Prisons & Probation Ombudsman
Independent Investigations

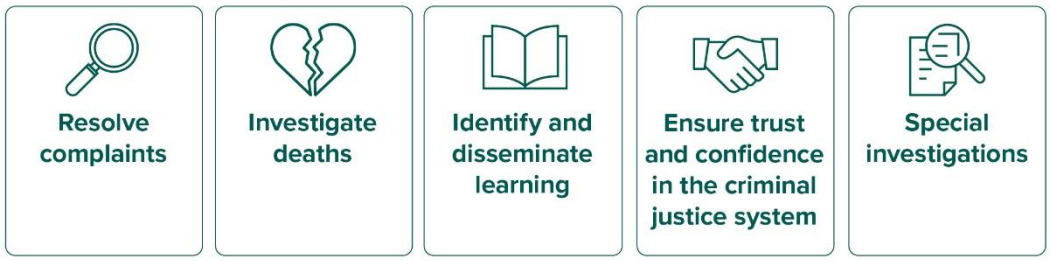
Independent investigation into the death of Mr Daniel Ayers, a prisoner at HMP Winchester, on 25 July 2021

A report by the Prisons and Probation Ombudsman

OUR VISION

To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.

WHAT WE DO



WHAT WE VALUE

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.

If my office is to best assist His Majesty's Prison and Probation Service (HMPPS) in ensuring the standard of care received by those within service remit is appropriate, our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.

Mr Daniel Ayers was found hanged in his cell at HMP Winchester on 25 July 2021. He was 43 years old. I offer my condolences to Mr Ayers' family and friends.

Mr Ayers arrived at Winchester on 30 June 2021. He had schizophrenia and a history of suicide attempts and substance misuse. I am concerned that Mr Ayers' risk of suicide and self-harm was not properly assessed by reception staff when he arrived at Winchester. I am also concerned that no one considered starting suicide and self-harm monitoring (known as ACCT) when Mr Ayers' presentation deteriorated a week or so after he arrived.

The clinical reviewer found that the clinical care Mr Ayers received at Winchester was not equivalent to that he could have expected to receive in the community. Despite Mr Ayers' diagnosis of a severe and enduring mental illness, and staff referring him for a mental health assessment four times, he was never assessed while at Winchester.

The clinical reviewer was also concerned about the management of Mr Ayers' medication. He did not receive any antipsychotic or antidepressant medication at Winchester, despite being on this medication in the community. Also, his benzodiazepine dose was reduced during his time at Winchester, without proper discussion with Mr Ayers or knowledge of the potential impact this may have based on his history in the community.

The night before Mr Ayers died, an officer signed to say that the evening roll check had been completed when CCTV footage shows it was not. Subsequent roll checks were completed as scheduled but I am nevertheless concerned that staff falsified the roll check record.

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

Adrian Usher
Prisons and Probation Ombudsman **May 2023**

Contents

Summary 1

The Investigation Process.....4

Background Information.....5

Key Events.....6

Findings 11

Summary

Events

1. On 30 June 2021, Mr Daniel Ayers was remanded in prison custody, charged with threatening a police officer with an imitation firearm, and sent to HMP Winchester.

2. Mr Ayers had schizophrenia and a history of substance misuse. He had also attempted suicide in 2003 and 2018. The reception nurse referred Mr Ayers for a mental health assessment and to the prison's substance misuse team.

3. Mr Ayers was prescribed multiple medications in the community, including methadone (a heroin substitute), antidepressants, antipsychotics, diazepam (a sedative) and pain relief. Staff recognised that the combination of drugs was risky alongside methadone, so they only prescribed that and the diazepam, which they reduced each week.

4. From 9 July, staff noted a deterioration in Mr Ayers' behaviour. He became more withdrawn and dishevelled and wore only a blanket. On 11 July, a substance misuse nurse became concerned about Mr Ayers and asked a mental health nurse to see him, but this did not happen.

5. On 22 July, members of the healthcare team met and recorded that they would expedite a mental health review for Mr Ayers. He was subsequently sent an appointment for 27 July.

6. On the evening of 24 July, an officer signed to say that she had completed a roll check at 8.30pm but CCTV shows that neither she, nor any of her colleagues, completed the check. A roll check was carried out later that evening and there were no concerns.

7. Shortly after 6.00am on 25 July, during the early morning roll check, an operational support grade (OSG) found Mr Ayers hanging from the light fitting in his cell. She called a medical emergency code blue at 6.02am, and nearby staff arrived at the scene within seconds. The control room called an ambulance at 6.05am.

8. Staff carried out CPR until ambulance paramedics arrived. When the paramedics arrived, they assessed that Mr Ayers had rigor mortis (stiffening of the body after death) and instructed staff to stop CPR. They declared Mr Ayers dead at 6.18am.

Findings

9. We are concerned that reception staff did not properly assess Mr Ayers' risk of suicide and self-harm when he arrived at Winchester. Paperwork was not completed properly and, crucially, staff did not consider the digital PER which flagged Mr Ayers' risk of suicide and self-harm. We are also concerned that no one considered starting suicide and self-harm monitoring (known as ACCT) when Mr Ayers' presentation started deteriorating a week or so after he arrived.

10. The clinical reviewer found that the care Mr Ayers received at Winchester was not equivalent to that he could have expected to receive in the community. He was not

assessed by mental health staff despite several referrals, which were closed by the same nurse without any action having been taken.

11. Staff identified that the combination of medications Mr Ayers was prescribed in the community was risky. However, they stopped various medications without ever trying to establish why he had been prescribed them. As a result, Mr Ayers was not given any antipsychotic or antidepressant medication during his time at Winchester. His diazepam dose was reduced without any discussion with him or consideration of the potential impact this would have, given that he had told the community mental health team that he would 'end up under a train' if they reduced it.

12. We are concerned that the night before Mr Ayers' death, an officer signed for a roll check she had not carried out, and that she routinely signed for checks that she thought other people had completed.

13. There was a delay of three minutes between the code blue and calling an ambulance. It made no difference in this case as Mr Ayers was dead when found, but any delay could be critical in a future emergency.

14. Staff should not have started CPR, as Mr Ayers was clearly dead when found.

15. Not all staff thought they had received adequate support after Mr Ayers' death.

Recommendations

- The Governor and Head of Healthcare should ensure that staff:
    - consider all information that arrives with the prisoner, including both the paper and digital version of the Person Escort Record.
    - record the information they have considered that is relevant to the risk of suicide and self-harm and their full reasoning if they decide not to start ACCT monitoring; and
    - are alert to any deterioration in the prisoner's presentation, particularly those who have a diagnosed mental health condition and/or are undergoing a drug detoxification process and consider ACCT monitoring where appropriate.
- The Head of Healthcare should develop a reporting tool to identify mental health referrals that are closed without action or explanation.
- The healthcare provider and the NHSE quality team should consider whether the behaviour of the nurse who cancelled multiple mental health referrals requires discussion with the appropriate regulator.
- The healthcare provider should ensure there is a GP onsite in line with the primary care service specification for prisons in England.
- The Head of Healthcare should ensure that prescribers consider the full list of a new prisoner's medications and record their reasons for any they do not continue.
- The Head of Healthcare should ensure staff request prisoners' community medical records at the earliest opportunity.

- The Head of Healthcare should ensure that a prisoner's perspective on detoxification is sought and recorded.
- The Head of Healthcare should share this report with the members of healthcare staff who were involved in Mr Ayers' care and discuss the Ombudsman's findings with them.
- The Governor should ensure that staff carry out roll checks at the required times and only sign for them if they have completed them themselves.
- The Governor should ensure that control room staff call an ambulance immediately when a medical emergency code is called.
- The Governor and the Head of Healthcare should ensure that staff are given clear guidance about the circumstances in which resuscitation is inappropriate in line with European Resuscitation Council Guidelines.
- The Governor and Head of Healthcare should ensure that staff are offered appropriate support following a death in custody.

The Investigation Process

16. 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.

17. The investigator interviewed eight members of staff at HMP Winchester between February and June 2022.

18. NHS England commissioned a clinical reviewer to review Mr Ayers' clinical care at the prison. The investigator and clinical reviewer jointly interviewed clinical staff and some custodial staff.

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

20. The Ombudsman's family liaison officer contacted Mr Ayers' next of kin to explain the investigation and to ask if she had any matters, she wanted us to consider. She did not raise any issues but asked for a copy of our report.

21. Mr Ayers' family received a copy of the initial report. They did not raise any further issues but commented on the spelling of Mr Ayers' name which we have amended throughout this final report (from Ayres to Ayers). Interview transcripts and the prison's action plan remain as 'Ayres', as this is how the former were originally sent to staff and the latter is a HMPPS document.

22. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

Background Information

HMP Winchester

23. HMP Winchester is a local men's prison, and holds up to 492 prisoners, including some young adults. Practice Plus Group (PPG) provides physical and mental health services.

HM Inspectorate of Prisons

24. The most recent inspection of HMP Winchester was in January and February 2022. Inspectors reported that levels of self-harm had reduced but remained among the highest of all local prisons. They found that improvements had been made to reception screening to identify prisoners' risk of suicide and self-harm.

25. Inspectors noted that there was one full-time GP in post, who ran five face-to-face clinics and five remote clinics for patient review and administration. There was only a remote GP service available to cover the onsite GP's leave or sickness, which meant that patients were at risk of not being seen.

26. The number of referrals to the mental health team was high, with a quarter of the population being referred each month. At the time of the inspection, there were 33 patients waiting for an initial triage assessment, the longest wait being three weeks and two days, which was too long.

Independent Monitoring Board

27. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report for the year to 31 May 2022, the IMB noted that the number of ACCT documents at Winchester had decreased, as management of 'at risk' prisoners had received attention. They noted, however, that this had not prevented the self-inflicted deaths of two prisoners.

28. The arrival of an interim Head of Healthcare in March and the continuity of other senior post-holders had ensured that stability and cohesion had been maintained. Vacancy levels and recruitment continued to require attention, however, with ongoing reliance on bank and agency staff.

Previous deaths at HMP Winchester

29. Mr Ayers was the eleventh prisoner to die at Winchester since July 2019. Nine of the previous deaths were from natural causes and one was self-inflicted. In two of those investigations, we found that the clinical care the prisoner received at Winchester was not equivalent to that they could have expected to receive in the community.

30. There have been two self-inflicted deaths since Mr Ayers' death. In one of those investigations, we found that staff did not properly assess the prisoner's risk of suicide and self-harm when they arrived at Winchester. We are still investigating the other death.

Key Events

31. On 30 June 2021, Mr Daniel Ayers was remanded in prison custody, charged with threatening police officers with an imitation firearm. He was sent to HMP Winchester. It was not his first time in prison, though he had not been in prison for 20 years.

32. The paper version of Mr Ayers' Person Escort Record (PER – a form that accompanies prisoners between police custody, courts and prisons which sets out the risks they pose) noted that Mr Ayers had attempted suicide on railway tracks in 2003 and 2018, but neither police nor court staff had completed the suicide and self-harm warning form which sets out the current perceived risk of suicide and self-harm. The digital version of the PER said that Mr Ayers was at risk of suicide and self-harm.

33. An officer carried out Mr Ayers' reception screen and noted that he presented well, was prescribed methadone (a heroin substitute) and that he was schizophrenic. The reception check sheet was signed by the officer, but none of the screening questions had been answered on the form. We do not know if the officer considered either versions of the PER as he has left the Prison Service and did not respond to attempts to contact him.

34. A nurse carried out Mr Ayers' reception health screen. She noted that Mr Ayers had a history of substance misuse and mental health issues including schizophrenia and psychosis. He said he did not engage with community mental health services because he did not get on with mental health workers. She noted that Mr Ayers had attempted suicide in 2003 and 2018 but had no current thoughts of suicide or self-harm. She made a referral to the mental health team and to substance misuse services (SMS). She also made a referral to the dentist, as Mr Ayers said he had problems with his teeth.

35. At interview, the nurse said she had seen the paper PER but could not remember if she had seen the digital PER. She said that digital PERs were relatively new at the time, and she thought she was more likely to have relied on the paper form. She said that, although she had some concerns about Mr Ayers, she was not sufficiently concerned to begin suicide and self-harm monitoring procedures (known as ACCT).

36. A nurse prescriber with SMS carried out a substance misuse assessment. He noted that Mr Ayers was on a methadone maintenance programme and took a range of prescribed medication for his mental health issues and arthritis.

37. The nurse considered that Mr Ayers' community prescription for dihydrocodeine (an opioid painkiller) and zopiclone (sleeping tablet) was inappropriate given his high methadone dose and prescription for diazepam (a benzodiazepine, a sedative), as it carried a risk of respiratory depression. He continued the methadone dose and prescribed diazepam at 30mg for seven days, to be reduced by 5mg each week. He noted that Mr Ayers' community prescription should be discussed with the prison GP. (There was no GP on site as she was on leave and another doctor was covering remotely.) He advised that Mr Ayers should be monitored daily for withdrawal symptoms. He noted that Mr Ayers had no thoughts of suicide or self-harm.

38. On 1 July, the remote prescribing GP reviewed Mr Ayers' medical records and noted that his combination of medication was high risk and that the SMS team were managing him appropriately with methadone and diazepam. He made a referral to the mental health team to consider Mr Ayers' need for quetiapine (an antipsychotic) and mirtazapine (an antidepressant), both of which he was prescribed in the community. He did not specify why the rest of Mr Ayers' community medications, omeprazole (used to treat heartburn), meloxicam (used to treat arthritis) and zolmitriptan (used to treat migraines), were not prescribed.

39. On 2 July, a member of the psychosocial support team noted that Mr Ayers had completed a full assessment with the substance misuse team and would be working directly with him. He noted that Mr Ayers did not seem too low in mood and was talking about the future. He recorded that he had mild concerns about Mr Ayers' risk of deliberate self-harm.

40. He made a referral to the mental health team and said that Mr Ayers had schizophrenia, struggled to engage with the community mental health team and was prescribed quetiapine and mirtazapine.

41. On 2 July, a nurse carried out observations on Mr Ayers. She noted that he had a swollen cheek and he said he had recently been taking antibiotics for a dental abscess. She sent a task asking a nurse to review Mr Ayers.

42. On 2 July, a nurse carried out the secondary health screen. He gave Mr Ayers two doses of ibuprofen but did not record why (probably for dental pain).

43. On 3 July, a mental health nurse closed the remote prescribing GP's mental health referral task noting the status as 'completed'. She also closed the referral made by the member of the psychosocial support team. Neither task had been completed and Mr Ayers had not had a mental health assessment.

44. On 3 July, a prison paramedic saw Mr Ayers, as he had told staff his jaw was tender and swollen and he thought he had an abscess. He said he had already applied to see the dentist. The paramedic sent a task asking for the dentist to see Mr Ayers at the next available slot. He also asked the nurse prescriber if he could prescribe antibiotics, but the nurse could only prescribe for SMS purposes. The paramedic also called HMP Bullingdon and left messages asking if they could provide antibiotics, as it would be a week before Winchester could get any.

45. On 4 July, a nurse noted she had not asked Mr Ayers if he would like his COVID-19 vaccination, as he was suffering from a nasty tooth infection.

46. On 4 July, a nurse saw Mr Ayers and noted considerable swelling on one side of his face. She gave him pain relief.

47. On 5 July, a dental nurse saw Mr Ayers by looking through the hatch in his cell door. She noted that she saw no evidence of infection and discussed a plan for prescribing painkillers with him, which he seemed happy with. She noted that he appeared 'distressed mentally' and was 'holding his head and ears'. She also recorded that she could not see any swelling and noted his dental referral as for no further action. She did not record whether she considered raising his mental distress with the mental health team.

48. On 7 July, Mr Ayers asked a nurse for quetiapine. The nurse told him to complete a request to see the mental health team.

49. On 8 July, the prison GP recorded that Mr Ayers' inappropriate prescribing in the community had been discussed at a multi-disciplinary team meeting (MDT). However, there was no record of any plan as a result.

50. On 9 July, a nurse noted Mr Ayers had demonstrated 'weird behaviour' when she gave him his medication. He came to the cell door to collect his medication and then returned to bed without saying anything and covered himself in a blanket. She checked the records and saw a mental health referral was made on 2 July. She sent a follow-up task setting out what she had observed and drawing attention to the previous task.

51. A nurse responded to the task the same day, saying she would see Mr Ayers either that day or the next day. She closed the task, but there is nothing in the medical record to suggest she saw Mr Ayers.

52. On 11 July, an officer noted that Mr Ayers' behaviour was bizarre. His presentation was 'flat' and even though he had been given fresh clothes, he was only wearing his blanket wrapped around him. He was not collecting food left at his door and the officer considered that he needed to be monitored to check he was eating. He initially refused to take his medication, but a SMS nurse eventually persuaded him to.

53. A nurse noted that Mr Ayers was sitting on the floor covered in a blanket, facing away from the door. He responded the third time the nurse called him and declined his medication but did not seem able to give a reason and just stared blankly. When the nurse explained it was diazepam, he took it and asked to see a chaplain.

54. The nurse noted the cell was dirty and messy and Mr Ayers looked dishevelled. He passed Mr Ayers' request to a wing officer and recorded that he had noted his presentation in the wing's observation book. The nurse also noted that he verbally asked the duty mental health nurse (unnamed) to review Mr Ayers and added him to the detox nurse's overnight checklist. The wing officer told the investigator he would have contacted the chaplain.

55. On 13 July, a nurse noted that Mr Ayers appeared mentally unwell, covering his face and grunting when she gave him his medication. She asked him if he was in pain, but he shook his head and went back to his cell. There is no record of whether she took any further action.

56. On 14 July, an unknown member of the mental health team noted: 'No access visit for Mental Health appointment with Mental Health A. Home visit – no reply'. We were not able to establish what this entry really meant but considered it most likely that it related to the COVID-19 restrictions in place at Winchester at the time.

57. On 16 July, Mr Ayers was moved from C Wing to B Wing.

58. On 20 July, the clinical lead for mental health reviewed Mr Ayers' record because he had been flagged as being under the Care Programme Approach (CPA – a package of care for people with mental health problems). She had access to the discharge letter from the community mental health team dated 10 May which said that Mr Ayers' mood was better when he was taking antipsychotic medication. A

nurse recorded that antipsychotic medication had been decreased and stopped in the community. This was not correct. Olanzapine had been stopped but not quetiapine (although it was suggested this could be reduced). Nurse Hopkin recorded there was a plan to triage Mr Ayers, but she did not take any further action.

59. The same day, an entry by the mental health team noted: 'No access visit for Mental Health appointment with Mental Health A. Home visit - no reply'.

60. On 21 July, a member of the mental health team noted, 'Due to increase in covid positive people on the wing, access to the wing is limited so unable to be seen in person for triage. Attempted to complete a telephone triage to in cell phone however no answer/line unobtainable. Will remain on triage list and be reviewed at earliest opportunity.'

61. On 22 July, the prison GP noted that an MDT meeting had taken place. The Head of Healthcare, a member of the substance misuse team, the mental health lead and the primary care lead attended. The GP noted that the SMS cover said Mr Ayers was tolerating his detox well, but they were concerned about his mental health. They planned to slow the diazepam withdrawal when he got down to 10mgs. They found him very vacant and distracted but there was no evidence he was using other substances. The GP noted that a nurse would 'expedite' a mental health review. (It is not clear that the discharge letter from the community mental health team formed part of discussions, particularly Mr Ayers' statement that he would harm himself if diazepam was stopped or the improvement in his mood when he was taking antipsychotic medication.)

62. On the same day, the mental health team sent Mr Ayers an appointment letter for 27 July for a mental health review. The nurse told the clinical reviewer that the term 'expedite' had been discussed after Mr Ayers' death and considered vague. In future, the team had agreed it would be better to be specific about time frames.

Events of 24 and 25 July

63. On 24 July, an officer signed the roll check (when a member of staff checks and counts each prisoner) record to say that a roll check had been completed at 8.30pm. However, CCTV shows that neither she nor any of her colleagues had carried out a roll check at that time.

64. At approximately 9.00pm, an Operational Support Grade (OSG) carried out the last evening roll check. Mr Ayers was in his cell, and she had no concerns. Mr Ayers did not press his cell bell during the night.

65. At around 6.00am on 25 July, the OSG started the morning roll checks. When she got to Mr Ayers' cell, she saw that he was hanging from the light fitting using a ligature made from ripped bedding. She called a code blue (a medical emergency code used when a prisoner is unconscious or having breathing difficulties). Several colleagues who were nearby arrived within 14 seconds and went into the cell.

66. An officer was one of the officers who responded. He went into the cell, cut down Mr Ayers and started CPR. More staff assisted. According to a Custodial Manager's statement, he and an officer thought Mr Ayers was dead, but they continued with CPR.

67. A nurse attended within four minutes of the OSG calling the code. Another nurse followed shortly afterwards, after she had finished locking medication away. A nurse attached the defibrillator and, at interview, said on two occasions it advised a shock, although no one else remembers this and he did not put this in the medical record. His medical record entry described Mr Ayers as pale and stiff. He did not discuss Mr Ayers' presentation with his colleague, who went to get the clinical record.

68. The control room log shows that the code blue was called at 6.02am and an officer called an ambulance three minutes later at 6.05am. The emergency service's log shows they received the call at 6.06am.

69. At 6.12am, the ambulance arrived at the prison and paramedics were at Mr Ayers' cell by 6.16am. They concluded that Mr Ayers' body showed signs of rigor mortis and advised staff to stop CPR. At 6.18am, they pronounced Mr Ayers dead.

Contact with Mr Ayers' family.

70. On 25 July, the prison appointed a family liaison officer. He telephoned Mr Ayers' named nest of kin that day to break the news.

71. Mr Ayers' funeral was on 1 September 2021. The prison contributed to the costs in line with national policy.

Support for prisoners and staff

72. After Mr Ayers' death, a senior 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. The OSG said that she felt officers had received better aftercare than her, and that while they were offered the opportunity to be relieved of their duties, she was not.

73. The prison posted notices informing other prisoners of Mr Ayers' 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 Ayers' death.

Post-mortem report

74. The post-mortem report concluded that the cause of Mr Ayers' death was hanging by ligature. The toxicology tests found evidence of benzodiazepine and methadone in his system, in line with his prescribed medications.

Findings

Assessing Mr Ayers' risk of suicide and self-harm

Reception

75. Prison Service Instruction (PSI) 64/2011, Management of prisoners at risk from self, from others and to others (Safer Custody) requires that all staff who have contact with prisoners are aware of the risk factors and triggers that might increase the risk of suicide and self-harm. Any prisoner identified as at risk of suicide and self-harm must be managed under ACCT procedures. PSI 64/2011 lists potential risk factors and triggers.

76. PSI 07/2015, Early Days in Custody, states that reception staff must examine the PER and any other available information and assess prisoners' risk of suicide and self-harm.

77. We are concerned that Mr Ayers' risk of suicide and self-harm was not properly assessed when he arrived at Winchester. An officer did not complete the reception checklist, and his NOMIS entry made no mention of Mr Ayers' history of suicide attempts or of the suicide and self-harm risk marker on the digital PER. The officer has since left the Prison Service, so we were unable to interview him.

78. The reception nurse was unable to recall if she had seen the digital PER but said she had seen the paper PER so was aware of Mr Ayers' previous suicide attempts. Neither the officer nor the nurse recorded that they had considered ACCT monitoring.

Post-reception

79. On 11 July, Mr Ayers initially refused to take his diazepam until a nurse persuaded him to take it. The nurse noted that Mr Ayers' engagement and eye contact was poor, he was dishevelled and was withdrawn. He recorded that he had asked the duty mental health nurse to see Mr Ayers, but he did not record the name of the nurse he spoke to. He also recorded that he had asked SMS staff to review Mr Ayers overnight (there is no record that they did). While the clinical reviewer noted that the nurse had apparently tried to escalate his concerns, there was no record that he had considered starting ACCT monitoring. The clinical reviewer considered that as Mr Ayers had an enduring mental illness, was not receiving his antipsychotic and antidepressant medication and was in a neglected and withdrawn state, the nurse should have considered ACCT monitoring.

80. On 13 July, a nurse noted that Mr Ayers seemed mentally unwell as he was grunting and covering his face. She had already chased up a mental health referral four days previously and may have thought this had already been organised, but this incident on 13 July was another missed opportunity to consider mental health intervention and ACCT monitoring. We recommend:

The Governor and Head of Healthcare should ensure that staff:

- **consider all information that arrives with the prisoner, including both the paper and digital version of the Person Escort Record;**

- **record the information they have considered that is relevant to the risk of suicide and self-harm and their full reasoning if they decide not to start ACCT monitoring; and**
- **are alert to any deterioration in the prisoner's presentation, particularly those who have a diagnosed mental health condition and/or are undergoing a drug detoxification process and consider ACCT monitoring where appropriate.**

Clinical care

81. The clinical reviewer found that the care provided to Mr Ayers at HMP Winchester was not equivalent to that he could have expected to receive in the community. There were multiple failings.

Mental health care

82. Despite staff referring Mr Ayers (who had a known diagnosis of schizophrenia) for a mental health assessment on four occasions between 30 June and 9 July, he was never assessed at Winchester. A nurse closed the referrals despite no action having been taken. The investigator and clinical reviewer were unable to speak to the nurse as she was no longer employed by the prison.

83. We are concerned that there was no safety net in place to provide oversight of the circumstances in which referrals were closed. We recommend:

    The Head of Healthcare should develop a reporting tool to identify mental health referrals that are closed without action or explanation.

    The healthcare provider and the NHSE quality team should consider whether the behaviour of the nurse who cancelled multiple mental health referrals requires discussion with the appropriate regulator.

84. Attempts to see Mr Ayers on 14, 20 and 21 July were unsuccessful, apparently due to COVID restrictions. And, despite staff agreeing on 22 July that they would expedite a mental health review, Mr Ayers was given an appointment for 27 July. The mental health team have accepted that 'expedite' was too vague and a more specific timescale should have been agreed.

Medication

85. Staff recognised quickly that Mr Ayers was prescribed a dangerous combination of drugs in the community. However, there was no onsite GP available at the prison when Mr Ayers arrived who could have spoken to Mr Ayers and his community GP and made a decision about continuing his current medication regime. At interview, the prison GP said that whenever she was on leave, getting GP cover was extremely difficult however much notice she provided.

86. The offsite regional medical lead was covering for the prison GP, and he requested the mental health team and the complex care team carry out a review before any more medication was prescribed. However, his message was not sufficiently detailed, and was not followed up with a specific task to the prison GP, or a face-to

face review or discussion with other members of the team. There is no written record of any detailed discussion with Mr Ayers about his medication. There is also no record to suggest his full GP record was requested before 17 July. As a result, Mr Ayers did not receive any antipsychotic or antidepressant medication at all while he was at Winchester, despite being used to significant doses in the community.

87. The clinical reviewer also noted that in the past, Mr Ayers had been very sensitive to benzodiazepine (diazepam) withdrawal. He had refused to engage with the community mental health team for fear they would reduce it and told them he would 'end up under a train' if they did. While reducing his benzodiazepine dose was good practice, it was done without talking to him in detail about it and without any knowledge of his past concerns about it. We make the following recommendations:

The healthcare provider should ensure there is a GP onsite in line with the primary care service specification for prisons in England.

The Head of Healthcare should ensure that prescribers consider the full list of a new prisoner's medications and record their reasons for any they do not continue.

The Head of Healthcare should ensure staff request prisoners' community medical records at the earliest opportunity.

The Head of Healthcare should ensure that a prisoner's perspective on detoxification is sought and recorded.

Dental care

88. Mr Ayers was clearly experiencing dental pain and facial swelling while he was at Winchester. The clinical reviewer is not satisfied that staff followed this up in line with good practice or the requirements of the dental contract.

89. It is unlikely that the dental nurse who assessed Mr Ayers through the hatch in his cell door could have carried out a proper examination in this way and while the regime at the time may have prevented anything more thorough, she should not have closed down the referral, particularly in the light of facial swelling that staff themselves had noted. While we do not make a specific recommendation, this is another incident which staff should reflect on.

Learning from this investigation

90. We consider it is important for staff to learn the lessons from this investigation. We recommend:

The Head of Healthcare should share this report with the members of healthcare staff who were involved in Mr Ayers' care and discuss the Ombudsman's findings with them.

Roll checks

91. On 24 July, the night before Mr Ayers hanged himself, an officer recorded that she carried out a roll check at 8.30pm. The investigator watched the CCTV and could see no evidence of anyone doing a check at this time.

92. At interview, the officer said she would not sign for a check that had not been completed, and that although the roll check sheet had a pre-typed time of 8.30pm, in practice, staff carried out the checks at around 7.30pm to ensure there was enough time to get them done before night staff came on duty.

93. The officer said that sometimes whoever she was on duty with would do the checks instead of her, but she would sign for it. She could not remember who she was on duty with that night. The investigator re-checked the CCTV footage and there was no sign of anyone completing the check that she had signed for.

94. It is unacceptable that the officer regarded it normal practice to sign for a check that she herself had not done. The issue of the missed check alone was picked up by the prison's Early Learning Review, so the investigator contacted the Governor to find out how he had responded to the review's findings. He did not reply.

95. Two further roll checks were carried out properly by the OSG after the missed check, so the officer's error did not affect the outcome for Mr Ayers. However, we are concerned that a roll check was missed, and the record was falsified to show it had been done when it had not. We recommend:

The Governor should ensure that staff carry out roll checks at the required times and only sign for them if they have completed them themselves.

Emergency Response

96. PSI 3/2013, Medical Emergency Codes, says that the control room must call an ambulance immediately when a medical emergency code is called.

97. An officer was on duty in the control room on the morning of 25 July when staff called the code blue after finding Mr Ayers hanging. The control room log shows that he waited three minutes before calling an ambulance. We were unable to interview him, as he had left the Prison Service. We recommend:

The Governor should ensure that control room staff call an ambulance immediately when a medical emergency code is called.

98. Resuscitation Council Guidelines say that resuscitation should not be attempted when there is clear evidence that it would be futile. Trying to resuscitate someone who is clearly dead is distressing for the people involved and undignified for the deceased.

99. Mr Ayers had rigor mortis when he was found, so had clearly been dead for some time. When interviewed, a nurse maintained that it might have been possible to resuscitate Mr Ayers. He said that the defibrillator had advised 'shock' on two occasions, but he did not note this in his record at the time and no one else at the scene recalled this. He was interviewed many months after the event, and it is likely he has misremembered this. We recommend:

The Governor and the Head of Healthcare should ensure that staff are given clear guidance about the circumstances in which resuscitation is inappropriate in line with European Resuscitation Council Guidelines.

Staff Support

100. Not all staff considered they were offered appropriate support after Mr Ayers' death. We recommend:

The Governor and Head of Healthcare should ensure that staff are offered appropriate support following a death in custody.

Inquest

101. The inquest, held on 27 January 2025, concluded that Mr Ayers died by suicide. However, the jury found that the cessation of his long-term medication and antipsychotic and antidepressant drugs, along with his inability to receive any quality of mental health care in prison, contributed to his death. This was exacerbated by the infection control measures and the reduced staffing levels imposed by COVID.

Prisons & Probation Ombudsman
Independent Investigations

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T I 020 7633 4100