

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Fraser Winton a prisoner at HMP Garth on 5 November 2016

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

Our Vision

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

Our Values

We are:

Impartial: *we do not take sides*

Respectful: *we are considerate and courteous*

Inclusive: *we value diversity*

Dedicated: *we are determined and focused*

Fair: *we are honest and act with integrity*



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

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

Mr Winton was found unresponsive in his cell at HMP Garth on 5 November 2016 and was taken to hospital, where he died of heart problems after a drug overdose. Mr Winton was 42 years old. I offer my condolences to Mr Winton's family and friends.

There were several incidents where staff suspected that Mr Winton had used New Psychoactive Substances (NPS) during his time in custody and in the months leading up to his death. Intelligence received after his death suggested that NPS use was widespread, organised and used by prisoners as a form of group entertainment, with Mr Winton as a possible willing victim. Garth's Violence Reduction and NPS policies were not effective in providing Mr Winton with the protection he required, either from his own willingness to take drugs or the actions of those who may have manipulated him or facilitated his access to drugs. Although Garth has taken steps to address the problem of NPS, it is clear that there is much more to do and that, as noted by HMIP, until this happens, the prison will remain unsafe.

It is troubling that there were delays in the control room calling an ambulance and staff did not provide the ambulance service with the information required to send an appropriate response.

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

Elizabeth Moody
Acting Prisons and Probation Ombudsman

November 2017

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Summary

Events

1. On 9 July 2015, Mr Fraser Winton was sent to HMP Durham after being charged with attempted murder.
2. Mr Winton had a history of suicide attempts, self-harm and substance misuse including alcohol, LSD and crack cocaine. A nurse referred him to the substance misuse and mental health teams. A psychological wellbeing practitioner referred him for counselling after he told her that he self-medicated with alcohol and drugs and had nightmares and trouble sleeping after being seriously assaulted in 2014.
3. Staff noted four incidents at Durham where Mr Winton was suspected to be under the influence of illicit substances. On one occasion, Mr Winton was going in and out of consciousness and having muscle spasms. Staff called an ambulance, but Mr Winton refused to go to hospital and received treatment from healthcare staff.
4. On 14 March 2016, Mr Winton transferred to HMP Garth and was referred to substance misuse and mental health services. On 22 April, Mr Winton saw a substance misuse worker to address his alcohol misuse. On 25 May, the mental health team referred him to a psychological therapist. He regularly attended appointments for trauma, low mood and sleeping problems.
5. On 6 June, Mr Winton told his psychological therapist that other prisoners had threatened him and he had been told to pay another prisoner's debt. He would not say who had threatened him, did not want to say anything else about the incident, and said that he could defend himself. The psychological therapist submitted an intelligence report and told a prison manager, who spoke to him. As Mr Winton did not want to talk about the incident, the prison manager noted in the observation book that staff should monitor him.
6. On 7, 8 and 9 June, staff found Mr Winton with symptoms that suggested he was under the influence of NPS. Mr Winton was seen by healthcare, referred to substance misuse services and disciplined in line with the prison's NPS Strategy.
7. Between 11.15am and 11.30am on 5 November, Mr Winton returned to his cell after finishing his work in the kitchen. CCTV footage showed 17 prisoners entering and leaving Mr Winton's cell between 11.23am and 12.00pm. One of those prisoners saw that he was lying on the bed and was blue and not breathing. He could not find a pulse, so he started CPR. Another prisoner found an officer and asked for help.
8. At 12.02pm, officers entered Mr Winton's cell, started CPR, and called an emergency code over the radio. The control room did not call an ambulance until 12.08pm. At 12.10pm, healthcare staff arrived and tried to resuscitate Mr Winton. At 12.21pm, paramedics arrived and transferred Mr Winton to hospital at 1.08pm. Hospital staff continued to try to resuscitate him but, at 1.41pm, recorded that he had died.

Findings

9. Garth's violence reduction and NPS policies were not effective in protecting Mr Winton or in reducing incidents of violence and NPS use. It appears that Mr Winton was able to access NPS with ease and was part of a culture of bullying and NPS abuse. Staff were aware that NPS were widely available in the prison and told the investigator that they felt limited in how they were able to respond to the problem.
10. Control room staff did not immediately call an ambulance after an emergency code was called and were unable to provide paramedics with sufficient information about Mr Winton's condition so that they could send the appropriate response.

Recommendations

- The Governor should review existing policies and their implementation to ensure they are effective in identifying indicators and risks of bullying and violent behaviour, including the impact of illicit substances and associated debt.
- The Executive Director for the Long-Term and High Security Estate should review this case in light of our recommendations and identify lessons learned and examples of good practice for managing challenging prison populations within the high security estate, which can be transferred and implemented at Garth.
- The Governor should ensure that all prison staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies as outlined in the local Medical Emergency Response Code Protocol so that staff efficiently communicate the nature of a medical emergency, and there is no delay in calling, directing or discharging ambulances.

The Investigation Process

11. The investigator issued notices to staff and prisoners at HMP Garth informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
12. The investigator visited HMP Garth on 16 November 2016. She obtained copies of relevant extracts from Mr Winton's prison and medical records and interviewed two prisoners.
13. NHS England commissioned a clinical reviewer to review Mr Winton's clinical care at the prison.
14. The investigator interviewed one member of staff by phone on 2 February 2017 and 10 members of staff at HMP Garth on 8 and 9 February 2017. The clinical reviewer attended interviews on 9 February 2017.
15. We informed HM Coroner for Preston and West Lancashire of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
16. One of the Ombudsman's family liaison officers contacted Mr Winton's brother to explain the investigation and to ask if he had any matters he wanted the investigation to consider. Mr Winton's brother wanted further information about Mr Winton's cause of death and the chronology of events, particularly in relation to the emergency response. He wanted to know when an ambulance was called by the prison and when it arrived, and the emergency equipment that was used by prison and ambulance staff. Mr Winton's brother received a copy of the initial report. He did not raise any further issues, or comment on the factual accuracy of the report.
17. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out some factual inaccuracies and this report has been amended accordingly.

Background Information

HMP Garth

18. HMP Garth holds up to 846 men, many serving indeterminate sentences for public protection, life sentences, or other long sentences. Lancashire Care Foundation Trust provides health services.

HM Inspectorate of Prisons

19. The most recent inspection of Garth was in January 2017. Inspectors found that Garth held some very challenging and serious offenders, with nearly every prisoner serving more than four years and half serving over 10 years. Nearly everyone had been convicted of serious violent offences and inspectors found that Garth held some very dangerous men and was managing considerable risk.
20. Inspectors found that the prison was very unsafe and its current approach to violence reduction was limited, one-dimensional and not working. Despite this, intelligence was well managed and the quality of security related information submitted was good, along with the recording and analysis of violence to identify patterns and trends.
21. Inspectors also found that Garth had a major drug problem. Survey results, positive mandatory drug testing results, and drug finds indicated high levels of illicit drugs, diverted medication and illegally brewed alcohol. The drug strategy committee, however, was much improved and good attendance and a 'whole prison' approach to action planning were helping to improve both demand and supply reduction efforts. Security searching had yielded considerable drug finds.
22. The inspection found that staff supervision was problematic, and that staff lacked confidence, were dismissive or disengaged. Poor prisoner behaviour went unchallenged, staff grouped together for long periods in wing offices, and wings were not supervised well enough. Inspectors recommended that staff presence and the supervision of all prisoner areas should be improved.

Independent Monitoring Board

23. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to November 2015, the IMB's main concern was the increase in use of illicit NPS substances. They also noted that there was an improved security strategy. The IMB found that there was a more strategic approach to the collection and analysis of intelligence which in turn led to more effective searching and improved levels of security.

Previous deaths at HMP Garth

24. Mr Winton's is the third of four non-natural deaths at HMP Garth since September 2016. Similar issues in relation to the bullying, the availability of drugs and the emergency response were also raised in these investigations.

New Psychoactive Substances (NPS)

25. New psychoactive substances, previously known as 'legal highs' are an increasing problem across the prison estate. They are difficult to detect and can affect people in a number of ways including increasing heart rate, raising blood pressure, reducing blood supply to the heart and vomiting. Prisoners under the influence of NPS can present with marked levels of disinhibition, heightened energy levels, a high tolerance of pain and a potential for violence. Besides emerging evidence of such dangers to physical health, there is potential for precipitating or exacerbating the deterioration of mental health with links to suicide or self-harm.
26. In July 2015, we published a Learning Lessons Bulletin about the use of NPS and its dangers, including its close association with debt, bullying and violence. The bulletin identified the need for better awareness among staff and prisoners of the dangers of NPS; the need for more effective drug supply reduction strategies; better monitoring by drug treatment services; and effective violence reduction strategies.
27. NOMS now has in place provisions that enable prisoners to be tested for specified non-controlled psychoactive substances as part of established mandatory drugs testing arrangements. Testing has begun, and NOMS continue to analyse data about drug use in prison to ensure new versions of NPS are included in the testing process.

Key Events

HMP Durham

28. On 9 July 2015, Mr Winton was remanded into custody and was sent to HMP Durham on charges of attempted murder. This was not his first time in prison.
29. Mr Winton had a history of depression, substance misuse, suicide attempts and self-harm. A reception nurse referred Mr Winton to the substance misuse and mental health teams. Staff monitored Mr Winton but no withdrawal symptoms were noted.
30. On 27 July, a psychological wellbeing practitioner assessed Mr Winton. He told her that he had been seriously assaulted in Scotland and had flashbacks and nightmares from the attack. Mr Winton said that he had made four previous suicide attempts, self-harmed by cutting his arms and used alcohol and drugs to cope when he was in the community. She referred him to the trauma service and an assistant psychologist provided strategies to help Mr Winton sleep.
31. During the period from 30 October until 30 November 2015, staff noted four incidents where they suspected that Mr Winton had taken NPS. In each incident, healthcare staff attended, staff submitted an intelligence report and managed Mr Winton under the Incentive and Earned Privileges (IEP) scheme (which aims to encourage and reward responsible behaviour. There are four levels: entry, basic, standard and enhanced).
32. On 30 November, staff called healthcare to the workshop where Mr Winton was going in and out of consciousness and having muscle spasms. A nurse assessed Mr Winton and called paramedics who arrived and monitored his heart rate. Against healthcare advice, Mr Winton refused to go to hospital and remained in prison under observation. On 7 December, a substance misuse worker spoke to Mr Winton but he said he did not need any services.
33. On 10 December, Mr Winton had a fight with another prisoner. He said they were 'winding him up' and poking him with a pen. In line with Garth's violence reduction policy, Mr Winton was placed on report, his IEP level was reduced to basic, and a Challenging Anti-Social Behaviour (CAB) document was started (a tool used to manage anti-social behaviour through assessment, monitoring and intervention).
34. On 1 April, Mr Winton was sentenced to 10 years and 9 months in prison for wounding with intent to do grievous bodily harm.

HMP Garth

35. On 14 April 2016, Mr Winton arrived at HMP Garth and told a nurse in reception that he felt low but did not feel like self-harming or suicide. The nurse referred him to the mental health team.
36. On 20 June, a mental health nurse assessed Mr Winton. He told her that since he was attacked in 2014 he had become increasingly stressed and had been prescribed citalopram for his mental health problems. She spoke to the

psychological therapist about Mr Winton and they agreed to refer him to counselling for trauma.

37. On 21 April, an offender supervisor referred Mr Winton for substance misuse services. The next day, a substance misuse worker spoke to Mr Winton and gave him a harm reduction and overdose leaflet. On 27 April, she assessed Mr Winton in a triage appointment. He said that he used alcohol to self-medicate because he had problems with anxiety and sleeping. She provided harm minimisation and overdose information, and discussed a referral to the counselling service. Mr Winton said he would be interested in participating in some groups. It was noted he would attend mindfulness, self-esteem, alcohol interventions and offending behaviour groups.
38. On 25 May, a psychological therapist assessed Mr Winton, using tests for depression and anxiety. She noted that he had severe depression and moderate anxiety and arranged a further appointment to complete the assessment, noting she needed more information about his low mood and trauma-related anxiety.
39. On 6 June, Mr Winton told the psychological therapist that other prisoners had threatened him and told him to pay another prisoner's debt. Mr Winton said that he did not want any action to be taken and would not say anything else about the incident. He said that he felt able to defend himself if anyone tried to assault him. She told the investigator that Mr Winton did not want to go into detail about the incident and when she asked him to tell her who was making the threats, he said it was not serious, he was not worried about it, and he did not want to talk about it any further. She submitted a security intelligence report about the incident.
40. On 7 June, an intelligence report noted that a workshop staff member saw that Mr Winton was grey in colour and unsteady on his feet. The staff member got Mr Winton a chair and asked him to sit down. They noted that he was slurring his words and slumping down on the table as he was working. Mr Winton said that he was okay. A nurse assessed him and staff took him back to the wing. Mr Winton told her that he had not taken NPS or any other substance and was suffering from anxiety because he was worried about his daughter who had been in an accident. She noted that Mr Winton was alert and oriented, able to talk in full sentences but was slightly unsteady on his feet.
41. The intelligence report noted that Mr Winton was to be put on basic IEP level for being under the influence of NPS but was given paperwork to appeal this decision and told his IEP level would be reviewed in seven days. The prison manager on Mr Winton's wing was told about the threats Mr Winton had disclosed so that they could speak to him, and the report noted he was being managed on the wing.
42. On 8 June, a workshop instructor found Mr Winton 'rocking' on the side of the workbench. Mr Winton had to be seated on a chair because his balance was becoming unstable and dangerous. He thought that Mr Winton was under the influence of NPS and notified healthcare staff immediately. A nurse assessed Mr Winton and noted that he was alert and knew the time but took three attempts to tell her what day it was. Mr Winton was able to walk back to his cell and she told officers to observe him every half an hour for two hours and to contact healthcare if they had any concerns. The workshop instructor submitted an intelligence

report and told a prison manager what had happened. The intelligence report recorded that there appeared to be 'a common practice of taking drugs in the workplace'. Mr Winton was placed on a CAB document for being under the influence of drugs.

43. On 9 June, a nurse assessed Mr Winton, as it was suspected he had taken NPS. Mr Winton told him that he had not taken anything and was worried about his daughter because he did not know if she has been seriously injured in an accident the day before. He noted that Mr Winton was conscious and oriented and that wing staff would get some information about his daughter.
44. A prison manager told the investigator that Mr Winton had previously told a member of staff that he was forced to take on someone else's debt but was refusing to accept it. Mr Winton said he had no safety issues, did not need any support and would not say who was threatening him. The manager noted that staff had been told to keep an eye on him. A supervising officer (SO) noted that Mr Winton had made a phone call to his mother, who told him that his daughter was fine and no longer in hospital.
45. On 13 June, Mr Winton was dismissed from his job in the workshop for being under the influence of NPS. The workshop instructor said that a prisoner would normally lose their job in the workshop when they are found under the influence of drugs, but because he thought of Mr Winton as a 'good prisoner' and Mr Winton promised it would never happen again, staff had initially decided to give him another chance. It was noted two days later that Mr Winton's mandatory drug test results were negative.
46. A prison manager in Safer Custody said that in response to the drug problem in the workshop, the prison reduced the number of prisoners in the workshop. They also increased the number of random searches of prisoners, increased the patrols of vulnerable areas and briefed staff on drug use and what action to take if they saw or suspected a prisoner had taken drugs. In addition, they increased the literature for prisoners about NPS.
47. On 16 June, a SO reviewed Mr Winton under the IEP process after he was reduced to basic level for being under the influence of NPS. He noted Mr Winton was under the care of the substance misuse team and had been working with them to address his alcohol misuse in the community. Mr Winton wanted to appeal against the IEP decision and said he had not been under the influence of NPS earlier that month, and was not drug tested at the time. He told Mr Winton that he would contact the workshop instructor and if there was doubt that he was under the influence of NPS, he would be removed from basic IEP level. The psychological therapist told the investigator that Mr Winton said that officers had mistaken his anxiety for drug use and that he had not taken any NPS.
48. On 17 June, a prisoner manager reviewed Mr Winton in line with Garth's NPS protocol. Mr Winton told her that he did not use NPS, but was very tired after not sleeping for days and had been crying. He said that he would attend the NPS sessions to get a better understanding of the substance.

49. On 23 June, a SO heard Mr Winton's IEP appeal, but it was not successful. In line with the prison's NPS policy, he remained on basic level until 1 July when his IEP level was increased to standard.
50. On 27 June, the psychological therapist noted that she had agreed with Mr Winton to use their appointments to address his low mood before starting trauma counselling. She talked to Mr Winton about medication for his mood and Mr Winton said that he would think about it. She noted that Mr Winton had no current thoughts of self-harm but felt hopeless at times. On 1 July, Mr Winton attended a NPS group session and two group sessions on building self-esteem.
51. On 25 July, a prison GP noted that Mr Winton had been feeling low and said that on some days he wished that he was not alive and did not know how he would cope with his lengthy sentence. He said that he had no thoughts of self-harm but had not been sleeping. The GP prescribed mirtazapine (an antidepressant).
52. From 25 July until 15 November, the psychological therapist worked with Mr Winton on his sleeping problem and helped him to engage in meaningful activity within the prison. In August, he started to work on his sentence appeal after renewing his application.
53. In September, Mr Winton's mood and sleep started to improve. On 3 October, Mr Winton said he had no thoughts to harm himself but he sometimes wished he had died in the attack in 2014. A week later, the psychological therapist noted that Mr Winton arrived at his appointment with marks on his nose where his glasses sat and a cut on his lower lip. Mr Winton said that he fell out of bed after having a nightmare. She said that she felt that Mr Winton was not telling her the truth and challenged him, but he was firm and said that he had fallen out of bed. She did not take any further action.
54. On 31 October, Mr Winton phoned his mother and spoke about his appeal. He told her that he felt safer in prison than in the community. The next day, Mr Winton attended a review with a prison manager. She noted that he said he was doing well but was stressed about his appeal and was having some issues with his family and contacting his daughter. They reviewed his recovery plan and noted that she would see Mr Winton again in November.
55. On 2 November, Mr Winton's appeal hearing was listed for 9 November. He arrived late to his appointment with the psychological therapist, who noted that instead of starting trauma work, they focussed on presenting his appeal. This was Mr Winton's last appointment with her.

5 November

56. Between 11.23am and 12.00pm, CCTV footage showed 17 prisoners entering and leaving Mr Winton's cell. Nine prisoners left Mr Winton's cell between 11.45am and 12.00pm.
57. A prisoner said that around 11.00am, a prisoner told him that someone on the wing had 'taken something'. He went back to his cell and 20 minutes later saw other prisoners on the wing looking worried and went to see what was happening. He said that other prisoners were saying 'He's dead'. He went into Mr Winton's

- cell and saw him lying on his bed and his lips were blue. He said that he could not find a pulse and that Mr Winton was not breathing. He started CPR.
58. Another prisoner went to Mr Winton's cell just before 12.00pm after he was told that a prisoner had taken some 'Mamba' (a form of NPS) and he should go and check on them. He saw Mr Winton lying on the bed. He said that Mr Winton was blue and he thought that Mr Winton had died. The prisoner performing CPR told him to get help, and he went to find an officer.
 59. At 12.00pm, the prisoner told Officer A that the prisoner in Mr Winton's cell was blue. Officer A went to Mr Winton's cell with Officer B, followed by Officer C. At 12.02pm, Officer C called a code blue emergency call (indicating a prisoner with breathing problems).
 60. Officers A and B moved Mr Winton from the bed to the floor, checked for a pulse but could not find one and noted that Mr Winton was not breathing. Officer B started CPR. He said he tried CPR in case there was a chance Mr Winton could be resuscitated, but thought he had died because he was blue in colour and he could not get any response from him.
 61. A SO arrived. Officer B asked Officer A to get the defibrillator machine (a life-saving device that gives the heart an electric shock in some cases of cardiac arrest). Officer A went onto the landing and asked an officer to get the defibrillator machine from the wing office. He took it to Mr Winton's cell and started setting it up on the bed.
 62. At 12.05pm, a nurse arrived. The nurse told the officer to continue giving chest compressions. Officer A said that he had not used the defibrillator machine before, so the nurse applied the defibrillator pads to Mr Winton's chest and maintained his airway.
 63. An operational support grade (OSG) working in the control room said that a fire alarm had been activated one minute before the code blue was called over the radio. She said that she was managing the fire alarm as her colleague had not been trained in emergency procedures. An experienced operational support grade arrived at the control room and managed the code blue while she managed the fire alarm.
 64. At 12.08pm, the ambulance service logged a call from the prison. The OSG said that her colleague told the ambulance service that they could not give them any information about the incident. The ambulance service said that paramedics would arrive in 11 minutes. The nurse asked an officer to tell the control room that it was a cardiac arrest so an officer called this over the radio.
 65. At 12.14pm, control room staff called the ambulance service a second time and told them it was a cardiac arrest. The ambulance service advised that paramedics would arrive in seven minutes.
 66. At 12.10pm, another nurse arrived and took over CPR. The first nurse noted that Mr Winton's pupils were fixed and dilated. She continued chest compressions and airway management until the ambulance arrived.

67. At 12.21pm, paramedics arrived at the prison and at Mr Winton's cell four minutes later. They asked an officer if Mr Winton had taken any substances, so he went to ask some prisoners. One prisoner said that Mr Winton had a pipe of NPS. Paramedics continued trying to resuscitate Mr Winton and moved him to the ambulance at 12.55pm.
68. At 1.08pm, paramedics took Mr Winton to hospital. The ambulance crew continued to try to resuscitate him in the emergency room, but were unsuccessful, and at 1.41pm, recorded that he had died.

Information received after Mr Winton's death

69. Several intelligence reports were submitted after Mr Winton's death. On 5 November, a prisoner who was located on the same wing as Mr Winton said that someone had given Mr Winton a joint of 'black Mamba' before he died. The prisoner said that it was common to 'get Mr Winton high' for a laugh because he 'always goes under'. He said that there were many people around Mr Winton in his cell, but they all left so they would not be implicated when the situation took a turn for the worse.
70. A further intelligence report noted that a staff member heard that prisoners on E wing were playing a game with drugs where if a prisoner could smoke £50 worth of NPS without effect, then they did not have to pay for it. The report noted that this might have been related to Mr Winton's death. Another report noted that a prisoner said that Mr Winton would have taken Spice (a form of NPS) and said that if prisoners were unable to afford to buy Spice, they were given a challenge to smoke it and get it for free.
71. In response to these reports, the prison worked with the substance misuse team, who delivered harm reduction advice to prisoners in all work areas that focussed on the dangers of pipes. The substance misuse team talked to prisoners about the entertainment culture of NPS and the dangers when a prisoner 'goes under', and developed a new six session course on NPS. The prison also published newsletters and notices on the dangers of NPS and arranged for an advanced paramedic to speak to the most prolific NPS users and substance misuse mentors to dispel myths around NPS and give information about survival rates.
72. On 7 November, an intelligence report was submitted noting that a prisoner told staff during a mental health appointment that officers should look at the CCTV footage because people entering the cell just before the incident are the ones who gave Mr Winton some NPS to 'test it out'. He said that another prisoner was also testing out the NPS and he saw them stumbling around the pool table. Another report suggested that Mr Winton would say to other prisoners 'give me some of that stuff if you want to see me go off my head and have a fit'. It was noted that another prisoner who was the organiser gave the pipe to Mr Winton. Staff tried to discuss what had happened with the prisoners that were seen entering and leaving Mr Winton's cell, but the prisoners refused to speak about it. Staff told the police the names of these prisoners but the police decided not to take any further action.

Contact with Mr Winton's family

73. At 2.00pm, the prison appointed an officer as the family liaison officer. At 5.15pm, Lancashire police contacted Scottish police, who told Mr Winton's family that he had died. Mr Winton's brother called the prison at 8.00pm and was given the officer's contact details. At 8.30pm, the Governor called Mr Winton's brother and explained the role of the family liaison officer and asked if they would like to visit the prison. On 9 November, Mr Winton's mother and brother visited the prison and collected his personal belongings. The prison contributed to the costs of Mr Winton's funeral, in line with national guidance.

Support for prisoners and staff

74. After Mr Winton's death, the Governor debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.
75. The prison posted notices informing other prisoners of Mr Winton's death, and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Winton's death.

Post-mortem report

76. Mr Winton's cause of death was noted as hypertensive heart disease and synthetic cannabinoid toxicity. Mirtazapine and carbamazepine (an anticonvulsant drug used in the treatment of epilepsy and bipolar disorder) were also detected in Mr Winton's system but in amounts that were within the therapeutic range. Mr Winton was not prescribed carbamazepine and it is unclear how Mr Winton obtained this drug. The presence of mirtazapine and carbamazepine did not contribute to Mr Winton's death.

Findings

Drugs, bullying and violence reduction

77. The HMIP inspection of Garth in January 2017 found that the prison had a major drug problem and that despite good efforts to reduce supply and demand, the use of NPS was particularly problematic, and that nearly half of all prisoners thought that drugs were easily available. Levels of violence had increased substantially since the last inspection and many incidents were related to drugs, gangs and debt. Inspectors noted that wings were not well supervised. Staff lacked confidence or were dismissive or disengaged, and poor prisoner behaviour went unchallenged while staff grouped around together for long periods in wing offices.
78. There were several incidents noted in Mr Winton's prison record where staff suspected that Mr Winton was under the influence of NPS. A number of intelligence reports were submitted after Mr Winton's death that noted it was 'common to get Mr Winton high' and that he had taken NPS on the day he died. Only two prisoners on the wing agreed to speak to the investigator. Mr Winton was under the care of the substance misuse team for his alcohol misuse, but he never admitted to staff that he had taken any illicit substances in prison.
79. The intelligence report submitted on 8 June noted that was a 'common practice' for prisoners to take drugs in the workshop. The workshop instructor said that workshop staff knew that prisoners took drugs in the workshop toilet, but that staff could not always be around this area. He said that the workshop is where prisoners from different wings get to mix and they know that this is where drug dealing takes place.
80. The prison manager on Mr Winton's wing told the investigator that there were drugs on the wing every single day. He said that there were 10 intelligence-led cell searches on the wing every month but that staff needed evidence that a prisoner had drugs in order to take further action, which was very difficult to obtain.
81. At interview, prison officers said that they felt limited in what they could do to respond to the drug problem at Garth. An officer told investigators that the prison needed more staff to conduct searches of prisoners, civilians and staff to stop drugs getting into the prison. He said that supervising prisoners was very difficult and that there were not enough staff. CCTV footage showed that prison staff were not visible on the wing during the period in which the incident on 5 November took place. In the most recent HMIP report, inspectors recommended that staff presence and supervision of all prisoner areas should be improved and consistent and confident staff-prisoner relationships should be embedded.
82. Mr Winton told staff that prisoners had threatened him and he was being forced to pay their debts. We are not satisfied that staff took Mr Winton's concerns sufficiently seriously and consider that he should have been more closely monitored him in line with the prison's Violence Reduction Strategy.
83. Garth's Violence Reduction and NPS policies were not effective in providing Mr Winton with the protection he required either from his own willingness to take

drugs or the actions of those who may have manipulated him or facilitated his access to drugs.

84. We are concerned that Garth's policies have also been ineffective in reducing incidents of violence and NPS use. The HMIP inspection and Mr Winton's death are testament to this. We make the following recommendations:

The Governor should review existing policies and their implementation to ensure they are effective in identifying indicators and risks of bullying and violent behaviour, including the impact of illicit substances and associated debt.

The Executive Director for the Long-term and High Security Estate should review this case in light of our recommendations and identify lessons learned and examples of good practice for managing challenging prison populations within the high security estate, which can be transferred and implemented at Garth.

Emergency response

85. PSI 03/2013 on Medical Emergency Response Codes requires staff to use a code blue or equivalent code in a medical emergency and for the control room to call an ambulance immediately when an emergency code is used. The PSI is clear that prisons should not wait for healthcare staff or a duty manager to decide whether an ambulance is needed and that an ambulance can be cancelled later if not needed. Garth's Information Notice 105/15 on 'Medical Emergency Response Codes' also makes it clear that control room staff should automatically call an ambulance when a code blue is called. We make the following recommendation:

The Governor should ensure that all prison staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies as outlined in the local Medical Emergency Response Code Protocol so that staff efficiently communicate the nature of a medical emergency, and there is no delay in calling, directing or discharging ambulances.

**Prisons &
Probation**

Ombudsman
Independent Investigations