# Investigation into the circumstances surrounding the death of a man at HMP Winchester in November 2008

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

**October 2009**

This is a report into the death of a man who had been at Winchester prison since August 2008, and took his own life three months later, on 17 November 2008.

I would like to offer my sincere condolences to man's family on their loss.

I must apologise for the delay in issuing this report. This was due in part to work pressures within the Ombudsman's office, but also a delay in obtaining the clinical review, which was received in this office on 23 June.

The investigation was undertaken by one of the Ombudsman's investigators and I would like to thank the Governor and the staff at Winchester for their co-operation during this investigation. A clinical reviewer was identified by Hampshire Primary Care Trust to undertake a review of the man's clinical care whilst at Winchester. I would like to thank the reviewer for his helpful review.

It is clear that the man's mood was low throughout his time at Winchester and staff were concerned enough about him to place him on the Assessment, Care in Custody and Teamwork (ACCT) monitoring system when he arrived there. Although his mood remained the same, the man expressed no actual plans to harm himself, although it was acknowledged that the thought was there. The healthcare professionals were aware, and carefully monitored any changes.

It is impossible to say with any certainty whether the man's decision to take his life was triggered by his court appearance on the day he died, but there is some evidence to suggest that he had felt anxious before previous appearances. The way in which information regarding court appearances is imparted to prisoners is something that I think should be reviewed by the Governor. I make a further three recommendations to the Governor, one of which I have made before regarding first aid training for staff, and one to the Head of Healthcare.

**Jane Webb**
**Deputy Ombudsman** **October 2009**

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## SUMMARY

The man was discovered in his cell at HMP Winchester on the morning of 17 November 2008. He had made a ligature from a bed sheet, which he had tied around his neck and the bars of the window. Despite the best efforts of staff, he could not be revived.

He arrived at Winchester in August 2008 and due to the nature of his offence was located on a wing with other vulnerable prisoners. He was described as a quiet man who rarely interacted with staff or other prisoners.

It was clear when the man arrived at the prison that he was in a low mood and at the risk of harming himself. He was immediately placed on the ACCT monitoring system, which remained open almost constantly until 14 October. He was regularly seen by members of the mental health team and by psychiatrists. They were alerted to the fact that he remained very low in mood throughout, although he displayed no actual intention to harm himself. It was agreed at the ACCT post closure review on 14 October that his mood remained the same and the monitoring could cease.

It appears that the man showed signs of anxiety whenever he had a court appearance. He collapsed on the morning of a scheduled court appearance on 13 October, and had to be taken to hospital with a suspected head injury, although this may have been coincidental.

It is likely that the man was told on 16 November that he had a court appearance the following day, although this is not made clear in the records. Given that he was a vulnerable prisoner, was low in mood and perhaps anxious about attending court, with hindsight it may have been advisable for staff to have paid extra attention to him that night, even though he was no longer on an ACCT.

An Officer carried out the roll check on the morning of 17 November. When she arrived at the man's cell she looked through the observation panel and noticed a green sheet hanging from the toilet area. On closer inspection she saw the top of the man's head. She immediately called for staff assistance, which arrived very quickly.

Despite the efforts of officers, nursing staff and paramedics, the man could not be resuscitated. He was pronounced dead at approximately 7.30am at the local hospital.

I have made four recommendations. They concern a review of the optician's service, first aid training for staff and another that all medical records are completed fully and accurately. There should also be a review of the way in which vulnerable prisoners are informed about court appearances, and whether checks should be made on such prisoners.

## THE INVESTIGATION PROCESS

1. My investigator was appointed to conduct the investigation. She made an initial visit to Winchester on 20 November to visit the cell where the man died and to collect prison documentation, including his medical record, for use in this investigation. Notices were issued to both prisoners and staff inviting anyone who had information regarding to his death to make themselves known to the investigator. However, no additional witnesses came forward.

2. My investigator returned to Winchester on 13 and 14 January, 25 February and 17 March to carry out recorded interviews with staff. She also wrote to a member of nursing staff who works permanent nights and who she was unable to meet for interview.

3. One of the Ombudsman's Family Liaison Officers, contacted the man's family to explain the role of the Prisons and Probation Ombudsman and to offer them the opportunity to participate in the investigation. The man's father did not have any questions about his son's time in custody, but spoke very highly of the prison and in particular of a Senior Officer who helped with funeral arrangements and returning the man's property.

4. A clinical review of the man's healthcare whilst he was in custody at Winchester was undertaken by the appointed clinical reviewer on behalf of Mid-Hampshire Primary Care Trust and forwarded to this office on 23June 2009.

## HMP WINCHESTER

5. HMP Winchester is a category B local male prison, located just outside the main city centre. Built in 1846, most of the prison is of a traditional radial design. It has a maximum capacity of 707 prisoners following a complete refurbishment of C wing this year.

6. The prison contains four residential units and one separate unit, West Hill, which is a training unit for category C adult men.

7. There have been 13 deaths at Winchester since the Ombudsman took responsibility for investigating deaths in custody in 2004. Three of these deaths were from natural causes and ten were self inflicted deaths.

8. Safer Custody meetings are held every month. They are chaired by a prison governor and attendees include representatives from the Samaritans, Listeners, Chaplaincy and staff from the wings. Standing items on the agenda include updates from Listeners and Samaritans, instances of self harm or attempted suicide, a sample review of prisoners on ACCT and an update on violence reduction amongst prisoners.

9. An investigation was conducted in March 2008 after a prisoner attempted to hang himself by tying a bed sheet to the cell bars. Staff on the wing were alerted to the situation, entered the cell and removed the ligature and commenced first aid until healthcare arrived. The prisoner was taken to the local hospital and made a full recovery.

### Healthcare

10. Winchester provides largely nurse-led primary care, inpatient care and a pharmacy service. Healthcare is separate from the main prison, although some healthcare and treatment takes place in facilities on A and B wings. Healthcare services are commissioned by Hampshire PCT and the doctors are provided by a local general practice.

11. Healthcare introduced an electronic record keeping system in June 2007. The system is designed to provide a full audit trail of medical histories and the interventions that each prisoner receives or is due to receive.

12. On arrival in reception each prisoner is seen by a nurse of healthcare officer and screened to identify immediate healthcare needs. Prisoners then have the opportunity to see a doctor within 24 hours if required and a secondary health screening where further details are taken (such as the prisoner's community doctor and next of kin details) and any existing health issues are explored. Prisoners are also asked to sign a medical compact that gives consent for the prison to access their previous medical history.

## Independent Monitoring Board (IMB)

13. The Prisons Act 1952 requires every prison to be monitored by an independent board appointed by the Secretary of State for Justice. The IMB issues a report about the prison annually. The IMB's most recent annual report was published in May 2008. The section on safer custody says:

> "Over the past year, the prison has taken a number of positive steps forward in terms of safer custody. There was a noticeable increase in "ownership" of this aspect of prison management, much of it owed to the efforts of a new Suicide Prevention Coordinator, and the close interest taken by the supervising Governor."

## Her Majesty's Chief Inspector Prisons (HMCIP)

14. Winchester was most recently inspected by HMCIP during a full announced inspection in April 2007. In her report, the Chief Inspector said with regard to self harm and suicide;

> "Assessment, care in custody and teamwork (ACCT) procedures were insufficiently multidisciplinary. Action plans from previous deaths in custody were not periodically reviewed. Listeners did not have adequate facilities and did not feel properly supported."

## Anti-ligature knives

15. Anti-ligature knives, also known as 'fish knives', are implements designed to cut ligatures. All staff who have contact with prisoners must be provided with, and carry on duty, their own personal knife.

## Assessment, Care in Custody and Teamwork (ACCT)

16. ACCT requires any member of staff who identifies concerns about a prisoner they believe to be at risk of suicide or harming themselves to take action and to record those actions. The ACCT document should be available to all staff where the prisoner is located, including workshops and visits. Within 24 hours of an ACCT being opened, the prisoner is seen by an assessor and has a case review meeting. ACCT reviews are held at appropriate intervals and are attended by the prisoner and a case manager, together with other members of staff.

## Listeners

17. A number of prisoners are trained and supported by the Samaritans to be Listeners and offer peer support. Other prisoners can speak to Listeners in confidence about any issues that affect them. Listeners are bound by confidentiality rules, like the Samaritans, and are unable to disclose details about conversations they have had (unless it is a matter which threatens the security of the prison).

**PIN phones**

18. Prisoners are given a PIN number to allow them access to make telephone calls. Prisoners are allowed up to 11 telephone numbers for their family and friends and five numbers for legal representatives.

**Roll check**

19. The roll check is the count of a number of prisoners on each wing within a prison. Roll checks occur at a number of specified times throughout the day and night, and staff sign that the roll is correct.

**Rule 45**

20. Prison Rule 45 relates to the separation of prisoners for either the good order of the prison or for the protection of vulnerable prisoners.

## KEY FINDINGS

21. At the time of his arrest the man lived in Portsmouth. He was born in Portsmouth and brought up in Surrey. He joined the Royal Marines at the age of 20, and completed a 22 year commission, ultimately leaving as a corporal. He retired over ten years ago and had a number of casual jobs. He had been married and had two children, but had lost contact with his family.

22. The man was arrested on 14 August 2008 for sexual offences. He went to South East Hampshire Magistrates' Court on 15 August and was remanded to the custody of HMP Winchester to await trial. The Prisoner Escort Record (PER) which accompanied the man to Winchester (and was completed by the police) said that he had issues of alcohol and self harm problems and due to the seriousness of his offence, he had been on observed constantly whilst in their custody.

23. On arrival at Winchester, the man was asked to provide details about himself and his next of kin. He gave no information apart from that he was unemployed, a smoker and would require a standard diet. He was then seen by a member of healthcare who carried out a health assessment. This information was recorded on the prison's electronic medical recording system (known as VISION). A first reception health screening form was not completed. A healthcare nurse recorded the man's height, weight and that he did not have any known allergies. The healthcare nurse also referred him to the Community Mental Health Team (CMHT).

24. A cell sharing risk assessment (CSRA) was also completed on 15 August. The Officer who carried out the assessment, only had the information in the PER form. The officer noted on the form that he had no concerns about the man and assessed him as low risk. (This meant that the man was considered to be a 'low risk' to other prisoners, not necessarily to himself.) The CSRA was then passed to the healthcare nurse. He was noted that the man had harmed himself in the past, but had no present intention of doing so. However the officer opened an ACCT for him. It was intended that he should be monitored closely for any change in his mood, and offer him support. It was again recorded that the man was referred to the CMHT. The healthcare nurse recorded that the man was of medium risk of harm to others. (This means that there is no immediate risk, but the situation needed to be reviewed regularly.)

25. The Officer (who saw the man in reception) was concerned that he seemed very low in mood said that he had nothing to live for and had attempted to take his own life four times in the last four months by attempting to hang himself and by taking an overdose. An immediate action plan was devised so that the man would be allocated a shared cell on the vulnerable prisoners (VP) wing, observed every two hours, and have access to the Samaritans telephone.

26. Due to the nature of his offence, the man asked to be placed on Rule 45 for his own protection. When a prisoner makes this request, it is assessed by a

member of staff and a decision made by a governor. (his request was agreed and he was placed on Rule 45 the same day.)

27. A first night, stage one induction was then carried out. It was noted that an ACCT was opened on reception and that he had mental health issues and suffered with depression. He was issued with an identity card, a prisoner information booklet, a smoker's pack, a letter and a PIN phone number. The man was also told about emergency cell bells, the role of Listeners and Insiders, fire procedures, race relations, anti bullying policy and details about the next stage of his induction. (The second part of his induction was to be held the next day and consists of information regarding benefits and housing issues, education, gym, work whilst in prison, bail information and alcohol and drugs issues.

28. The man was allocated a shared cell on D wing. The D wing SO said she remembered the man as a very quiet man, who did not really like to engage in conversation with staff.

29. The next day, 16 August at 10.00am, an Officer carried out an ACCT assessment interview. These assessments must be conducted within 24 hours of a concern about a prisoner being raised. The Officer recorded that the man said he had nothing to live for and that life seemed pointless. He said he had thought of suicide whilst on constant watch in the police station, but did not act on them. He said he had family, but they had not had any contact for years and said he did not know where they lived. Later that day three members of staff held a review with the man as a follow up to the assessment interview. The record of the meeting noted that the man felt 'like everything is against him'. He felt suicidal, but doubted that he would be able to cut himself. The role of the Listeners and Samaritans was explained and staff told him that he could always speak to them too. The next review was set for the following day and the two hourly checks continued.

30. An ACCT review was held on D wing the following day. Two SOs attended along with the man. A summary of the meeting said that he appeared calm, but was not particularly easy to engage in conversation. He said he was suffering from depression and had done so for the past six months. He had recently spent time in a hospital in Portsmouth. It was noted that a referral to CMHT had already been made and another review was arranged for three days later.

31. The next review was held 20 August. Three members of staff attended, along with the man. He said he was feeling 'pretty much the same'. He was still waiting to see somebody from CMHT, but said he was pleased that he would be seen for an assessment. He was happy that he was moving cells (to share with another prisoner who he got along with). He agreed that he would try to come out of his cell during association to mix with other prisoners. Staff agreed to keep the ACCT open for at least another week and set a review date for 27 August. A senior mental health nurse, practitioner and a member of the CMHT, was invited to attend this review.

32. The senior mental health nurse saw the man on 21 August. She noted that he had not attended the first appointment made for him, so she spoke to him on D wing. The man reported a long history of depression and suicidal thoughts. He said that he was currently "low in mood" but was managing to cope. Although he had some thoughts of suicide, he had no current plans or intentions of harming himself. They agreed to meet again on 27 August following the man's next scheduled court appearance.

33. The man went to Portsmouth Crown Court on 26 August. It was noted on the PER form that he was being monitored via the ACCT process and was checked constantly during his time at the court. The man received two visits from his solicitor, one at 9.52am and the second at 10.23am. He was remanded to appear at court again on 13 October.

34. The next day, 27 August, the man was seen by the senior mental health nurse for an initial psychiatric assessment. He described himself as feeling fed up and depressed, although he could not identify a trigger, but said that his mood had not deteriorated since he had been in prison. He said that he had taken an overdose and attempted to hang himself whilst in hospital, although this was not confirmed by his discharge summary. He reported ongoing thoughts of suicide, but with no plans or intentions.

35. Another ACCT review was held later that day and the mental health nurse was present. It was noted that the man was very depressed but refused any medication. He was due to meet the mental health nurse again. It was agreed that, as he needed glasses, they would arrange for him to go to the top of the optician's list when he next visited. The man said he was happy with the cell mate he was sharing with and was generally a quiet person. The next review was arranged for 3 September and the ACCT monitoring continued.

36. The mental health nurse held an unscheduled meeting with the man on 28 August as his cell mate had reported some concerns about him not eating or attending to his personal hygiene. The man was uncommunicative and so it was difficult to assess his mental state. The mental health nurse arranged for him to see a prison psychiatrist. The prison psychiatrist saw him later that day and noted that he had poor eye contact, was quietly spoken, showed little animation and felt worthless and useless. The prison psychiatrist prescribed 150mg of trazodone at night (an anti-depressant medication) and advised that he should transfer to healthcare for monitoring.

37. The mental health nurse saw the man again the next day. He had not moved to healthcare as no beds were available. He continued to speak about his low mood and thoughts of harming himself and suicide, although he still denied that he had any plans or intentions. However, he engaged better with the mental health nurse and showed her that he was planning for the future. Healthcare agreed to monitor the situation and try to find a bed for him.

38. It is noted on VISION that a nurse went to the wing to see the man the next day. However, as the wing was in patrol state (meaning that all prisoners

were in their cells) she spoke to him through the door. He told her he was okay.

39. Another nurse saw the man on 31 August. He still appeared to be low in mood, but said he had started his medication the night before. The nurse explained that she had been asked to check on him by the CMHT. He mentioned that he could not take part in any education or reading as he still had no glasses. The nurse said she would look into this. The man was unwilling to discuss his current situation, only saying he was on remand. The nurse told him that, in the absence of talking to someone from the CMHT, he could always ask to speak to her instead.

40. The mental health nurse saw the man the next day. Although he appeared brighter and more engaging and had slept better, he still felt low in mood. His thoughts of harming himself and suicide remained, although he still had no plans or intentions.

41. On 2 September a psychiatrist saw the man. His impression was that the man had 'moderate-severe depressive episode with no psychotic symptoms and that he felt pessimistic and hopeless about his life'. He noted he was awaiting a bed in healthcare.

42. The mental health nurse saw him the next day, 3 September and reported no change in his mood. Later that day he was transferred to healthcare. He was not happy about this move and was much less engaging, refusing to discuss his thoughts. The next ACCT review was held later that day in healthcare. It was agreed that staff would work closely with him to enable him to move back to the wing in due course. The next review was arranged for 11 September.

43. The man was seen by the mental health nurse on 4 and 5 September. There was a further decline in his mood as he was unhappy about being in healthcare and wanted to return to the wing. He went back to D wing at 5.30pm on 5 September.

44. Another ACCT review was held on 7 September. The man said he felt happier on D wing and more secure and less vulnerable than he did in healthcare. He said he still had thoughts of harming himself but they were less frequent.

45. The mental health nurse next saw the man on 8 September. He said he preferred being back on the wing and she noted an improvement in engagement, eye contact and co-operation. His ACCT remained open as he continued to think about harming himself and of suicide, although he had no active plans or intentions. The mental health nurse saw him over the next four days and his mood appeared unchanged.

46. A further ACCT review was held on 11 September. The man was still very withdrawn and it was noted that it was difficult to hold a conversation with him. It was hoped that, as he had now been taking his medication for two weeks, an improvement would be seen in the next few weeks.

47. The prison psychiatrist saw the man again on 16 September, and noted that there was no change in his presentation. His impression was that the man had a "moderate depressive episode and an unspecified dissociative disorder probably related to stress". He recommended a move back to healthcare (although on reflection and in discussion with the mental health nurse and another doctor, decided that a move back to healthcare would not be helpful).

48. Another ACCT review took place on 17 September. It was recorded that nothing had changed although the man had an appointment to see the optician on 1 October. It was agreed to hold a review in three weeks on 6 October to allow the man to settle.

49. The mental health nurse saw the man on 17, 19, 22, 24 and 30 September. She noted no change in his presentation and that he did not want to engage in any activities in the prison. At the end of September, he was also seen by a prison doctor who increased his dosage of trazodone from 150 mg to 300 mg.

50. Another ACCT review was held on 6 October. It was noted that the man had now seen a doctor and an optician (he had finally been given some reading glasses) and had applied for work in the prison and to attend education classes. He said he still thought of harming himself but had no plans to act upon his thoughts. It was agreed by the staff and the man that being on an ACCT was not helping him. The ACCT was closed with a post closure review date set for 13 October.

51. The man was also due to attend court on 13 October, but as he left his cell he collapsed. Healthcare staff responded and found that he was initially unresponsive to their checks. The man had banged his head as he fell to the floor, and so an ambulance was called. The paramedic advised that he should go to hospital and so he did not attend court. A letter from the hospital's emergency department to healthcare said that the man had no obvious head injury, and his blood tests and echocardiograms (ECG) were normal. It was advised that he should be observed for 24 hours due to a possible head injury. The man returned to the prison later that morning and was located in healthcare for further observation. He returned to the wing the next day.

52. The ACCT post closure review was held on 14 October. The D wing SO and the mental health nurse attended with the man. The review was held a day later than intended as he had spent the previous day in healthcare following his fall. It was agreed that there was no change to the man's mental state and that the ACCT document should remain closed. No further post closure reviews were thought to be required.

53. The man went to Portsmouth Crown Court on 4 November. He was again remanded into custody, to appear again on 17 November.

54. The man did not go to two further appointments with the mental health nurse on 6 and 10 November. The mental health nurse asked a colleague to see the

man when she was next on the wing, which she did the next day. The nurse noted that he did not engage with her and his eye contact and self care were poor. The man again spoke of harming himself but said he had no plans or intentions to do so. The nurse heard from another prisoner (who was not identified) that the man was not taking his medication and did not like his current cell mate.

55. The mental health nurse put in a request for the man to move cells. She also discussed his low mood and lack of response to medication with the prison psychiatrist who agreed to bring his next review forward.

56. A note was made on the computer system on 14 November which said that the man was fit to attend court. However, no further information, including the date of the court appearance, was provided (the man was next due to attend Portsmouth Crown Court on 17 November for a plea and case management hearing).

57. It is not possible to be certain whether the man knew he was due to go to court on 17 November, although it seems likely that he was told by staff. The D wing SO confirmed that staff on D wing would have received a court list which showed which prisoners were required to attend court the following day.

**Events of 17 November**

58. An Officer had been working a night shift at the prison and was carrying out a final roll check of prisoners (to ensure that all the prisoners were accounted for) at approximately 6.40am, before she handed over to day staff. As she opened the observation panel to look into the man's cell, she noticed that a green sheet was hanging down by the toilet area. The Officer thought this seemed strange, so she closed the flap and looked at the names of the prisoners who were in the cell (the man and his cell mate). She looked through the observation panel again. She could see the green sheet and what looked like the top of someone's head. One prisoner was in bed, and the second bed was empty. The Officer immediately called for assistance from staff.

59. Two Officers and an SO were on the wing and heard the call for help. The Officer who called for assistance also made an emergency call over the prison radio system which alerted a further two Officers and a Staff Nurse to the emergency.

60. An Officer and the SO ran to the cell via different routes. The SO arrived first, closely followed by a further two Officers . As they approached the cell the Officer who raised the alarm unlocked the door. The SO said he found the man at the back of the cell with a ligature around his neck, suspended from the bars of the window. The SO said he noticed that the man's face appeared dark, his tongue seemed to be swollen and he felt warm.

61. The SO used his anti-ligature knife to cut the ligature from the window bars. He then cut the ligature to release it from the man's neck. Whilst doing so,

the SO instructed one of the other Officer's to take the man's cell mate, who had begun to wake up, out of the cell and away from the wing.

62. The SO lowered the man onto the floor and began to check for signs of life. By this time two Officers were in the cell with him. (a third Officer had taken the man's cell mate away from the area and the Officer who had raised the alarm was standing outside the cell.) They checked for signs of breathing and for a pulse in the man's neck and wrist, but they found none. an Officer used a pocket torch to shine into the man's eyes, but there was no reaction from him. (None of the officers present had current first aid qualifications.)

63. At this point, the SO began cardio-pulmonary resuscitation (CPR) and commenced chest compressions. One of the officer's in the cell took out his face mask to start administering mouth to mouth breaths, but thought that this was no longer the correct procedure and so did not begin these. The other Officer took over chest compressions from the SO to allow him to take charge as the senior officer.

64. A nurse then arrived at the cell. En-route he had collected the emergency response bag from the treatment room on C wing, and upon going to D wing asked a member of staff to telephone for an ambulance. He re-assessed the man but found no pulse and that he was not breathing. The nurse took an oxygen cylinder from the emergency bag whilst the Officer continued with chest compressions.

65. The nurse began to administer oxygen using an ambu-bag (a mechanical aid to assist with breathing) whilst the SO and Officer continued with chest compressions between them. Within five minutes the paramedics arrived at the cell.

66. The paramedics asked the Officer to continue with the chest compressions whilst they assessed the man. They inserted a tube down his throat to open his airway and also attached defibrillator pads. The defibrillator instructed the paramedics to continue with CPR, which they did for another 20 minutes, but they were unable to resuscitate him. The paramedics agreed that the man had died and that he should be taken to the local hospital (this is situated just across the road from the prison).

67. The prison's duty Governor for that day arrived at the prison at approximately 7.00am. The SO briefed the duty Governor about what had happened

68. An Officer (who had heard about the emergency when he arrived for duty and had made his way to the wing immediately) used the Evac-chair to carry the man out to the ambulance. He used a head strap to secure him in the chair and covered him with a blanket. The Officer realised that staff were coming into the prison for duty. He rang the gate and instructed that no more staff should be allowed in until the ambulance had left the prison. The Officer asked another Officer to go with the man in the ambulance to the hospital. The ambulance left the prison at about 7.20am. The duty Governor arrived at the hospital about ten minutes later and was told that the man had died.

69. As most of the staff who had been involved in the discovery and attempted resuscitation of the man were finishing a night shift, they left the prison once they had written their statements rather than attend a de-brief (a meeting held after an emergency when staff can discuss events and how the situation was managed). However, one Officer was just starting a day shift. He was not spoken to by anyone from the Care Team or senior management. The Care Team rang those staff who had gone off duty later that morning, to check how they were feeling and to give the opportunity to talk if they wanted to.

70. When staff arrived for duty on D wing the SO spoke to them all and briefed them about what had happened. Staff checked on the man's cell mate, but he said he felt absolutely fine and unaffected by what had happened. The SO ensured that the Listeners were fully appraised and able to deal with approaches from prisoners who felt affected by the man's death, and the Samaritans spent the day on the wing. The Samaritans also offered to speak to the man's cell mate but he declined. Staff ensured they were visible on the wing and available to talk to prisoners if they wished to do so and all ACCT documents were reviewed. The SO said that general feeling on the wing was one of sadness. A small memorial service was held for the man.

71. A different SO was the prison's family liaison officer. At 9.30am he was asked to attend a briefing with the deputy governor and the police. They discussed how to trace the man's relatives as there was no information on file. At 11.00am the SO received a telephone call from the police to say they had located an address for the man's parents. The deputy governor asked the second SO and the prison chaplain to visit them and inform them of their son's death.

72. The SO and Reverend left the prison at about midday and travelled to the man's parents' house in Surrey. They arrived at about 2.00pm and, as there was no answer, they waited outside. Shortly afterwards the man's father arrived at the house.

73. The man's father took them into the house and they explained what had happened. It came as a complete shock to him, who did not know his son was in prison. He asked if they would stay until his wife arrived home as he said he did not know how he would tell her what had happened, which they did. The SO told them they could visit the prison and the man's cell if they wished to do so, and he also informed them which hospital their son was at and gave them contact details for both himself and the Reverend .

74. The next day the SO telephoned the man's father, who was still very upset. The SO agreed to deal with the funeral arrangements for the man's parents, and did so. (The funeral was held on 25 November and the SO attended along with the deputy governor and members of the man's family.)

75. The SO collected the man's ashes from the undertaker on 3 December and returned them to his parents along with items of property from the prison.

76. A critical incident de-brief was held approximately two weeks later. Most of the staff involved were invited to attend, although it appears that some were overlooked. The general feeling, however, was that the Care Team and the critical incident de-brief were handled well and that staff felt supported.

## ISSUES

### Assessment, Care in Custody and Teamwork (ACCT)

77. The man was almost constantly subject to ACCT monitoring from his arrival at Winchester until 6 October. His mood had not significantly altered throughout and, although he was assessed as low in mood, he did not appear to have plans to harm himself. The investigator found that the ACCT reviews were carried out thoroughly, in a timely manner and with a member of healthcare in attendance. I am satisfied that their judgements were appropriate. The post closure review a week later confirmed that the man was no worse once the ACCT monitoring was withdrawn.

### Length of time to see optician

78. The man was unable to read without glasses, yet it took almost two months for him to see the optician and be given a pair of reading glasses. This seems to be an unacceptably long time for someone to wait, given that he was unable to read at all without them, and far less than he would have received in the community. This recommendation was also made by the HMCIP in their report on Winchester.

    **The Governor and Head of Healthcare should review the optician's service to determine the level of demand and ensure the current service level meets that demand.**

### Medical records

79. The Clinical Reviewer found that the man's medical records were factual and consistent, but not accurate or comprehensive, particularly in relation to correspondence received by healthcare or the Community Mental Health Team. Records are legible and accurately dated where computerised, but not timed. Although staff names are clearly annotated, their roles are not. The recording of the dispensing of medication could have been clearer.

    **The Head of Healthcare should ensure that all medical records are completed fully and accurately.**

### Court dates

80. There were signs that the man became particularly anxious when he had to go to court. On 13 October, when he should have returned to court, he collapsed when leaving his cell. It would have been helpful if staff on the wing had been mindful that the news of his appearance on 17 November might have been a trigger affecting his mood. The member of staff who told him about the appearance could have alerted other wing staff and ensured that he was perhaps checked more regularly that evening, even though he was no longer on an ACCT. It is easy with hindsight, but consideration could also been given as to whether resuming the ACCT monitoring would have been beneficial.

**The Governor should ensure that staff are mindful of the effect that a pending court visit may have on a prisoner, especially when there have been signs of anxiety before previous court appearances. He should review or formulate a policy for notifying vulnerable prisoners of court appearances.**

## First aid training

81. None of the officers who responded to the emergency had up to date first aid qualifications. The Ombudsman has recommended previously that first aid training is provided for all staff in contact with prisoners, most recently in the case of a prisoner who died at Winchester in January 2009. I repeat the recommendation here.

**The Governor should review the need for first aid training for staff on frontline duties. This recommendation, made in previous reports, has been accepted by the prison.**

## Family Liaison Officer

82. I was impressed with the level of care and compassion shown by the SO towards the man's family. He also took responsibility for arranging the funeral and kept in close contact with them, whilst maintaining a comprehensive Family Liaison Log. I understand the man's family were grateful for this.

## CONCLUSION

83. During his time at Winchester, the man had frequent contact with the senior health care nurse and other members of the mental health team. He was assessed at regular intervals via the ACCT procedures and by wing staff generally, who tried to engage him in conversation whenever possible. The man did not share his thoughts and feeling readily with staff, but although he remained low in mood and had ideas of harming himself, he at no point told staff he had specifically planned to do so.

84. The man remained on an ACCT for much of his time at Winchester, finally coming off of the process on 14 October following a post closure review. Despite the fact that he had remained low in mood, his mood had not significantly altered and it was the opinion of staff that although he still had ideas of harming himself, he had no plans to actually carry this out.

85. There is evidence to suggest that the man was reluctant to attend court appearances. On 13 October he became unwell and was taken to hospital, although it remained unclear what was wrong with him. Although there is no documented evidence to confirm that he had been told he was due to attend court on 17 November, it is almost certain that he had been told by staff the night before, as is the usual procedure. It is possible that this may have led to his decision to seemingly take his own life.

## RECOMMENDATIONS

### To the Governor:

1. The Governor and Head of Healthcare should review the optician's service to determine the level of demand and whether the current service level meets that demand.

2. The Governor should ensure that staff are mindful of the affect that a pending court visit may have on a prisoner, especially when there have been signs of anxiety before previous court appearances. He should review or formulate a policy for notifying vulnerable prisoners of court appearances the night before, and determine whether checks should be made on such prisoners.

3. The Governor should review the need for first aid training for staff on frontline duties. This recommendation, made in previous reports, has been accepted by the prison.

### To the Head of Healthcare:

4. The Head of Healthcare should ensure that all medical records are completed fully and accurately.