Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Thomas Huntley, a prisoner at HMP Winchester, on 29 May 2020

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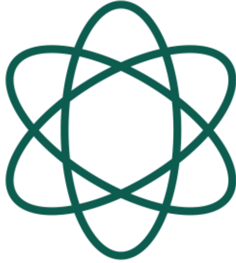
Our vision

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

OGL

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The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out independent investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

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

Mr Thomas Huntley was found hanging in his cell at HMP Winchester on the evening of 28 May 2020. Staff were unable to resuscitate him, and he was pronounced dead in the early hours of 29 May. He was 54 years old. I offer my condolences to Mr Huntley's family and friends.

On 25 May, Mr Huntley tried to take his life by cutting his wrist. He told staff that he thought he would never be released from prison again after being recalled for a fifth time, was struggling to readjust to prison life and was finding it hard to cope with the noise on the wing. Staff began suicide prevention procedures (known as ACCT) and sent Mr Huntley to hospital.

When Mr Huntley returned from hospital later that day, staff placed him in a cell in the prison's inpatient unit. Initially, he was in a cell in the quiet part of the inpatient unit but on 28 May, staff moved him to a different cell in a noisier part of the unit which held prisoners with mental health problems. He was found hanging that night.

I am concerned that when staff moved Mr Huntley on 28 May, they failed to consider the impact of the move on Mr Huntley's risk of suicide and self-harm. I am also concerned that staff reduced the level of observations on Mr Huntley too quickly, which meant he was not being checked as often as we consider he should have been on the night he was found hanging.

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 **January 2021**

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Summary

Events

1. Mr Thomas Huntley was recalled to prison on 22 May 2020. This was the fifth time he had been recalled to prison following his release on licence after serving a life sentence for armed robbery. Mr Huntley was sent to HMP Winchester on 23 May.

2. In the early hours of 25 May, Mr Huntley told staff that he had cut his wrist the previous evening. He had hoped to ‘bleed out’ overnight but when he realised he was still alive, he had called for staff. Staff began suicide and self-harm monitoring (known as ACCT) and took Mr Huntley to hospital. He was returned to Winchester later that morning. Staff placed him in a cell in the healthcare inpatient unit for observation.

3. Mr Huntley told staff he feared that he would never be released from prison now that he had been recalled for a fifth time. He said he had post-traumatic stress disorder (PTSD), was struggling to readjust to prison life and had found it difficult to cope on the standard wing because of all the noise.

4. On 28 May, healthcare staff moved Mr Huntley to a different cell in the inpatient unit, as he was in a cell with a hospital bed, which he did not need and which was not safe for someone being monitored under ACCT because of potential ligatures (such as electrical cords attached to the bed).

5. The final entry in the ACCT ongoing record, made at 8.30pm on 28 May, said, “Seen on [roll] count, no issues”. When interviewed, the officer said he saw Mr Huntley sitting on the floor of his cell and he said, “Alright guv”.

6. When the same officer carried out an ACCT check at 11.30pm, he saw that Mr Huntley’s legs were in the same position as before, so he was concerned. He could not see Mr Huntley properly or get a response from him. The officer called for assistance and when staff were making their way to the cell, they saw through the cell window that Mr Huntley was hanging. Staff and paramedics tried to resuscitate Mr Huntley, but he was pronounced dead at 12.10am on 29 May.

7. On the night Mr Huntley died, a prisoner in a nearby cell was very noisy all night. A mental health nurse told us that she was concerned about the impact this may have had on Mr Huntley, as he struggled with loud noises due to his PTSD. She said that the cell Mr Huntley had been in originally was in a much quieter part of the inpatient unit, whereas the part he was moved to on 28 May was known to be noisy, because it held prisoners with mental health issues, some of whom were known to be extremely loud and disruptive.

Findings

8. We accept that there were sound reasons to move Mr Huntley from his original cell, which was designed for prisoners with physical healthcare needs and not for prisoners being monitored under ACCT, but we are concerned that healthcare staff failed to consider the impact on Mr Huntley’s risk of suicide and self-harm of moving him to a much noisier part of the inpatient unit. We cannot say how much of an

impact this had on Mr Huntley, but it is possible that it influenced his actions on 28 May.

9. On the morning of 27 May, staff reduced the level of observations on Mr Huntley from every hour to three times during the night. We consider the level of observations was reduced too quickly. We are also concerned that no one reviewed the level of observations when Mr Huntley was moved on 28 May.

10. Some ACCT observations were carried out at regular, and therefore predictable, intervals. We are also concerned that the officer who made the final entry in the ongoing ACCT record did not record at the time what he later said he had observed.

Recommendations

- The Governor and Head of Healthcare should ensure that where prisoners are subject to ACCT monitoring, staff should:
    - assess risk based on the prisoner's behaviour and known risk factors, and not on what the prisoner tells them;
    - set an appropriate level of observations based on the prisoner's risk and review the level of observations if circumstances change;
    - consider the impact of a cell move on the prisoner's risk and if a cell move is agreed, consider how to mitigate any risks; and
    - record full reasons for the decisions taken.
- The Governor should ensure that when staff carry out ACCT checks they:
    - vary the times of the checks, while remaining within set observation periods, to avoid prisoners being able to predict when they will be checked; and
    - make full, accurate entries in the ongoing record.
- The Governor should share a copy of this report with Officer A and ensure that a senior manager discusses the Ombudsman's findings with him.

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 her. No one responded.

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

13. NHS England commissioned a clinical reviewer to review Mr Huntley's clinical care at the prison. The investigator interviewed 11 staff on 24-25 June and 2 July, including three healthcare staff she interviewed jointly with the clinical reviewer. Due to coronavirus restrictions, all interviews were conducted by telephone.

14. We informed HM Coroner for Hampshire Central of the investigation. The coroner gave us the results of the post-mortem and toxicology reports. We have sent the coroner a copy of this report.

15. One of the Ombudsman's family liaison officers contacted Mr Huntley's family, to explain the investigation and to ask if they had any matters they wanted the investigation to consider. They raised no issues.

16. We shared our initial report with HM Prison and Probation Service (HMPPS). They raised a factual inaccuracy, which has been corrected in this report.

17. We provided Mr Huntley's next of kin with a copy of our initial report. They did not raise any issues or comment on the factual accuracy of the report.

Background Information

HMP Winchester

18. HMP Winchester is a local prison, serving courts in Hampshire. It holds around 500 adult remanded and sentenced men. It includes a separate lower security unit for up to 129 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 full inspection of HMP Winchester was in June and July 2019. Inspectors found there had been significant deterioration since the last inspection in 2016. They expressed concern at the lack of improvement in work to reduce self-harm. The level of self-harm incidents had doubled since the last inspection and was now higher than any other local prison in the country. Inspectors reported that the prison's response to previous Prisons and Probation Ombudsman recommendations was not robust, and many actions were not well embedded.

20. Many prisoners were subject to suicide prevention monitoring procedures, with the risk that it was becoming unmanageable. Case management was not applied consistently, and care was often insufficient.

21. Inspectors noted that the prison's inpatient unit was staffed by prison officers and supported by visiting nurses. Inspectors observed positive interactions from officers who knew the prisoners in their care well. The unit catered for up to 15 prisoners and ran as two discrete areas, one for prisoners with physical health needs and the other for those with psychological and psychiatric needs. Inspectors found that the outside space was good, but the unit itself was impoverished. Inspectors noted that prisoners with physical health needs were unlocked for most of the day, but other prisoners had a much more restrictive regime; many spent hours locked in their cells with limited access to areas away from the inpatient unit or to structured therapeutic activities. There was a weekly ward round, led by a psychiatrist which provided some clinical insight into prisoners' conditions, but it was unclear who was accountable for day to day care.

22. Inspectors carried out a short scrutiny visit in June 2020. They reported that the level of self-harm was similar to before the COVID-19 regime restrictions were introduced in March, but that self-harm had risen sharply during the early weeks of the restricted regime before dropping in May. Suicide monitoring procedures were delivered efficiently. Inspectors noted that healthcare staffing levels remained sufficient and mental health support remained proactive.

Independent Monitoring Board

23. 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 31 May 2020, the IMB welcomed a reduction in self-harm incidents over the year but noted they had increased since the COVID-19 regime restrictions had been introduced, albeit many were classified

as minor. The IMB noted there had been a significant improvement around the recording and monitoring of dates, such as court appearances, that might be a trigger for self-harm.

Previous deaths at HMP Winchester

24. Mr Huntley was the 11th prisoner to die at HMP Winchester since June 2018. Of the previous deaths, four were self-inflicted and six were from natural causes. In some of our investigations into the previous self-inflicted deaths we have raised concerns about the adequacy of risk assessment.

Assessment, Care in Custody and Teamwork

25. 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. Checks should be at irregular intervals to prevent the prisoner anticipating when they will occur. 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

26. Mr Thomas Huntley was sentenced to life imprisonment for armed robbery on 24 June 2000. After serving his minimum term, he was released from prison on licence, but was recalled four times. He was last released from prison on 24 August 2018.

27. On 22 May 2020, HMPPS issued a licence revocation for Mr Huntley for domestic assault and not living at an agreed address. Police arrested him in the early hours of 23 May.

28. Police took Mr Huntley to HMP Winchester later that day. His Person Escort Record (PER – a document that accompanies prisoners between police custody, courts and prisons, which sets out the risks they pose) completed by police, noted that Mr Huntley had post-traumatic stress disorder (PTSD), anxiety and a back injury, and was on medication.

29. Mr Huntley told the reception nurse that he had never self-harmed and had no thoughts of doing so, but that he had been under the care of the community mental health team for PTSD. The nurse referred Mr Huntley to the prison's mental health team. Mr Huntley arrived at Winchester with pregabalin (a painkiller), sertraline and mirtazapine (both antidepressants). The nurse arranged for Mr Huntley to continue his medication until he could be reviewed by a doctor on Tuesday 26 May (as Monday 25 May was a Bank Holiday). Mr Huntley was given a cell on C Wing.

30. A mental health nurse met with Mr Huntley for a mental health review on 24 May. Mr Huntley said he had struggled to cope in the community, and had been diagnosed with PTSD, for which he had been receiving counselling prior to the COVID-19 lockdown. He said he had never self-harmed and had no thoughts of self-harm. He said he was willing to engage with healthcare staff at Winchester. The nurse advised him to contact the mental health team as and when needed.

25 May

31. At around 1.40am on 25 May, Mr Huntley pressed his cell bell. He told an officer he had cut his left wrist the previous day at approximately 5.00pm. He said he had covered himself with blankets so staff could not see and that he had hoped he would die as he had had enough. Staff started suicide and self-harm monitoring (known as ACCT) and called an ambulance to take Mr Huntley to hospital.

32. Mr Huntley returned to Winchester at 5.30am. While being escorted back to his cell on C Wing, he became dizzy and collapsed to the floor. A nurse examined Mr Huntley, who was pale and clammy and had low blood pressure, and decided he should be monitored in the healthcare inpatient unit rather than return to C Wing. Mr Huntley was allocated cell number 4 in the inpatient unit and checked every 30 minutes. Due to COVID-19, he was required to isolate in his cell for 14 days after going out to hospital, in line with prison procedure.

33. An officer carried out an ACCT assessment interview at 8.40am. Mr Huntley said he thought he would never get out of prison now as this was the fifth time he had been recalled and he had been warned that if he was recalled again, he would never be released. Mr Huntley said he had PTSD, was not sleeping well and had been

struggling with other prisoners coming to his cell door. He said he wished his suicide attempt had worked but said he would never do it again.

34. A Custodial Manager (CM) held Mr Huntley's first ACCT review straight after the assessment interview. An officer and a mental health nurse attended. Mr Huntley said he had been struggling with the noise on C Wing and with prisoners constantly coming to his door asking for things. He thought if he had to spend the rest of his life on a wing like that, he would be better off dead. He said he had decided to end his life and had laughed and joked with staff so they would not suspect, then had got into bed, cut his wrist under the covers and had hoped to 'bleed out' and die during the night. He rang his cell bell when he realised that he was still alive.

35. Mr Huntley said he had had some bad experiences during his time in prison and his GP thought he had PTSD. He was struggling to readjust to prison life, was not sleeping well, and could not eat prison food as the smell gave him flashbacks to past incidents in prison. He said he had been working with the community mental health team for help with his PTSD, but this had been suspended due to COVID-19. Mr Huntley thought he would now spend the rest of his life in prison. He agreed to work with the mental health team on his PTSD and said he would not harm himself again. Staff assessed Mr Huntley's risk as low and set hourly observations day and night and two meaningful conversations a day. Staff agreed that Mr Huntley should remain in the inpatient unit for now, to help him adjust back to prison life.

26-27 May

36. A prison GP saw Mr Huntley on 26 May. They discussed his antidepressant medication. Mr Huntley thought the sertraline and mirtazapine worked well for him and she said she would wait for the psychiatrist to review his medication before making any changes. She noted that Mr Huntley was pleasant and talkative but seemed low. He said he no longer felt like self-harming but was ambivalent about the future. He said he was institutionalised, did not have the skills to cope outside prison and no one to go out to.

37. A CM held Mr Huntley's second ACCT review on 27 May. Also present were a SO (Supervising Officer) and a mental health nurse. The nurse noted in Mr Huntley's medical record that he engaged fully, was polite and pleasant and maintained good eye contact. He said he was frustrated with the system, fed up of prisons and was 'fucked in the head'. He said that just as he had started therapy for his PTSD and depression, it had been stopped and he had never received the mental health care he needed. The nurse said she would take him onto her caseload. Mr Huntley said he had no thoughts of suicide or self-harm and felt settled in the inpatient unit. She arranged to meet with Mr Huntley on 29 May. She noted that overall Mr Huntley seemed positive about the future and seemed to appreciate the help that was being offered to him. Staff reduced Mr Huntley's observations to three random observations overnight and two meaningful conversations a day.

28 May

38. During a healthcare meeting on the morning of 28 May, attended by a prison GP, two nurses and a psychiatrist, staff agreed that Mr Huntley should not be in cell 4, as it was a cell for prisoners with physical health needs rather than mental health needs. They also considered it was not suitable for a prisoner being monitored under ACCT as it was not ligature free (for example, there were electrical cables attached to the bed). He was moved to cell 13 that afternoon.

39. Officer A carried out a roll check (count of prisoners) at 8.30pm. He recorded in the ongoing record of Mr Huntley's ACCT document, "Seen on count, no issues". He told the investigator that he saw Mr Huntley sitting on the floor of his cell next to the door and that Mr Huntley said, "Alright guv".

40. Officer A next checked Mr Huntley at 11.30pm. He told the investigator that he saw that Mr Huntley's legs were in the same position as before, which concerned him. He tried to get a response multiple times but Mr Huntley did not answer. He radioed the CM for assistance.

41. The CM and an officer made their way to the healthcare department, which took approximately a minute. Before going into the healthcare department, they looked through Mr Huntley's cell window from outside. They could see he was hanging. At 11.33pm, the CM called a code blue (a medical emergency code used when a prisoner is unconscious or having breathing difficulties, which alerts healthcare staff and tells the control room to call an ambulance immediately) and ran into the healthcare department, shouting to Officer A to open his sealed pouch containing the cell key.

42. The three men went straight into Mr Huntley's cell and could see he had used a television aerial as a ligature which he had tied around a telephone socket. (These sockets had been installed a few months earlier, ready for the introduction of in-cell telephones.) Officer B used his anti-ligature knife to cut the aerial and laid Mr Huntley on the floor. Officer A checked Mr Huntley's pulse, but found none. It was apparent Mr Huntley was not breathing. Officer A untied the rest of the ligature from around Mr Huntley's neck, as he had difficulty cutting through it. Officer B started cardiopulmonary resuscitation (CPR).

43. A nurse told the investigator he did not hear the code blue but heard a call for assistance over the radio. He went quickly to Mr Huntley's cell, and collected a defibrillator and oxygen on the way. He saw Mr Huntley lying on the cell floor. He appeared unresponsive, his eyes and jaw were open and the nurse saw obvious signs of pallor mortis (an after-death paleness). Mr Huntley had no pulse and his hands and feet felt cold. As Officer B had already started CPR, he attached the defibrillator and took over chest compressions. Two more officers arrived at the cell. One took over chest compressions from the nurse, who inserted an airway into Mr Huntley's mouth. CPR continued until paramedics arrived at 11.50pm and took over. They continued CPR but pronounced Mr Huntley's death at 12.10am on 29 May.

44. Staff told the investigator that on the night that Mr Huntley died, a prisoner in one of the cells near to him, who had been mentally unwell for some time and was known to be extremely loud, had been very noisy and had been banging a lot. A nurse told us that she was concerned about this because loud noises were a particular

problem for Mr Huntley due to his PTSD. She said that the cells around cell 4, Mr Huntley's original cell in the inpatient unit, were much quieter. She thought it possible that Mr Huntley would have struggled with hearing loud noises and banging during the night after he was moved to cell 13.

Contact with Mr Huntley's family

45. The prison's family liaison officer telephoned Mr Huntley's next of kin at 2.20am, to break the news of his death, in line with the prison's COVID-19 procedures.

46. The prison contributed to the cost of Mr Huntley's funeral, in line with national guidelines.

Support for prisoners and staff

47. After Mr Huntley's death, a prison manager 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.

48. The prison posted notices informing other prisoners of Mr Huntley'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 Huntley's death.

Post-mortem report

49. Mr Huntley's post-mortem report concluded he had died from hanging. The toxicology report noted no trace of illicit drugs.

Findings

Management of Mr Huntley's risk of suicide and self-harm

50. Prison Service Instruction (PSI) 64/2011, *Management of prisoners at risk of harm to self, to others and from others (Safer Custody)*, sets out the procedures (known as ACCT) that staff should follow when they identify that a prisoner is at risk of suicide and self-harm.

51. Staff started ACCT monitoring for Mr Huntley on 25 May, after he cut his wrist. At the first ACCT review on 25 May, staff set hourly observations. At the second ACCT review on 27 May, staff reduced observations to three observations during the night and two conversations during the day. When interviewed, the chair of both ACCT reviews, a CM, said that Mr Huntley appeared to be very settled in cell 4 on the inpatient unit and that he said he had no thoughts of self-harm.

52. Staff moved Mr Huntley from cell 4 to cell 13 on the afternoon of 28 May, and he was found hanging at 11.30pm that night. Healthcare staff had decided to move Mr Huntley from cell 4, as it was designed for prisoners with physical health needs rather than mental health needs and was not suitable for a prisoner subject to ACCT monitoring as there were features that could be used as ligatures (such as electrical cables attached to the bed). This was not an unreasonable decision.

53. However, Mr Huntley's new cell was in the part of the inpatient unit for prisoners with mental health needs and was often very noisy, and on the night of 28 May, a prisoner in one of the cells near to Mr Huntley was banging a lot. It is likely that Mr Huntley, who had PTSD and struggled with loud noises, would have found this environment difficult. We cannot say what part this played in Mr Huntley's actions that night, but it is possible it had some influence. We know that Mr Huntley told staff after he cut his wrist that he was struggling with the noise on C Wing and thought if he had to stay on that wing that he would be better off dead.

54. We are concerned that staff reduced the level of observations on Mr Huntley prematurely. On the morning of 27 May, only two days after Mr Huntley had made a serious attempt to take his life, staff reduced observations from hourly to two conversations during the day and three observations during the night. We note that the CM thought that Mr Huntley seemed settled in cell 4 and he told us he did not know he was about to be moved. Nevertheless, given Mr Huntley's recent suicide attempt and that he had told staff that he had tried to act normally beforehand so that staff did not suspect his intentions, we consider that observations were reduced too quickly and before staff could be satisfied that Mr Huntley's risk had significantly reduced. Staff seemed to base their assessment on what Mr Huntley told them about his intentions rather than on his recent behaviour and known risk factors.

55. More concerning though is that no one considered the impact of the cell move on Mr Huntley's risk of suicide and self-harm. Staff should have considered whether the move might increase Mr Huntley's risk, and if so, how the risk could be mitigated if the move was still deemed necessary. At the very least, the level of observations should have been reviewed given Mr Huntley was being moved from a cell where he seemed settled, to a new cell in a much noisier part of the inpatient unit.

56. We recommend:

The Governor and Head of Healthcare should ensure that where prisoners are subject to ACCT monitoring, staff should:

- **assess risk based on the prisoner's behaviour and known risk factors, and not on what the prisoner tells them;**
- **set an appropriate level of observations based on the prisoner's risk and review the level of observations if circumstances change;**
- **consider the impact of a cell move on the prisoner's risk and if a cell move is agreed, consider how to mitigate any risks; and**
- **record full reasons for the decisions taken.**

57. PSI 64/2011 says that ACCT observations should be at unpredictable times, such as twice an hour rather than every 30 minutes. There were periods when Mr Huntley was checked at exactly hourly intervals. An example is on 25/26 May, when Officer A checked Mr Huntley on numerous occasions at exactly 20 past the hour.

58. We are also concerned at Officer A's entry in the ACCT ongoing record at 8.30pm on 28 May, which merely said, "Seen on count, no issues". This does not reflect what he told the investigator at interview, when he said that he saw Mr Huntley sitting on the floor of his cell and that Mr Huntley spoke to him. If that is what happened, it should have been noted in the ongoing ACCT record. There is no CCTV, so we cannot comment on the quality of his check.

59. We recommend:

The Governor should ensure that when staff carry out ACCT checks they:

- **vary the times of the checks, while remaining within set observation periods, to avoid prisoners being able to predict when they will be checked; and**
- **make full, accurate entries in the ongoing record.**

The Governor should share a copy of this report with Officer A and ensure that a senior manager discusses the Ombudsman's findings with him.

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