PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent Investigations

A Report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

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

Our Vision

‘To be a leading, independent investigatory body,
a model to others, that makes a significant contribution
to
safer, fairer custody and offender supervision’

This is the investigation report into the death of a man, who was found hanged in his cell at HMP Winchester in June 2014. He was 39 years old. I offer my condolences to his family and friends.

A review of the clinical care the man received at the prison was conducted. HMP Winchester and National Probation Service, Hampshire Area, co-operated fully with the investigation.

The man was released from HMP Lewes in January 2014. He had a history of alcohol and drug dependency, depression and self-harm. After his release, he tried to address his substance misuse problems and had a place arranged at a residential alcohol detoxification and rehabilitation unit. He was arrested on 7 June 2014, three days before he was due to take up the place.

The man arrived at HMP Winchester on 9 June. Court custody staff had noted on his escort form that he had previously self-harmed and had a history of depression and substance misuse. He told the reception nurse that he had harmed himself four weeks earlier. He saw the substance misuse team but chose not to continue with his methadone and decided to 'go cold turkey'. Officers found him hanging a few days later.

Important information about the man's risk of suicide and self-harm, was known to probation staff, but was not effectively communicated. Even so, staff at Winchester had warnings from court custody staff about his risk and did not act on this or consider his other known risk factors. The investigation found that this should have led staff to monitor and support him under suicide and self-harm prevention procedures. Instead they placed too much weight to his assurances that he did not intend to harm himself. After he arrived at the prison, he decided not to continue a methadone maintenance programme, yet this was not identified as increasing his risk and he was not monitored as he should have been afterwards.

Overall, I do not consider that the man received the support he should have had in the short time he was at the Winchester.

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.

Nigel Newcomen CBE
Prisons and Probation Ombudsman **February 2015**

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SUMMARY

1. The man had been in prison many times and misused drugs and alcohol. After a crisis in May when he felt suicidal, he was due to enter a residential alcohol detoxification unit on 10 June, which he hoped would help resolve his substance misuse problems. However, on 7 June, he was arrested and charged with robbery and possession of an offensive weapon. He remained in police custody and appeared at Magistrates' Court on 9 June. He did not see anyone from the Probation Service and information about his crisis in May and planned detoxification was not passed to the court custody staff or to the prison. He was remanded to HMP Winchester.

2. None of the staff who assessed the man when he arrived at Winchester recalled seeing or reading the escort record which accompanied him and which mentioned that he had previously harmed himself. A nurse referred him to the prison reception doctor as he was on a methadone maintenance programme. The reception nurse, reception prison officer and prison doctor did not consider that he was at raised risk of suicide and, although he had disclosed some of his history of self-harm, they were reassured by his presentation.

3. The man was allocated a shared cell in the prison's induction wing (A wing). He did not go to the wing for prisoners with substance misuse problems, as would have been expected, because he said he wanted to keep away from another prisoner who was there. There is no evidence that he came into contact with the other prisoner while he was at Winchester, and we are satisfied that his concerns were dealt with appropriately by allocating him to another wing.

4. On 10 June, the man told substance misuse workers he did not want to continue with his methadone and wanted to 'go cold turkey' by giving up immediately without any medication to help. The doctor was concerned that he might use illegal drugs as an alternative. A cell search found no evidence that he had drugs. The doctor asked staff from the substance misuse team to monitor him for withdrawal symptoms, but there is no record these were completed.

5. A substance misuse worker assessed the man on 11 June and encouraged him to engage with detoxification and rehabilitation services if he was bailed or received a drug rehabilitation order when he next appeared at court. He did not explore his risk of suicide and self-harm.

6. The next day the man collected his lunch, but gave it away to another prisoner. Other prisoners on the wing did not think there was anything unusual about this and said they had not had any concerns about him. All prisoners on the wing were locked in their cells by 12.20pm. At approximately 1.30pm, a custodial manager took some mail to his cell and saw that he was hanging. He called for help, unlocked the cell, cut

him down and began resuscitation. Prison and healthcare staff quickly joined him and paramedics arrived a short time later. Despite attempts to resuscitate him, he was pronounced dead at 2.06pm.

7. We are concerned that probation staff did not effectively communicate information about the man's risk of suicide and self-harm to either court custody or prison staff. Although his history of self-harm was noted on his escort record, prison staff relied too heavily on his presentation when assessing his risk of suicide and self-harm. He was not appropriately monitored for signs of substance withdrawal despite a doctor asking the substance misuse team to do this. Healthcare staff did not record all interactions with him on his medical record. The emergency response was not conducted in line with national instructions. We make four recommendations.

THE INVESTIGATION PROCESS

8. The investigator issued notices to staff and prisoners at HMP Winchester, informing them of the investigation and inviting anyone with relevant information to contact her. No one responded.

9. The investigator obtained copies of the man's prison medical records and core prison record. She interviewed staff and prisoners at Winchester on 12 June and 18 July 2014. She viewed CCTV footage of the emergency response. She also interviewed four probation staff. She informed the Governor and the Assistant Chief Officer of Hampshire Probation of the preliminary findings of the investigation.

10. NHS England commissioned a clinical reviewer to assess the man's clinical care.

11. We informed the Coroner for Hampshire Central of our investigation and have sent him a copy of the investigation report.

12. One of our family liaison officers contacted the man's brother to explain the investigation process. He wanted to know if his brother was sharing a cell and whether the prison was aware of his history of substance misuse and self-harm.

13. The man's family received a copy of the draft report, but made no further comment. The prison and Hampshire Probation Area received a copy of the draft report, and has submitted an action plan detailing what they have done to address the issues we raised in the report. This is included at the end of the report.

HMP WINCHESTER

14. Winchester is a local prison serving the courts in Hampshire. It holds around 700 adult remand and sentenced men. Central and North West London NHS Foundation Trust provides health services at the prison.

HM Inspectorate of Prisons

15. The most recent inspection of HMP Winchester was in February 2014. Inspectors found that reception processes were reasonable and risk assessments generally good, although there was a lack of first night support. Levels of violence were high, and there was no effective system to address bullying behaviour or to support prisoners identified as victims of violence. Although the use of illicit substances had reduced, the use of drugs not covered by mandatory testing was widespread. Inspectors noted that only 20% of prisoners with drug and alcohol problems had spent their first five nights on the wing which contained the prison's stabilisation unit. They noted that observations had been done appropriately but this made their clinical management less safe. The standard of day-to-day care for prisoners on opiate substitution programmes had improved and was regarded as good.

Independent Monitoring Board

16. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help ensure that prisoners are treated fairly and decently. In its most recently published report for the year to May 2014, the IMB noted that, although there were fewer illicit drugs available, there had been an increase in the production of illicit alcohol and the trading of prescription medication. They also reported that first night accommodation was often unavailable and that staff allocated prisoners to areas unsuitable for their needs.

Assessment, Care in Custody and Teamwork

17. Assessment, Care in Custody and Teamwork (ACCT) is the care planning system the Prison Service uses to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk posed, the steps that staff might take to reduce this and the extent to which staff need to monitor and supervise the prisoner. Checks should be at irregular intervals to prevent the prisoner anticipating when they will occur. Part of the ACCT process involves assessing immediate needs and drawing up a care-map to identify the prisoner's most urgent issues and how they will be met. Regular multi-disciplinary reviews should be held. Staff should hold regular multidisciplinary reviews and should not close the ACCT plan until all the actions of the care map are completed. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

Previous deaths at Winchester

18. The man's death was the third apparent self-inflicted death at Winchester since the beginning of 2012. There were no significant similarities with the circumstances of the previous deaths, but we repeat a recommendation about the need to call an ambulance immediately an emergency code is called.

KEY EVENTS

19. The man had served several previous prison sentences when he was released from HMP Lewes in January 2014. He had long-term alcohol and drug misuse problems. Although not under formal probation supervision, when he was released from prison he worked voluntarily with the Probation Service to address his substance misuse problems. (Probation staff support ex-offenders who want to engage with community services to address their needs and reduce the likelihood of re-offending.)

20. On 8 May 2014, the man had a crisis. His drug intervention worker accompanied him to the mental health team at hospital, as he was feeling suicidal about his homelessness and long standing addiction. As a result, funding was found for a place at an alcohol detoxification and rehabilitation centre from 10 June, for two weeks, and then at a drug rehabilitation unit immediately afterwards. However, on 7 June, he was arrested and charged with robbery and possession of an offensive weapon. He was held in police custody until 9 June, when he appeared at Magistrates' Court. Magistrates remanded him in custody and he was due to appear at Crown Court on 30 June.

21. The man did not see any probation staff at Magistrates' Court on 9 June. The court duty probation worker did not recall checking his probation records. His solicitor spoke to the bail information officer and asked her to confirm that he had a place at the alcohol detoxification and rehabilitation centre. She told the solicitor that he had a place, and assumed that the solicitor would tell the magistrates.

22. Staff from Hampshire Police and the court custody staff completed a Person Escort Record (PER, a form that is used to inform other agencies about a person's risks). They noted that the man had a history of self-harm and that he was prescribed methadone and had fits when withdrawing from alcohol. The escort record went with him to Winchester.

23. The man arrived at Winchester at 12.57pm on 9 June. It is not clear from the records which officer saw him when he arrived. A nurse saw him in reception at 2.23pm and recorded that he had disclosed a history of self-harm but had no current thoughts of self-harm. When interviewed, the nurse could not remember seeing the escort record and told the investigator that he did not always see them when he was working in reception. He did not assess him as at risk of suicide or self-harm. He gave a urine sample that indicated he had recently used methadone and benzodiazepines, but not heroin. The nurse referred him to the reception doctor to assess his drug dependency needs and, if necessary, prescribe methadone.

24. Induction staff at Winchester use a form titled "Admissions Group" to record their assessment of newly-arrived prisoners. An officer signed

the man's form, but she told the investigator that, although she had prepared the form in advance and entered some details about him, she did not interview him as she had finished her shift. An officer completed the assessment on A wing, the first night and induction unit. He said that he did not recall him and he did not usually see PER forms. He said that he had recorded that he did not have a history of self-harm and said that he would have recorded this solely on what he told him as he had no other information about him.

25. A Senior Officer (SO) completed a cell sharing risk assessment form to determine the man's risk of violence to other prisoners. He assessed him as a standard risk which meant he was suitable to share a cell. The SO noted on the form that there were no concerns about his risk of suicide or self-harm but that he was not to go to C wing (the stabilisation unit for prisoners withdrawing from drugs or alcohol). At 4.16pm, the SO noted on his prison record that he had a 'major issue' with a prisoner on C wing and that he should not move there. The SO told the investigator that he did not consider starting anti-bullying or violence reduction measures. He said that he had told him to let wing staff know about this issue, if they planned to move him.

26. The integrated substance misuse service doctor examined the man at 7.21pm. She noted that he said he had been prescribed 40ml of methadone daily in the community and had been given this in police custody. Although his urine test indicated that he had not used heroin, the doctor prescribed a 20ml dose to avoid the risk of overdose which is standard practice until his prescription could be confirmed. She assessed that he had few signs of withdrawal from alcohol, with no immediate cause for concern. She prescribed a single dose of Librium (to combat the affects of alcohol withdrawal) in case he needed it that night. She noted that nurses should take his clinical observations twice daily for at least five days to check for any signs of withdrawal. (These observations were never completed.)

27. As the man could not go to C wing, he went to A wing, the induction wing. He shared a cell with another newly-arrived prisoner, who he knew from his home area.

28. On 10 June, the man completed a gym and second stage induction. He did not attend an appointment with the lead substance misuse doctor, which the other doctor had made the night before. He told a member of the substance misuse team that he did not want to be prescribed methadone as he wanted to 'go cold turkey'. The drugs worker told the investigator that he was quieter than he remembered him. He said that he was sweating profusely, possibly because of alcohol withdrawal. His cellmate told him that he should have accepted help.

29. The drugs worker said that when a prisoner refused drug maintenance treatment, they should still have their observations taken, and staff

would encourage them to re-engage with the methadone programme. If the prisoner still did not want treatment, the substance misuse team would ask them to sign a disclaimer that they had refused treatment against medical advice. She told the investigator that she had seen the man on A wing and told him about the possible withdrawal symptoms. He again refused to take methadone and said that he did not want any other medication to relieve withdrawal symptoms. She did not record this in his medical record but, at 11.25am, wrote in the wing observation book that he had refused methadone and would be 'quite ill without medication'.

30. The man signed a disclaimer later that day to say that he did not want any drug treatment. Although the form states that a GP appointment would be made to review him, there is no evidence that this was done. No one took his medical observations after his reception at Winchester.

31. A doctor had confirmed that the man received 40ml of methadone a day in the community. He thought it would be difficult for him to cope without it, and was concerned that he might use illegal drugs on the wing as an alternative to methadone. He asked an officer to complete a security information report. Officers searched his cell that day, but did not find any drugs or other illicit items.

32. The cellmate told the investigator that, during the afternoon, he and the man had discussed how they would kill themselves, and noted the possible ligature points in the cell. He said he did not think the conversation was unusual and described it as 'gallows humour'.

33. The same day, 10 June, a drug worker employed by RAPT (Rehabilitation for Addicted Prisoners Trust), who knew the man from a community drug project, spoke informally with him on the wing. He noted that he was in a low mood. He contacted the man's community drug intervention worker who confirmed the details of his alcohol and drug rehabilitation plans. He told the investigator he was unaware of his history of self-harm and did not discuss this with the drug intervention worker. He reassured him that funding for his rehab was still in place and told him that, when he went to court on 30 June, the Probation Service would propose a drug rehabilitation requirement (a non-custodial sentence managed and supervised by the Probation Service). He arranged to complete a full assessment with him the next day at 10.15am.

34. On 11 June, the cellmate moved to C wing, leaving the man alone in the cell. The man met the drug worker for his assessment. They discussed his history of drug and alcohol dependency and his intention to get clean. The drug worker helped him to complete a number of documents about his alcohol and drug use to determine his level of motivation. They set goals to help him address his problems. He said that receiving treatment at the rehabilitation centre meant everything to him.

35. The man told the drug worker about his history of self-harm and that he had cut his arms six times in the previous year. The drug worker thought that he was more positive than the previous day and was not at risk of suicide or self-harm. He gave him some information on how to use drugs safely if he carried on doing so and referred him to the community drug team, Stepping Stones, to ensure he was supported if he received a drug rehabilitation requirement when he appeared at court on 30 June.

36. When interviewed, the drug worker could not recall all the details of his meeting with the man, but said that his priority had been to ensure that his arrangements for the residential detoxification and rehabilitation were still in place. He said he had not been trained in ACCT procedures, but was aware of the process. He had not thought that the man was at risk of suicide or self-harm when he spoke to him.

37. There were no other significant events recorded on 11 June. Prisoners who spoke to the investigator said that the man kept himself to himself, but seemed relaxed and spent much of his time in his cell.

Day of Incident

38. At 9.00am the man was unlocked for a morning association period, when prisoners can spend time out of their cells. Officers did not note anything of concern about him and did not report any incidents on the wing. Another prisoner told the investigator that the man gave him his lunch. He assumed that he did not want it, as the food was often poor. After lunch was served, all prisoners were locked in their cells.

39. An officer who did not normally work on A wing and who did not know the man, locked and checked the cells on his landing. He noted in statement for the police that the man's door was already locked and he was sitting on his bed staring at the floor. The officer did not speak to him. He recorded in the wing observation book that all cells were secured by 12.20pm.

40. A custodial manager started delivering mail to A wing prisoners at approximately 1.30pm and had a letter for the man. When he got to his cell, he checked the name card, looked through the observation panel and saw him hanging from a ligature (which he thought was made from a sheet) attached to a ceiling rail. He shouted for help, opened the door and went in and supported the body. He cut the ligature and lowered him to the floor.

41. A physical education instructor was on the wing and heard the manager's shout for help. CCTV shows her running up the stairs to the cell at 1.32pm. They turned him on his back and noted that he did not have a pulse and he was not breathing. The manager recalled that there were superficial scratches on his wrist. They began

cardiopulmonary resuscitation. An officer also heard the manager's shout, went to the cell and assisted with the resuscitation attempt.

42. At some point, someone (we do not know who) radioed a code red emergency. A code red is used for emergencies involving blood loss, and code blue should be used when a prisoner is unconscious or has breathing difficulties. According to the CCTV timings, a nurse arrived at 1.34pm, followed by another nurse at 1.36pm (which he said was in response to the emergency code). South Central Ambulance Service records show that they received an ambulance request at 1.37pm. The prison's control room log gives the time of the code red as 1.37pm and the ambulance request at 1.40pm.

43. An officer heard the emergency code over his radio and, when asked, went to get a defibrillator from E wing, which was nearby. (A defibrillator is a life-saving device that gives the heart an electric shock in some cases of cardiac arrest.) He then went to bring paramedics to the man's cell. According to ambulance service records, the paramedics arrived at the cell at 1.52pm. They assessed him using their own heart monitoring equipment, but, after further emergency treatment, at 2.06pm, they declared him dead.

Informing the man's next of kin

44. The prison family liaison officer and a prison manager visited the man's brother at 4.30pm, to break the news of his death. They offered condolences and support. The funeral was held on 25 June. The prison contributed towards the cost in line with Prison Service policy.

Support for staff and prisoners

45. The Governor issued a notice to staff and prisoners informing them of the man's death and offering support to anyone affected. He debriefed all the staff involved in the emergency response. Officers and healthcare staff told the investigator that they had felt well supported.

46. The cellmate said that staff had supported him at the time of the man's death, but he would have liked better access to the prison chaplain. Staff reviewed prisoners identified as at risk of suicide or self-harm in case they had been affected by the death.

ISSUES

Managing the risk of suicide and self-harm

47. The man was well known to the Probation Service and community substance misuse services. However, his probation worker had not flagged the probation electronic case record (known as Delius) to show that he was at risk of self-harm. Even had she done so, when he appeared at court on 9 June, the court duty probation worker did not check his records. As a result, important information about his suicidal crisis in May was not included on the Person Escort Record or sent to the prison.

48. When we interviewed probation staff at court, we found that the court duty officer was unsure of her job description and the requirements of the role. However, there was no self-harm warning flag on the man's record to show that he was at risk, which might have prompted some action. We are concerned that probation staff had information directly relevant to his risk of suicide and self-harm which they did not communicate effectively to court custody or prison staff. We make the following recommendation:

    The Assistant Chief Officer of the National Probation Service - Hampshire Area should ensure that probation staff appropriately record the risk of suicide and self-harm on offender records and share this information with court custody and prison staff.

49. Staff judgement is fundamental to the ACCT system. ACCT relies on staff using their experience and skills, as well as local and national assessment tools, to determine risk. They must balance this against the prisoner's known risk factors and their presentation. Prison Service Instruction (PSI) 64/2011 states that "all staff who have contact with prisoners must be aware of the triggers that may increase the risk of suicide, self-harm or violence and take appropriate action".

50. When the man arrived at Winchester in June 2014, he had a number of the suicide risk factors outlined in PSI 64/2011 (Safer Custody) which increase the risk of suicide and self-harm. He was single, was in the early days of custody, had a history of self-harm, mental health issues, substance misuse problems and was withdrawing from drugs and alcohol. He thought he had lost the opportunity of a place at an alcohol detoxification and rehabilitation centre, which he had been due to begin on 10 June. This was significant, as he had hoped it would help turn his life around.

51. The man arrived with a Person Escort Record form that set out that he had a history of self-harm. However, the officer responsible for conducting the assessment of his risk of suicide and self-harm said that he did not usually see PER forms.

52. Prison Service Instruction (PSI) 74/2011, about early days in custody, requires reception staff to examine the 'Person Escort Record (PER) form that must accompany each new prisoner and any other available documentation to identify any immediate needs and risks already recorded'. None of the members of staff we interviewed recalled seeing the man's PER, and a nurse said that it was "hit or miss" whether he saw the PER when he assessed newly arrived prisoners. We do not consider that the prison complied with this instruction and are concerned that reception practices at Winchester are not robust enough to ensure that all staff tasked with assessing a prisoner's risk of suicide and self-harm receive all the information they need to make an informed assessment.

53. In a PPO thematic report, published in April 2014, about risk factors in self-inflicted deaths, we identified that too often assessments of risk place insufficient weight on known risk factors and too much on staff perceptions of the prisoner's behaviour and demeanour. The man had a number of factors known to increase the risk of suicide and self-harm which are identified in our report and in Prison Service instructions. We are concerned that staff relied too heavily on his presentation and what he said, when he arrived at Winchester, rather than his risk factors.

54. It is unfortunate that probation and substance misuse staff in the community held information about the man's suicidal crisis in May 2014 that did not reach the prison. However, a number of other risks were not considered. When he decided to 'go cold turkey', it was treated as a security matter and staff checked for illicit drugs rather than considering that this might increase his risk of suicide and self-harm. We are not satisfied that staff at Winchester fully assessed his risk of suicide and self-harm using all the information available to them. We make the following recommendation:

The Governor should produce clear local guidance about procedures for identifying prisoners at risk of self-harm and for managing and supporting them. In particular, this should ensure that reception, induction and substance misuse staff:

- **Have a clear understanding of responsibilities and the need to share all relevant information about risk.**
- **Consider and record all the known risk factors of a newly-arrived prisoner when determining their risk of suicide or self-harm, including information from suicide and self-harm warning forms and PERs.**
- **Open an ACCT whenever a prisoner has recently self-harmed or expressed suicidal intent.**

Clinical care

55. The man said when he arrived at Winchester that he was prescribed mirtazapine, an antidepressant, which he had last taken on 7 June. There is no record that he received mirtazapine at Winchester. The clinical reviewer noted that antidepressants work over weeks and months, so it is unlikely that this omission was clinically significant in the context of complex substance misuse. While there is no indication that the risk of suicide increases when mirtazapine is stopped, it is a concern that he did not receive continuity of care.

56. When the man arrived at Winchester, he had a 20 year history of alcohol and drug dependency, was on a methadone maintenance prescription of 40ml and had recently been prescribed medication for depression. The initial healthscreen was comprehensive and the clinical reviewer concluded that prescribing a standard 20ml dose of methadone pending confirmation from community drug services (to avoid overdose if other opiates had been taken) was appropriate.

57. The substance misuse doctor requested that the substance misuse team should set up a five-day care plan to monitor the man for signs of withdrawal. However, there is no evidence that this was done. A drugs worker told the investigator that the man refused to have his observations taken on 10 June, but there is no corresponding entry in his medical record. The doctor told the investigator that the lack of montitoring and recording was ‘quite typical’. Despite his long history of substance misuse, he was not monitored as the doctor had requested.

58. We accept that the man declined to continue methadone maintenance treatment and appears to have been unwilling to accept symptomatic relief for withdrawal (although the latter is not recorded). However, withdrawal from drugs and alcohol increases the risk of suicide and self-harm, and can have serious physical health consequences. It is important that staff monitor prisoners appropriately to ensure that they are coping, even if they refuse to cooperate with clinical treatment. If the man declined to have clinical observations taken, we consider that this made it all the more important that he should have been closely observed for adverse reaction to withdrawal symptoms. We make the following recommendation:

The Head of Healthcare should ensure that substance misuse service staff monitor prisoners as required when they are withdrawing from drugs or alcohol and record all their interactions on the SystmOne medical record. Monitoring should continue, even when prisoners decline clinical intervention.

Anti-bullying & violence reduction

59. When the man arrived at Winchester, he told staff that he had a "major issue" with another prisoner on the substance misuse wing. The SO noted this on his prison record and the cell sharing risk assessment. Winchester's "Management of Violence Reduction" policy states that officers should submit a violence reduction report and intelligence report if they observe, or a prisoner notifies them of, a violent incident. The SO did not do this, although he did put a note on his prison record and cell sharing risk form that he should not move to C wing. It does not appear that the SO was aware of the details of his concerns, which involved a violent incident in the community. In the circumstances, we are satisfied that the SO took appropriate action to keep the two prisoners apart. There is no indication that he encountered the prisoner he wanted to avoid, during his short time at the prison.

Emergency response

60. Prison Service Instruction (PSI) 3/2013 Medical Emergency Response Codes, issued in February 2013, sets out the actions staff should take in a medical emergency. It contains mandatory instructions for prisons to efficiently communicate the nature of a medical emergency using a two level code system to differentiate between a blood injury and all other injuries. Usually code red for blood or burns and code blue for breathing and collapses. This is to ensure that staff take relevant equipment to the incident and that there are no delays in calling an ambulance. The PSI states that all prison staff should know about and understand the instruction and their responsibilities in emergencies. Winchester has an appropriate instruction to staff.

61. However, no one called a code blue, immediately when the man was found hanging as should have happened. Someone called a code red but it does not appear that anyone called an ambulance until nurses arrived on A wing and asked for one. This should have been done automatically as soon as the emergency code was called. We interviewed staff who did not appear to fully understand the local medical emergency protocol or the requirements of the national instruction. We have previously made a recommendation to Winchester about ensuring that staff call an ambulance immediately in an emergency. We make a similar recommendation:

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

- **Staff efficiently communicate the nature of a medical emergency using the appropriate code;**
- **Staff called to the scene bring the relevant equipment; and**
- **The control room calls an ambulance as soon as an emergency medical code is received.**

RECOMMENDATIONS

1. The Assistant Chief Officer of the National Probation Service - Hampshire Area should ensure that probation staff appropriately record the risk of suicide and self-harm on offender records and share this information with court custody and prison staff.

2. The Governor should produce clear local guidance about procedures for identifying prisoners at risk of self-harm and for managing and supporting them. In particular, this should ensure that reception, induction and substance misuse staff:

   - Have a clear understanding of responsibilities and the need to share all relevant information about risk.
   - Consider and record all the known risk factors of a newly-arrived prisoner when determining their risk of suicide or self-harm, including information from suicide and self-harm warning forms and PERs.
   - Open an ACCT whenever a prisoner has recently self-harmed or expressed suicidal intent.

3. The Head of Healthcare should ensure that substance misuse service staff monitor prisoners as required when they are withdrawing from drugs or alcohol and record all their interactions on the SystmOne medical record. Monitoring should continue, even when prisoners decline clinical intervention.

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

   - Staff efficiently communicate the nature of a medical emergency using the appropriate code;
   - Staff called to the scene bring the relevant equipment; and
   - The control room calls an ambulance as soon as an emergency medical code is received.

ACTION PLAN

No	Recommendation	Accepted/Not accepted	Response	Target date for completion and function responsible	Progress (to be updated after 6 months)
1	The Assistant Chief Officer of the National Probation Service - Hampshire Area should ensure that probation staff appropriately record the risk of suicide and self-harm on offender records and share this information with court custody and prison staff.	Accepted	The Assistant Chief Officer (ACO) will ensure that Probation staff flag on Delius any concerns around suicide/risk of self harm issues and that this is shared with court custody and prison staff. Systems are now in place to record risk of suicide and self harm on offender records and staff will be reminded of the importance of ensuring the recording of information of risk in future and sharing this information with court custody and prison staff.	Target date for completion: 16 January 2015 Assistant Chief Officer of National Probation Service- Hampshire Area.	
2	The Governor should produce clear local guidance about procedures for identifying prisoners at risk of self-harm and for managing and supporting them. In particular, this should ensure that reception, induction and substance misuse staff: • Have a clear understanding of responsibilities and	Accepted	All prisoners received into HMP / HMYOI Winchester receive a first night assessment. This includes a full initial screening interview covering all aspects of personal health including self harm, addictions, detox, mental health and safeguarding needs. All staff have been made aware of the need to ensure that any assessment of a newly received prisoner's potential risk of suicide and/or self-harm draws from information contained within available including from a previous custody, previous medical history in the community involving self harm, the accompanying PER, and all staff are familiar with	Completed Head of Safer Prisons	

	the need to share all relevant information about risk. • Consider and record all the known risk factors of a newly-arrived prisoner when determining their risk of suicide or self-harm, including information from suicide and self-harm warning forms and PERs. • Open an ACCT whenever a prisoner has recently self-harmed or expressed suicidal intent.		known risks and triggers as set out in PSI 64/2011. If risk information is obtained from the PER, or should risk information be provided from external sources by other routes, staff will ensure this is taken into account when assessing a newly received prisoner's risk. This information has been cascaded to staff through the publication of policy documents and Notices to Staff. Internal audit checks ensure that these procedures are complied with. All prisoners deemed to be at-risk of suicide and/or self-harm, or who have recently self-harmed or express suicidal ideation, will have an ACCT opened. Local guidance about procedures for identifying prisoners at risk of self-harm and for managing and supporting them is in place. All new staff in post receive refresher training from the Head of Safer Custody in the use of Assessment, Care in Custody through Teamwork (ACCT) documentation and ACCT procedures. This forms part of their mandatory training programme, and reminds staff of the need to open an ACCT whenever a prisoner has recently self –harmed or expressed suicidal intent. As part of this training, all staff have been made aware of the need to share all relevant information about risk and to record all the known risk factors of		

			a newly-arrived prisoner when determining their risk of suicide or self-harm, including information from suicide and self-harm warning forms and prisoner escort records (PERs). Reception staff are aware of the need to review the contents of the PER and either share the document itself, or key information contained within about a prisoner's risk to self, with other staff assessing the newly received prisoner in reception, including healthcare staff completing the first reception health screen. Winchester staff have regular full staff meetings chaired by the Governor along with a Governors Blog. This highlights areas of concern and good practice. Residential managers have daily morning briefings by the Head of Function; this in turn is cascaded down to Winchester staff allowing full and speedy methods of communication to those on duty. ACCT referral meetings are held weekly and full Safer Custody meetings are held monthly. These meetings are themed to address specific issues, such as mental health, first night in custody, violence reduction and the effects that these things can have on prisoners and staff at risk of suicide and self harm.		

3	The Head of Healthcare should ensure that substance misuse service staff monitor prisoners as required when they are withdrawing from drugs or alcohol and record all their interactions on the System One medical record. Monitoring should continue, even when prisoners decline clinical intervention.	Accepted	All integrated substance misuse service (ISMS)) staff are trained in the use of SystmOne. Prisoners who decline treatment will be monitored through welfare checks from the clinical team at regular periods and recorded on to SystmOne. This will be discussed in the Clinical handover meeting as appropriate. Wing Observation books are updated as appropriate by clinical and psychosocial staff. All medical support staff have been made aware of the responsibility to alert wing staff via the obs books about prisoners that require closer monitoring. A new procedure was written to this effect and introduced by the Substance misuse services .This procedure which began in August 2014, ensures that all staff have been informed about observation book entries.	Complete Head of Healthcare	
4	The Governor should ensure that all prison staff are made aware of and understand PSI 03/2013, the local protocol, and their responsibilities during medical emergencies and that: • Staff efficiently communicate the	Accepted	A re-published notice to all staff was issued in June 2014, instructing staff in the responses to be used in a medical emergency and their responsibilities during medical emergencies. Cards were also published in June 2014 and attached to staff wages slips as a reminder. The notice makes reference to PSI 03/2013, that explains	Complete Head of Safer Prisons	

	nature of a medical emergency using the appropriate code; • Staff called to the scene bring the relevant equipment; and • The control room calls an ambulance as soon as an emergency medical code is received.		the correct methodology for control room staff in calling an ambulance as soon as an emergency code is received, including use of relevant equipment. This information is displayed in the control room for reference. Medical staff have all been briefed on the equipment to bring to a medical emergency dependent on the colour code called. Local contingency plans now reflect the need to summon an ambulance once this medical code is received.		