



A Report by the
Prisons and
Probation
Ombudsman
Nigel Newcomen CBE

**Investigation into the death of a man in
December 2013, while a prisoner at HMP Ford**

Our Vision

*'To be a leading, independent investigatory body,
a model to others, that makes a significant contribution to
safer, fairer custody and offender supervision'*

This is the report of an investigation into the death of a man who absconded from HMP Ford on 17 December and was found hanged in a public lavatory in Bournemouth a few days later. He was 35 years old. I offer my condolences to his family and friends.

A clinical reviewer assessed the man's clinical care and treatment at Ford. The prison cooperated fully with the investigation.

The man received a ten months suspended sentence in April 2013 but the sentence was activated in October when he failed to comply with the conditions of his sentence. His expected date of release was 18 March 2014. He had a long history of substance misuse and was sent to HMP Winchester where he was prescribed methadone for heroin withdrawal. He was not identified as a risk of suicide and self-harm. His community records, which would have shown he had recently reported feeling suicidal, were not received at Winchester until the day he transferred to Ford on 30 October. Winchester did not flag up to Ford that the records had just been received. While the records might have led to some further consideration of his risk, I am satisfied that it is unlikely that by themselves, they would have led to him being managed under Prison Service suicide and self-harm prevention procedures. He appeared to settle well at Ford. He completed a methadone detoxification programme and no one had any concerns about him, including the prison GP, who saw him frequently about his substance misuse problems.

In December, the man appears to have been upset that he had been turned down for release on temporary licence and thought he was also unlikely to get released early under the home detention curfew scheme. On the evening of 16 December, he told his room mate that he had taken some heroin earlier that afternoon and that he intended to abscond from the prison. The next morning he was missing. He was found hanged in Bournemouth four days later.

I am satisfied that during the man's time at Ford, there was little to indicate to staff that he might abscond or be at risk of harming himself. However, there is a need to ensure that community medical records are taken into account in a prisoner's care. There is also a need for better procedures at Ford to inform prisoners in person of the outcome of risk assessment boards. Finally, I am concerned that the prison made no active efforts to contact his family after his death, which meant that his mother, who was abroad, learnt the sad news from a social network site.

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

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SUMMARY

1. The man arrived at HMP Winchester on 18 October 2013 after a previous ten month suspended sentence was activated. At Winchester, he received methadone treatment for heroin addiction. On 30 October, he transferred to HMP Ford. That day, Winchester had received his community health records which showed that he had gone to a hospital on 8 October and said he was feeling suicidal. The records went with him to Ford but no one seems to have read them until after his death.
2. At Ford, the man received support for his substance use problems. He successfully completed a methadone detoxification programme in early December and was optimistic that he would not relapse. On 12 December, a risk assessment board decided that, because of his previous drug and alcohol problems, he would not be allowed release on temporary licence. He appears to have been informed of this but it is not clear who told him. He also seems to have been told, or he inferred, that he was unlikely to be released early on home detention curfew. He was disappointed about this, as he had hoped to re-engage with his children who he had not seen for some time. No one identified him as at risk of suicide or self-harm and he gave no indication that he intended to harm himself.
3. Staff regarded the man as a good worker at the prison and no one had any concerns about him. Two men he had shared a room with said they had noticed nothing to suggest he might be at risk of harming himself. However, on the evening of 16 December, he told his roommate that he had taken some heroin and that he intended to abscond. His roommate said he had pointed out to him that he had only three months left to serve and said that he would try to stop him if he attempted to abscond.
4. Officers who conducted roll checks on the night of 16 December and early morning of 17 December could not recall anything unusual. His roommate said he had spoken to him about 3.00am when the man was watching television, but thought he had then gone to bed. The next morning his roommate went to work early and assumed he was asleep. He did not turn up for work that morning and, at 9.30am, an officer checked his room and found that he had stuffed towels under his bedclothes to form a body shape. A few days later he was found hanged in a public lavatory in Bournemouth. The police found no suspicious circumstances.
5. The man's mother was in Australia at the time of her son's death and heard the news through a social networking site. The police had said they would contact her but prison staff did not check that this had happened and did not take the opportunity to contact her or other family members themselves.
6. We make three recommendations about checking community medical records, informing prisoners of risk assessment decisions and family liaison after a death.

THE INVESTIGATION PROCESS

7. Notices were issued to staff and prisoners at HMP Ford, informing them of the investigation and inviting them to contact the investigator if they had relevant information. No prisoners responded.
8. On 6 January 2014, the investigator visited Ford and obtained copies of the man's prison and healthcare records. He subsequently interviewed eight members of staff and two prisoners.
9. The investigator informed HM Coroner Bournemouth and Poole of the investigation and we have sent him a copy of this report.
10. NHS England (Kent and Medway Area) appointed a clinical reviewer to assess the clinical care the man received at HMP Ford.
11. One of the Ombudsman's family liaison officers contacted the man's mother to inform her of the investigation and offer her the opportunity to identify issues for the investigation to consider. She asked that the investigation take into account the following:
 - Her son had a history of suicide attempts and had gone to a hospital in October 2013, as he was feeling suicidal. During the following weeks, he had been 'living rough' and had tried to kill himself again.
 - Her son had a history of breaking community orders so she questioned why he had been transferred to an open prison.
 - Her son had been diagnosed as having a personality disorder and she wanted to know if that was taken into consideration when he was in Ford. For example, her son had written to say that his reason for going through methadone detoxification was to make his 'risk assessment' read better.
 - Her son had mentioned in letters that he would be able to 'jump the fence' at anytime. She asked whether prisoners' letters were read.
 - Her son had written to his father to say he had been refused day release from prison as he was a high risk and she asked whether the risk assessment was explained to him and whether he was given support.
 - She had been told her son had been able to take heroin at Ford and she thought that, if his depression, suicidal ideation and mental health problems had been addressed, he would still be alive.
 - She had received conflicting messages about whether her son had a large amount of money in his possession when he was found dead.
 - She thought security at Ford should be improved with more CCTV cameras, greater checking of prisoners and un-climbable fences.
12. The man's mother received a copy of the draft report. She pointed out that the clinical review referred to the fact that her son had reported that both his parents had died of heart attacks, which was not correct. She said her son would have had nothing to gain by saying this.

HMP FORD

13. HMP Ford is an open prison for category D prisoners who require only a minimum level of security and who have less than two years of their sentence left to serve. It can hold just over 500 men in single or two-person rooms based in prefabricated units (referred to at the prison as billets). The units are left unlocked at night and prisoners have keys to their rooms. The residential units are enclosed within a perimeter fence.
14. Sussex Partnership NHS Foundation Trust provides health services at the prison. A healthcare unit is open from 8.00am until 5.00pm, Monday to Friday with a range of nurse-led clinics, including mental health support. There are two GPs who provide cover five days a week. One of the GPs has a specialist role for substance misuse.

HM Inspectorate of Prisons

15. The Inspectorate of Prisons carried out a full announced inspection of HMP Ford in August 2012. Inspectors found Ford a much improved prison compared to the previous inspection and that relationships between staff and prisoners were significantly better. Inspectors found that prisoners requiring opiate substitute treatment received a very good level of care and support. Previous high levels of drug misuse in the prison appeared to have reduced
16. Inspectors noted that 25 prisoners had absconded in 2011 and that between January and August 2012, 13 had done so. Absconds had fallen from previous levels and senior managers had emphasised the need for staff to discuss the consequences of absconding with prisoners and ensure they understood the level of support that was available at the prison to help resolve problems in the prison or at home. Inspectors found that there was a lack of planning and interventions to meet the resettlement needs of low risk short-term prisoners.

Independent Monitoring Board

17. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help ensure that prisoners are treated fairly and decently. In their 2012/13 annual report, the Board noted that the availability of illicit drugs remained a problem at Ford but the Board considered that the prison had worked hard at seeking out those prisoners involved and returning them to closed prisons.

Release on temporary licence (ROTL) and home detention curfew (HDC)

18. Prisoners can be allowed release on temporary licence (ROTL) for a number of reasons. Special purpose licences can be granted for prisoners to attend medical out-patient appointments or in-patient treatment. ROTL is also used to allow prisoners to participate in activities outside the prison that directly contribute to their resettlement into the community. The decision to allow temporary release has to be balanced against the need to maintain public safety and public confidence in the judicial system.

19. Home detention curfew (HDC) is a scheme that allows prisoners to be released from prison early subject to an electronically monitored curfew ('tagging'). Prisoners serving sentences of between three months and four years can be considered for the scheme, which can grant early release between two weeks and 135 days earlier than the half way point of the sentence. Prisoners do not have to apply for HDC as it is considered automatically by the prison.

Previous deaths at Ford

20. The man's death was the sixth death of a prisoner in the custody of Ford since this office began investigating deaths in custody in 2004 and the first apparently self-inflicted death. There were no similarities between the circumstances of his death and the previous deaths.

KEY EVENTS

21. The man had been convicted of a variety of offences dating from 1995. He had a history of breaches of community orders and of failing to surrender to custody. He had served a five month prison sentence in 2000. In April 2013, he received a ten month suspended sentence for burglary. On 18 October, he was sent to HMP Winchester for failing to comply with the conditions of his suspended sentence. His release date was 18 March 2014.
22. When he arrived at Winchester, the man told a reception officer that he had never harmed himself or attempted suicide. He then saw a reception nurse. Again he denied any history of self-harm or any current thoughts of suicide and self-harm. He said that he had been treated for depression six years earlier but was not currently receiving any treatment. On the same day, Winchester requested his community GP records.
23. The man spent 12 days at Winchester and was prescribed methadone (a synthetic opioid used to alleviate the symptoms of heroin withdrawal). After being assessed as medically fit, he transferred to HMP Ford on 30 October where he continued to be prescribed methadone at a reducing rate as part of a detoxification programme. On the afternoon of his transfer, Winchester received copies of his community medical records. These included that he had attended a hospital accident and emergency department on 8 October and reported feeling suicidal. The documents were scanned into his prison healthcare records that day, but there is no evidence that anyone at Winchester reviewed them or alerted Ford that they had just been received.
24. A worker from Ford's Drug and Alcohol Recovery Team (DART) assessed the man when he arrived. He noted that he had said he had used LSD, cannabis, ecstasy and amphetamines since he was 13 and had started using heroin and crack cocaine when he was 28. He said that he had been completely abstinent from 2011 to 2012 when he was in Australia but had begun to use heroin and crack cocaine again when he came back to the UK. His use of amphetamines had also increased at that time. He agreed to a drug recovery plan.
25. Within a few days of arriving at Ford, the man started work in the prison laundry. An officer said that he was a very good worker who mixed well with other prisoners. She said that he was always polite when he spoke to her, although he was not generally very chatty with officers. She said that she had never noticed anything in his demeanour to cause her any concern and no other prisoners ever reported having concerns about him.
26. On 4 November, the man saw one of the GPs at Ford who has a specialist function in substance misuse. The substance misuse GP noted that he was receiving 45 milligrams (mg) of methadone a day but wanted to reduce to 35mg a day and after that to reduce by 5mg each week with a plan to reduce at a faster rate as his dose lowered.
27. The man's first room-mate told the investigator that at first he had had to remind the man to take a shower each day, but after that, they started to get on with

each other. He said the man did not talk much about his family, but mentioned that he had a daughter who was around six or seven and who lived with her mother. The man said that he wanted to get back in touch with his daughter. The first room-mate moved to a single room around 10 days later as he preferred not to share. He said that he had been surprised to hear that the man had absconded as he had only a few months left to serve. He was shocked when he heard that he had hanged himself and said he had showed no signs of being at risk of suicide or self-harm while they shared a room. (Another prisoner then moved into the room.)

28. The man's next appointment with the substance misuse GP was on 18 November. He reported neck pain from an old injury and said he had been sleeping poorly since his time in custody. By then he was receiving 30mg of methadone each day and he asked to speed up the rate of reduction to 10mg each week. The doctor agreed.
29. By 25 November, the man's methadone dose was 15mg a day. He said that he was still having trouble sleeping. The substance misuse GP noted that the man was not depressed, but he prescribed mirtazapine (an antidepressant often prescribed to people experiencing prolonged periods of poor sleep).
30. The man took 4mg of methadone on 1 December and said that he wanted that to be his last dose with only symptomatic treatment for withdrawal after that. The next day, the substance misuse GP prescribed medication to help the man with symptoms of opiate withdrawal, including diazepam for anxiety.
31. On the morning of 9 December, an officer wrote a summary of the man's performance at work. She noted that he had worked in the laundry for one month and was always polite and punctual.
32. At a consultation with the substance misuse GP that afternoon, the man reported a number of problems. He said that he had ongoing toothache, for which he was awaiting an emergency dental appointment later that week. He reported stomach cramps but said his major physical problem was neck pain. The substance misuse GP told the investigator that this was a chronic condition that had probably been controlled by methadone and was now becoming more obvious when he had stopped taking it. He prescribed gabapentin (a medicine used for epilepsy but also for neuropathic pain). He noted that the man was in a low mood and said that he had been turned down for home detention curfew. (HDC is when offenders are released from prison early subject to an electronically monitored curfew). However, the substance misuse GP told the investigator that there was nothing about the man's mood to indicate a need for him to be monitored for any risk of suicide or self-harm and he stopped the prescription for diazepam.
33. A drugs worker reviewed the man on 10 December. The man was optimistic about his drug treatment and said that he had no thoughts of resuming drug use after his release because of the damage this had caused in the past. The man said that he had been informed that he was unlikely to get either release on temporary licence or be released early on home detention curfew. He was

concerned about this as he had hoped to re-establish contact with his children who he had not seen for some time.

34. At another review with a drugs worker on 12 December, the man said that he felt well on his symptomatic medication but he had sore legs and was still having difficulties sleeping. He added that he was keen to have time in the community to begin building ties with his family.
35. On the same day, a risk assessment board considered the man's suitability to be released on temporary licence and decided that he should only be allowed out of the prison on a special purpose urgent medical licence if he needed treatment and not for wider purposes at that stage. The reasons given were his history of drug and alcohol use and previous breaches of conditions. The board added that his suitability for other types of ROTL would be considered on individual application.
36. The man's offender supervisor told the investigator that it would have been for her to inform the man of the board's decision. She said that she had planned to do that at a meeting with him on 17 December. She said that decisions about HDC are made separately to decisions about release on temporary licence and the fact that the man had not been found suitable for most forms of ROTL did not mean that he would not have been granted HDC.
37. On 13 December, the man saw another of Ford's doctors and told her that the substance misuse doctor had prescribed 300mg gabapentin tablets when he had been prescribed double that dose in the community. She temporarily increased the dose to 600mg and arranged for the other substance misuse doctor to review the prescription the next week.
38. While he was at Ford, the man's main telephone contact was with his elder daughter. During these calls, he also sometimes spoke to his daughter's grandmother (the mother of his ex-partner) who his elder daughter lived with. He asked if he could contact his younger daughter but his ex-partner did not want this to happen. In November, he told his daughters' grandmother that he was hopeful that he would obtain HDC in the New Year, but in a final telephone call from the prison on 15 December, he said that he had been told that it would not be granted. He did not sound distressed during any of these calls.
39. The man saw the substance misuse doctor at about 3.00pm on 16 December and said that he was more stable on the increased dose of gabapentin but four tablets had been stolen from him the previous evening. The substance misuse doctor agreed to continue with gabapentin at the increased dose. He gave the man some additional tablets to replace the stolen ones but made it clear that he was responsible for taking care of his medication and he would not get any further replacements. The man gave back some sleeping tablets that he said he no longer needed, which the substance misuse doctor took as a positive sign suggesting that the man had settled with the increased dose of gabapentin. The substance misuse doctor told the investigator that the consultation ended with him feeling that the man had had a good detoxification and that things should only get better for him. He said that it was a dreadful

shock when he heard that the man had been found dead as he had seen no sign to indicate that he was at risk of harming himself.

40. The investigator asked the substance misuse doctor whether he had seen the man's community health records and, in particular, a letter from the hospital about him attending the hospital's accident and emergency department on 8 October 2013 to report that he was feeling suicidal. He had told staff at the hospital that he had not been taking his prescribed anti-depressants. He was discharged from hospital the same day. The records had been faxed to HMP Winchester on 30 October 2013 and were scanned into his clinical record at 4.27pm (by which time he had already arrived at Ford). The substance misuse doctor told the investigator that he could not recall seeing these documents. He said the process when community records are received for prisoners at Ford is that one of the doctors checks the records for any action that needs to be taken.
41. An officer carried out two room checks on the afternoon and evening of 16 December. The first check was at about 4.45pm and the second, the final roll check of the evening, was at 8.30pm. The man was in his room on both occasions with his room-mate.
42. At Ford two routine room checks are made during the night, one at 1.00am and the other at 5.00am, to check that prisoners are in their rooms. The two operational support officers who carried out the checks that night told the investigator that they had noticed nothing to suggest that the man was not in his room when they checked.
43. The man's second room-mate told the investigator that he and the man got on well in the time they shared a room. On 16 December, the man said that he had been refused release on temporary licence and had also been told that he was unlikely to be released on home detention curfew. He said that he had taken some heroin that afternoon and that he intended to abscond that night. He also said that he had had a letter from his bank telling him that he was £200 in credit. The room-mate said that he reminded the man that he only had three months to serve and that Ford was a comfortable prison. He said that would stop him absconding if he tried.
44. The room-mate said he had woken at about 3.00am on 17 December and he spoke to the man, who was awake and watching the television. He fell asleep again and then got up at 8.00am to go to work. He thought that the man was in bed at the time. It was not until he came back to his room at 12.30pm, that he learned that the man had absconded. He said he had not believed that the man really would abscond. He was later shocked to hear that the man had taken his own life as he had shown no signs of this.
45. At approximately 9.30am on 17 December, after the man had failed to report for work, an officer went to his room. The officer found that the man was missing and had stuffed towels in his bed to form a body shape. The prison informed the police that the man had absconded.

46. A few days later the man was found hanged in a public toilet in Bournemouth. Police attended and found some evidence of drug use at the scene but no suspicious circumstances. (The Coroner's officer has subsequently confirmed that no money was found with the man when he was found dead.) A post-mortem examination found that the cause of death was by hanging. A toxicology report found there were traces of opiates, morphine and cocaine in his body.
47. The man's next of kin was his mother, who lived in Wiltshire. As he had been found dead outside the prison, the police and Coroner said they would take responsibility for informing her of the news of her son's death. Unfortunately, she was on an extended visit to Australia and eventually learnt that her son had died by reading a message on a social network site on 6 January 2014. In the meantime, the prison did not attempt to contact any other member of the man's family, including his father, or the mother or grandmother of his daughters.
48. The man's mother initially paid for her son's funeral. The prison subsequently reimbursed the costs, in line with national prison service policy.

ISSUES

The man's community medical records

49. HMP Winchester requested the man's community medical records when he arrived on 18 October but these were not received until 30 October, the day he transferred to Ford. Staff at Winchester scanned the records into his prison clinical records that day, but it does not appear that healthcare staff at either prison reviewed the records and they were not aware of the information in them, including that he had attended a hospital accident and emergency department on 8 October and reported feeling suicidal.
50. The substance misuse doctor told the investigator that at Ford, it was usually the responsibility of the doctor who had requested a prisoner's community records to review them and identify if any action was needed. As the records were received at Winchester and scanned into the man's prison medical record at Winchester we consider that a member of the healthcare team at Winchester should have reviewed the records and identified any concerns, or at the least have alerted Ford that the records had been received that day and had not been reviewed.
51. The substance misuse doctor considered that, while it would have been helpful to know the background, the fact that the man had reported feeling suicidal on 8 October would have made no difference to his clinical treatment at Ford. The incident was over four weeks before he transferred to Ford from Winchester and he had been discharged from the hospital the same day. He had not raised any significant concerns at Ford, and his detoxification had been successful and at the pace that he had felt comfortable with.
52. The man's mother asked whether Ford took into account that her son had a personality disorder. The clinical reviewer obtained copies of his full community records which included a letter from 2008 in which a hospital doctor noted his impression that at the time he was presenting with symptoms of a "dissocial and unstable personality disorder". There was nothing further in the record to indicate that he was formally diagnosed with a personality disorder or that he received any ongoing treatment. This letter was not included in the records faxed to Winchester on 30 October so it would not have been possible for the prison to have taken it into account.
53. The clinical reviewer found that the man's clinical care at both Winchester and Ford was comprehensive and appropriate, especially with regard to his detoxification. We agree. However, while we accept the view that knowledge of the content of his previous medical records would not have affected the man's subsequent clinical treatment, it is important that when prisons receive such records they review the content and take any appropriate action. We make the following recommendation:

The Head of Healthcare at HMP Winchester should ensure that community medical records are reviewed when they are received and any required action taken.

The man's allocation to HMP Ford

54. The man's mother questioned the decision to move her son from Winchester (a closed prison) to Ford, a category D (open) prison and aspects of security there. The Prison Service uses a standardised process to determine the appropriate categorisation for each prisoner. The process includes an assessment of the likelihood that they might escape or abscond and the risk of harm they pose to the public should they escape or abscond. The aim is to assign the prisoner to the lowest security category consistent with managing their risks. Guidance about categorisation is contained in Prison Service Instruction 40/2011 and says that prisoners sentenced to a determinate sentence of less than 12 months must be considered for categorisation to category D and allocation to open conditions as soon as possible after sentencing, subject to a requirement that they spend a minimum of seven days in closed conditions. If a person has previously absconded from prison more than once, or has breached bail more than once in the previous three years, they would usually first be allocated to category C (medium security) but this did not apply in the man's case. A person's compliance with previous licence conditions is not in itself a factor used in determining categorisation. We are therefore satisfied that the man's allocation to Ford was reasonable and within the Prison Service categorisation guidance.
55. Prisoners in open prisons are those either serving shorter sentences or are nearing the end of a longer sentence and are regarded as low risk to the public. In preparation for their return to the community, many prisoners in open prisons receive day release for unaccompanied town visits and visits to their families. Some have day release to work in the community. Security at open prisons is appropriately more relaxed than at closed prisons. Incoming and outgoing letters are not read routinely unless there is intelligence to suggest that a particular prisoner's mail should be checked. The man's mother said that her son had written to his father to say that he would have been able to climb the prison fence. This would not have been seen by staff and, in any event, it is unlikely that his description of the prison's fence would have been interpreted as an intention to escape.

Informing prisoners of decisions about release on temporary licence (ROTL)

56. On 12 December, a risk assessment board decided that the only form of release on temporary licence which they would approve for the man at that stage was in the event of him needing urgent medical care. That decision was based in particular on his significant offending history, the fact that he had a significant history of drug use and a history of breaches. The assessment board added that the man's suitability for other types of ROTL would be considered on the basis of an individual application from him.
57. Based upon the man's history this would appear to have been a reasonable conclusion for the risk assessment board to have reached. The fact that a prisoner is regarded as suitable for open conditions does not mean that he is always suitable for release on temporary licence for any purpose. The board

was prepared to consider future individual applications from him for specific purposes but at that stage did not give a blanket approval to such releases. The prison said that consideration of the man's suitability for home detention curfew, for which he became eligible on 2 January 2014, had not begun by the time he absconded.

58. It seems that the man was very keen to be approved for release on temporary licence and subsequently to obtain early release under home detention curfew arrangements. It is possible that he hastened his detoxification in a bid to demonstrate his positive approach for risk assessment board. If so, this must have increased his disappointment at learning about the decision of the risk assessment board not to allow him temporary release and it might have led him to believe his efforts had been in vain. As he had not been informed officially of the decision, it would have been difficult for any member of staff to assess his reaction to this. As his room-mate pointed out to him, he had only a relatively short time to serve, even if he served his full sentence and there was little to indicate to staff that he was at risk of absconding.
59. The man's offender supervisor said she had planned to explain the decision of the risk assessment board to the man at a meeting on 17 December and said that other staff would not have informed him of the decision in the meantime. However, it is evident that he became aware of the decision at some stage. It is important that prisoner's have such decisions explained to them in person, before they learn of it by other means, so that staff can gauge their reaction and consider whether it affects their risk in any way. We make the following recommendation:

The Governor of Ford should ensure that decisions of risk assessment boards are explained to prisoners promptly and in person.

Assessing the man's risk of suicide

60. We consider that there was little to alert staff that the man was at risk of suicide. However, it is regrettable that staff at Winchester did not receive his community records until 30 October and so were unaware of his recent suicidal thoughts when he arrived there. (More historical information about apparent suicide attempts when he was a teenager was not included in the records.) The information, that he had reported suicidal thoughts on 8 October, combined with his dependence on drugs at the time, might possibly have led to Winchester managing him under suicide and self-harm prevention procedures as a precaution when he first arrived, but it is unlikely that this would have continued for long. He gave no indication when he arrived at Winchester that he had any suicidal thoughts and there was no subsequent suggestion that he was at risk.
61. When the man spoke to his daughters' grandmother on the evening of 15 December he asked if she would bring his elder daughter for a visit in the New Year which suggested he was looking forward to the future.
62. The substance misuse doctor at Ford saw the man regularly but had no concerns about him and noted no indication that he was at risk of suicide

including on 16 December, just before he absconded. By 16 December, the man had been off diazepam for a week and had not reported any significant concerns.

63. The man told his room-mate that he had taken heroin on the afternoon before he absconded. There is no suggestion that he had been using heroin at Ford previously. If he did relapse after a successful period of detoxification this might have been the trigger for his abscond and subsequent death. However, we consider it would have been very difficult for any member of staff to have predicted or prevented the man's actions.

Liaison with the man's family

64. Prison Service Instruction 64/2011 instructs prisons on action to be taken after a death, including responsibility for promptly informing the prisoner's next of kin. The man's death was in unusual circumstances for the death of a prisoner as he had absconded from the prison before he was found hanged in the community several days later. In the circumstances, the local police informed Ford that they would take responsibility for informing his mother. Unfortunately, she was on an extended visit to Australia at the time and it seems that the police were unable to trace her. The prison does not appear to have kept in communication with the police about this and, most regrettably, she learnt of her son's death on 6 January 2014 through Facebook.
65. The man's mother had sent her son a New Years Eve email message by a system which allows a friend or family member to send an email to the prison where their friend or relative is located. At Ford, a list of those who have had any mail or email is published each day in the post-room window. Prisoners are responsible for checking the list and collecting their mail. Mail that is not collected is placed in a box of undelivered and uncollected mail and this is what happened to the message from the man's mother. We are very concerned that an email addressed to a prisoner who had so recently died was dealt with in this way. It is difficult to understand how it was not identified and used to establish contact with her.
66. We are also concerned that, in the absence of contact with his mother, no one at Ford attempted to contact any other family members such as his father, or his daughters' mother or grandmother, who the man was in telephone contact with.

The Governor of Ford should ensure that the prison takes active steps to contact family members after the death of a prisoner, including when other agencies take responsibility for initial notification.

RECOMMENDATIONS

1. The Head of Healthcare at HMP Winchester should ensure that community medical records are reviewed when they are received and any required action taken.
2. The Governor of Ford should ensure that decisions of risk assessment boards are explained promptly to prisoners and in person.
3. The Governor of Ford should ensure that the prison takes active steps to contact family members after the death of a prisoner, including when other agencies take responsibility for initial notification.

ACTION PLAN

No	Recommendation	Accepted/Not accepted	Response	Target date for completion	Progress (to be updated after 6 months)
1	The Head of Healthcare at HMP Winchester should ensure that community medical records are reviewed when they are received and any required action taken.	Accepted	<p>A new system is in place through SystmOne (the clinical IT system) that enables staff to run a report on all individuals whose community medical records are outstanding. Once received these are scanned on to the system to ensure they are available for nursing staff to view them immediately, and they are placed in a workflow system for GPs to sign off formally once checked.</p> <p>A monthly report is prepared to ensure records are received as requested.</p>	Complete	
2	The Governor of Ford should ensure that decisions of risk assessment boards are explained promptly to prisoners and in person.	Accepted	<p>Wherever possible, the Offender Supervisor will inform the prisoner of the decision of the risk assessment board decisions within 24 hrs of the Board Chair approving the decision. Where this is not possible, the Offender Development Unit hub manager will delegate the task to another member of staff.</p>	Complete	
3	The Governor of Ford should ensure that the prison takes active steps to contact family members after the death of a prisoner, including when other agencies take responsibility for initial notification.	Accepted	<p>It is accepted that steps should be taken to notify the next of kin of a death at the earliest opportunity. Should a similar set of circumstances as in this case occur in the future, where the recorded next of kin cannot be contacted after repeated attempts, Family Liaison Officers (FLOs) will liaise with the police/Coroners staff to locate alternative Next of Kin.</p>	Complete	