

**Investigation into the circumstances surrounding the  
death of a man  
at HMP Winchester in July 2008**

**Report by the Prisons and Probation Ombudsman  
for England and Wales**

**November 2009**

This is the report of an investigation into the circumstances of the death of a man in July 2008. At just before 9.00am, he was found hanging in his cell at HMP Winchester. Cardio pulmonary resuscitation (CPR) was carried out but he was pronounced dead at 9.14am. He was 27 years old and had been in custody for ten weeks. It was his first time in prison and he was facing a very serious charge. He was from Bangladesh, in Britain on a student visa and could speak and write English fluently. He left two hand written documents of significance in his cell.

I would like to offer this public expression of sympathy and condolences to the man's family and friends for their loss. A key objective of all the Ombudsman's investigations is to ensure that the bereaved family has the opportunity to raise any concerns and contribute to my enquiries. His family raised a number of concerns with one of the family liaison officers and with the investigator. I hope this report offers answers to their questions and I regret the delay in its completion.

The investigation was carried out by my colleague. A clinical review was conducted by a clinical reviewer for the local Primary Care Trust, and I am very grateful for his report. I would also like to thank staff at HMP Winchester for their assistance.

At HMP Winchester, the man appears to have been 'invisible'. Not one of the staff interviewed knew anything about him. The only evidence about him has been provided in a statement by his cellmate. No staff at Winchester could recall him and the mechanisms which should have been in place to support him – the Personal Officer scheme and the Foreign National policy – failed him. Indeed, the prison was unable to even identify who his personal officer should have been. Also, in spite of being appropriately identified upon reception as a foreign national, he did not have any contact with those responsible. He did not make any telephone calls or arrange any visits. Whilst it is not possible to say whether more contact with staff would have made a difference to his state of mind, this report is a disappointing account about the care offered prisoners in HMP Winchester.

My report reveals failings in the Personal Officer scheme and the process of dealing with Foreign National prisoners, and contains four recommendations.

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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**November 2009**

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## **SUMMARY**

The man was arrested on 14 May 2008 for murder and held in police custody for five days. During this time, and because of the nature of the offence, he was assessed by a Forensic Medical Officer (FME) but was not deemed to be at risk of suicide or harm to himself.

He appeared at Magistrates Court on 19 May and was remanded to HMP Bullingdon. He was placed overnight in the healthcare centre in accordance with Bullingdon's policy regarding those charged with those charged with murder. He was also referred for a mental health assessment. He saw the prison doctor the following morning who did not detect any mental health problems or suicide risk. He was deemed fit for ordinary location and transferred that afternoon to the main prison. He had been correctly identified as a foreign national.

On 30 May, the man appeared at Crown Court and was remanded to HMP Winchester. A further health screen was carried out and no concerns were raised. He was not referred for an urgent mental health screen despite Winchester's policy.

Again, he was identified as a foreign national. Rather than being located onto A wing, the induction wing, he went into the main prison, B wing. (No more qualitative information about him was documented by staff from then on.)

On 2 June, his cell mate moved into the cell with him and they continued to share a cell until 28 July. He was described by the cellmate as being 'a bit odd' and he did not socialise with anyone else on the wing.

Seven weeks later, on 25 July, the man saw his solicitor who did not have any concerns about him. Over the weekend, his cell mate described a deteriorating relationship between them. On Monday, 28 July, the cell mate left the cell early in the morning to go to court. At approximately 9.00am, the man was found hanging when staff went to unlock his cell so that he could go for exercise. CPR was performed but, sadly, he was pronounced dead at 9.14am.

Four recommendations have been made in response to the serious failings of what should be established processes, including two about the Personal Officer scheme and the Foreign National Policy.

## THE INVESTIGATION PROCESS

1. One of my colleagues conducted a preliminary visit to HMP Winchester on 5 August on behalf of the investigator responsible for the investigation. She met the Governor and collected all the relevant documentation. At a later date, the investigator met a representative from the Independent Monitoring Board. Feedback was provided as the investigation went on and she met again with the Governor during the investigation.
2. Notices were issued to staff and prisoners telling them of the investigation and offering the opportunity to speak with the investigator. No one came forward as a result. Ten interviews were recorded with members of staff.
3. The clinical reviewer for the local Primary Care Trust undertook a clinical review of the healthcare provided for the man whilst at HMP Winchester. Four medical staff were interviewed jointly with the investigator.
4. The investigator made contact with the police officers responsible for investigating the man's death and those investigating his alleged offence. The cellmate, who was released on the morning of the man's death, was interviewed by police and a copy of his statement was shared with the investigator. The investigator wrote to the cellmate at the address provided by the prison asking him to contact her but he did not do so. She subsequently asked the police to help contact him and was provided with a mobile telephone number. Again, attempts to reach him by mobile were not successful.
5. HMP Bullingdon was contacted by the investigator and she spoke on the telephone with the Operations Lead in Healthcare to obtain information about the man's time there and the notes from this conversation are annexed.
6. In addition, the investigator telephoned the man's solicitor to obtain background information and to discuss the visit which took place three days before his death.
7. One of the family liaison officers and the investigator met the man's family. The purpose of the meeting was to listen to their concerns about the circumstances surrounding his death. His sister said she tried vigorously to contact her brother, both via letters and telephoning the prison, but was unsuccessful. Being both unfamiliar with prisons, and with limited English, she found it difficult to navigate her way through the system.
8. A copy of the draft report was sent to the Prison Service. They reported that there were no factual errors and accepted all the recommendations. The responses to the recommendations are repeated verbatim in the relevant section.
9. A copy of the draft report was translated into Bengali for the man's next of kin, his sister. Also, my family liaison officer and the investigator, in the company

of an interpreter, visited the man's sister to answer any questions in response to the draft. No changes to the report were requested.

## HMP WINCHESTER

10. HMP Winchester is a category B local prison built in 1846 to a Victorian radial design. Winchester is currently undergoing major refurbishment with a build programme lasting five years. Work which has already been completed includes safer custody changes to the healthcare centre, first night centre and detoxification unit, a new electrical system, renewal of the fire and general alarms, a new visits complex and pedestrian access at the main gate.

11. Prior to the man's death there were nine deaths at Winchester since the Ombudsman began investigating deaths in prison custody in 2004. Seven were a result of natural causes, and two were apparently self-inflicted.

12. The Independent Monitoring Report of 2007/2008 concluded:

“HMP Winchester performs well for a local prison under tight financial constraints. This is due to a highly committed team, both management and staff. The closure of C Wing has made the segregation of different groups of prisoners difficult at times. The constant churn of prisoners and the lack of funding for courses continue to provide problems.”

13. HM Chief Inspector of Prisons last inspected Winchester in April 2007. She published her report in June 2007 and commented:

“Like all local prisons it faces considerable pressures and increased demands. There was some evidence, at this inspection, that this combination was testing the prison's ability to sustain and continue improvements. Winchester remains a reasonably well performing local prison, in spite of the pressures in the prison system as a whole. However, there are some warning signs – the lack of sufficient activity spaces in the main prison, the somewhat dislocated resettlement places and, in particular, the fact that residential staff are not fully engaged in the support and rehabilitation of prisoners. These are all matters that prison managers, and the National Offender Management Service, will need to monitor closely.”

## KEY FINDINGS

14. The man was arrested in London on 14 May 2008. He was taken to a police station for questioning and during this time was seen by a Forensic Medical Examiner (FME) who deemed him fit for interview. He remained in police custody for five days, during which time there were no concerns about suicide or self-harm.
15. He appeared at Magistrates Court on 19 May and was remanded to HMP Bullingdon. His Prisoner Escort Record (the key instrument for ensuring that information about risk is shared between agencies) stated that he had no known risks. Upon his reception at Bullingdon at 4.50pm, he went through the usual procedures which included completing the Core Record. When asked to identify his next of kin, the author wrote 'none'. He described his occupation as a waiter, his place of birth as Bangladesh and said that he was a Muslim.
16. The Cell Sharing Risk Assessment (CSRA) described him as a low risk for sharing a cell, noting that it was his first time in prison and that the author had no concerns about the man. Part three of the CSRA was completed by a nurse who ticked that she had no concerns about self-harm.
17. The nurse also carried out the First Reception Health Screen (FRHS). (Bullingdon has a computer medical system so responses to questions are entered onto the computer by the nurse at the time of the interview.) The man was not identified as having any physical or mental health problems. He was, however, admitted to healthcare for the night because of the severity of his offence. He was also referred for a mental health assessment. The Operations Lead in Healthcare said in a telephone interview that the procedure at Bullingdon is for the prisoner to be seen the following day by medical staff who assess whether someone needs to be referred for a mental health assessment.
18. An entry at 8.06pm, in the man's medical record said,

'in-patient admission due to the severity of offence – searched and located into H118 quite demanding since being located – asking continuously about extra food despite having a meal in reception – regime explained and advised against inappropriate use of cell bell'.

The following morning, 20 May, the daily nursing comment noted 'quiet and settled overnight'.
19. A General Practitioner wrote at 11.36am,

'Denies any medical or mental health problems. 1<sup>st</sup> time in prison. No thoughts of dsh [deliberate self-harm]. Denies drug or alcohol use. No concerns from staff. Fit for o/l [ordinary location].'

Consequently, the man was not referred for a mental health assessment. Later that afternoon, he transferred to the Blackthorn Unit and located into cell B3-08.

20. A Reception Board document was completed on 20 May. The man was identified at this stage as a foreign national. However, this information was not recorded on his record of events booklet (known as a history sheet). (There are no more entries in any records at Bullingdon.)
21. On 30 May, the man appeared at Crown Court and was remanded to HMP Winchester. His PER had marked violence as a risk with the additional comment 'main offence: murder, violence = main offence'. He arrived at HMP Winchester at 12.20pm. His CSRA identified him as a medium risk to others (that is no immediate risk, but the situation will need to be reviewed regularly) with an additional comment 'would prefer a single cell; states he gets angry quickly'. A Health Care Officer (HCO) completed part three of the CSRA and indicated that no concerns about self-harm had been raised. (A HCO is a prison discipline officer who specialises in healthcare and is able to perform some nursing duties such as first night health screens and looking after in-patients.)
22. The HCO, who regularly worked in reception, completed a health screen; again this involved entering information directly into the computer. In interview, he was unable to recall the man or whether his medical record had arrived with him. He carried out a full healthcare screen (indicated by the detailed information about him) which, in interview, the HCO felt might indicate that he did not have access to the previous records. Otherwise, he said he would have done a limited screen. Amongst the comments recorded, the HCO wrote -

'General mental health. Has been to Crown Court today. Say he feels alright.

'Full history taken.

'Past medical history states normally fit and well.

'Remanded for murder.'

23. In interview, the HCO was asked whether he was aware of Winchester's Suicide Prevention and Self-Harm Management Policy and Strategy Document which reads 'to help manage the risk these prisoners present (those charged with offences related to violence against a family member and/or homicide), all prisoners that are charged with these offences will have an urgent mental health referral submitted by the health-screener in reception'. He responded,

'not really, no, and really that should be done by the prison that he goes to first anyway, things have changed a bit over the years so I won't relate to what we used to do, or how we used to do things, but as

a matter of course people aren't referred for a mental health assessment if they are on a murder charge'.

24. Later that day, the man completed the first stage of his induction. He was identified as a foreign national and it was noted that he could speak English and read and write. However, this information was not recorded on any of his other documents, including his history sheet. He only identified significant problems with 'close relationship with family members' and 'current relationship with partner'. No other problems were identified. He was also seen by the legal services team and no issues were identified. However, he gave details of a different firm of solicitors (a London firm rather than the firm representing him) when asked to identify his solicitors name and contact details.
25. The man was located onto B wing, cell B3-07. (Winchester uses A wing as a first night centre and it is the usual practice is for prisoners to go there first if there is available space. A prisoner may spend as long as a week there as he becomes familiar with prison life, especially if it is there first time in custody.) However, for reasons unknown, he was located onto B wing. (His future cell mate, who arrived at the same time as him, was located initially on A wing.) On 31 May, an entry in his history booklet by one of the personal officers for prisoners on the third floor landing, wrote 'only just arrived on the wing too early to make a proper entry'. (Every prisoner should be allocated a named personal officer who is required to take a specific interest in them and complete entries in their history booklet every 14 days. Personal officers are allocated prisoners on a particular landing, rather than the same personal officer remaining with a prisoner wherever they move within the prison.)
26. On 1 June, the man moved into cell B4 -13. There is no entry about this move in the wing's observation book or his history booklet and the reason is unknown. Having moved to a different landing, his personal officer would have changed. However, having wrongly interviewed the personal officer, the investigator asked to interview the officer responsible for B4-13 but no one could be identified.
27. The next day, 2 June, the man's cell mate moved into the cell and remained there with him until 28 July. The man went through a Stage 2 induction on 3 June, which is a group induction.
28. Three days later, he was seen by a second HCO for the second health screen during which his weight, height and blood pressure were taken.
29. On 11 June, an entry in his history booklet says 'SO check', meaning that a senior officer had checked the record. The following day, a scheduled CSRA review was completed by a SO. This is a paper exercise and he was not present. He was again identified as a medium of risk of harm to others as first assessed on his CSRA when he arrived at Winchester. Under the section, 'action required', the SO has written 'unknown quantity at the moment to be monitored closely by wing staff'.

30. The next entry in his history booklet was made on 1 July and reads 'CSRA Mgt check. Review due 12/9/08', also referring to a check by a prison manager. On 6 July, the SO wrote 'wing SO check entries required every 14 days.' Another management check was made two days later on 8 July, 'CSRA Mgt check. Review due 12/9/08'. There are no further comments on the man's history booklet. (It is worth noting that his cell mate's history booklet is equally brief.) In interview, the Senior Officer (SO) said that he was the senior officer with responsibility for the fourth floor landing and would have expected to see a comment from the personal officer every 14 days.
31. In the statement provided to the police, the man's solicitor said that he saw him on 25 July and was with him for about an hour. There was some disagreement between the solicitor and a legal visit officer about the amount of legal documents he was allowed to hand over to him. In the end, a compromise was reached and the solicitor was able to pass some, but not all, of the case papers to him. He was going to send in the remainder of the papers. The solicitor said that the man 'did not appear any different in his demeanour than in my other meetings with him'. He added that the man 'did provide instructions to me which due to client confidentiality and further from advice that I have sought for the Law Society Ethics Advisory Department I do not wish to disclose'.
32. The cell mate gave a very frank statement to the police in which he described the deterioration in his relationship with the man over that last weekend following the solicitor's visit, and their previous contact. He said that they had first met in the holding cell at Bullingdon. He described the man as 'a bit odd. He didn't say a lot and was always staring like having tunnel vision'. At first they did not speak much but neither of them liked football and so they had that in common. He said that the man did not socialise with any other prisoners on the wing. The cell mate said that the man told him why he was there although repeatedly said that 'I never done it'.
33. In his statement to the police, the cell mate said,
- 'We must have shared a cell for about a week when the man first mentioned suicide. I can recall him saying he wanted to kill himself and that he did not want to spend the rest of his life in prison. I did not think much about what he was saying because most people in prison feel like this at some stage and it is just one of those things that you go through. ... I have also just remembered that about three weeks ago when he was asleep I went through his unit as I did not have any clean kit – T-shirt and thought I would take one of his. I can remember when looking through his stuff I noticed a cord of sheets like a rope. I didn't think much of it and thought it was a rope used as a 'swinger' to swing items from cell windows and that it had been left in the locker. I never mentioned it to him and did not give it much thought until today.'
34. The cell mate said that the man confessed in June to the allegation of murder and told him details of the events leading up to it. On 21 June, the cell mate

wrote a letter to his own mother saying that the man had confessed and he did not know what to do as he did not want to be a 'grass'.

35. Following the visit from the man's solicitor, the cell mate said that on Saturday 26 July he asked him if he could read the case papers he had been given. He said that the papers did not support what the man had told him and said,

'I did not feel the same about the man after reading this. I spoke to him if he spoke to me but did not make conversation with him. Around 8.00pm on the Saturday the 26 July in the evening I can recall him writing a long letter. I kept trying to read what he was writing in his book but he kept covering it up. I can recall that we had a bit of an argument because I wanted the cell lights off. At around midnight he turned the lights back on and said to me 'I need the lights on for ten minutes'. After 10 minutes I wanted the light off and could see him reading the statements in his depositions (that is his deposition). I got up and put the lights off and got annoyed with him and pushed him onto his bed. The rest of the night was uneventful.

'On Sunday 27 July 2008 nothing much happened. I did not speak to him much. He spent most of the day writing in his book. ... On Sunday night I could not sleep because I was due in court the next day. I spent all night with the telly on. I know he could not sleep as I could see him on his bed and he kept clicking his fingers and tapping on the wall all night. He would often do this but was doing it more and more in the last couple of weeks.'

36. The morning roll check took place before prisoners were unlocked to be taken to court. On Monday 28 July, an officer collected the cell mate between 7.15am and 7.30am. The officer recalled in interview that the man was in bed and appeared to be asleep. In his statement, the cell mate said

'On Monday 28 July 2008 I got up and got ready for going to court. He was laid on his bunk and was clicking his fingers again which was driving me mad. When the prison officers came to get me I got up and jokingly said to him 'see you later mate, enjoy your 20 years'. He did not reply. I left the cell.'

37. The cell mate was released by the court and did not return to Winchester prison that day.
38. As prisoners are given a breakfast pack when they are locked up for the night, the first time that the remainder are unlocked is for exercise. An officer was unlocking B wing for exercise. Usually this takes place at 8.30am but staff shortages meant that it was delayed that day. At approximately 8.59am, he reached B4-13 and called through the door asking if the prisoner wanted to go for exercise. There was no reply and he opened the observation hatch to see the man hanging from the window bars. The officer immediately unlocked the door, calling to his colleague who was on the other side of the landing for assistance. The second officer put out a Code One call (the call sign for a life

threatening emergency) over his radio as he made his way across the landing. The control room recorded that this call was made at 9.01am.

39. The first officer held the man's weight whilst he also tried to cut the ligature with his anti-ligature knife. He was unable to do so and, at this point the second officer arrived and took the knife cutting the ligature. Initially the officers placed him on the bed and then moved him onto the floor with the help of another officer. The first officer blew his whistle and the third officer, who had checked for a pulse but could not find one, began cardio pulmonary resuscitation (CPR) with the second officer. The second officer was doing the compressions and the third officer, using his face mask, started breaths at a ratio of thirty to two. (The third officer is a first-aid instructor.)
40. A nurse arrived with the emergency bag and set up the ambu-bag (a hand-held device used to provide positive pressure ventilation to a patient who is not breathing or who is breathing inadequately) and oxygen. He and the second officer rotated doing chest compressions. A second nurse also responded to the Code One call and, according to the scene log, arrived at the cell a minute later. She asked whether an ambulance had been called, and discovering it had not, radioed the control to call for one. The control log recorded the ambulance being called at 9.02am. She also asked for the prison doctor to be redirected to B wing when he arrived at the prison gate for his morning duties. She asked for the defibrillator to be collected which was locked in the treatment room on C2 level. (In reality, this was very near by.) The second nurse attached the defibrillator which indicated that CPR should be continued.
41. The prison doctor was already in healthcare and went to the cell after being told by a prison officer that he was needed. In interview, he said there was little urgency about the request. He arrived at the cell at 9.11am and the man was pronounced dead at 9.14am. The ambulance arrived at the prison at 9.20am.
42. The man had not given any details of his next of kin. However, the prison was able to establish that his sister lived in Haringey. At 9.30am, the Head of Residence, contacted HMP Pentonville (which was the nearest prison) to ask a senior manager to go to the home of the man's sister. The Deputy Head of Prisoner Care at Pentonville contacted the man's sister by telephone to say that he would like to come and speak with her in person. He arrived at her home 25 minutes later and broke the news. He gave the family contact details for the duty governor and the Family Liaison Officer (FLO) at Winchester. When he returned to Pentonville he asked their Imam to contact the family as his sister requested.
43. On 31 July, the prison FLO drove to the family home to collect six members of the man's family and take them to the prison. It had been arranged that the Imam from another prison would also be present. They were then taken to view his body at the hospital. His parents live in Bangladesh and the family wanted to have his body returned there. The prison helped to arrange this and paid the cost of returning his body home.

44. The police removed two 'letters' from the cell. One very short one began 'I am very sorry to her mum' (referring to the victim). Unfortunately the man's family understood that the message was addressed to his own mother. Another document of more than 37 pages was retrieved from the cell. The police did not pass them to the family, and the Ombudsman's investigator and family liaison officer passed them over when they came into their possession.

## ISSUES

### First reception health screen

45. The man went through the reception procedures when he arrived at HMP Winchester. He had already spent time at HMP Bullingdon where it had been thought that he did not need to be referred for a mental health assessment. It is not clear whether these medical notes were available to the first HCO who saw him in reception. However, he was not referred to the mental health team in accordance with Winchester's Suicide Prevention and Self-Harm Management Policy and Strategy Document. It is an example of good practice that prisoners charged with murder are automatically referred for a mental health assessment. Neither the first HCO nor the HCO who accompanied him at the interview, were familiar with the policy. Both staff regularly carry out reception duties. They both referred to a previous policy which required such prisoners to be placed in healthcare overnight, saying that it had not been in existence for some time. Of the two nurses interviewed, also responsible for reception duties, one said she was aware of the policy and the other was not.

**I recommend that the Governor and the Primary Care Trust ensure that all healthcare staff are familiar with the relevant section of the Suicide Prevention and Self-Harm Management Policy and Strategy Document.**

### Induction and Foreign Nationals

46. It is not known why the man was not located on the induction wing, A wing, when he first arrived at Winchester. Furthermore, his alleged offence generated a considerable amount of press coverage and it does not seem that any consideration was given to how to manage him on the wing.

47. The man was appropriately identified as a foreign national at Bullingdon and Winchester. In accordance with Winchester's Foreign National Prisoner Policy, this should have resulted in a number of things taking place,

'As part of the Induction Programme, induction staff will ask every prisoner what their nationality and first language and record this on the Foreign National documentation and their history sheet.

'All foreign national prisoners to be asked to complete the Foreign National questionnaire during the first 48 hours.

'The FNLO (Foreign National Liaison Officer) must see all foreign national prisoners within 48 hours of notification of reception:-

- a) to check on immediate needs and concerns
- b) to deliver a copy of the Foreign National self-assessment questionnaire and explain how it should be completed.'

48. Although identified as a foreign national, the man's history sheet was not marked to indicate this. He does not seem to have been spoken to about any immediate needs or concerns. The investigator was told that a Foreign Nationals Liaison Officer was in post at the time although had left subsequently and it is unclear how he came to be overlooked.
49. The 'maintaining family ties' section of the policy explains how a foreign national prisoner is entitled to extra telephone calls if they have had no family visits during the previous month. The policy does not say who will be responsible for checking this. Although the man had family in this country, he did not send out any visiting orders and did not make any telephone calls.

**I recommend that the Governor ensures that the Foreign National Prisoner Policy is implemented by all staff.**

50. Neither the man's history booklet, nor that of his cell mate, have any entries to suggest that they were seen by their personal officer once they moved onto B4-13. Neither record contains anything of substance about them as individuals. When the investigator asked to speak with the man's personal officer, she was given the name of an officer responsible for him during his first two days on B wing which is before he moved to another landing and became the responsibility of the officers on that landing. The error was not identified until the officer was interviewed. The investigator asked for the correct personal officer to be identified but no one could be named.
51. An entry should be made in every prisoner's history sheet at least every 14 days. There was a comment in the history document by a senior officer reminding the personal officer to write an entry. This did not, however, prompt any entries to be made. The system should be monitored in other ways, for example, at the morning staff meeting and reminders in the wing observation book. Indeed, given that the man's personal officer could not even be identified is of concern.

**The Governor should ensure that the personal officer scheme is working in accordance with policy and that senior officers monitor it robustly.**

### **Response to the emergency**

52. In his review, the clinical reviewer concluded that 'the response to finding the man was immediate and appropriate but, unfortunately, efforts to resuscitate him were unsuccessful'. However, he goes on to comment that,

'There should be a review of the emergency call system ... the arrival of the equipment and call for external help needs to be formalised. If a 'code one' is called, namely a life threatening emergency, one of the nurse radio holders should be clear that they are 'on call' for such calls at any particular time and must respond urgently, rather than relying on all available personal to attend ... as in hospital, it would seem appropriate to allocate a specific member of staff to have responsibility to collect emergency equipment and bring it to such emergencies.

Similarly, protocols for calling for a 999 ambulance need formalising as part of the set response to receiving such a confirmed call in the control room.'

53. I note that the Ombudsman has made the same recommendation after an earlier death at Winchester and, given the clinical reviewer's comments, I am disappointed to repeat it here.

**The Governor and Head of Healthcare, in collaboration with the Primary Care Trust, should review the emergency medical response system.**

## **CONCLUSION**

54. The man did not have any significant contact with staff for the entire period he was at Winchester. The Prison Service has well established systems to identify and support vulnerable prisoners. Tragically none of the systems – that is a mental health assessment, being located on the induction wing, identified as a foreign national prisoner and regular contact with a personal officer – were provided for him. He was in prison for the first time, on remand and facing a very serious charge, and had distanced himself from his family. It is only the account of his cell mate which has provided some insight into what was happening during his time in custody. This investigation has uncovered serious failings in the lack of management of the man who managed to ‘slip completely through the net’.

## RECOMMENDATIONS

1. I recommend that the Governor and the Primary Care Trust ensure that all healthcare staff are familiar with the relevant section of the Suicide Prevention and Self-Harm Management Policy and Strategy Document.

The recommendation was accepted. All Portsmouth PCT staff are currently receiving ACCT awareness training to case management level. The suicide prevention and self harm policy is readily available to the HCC staff in the ACCT policy box folder in the office for those on duty for reference and guidance. During ACCT awareness training the SPC refers to the relevant section during training for the familiarisation of PCT's involvement in the care of those at risk of self harm and suicide.

2. I recommend that the Governor ensures that the Foreign National Prisoner Policy is implemented by all staff.

The recommendation was accepted. Complete – The Foreign National Policy has been published and a local notice to staff generated.

3. The Governor should ensure that the personal officer scheme is working in accordance with policy and that senior officers monitor it robustly.

The recommendation was accepted. The revised personal officer policy document has been submitted to the Head of Custody and will be published by the end of November 2009.

4. The Governor and Head of Healthcare, in collaboration with the Primary Care Trust, should review the emergency medical response system.

The recommendation was accepted. This recommendation has been raised in previous DIC action plans and completed in August 2009 with a new system devised and a local notice to staff published.