Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Andrew Winspear, a prisoner at HMP Hull, on 8 August 2023

A report by the Prisons and Probation Ombudsman

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OUR VISION

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

WHAT WE DO

WHAT WE VALUE

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

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

Mr Andrew Winspear was found hanging in his cell at HMP Hull on 8 August 2023. Staff and paramedics tried to resuscitate him but were unsuccessful. Mr Winspear was 53 years old. I offer my condolences to his family and friends. Mr Winspear was the fourth self-inflicted death at Hull in three years.

Staff had started suicide and self-harm procedures (known as ACCT) for Mr Winspear on the morning of 8 August, after he self-harmed by cutting. Later that day he received a longer than expected prison sentence at a video link court hearing, but staff did not reassess his risk.

We found similar failings in our investigation into a death at Hull in 2021 and were assured that processes had since been reviewed and staff had been briefed on the correct procedures to follow. It is disappointing therefore that the same issues have arisen again. I have asked the Governor to carry out an audit to assure himself that staff are following the correct procedures following video link appearances.

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

Adrian Usher
Prisons and Probation Ombudsman **April 2024**

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Summary

Events

1. On 21 March 2023, Mr Andrew Winspear was remanded in prison, charged with burglary, and sent to HMP Lincoln. It was not his first time in prison.

2. Mr Winspear had a long history of self-harm and was supported using suicide and self-harm prevention procedures (known as ACCT) multiple times during previous sentences.

3. From 15 to 16 May, staff supported Mr Winspear using ACCT procedures after he self-harmed by cutting. Mr Winspear told staff that he was worried about his baby son who had been taken into foster care as his ex-partner was also in prison. Mr Winspear said he hoped to be released in a few months and then seek custody of his son.

4. On 5 July, Mr Winspear was moved to HMP Hull.

5. On 27 July, Mr Winspear saw his son on an arranged visit. His son was then taken to HMP New Hall's Mother and Baby Unit to be with Mr Winspear's ex-partner.

6. On 8 August, Mr Winspear was due to be sentenced at a video link hearing. He refused to go, jumped from the first-floor landing onto the netting and then made cuts to his arm. Staff started ACCT procedures. Mr Winspear said he had hoped to go to court in person as he thought he could defend himself better and was more likely to be released.

7. Later that morning, Mr Winspear did attend his video link court hearing and was sentenced to 16 months. With time already served, it left him with three more months in prison.

8. At around 5.18pm, two officers went to Mr Winspear's cell and found him with a ligature around his neck. One of the officers called a medical emergency code. The other officer removed the ligature from Mr Winspear's neck and started cardiopulmonary resuscitation (CPR). Other prison staff arrived and continued CPR.

9. Ambulance paramedics arrived at 5.28pm and took over CPR. They were unable to resuscitate Mr Winspear and at 5.56pm, they pronounced that he was dead.

Findings

10. Mr Winspear's ACCT document did not accompany him when he attended his video link court appearance as it should have done, so staff in Official Visits did not know that Mr Winspear was on an open ACCT. The prison told us that managers had spoken to the member of staff responsible who acknowledged that he had not followed correct procedures.

11. Staff in Official Visits were unaware that Mr Winspear's status had changed (to a sentenced prisoner) after his video link appearance. Under national policy, Mr Winspear's risk of suicide and self-harm should have been reassessed and he should have been referred to healthcare staff. However, neither happened.

12. We found similar failings following a death at Hull in 2021. We were told then that a review was undertaken in March 2022 and staff had been briefed on the correct procedures to follow, including referring prisoners who have had a change in status for a risk assessment in reception and to see a nurse. We have been told that staff have again been briefed following the death of Mr Winspear but we have some concerns about how well the new procedures have been embedded given that the same issue has arisen again. We require assurance that staff are routinely following the correct procedures following video link court appearances.

13. More generally, we are concerned that HMPPS' policy relating to prisoner safety should be amended to ensure that prisoners appearing in court by video link are subject to the same processes to assess their risk as those appearing in court in person. HMPPS has assured us that the new Prisoner Safety Framework, due to be implemented in 2024, will reflect this.

Recommendations

- The Governor should undertake an audit to assure himself that staff are adhering to the correct procedures following court appearances by video link and report the results to the Ombudsman.

The Investigation Process

14. HMPPS notified us of Mr Winspear's death on 8 August 2023.

15. The investigator issued notices to staff and prisoners at HMP Hull informing them of the investigation and asking anyone with relevant information to contact him. No one responded.

16. The investigator visited Hull on 17 August. He obtained copies of relevant extracts from Mr Winspear's prison and medical records.

17. The investigator interviewed one member of prison staff at Hull on 17 August. He interviewed two other members of prison staff over video call on 1 and 8 December.

18. NHS England commissioned an independent clinical reviewer to review Mr Winspear's clinical care at the prison. The clinical reviewer and investigator conducted joint interviews with three members of healthcare staff on 6 October, and on 4 and 7 December by video call.

19. We informed HM Coroner for Hull and East Riding of the investigation. The Coroner gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

20. The Ombudsman's family liaison officer wrote to Mr Winspear's brother to explain the investigation and to ask if he had any matters he wanted us to consider. He did not respond.

21. We shared our initial report with HMPPS. They found no factual inaccuracies.

Background Information

HMP Hull

22. HMP Hull is a local prison that holds up to 958 men in ten wings. Spectrum CiC Healthcare took over delivery of primary healthcare services in August 2022, from City Health Care Partnership. Mental health and substance misuse services are still provided by City Health Care Partnership.

HM Inspectorate of Prisons

23. The last full inspection of Hull took place in July 2021. It found that standards and outcomes had slipped after a succession of more positive inspections. Inspectors noted that there had been eight self-inflicted deaths and two non-natural deaths since the previous inspection in March 2018 and there was a lack of evidence that PPO recommendations made following these deaths had led to sustained change, particularly in relation to health care services. Inspectors reported that prisoners they spoke to were positive about the care they had received while subject to ACCT procedures. Working relationships between staff and prisoners remained positive.

24. Inspectors reported that health care services were weak well before the pandemic and were failing in some critical areas. Mental health services were not properly resourced. There were significant risks and unmet need which required immediate attention.

25. HMIP carried out an independent review of progress in March 2022. Inspectors found that there had been good or reasonable progress against eight of the recommendations reviewed. The strategic oversight of PPO recommendations had improved. Recommendations were now subject to monthly assurance checks, led by a custodial manager, and were discussed at the monthly 'safe and secure' meeting. However, healthcare leaders did not attend these meetings, due to clinical pressures, which meant that key recommendations for which health care managers were responsible were not subject to multidisciplinary oversight with prison colleagues. Inspectors found several examples of health recommendations which had still not been implemented or reviewed. Despite assurances from City Health Care Partnership that PPO recommendations were subject to corporate oversight, inspectors were not confident that actions to drive up service improvement were always implemented or embedded in practice.

Independent Monitoring Board

26. 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.

27. In its latest annual report for the year to 28 February 2023, the IMB reported that positive prisoner and officer relationships were observed throughout the prison, with officers demonstrating a detailed knowledge of prisoners in their care. They noted that prisoner applications to the IMB on health matters had reduced when compared to the previous reporting year and the Board had observed significant

operating changes and improvements from the new healthcare providers. However, at the end of the reporting year, the provision of healthcare services was still in a state of transition, with further improvements planned into the next year.

Previous deaths at HMP Hull

28. Mr Winspear was the 15th prisoner to die at Hull since August 2020. Of the previous deaths,11 were from natural causes and three were self-inflicted.

29. Following a self-inflicted death in May 2021, we made a recommendation to Hull that following a court appearance by video link, staff must record the outcome in the prisoner's prison record and should speak to the prisoner and consider whether the risk to themselves has changed.

30. Several PPO investigations in 2020, when the COVID-19 pandemic meant all court appearances were remote, found that prisoners were not being risk assessed after attending court by video link. We made a national recommendation to HMPPS to review their guidance. In March 2021, the Director General wrote to all Governors and Directors requiring them to review local processes to ensure that similar health screening arrangements, and the same processes for assessing risk of suicide or self-harm, were followed after video link appearances, as in reception following a physical appearance in court.

31. Also in March 2021, HMPPS issued a safety briefing on assessing the risk of harm in prisoners attending court by video link. In April 2021, they followed this up with another safety bulletin containing early learning review analysis of several issues including video court appearances. Both documents advised that it was vital that staff engage with prisoners after a video court appearance, and that they assess the prisoner's risk on the basis of official information, as well as the individual's presentation. They also advised that a verbal handover of key information should be given to wing staff and any new risk information should be recorded and shared on the prisoner's record (NOMIS) and the wing observation book. If necessary, concerns should be escalated, including starting ACCT procedures where appropriate.

32. We were told that in March 2022, the Head of Operations at Hull had completed a review of the procedures that must be undertaken following a prisoner's court appearance by video link to ensure any change in risk is fully considered. All staff involved in the process had been briefed by line managers regarding the updated procedures to ensure they were aware that when there is a change in circumstance, the prisoner should be taken to reception to undergo a Reception Risk Review. Staff were also reminded that the Visits Log Book and the prisoner's electronic prison record should be updated with the details of the hearing and the outcome. In addition, prisoners would be seen by the reception nurse to assess if the risk to themselves had changed.

Assessment, Care in Custody and Teamwork

33. ACCT is the Prison Service care-planning system used to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk, how to reduce the risk and how best to monitor and supervise the prisoner. After an

initial assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. Checks should be carried out at irregular intervals to prevent the prisoner anticipating when they will occur. Regular multidisciplinary review meetings involving the prisoner should be held.

Key Events

34. On 21 March 2023, Mr Andrew Winspear was remanded in prison, charged with burglary, and sent to HMP Lincoln. It was not his first time in prison.

35. Mr Winspear had a long history of self-harm (normally by cutting) and had been managed using Prison Service suicide and self-harm procedures (known as ACCT) multiple times during previous sentences. He also had a history of substance misuse (including heroin) and depression.

36. Staff at Lincoln managed Mr Winspear using ACCT from 15 to 16 May, after he made cuts to his arm. He told staff that he was worried about what would happen to his five-month-old son, who had been taken into foster care as his ex-partner, his son's mother, was also in prison. Mr Winspear said his sentencing was in September and he was hoping his charges would be reduced which would give him a better chance of being released and getting custody of his son.

37. On 23 May, Mr Winspear told his key worker that all his burglary charges had been dropped but he had one outstanding charge (of handling stolen goods, for which he had been convicted on 18 May). He thought he would be released due to time served on remand. Mr Winspear also said that he was offered the opportunity to be released on bail but refused as he thought it was best to stay in prison to help him with detoxification from alcohol and drugs.

HMP Hull

38. On 5 July, Mr Winspear was moved to HMP Hull.

39. A nurse conducted the reception screening. She noted Mr Winspear said he had no thoughts of suicide or self-harm. She also noted that Mr Winspear had not harmed himself in prison (which was incorrect as he had harmed himself as recently as 15 May).

40. The nurse noted that Mr Winspear said he had a problem with alcohol and drugs within the last three months and that he had previously been diagnosed with depression and was taking mirtazapine.

41. The nurse noted Mr Winspear was on methadone to treat his heroin addiction. Mr Winspear was expected to be released that day to a rehabilitation facility, but instead was remanded to Hull pending a court appearance on 17 July. A reduction of methadone was started, as per the conditions of acceptance into rehabilitation.

42. On 6 July, Hull's Mental Health Team (MHT) received a handover via email from Lincoln's MHT. The email said that Mr Winspear had been engaging in Eye Movement Desensitization and Reprocessing (EMDR) and was due to be discharged as he had completed the therapy. (EMDR is a comprehensive psychotherapy that helps people process and recover from past experiences that affect mental health and wellbeing.) A referral was created for the MHT at Hull.

43. Later that day, a nurse completed a MHT triage. He noted that there were no current risks or behaviours suggesting Mr Winspear was a risk to himself. Mr

Winspear was referred to 'Rethink' for a suitability assessment for 'Step 2' mental health support.

44. All prisoners' telephone calls, except those that are legally privileged, are recorded, and prison staff listen to a random sample. On 20 July, Mr Winspear telephoned his son's social worker. Mr Winspear asked the social worker the outcome of an assessment she was doing, but she said it was incomplete. Mr Winspear said he was due to be sentenced on 21 July, and expected to be released as he had a place booked in a rehabilitation facility near Glasgow. Mr Winspear sounded very positive and said he would be in some sort of isolation for a couple of weeks and then would be set up with his own flat.

45. On 20 July, an officer saw Mr Winspear for a key work session. She noted Mr Winspear said his ex-partner had gained custody of their son, and his son was going to stay with her at HMP New Hall's Mother and Baby Unit. She noted Mr Winspear was very happy about this and was continually smiling when he spoke about his son.

46. The key worker said Mr Winspear told her that he had been working hard to get himself back on track and clean (off drugs and alcohol). Mr Winspear said he had completed several courses while in custody and EMDR therapy to deal with past trauma. Mr Winspear said he had been sexually abused as a child while in the care system and had used drugs to cope with the trauma. She noted that Mr Winspear said he knew people in the care system should have protected him and he did not ever want that to happen to his son.

47. The key worker had contacted Mr Winspear's son's social worker about organising a visit, so Mr Winspear could see his son. She noted Mr Winspear was happy about this and he hoped to be released soon but, if that did not happen, he wanted the visit so he could see his son.

48. On 21 July, Mr Winspear called his son's social worker, leaving a message on her answer phone and asking if she could arrange for his son to visit him at Hull. This was the last call Mr Winspear made from his prison phone account. (Mr Winspear was not released on this date as he had anticipated.)

49. On 24 July, the key worker saw Mr Winspear for another key work session. She noted that Mr Winspear talked a lot about his son. She said Mr Winspear's son's social worker was trying hard to organise a visit for 27 July, so Mr Winspear could see his son before he went to New Hall. She said Mr Winspear had asked for more photographs of his son as he only had one and the social worker agreed to send some new pictures. She noted that Mr Winspear was excited about this news.

50. On 26 July, a Senior Psychological Wellbeing Practitioner contacted Mr Winspear on his in-cell telephone to assess whether Mr Winspear needed mental health services. He noted that Mr Winspear declined talking therapies. He said Mr Winspear told him that he had no thoughts of suicide or self-harm. He discharged Mr Winspear from the MHT.

51. Later that day, the key worker saw Mr Winspear for a key work session. She told Mr Winspear he would have the visit with his son the following day at 3.00pm. She noted that Mr Winspear was "over the moon".

52. On 27 July, the key worker saw Mr Winspear during his visit with his son. She noted that Mr Winspear's son reacted to his voice which left Mr Winspear in tears. She said that photographs were taken of Mr Winspear with his son, which would be printed out and given to Mr Winspear.

Events of 8 August

53. On the morning of 8 August, Mr Winspear was due to attend a video link court appearance for sentencing. An officer noted that, when told which way he would walk to Official Visits (where video link court appearances take place at Hull) Mr Winspear refused to go. As Mr Winspear would not follow staff's directions, they told him to go back to his cell.

54. At around 8.45am, Mr Winspear jumped onto the netting (which stops prisoners from falling between floors on the wing) from the first-floor landing. He said he was not getting off the netting because staff had stopped him going to court. Prison staff convinced Mr Winspear to come off the netting and escorted him back to his cell.

55. At around 10.10am, staff found that Mr Winspear had made a cut to his left arm. They called a code red medical emergency (used to indicate severe bleeding).

56. A nurse attended and dressed Mr Winspear's wound. She told the investigator that the cuts were not very deep. She said Mr Winspear told her that he was triggered to self-harm because he was expecting to go to court in person, but this was changed to video link. He felt that he could better defend himself in person, which he thought would have made it more likely he be released.

57. A Supervising Officer (SO) on G Wing noted in his statement that Mr Winspear said he self-harmed because he felt prison staff were stopping him from attending his court appearance.

58. An officer started ACCT procedures for Mr Winspear and handed the ACCT document to the SO.

59. At around 10.30am, the SO noted he received a telephone call requesting Mr Winspear attend the video link court appearance. He noted that he completed the ACCT Immediate Action Plan (IAP) verbally while he escorted Mr Winspear to Official Visits. He then returned to G Wing to complete Mr Winspear's ACCT document. He noted that he had forgotten to inform the prison staff in Official Visits that Mr Winspear was on an open ACCT, and because he wanted to complete his section of the ACCT document, it did not accompany Mr Winspear to Official Visits as it should have.

60. A Custodial Manager (CM) completed a 'Lessons Learnt Review' following Mr Winspear's death and spoke to several staff involved.

61. An officer told the CM that she personally set Mr Winspear up in video link booth 9. He was on his own as there were not enough staff to sit in with him. The officer said she told Mr Winspear that he needed to let an officer know the outcome of his court hearing when it finished. She said she was then deployed to another area and did not see Mr Winspear leave his hearing and was not aware that he had any communication with other staff.

62. A SO said that a prisoner from the segregation unit also had a video link court appearance that morning and additional staff were required to supervise him. As a result, no one was available to sit with Mr Winspear during his court appearance.

63. At his court appearance, for handling stolen goods, Mr Winspear received a determinate sentence of 16 months. (Accounting for the time he had already served, this meant Mr Winspear would not be released from prison for a further three months.)

64. At around 12.00pm, Mr Winspear was taken back to G Wing. No prison staff in Official Visits recalled interacting with Mr Winspear before he left.

65. The Head of Residence and Safety told the investigator he saw Mr Winspear sometime between 4.30pm and 4.45pm. He said Mr Winspear told him he had just been sentenced and asked what would happen to him next. He said he told Mr Winspear about the normal procedure. He did not know that Mr Winspear's risk to himself had not been reassessed following the court appearance as it should have been.

66. At around 4.55pm, an officer completed an ACCT check on Mr Winspear.

67. At around 5.18pm, two officers attended Mr Winspear's cell to hand Mr Winspear his adjudication paperwork for climbing on the netting earlier that day.

68. Officer A looked through the observation panel in Mr Winspear's cell door and saw that Mr Winspear had a ligature around his neck. Officer A turned to Officer B, who was approaching, and said, "Code Blue" (a medical emergency code used when a prisoner is unconscious or having breathing difficulties).

69. Officer B looked through the observation panel and saw Mr Winspear on the left side of the cell sitting on the floor, with his back resting on furniture units and his feet towards the bed. He said Mr Winspear had a ligature around his neck made from a ripped green bedsheet, which was attached to a screw in the wall.

70. Officer B unlocked the cell door and entered, while Officer A radioed a Code Blue. Staff in the control room immediately called for an ambulance.

71. Officer B activated his Body Worn Video Camera (BWVC). He used his anti-ligature knife to cut the ligature from around Mr Winspear's neck. He said Mr Winspear was blue and purple in colour. After checking and finding no signs of breathing, he started CPR.

72. More prison staff attended the cell and they took it in turns to carry out CPR.

73. A nurse attended the cell and set up an automated external defibrillator (AED). (An AED is a medical device that can analyse the heart's rhythm and, if necessary, deliver an electrical shock, or defibrillation, to help the heart re-establish an effective rhythm.) Two other healthcare staff arrived. Another nurse noted that the AED advised no shock, so staff continued CPR.

74. At around 5.28pm, an ambulance crew arrived at the cell and took over CPR. They were shortly followed by a second ambulance crew. Paramedics were unable to resuscitate Mr Winspear and at 5.56pm, pronounced that he was dead.

Contact with Mr Winspear's family

75. On 8 August, the prison appointed two family liaison officers (FLOs). At around 10.00pm, they attended Mr Winspear's brother's home and informed him of Mr Winspear's death.

76. The following day, the FLOs contacted New Hall and arranged for Mr Winspear's ex-partner to be informed of his death.

77. The FLOs stayed in touch with Mr Winspear's brother over the following weeks, offering support and advice.

78. The prison contributed to the costs of Mr Winspear's funeral in line with national policy.

Support for prisoners and staff

79. Postvention is a joint HMPPS and Samaritans initiative that aims to ensure a consistent approach to supplying staff and prisoners support following all deaths in custody. Postvention procedures should be started immediately after every self-inflicted death and on a case-by-case basis after all other types of death. Key elements of postvention care include a hot debrief for staff involved in the emergency response and engaging Listeners (prisoners trained by the Samaritans to supply confidential peer-support) to identify prisoners most affected by the death.

80. Postvention is not fully embedded at Hull. The Samaritans are not able to fully support Hull due to staffing levels. However, the Samaritans will be added to Hull's death in custody contingency plans early in 2024.

81. After Mr Winspear's death, a prison manager debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

82. The prison posted notices informing other prisoners of Mr Winspear'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 Winspear's death.

Post-mortem report

83. The post-mortem report concluded that Mr Winspear died from hypoxic brain injury (lack of oxygen to the brain) caused by hanging.

84. The toxicology report showed no illicit substances in Mr Winspear's system at the time of his death.

Findings

Management of Mr Winspear's risk of suicide and self-harm

85. Prison Service Instruction (PSI) 64/2011, Managing prisoners at risk of harm to self, to others and from others (Safer Custody), sets out the procedures (known as ACCT) that staff should follow when they identify that a prisoner is at risk of suicide and self-harm. It says that, once opened, the ACCT document must accompany the prisoner to any activities outside of the wing/unit where they are located.

86. Staff at Hull started ACCT procedures for Mr Winspear on the morning of 8 August, after he self-harmed by cutting. He had failed to attend his video link court appearance earlier that morning. The noted reasons for his refusal to attend differ, but he said he was expecting to go to court in person and thought that he could better defend himself in person and have a better chance of being released.

87. Later that morning, Mr Winspear did attend his video link court appearance, which took place in Official Visits. However, his ACCT document did not accompany him.

88. A SO took Mr Winspear to Official Visits but did not take Mr Winspear's ACCT document with him, nor tell staff in Official Visits that Mr Winspear was on an ACCT, so they were unaware.

89. The Head of Safety told us that he and two other prison managers had spoken with the SO. He said the SO was fully aware of the errors that he had made during the ACCT process and understood what he should have done differently.

90. As the SO has acknowledged his mistakes, has received feedback from senior managers and understands the correct procedure, we make no recommendation.

Change in status

91. Mr Winspear was sentenced to 16 months at his video link hearing. With time already served, he had three months left to serve.

92. Prison Service Order (PSO) 3050, *Continuity of healthcare for prisoners*, says that events such as attending court or sentencing at court, are factors that might have a significant impact on the health of a prisoner. When prisoners pass through reception on their return from court, prisons are required to have protocols in place for risk assessing them to identify any potential suicide and self-harm issues. Prison Service Instruction (PSI) 07/2015, *Early days in custody*, states that there must be arrangements in place to assess prisoners whose status or demeanour may have changed after a court appearance by video link.

93. As prisoners appearing by video link do not leave the prison, they are not always subject to the standard screening procedures that they would receive when returning to the prison and passing through reception.

94. Several PPO investigations in 2020, when the COVID-19 pandemic meant all court appearances were remote, found that prisoners were not being risk assessed after attending court by video link. We made a national recommendation to HMPPS to review their guidance. In March 2021, the Director General wrote to all Governors

and Directors requiring them to review local processes to ensure that similar health screening arrangements, and the same processes for assessing risk of suicide or self-harm, were followed after video link appearances, as in reception following a physical appearance in court.

95. Also in March 2021, HMPPS issued a safety briefing on assessing the risk of harm in prisoners attending court by video link. In April 2021, they followed this up with another safety bulletin containing early learning review analysis of several issues including video court appearances. Both documents advised that it was vital that staff engage with prisoners after a video court appearance, and that they assess the prisoner's risk on the basis of official information, as well as the individual's presentation. They also advised that a verbal handover of key information should be given to wing staff and any new risk information should be recorded and shared on the prisoner's record (NOMIS) and the wing observation book. If necessary, concerns should be escalated, including starting ACCT procedures where appropriate.

96. Mr Winspear was in a video link booth on his own. The officer who took Mr Winspear into the booth, told a prison manager that she asked Mr Winspear to let staff know the outcome of his hearing. She was then deployed elsewhere and did not see Mr Winspear leave the booth. No one checked on Mr Winspear following his hearing, he did not tell staff what had happened in court and staff were unaware of his change in status. No one assessed him for suicide and self-harm risk or referred him to healthcare staff. This was even more important given that Mr Winspear was being supported using ACCT. While we accept that staff in Official Visits did not know about the ACCT, it should still be standard procedure to assess prisoners who have had a change in their status following a video link hearing.

97. Following a death at Hull in May 2021, we made a similar finding that prisoners were not being properly risk assessed after attending court by video link. We were told that a review had been undertaken in March 2022 and that staff had been briefed on the correct procedures to follow, including that prisoners whose circumstances had changed should be taken to reception for a Reception Risk Review and referral to a nurse, as well as having details of the outcome of their hearing added to their electronic prison record. None of this happened in Mr Winspear's case.

98. The Head of Safety told us that after Mr Winspear's death, all staff in reception and in Official Visits had been briefed on the HMPPS safety briefing on 'Assessing risk of harm in prisoners attending court and other appointments by video link'. He said that the safety briefing was displayed in Reception and Official Visits to remind staff and that custodial managers had been told to add the safety briefing to their regular meetings with staff.

99. We note that despite being assured that all staff had been reminded in March 2022 of the correct procedures following a court appearance by video link, staff failed to follow the correct procedures for Mr Winspear in August 2023. We therefore consider that some assurance is needed that the correct processes are fully embedded at Hull and being followed routinely by staff. We recommend:

The Governor should undertake an audit to assure himself that staff are adhering to the correct procedures following court appearances by video link and report the results to the Ombudsman.

100. We discussed with senior HMPPS colleagues our continued concerns about how the risk of suicide and self-harm in prisoners appearing in court by video link was managed. They confirmed that the new Prison Safety Policy Framework, due to be implemented in 2024, would highlight that the period following a video court appearance is one of heightened risk and would restate the requirement for a fresh assessment of risk. Prison Group Directors will be responsible for monitoring their establishments' compliance with the requirements.

101. A review of PSO3050 Continuity of Healthcare for Prisoners is also underway and the revised policy will be clear that where there is a change of circumstances or demeanour following a video court hearing there is a requirement for healthcare staff to see the prisoner, in the same way as following an in-person court appearance.

Clinical care

102. The clinical reviewer concluded that the care Mr Winspear received at Hull was in the main of a good standard and was equivalent to that which he could have expected to receive in the community. She made several recommendations, not directly related to Mr Winspear's death, which the Head of Healthcare will wish to address.

Good practice

103. The key worker supported Mr Winspear with the difficulties he was experiencing, which included the complex issues surrounding his son. She spent several weeks liaising with Mr Winspear's son's social worker to help arrange a visit between Mr Winspear and his son. It is due to her efforts that Mr Winspear and his son were able to spend some time together before Mr Winspear died. She showed genuine kindness and compassion and went above and beyond her normal professional duties to support Mr Winspear. We consider that this is an example of best practice and that she should be commended for the quality of her key work.

Inquest

104. The inquest, held from 7 to 13 May 2025, concluded that Mr Winspear died by misadventure.

Prisons & Probation Ombudsman
Independent Investigations

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