Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Craig Steadman, a prisoner at HMP Winchester, on 27 February 2022

A report by the Prisons and Probation Ombudsman

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

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

T l 020 7633 4100

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.

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 Craig Steadman died after he was found hanged in his cell at HMP Winchester on 27 February 2022. He was 32 years old. I offer my condolences to his family and friends.

Mr Steadman had been at Winchester for just over six weeks when he died. I am concerned that staff did not properly assess his risk of suicide and self-harm when he arrived at the prison. This meant that they missed an opportunity to identify at the start of his time in prison that Mr Steadman was at increased risk of suicide and self-harm. In addition, significant information about Mr Steadman's prescribed antipsychotic medication was not shared with the mental health team in a timely manner.

During his stay at Winchester, Mr Steadman was monitored under suicide and self-harm prevention procedures (known as ACCT) on two occasions. There were deficiencies in the way prison staff managed Mr Steadman's first period of ACCT procedures and were closed prematurely. On the night that Mr Steadman died, staff did not complete ACCT observations at the required frequency.

I am also concerned that staff did not use an emergency code when Mr Steadman was first discovered hanging, though this was unlikely to have affected the outcome for him.

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

Kimberley Bingham
Acting Prisons and Probation Ombudsman **April 2023**

Contents

Summary

Events

1. On 13 January 2022, Mr Craig Steadman was recalled and remanded to HMP Winchester. He had breached the terms of his licence. At the time, Mr Steadman had been prescribed antipsychotic medication and antidepressants in the community.

2. Mr Steadman arrived at Winchester with both a paper and electronic version of his Person Escort Record (PER, a document that sets out a prisoner's risks). Only the electronic version of the PER had a suicide and self-harm warning for Mr Steadman. It said that Mr Steadman had harmed himself several years ago and was taking unspecified medication. Reception staff did not record Mr Steadman's risks during their assessments and did not consider whether they needed to start suicide and self-harm monitoring (known as ACCT).

3. The next day, a pharmacy technician noted that Mr Steadman had been prescribed antipsychotic medication in the community. This was not recorded on the PER and Mr Steadman had not told healthcare staff about this prescription during his reception screen. Mr Steadman was re-prescribed the medication, but this information was not shared with the mental health team and he was not referred to them.

4. On 17 January, staff started ACCT procedures after Mr Steadman deliberately took an overdose of insulin. They stopped ACCT monitoring the next day.

5. At around 5.25pm on 26 February, staff started ACCT procedures after Mr Steadman made cuts to his arms and neck. He said that he felt trapped and struggled with spending so much time in his cell. Staff set a minimum of two ACCT observations per hour. The night patrol officer completed observations at 11.20pm and 12.05am.

6. At around 12.44am on 27 February, while completing an ACCT observation, the night patrol officer found Mr Steadman hanging in his cell. They radioed for assistance. Other staff responded quickly and called a medical emergency code blue. Staff tried to resuscitate Mr Steadman until paramedics arrived and took over. They were unable to resuscitate him and confirmed that he had died.

Findings

Identifying the risk of suicide and self-harm

7. Mr Steadman's risk of suicide and self-harm was not properly assessed when he arrived at Winchester. Staff failed to consider information on the electronic PER and from other important sources.

8. When ACCT procedures were opened on 17 January, they were closed after just 15 hours. We consider that this was premature. Given Mr Steadman's risk factors, this was an inadequate amount of time for staff to monitor and assess his risk.

There were also outstanding actions in Mr Steadman's support plan that had not been completed before ACCT monitoring stopped.

9. The officer who started ACCT monitoring on 27 February was unsure of the correct procedures to follow, and the set observations were not properly completed in the time immediately before Mr Steadman's death.

Emergency response

10. The night patrol officer who discovered Mr Steadman hanging in his cell did not immediately call a medical emergency code blue.

11. Staff failed to write incident statements after Mr Steadman's death, which was not in line with national instructions.

Clinical care

12. The clinical reviewer found that the clinical care extended to Mr Steadman was equivalent to that which he could have expected to receive in the wider community. However, when a pharmacy technician discovered that Mr Steadman was prescribed antipsychotic medication in the community, this information was not shared with the mental health team. This led to a delay in Mr Steadman being added to the mental health team's caseload.

Recommendations

- The Governor and Head of Healthcare should ensure that all staff have a clear understanding of their responsibilities to identify prisoners at risk of suicide and self-harm in line with national guidelines and, in particular, the need to record, share and consider all relevant information about risk, and start ACCT procedures when indicated.

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

    - ACCT monitoring does not stop until all support actions have been completed and their risk is no longer considered raised;

    - post-closure reviews consider the support actions and progress made since the ACCT was closed;

    - observations are carried out as directed; and

    - all staff in contact with prisoners receive appropriate ACCT training in line with PSI 64/2011.

- The Governor should ensure that all prison staff understand their responsibilities during a medical emergency, including that staff use an emergency code promptly to communicate the nature of the emergency.

- The Governor should ensure that staff directly involved in a death in custody complete incident statements as soon as possible after a death.

- The Head of Healthcare should ensure that staff refer newly arrived prisoners who are taking antipsychotic medication to the mental health team for assessment.

The Investigation Process

13. 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.

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

15. NHS England commissioned a clinical reviewer to review Mr Steadman's clinical care at the prison.

16. The investigator and clinical reviewer jointly interviewed eight members of prison staff in person at Winchester. Three additional staff were interviewed by telephone.

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

18. The Ombudsman's family liaison officer wrote to Mr Steadman's mother to explain the investigation. She wanted to know the circumstances leading to Mr Steadman's death and asked:

    - What type of cell did Mr Steadman live in?
    - Was Mr Steadman being monitored under suicide and self-harm procedures?
    - Had Mr Steadman given any indication that he intended to take his life in telephone calls he made?
    - What medication was Mr Steadman prescribed and could this have affected his mood?

19. Mr Steadman's family received a copy of the initial report. The solicitor representing them did not make any comments.

20. The initial report was shared with HM Prison and Probation Service (HMPPS). They found no factual inaccuracies in the report and accepted all recommendations.

Background Information

HMP Winchester

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

HM Inspectorate of Prisons

22. The most recent inspection of HMP Winchester was on 31 January 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. Inspectors reported that the ACCT documents they reviewed were of a mixed standard, although they identified some impressive examples of care for prisoners in crisis.

23. Inspectors also found that most prisoners were locked in their cells for 22.5 hours a day, and even longer at the weekend. The prison had struggled to recruit and retain enough staff and this problem was affecting the day-to-day running of the prison, where at times, there were simply not enough officers to ensure even the most basic regime for prisoners.

Independent Monitoring Board

24. 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 2021, the IMB reported that improvement had been at a slower pace as the regime and management of HMP Winchester had been dominated by the COVID-19 pandemic. Time out of cell and meaningful activity had been particularly negatively affected. The prison continued to experience very high levels of violence. The continued impact of new arrivals with mental health issues and a history of self-harm exacerbated the strain on safety, creating the underlying volatile atmosphere on the main wings. Focused attention on improving ACCT procedures had seen a reduction in the number of prisoners needing to be monitored.

Previous deaths at HMP Winchester

25. Mr Steadman was the third prisoner to take his life at Winchester since January 2020. Following the death of a prisoner in May 2020, we made recommendations about the way staff managed ACCT procedures.

Assessment, Care in Custody and Teamwork

26. ACCT is the Prison Service care-planning system used to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk, how to reduce the risk and how best to monitor and supervise the prisoner. After an initial assessment of the prisoner's main concerns, levels of supervision and

interactions are set according to the perceived risk of harm. Checks should be carried out at irregular intervals to prevent the prisoner anticipating when they will occur. Regular multidisciplinary review meetings involving the prisoner should be held.

27. As part of the process, a care plan (a plan of care, support and intervention) is put in place. The ACCT plan should not be closed until all the actions of the care plan have been completed. All decisions made as part of the ACCT process and any relevant observations about the prisoner should be written in the ACCT booklet, which accompanies the prisoner as they move around the prison. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011 on safer custody.

Key Events

Background

28. Mr Craig Steadman had a history of suicidal ideation and self-harm. He had been monitored several times in prison under suicide and self-harm prevention procedures, known as ACCT, most recently in July 2021. He also had a history of drug overdose while in custody. Mr Steadman had schizophrenia, obsessive compulsive disorder and a general personality disorder. He had previously been admitted to a psychiatric hospital (2007) and was under the care of the community mental health team.

29. On 7 January 2022, Mr Steadman was released from HMP Exeter, having served a sentence for several counts of indecent exposure.

HMP Winchester

30. On 13 January, Mr Steadman was arrested, recalled to prison and sent to HMP Winchester. He had breached the terms of his licence due to inappropriate behaviour towards women and his use of illicit substances.

31. When he arrived at Winchester, Mr Steadman's paper Person Escort Record (PER) was blank, apart from the 'History and Record of Events' page and escort handover details. There were no risk indicators shown. However, there was also an electronic PER which the police had completed. The front of the form noted that Mr Steadman had been recalled to custody and arrived with medication (no details of the medication were given). The form said that Mr Steadman had a history of self-harm (by injecting and use of ligatures) and had last harmed himself in 2014. The form noted that Mr Steadman had a history of concealing drugs.

32. An officer noted during Mr Steadman's reception interview that he had checked Mr Steadman's PER. The officer recorded, "No issues". He noted that Mr Steadman had been in custody before, had no substance misuse problems, no thoughts of suicide or self-harm and no mental health problems. He did not record that Mr Steadman had been recalled to prison.

33. A nurse completed Mr Steadman's healthcare reception screen. Mr Steadman said that he was a Type 1 diabetic and received insulin injections. He arrived with an insulin pen and sertraline (an antidepressant). He said that he did not need any alcohol intervention support and that he had no mental health problems. He said that he was "fed up" but had no thoughts of suicide or self-harm. Mr Steadman denied that he had any history of attempted suicide or self-harm or that he had spent time in a psychiatric hospital. The nurse noted Mr Steadman's history of substance misuse, including heroin, cocaine, cannabis, psychoactive substances (PS) and crack cocaine. She made an appointment for a nurse to review his diabetes. Mr Steadman was not referred to the mental health team.

34. An officer completed Mr Steadman's first night interview. He recorded that Mr Steadman was diabetic and also noted (incorrectly) that he had no current or historic mental health or self-harm issues.

35. An officer noted that Mr Steadman's first night interview had been completed and no concerns or thoughts of suicide or self-harm were raised. He noted that Mr Steadman had been recalled to prison.

36. An officer assessed that Mr Steadman needed a single cell due to risk and concerns about his sexually inappropriate behaviour. He applied to live on the Vulnerable Prisoners' Unit after his period of induction.

37. On 14 January, Mr Steadman continued with his prison induction and asked for help with his diabetes. An officer relayed this information to the healthcare team.

38. A nurse completed Mr Steadman's secondary health screen. A pharmacy technician also completed a medication reconciliation and confirmed Mr Steadman's community medication with HMP Exeter. Mr Steadman's prescribed medications were recorded as a laxative, insulin and sertraline. He was re-prescribed these drugs and was allowed to keep them in his cell and administer them himself. In addition, the pharmacy technician highlighted that Mr Steadman had been prescribed a depot injection of aripiprazole (an antipsychotic) in the community for his schizophrenia, and that this was administered monthly. This was also re-prescribed. Mr Steadman had not told prison or healthcare staff during his reception screens that he had a mental health diagnosis or that he was prescribed medication for this. There is no evidence that healthcare staff referred him to the mental health team.

39. At around 8.00pm on 17 January, Mr Steadman told staff that he had deliberately taken an overdose of his prescribed insulin. He said that he wanted to die and had harmed himself due to his return to prison and not being able to contact his grandmother. An officer started ACCT procedures. Mr Steadman was admitted to hospital.

40. At 3.40am on 18 January, Mr Steadman discharged himself from hospital and returned to Winchester. He was allocated a cell in the healthcare inpatient unit. Staff set ACCT observations at a minimum of two per hour and referred Mr Steadman to the mental health team.

41. Staff assessed that Mr Steadman would no longer be allowed to keep and administer his medication and would have to attend the medication hatch daily for his insulin to be administered under the supervision of healthcare staff. Staff agreed that when the prison was in patrol state (when all prisoners are locked in their cells such as at night), healthcare staff would check Mr Steadman's blood sugar and administer his insulin at his cell.

42. A mental health nurse reviewed Mr Steadman's medical records. She noted that although it had been recorded that Mr Steadman was prescribed an aripiprazole depot injection, no one had referred him to the mental team following this. A nurse added Mr Steadman to her caseload and arranged to see him, initially on the daily ward round, and then monthly to administer his depot injection.

43. At 9.30am, an officer completed Mr Steadman's ACCT assessment. Mr Steadman said that he had taken an overdose because he was unable to contact his grandmother. He also said that he had substance misuse issues. Mr Steadman said that he felt better, was sorry for his actions and that he no longer had any thoughts of self-harm. The officer referred Mr Steadman to the substance misuse team. Mr

Steadman said that he was unsure if his recall to prison was for 28 days or longer. The officer contacted the Finance/PIN phone clerk to check and add Mr Steadman's family's phone numbers to his account. He noted Mr Steadman's self-harm triggers as having no vapes or contact with his family.

44. A consultant psychiatrist assessed Mr Steadman during the ward round. He noted Mr Steadman's history of psychotic illnesses, with symptoms mainly characterised by paranoia. Mr Steadman displayed no psychotic symptoms. He noted that Mr Steadman's aripiprazole depot medication had controlled his symptoms well and he regarded Mr Steadman's overdose as an acute stress reaction to being recalled to prison. He noted that Mr Steadman appeared to be through the crisis phase, and it was agreed that Mr Steadman could return to the residential wings. He arranged to review Mr Steadman again in three weeks' time.

45. A Custodial Manager (CM) completed the first ACCT case review. An officer and a mental health nurse assisted. He said that he felt much better and had no thoughts of self-harm. He wanted to return to C Wing, where he felt supported by staff and other prisoners. He asked for support from the substance misuse team. Staff offered Mr Steadman distraction packs to use in his cell. The panel agreed to close the ACCT procedures and noted that Mr Steadman would be discharged from the healthcare unit.

46. The CM created an ACCT support plan which identified that Mr Steadman should have regular integration with unit staff, be referred to the substance misuse team (Mr Steadman said that he would submit an application) and check that the finance/PIN clerk had his family contact numbers and that they were loaded onto his PIN phone account. (It was noted that the finance department had been contacted.) The nurse also noted that Mr Steadman's grandmother's phone number had been added to his PIN contacts.

47. A member of the substance misuse team tried to see Mr Steadman, but he was unavailable, and the appointment was rebooked.

48. That day, Mr Steadman was moved to D Wing, the Vulnerable Prisoners' Unit.

49. On 24 January, a nurse administered Mr Steadman's aripiprazole depot injection and noted that he appeared settled. Mr Steadman said that he was okay.

50. On 28 January, a worker from the substance issue interventions team assessed Mr Steadman. He created a care plan for Mr Steadman and gave him substance misuse advice and in-cell workbooks to use in one-to-one sessions.

51. On 30 January, staff completed Mr Steadman's ACCT post-closure review. Mr Steadman said that he was positive about his future.

52. That evening, Mr Steadman refused to have his blood sugar levels reviewed. A nurse noted that he continued to eat sugary foods against medical advice.

53. The next day, the worker from the substance issue interventions team reviewed Mr Steadman, who said that he had no thoughts of self-harm and that he wanted to stop using illicit substances, including PS, in prison. (There were no entries during his time at Winchester to indicate that Mr Steadman was suspected of being under the influence of PS or any other illicit substance.) The worker discussed support options.

54. On 1 February, the psychiatrist reviewed Mr Steadman. Mr Steadman said that he felt much better and had no concerns. He said that he used the gym, had applied for a prison job and was optimistic about his future. Mr Steadman said that he had no thoughts of suicide or self-harm. His next review with the psychiatrist was scheduled for three months' time.

55. On 2 February, Mr Steadman's prison offender manager (POM) introduced herself and discussed his sentencing.

56. On 14 February, the POM told Mr Steadman that she would try to find out where he could be transferred to undertake sexual offending programmes and would update him as soon as possible.

57. On 22 February, a nurse assessed Mr Steadman's antipsychotic medication, and noted that he would continue to receive his monthly injections.

58. That day, the POM noted that she had received an email from the Parole Board, who told her that Mr Steadman had to submit representations towards his parole by 4 March. She told Mr Steadman, who said that he intended to submit representations but had not yet discussed them with his solicitor as he had no PIN phone credit. She agreed to contact his solicitors on his behalf and ask them to contact Mr Steadman.

59. On 24 February, a nurse administered Mr Steadman's aripiprazole depot injection. Mr Steadman told her that he was about to attend a visit from his grandmother. He said that he was eligible for parole in July and hoped that he would be released.

60. On 25 February, security intelligence reports noted that a letter addressed to Mr Steadman, supposedly from his solicitor, was found to contain traces of drugs. There is no record that anyone spoke to Mr Steadman about this.

61. That night, Mr Steadman made two telephone calls (one to his grandmother, the other to a female friend) from his in-cell telephone. In one conversation, he said that he would be released from prison in 16 weeks.

26 February 2022

62. At 10.43am on 26 February, Mr Steadman telephoned his female friend again. He was happy that his friend had planned to visit him. He said that he had been locked up all day due to staff shortages and was bored. He said that he had "tried something" recently but gave no indication what he meant. The call ended when Mr Steadman said that he had run out of phone credit and would call her back later.

63. Due to the regime, most prisoners remained in their cells for the majority of the day. Mr Steadman attended the medication hatch at around 4.00pm. A nurse administered his insulin.

64. CCTV footage shows that staff completed a roll check at around 4.10pm.

65. At 5.25pm, Officer A responded to Mr Steadman's emergency cell bell and spoke to him through his cell door observation panel. At interview, she told us that Mr Steadman's mood was low and he was very despondent. She said that she spoke to him for around 15 minutes. (CCTV footage shows that her conversation lasted about

one minute.) She said that Mr Steadman had not harmed himself at this point. She left his cell, intending to ask a colleague to keep an eye on him and so that she could start ACCT procedures. She told us that she had not received any recent ACCT training and felt that she was not fully proficient in starting ACCT procedures. She therefore had to ask for help.

66. A Supervising Officer (SO) told us that at approximately 5.45pm, he received a telephone call from Officer A, who told him that she was starting ACCT procedures because Mr Steadman had made cuts to his arms. He was not on the wing at the time and went to Mr Steadman's cell.

67. A nurse told us that he received a telephone call from a female officer (from D Wing) and was given similar information. He also went to the wing. At 5.48pm, the nurse arrived at Mr Steadman's cell and spoke to him through his cell door. The prison was in patrol state which meant that Mr Steadman's cell could not be opened without three officers present.

68. A nurse spent around eight minutes at Mr Steadman's cell door. He told us that he could not see any cuts on him, but that Mr Steadman said that he had harmed himself.

69. At 5.56pm, the SO, Officer A and Officer B arrived at the cell. The door was unlocked, and the officers went in. The SO saw that Mr Steadman had made "superficial" cuts to his arm and neck with a razor blade. Mr Steadman said that his mood was low, he felt trapped, struggled with spending so much time in his cell and had suicidal thoughts. The nurse examined Mr Steadman and dressed his wounds.

70. Officer A started ACCT procedures and the SO set ACCT observations at a minimum of two per hour. Prison staff removed the razor blade that Mr Steadman had used. At 6.04pm, all the staff left Mr Steadman's cell.

71. At 6.08pm, Mr Steadman telephoned his female friend but did not tell her that he had harmed himself. He said that he had not done anything that day, had been daydreaming and thinking about escaping. He said that he had received a letter from his solicitor, and he expected to be told his parole date soon. Mr Steadman said that he just wanted to get out of prison. He said that he wanted medication to help him sleep and for anxiety. The call ended with Mr Steadman telling his female friend that he loved her and would speak to her in a few days' time.

72. Officer A noted that she completed ACCT observations at 6.15pm, 6.40pm, 7.05pm, 7.35pm, 8.00pm and 8.20pm. CCTV footage does not show that the first ACCT check was formally completed, and it is likely that this was when staff were in Mr Steadman's cell. When Officer A checked on Mr Steadman at 8.00pm, she talked to him and noted that his mood had improved.

73. At 8.30pm, an Operational Support Grade (OSG) started her duty and received a handover from Officer A. The OSG completed the roll check and ACCT checks on the wing.

74. When the OSG completed her ACCT check on Mr Steadman at 9.00pm, he said that he was okay. Subsequent checks took place at 9.40pm, 10.10pm, 10.45pm,

11.05pm, 11.20pm (when she noted that he appeared asleep) and 12.05am (when he again appeared asleep).

75. At around 10.00pm, a nurse saw Mr Steadman in his cell to administer his insulin and check his blood sugar level. Mr Steadman refused his insulin but allowed the nurse to check his blood sugar level. She told us that Mr Steadman appeared okay and was watching television.

Events of 27 February

76. Just before 12.44am on 27 February, during an ACCT observation, the OSG found Mr Steadman sitting "half on and half off" the bed with "something around his neck". She told us that she was unsure what was around Mr Steadman's neck but thought it might have been part of a bed sheet. She said she was "not 100 per cent sure what [she] was seeing" and therefore radioed for staff "assistance" on D Wing. The prison control room incident log recorded that this occurred at 12.44am. CCTV footage shows that a CM, and two officers arrived at Mr Steadman's cell after one minute and 40 seconds. The control room incident log noted that at 12.45am, wing staff called a medical emergency code blue (which indicates that a prisoner is unconscious or has breathing difficulties) and the control room operator called an ambulance.

77. Officer C unlocked the cell door. The officers went in and found Mr Steadman hanged from a ligature made from a bed sheet that he had tied over the privacy curtain rail. Officer D cut the ligature and Officer C lowered Mr Steadman onto the bed. Other prison staff also responded.

78. A nurse arrived within 23 seconds of the call for assistance and just as the officers had removed the ligature from around Mr Steadman's neck. He radioed for additional healthcare support and for the medical emergency equipment to be brought to the cell. He then checked Mr Steadman for signs of life, but found none, so started cardiopulmonary resuscitation (CPR).

79. After three minutes, another nurse arrived with medical emergency equipment. Officer C assisted and took over CPR.

80. At 1.04am, paramedics arrived at the cell and took over the resuscitation. At 1.25am, they confirmed that Mr Steadman had died.

Contact with Mr Steadman's family

81. Winchester appointed two family liaison officers. They visited Mr Steadman's grandmother at around 10.30am on 27 February and broke the news of Mr Steadman's death to Mr Steadman's mother and her. The family liaison officers offered their condolences and ongoing support. In line with Prison Service instructions, the prison contributed towards the costs of Mr Steadman's funeral.

Support for prisoners and staff

82. After Mr Steadman's death, the duty governor debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

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

Information reported after Mr Steadman's death

84. After Mr Steadman's death, a prisoner came forward with information to suggest that Mr Steadman had used PS before his death and was acting strangely, talking to himself and punching walls.

Post-mortem report

85. The post-mortem examination established the cause of Mr Steadman's death as ligature suspension. Toxicology tests found that Mr Steadman had only prescribed medicinal drugs in his system and, although sertraline was found in a slightly excessive quantity, it was well below a significant level.

Findings

Identifying the risk of suicide and self-harm

Reception procedures

86. PSI 64/2011 on 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 several risk factors and states that potential triggers should be continually assessed.

87. 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. National Institute for Health and Care Excellence (NICE) guidelines state that initial health screens in reception should ensure continuity of care for people transferring from one custodial setting (including courts) to another by accessing relevant information from the patient's clinical record, PER, cell-sharing risk assessments, medication prescriptions and outstanding medical appointments.

88. When Mr Steadman arrived at Winchester, he had a number of significant risk factors for suicide and self-harm: he had been recalled to prison; he had a history of mental health issues and of substance misuse; he had previously harmed himself and attempted suicide and had been monitored under ACCT procedures during previous custodial sentences (most recently in July 2021). Mr Steadman was also prescribed antidepressants and antipsychotic medication.

89. The electronic PER, completed by the police, outlined some of Mr Steadman's previous attempts at suicide and self-harm but did not contain all of his history and did not fully reflect his risk history. It said that there was a risk of suicide or self-harm, that Mr Steadman had harmed himself several years ago and that he was taking (unspecified) medication. It is unclear whether reception staff properly reviewed the PER. There were discrepancies in the answers that Mr Steadman provided and there is no evidence that he was challenged when his answers to staff questions contradicted risk information in the PER.

90. We are concerned that staff took what Mr Steadman said at face value, without probing what he was telling them or using their own judgement to assess whether he was telling the truth. We note that staff failed to demonstrate that they had also checked other sources of information that were available to them such as NOMIS and medical records to identify Mr Steadman's risk history. Had they done this, they would have seen he had been monitored under ACCT procedures several times previously and had previous contact with mental health teams. This information could have helped them to make a more holistic decision about Mr Steadman's risk. Without properly considering all relevant sources of information about a newly arrived prisoner, it is difficult for staff to determine whether to start ACCT procedures.

ACCT procedures

ACCT procedures started on 17 January 2022

91. Mr Steadman was supported under ACCT procedures on two separate occasions. We have concerns about how the ACCT was managed when it was opened on 17 January. In this instance, Mr Steadman had taken an overdose of his insulin medication. ACCT monitoring was subsequently stopped the next day (after just 15 hours) when Mr Steadman said that he was sorry for his actions and denied further thoughts of self-harm.

92. PSI 64/2011 states that an ACCT can be closed when the risk of harm has been reduced to a level where it is no longer considered raised and all support actions have been achieved. Mr Steadman's support plan included actions that had not been completed when the ACCT was closed, notably that he said he would, but had not yet, submitted an application to the substance misuse team. He had also not yet contacted his grandmother.

93. We consider that the ACCT was closed prematurely. Mr Steadman had a history of self-harm, which included taking overdoses and was prescribed antidepressant and antipsychotic medication. He had only been at Winchester for three days, which is not long enough for staff to know him. It would have been prudent for staff to have continued ACCT monitoring to assess Mr Steadman's risk properly and until all of the support actions were complete.

94. PSI 64/2011 also states that after the closure of ACCT procedures, a post-closure review should be held. The review should take into consideration how the prisoner is feeling, their access to support and their progress since ACCT monitoring stopped.

95. Mr Steadman's post-closure review did not refer to his recorded issues, support plan nor his risk of self-harm. While these would not necessarily have led to the ACCT procedures being restarted, staff should have considered and recorded information about these issues and what action had been taken to address them. This was a missed opportunity.

ACCT procedures started on 26 February 2022

96. ACCT procedures were appropriately started on 26 February when Mr Steadman harmed himself.

97. However, we are concerned about the timing of the final ACCT observations. PSI 64/2011 states that staff must follow the level of observations and conversations noted in the ACCT document. Mr Steadman's ACCT required him to be monitored at least twice an hour, but the final three observations were completed at 11.20pm, 12.05am and 12.44am. This was unacceptable and did not meet the requirement of two observations per hour.

98. PSI 64/2011 requires all staff in contact with prisoners to receive ACCT training, with ACCT refresher training provided according to local needs. Officer A told us that she was not familiar with ACCT procedures and therefore had to seek help from a colleague. She told us that she had not received ACCT training since her

initial prison officer training. A new version of Prison Service ACCT procedures was released in 2021, including new guidance and the roll out of additional training. Although we are pleased that she told us that she received further ACCT training since Mr Steadman's death, we are concerned that a wing officer, who has frequent daily contact with prisoners, was unsure how to start ACCT procedures. We make the following recommendation:

The Governor and Head of Healthcare should ensure that all staff have a clear understanding of their responsibilities to identify prisoners at risk of suicide and self-harm in line with national guidelines and, in particular, the need to record, share and consider all relevant information about risk, and start ACCT procedures when indicated.

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

- **ACCT monitoring does not stop until all support actions have been completed and their risk is no longer considered raised;**
- **post-closure reviews consider the support actions and progress made since the ACCT was closed;**
- **observations are carried out as directed; and**
- **all staff in contact with prisoners receive appropriate ACCT training in line with PSI 64/2011.**

Emergency response

99. PSI 03/2013 sets out the actions staff must take in a medical emergency, including about how to communicate the nature of a medical emergency, ensuring staff take the relevant equipment to an incident and that there are no delays in calling an ambulance.

100. When the OSG found Mr Steadman, she radioed for staff assistance, instead of calling a code blue emergency. There was a short delay of approximately a minute before a code blue was called which triggered the calling of an ambulance. While she told us that she was unsure what she could see in Mr Steadman's cell, she described seeing something around his neck that appeared to be a ligature. While we understand her caution in not opening the cell until support arrived, our view is that the circumstances warranted an immediate code blue. At interview, she told us that she now knew when a code blue should be used. In this case, the delay in calling a code blue, and therefore an ambulance, was minimal. We cannot say if this affected the outcome for Mr Steadman, but we know that a delay of even a few minutes may make a difference in a medical emergency. We make the following recommendations:

The Governor should ensure that all prison staff understand their responsibilities during a medical emergency, including that staff use an emergency code promptly to communicate the nature of an emergency.

Incident report forms and staff statements

101. PSI 64/2011 says that staff directly involved in a death in custody, particularly those who were first on scene, must complete incident statements as soon as practicable. In Mr Steadman's case, staff did not complete incident statements. This would have provided greater oversight and understanding of what happened when Mr Steadman was found. It would likely also have helped staff recall events and reduce disparities between accounts. We make the following recommendation:

The Governor should ensure that staff directly involved in a death in custody complete incident statements as soon as possible after a death.

Clinical care

102. The clinical reviewer found that the clinical care extended to Mr Steadman at Winchester was of a standard reasonably expected and equivalent to that which he could have expected to receive in the community.

103. When staff completed a medication reconciliation on 14 January, they identified that Mr Steadman had been prescribed antipsychotic medication in the community. Mr Steadman had not told healthcare staff when he arrived at Winchester. Although his antipsychotic medication was appropriately re-prescribed, staff did not share this information with the mental health team. Mr Steadman was only referred to the mental health team after he harmed himself and healthcare staff reviewed his medical records. We make the following recommendation:

The Head of Healthcare should ensure that staff refer newly arrived prisoners who are taking antipsychotic medication to the mental health team for assessment.

Inquest

104. An inquest was concluded on 1 August 2024 which concluded that Mr Steadman's death was due to suicide by ligature suspension. The coroner gave a verdict in which she said:

"A probable contributing factor was the extended lock up due to the covid regime and staff shortages meaning that Mr Steadman had not left his cell at all on 26/02/2022. A possible contributing factor was the inadequate implementation of the ACCT process on 26/02/2022."

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 l 020 7633 4100