an officer from Lewes completed a Basic Custody Screening (BCS) risk assessment for Mr Walton. The officer could not interview Mr Walton as he had temporarily moved to Winchester and recorded in the assessment that the information he used was from a previous screening. The old assessment identified housing and health and wellbeing as concerns.
20. Mr Walton's mood and presentation improved and on 29 July, he moved from a constant observation cell to a main cell in the healthcare wing. His ACCT observations were reduced to hourly. A decision was made for him to remain at Winchester as he was settled, and his sentence was short.
21. On 3 August, Mr Walton had an ACCT review and was pleased to move back to a general wing as his risk had reduced.

Pre-release planning

22. Mr Walton was not allocated a prison offender manager as he was serving a short sentence, in line with the Offender Management in Custody Model (OMIC).
23. On 8 August, Mr Walton's COM referred Mr Walton to Integrated through-the-gate (ITTG) services to help him find housing. She also completed a duty to refer form to the local authority in Brighton. This is a referral that helps people get access to homelessness services as soon as possible when they are released from prison.

24. Mr Walton was known to the homeless prevention team (a service provided by local councils to help people remain in their home or to help find alternative accommodation if they are homeless) but had been discharged from their services in June 2021 as he had refused offers of emergency accommodation. On 18 August, the local authority told Mr Walton's COM that Mr Walton would not be considered as priority need for emergency accommodation on release from custody.
25. On 19 August, Mr Walton's COM requested additional licence conditions to the standard ones, in preparation for Mr Walton's release. Mr Walton's extra conditions included an instruction to attend appointments with a mental health practitioner and cooperate with treatment, to avoid entering some named areas and addresses and to attend Change Grow Live (CGL- a community alcohol and drug treatment and support agency) as directed.
26. On 27 August, Mr Walton's COM spoke to a community accommodation support officer, to ask if a housing officer had yet been allocated. She was concerned that Mr Walton's release was in four days and he had no accommodation.
27. On 28 August, a prison offender manager contacted Mr Walton's COM. He told her that Mr Walton had no address for his release on 31 August and that the one housing officer employed by Catch22 at Winchester had no capacity to support him.
28. Mr Walton remained on an ACCT during his time at Winchester. There is no record of a handover from prison to probation about Mr Walton's ongoing risk to himself.

Post-release planning

29. On 31 August 2021, Mr Walton was released. He reported to Brighton probation office, where he had a supervision appointment with his COM. A housing officer from Interventions Alliance also joined the appointment on the telephone. She advised Mr Walton where he could get support from rough sleeper services whilst she tried to find him accommodation.
30. Mr Walton did not sign or keep a copy of his licence conditions but expressed his understanding of the expectations when his COM went through them. Mr Walton's COM recorded that Mr Walton presented as "closed off". She instructed Mr Walton to meet her and his community mental health worker at the probation office on 8 September. The housing officer agreed that she would keep Mr Walton and his COM up to date with her progress in finding a home.
31. On 3 September, Mr Walton went to the emergency department at the Royal Sussex County Hospital. The discharge letter states that he had allegedly taken an overdose of paracetamol and other medications with suicidal intent. He told them that he wanted to "jump off the local cliffs". Blood tests had not detected paracetamol in his system. It is recorded that prior to discharge he was seen by the mental health team.
32. On 8 September, Mr Walton attended his appointment at probation as planned. This appointment was a three-way meeting with mental health professionals at Millview Hospital. Mr Walton's COM recorded that Mr Walton seemed under the influence of alcohol and Mr Walton told them that he had a plan to end his life. The

mental health practitioner attempted to arrange an assessment for him at the hospital that day, due to the concerns they had. However, Mr Walton left before the assessment could take place and his COM called the police to report concerns for his welfare. Mr Walton's alcohol misuse was not discussed in this appointment as his mental health needs took priority

33. Later that day, Mr Walton went to the local police station and was assessed there by the Street Triage team (this is a team of mental health nurses who work with local police to ensure people who need mental health treatment receive it as quickly as possible). Mr Walton assured them that he could guarantee his safety but he would not provide information about where he planned to go that evening. He was given emergency contact numbers for out of hours mental health services and advised of how to access places of safety should he need.
34. On 16 September, Mr Walton was arrested for breaching a restraining order against his ex-partner. Mr Walton had stayed at his ex-partner's mother's house. The police did not charge Mr Walton as they identified that his ex-partner's mother's address was not on his restraining order. The police reported this incident to his COM's manager.
35. On 17 September, Mr Walton's COM spoke to him on the telephone. This was his planned probation appointment which did not take place face to face due to the COVID-19 pandemic. She told him that she was giving him a licence warning for not seeking probation approval before staying at an address overnight, in line with his licence conditions. This warning was an alternative to recall to prison but meant that any further warning could result in his return to custody.
36. Mr Walton's COM noted that she was concerned that Mr Walton was intoxicated, although he denied this. He also stated he had no food, money or a sleeping bag. She emailed Brighton Street Outreach Service (Brighton SOS) and the community mental health worker to advise them of his current circumstances and to ask if they could offer him support that evening. The local authority would not accept a duty to offer him emergency housing.
37. On 19 September, Mr Walton went to hospital, having contacted the GP out of hours service. The discharge letter states that he had not taken an overdose but had been on the cliffs and came to the hospital for safety. He told staff that he was homeless. He was seen and assessed fully by the mental health team before discharge.
38. On 21 September, Mr Walton's COM completed an assessment of Mr Walton's risks and needs in the community following his release. She assessed that Mr Walton was at risk of causing serious harm to himself if he did not engage with housing, mental health and alcohol services in the community.
39. On 22 September, Mr Walton was taken to hospital by a relative. He had taken a confirmed overdose of paracetamol and other medication. He told staff he was homeless. He was discharged when medically fit. There is no evidence in the discharge letter that he was seen by a mental health practitioner.
40. A local risk management panel, led by police and probation staff, met on 23 September and asked the council housing department if they would consider

prioritising Mr Walton because of the risk that he posed to himself and others in the community.

41. On 24 September, Mr Walton spoke to his COM on the telephone, as arranged. He told her that he had taken an overdose the weekend before and was currently an inpatient at Haywards Heath Hospital. This was his last contact with her.
42. On 25 September, Mr Walton went to hospital and told staff he had taken a paracetamol overdose. A blood test did not confirm this, and Mr Walton discharged himself that day before being seen by mental health staff.
43. On 26 September, Mr Walton called the mental health crisis team and told them he had taken a further overdose of paracetamol. They arranged for an ambulance to take him to hospital. Blood tests did not detect any paracetamol. He was observed to be intoxicated and was referred to mental health services. It is not clear whether he was seen. He was to be followed up by the community mental health service the following day.
44. On 27 September, Mr Walton's housing advisor told his COM, in an email, that she was closing his case. She said that Mr Walton was getting mental health support and did not wish to consider housing outside of Brighton.

Circumstances of Mr Walton's death

45. On 27 September, the police informed Mr Walton's COM that Mr Walton had died.
46. Mr Walton had been discovered by a member of the public hanging in a local park that morning. They had called emergency services and the police and paramedics arrived. CPR was not commenced, as it was clear that Mr Walton had been dead for some time.

Post-mortem report

47. A post-mortem did not take place. The Coroner accepted the cause of death as hanging.

Support for staff

48. On 27 September, Mr Walton's COM met with her manager to talk about Mr Walton's death and identify what support she might need.

Contact with Mr Walton's family

49. On 27 September, Sussex Police informed Mr Walton's mother that Mr Walton had died.

Findings

Management of risk of suicide and self-harm

50. Mr Walton was on an open ACCT and subject to regular support and monitoring when he was released from custody. There is no record of a handover from Winchester to his COM about Mr Walton's ongoing risk to himself. Mr Walton's risk of harm was well recorded by probation and his COM was fully aware of his risk on release. She acted appropriately to try to manage this risk. However, it is not unusual that people serving short sentences are not well known by the probation service. We therefore make the following recommendation:

The Governor of HMP Winchester should ensure that concerns about a prisoner's risk of suicide and self-harm are shared with community probation staff before they are released.

Alcohol Misuse

51. Mr Walton's prison and probation records document that his regular use of alcohol increased his risk of self-harm and suicide. His licence had a condition to address his alcohol use by attending appointments with CGL. Mr Walton's sentence plan states an action for his offender manager to refer him for this service if his alcohol use increased. It is clear from records of his probation appointments and hospital admissions that Mr Walton was likely to have been drinking regularly. There is no evidence that a referral to CGL was made. We accept that the sequencing of objectives is important for those presenting with complex needs and that Mr Walton's primary need was likely to be his mental health. Taking this into account, we make the following recommendation:

The Local Delivery Unit manager of Brighton and Hove probation should ensure that offender managers clearly record in nDelius decisions about sentence plan objectives relating to licence conditions.

Mental Health Provision

52. In the four weeks between his release and his eventual self-inflicted death, Mr Walton went to the hospital on five occasions having either taken an overdose or after making a statement of suicidal intent. On each occasion, Mr Walton left with no accommodation. On two of these occasions, Mr Walton discharged himself before he was seen. There is no evidence that his COM was made aware of his hospital admissions aside from the incident on 22 September. There is not a mechanism in place for hospital mental health teams to contact probation following incidents. The Mental Health Act (1983) sets out that a hospital does not have a duty to provide aftercare services for those admitted and detained for a mental health assessment. These considerations fall outside the scope of our investigation.

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