



A Report by the
Prisons and
Probation
Ombudsman
Nigel Newcomen CBE

**Investigation into the death of a man in January 2014
at HMP Winchester**

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 investigation report into the death of a man who was found hanging in his cell at HMP Winchester in January 2014. He was 28 years old. I offer my condolences to the man's family and friends.

The investigation was carried out by an investigator. A clinical reviewer reviewed the clinical care the man received in prison. Staff at Winchester cooperated fully with the investigation.

The man had been in prison since 2008, serving an indeterminate sentence. He went to HMP Ford, an open prison, in January 2013 as part of his preparation for release. He was sent back to Winchester on 5 April 2013, after he failed a drug test for cannabis. The man was given medication for an anxiety disorder and for enuresis (bed wetting). A mental health referral was not followed up.

The man began a substance misuse programme at Winchester to try to deal with his drug problems. On 1 November, he was found guilty at a prison disciplinary hearing of refusing an order to provide a urine sample for a drug test. The man contended that the medication he had been taking for enuresis impacted on his ability to comply and this had previously been accepted. He was aggrieved that he was not allowed to question the officer who had brought the charge and we consider that this was a fundamental flaw in the adjudication. He received a severe punishment and, as a result, also lost his prison job. This left him with very little money for tobacco and other items. The man had a parole hearing scheduled for 9 January and was worried about the impact the adjudication would have. Nevertheless, none of the staff or prisoners who knew him considered he was suicidal. On the evening of 2 January, The man played cards with his friends as usual and appeared in good spirits. The next morning, at about 6.25am, officers found the man hanging in his cell. It was clear that he had been dead for some time.

Overall, I am satisfied that the man received appropriate care at Winchester and that staff there could not have foreseen or prevented his death. However, with hindsight, it appears that the man had become increasingly frustrated about his lack of progress and his morale was drifting downwards. I am concerned that the adjudication, which evidently caused the man some distress, was poorly conducted and the punishment and loss of his job took insufficient account of the impact on his welfare. The investigation also found a need to ensure that mental health referrals are appropriately followed up. Although it would not have affected the outcome for the man, there is also a need to improve emergency procedures at the prison.

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. In August 2008, the man was sentenced to an indeterminate sentence for public protection with a minimum period to serve of three years before he could be considered for release. He had a long history of drug misuse and had tried to tackle this by undertaking substance misuse programmes at different prisons. He suffered from an anxiety disorder for which he was prescribed pregabalin.
2. The man had been found guilty of offences against Prison Rules on 24 separate occasions, mostly drug or alcohol related incidents and had spent several periods in prison segregation units as a result. He had transferred between prisons nine times.
3. In December 2009, he told an officer that he felt stressed and suicidal. As a result, Assessment Care in Custody and Teamwork (ACCT) procedures, (the Prison Service suicide and self-harm prevention process) were begun. The man said that he had told the officer he was suicidal to cause staff work and annoy them and he had no intention of harming himself. He was never regarded as at risk of suicide and self-harm at any other time in prison.
4. While the man was in the segregation unit at HMP Rye Hill in 2011 he said he had reflected on the direction of his life and confessed to the police his responsibility for burglaries he had not been arrested for. He was charged with a further two offences and given a 12 month sentence. In July 2012, the Parole Board acknowledged that he had made serious efforts to address his offending behaviour and recommended that he should go to an open prison.
5. In January 2013, the man went to HMP Ford but was sent back to Winchester in April when he failed a drug test after smoking cannabis. When he arrived, he told a reception nurse that he wanted to see a mental health worker as he felt stressed at being back in a closed prison. The nurse referred him to the mental health team but no one from the team ever saw him. At the end of April a doctor prescribed him medication after he reported bedwetting at night.
6. On 16 October, an officer asked the man to provide a urine sample for a drug test but he said he was unable to do so. A member of healthcare staff confirmed that his medication would inhibit his ability to give a sample. A week later, he was again asked to provide a urine sample for testing and said he could not. This time, a nurse apparently said that there was no medical reason why he could not do so, although this was not recorded. He was charged with a disciplinary offence for disobeying a lawful order. He was found guilty at the subsequent adjudication (disciplinary hearing) and received what he regarded as a severe punishment. We consider that the adjudication hearing was fundamentally flawed as the man was not allowed to question the evidence of the reporting officer. This had further significant consequences as, in addition to the punishment, the man lost his prison job and was downgraded from the highest level of the prison's incentives and earned privileges scheme which meant he lost a number of privileges such as extra gym and visits.

7. In early December, the man told his substance misuse key worker that he was resentful about the adjudication and felt he had been labelled as a liar. He did not appear to be in a low mood but was not very forthcoming with her at the time. On 20 December, he met his offender supervisor to discuss his forthcoming parole hearing in January. His offender supervisor intended to recommend him going back to open prison but he said that he had been very frustrated about not being able to comply with the drug tests and was worried about the implications for his parole hearing.
8. On the morning of 3 January, an officer was conducting a roll count and found the observation flap of the man's cell covered. He was unable to get any response from him and after getting help from two other colleagues opened the cell and found the man hanging by a bed sheet attached to the window. It was clear that he had been dead for some time. An officer radioed an emergency and nurses went to the cell. One of the nurses began to prepare to give cardiopulmonary resuscitation, but immediately realised it would be futile.
9. The officers involved in the emergency response told the investigator that they had been shocked and distressed by what they had seen. They were critical that managers had not offered them appropriate support.
10. Contrary to Prison Service instructions, the prison informed the man's family of his death by telephone, rather than in person. His father said that his son had been concerned about the unfairness of his last adjudication and the potential for it to impede his sentence progression had weighed on his mind.
11. It appears that the man was becoming frustrated about his progression and it is concerning that this seems to have been exacerbated by an adjudication that was poorly conducted. However, the investigation found there was no indication that the man intended to harm himself and staff at Winchester could not have foreseen or prevented his death. We make seven recommendations about the failure to arrange a mental health assessment, deficiencies in recording medical information, conduct of adjudications and emergency response procedures.

THE INVESTIGATION PROCESS

12. The investigator issued notices to staff and prisoners at HMP Winchester informing them of the investigation and inviting anyone with relevant information to contact her. No one responded.
13. The investigator visited Winchester on 23 January and met the Governor and obtained copies of the man's medical records and all relevant prison records. She interviewed three prisoners. Two prisoners in the cells nearest to the man declined to talk to her. The investigator subsequently interviewed eight members of staff at Winchester and one former member of staff by telephone. She gave initial feedback to the deputy governor and wrote to the Governor about the preliminary findings of the investigation.
14. NHS England appointed a clinical reviewer to review the man's clinical care at HMP Winchester.
15. We informed HM Coroner for Winchester of our investigation who provided the results of the post-mortem examination. We have sent a copy of this report to the Coroner.
16. One of the Ombudsman's family liaison officers contacted the man's uncle, who he had nominated as his next of kin, to explain the purpose of the investigation and invite him to raise matters that he wanted the investigation to consider. The man's uncle wanted to know whether he has been given any bad news about his parole decision and whether there was any evidence of bullying or violence against him. The investigation found no evidence that either of these matters was an issue.
17. The man's father said that he did not consider that the prison had done its job correctly otherwise someone would have noticed his son was vulnerable and needed closer monitoring. He believed that the finding of guilt at the adjudication in October had been a major concern for his son as he had worried about how it would affect his sentence progression. He wanted to know more details about his last two adjudications. He had questions about the functioning of the cell bells on B wing on the night his son died and wanted to know whether a member of staff was victimising him. His father said that some of his property was missing, broken and not accurately recorded. He asked what time the ambulance was called. Finally, he asked why his family were told of the death by telephone rather than in person.
18. The man's family received a copy of the draft report. The solicitor representing the man's father wrote to us pointing out some factual inaccuracies and omissions. The report has been amended accordingly. They also raised a number of questions that do not impact on the factual accuracy of this report. We have provided clarification by way of separate correspondence to the solicitor. We have aimed to answer the man's family's questions in the report where they are relevant to the circumstances of his death. We have covered other matters in separate correspondence.

HMP WINCHESTER

19. Winchester is a local prison, serving the courts in Hampshire and holds around 700 adult remand and sentenced men. Central and North West London NHS Foundation Trust provides health services at the prison (before November 2013, healthcare services were provided by Solent NHS Trust). The healthcare centre has 24-hour nursing cover, and doctors from a local practice hold surgeries from Monday to Saturday.

HM Inspectorate of Prisons

20. The most recent inspection of HMP Winchester was in October 2012. The Inspectorate found that standards at the prison had deteriorated significantly since the previous inspection. Although resources to deal with a challenging and needy population were very stretched, arrangements for supporting prisoners at risk of suicide and self-harm were reasonable. Staff-prisoner relations were described as generally polite but distant. The personal officer policy was not operating effectively, and case records indicated infrequent and poor-quality engagement with prisoners. Substance misuse services were good and the inspection noted that the prison had taken action to combat the supply of drugs and alcohol. Nevertheless, there was a high mandatory drug test failure rate and drugs remained readily available.

Independent Monitoring Board

21. 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 its most recently published report for the year to May 2013, the IMB described B wing (where the man lived) as containing many of the most challenging prisoners. It recognised the high level of compassion shown in caring for individual prisoners at risk of suicide and self-harm. The IMB had found that there were problems with the personal officer scheme, and prisoners often claimed not to know who their personal officer was. The IMB concluded that quieter prisoners could easily be overlooked. The IMB also noted that an integrated substance misuse service was in its early stages but was taking a holistic approach to its work and appeared to be well founded.

Previous deaths at HMP Winchester

22. The man was third apparently self-inflicted death at Winchester since 2011. There are no significant similarities between the two previous deaths and the man's.

KEY EVENTS

The man's initial period in prison

23. The man was born in October 1985 and started to use cannabis when he was 12 years old. He had a number of convictions related to substance misuse and first served a prison sentence in 2006
24. In July 2008, he was remanded to prison after pleading guilty to two counts of robbery at knifepoint. He was later sentenced to imprisonment for public protection with a minimum period to serve of two years 109 days before he could be considered for release. After the minimum period is served the Parole Board has to be satisfied that imprisonment is no longer necessary for the protection of the public.
25. In November 2008, the man was sent to HMP Lowdham Grange. After failing a drug test and being found guilty of a disciplinary offence for using opiates, his offender supervisor referred him to drug services to address his substance misuse problems. In December 2009, the man told a prison officer that he felt stressed and suicidal. The officer opened an ACCT and noted that the man had become very upset and aggressive. The next day, the man insisted that he had no thoughts of self-harm or suicide and said he had just said it to annoy staff by generating more paperwork. He refused to attend a case review and the ACCT was closed three days later. He was never monitored under ACCT procedures again.
26. At Lowdham Grange, the man was found guilty 14 times for disciplinary offences such as being intoxicated, possession of fermenting liquid or refusing a drug tests. Punishments included periods in the segregation unit, loss of pay and loss of use of facilities.
27. On 16 May 2011, the man transferred to HMP Rye Hill. At his reception health screen he said he had no thoughts of suicide or self-harm. At the time he was prescribed diazepam and zopiclone to assist a detoxification and sertraline for depression. He later said that while he was in the segregation unit at Rye Hill, he had questioned the direction his life was going. He had concluded that he did not wish to continue on a negative path and subsequently told the police about burglaries he had committed but had not been arrested for. He was charged with two further offences of burglary.

HMP Winchester November 2011 – January 2013

28. On 1 November 2011, the man transferred to Winchester. At his reception health screen he said that he did not have any thoughts or intention to harm himself. The man told his offender supervisor that he recognised he had a long history of poor behaviour during his sentence. He said that he wanted to change as he realised it was damaging his chances of release.
29. On 13 January 2012, the man was sentenced to 12 months in prison for two offences of burglary with intent. (These were the offences which he had

confessed to the police while he was at Rye Hill and had been committed before his current sentence.)

30. On 26 January, the man was accepted for PASRO (Prisoners Addressing Substance Related Offending), an offending behaviour programme designed to help prisoners overcome their dependence on substance use. The man's offender supervisor had regular monthly contact with him and wrote in the man's records that, in contrast to his time at previous prisons, his behaviour had improved at Winchester and he was receiving more positive feedback. In February, the man got a job as a wing cleaner.
31. The man took voluntary drug tests in February, March and April. All were all negative, indicating that he had not been taking illicit substances. On 18 July, a random mandatory drugs test was also negative.
32. On 12 July, the man had an oral hearing with a Parole Board panel at Winchester. He explained that he had decided to confess his outstanding offences to the police while he was at Rye Hill as he did not want to continue on a negative path. The panel recognised that the man had made a major step in acknowledging responsibility for his offending and recommended a move to open conditions. On 20 July, the man's offender supervisor gave him a letter confirming that the Parole Board's recommendation had been accepted but advised him that it could take up to six months to move to an open prison. The next day, 21 July, the man failed a mandatory drug test which meant that the Parole Board would be reviewing their recommendation.
33. On 28 December, the Parole Board decided to maintain their recommendation and it was agreed that the man could go to an open prison.

January to September 2013

34. The man moved to HMP Ford, an open prison, on 15 January 2013. The man started a substance misuse programme called Foundations of Recovery. On 24 February, a test for cannabis was positive on and the man was found guilty at an adjudication on 9 March. His punishment was 21 days stoppage of earnings at 50% of his wage and 21 days loss of canteen facilities. After the adjudication, his incentives and earned privileges status was reviewed and he was downgraded from enhanced to standard. He was told he could re-apply for enhanced status eight weeks later if he had no further adjudications or behaviour warnings.
35. On 5 June, the man received a letter from the Public Protection Casework Section of the National Offender Management Service (NOMS) explaining that his risk had been reviewed after his positive test for cannabis and the outcome was that he should return to closed conditions. The man was taken back to Winchester on 5 April. When he arrived, the man told a nurse that he was teetotal, a smoker, had asthma, used marijuana, had not tried to harm himself in the past (in or out of prison) but had suffered from depression. He said he was taking pregabalin, co-codamol and used an inhaler. He told the nurse that he was feeling low and wanted to see a mental health worker

because of the stress of moving back from an open prison to a category B prison. The man's clinical record indicates that the nurse made a referral to the primary care mental health team but it does not appear that anyone from the team ever saw him. The next day, 6 April, a prison doctor, prescribed the man pregabalin for anxiety and co-codamol for back pain. It is not clear from the clinical record whether the doctor saw him in person.

36. The man's offender supervisor continued to be the man's offender supervisor at Winchester and he saw the man on 9 April. The man was upset that he had been sent back to Winchester for smoking cannabis. He told the man's offender supervisor that he knew he had been stupid but he had succumbed to temptation as everybody was doing it at Ford. He considered that the response was very severe and wanted to appeal about it. There is no record that he made any representations against the decision to return him to closed conditions.
37. In May, the man applied to take a substance misuse course, 'Stepping Stones'. His offender supervisor and the substance misuse practitioner saw this as a positive move. At a sentence planning meeting on 2 August, they agreed that the man should be set this as an objective and reinforce this by one-to-one sessions every four to six weeks. (The man later began the Stepping Stones programme on 7 October.)
38. On 24 April, a health promotion specialist, saw the man to begin a smoking cessation course. He said he wanted to get out of Winchester in a couple of weeks and was angry to hear that the course would last eight weeks. He saw the health promotion specialist again on 29 April and said he was still motivated to stop smoking for his health. She gave him nicotine patches and lozenges and some information sheets.
39. On 30 April, the man told a doctor that he had begun to wet the bed at night. The doctor prescribed oxybutynin which works by reducing the activity of the bladder and therefore helps to control the release of urine. The man did not attend his appointments for the smoking cessation course on 23 and 29 May. On 14 June the man saw a locum GP and said he was still wetting his bed at night. He attributed this to sleeping in a shared cell and felt that it was linked to taking pregabalin. He told the GP that he had been in care as a child and had seen a lot of violence. She prescribed modified-release oxybutynin.
40. On 24 June, the man's offender supervisor saw the man. He was upset about being found guilty at an adjudication for throwing a plate of food at a prisoner. He said it had hit an operational manager who had been passing at the time. The prison has been unable to find the record of this adjudication so we have no further information about it and who heard the charge. Segregation unit records show that the man received a punishment of 14 days cellular confinement and 28 days loss of association, both of which were suspended for four months.

October to November 2013

41. On 9 October, intelligence was received that the man appeared to be under the influence of drugs. As a result, on 16 October, an officer asked the man to take a mandatory drug test (MDT) on grounds of suspicion but he told the officer he was unable to provide a urine sample. An officer sought advice from a member of healthcare staff who said that the medication the man was taking would inhibit him from providing a urine sample. There is no record of who gave the advice. The officer cancelled the test but told the man that this did not mean he was exempt from future tests.
42. On 23 October, the officer asked the man to take another test. After five hours he had not provided a urine sample and an other officer consulted a nurse. The officer wrote in the man's case notes that he had contacted the healthcare centre and was told that there was no medical reason why the man could not provide a urine sample. The nurse did not make a note of this advice in the man's clinical record. The officer charged him with a disciplinary offence of disobeying a lawful order.
43. The record of this adjudication was available. An operational manager, opened the adjudication on 24 October and established that the man understood the charge, did not require assistance and did not have any questions. The man had not prepared a written statement but said he had had enough time to prepare. He pleaded not guilty and asked for legal advice and the hearing was adjourned until 1 November for this purpose.
44. On 1 November, the operational manager resumed the adjudication. A supervising officer read out the evidence against the man and the man said he had no questions. When the operational manager asked him to say what had happened in his own words, the man asked for the reporting officer to be present to question him. The operational manager declined the request, and said that the man had previously said he did not wish any witnesses to be called. The operational manager wrote that the man then became abusive and demanded the officer's presence. The operational manager asked staff to remove him from the room and found the charge proved in his absence.
45. After an adjudication charge is proved, the prisoner is normally given an opportunity to offer any mitigation before the governor decides the punishment. Reports about their conduct are read out and the prisoner had the opportunity to comment. As the man was not present he was not able to comment. The operational manager punished the man by 42 days stoppage of earnings at 80% (The man earned £8.00 a week as a wing cleaner which meant he would have been left with (£1.60 a week for six weeks.) He lost a range of privileges for 42 days, including being able to buy items from the canteen (prison shop), use his own money or have a television. He was unable to use the gym for 42 days. In addition a punishment of 42 days loss of association (the ability to socialise with other prisoners in free time) was suspended until 24 January 2014 and a punishment of seven days cellular confinement was suspended until 1 February 2014. The operational manager wrote that his reasons for giving his punishment was that refusing an mandatory drug test was very serious and that the man's behaviour during the adjudication caused him to be removed. He did not specify what the

behaviour was. On 5 November, the man lost his job as a wing cleaner, as a result of a labour board review because of the adjudication. We understand he was also downgraded in the incentives and privileges scheme but the prison was unable to find the records about this.

46. On 6 November, the man told a nurse that the oxybutynin was not working and he needed a medication review with a GP. On 14 November, he saw a doctor who thought that pregabalin might be aggravating the problem. Contrary to what he had told the other doctor. The man said that he had had a problem with bed wetting before he had started taking pregabalin and he wanted a single cell which he believed would help. The doctor did not alter his medication, but he was allocated a single cell, B4-12, that day.
47. On 19 November, while he was waiting for medication in the treatment room at about midday, the man told a nurse that he would take someone hostage if he did not get the medication that day. He said that he was a life sentenced prisoner and had nothing to lose. The nurse reported this to wing officers and wrote an incident report about it. It is not clear why the man was so angry or whether he had been waiting for his medication a very long time. At 5.30pm, a doctor prescribed his pregabalin for anxiety.
48. On 22 November, a nurse examined the man, as an officer had said he had breathing difficulties. The man said he just needed an inhaler. The nurse measured his oxygen saturation in his blood which was 96% (the normal rate of oxygen saturation is between 96-100%). It does not appear from the medical records that the man was given an inhaler.
49. An officer who worked on B wing (and would later find the man dead in his cell) told the investigator of an incident when he had clashed with the man. The officer was not sure of the date but believed it might have been in late November. He said he had placed two prisoners on disciplinary report for inciting another prisoner not to cooperate with being locked in his cell. The man had taken exception to the officer's actions and told him so. The officer said he had told him to stay out of it, but the man had refused to do so and he therefore gave the man a formal warning about his behaviour. (Subsequently, on 8 December, security intelligence was received that the man had warned an officer that if 'this sort of behaviour' continued, he would refuse to go into his cell and there would be issues on the wing. This appears to have been related to this incident.)

December 2013

50. The man's substance misuse key worker, saw him on 6 December. She told the investigator that the man appeared motivated, his body language was comfortable and he maintained good eye contact. They discussed his upcoming parole board hearing and the importance of not giving up. He spoke positively about having experienced an open prison in the past and they talked about relapse prevention. He said that he did not want to mess

things up when he was released. She said that he did not disclose any concerns about low mood or thoughts of self-harm. However, her case notes of the meeting record that she thought that the man was not very forthcoming and did not appear to want to open up about his needs, current problems or vulnerability. He had talked about the adjudication which he described as '6 week losses of everything' and said he should not have been found guilty. He said that he felt 'pigeon-holed' as a liar.

51. On 11 December, the man attended a forum for prisoners serving indeterminate sentences, a new initiative at Winchester. A member of staff from the Substance Misuse and Recovery Team, said the man shared his views on how Winchester could support such prisoners better. He spoke to her and his offender supervisor about his parole hearing and he said he was hopeful he would be successful in regaining his category D status and move to an open prison again.
52. The man had a meeting with his offender supervisor on 20 December. They discussed the upcoming parole hearing. The man said that he knew that the man's offender supervisor supported his application to return to an open prison but he felt frustrated that he had been unable to comply with the mandatory drug test which led to the adjudication. There were no more entries in any of his prison records for the rest of 2013.

2 and 3 January

53. On the evening of 2 January, the man played dominoes with three of his friends. They said they were all jovial and before he was locked in his cell for the night, he had asked them for some tobacco and said he would see them the next day. The officer, who was on night duty, counted the prisoners on B4 landing and said he had seen The man sitting on his bed, probably between 8.15pm and 8.30pm. He recalled it was a quiet night and no one rang their cell bells that night. The cell bell records indicate that cell bells on B wing were operating normally and there is no record that the man pressed his cell bell that night. After 11.01pm, there is no record of a prisoner using a cell bell until 5.14am.
54. On 3 January 2014, the officer and an operational support grade, began the early morning roll count on B wing. At about 6.10am, the officer started on B4 landing, checking each cell to make sure that every prisoner was present. When he opened the observation flap to the man's cell, B4-12, the glass panel was covered on the inside with tissue paper. He tried to look through the gap between the door and frame but could not see any movement in the cell. He tapped on the door and called the man but got no response.
55. The officer counted the rest of B4 and B3 landings. He radioed the night orderly officer in charge of the prison that night, and said he could not see or get a response from the man. The night orderly officer asked him to get help from the other two officers on duty and go into the cell. The officers accompanied the officer who unlocked the cell door. They found the man

hanging from a sheet attached to the window. His head was slumped forward and the officer said to his colleagues that he believed that the man was dead.

56. The officer cut the sheet from the window (using a ligature-cutting tool carried by all officers) and another officer stood ready to receive the man's body as he was released from the ligature. He said he did not recall a third officer being in the cell at that time, but she said that she was behind him. The third officer said that the officer cut the ligature before she could get to help lower the man's body to the floor. His weight was heavier than the officer had anticipated and his body fell hitting his head on the toilet and the wall.
57. At 6.24am, the officer said he radioed an emergency code blue, which indicates that a prisoner is unconscious or has breathing difficulties. Two nurses were on night duty. At night, the radio system is placed into a talk-through setting, which enables all staff carrying radios to hear both sides of a radio communication. One nurse said he was alerted to the incident when he heard a radio message mentioning a blue light. He wondered whether there was an emergency and went to the prison centre where the medical emergency bags were kept. The nurse told the investigator that she was answering an external telephone call in an office when she heard a radio message for The night orderly officer about a prisoner, which sounded panicked. She ended the telephone call and went to join the other nurse. She asked over the radio whether healthcare assistance was required and was told the location she needed to go to. The nurse ran up the stairs, which was the quickest route and the nurse followed in the lift with two emergency bags of medical equipment as they were heavy.
58. The nurse arrived at the man's cell. He said he was lying on the floor between the toilet and the wall, on top of some bedding. One of the officers said to him that the man was 'long gone'. The nurse noticed that the man still had a thin strip of ligature around his neck, which had made a deep indentation. One officer handed another officer his ligature-cutting knife, which he used to cut the remaining strip of sheet from the man's neck. The nurse said that the man's limbs were stiff and he was difficult to manoeuvre. He prepared to start cardiopulmonary resuscitation (CPR) but when he began chest compressions he found that the man's body was hard and decided that CPR would not be possible.
59. The officer found a note on top of the man's cupboard which indicated that he had intended to take his life. The officer said that she had noticed that the man's cell was very clean and the officer remarked at interview that his bed was neatly made,
60. The night orderly officer told the investigator that he had been in the prison grounds, unlocking a building contractor's gate, when he received the officer's radio message about the man. As he was going back into the main prison building and on to B wing, he heard the code blue. When he got to the landing he was briefed by the two officers who were now outside the cell. They told him that the man was dead and he said that he was satisfied by their accounts as they were experienced officers. He did not go into the

man's cell as he did not want to see his body. When interviewed, he said that he had dealt with a number of self-inflicted deaths of prisoners at Winchester some 20 years earlier and he was still struggling to cope with trauma of what he had seen. At the time, he had not received any workplace support. The officer told the investigator that when they were outside the cell he had told the night orderly officer that there was something he wanted to show him, but the other officer said that he would rather not go into the cell. The night orderly officer later found out that the officer had wanted to show him that the man had sustained a cut to his head when his body fell.

61. The night orderly officer said he asked the radio controller to call an ambulance and then left B wing to go to the control room to follow the contingency plans for a death in custody. When he arrived there, he found that the copy of the contingency plan was incomplete and he had to look for a full set in the command suite. The night orderly officer telephoned the duty governor, at home to inform her of the man's death. He then escorted the paramedics to the man's cell where they arrived at 6.55am. At 7.00am, the paramedics confirmed the man's death. South Central Ambulance Service confirmed to the investigator that a telephone call was received from Winchester at 6.27am. They despatched a vehicle at 6.36am which arrived at the prison at 6.47am.

Contact with the man's family

62. The prison's Head of Safer Custody and also a trained family liaison officer, arrived on duty at around 7.00am and took over the incident management from The night orderly officer. The post-incident check list which lists all the actions which need to be taken when a death of a prisoner has occurred has 'N/A' written across the columns which say that a meeting should be arranged if the prisoner's next of kin are within reasonable travelling distance. He telephoned the man's uncle (who was his nominated next of kin) at 8.00am and told him of his nephew's death. The man's father telephoned the prison chaplain when he heard the news. The man's father told us that he had asked an operational manager at Winchester, about visiting his son's cell on the morning of his death but the operational manager had told him that was not possible and it was only after the chaplain had intervened that he was able to do so. The prison said that it did not have a manager called the operational manager and we have been unable to establish who told him this. The family liaison log showed that the operational manager telephoned the man's father at 8.45am and he said that he would arrange for relatives to view the man's cell. The log shows the operational manager continued to liaise with the man's family and offered financial assistance towards funeral expenses in line with national guidance. His father said his family was appreciative of the memorial service organised at Winchester.

Support for staff and prisoners

63. Notices to prisoners and staff were issued to let them know of the man's death and sources of support for anyone affected by it. Individual notices were put under each cell door on B wing that morning explaining what had

happened. Prisoners assessed as at risk of suicide or self-harm were reviewed in case they had been adversely affected by the man's death. A memorial service was held at the prison which was well attended by prisoners and staff.

64. The operational manager, who has since retired, wrote a memo which described a staff debrief at 8.30am, but none of the staff immediately involved in finding the man could recall such a meeting taking place. The nurse remembered a manager had asked him if he was all right, but he said no one had offered him any support until some days later. The nurse said that as part of the substance misuse and recovery team she had received support from her colleagues and from the nursing agency she worked for.
65. All the prison officers interviewed acknowledged that they were subsequently spoken to or contacted by a member of Winchester's care team, but were negative about support at the prison on the day. The two officers said that one of their colleagues had talked through the experience with them, but no manager had asked them if they were all right or discussed whether they felt able to work that evening. The third officer described the post-incident care as badly handled and wanted someone to recognise that what they had experienced was traumatic and not a petty incident. The night orderly officer said that he had been anxious about returning to work that evening it, but felt he could not say so for fear of seeming weak. Several staff said they had experienced flashbacks and other distressing symptoms in the aftermath of the man's death
66. A critical incident debrief for staff did not take place until 16 April, several months after the man's death. It was chaired by the Deputy Governor and offered the staff involved an opportunity to share their feelings about what had happened. The investigator was told that the debrief took place so long after the man's death because when the Deputy Governor took up his new post at Winchester on 31 March, he noticed it was still outstanding.
67. The investigator asked the man's friends at Winchester whether they had any indication he might take his life. One prisoner said that he had known the man for about a year. He described him as popular, outgoing and likeable but said he was feeling some stress at around Christmas as his parole hearing drew nearer. He had noticed that the man did not have any Christmas cards or festive items in his cell. The man had told the prisoner about an adjudication he was appealing against and said he had been given 42 days punishment and that he had been downgraded to basic, the lowest level of the incentives and earned privileges scheme. We have found no record of an appeal against the adjudication.
68. The second prisoner had similar concerns and mentioned a couple of altercations with staff. He said that the man had told him that he had failed a mandatory drugs test because he could not urinate in front of others and did not produce a urine sample. He had also talked of making mistakes and going back a step by moving from an open to a closed prison. As a Listener (trained by the Samaritans to listen in confidence to other prisoners feeling

distress), the prisoner said that he felt bewildered by the man's death. He knew that the man thought he might not be granted parole due to his failed drug test. He was stressed that as he serving an indeterminate sentence, he did not know when he was going to be released. The second prisoner had the impression that the man would rather soldier on rather than get help or get matters off his chest. Although all four of them were close, and listened to music and played dominoes together every day, none of them had seen any signs that he intended to take his life.

69. The third officer told the investigator that she did not normally work on B wing, but said that the man used to greet her when he was working as a cleaner if she walked through the wing. She described him as a lonely young man who appeared cheerful, but he had told her before that he had no-one to talk to. There are no personal officer entries in the man's case notes for the time he was at Winchester. The records show that his personal officer was a particular officer but when the investigator asked the prison, they said they did not have an officer of that name.

ISSUES

Clinical care

70. The clinical reviewer notes that the man had a history of substance misuse which had started at the age of 12 with cannabis and had escalated with age to use of crack cocaine and heroin. In prison he had participated in a number of drug-related offender behaviour programmes which had helped him to address his drug use but, as with many recovering addicts, he found total abstinence difficult and had occasional relapses.
71. The man was given repeat prescriptions for anxiety, enuresis (bedwetting) and back pain, although there was no clear management of these long-term medical conditions. The man suffered from anxiety but no other mental illness and there was no overt risk of suicide or self-harm. The clinical reviewer observed that at each prison the man was at, his risk of suicide was appropriately assessed. There was no evidence to suggest he was suffering from clinical depression.

Mental health referral

72. When the man returned to Winchester from Ford in April 2013, he said he was stressed and low in mood. The nurse referred him to the mental health team and this referral is clearly indicated in the man's clinical record. However, there is no record of any contact between the mental health team and the man. The mental health referral was made nine months before his death. In the absence of any other evidence that the man was suffering from depression, it would be difficult to draw the conclusion that the failure to establish contact with him had a direct impact on his death. The man's father queried why the clinical review said the man did not have a history of depression when his prison records make several references to it. However, this was a missed opportunity to explore whether the man needed more support. We make the following recommendation:

The Head of Healthcare should ensure that a member of the mental health team follows up all mental health referrals.

Healthcare advice and drug testing

73. Prison Service Order 3601 sets out the requirements of the mandatory drug testing process. Chapter 10 deals specifically with involvement of healthcare staff in the process and states that healthcare staff can participate in assessing whether failure to provide a specimen of urine has an underlying medical cause if a prisoner has given their consent.
74. The man's records show that an officer was told on 17 October that the man's medication would inhibit him from providing a urine sample. According to his clinical record, no alterations to the man's medication were made between 17 and 23 October. Yet on 23 October, the nurse told the officer in similar circumstances, that there was no medical reason preventing the man from

providing a urine sample. It is of course possible for two different healthcare professionals to have different opinions but we would have expected some explanation the second time, why the advice differed from that given the week before. The advice given each time, and the person who gave it, should have been recorded in the man's clinical record yet this was not done. We make the following recommendation:

The Head of Healthcare should ensure that healthcare staff record any advice given about a prisoner's medical conditions in his clinical record.

Adjudication on 1 November

75. Prison Service Instruction (PSI) 47/2011 sets out the process and procedures that must be followed when a prisoner is charged with a breach of prison rules. Usually charges of refusal to obey a lawful order related to a mandatory drug test are referred to an independent adjudicator (a district judge) as the charge is regarded as serious and only they can punish by the addition of added days to sentences. Such adjudications for prisoners serving indeterminate sentences are normally heard by a prison manager as added days cannot be imposed.
76. The operational manager adjourned the first hearing for the man to seek legal advice. When it was resumed, there is no mention in the record of hearing whether such advice had been obtained. The man said he did not have any questions about the evidence when it was read out by a supervising officer but he asked for the reporting officer to be present. We are very concerned that the adjudicator declined the man's request on the grounds that he had said he did not wish to call any witnesses. Although the reporting officer is technically a witness, it is unlikely that a prisoner would be aware of that and in any event it is open to an accused prisoner to ask to call a witness at any stage. It is open to an adjudicator to decline to call a witness if he or she believes that the witness' evidence would not be relevant but that is not possible in the case of a reporting officer.
77. Paragraph 2.29 of PSI 47/2011 under the heading 'hearing procedures – witnesses' states "if the prisoner wishes to question a reporting officer who is not present or not available via a videolink, the hearing is to be adjourned until the officer is available'. The adjudicator should therefore have adjourned the adjudication until the officer could attend. This should have been the case whatever the charge, but it was particularly important for the man, for whom so much was at stake, if the charge was proven.
78. In addition to investigating the deaths of prisoners, the Prisons and Probation Ombudsman also investigates complaints by prisoners, including appeals against adjudications. If the man had complained about this adjudication on the grounds that the adjudicator had refused his request to allow the reporting officer to attend, the Ombudsman would have recommended that the adjudication be quashed. Excluding the reporting officer was contrary to natural justice and the adjudication was fundamentally flawed. While we would not condone verbally abusive behaviour by any prisoner, no matter

what the provocation, it is understandable that the man felt aggrieved that he was not able to question the officer.

79. Section 8 of the adjudication hearing document allows for a prisoner to offer mitigation before the punishment is decided. The man was not offered such an opportunity as he was removed from the hearing. Before reaching his decision about the punishment we consider the adjudicator should have informed the man of the verdict and asked him if he had any mitigation which he could have taken into account. If necessary this could have been done through a cell door in the segregation unit. We are also concerned that the adjudicator said that he had taken the man's behaviour at the adjudication into account when deciding on the level of punishment. Punishments should be based on the actual charge proved and not on the adjudicator's view about the prisoner's conduct during the hearing. We make the following recommendation:

The Governor should ensure that all managers conducting adjudications are fully competent and understand their responsibilities to conduct fair adjudication hearings, in accordance with Prison Service Instruction 47/2011

80. The consequences of being found guilty at this adjudication were severe for the man, both for his future progression and his immediate quality of life in the prison. The man lost access to money, to a television and use of the gym. He felt badly treated and in his own words, seen as a 'liar'. His description of '6 weeks losses of everything' reflects how he saw the punishment and his mood. Although, he knew that his offender supervisor had recommended he should be allowed to return to Ford, he was worried that the adjudication result would adversely affect his chances of moving back to open conditions and ultimately of release.
81. The man did not have any earnings and could not spend his own money in canteen until 12 December. He had been earning £8.00 a week and the loss of 80% of it would only have left him with £1.60 a week. However, he then lost the ability to earn even this amount when he lost his job altogether after a labour board review directly because of the adjudication. The man smoked and had given up the smoking cessation programme as he found it too stressful but a lack of earnings would have made it impossible to buy tobacco. It appears that the man was also demoted in the prison's incentives and earned privileges scheme. One of his friends said that he was moved to the basic level but we have been unable to check this as the prison had been unable to supply the records.
82. We know that before the man was locked up on the night of his death, he had asked his friends for tobacco because he did not have any. We have not come across evidence that the man was in debt to other prisoners, but leaving him with no income and unable to spend any private cash for a prolonged period left him vulnerable to illicit behaviour in order to get by. His drastic reduction in spending power in the period leading up to the festive season is

perhaps illustrated in the bleakness of his cell as his friends described it. This cannot have helped his state of mind.

83. While we understand that a refusal to take a mandatory drug test is a serious offence and can be regarded as seriously as a positive test, we consider that the combination of the adjudication punishment, and the separate but associated loss of his employment (and loss of IEP status) had too severe an effect on the man's wellbeing. PSI 47/2011 requires adjudicators to take account of the likely impact on the prisoner, including their health and welfare. It is not apparent that this was done and we consider that further decisions resulting from the adjudication, such as the loss of employment and change in IEP status, should also take a prisoner's welfare into account. We make the following recommendation:

The Governor should ensure that managers imposing punishments at adjudications, and taking associated decisions afterwards, fully consider the likely impact on the health and welfare of the prisoner.

Bullying

84. The man's family asked whether he had been bullied or subject to violence at the prison. The investigator examined 72 pages of security documents covering his period in custody but found no evidence to suggest the man was ever the victim of bullying. She spoke to his friends and none of them believed that the man was being bullied. Neither did staff have any information that this was the case. Although the man had clashed with the officer which resulted in an incentives and earned privileges warning, there was no evidence to suggest there were on-going issues with staff which would suggest any staff intimidation, at the time of his death.

Emergency response

85. Prison Service Instruction (PSI) 03/2013 *Medical Emergency Response Codes* issued in February 2013 sets out the actions staff should take in a medical emergency. It contains mandatory instructions for governors to provide guidance on efficiently communicating the nature of a medical emergency and to ensure that there are no delays in calling an ambulance. It stipulates that if an emergency code is called over the radio, an ambulance must be called without delay and that it should not be a requirement for a member of the healthcare team or a manager to attend the scene before an ambulance is called. Winchester has an emergency protocol in line with the PSO which sets out the mandatory contingency responses when an emergency code is used. It requires that 'communications/ control room automatically calls an ambulance and awaits updates from the scene.'
86. The officer radioed a code blue at 6.24am but although the communications room contacted the ambulance service, it is unclear whether an ambulance was despatched until after the night orderly officer arrived on B wing and radioed to ask that one should be requested. This should have been done automatically as soon as the code blue was received. In this case, it is

apparent that the man was dead when he was found and we are satisfied that the staff made an appropriate decision not to attempt resuscitation, but in other emergencies an immediate response is crucial.

87. There were other aspects of the emergency response which were not handled well. Officers did not support the man's body as the ligature attached to the window was being cut, which the prison's local protocol requires. The ligature around the man's neck was not cut until the nurse arrived and noticed it. There was a lack of clarity about how the nurses were alerted to the emergency and no log of timings was kept between the discovery of the man and the arrival of the paramedics. Full contingency plans were not readily to hand and the night orderly officer appears to have been too damaged by trauma from earlier incidents to have operated fully effectively. (Underlying the need for good staff support at the time of traumatic incidents.) We make the following recommendation:

The Governor should ensure that all prison staff are made aware of and understand PSI 03/2013, the local protocol and their responsibilities during medical emergencies and that:

- **Staff efficiently communicate the nature of a medical emergency;**
- **There are no delays in calling, directing or discharging ambulances; and**
- **Contingency plans are readily available which managers and staff are familiar with and follow.**

Informing the man's family of his death

88. National guidance requires that the news of a prisoner's death is given in person by a trained member of Prison Service staff. Prison Service Instruction (PSI) 64/2011 "Management of prisoners at risk of harm to self, to others and from others (Safer Custody)" states:

"Wherever possible, the FLO (family liaison officer) and another member of staff must visit in person the next of kin or nominated person to break the news of the death. Where the prisoner had been located a long distance from their next of kin, consideration must be given to requesting the assistance of a FLO from the nearest prison."

89. The man's uncle, who he had nominated as his next of kin, was told of his death over the telephone which was inappropriate and not in line with Prison Service guidance. His uncle lives in west London, 60 miles from Winchester, and no more than one and a half hours drive from the prison. We do not consider that this was too far to prevent staff from the prison going in person to inform his family of the sad news. Even if the distance was regarded as too far, there was no attempt to contact another prison, or even the police, so that his family could have been informed by someone in person rather than by a telephone call. We make the following recommendation:

The Governor should ensure that wherever possible staff from Winchester should visit the next of kin in person to break the news of a death unless the distance is so far that there are clear benefits in using family liaison officers from other prisons.

Post-incident staff care

90. Even though the number of self-inflicted deaths in prisons has risen in the period 2013-14 by 68% over the previous year, self-inflicted deaths in prison are still an unusual occurrence. Many prison staff finish their career not having dealt with a death. Others, particularly in busy local prisons with a high turnover of prisoners with complex needs, may suddenly encounter a traumatic scene such as the one faced by staff who found the man. As the night orderly officer's unfortunate experience showed, the effects can be long-lasting if staff are not given timely and effective support after an incident. In turn, this can impact on the safety of prisoners in future emergencies.
91. PSI 64/2011 says that, in line with PSI 08/2010 Post Incident Care a 'hot debrief' must be held immediately after all deaths in custody. A senior member of staff must act as the debriefer and a member of the care team must attend. All staff directly involved in the incident, including healthcare staff, should be invited. The hot debrief is to acknowledge what happened, acknowledge the role of the staff involved, normalise the situation and ensure that immediate needs of the staff have been met. A hot debrief is an opportunity for staff involved in a traumatic incident to reflect when it is over on how it was managed, to support each other and for managers to offer support.
92. Although the operational manager's memo described a staff debrief it is notable that it did not contain anything about the response of the staff involved. It is clear that the staff concerned did not recognise that a debrief had taken place and did not feel sufficiently supported. Despite the period that had elapsed between the man's death and the interviews, all the officers expressed dissatisfaction to varying degrees with the how they were treated by managers after the death. We are concerned that staff felt unsupported and that senior managers on the day did not personally acknowledge the impact of the man's death.

The Governor should ensure that a hot debrief takes place after a death in the prison and that all staff involved are offered effective support.

RECOMMENDATIONS

1. The Head of Healthcare should ensure that a member of the mental health team follows up all mental health referrals.
2. The Head of Healthcare should ensure that healthcare staff record any advice given about a prisoner's medical conditions in his clinical record.
3. The Governor should ensure that all managers conducting adjudications are fully competent and understand their responsibilities to conduct fair adjudication hearings, in accordance with Prison Service Instruction 47/2011
4. The Governor should ensure that managers imposing punishments at adjudications and taking associated decisions afterwards, fully consider the likely impact on the health and welfare of the prisoner.
5. The Governor should ensure that all prison staff are made aware of and understand PSI 03/2013, the local protocol and their responsibilities during medical emergencies and that:
 - Staff efficiently communicate the nature of a medical emergency
 - There are no delays in calling, directing or discharging ambulances and
 - Contingency plans are readily available which managers and staff are familiar with and follow.
6. The Governor should ensure that wherever possible, staff from Winchester should visit the next of kin in person to break the news of a death unless the distance is so far that there are clear benefits in using family liaison officers from other prisons.
7. The Governor should ensure that a hot debrief takes place after a death in the prison and that all staff involved are offered effective support.

Prison Service Action Plan

No	Recommendation	Accepted/Not Accepted	Response	Target date for completion and function responsible	Progress (to be updated after 6 months)
1	The Head of Healthcare should ensure that a member of the mental health team follows up all mental health referrals.	Accepted	<p>A pathway is in place to ensure that all mental health referrals are picked up by the primary care mental health team: the referral is logged on SystemOne, which provides an auditable trail of the date of the referral, the name of the member of staff who made it, and the date that the prisoner was seen by the primary care mental health nurse. A monthly management check of the referrals on SystemOne will be undertaken in order to identify any outstanding referrals that require action.</p> <p>From 1 October 2014, the Central and North West London NHS Foundation Trust will comprehensively manage the secondary mental health provision at Winchester, and this will promote joint working and more robust pathways.</p>	Head of Healthcare Completed Clinical audit to be undertaken December 2014.	
2	The Head of Healthcare should ensure that healthcare staff record any advice given about a prisoner's medical conditions in his clinical record.	Accepted	<p>All staff have been reminded about the Nursing and Midwifery (NMC) code regarding record keeping and any breaches to the code will be reported onto the DATIX incident management system. Details of the NMC website were shared with staff and verbal guidance was provided at team huddles.</p> <p>We will also introduce a peer review of medical records, sharing learning from best practice and identifying areas for improvement.</p>	Head of Healthcare 30/09/14	
3	The Governor should ensure that all managers conducting adjudications are fully competent and understand their responsibilities to conduct fair adjudication hearings, in accordance with Prison Service Instruction 47/2011	Accepted	<p>Written guidance will be sent to all adjudicators, reflecting PSI 47/2011, to remind them of relevant requirements, including the circumstances in which it is appropriate to conduct an adjudication in the prisoner's absence and the requirement that the prisoner must be informed of the verdict and given the opportunity to offer any mitigation before the level of punishment is decided.</p>	Deputy Governor 30/09/14	
4	The Governor should ensure that managers imposing punishments at adjudications and	Accepted	<p>Written guidance will be sent to all adjudicators reflecting PSI 47/2011, to remind them that they must consider the likely impact on the health and welfare of</p>	Deputy Governor 30/09/14	

Prison Service Action Plan

No	Recommendation	Accepted/Not Accepted	Response	Target date for completion and function responsible	Progress (to be updated after 6 months)
	taking associated decisions afterwards, fully consider the likely impact on the health and welfare of the prisoner.		<p>the prisoner when deciding on the level of punishment, and ensure that this is noted on the record of hearing.</p> <p>Management checks on the records of hearings will be undertaken monthly by the Governor to ensure compliance.</p> <p>Written guidance will be issued to staff to inform them that they must consider the likely impact on the health and welfare of the prisoner when taking decisions after an adjudication, such as reviews of employment or IEP status.</p>		
5	The Governor should ensure that all prison staff are made aware of and understand PSI 03/2013, the local protocol and their responsibilities during medical emergencies and that: <ul style="list-style-type: none"> • Staff efficiently communicate the nature of a medical emergency • There are no delays in calling, directing or discharging ambulances and • Contingency plans are readily available which managers and staff are familiar with and follow. 	Accepted	<p>A local notice to staff regarding medical emergencies has been re-published. This is displayed in the control room, the centre and wing offices. It includes specific instruction on efficient communication of the nature of a medical emergency.</p> <p>The Local Security Strategy (LSS) on access for emergency vehicles has been reviewed.</p> <p>A local notice to staff has been issued informing them of the location of contingency plans and how they should be used.</p>	Head of Operations Complete	
6	The Governor should ensure that wherever possible, staff from Winchester should visit the next of kin in person to break the news of a death unless the distance is so far that there are clear benefits in using family liaison officers from other prisons.	Accepted	Written guidance will be shared with all Duty Governors and Family Liaison Officers about the procedure for notifying the next of kin following a death in custody, including the requirement that telephone notification should only be used as a last resort and in exceptional circumstances. Representatives from HMP Winchester will visit next of kin unless this is not practical, in which case another prison should be contacted and asked to appoint an FLO to ensure that the next of kin is informed in person.	Head of Safer Custody 30/09/14	
7	The Governor should	Accepted	Written guidance has been sent to all Duty	Head of	

Prison Service Action Plan

No	Recommendation	Accepted/Not Accepted	Response	Target date for completion and function responsible	Progress (to be updated after 6 months)
	ensure that a hot debrief takes place after a death in the prison and that all staff involved are offered effective support.		Governors regarding the importance of holding the hot debrief, and we will ensure that this takes place after every death in custody.	Safer Custody complete	

