

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Haydn Burton a prisoner at HMP Winchester on 18 July 2015

**A report by the Prisons and Probation Ombudsman
Nigel Newcomen CBE**

Our Vision

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

Our Values

We are:

Impartial: *we do not take sides*

Respectful: *we are considerate and courteous*

Inclusive: *we value diversity*

Dedicated: *we are determined and focused*

Fair: *we are honest and act with integrity*



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

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

Mr Haydn Burton was found hanged in his cell at HMP Winchester on 15 July 2015 and died in hospital on 18 July. He was 42 years old. I offer my condolences to Mr Burton's family and friends.

The investigation found that Mr Burton's risk of suicide was not properly considered when he first arrived at Winchester. He was subsequently identified as at risk of suicide and was monitored for two brief periods, the second time for a day before he died. I am concerned that staff at Winchester did not operate Prison Service suicide and self-harm prevention procedures properly, and in line with national policy, to support Mr Burton and keep him safe.

I have identified a number of the deficiencies in suicide prevention procedures in previous investigations into deaths at Winchester and some have also been found in recent inspections of the prison. The Governor and senior Prison Service managers need to assure themselves that safer custody systems at Winchester operate appropriately to safeguard prisoners.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman

April 2016

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Summary

Events

1. Mr Haydn Burton served a sentence at HMP Winchester from October 2014 and was released in January 2015. He had been monitored as a risk of suicide and self-harm for two periods during this sentence. On 26 May 2015, he was remanded to Winchester, charged with further offences. At an initial health screen, Mr Burton told a nurse that he had been diagnosed with a range of mental health problems. He behaved oddly, but the nurse did not refer him for a mental health assessment.
2. On 29 May, a healthcare assistant began Prison Service suicide and self-harm prevention procedures, known as ACCT, when Mr Burton said he had suicidal thoughts, but a case review the next day decided to end the monitoring. A post-closure review did not take place until almost a month later. Mr Burton said that the issues, which had been troubling him at the time the ACCT had been opened had still not been resolved. Nothing further was done.
3. At 9.30am on 14 July, an officer was concerned about Mr Burton and began ACCT procedures. A manager did not complete an immediate action plan until 5.00pm, which should have been done within an hour. At 6.00pm, Mr Burton asked to speak to a Listener (a prisoner peer support trained by the Samaritans) but did not see one until four hours later. Staff should have assessed Mr Burton and held the first ACCT case review within 24 hours of ACCT procedures beginning, but this did not happen. At 10.00am on 15 July, Mr Burton's cellmate went back to his cell after spending some time on the wing and found that Mr Burton had hanged himself. Officers and nurses attempted resuscitation. When paramedics arrived, they found a shallow heart rhythm and took Mr Burton to hospital. Mr Burton never recovered and died in hospital on 18 July.

Findings

4. The investigation found some serious failings in the operation of the prison's suicide and self-harm prevention procedures. Reception staff did not identify and consider Mr Burton's risk factors. During the first period of ACCT monitoring, which lasted just a day, the immediate action plan, assessment and case review were all late. There was no multidisciplinary involvement and no member of healthcare staff was present at the first and only case review. We consider the review did not properly consider Mr Burton's risk and the decision to end ACCT monitoring was premature and inappropriate. At a post-closure review, which was three weeks late, Mr Burton said that the issues which had prompted the original monitoring had still not been resolved, but nothing further was done to support him.
5. When staff began ACCT monitoring again, the day before Mr Burton was found hanged, there was a significant delay before an immediate action plan was completed. There was no ACCT assessment or case review within 24 hours, as should have happened. This meant that no one formally assessed the issues that had led to an increase in Mr Burton's risk of suicide and self-harm or had formulated a plan to support him and help address his concerns. The

investigation found that the last check was too brief and simply observational. The officer did not interact with Mr Burton to check how he was feeling.

6. We are concerned that Mr Burton did not get prompt access to a Listener on 14 July, when he was evidently in crisis. The investigation found no reason why he could not have seen a Listener earlier. The Listeners' Suite was a bleak and inappropriate environment to support prisoners in distress.
7. We consider the reception nurse should have made a mental health referral when Mr Burton first arrived, based on his presentation at the initial health screen and what he told her. We are not satisfied that Mr Burton received appropriate mental health support during his time at the prison. Mr Burton had a painful back injury. Although he received appropriate pain medication, there is no record that healthcare staff considered further investigation or treatment of the injury.
8. Although Mr Burton did not tell officers, he appears to have been in debt to other prisoners for tobacco and this was preying on his mind and causing him anxiety. The prison did not respond in line with their local policy when Mr Burton's family reported that he might have been assaulted for tobacco.

Recommendations

- The Governor should introduce clear and effective reception operating procedures so that all staff understand and follow the procedures for identifying prisoners at risk of suicide and self-harm. In particular, staff should:
 - Have a clear understanding of responsibilities and the need to share all relevant information about risk.
 - Consider and record all the known risk factors of a newly arrived prisoner when determining their risk of suicide or self-harm, including information from suicide and self-harm warning forms, PERs and other records.
 - Open an ACCT whenever a prisoner has recently self-harmed or expressed suicidal intent.
- The Governor and Head of Healthcare should ensure that prison staff manage prisoners at risk of suicide or self-harm in line with national guidance, including in particular:
 - Immediate action plans, assessment interviews, first case reviews and post-closure interviews should be completed within the timescales set out in PSI 64/2011.
 - All case reviews should be multidisciplinary where possible and a member of healthcare staff should attend all first case reviews.
 - Care map actions should be set, which address all identified issues and ACCT monitoring should continue until all care map actions have been completed.
 - Case reviews should assess the risk of suicide or self-harm based on all available information.
 - ACCT checks and observations should be meaningful and evidence caring support.

- The Governor should ensure that prisoners have timely access to Listeners in an appropriately supportive environment.
- The Governor should ensure that all information indicating bullying and intimidation is fully coordinated and investigated; that alleged perpetrators are appropriately challenged; and that victims are effectively supported and protected.
- The Head of Healthcare should ensure that healthcare staff are competent to identify mental health concerns and refer prisoners to the mental health team when indicated.
- The Head of Healthcare should ensure that prisoners with long-term physical health problems are referred appropriately for further investigation.

The Investigation Process

9. The investigator issued notices to staff and prisoners at HMP Winchester informing them of the investigation and asking anyone with relevant information to contact him. No one responded.
10. The investigator visited Winchester on 23 July. He obtained copies of relevant extracts from Mr Burton's prison and medical records and interviewed a prisoner.
11. NHS England commissioned a clinical reviewer to review Mr Burton's clinical care at the prison.
12. The investigator interviewed 11 members of staff and one prisoner at Winchester in September 2015. The clinical reviewer joined the investigator for interviews with healthcare staff. The investigator later interviewed three other members of staff by video link and telephone.
13. We informed HM Coroner for Hampshire Central of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
14. One of the Ombudsman's family liaison officers contacted Mr Burton's mother to explain the investigation and to ask if she had any matters they wanted the investigation to consider. She wanted to know whether Mr Burton was on remand or whether he had been convicted. She asked whether Mr Burton was in debt to other prisoners and whether he was being threatened because of this.
15. A legal representative acting for Mr Burton's family wrote to us and asked us if we could clarify whether Mr Burton had been stabbed a month before his death. Mr Burton's family was also concerned that the prison had offered to pay funeral costs while he was still on life support, which they found insensitive. His family also considered that the level of prison escort staff in hospital was inappropriate.
16. Mr Burton's family received a copy of the initial report. Their solicitor wrote to us pointing out a factual inaccuracy and the report has been amended accordingly. They also raised a number of questions that do not impact on the factual accuracy of this report. We have provided clarification by way of separate correspondence to the solicitor.

Background Information

HMP Winchester

17. HMP Winchester is a local prison, serving the courts in Hampshire. It holds around 700 adult remanded and sentenced men. Central and North West London NHS Foundation Trust provide healthcare services. There is a primary care team, a substance misuse team and a community mental health team providing secondary mental healthcare on weekdays. There is a member of primary care staff on duty 24 hours a day, seven days a week. There is a healthcare inpatient unit.

HM Inspectorate of Prisons

18. The most recent inspection of Winchester was in February 2014. Inspectors found that progress, after a very critical inspection in 2012, had been slow and described the main prison as insufficiently safe. The inspectors reported that support for prisoners at risk of suicide and self-harm was reasonable with good attendance at case reviews. The quality of ACCT documents was generally good. Listeners complained that staff were slow to take them to prisoners who needed this support. As at the previous inspection, inspectors found that Listeners' suites were not properly furnished to provide an appropriate environment. The inspection found there were no procedures to monitor and challenge bullies and support victims.
19. Healthcare services had begun to improve, but staff shortages had had an adverse effect on service delivery. Too many prisoners did not receive their medication on time.

Independent Monitoring Board

20. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to May 2015, the IMB reported that officer supervision was highly stretched on some wings and was barely enough to cover routine operations. The IMB was concerned that many of the staff were new and inexperienced and reported an increase in violent incidents and bullying at the prison.

Previous deaths at HMP Winchester

21. Since 2013, we have investigated ten deaths at Winchester. Three of these were self-inflicted deaths and seven were from natural causes. In our investigation reports of the self-inflicted deaths, we were concerned about failures to identify the risk of suicide and self-harm in reception and the poor quality of ACCT procedures.

Assessment, Care in Custody and Teamwork

22. Assessment, Care in Custody and Teamwork (ACCT) is the care planning system the Prison Service uses to support prisoners at risk of suicide or self-harm. The purpose of ACCT 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. Checks should be irregular to prevent the prisoner anticipating when they will occur. Part of the ACCT process involves drawing up a care map to identify the prisoner's most urgent issues and how they will be met. Regular multi-disciplinary reviews should be held. The ACCT plan should not be closed until all of the actions on the care map have been completed. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

Key Events

23. On 20 October 2014, Mr Haydn Burton was remanded to HMP Winchester. On 28 November, he was sentenced to five months in prison for actual bodily harm and carrying a knife. Mr Burton was managed under ACCT suicide and self-harm monitoring procedures from 3 December to 11 December, when he said he had thought about hanging himself and was worried about his daughter. On 29 December, staff began ACCT procedures again because Mr Burton was behaving strangely and was very tearful. Staff continued to monitor him under ACCT procedures until he was released on 2 January 2015.
24. On 26 May 2015, Mr Burton was charged with offences of actual bodily harm against two women and breaching a criminal behaviour order. He was remanded to Winchester and arrived at 6.00pm. Escort staff recorded on the Person Escort Record (PER, a document which accompanies prisoners when they are moved between police stations, courts and prisons and identifies any risks) that Mr Burton had threatened suicide more than once in the past, had previously self-harmed and had mental health issues.
25. A Supervising Officer (SO) booked Mr Burton in at the reception front desk. A nurse assessed Mr Burton in reception, after checking his PER. She had just started working at the prison and this was one of her first reception assessments. (The entry is recorded under another nurse's name, as she did not yet have her own log-in to SystemOne, the electronic medical record. The entry gives no indication that it was her who completed the assessment.) Mr Burton said he drank two litres of cider each day and she recorded that he was a very heavy drinker.
26. Mr Burton told the nurse that he had been diagnosed with multiple personality, emotional instability and paranoid tendencies. He said that he been refusing food in police custody in protest at what he considered was a judicial injustice. (There is no further record that Mr Burton refused food in prison.) He said he had previously harmed himself in the community and in prison but did not have any current thoughts of suicide or self-harm. He seemed fixated on certain issues and kept repeating himself.
27. Mr Burton said he was prescribed codeine and amitriptyline for back pain. He said he had legally changed his name to Mr Handy Haydn and had a bottle of amitriptyline in this name. The nurse said that she could not issue this until staff had checked with his GP that he had been prescribed this medication. Mr Burton became upset, verbally aggressive and walked out. She was unable to complete the assessment.
28. The nurse referred Mr Burton to the doctor and the substance misuse service and made a note of his community GP's details. She did not begin ACCT procedures because she did not consider that Mr Burton was at risk of suicide or self-harm. She did not make a mental health referral.
29. An officer interviewed Mr Burton as part of first night procedures. Mr Burton said he was of no fixed abode and gave no next of kin details. She noted that he had been in prison before and interacted well with her. She wrote that he needed detoxification, (she did not specify from what), that he claimed to have a

personality disorder and that he had no thoughts of suicide or self-harm. She did not begin ACCT procedures.

30. An officer assessed Mr Burton's risk for cell sharing risk to determine if he was a risk of violence to a potential cellmate. He concluded that he was a standard risk, which meant that he could share a cell. Mr Burton was allocated to a double cell on B Wing, shared with another prisoner.
31. That evening, a nurse from the substance misuse service assessed Mr Burton, who was shouting and pacing up and down, demanding his pain relief medication. Mr Burton said he had a 30-year history of alcohol misuse and had recently been drinking a bottle of wine and a bottle of sherry each day. The nurse could not complete his observations because of Mr Burton's verbal aggression. He identified no symptoms of alcohol withdrawal, but prescribed chlordiazepoxide to relieve symptoms, in case further monitoring identified that he needed it. The nurse referred Mr Burton to the substance misuse doctor.
32. The next day, 27 May, an offender supervisor interviewed Mr Burton for part one of his basic custody screening. He said he preferred to be called Mr Handy Haydn. She noted he was very aggressive and rude, and claimed he had paranoid tendencies. Later, Mr Burton was reported to be abusive to substance misuse staff because they would not give him amitriptyline. He refused to attend a secondary health screen. A prison GP reviewed Mr Burton, who said he was prescribed codeine and amitriptyline for back pain. She tried to obtain his community records but he had not given the correct contact details, so she asked staff to obtain them. A substance misuse team meeting discussed Mr Burton that day and agreed to continue monitoring him for withdrawal symptoms from alcohol.
33. On Thursday 28 May, the substance misuse doctor saw Mr Burton and recorded that he was uncooperative, agitated, verbally aggressive and hostile. He refused to sit down and said he was in severe pain. He denied any illicit drug or alcohol misuse. The doctor did not identify any withdrawal symptoms and noted that Mr Burton had not needed chlordiazepoxide since he had arrived. The doctor concluded that Mr Burton did not need any help from the substance misuse team.
34. Healthcare staff had still not obtained Mr Burton's community GP records, so the substance misuse doctor requested and received them the same afternoon. The GP records confirmed that Mr Burton had a genuine back condition and was very likely to be suffering pain. The doctor prescribed amitriptyline and dihydrocodeine, a variant of codeine, for pain relief and to minimise the effects of withdrawal from codeine and the associated increased risk of suicide. This was subject to a further review by the primary care GP.
35. On the morning of 29 May, an officer interviewed Mr Burton for the second part of his basic custody screening. He recorded that Mr Burton was very aggressive and rude and did not listen.
36. Later that morning, a healthcare assistant saw Mr Burton for his delayed secondary health screen. Mr Burton told him that he had been mentally and sexually abused as a child and that a member of his family had been sexually abused. He talked about the media's coverage of sexual abuse. Mr Burton told him that he had harmed himself in the past and had constant thoughts of suicide

but did not 'have the bollocks to do it'. He said that suicide was not the coward's way out and he would rather be dead. Mr Burton was very intense and talked constantly. The healthcare assistant was concerned about Mr Burton's state of mind and, at 10.45am, began ACCT procedures.

37. A manager is supposed to complete an ACCT immediate action plan within an hour of an ACCT being opened, to set out the most appropriate environment and regime to support the prisoner at risk, including the level of observations required, until the first case review. A supervising officer did not complete an immediate action plan until 7.00pm. He decided that staff should check Mr Burton once an hour until the first case review the next day.
38. At 1.50am on 30 May, Mr Burton was moved to another cell on B Wing, and stayed in the cell for a week. No reason for this move in the middle of the night was recorded in his ACCT document or elsewhere. An acting Custodial Manager, the night manager, could not recall for certain but thought that Mr Burton had been arguing with his cellmate and repeatedly pressing his cell bell, so she had separated them, for safety.
39. An ACCT assessment and the first case review are supposed to take place within 24 hours of the ACCT being opened, so should have been held by 10.44am, on Saturday 30 May. An officer did not assess Mr Burton until 3.10pm. The ACCT case manager also attended the assessment, which was in effect the first ACCT case review. The case manager could not remember why the interview and case review were overdue. He said that he sat in for the assessment, because he knew Mr Burton well and thought he was more likely to engage with him.
40. Mr Burton said that the healthcare assistant had misinterpreted what he had said the day before and had blown the situation out of proportion. He said that it had been a passing comment; he was not suicidal and had not tried to kill himself recently. He spoke about his daughter, his commitment to children's rights and said he was involved in the 'Fathers for Justice' campaign. He said he was unhappy with the prison and the criminal justice system in general.
41. An officer recorded three actions resulting from the assessment on his record of the assessment interview: the ACCT would be closed, Mr Burton would refer himself to the community mental health team (who deliver secondary mental health services in the prison) and Mr Burton would approach staff if he had any further issues.
42. At 3.30pm, a supervising officer and an officer held the first ACCT case review. There was no member of healthcare staff present, which is a mandatory requirement of ACCT procedures. The supervising officer said that he had left a telephone message inviting a nurse to attend. Nobody had replied and he had not pursued this.
43. Mr Burton told the supervising officer and the officer that, because of all of the bad things in his life, he sometimes wished he were dead. He would then not have to deal with the abuse and neglect he had suffered in the past and could escape his thoughts and anxieties. He said that he would always have some

suicidal thoughts because of his previous experiences, but said that he was not brave enough to go through with it and did not have 'what it takes' to kill himself.

44. The supervising officer told the investigator that, from what Mr Burton said, he did not think he intended to harm himself and he had no significant concerns about him. He assessed Mr Burton's risk of suicide as low. He did not record any issues on the ACCT care map and did not record any triggers for suicide or self-harm. He ended the ACCT procedures and scheduled a post-closure review for 5 June.
45. On 2 June, a nurse from the primary care team went to B Wing to assess the mental health of a prisoner, also called Burton. The wing staff brought her the wrong Mr Burton and she began to assess him but soon realised that he was not the prisoner she had come to see. However, Mr Burton seemed keen to talk and she thought it best to carry on, as she did not want to upset him.
46. Mr Burton remained standing throughout the nurse's assessment, which lasted about 45 minutes. He did not answer her questions but was very angry about events before he came to prison and was fixated on the police. He talked passionately about his campaigning with Fathers for Justice. He said he had been physically and sexually abused when he was a child. He told her that he had been held in police custody for his own safety under section 136 of the Mental Health Act several times, but had never had a firm mental health diagnosis or any ongoing support.
47. The nurse noted in Mr Burton's medical record that she did not think that Mr Burton had a mental health problem and she had no serious concerns about him. Mr Burton did not mention any thoughts of suicide or self-harm during the assessment and she concluded that no further action was necessary.
48. On 6 June, staff moved Mr Burton back to his previous cell, which he now shared with another prisoner. The next day, that prisoner moved out and, on 8 June, Mr Burton got a new cellmate. On 9 June, a primary care GP renewed Mr Burton's prescription for dihydrocodeine. On 13 June, he renewed his prescription for amitriptyline.
49. On 15 June, Mr Burton's cellmate changed again. The same day, the prisoner monies clerk received a cheque for £40, which had been posted to Mr Burton. This was added to his prison account but Mr Burton could not spend it until 10 working days later, while the cheque cleared. Mr Burton was upset and agitated about this over the next three weeks and wing staff spoke to the clerk to try to speed up the process.
50. On 17 June, Mr Burton appeared at court by video link. He told the court that, while on the wing, he had been stabbed with a pen, but would not give any further details about this. There is no mention of this incident in Mr Burton's prison records and he did not report it to prison or healthcare staff.
51. On 19 June, a prison GP reviewed Mr Burton's medication with him and recorded that Mr Burton was very aggressive, threatening and swore. He refused to engage or be examined and said he would be making a claim for medical negligence. The GP wrote to Mr Burton's community GP for more information,

because he had said that he had a forthcoming hospital outpatient appointment and had claimed that his GP had allowed him to have as much amitriptyline as he liked.

52. On 22 June, an administrator in the safer custody team received a call from Mr Burton's uncle, who said that Mr Burton had written to his grandmother saying that his cellmate had been stealing his tobacco and had stabbed him. Officers on B Wing told her that they had no record of this stabbing and healthcare staff said that they had never treated Mr Burton for a stab wound. She went back to B Wing and officers said that Mr Burton had been examined and he was not injured. (There is nothing in his medical record to indicate that a nurse examined him, so presumably it was the officers who checked.) She telephoned Mr Burton's uncle to update him. Staff questioned Mr Burton and his cell mate but both of them said that it had been a joke involving a biro pen. Mr Burton said he did not want to make a complaint. No one submitted an intelligence report to the security department about this information and no one monitored Mr Burton's cellmate further.
53. On 24 June, an acting supervising officer interviewed Mr Burton for an ACCT post-closure review, which had originally been scheduled for 5 June. The supervising officer told the investigator that he had just taken up his temporary managerial role and had found a backlog of about 15 or 20 ACCT post-closure reviews, which had not been done. He had been working through the backlog, but this had taken some time.
54. The supervising officer wrote in Mr Burton's prison record that he was belligerent and very vocal about the failings of the justice system, when he spoke to him. Mr Burton told the supervising officer that the problems that had caused the ACCT to be opened had not been resolved, as he was still in prison, but was dealing with it. He said he had nobody to turn to for support in the prison, had no activity or work, no hobbies and did not go to the gym. Mr Burton said that the prison staff did not care about him. He refused to sign the record of the review.
55. The supervising officer told the investigator that he knew Mr Burton well and he was always in a negative frame of mind, so he had not been surprised by his comments. He said that, when he reviewed Mr Burton, his mood was not as bad as it could sometimes be and he had had no significant concerns about him then or afterwards. Mr Burton had told him that he had no plans to harm himself. The supervising officer said that Mr Burton kept referring to his plans to sue a number of different bodies and individuals about his previous abuse and he did not consider there was any reason to begin ACCT monitoring again. The supervising officer said that he and an officer arranged a job for Mr Burton in a prison workshop, but he had refused to attend.
56. On 25 June, a substance misuse doctor re-prescribed Mr Burton's dihydrocodeine for 28 days. That day, Mr Burton appeared at a magistrates' court by video link and his case was committed to crown court. On 2 July, his cellmate moved and, on 3 July, a new cellmate moved in. That day, Mr Burton was taken to court and pleaded guilty. The court ordered a pre-sentence report. Mr Burton was due to be sentenced on 18 July. There is no record that reception

staff assessed Mr Burton's risk of suicide and self-harm when he got back from court, as should have happened.

57. On 6 July, Mr Burton was informed that the £40 cheque, which had arrived three weeks earlier, had cleared and the funds were now in his account. On 7 July, a prison GP re-prescribed amitriptyline for a further 28 days.
58. On 11 July, Mr Burton complained that he was not able to phone his family at regular times. On 16 July, the B Wing manager partially upheld the complaint, but noted that it was not always possible to offer calls at the same times each day due to last minute, unexpected, changes to the regime. On 13 July, Mr Burton complained about the state of the showers. The wing manager upheld the complaint on 16 July and arranged for a problem with the showers to be sorted. In July, Mr Burton applied to see the contents of his prison record from his previous sentence, under the Freedom of Information Act. A member of staff replied and explained how to go about this.
59. On 13 July, a prison manager spoke to Mr Burton about his spending allowance. Mr Burton thought he was a remand prisoner but the wing manager told him that, as he was now convicted (although not yet sentenced) this reduced the amount of money he was allowed to spend.
60. At 7.30pm that evening, Mr Burton asked to speak to the chaplain because he was unhappy that he had not been able to speak to his father. Staff told him that this was not possible at the time but he could speak to a Listener instead. (Listeners are prisoners trained by the Samaritans to support other prisoners in distress.) Mr Burton did not want to speak to a Listener.

Tuesday 14 July

61. At 9.30am on Tuesday 14 July, an officer was concerned about Mr Burton and began ACCT procedures. She said Mr Burton was shouting and 'raving' in his cell, which was very out of character. She said Mr Burton was often opinionated but this behaviour was very different. Mr Burton initially seemed to be agitated about money problems, but then started shouting about sexual abuse he and another family member had suffered and about institutional sexual abuse.
62. Mr Burton said that the prison would have a death in custody. The officer assumed this was a suicide threat and, when she followed him to his cell, he made more threats to kill himself. Another officer said that what Mr Burton was saying was very extreme and did not make very much sense. She thought it was unusual for him to be so angry.
63. Mr Burton calmed down. At 10.50am, he handed in some paperwork to the office, but he did not speak. (It is not apparent what these papers were.) An officer thought he seemed very low. At 12.20pm, he collected his lunch and was still not speaking. In the afternoon, he came out of his cell for an association period (when prisoners can mix with each other, have showers, make telephone calls and complete other domestic tasks).
64. After an ACCT is opened, a manager should complete an immediate action plan within an hour but an acting supervising officer did not do this until 5.00pm. The supervising officer was in charge of B Wing, but was on a training course

elsewhere in the prison and no one had been allocated to manage the wing in his absence. The orderly officer for the day (in charge of the operational management of the prison) had not completed the immediate action plan but someone had recorded on the front of the ACCT document that staff should check Mr Burton every hour. The prison has not been able to identify who set the frequency of observations.

65. The supervising officer got back to B Wing at 5.00pm and he and an officer went to Mr Burton's cell to speak to him. Mr Burton's cellmate was there and the supervising officer asked Mr Burton to come to the office but he said he was watching television and did not want to move. They spoke at the cell door for a few minutes. The supervising officer asked him how he was feeling and he said that Mr Burton had started ranting about politicians and paedophilia. The supervising officer reminded him that he could speak to a Listener or the Samaritans if he needed further support.
66. The supervising officer completed the ACCT immediate action plan and kept the frequency of observations at one an hour. He wrote in the wing observation book, that Mr Burton believed that his canteen (order from the prison shop) was wrong but that a manager had confirmed that it was correct. The supervising officer wrote: '[Mr Burton] now says there will be a death in custody'. He could not remember if Mr Burton had said this to him or if he had copied it from the officer's concern and keep safe form. The supervising officer told the investigator that he had decided that Mr Burton should have an ACCT assessment the next morning, followed by the first case review.
67. Mr Burton collected his evening meal at 5.15pm. At 6.00pm, he asked an officer if he could speak to a Listener. He passed Mr Burton's request onto the evening staff. At 7.50pm, another officer asked the orderly officer in charge of the prison for a Listener, but he said that the Listeners were busy at the time. The officer told Mr Burton that there would be a delay and he did not seem distressed.
68. At 10.20pm, Mr Burton was taken to the Listeners' suite on C2 landing to speak to a Listener. He told the investigator that he was the duty Listener that night and that there was also a reserve Listener on the rota. He said he did not understand why Mr Burton had not been able to see the reserve Listener earlier in the evening, when he had asked for support. He did not recall being particularly busy that evening and did not understand why it had taken over four hours for Mr Burton to see a Listener, after he had requested one.
69. The Listener said that he knew Mr Burton from his last sentence. While he had seemed eccentric, he had never previously regarded him as a suicide risk. This was the first time that he had seen Mr Burton during this sentence. He said that Mr Burton had given him permission to share what he had told him after his death, which is why he felt able to disclose information to the investigator. Mr Burton wanted him to tell the officers after he died that it was their fault and that he blamed them. He told him that he had already made a noose.
70. Mr Burton told the Listener that he had borrowed tobacco and had ordered some from the canteen to repay the debt, but this had not arrived because he did not have the money in his account to pay for it at the time. He said that his debt had now doubled to £15 because he was now late in paying it. He said he was

worried about being assaulted if he could not repay the debt and would hang himself that Friday, if his tobacco order did not arrive.

71. Mr Burton had a long handwritten document with him, which he said was his autobiography and he planned to send it to his solicitor. He read some of it to the Listener. He made specific allegations about sexual abuse when he was a child. The Listener thought that he seemed better at the end of their meeting and Mr Burton shook his hand and thanked him for listening. Mr Burton went back to his cell at 11.10pm. In line with the Listeners' confidentiality agreement, the Listener did not disclose anything about what Mr Burton had told him to the staff at the time. Hourly checks recorded at irregular intervals in the ACCT document indicate that Mr Burton was asleep throughout the night.

Wednesday 15 July

72. At 8.00am on Wednesday 15 July, an officer recorded in the ACCT document that Mr Burton was in bed. At about 9.00am, officers unlocked the cells on the wing and Mr Burton's cellmate went onto the wing to talk to other prisoners. Mr Burton did not leave the cell to collect his medication, as he would normally do.
73. At 9.05am, 65 minutes after the last recorded ACCT check, CCTV footage shows that the officer looked into Mr Burton's cell for about one second. He did not speak to Mr Burton. At 9.10am, he wrote in the ACCT record that Mr Burton was still in bed when he had checked him.
74. Mr Burton's ACCT assessment interview and first case review should have been held by 9.30am that morning to comply with the Prison Service Instruction that they should be completed with 24 hours of the ACCT being opened. A supervising officer said he had planned that these would be done after other prisoners had gone to work and education, at about 9.00am. However, a prisoner had threatened an officer and this incident had delayed all other activities. The supervising officer did not know that Mr Burton had asked to see a Listener the night before, although this was recorded in the ACCT record.
75. CCTV footage shows that the cellmate went back to his and Mr Burton's cell at 9.30am, but the door was locked and the observation panel was closed. Officers do not usually lock cell doors while prisoners are out on the landings, but the door will lock if a prisoner inside shuts it. The cellmate said that he opened the observation panel and thought Mr Burton was standing at the back of the cell by the toilet. He assumed he was using the toilet, so he closed the observation panel and went back to talk to his friends.
76. At 10.01am, (according to the CCTV footage), the cellmate asked an officer to let him into the cell and the officer unlocked the door. He went in but immediately called the officer for help. Mr Burton was hanging by a piece of torn bed sheet from window bars. He was slumped in a kneeling position.
77. The officer shouted to a colleague who was on the landing and went into the cell immediately, supported Mr Burton's body and cut the bed sheet from above his neck. The other officer was about five seconds behind him. As she arrived, she blew her whistle and pressed the general alarm button on the wall outside the cell. She did not radio the control room.

78. Within 20 seconds, another officer arrived and radioed a code blue medical emergency. Control room staff called an ambulance immediately. (Both initial officers should have radioed a code blue, but we accept there was no significant delay.) The officer lowered Mr Burton to the floor, untied the ligature from Mr Burton's neck and began chest compressions. Another officer gave rescue breaths. By 10.02am, ten prison staff had arrived at the cell.
79. At 10.03am, two nurse arrived with an emergency response bag and a defibrillator. One nurse said that she had initially been confused by the general alarm but realised the situation was serious as she heard radio calls for a defibrillator. Three nurses took over the resuscitation attempt. They attached the defibrillator and gave Mr Burton oxygen using a bag-valve-mask. The defibrillator could not find a shockable heart rhythm.
80. A first response paramedic arrived at the prison gate at 10.06am and at Mr Burton's cell at 10.10am. An ambulance arrived shortly afterwards. Paramedics gave Mr Burton two doses of adrenaline and found a shallow heart rhythm. At 10.40am, they took Mr Burton to hospital. Mr Burton never recovered and at 5.55am on Saturday 18 July, a doctor recorded that he had died.
81. A complaint form Mr Burton had addressed to David Cameron was found in his cell after he died. (We assume this was meant for the Prime Minister.) Under location, he had written, 'Hell'. He had written a poem, which referred to the rising suicide rate, the fact he was in debt, systemic abuses, children's rights and bringing back the death penalty for those who commit sex offences against children.
82. When the investigator looked at Mr Burton's cell, he found numerous newspaper clippings on the wall relating to historical sexual abuse cases. There were also clippings about the Secretary of State for Justice and the increase in the prison suicide rate.

Contact with Mr Burton's family

83. Mr Burton had named his father as his next of kin. At 11.45am on 15 July, the duty governor telephoned Mr Burton's father to tell him that his son was in a critical condition in hospital. The prison arranged for a taxi to take him to the hospital and she met him there at 12.45pm. Hospital staff explained that Mr Burton was unlikely to recover.
84. Two officers had accompanied Mr Burton to hospital, but from 9.00pm that evening, the duty governor reduced this to one officer. The prison said he was positioned away from Mr Burton to allow his family privacy. A supervising officer acted as the prison's family liaison officer. In line with Prison Service instructions, the prison contributed towards the cost of Mr Burton's funeral, which took place on Friday 7 August.

Support for prisoners and staff

85. At 11.00am on 15 July, the deputy governor debriefed the staff involved in the emergency response and offered his support and that of the staff care team.

86. After Mr Burton died, the prison posted notices informing other prisoners, and offering support. Staff reviewed all prisoners assessed as at risk of suicide and self-harm, in case they had been adversely affected by Mr Burton's death. Officers placed the cellmate with another prisoner for support and later moved him to a different shared cell.

Post-mortem report

87. A post-mortem examination found that the cause of death was from the delayed effects of ligature suspension.

Findings

Assessment of risk in reception

88. Prison Service Instruction (PSI) 64/2011 (Safer Custody) lists risk factors and potential triggers for suicide and self-harm. It states that 'all staff who have contact with prisoners must be aware of the triggers that may increase the risk of suicide, self-harm or violence and take appropriate action'. Mr Burton had a number of risk factors:
- There were warnings on his escort record about mental health issues, previous suicide threats and incidents of self-harm.
 - He reported significant alcohol misuse.
 - He claimed that he had been refusing food as a protest.
 - He said he had been diagnosed with multiple personality, emotional instability and paranoid tendencies.
89. Mr Burton also behaved aggressively and bizarrely when interviewed in reception. There is no evidence that anyone in reception considered that these factors increased Mr Burton's risk of suicide or self-harm and no one began ACCT procedures. A nurse told the investigator that she did not think it unusual to have warnings about previous self-harm on the PER and this did not prompt her to consider ACCT procedures. Staff seem to have relied too heavily on Mr Burton's assurances that he did not intend to harm himself. Although he mentioned that he had been refusing food, this was never addressed or mentioned again, if only to confirm that he was eating normally.
90. We identified the need to take full account of risk factors for newly arrived prisoners in the investigation report into the death of a prisoner at Winchester in 2014. The prison accepted our recommendation and said it had taken action to ensure that reception staff were aware of all risk factors and took into account all information from external sources when assessing a newly arrived prisoner's risk. However, we found similar failures in the investigation into subsequent deaths at the prison in March and July 2015. It is apparent that there is still a need to ensure that all reception staff properly consider risk factors. We make the following recommendation:

The Governor should introduce clear and effective reception operating procedures so that all staff understand and follow the procedures for identifying prisoners at risk of suicide and self-harm. In particular, staff should:

- **Have a clear understanding of responsibilities and the need to share all relevant information about risk.**
- **Consider and record all the known risk factors of a newly arrived prisoner when determining their risk of suicide or self-harm, including information from suicide and self-harm warning forms, PERs and other records.**
- **Open an ACCT whenever a prisoner has recently self-harmed or expressed suicidal intent.**

ACCT procedures

91. PSI 64/2011 notes that 'The ACCT process is necessarily prescriptive and it is vital that all stages are followed in the timescales prescribed'. The investigation identified a need for improvements in a number of aspects of the operation of ACCT procedures, which we outline below.
92. There is a requirement for a manager to talk to the prisoner and complete an immediate action plan within an hour of an ACCT being opened. When ACCT procedures began on 29 May, this did not happen until over eight hours later. An ACCT assessment and first case review was not held within 24 hours as should have happened but were held after 28 hours had elapsed. The staff involved could not explain why there had been a delay.
93. The ACCT assessment and the first case review are separate processes. The purpose of the assessment is to allow the prisoner to discuss their concerns individually with one member of staff. The case review should be a multidisciplinary team who consider how best to address the issues identified at the assessment and decide on the level of risk. On 30 May, the two processes were combined. The case manager attended the assessment interview and the assessor recorded a decision to close the ACCT document before the case review was formally held. This was not good practice and there was no multidisciplinary review. A member of healthcare staff did not attend, which is a mandatory instruction of PSI 64/2011. The case manager said he was unaware of this requirement.
94. A healthcare assistant had begun ACCT procedures on 29 May, because Mr Burton had told him he had constant suicidal thoughts. On 30 May, Mr Burton said at the case review that he sometimes wished he were dead so he could escape his thoughts and anxieties. In these circumstances, we would have expected the case review to have assessed Mr Burton's risk as raised and to have continued ACCT monitoring, with a care map to ensure that all his issues were properly addressed. We are concerned that the review assessed Mr Burton's risk of suicide or self-harm as low and ended ACCT procedures at this first case review without properly considering or putting in place support to reduce Mr Burton's risk. Although the ACCT assessment identified mental health concerns, an officer and a supervising officer did not make a mental health referral or speak to the mental health staff. They advised Mr Burton to refer himself.
95. Prison staff are required to hold an ACCT post-closure review within seven days, but this did not happen until 24 June, over three weeks later. A SO, who was temporarily promoted at the time, said that he had been tackling a backlog of post-closure reviews on B Wing. He said this was a chaotic time on B Wing with a lot of new and inexperienced officers and a lack of support from managers. Mr Burton told the supervising officer that none of the issues, which had led to the ACCT being opened, had been resolved. Despite this, the supervising officer did not start ACCT procedures again or take any further action to help Mr Burton.
96. On 14 July, when staff began ACCT procedures for the second time, there was again a significant delay in completing the immediate action plan, which did not happen until seven and a half hours later. Mr Burton was being checked hourly.

CCTV shows that the last check was a little late, at one hour five minutes after the previous check. The footage shows that the officer passed by the cell and checked as he carried on walking. He did not pause to speak to Mr Burton or get a proper response. We do not consider this was adequate care for someone identified as at risk of suicide and self-harm. We consider that the officer should have made some effort to engage with Mr Burton and check how he was feeling.

97. Mr Burton was found hanged just after 10.00am on 15 July, more than 24 hours after staff had begun ACCT procedures. Again, there had been no ACCT assessment or first case review within 24 hours, as should have happened. A supervising officer said he had planned to start the assessment interview at about 9.00am, but had been delayed because of an operational problem on the wing. There is no evidence that anyone had been identified to interview Mr Burton for the ACCT assessment or that anyone else, such as healthcare staff, had been contacted to attend the ACCT case review. We consider that once someone has been identified as at risk of suicide and self-harm, it is important that the prisoner is assessed and there is a first case review as soon as possible to identify the issues and implement support to help reduce risk.
98. Mr Burton had been identified as a risk of suicide and self-harm at Winchester twice since he had arrived at the prison in May 2015. Each time ACCT procedures operated for little more than a day or so, yet the investigation has identified a number of procedural failures in those short separate periods of monitoring. We do not consider that the prison operated ACCT procedures effectively, in line with national instructions, to keep Mr Burton safe. We make the following recommendation:

The Governor and Head of Healthcare should ensure that prison staff manage prisoners at risk of suicide or self-harm in line with national guidance, including in particular:

- **Immediate action plans, assessment interviews, first case reviews and post-closure interviews should be completed within the timescales set out in PSI 64/2011.**
- **All case reviews should be multidisciplinary where possible and a member of healthcare staff should attend all first case reviews.**
- **Care map actions should be set, which address all identified issues and ACCT monitoring should continue until all care map actions have been completed.**
- **Case reviews should assess the risk of suicide or self-harm based on all available information.**
- **ACCT checks and observations should be meaningful and evidence caring support.**

Listeners

99. It took four hours for Mr Burton to see a Listener on 14 July, after he had asked to speak to one. The Listener could not understand why there had been such a delay. We consider that this was too long for someone who had just been identified as at risk of suicide or self-harm, particularly as Mr Burton had not had

the opportunity to speak to staff at an assessment interview or at a case review. The Listener told the investigator that there were often delays bringing prisoners to Listeners' suites and in staff taking prisoners and Listeners back to their cells afterwards.

100. We found that the Listeners' suite on C2 landing, where Mr Burton saw the Listener on the evening of 14 July, was an unsuitable environment. It was often used as a holding cell and was in a very poor condition. There were no comfortable chairs and it was not a calm or safe space to support prisoners in crisis or distress.
101. At the inspection in February 2014, HM Inspectorate of Prisons also identified problems with delays in prisoners seeing Listeners and the poor condition of the Listeners' suite (which was also an issue at the inspection before). It does not appear that the prison has made any progress in addressing these concerns. We make the following recommendation:

The Governor should ensure that prisoners have timely access to Listeners in an appropriately supportive environment.

Bullying and debt

102. In the weeks before he died, Mr Burton was anxious that money sent by cheque had not yet been credited to his prison account. On the evening before he hanged himself, Mr Burton told a Listener that he was in debt to another prisoner for tobacco, because he had had no money. He said he had been late in repaying and that the debt had doubled. He said he would hang himself if the tobacco he had ordered to repay the debt did not arrive at the end of the week. (He hanged himself before his tobacco order had arrived.) Mr Burton referred to this debt in the writings found in his cell after he hanged himself.
103. Mr Burton never reported any issues with debt to staff, and therefore they could not have been expected to have investigated this. However, he had been anxious about money and it is possible that his problems with debt were exacerbated by the delay in crediting funds to his spends account from a cheque which had arrived on Monday 15 June. The cheque was sent for banking on Wednesday 17 June and should have cleared on Wednesday 1 July, but the funds were not made available to Mr Burton until 6 July. We have found no evidence to explain the additional delay. It is possible that this was a delay with the bank but we draw the prison's attention to the need for prisoner's monies to be credited to their accounts as quickly as possible to help avoid the problem of debt.
104. In June, Mr Burton and his family reported that his cellmate had stabbed him with a pen and had stolen his tobacco. We do not know exactly what happened or whether it was connected to a possible debt. The safer custody clerk made some enquiries and wing staff said there was no evidence that Mr Burton had been stabbed. When questioned by staff, both parties insisted that it was a joke involving a biro pen and neither wished to make a complaint. No one submitted an intelligence report to the security department. There is no record that healthcare staff ever examined Mr Burton, to see whether he had been injured,

although it appears that officers checked him and found no injuries. The post-mortem examination found no evidence of any significant recent injuries.

105. At the inspection of Winchester in 2014, HM Inspectorate of Prisons was critical that there was no prison-specific violence reduction policy and an over-reliance on the national Prison Service Instruction. Almost 30% of submitted violent incident reports (VIRs) were not investigated and little was done when allegations were proven. There was no effective system to monitor prisoners suspected of bullying or to support victims. Inspectors recommended that there should be a local violence reduction policy.
106. At prison implemented a new policy on 15 June 2015, a week before Mr Burton's family contacted the prison with their concerns. The local policy adopts a zero tolerance approach to violence and requires staff to record any incidents in a timely manner. None of the wing staff or healthcare staff recorded anything about the 'stabbing', even if only to indicate that it was a minor incident. Nobody submitted any information reports to the security department. The policy states that 'play fighting' where no injury is sustained, can still be dealt with by a reduction in privileges or a more serious sanction. There is no evidence that any such measures were implemented. We make the following recommendation:

The Governor should ensure that all information indicating bullying and intimidation is fully coordinated and investigated; that alleged perpetrators are appropriately challenged; and that victims are effectively supported and protected.

Clinical care

107. Mr Burton's escort record indicated he had a history of suicide threats and mental health problems. He told a nurse in reception that he had been refusing food (which can be regarded as a form of self-harm) and he behaved strangely and aggressively. He said that he had been diagnosed with multiple personality, emotional instability and paranoid tendencies. This should have prompted a mental health referral but she did not make a referral.
108. The nurse had only recently started working in Winchester, had little experience of the prison reception process and had not yet been given log-in details to make her own entries and referrals in the clinical record. She told the investigator that she did not feel comfortable assessing mental health. This is concerning, as reception nurses are required to screen new prisoners for physical and mental health issues.
109. No other member of healthcare staff referred Mr Burton for a mental health assessment subsequently. When staff closed the ACCT on 30 May, there was a reference in the assessment interview to Mr Burton referring himself, which he never did. On 2 June, a nurse assessed Mr Burton (because of a mix up of prisoners) and did not think he needed further input from mental health staff. However, as the assessment had not been planned, she had not read his medical record before she saw him. She did not know his history or that Mr Burton had reported constant suicidal thoughts to a healthcare assistant only four days earlier. It cannot be regarded as a complete assessment.

110. Mr Burton's community GP records included a scan in January 2015, which suggested that he was suffering from significant back pain. However, apart from pain relief, there was no record of any further proposed action, such as a hospital referral for further investigation. The clinical reviewer considered that some aspects of Mr Burton's mental and physical care were not equivalent to the standard of care that he could have expected to receive in the community. The clinical reviewer made a number of recommendations in his clinical review that the Head of Healthcare will need to address. We make the following recommendations:

The Head of Healthcare should ensure that healthcare staff are competent to identify mental health concerns and refer prisoners to the mental health team when indicated.

The Head of Healthcare should ensure that prisoners with long-term physical health problems are referred appropriately for further investigation.

Family liaison

111. Mr Burton's family complained about the level of escort after Mr Burton had gone to hospital. They also said that they were offered a contribution towards his funeral expenses before he had died, which they found insensitive and inappropriate.
112. When Mr Burton was first taken to hospital, two officers accompanied him. A nurse also went to hand over care to hospital staff. The prison reduced the level of escort to one, the minimum possible, about nine hours after Mr Burton arrived. The deputy governor told us that the remaining officer stayed in the family room outside the intensive care unit. (Release on temporary licence, which would have allowed no escort, was not possible as although Mr Burton had been convicted, he had not yet been sentenced.)
113. The deputy governor said he did not speak to Mr Burton's family himself. However, he said that the duty governor had told him that Mr Burton's family had asked her what would happen if Mr Burton died. She had then said that the prison would contribute towards the funeral costs. We understand that this might have been upsetting for Mr Burton's family, and sympathise with them, but we cannot judge whether this was inappropriate, without a full awareness of the context.

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