Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Sean Plumstead a prisoner at HMP Winchester on 18 September 2016

A report by the Prisons and Probation Ombudsman
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Our Vision

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

Our Values

We are:

Impartial: *we do not take sides*
Respectful: *we are considerate and courteous*
Inclusive: *we value diversity*
Dedicated: *we are determined and focused*
Fair: *we are honest and act with integrity*

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

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

Mr Sean Plumstead was found hanged in his cell at HMP Winchester on 15 September 2016. He died in hospital three days later. Mr Plumstead was 27 years old. I offer my condolences to Mr Plumstead's family and friends.

I am satisfied that there was little to indicate that Mr Plumstead was at risk of suicide in the period immediately before his death. Despite this, I am concerned that nothing was done to consider whether suicide and self-harm prevention measures might have been appropriate after he asked staff about suicide methods two days before he hanged himself. The staff concerned had not been trained in suicide and self-harm prevention measures. There was also a delay of several minutes in responding to the emergency cell bell after Mr Plumstead's cellmate found him hanging.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman **June 2017**

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Summary

Events

1. On 9 January 2016, Mr Sean Plumstead was remanded to HMP Winchester after he assaulted his partner. He had served time in prison before, had no history of suicide attempts or self-harm and settled well.

2. On 13 September, Mr Plumstead asked a store clerk where he worked about suicide methods. The store clerk was taken aback and told Mr Plumstead that he did not want to discuss the matter. He was not trained in operating suicide and self-harm prevention procedures (known as ACCT), did not tell anyone about his conversation with Mr Plumstead and did not note the conversation in Mr Plumstead's records. Winchester has since provided staff training.

3. Mr Plumstead gave no indication of his risk of suicide during a telephone conversation with his mother on 14 September or conversations with other prisoners on 15 September.

4. During the evening of 15 September, Mr Plumstead's cellmate found him hanged in their cell. He rang the emergency cell bell but it took staff over ten minutes to respond, go into the cell, remove the ligature from Mr Plumstead's neck and begin to attempt to resuscitate him. Paramedics attended and took Mr Plumstead to hospital, where he died on 18 September.

5. After Mr Plumstead's memorial service, his ex-cellmate told his family that Mr Plumstead had made a ligature a few weeks before his death, and that staff had agreed to monitor Mr Plumstead. Staff denied this.

Findings

6. While Mr Plumstead had no history of suicide or self-harm, we are concerned that no one followed the issue up with him after he asked a store clerk what the best way to commit suicide was.

7. We found no evidence to support an allegation made by Mr Plumstead's ex-cellmate that staff took no action after he had reported to them that Mr Plumstead was at risk of suicide or self-harm.

8. It took staff over ten minutes to answer Mr Plumstead's emergency cell bell.

Recommendations

- The Governor should ensure that all staff understand the circumstances when they should consider whether to start ACCT monitoring, including when a prisoner has expressed suicidal intent.
- The Governor should ensure that all cell bells are answered promptly, in line with HMIP expectations.

The Investigation Process

9. The investigator issued notices to staff and prisoners at HMP Winchester informing them of the investigation and asking anyone with relevant information to contact him.

10. The investigator visited Winchester on 21 September. He obtained copies of relevant extracts from Mr Plumstead's prison and medical records.

11. NHS England commissioned a clinical reviewer to review Mr Plumstead's clinical care at the prison.

12. The investigator interviewed ten members of staff and one prisoner at Winchester. Three prisoners declined to be interviewed, including Mr Plumstead's cellmate.

13. We informed HM Coroner for Western Hampshire of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

14. One of the Ombudsman's family liaison officers contacted Mr Plumstead's parents to explain the investigation. They were concerned that prison staff did not support Mr Plumstead when his ex-cellmate found him making a ligature and when he asked a store clerk about suicide. They wanted to know why there was a delay in answering the emergency cell bell and in notifying them about Mr Plumstead's admission to hospital. They were concerned that the two members of the staff on bedwatch duty behaved unprofessionally at the hospital on the day Mr Plumstead died.

15. Mr Plumstead's parents received a copy of the initial report. The solicitor representing Mr Plumstead's parents wrote to us pointing out some factual inaccuracies. The report has been amended accordingly. They also raised a number of questions that do not impact on the factual accuracy of this report. We have provided clarification by way of separate correspondence to the solicitor.

16. The initial report was shared with the Prison Service. The Prison Service did not find any factual inaccuracies.

Background Information

HMP Winchester

17. HMP Winchester holds up to 685 men. Central and North West London Foundation Trust provide all healthcare services, including primary care, substance misuse services and mental health services.

HM Inspectorate of Prisons

18. HM Inspectorate of Prisons most recently inspected Winchester in July 2016. Inspectors reported that the prison had operated a restricted daily routine for many months due to inadequate staffing levels. They said that there had been five self-inflicted deaths at Winchester since their last inspection, but there was little analysis of data or trends to inform a local strategy.

19. Against an expectation that they should be answered within five minutes, inspectors recommended in 2014 that emergency cell bells should be answered promptly, Winchester had not implemented this recommendation when inspectors returned in 2016. They found that only 11 per cent of the prisoners questioned said that their emergency cell bell was answered within five minutes (compared to 25% in comparable prisons).

Independent Monitoring Board

20. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report for the year to May 2016, the IMB reported concerns about staffing levels, which it viewed as barely sufficient to sustain the day-to-day operation of the prison. They also reported that there was little capacity to deal with incidents or to provide one-to-one prisoner contact and care.

Previous deaths at HMP Winchester

21. Mr Plumstead was the seventh prisoner to take his life at Winchester since 2014. We have previously recommended that Winchester should improve how they manage prisoners at risk of suicide or self-harm.

Assessment, Care in Custody and Teamwork

22. Assessment, Care in Custody and Teamwork (ACCT) is the care planning system the Prison Service uses for supporting and monitoring prisoners assessed as at risk of suicide and self-harm. The purpose of the ACCT process is to try to determine the level of risk posed, the steps that might be taken to reduce this and the extent to which staff need to monitor and supervise the prisoner.

Key Events

23. On 9 January 2016, Mr Sean Plumstead was remanded to HMP Winchester, charged with assaulting his ex-partner. He had previously spent time at Winchester.

24. A nurse from the primary healthcare team assessed Mr Plumstead in reception. She noted his history of alcohol misuse but that he had not had alcohol for more than two days and had no thoughts of suicide or self-harm.

25. Mr Plumstead was moved to a shared cell on B wing, a standard residential wing. On 14 January, wing staff completed a security information report which said that there was a strong smell of cannabis coming from Mr Plumstead's cell. Mr Plumstead's cellmate was known to the security department. They linked the intelligence to him rather than Mr Plumstead, who had no known history of substance misuse.

26. On 4 March, Mr Plumstead was sentenced to 16 months in prison.

27. On 23 March, Mr Plumstead met his offender supervisor. He told her he did not want to address his alcohol problems while in prison. She asked Mr Plumstead to reconsider this before he was released.

28. On 29 March, Mr Plumstead started work at Winchester's clothing exchange store. A store clerk noted that Mr Plumstead was an "enthusiastic and effective" team member and a good worker. He said that no one spoke to him about any concerns for Mr Plumstead.

29. On 21 June, wing staff completed a security information report about Mr Plumstead and his cellmate, which said that a prisoner had passed and collected items from their cell and that it might merit a targeted search of B wing. There is no record that a search took place.

30. On 21 July, Mr Plumstead saw his new offender manager. He told Mr Plumstead to consider completing an alcohol awareness course to help to address his offending behaviour. He described Mr Plumstead as a well-behaved prisoner, who was committed to his job.

31. On 27 July, the Head of the Offender Management Unit chaired the meeting to decide Mr Plumstead's application for release on Home Detention Curfew (HDC). The offender manager and an officer attended the meeting, and said that Mr Plumstead had not addressed his alcohol misuse problems. The officer said that Mr Plumstead had not previously abstained from alcohol for more than a few days. They decided to reject Mr Plumstead's HDC application as his risk of re-offending had not reduced.

32. Afterwards, the offender manager spoke to Mr Plumstead. He was upset that his HDC application had not been successful. He explained to Mr Plumstead that he needed to address his issues with alcohol both for early release and for his future. He later found out that Mr Plumstead had referred himself to a support

programme for alcohol misuse. He saw this as a positive step, which would help Mr Plumstead on his release in October. He was on leave at the beginning of September, so did not see Mr Plumstead in the weeks before he died.

33. On 17 August, Mr Plumstead completed a programme about motivation and taking responsibility which had been organised by the substance misuse team. The course tutor recorded that he participated well.

13 September 2015

34. On 13 September, while at work, Mr Plumstead asked the store clerk what the "best way to kill yourself" was. He explained to the store clerk that he had been discussing this topic with the other workers in the clothing exchange store. The store clerk told him he did not want to discuss it, and said he thought Mr Plumstead's question was "banter". He said Mr Plumstead's question had not concerned him as Mr Plumstead moved on to talking about football. He said that another store clerk had told him that week that Mr Plumstead seemed a little down. He did not consider that Mr Plumstead was at risk of suicide or self-harm and did not tell anyone about their conversation.

35. The other store clerk said that the week before his death, Mr Plumstead had been quieter than usual but his behaviour did not give him cause for concern. He described Mr Plumstead as preoccupied and said there was clearly something worrying him but he did not discuss it. He did not think this was unusual because Mr Plumstead was close to his release date. He said Mr Plumstead had made a minor error in the stock record but when he asked him about it, he said he was fine. He took no further action. Neither store clerks had been trained in operating ACCT procedures. Winchester has since addressed this issue.

14 September 2015

36. At around 3.00pm on 14 September, Mr Plumstead phoned his mother. (The investigator listened to the call, which lasted just over one minute.) They discussed her prison visit later that week and his forthcoming release from prison in October. Mr Plumstead did not discuss any concerns and did not sound distressed. Mr Plumstead said he would call her later that day but did not do so.

37. A prisoner who lived in the cell next to Mr Plumstead's said they knew each other from the community. Following Mr Plumstead's death, he told the police that Mr Plumstead had asked him on 14 September whether he would like to share a cell with him, as his cellmate was due for release. The prisoner asked an officer if this was possible and she asked him to speak to her about it the next day. He told the police that the only time Mr Plumstead talked about suicide was a week and a half before his death. He said that, during a group conversation, Mr Plumstead had asked: "Would you kill yourself if you were a lifer?" He said that nobody had been concerned about this comment.

15 September 2015

38. On 15 September, Mr Plumstead went to work and returned to the wing for lunch. A Supervising Officer (SO) was in charge of B wing that day. He said that, at around 11.30am, the food had run out and some prisoners refused to return to

their cells. He said that additional staff had arrived to help, and they had to use control and restraint procedures to put one of the prisoners in his cell. The SO said that for a short time, the situation was dangerous. The prisoners involved remained locked in their cells and were not allowed to socialise that afternoon.

39. One of the servery workers told the investigator that when Mr Plumstead collected his evening meal they had a short conversation, and Mr Plumstead told him that he had a family visit coming up. He said there was nothing in Mr Plumstead's behaviour that concerned him. After lunch, another prisoner was moved into Mr Plumstead's cell. The prisoner told the police that after Mr Plumstead and he had collected their dinner, they laid on their beds chatting and watching television. Mr Plumstead spoke about his family visiting at the weekend and said that he had a job arranged for when he was released from prison in October.

40. At 3.15pm, Mr Plumstead tried to phone his mother but he could not reach her.

41. Later, Mr Plumstead went to the toilet and pulled the privacy curtain round. He asked his cellmate how Liverpool football club was doing as another prisoner had a bet on the game. This was the last thing he said. The cellmate continued watching television and was thinking about going to sleep, but needed to use the toilet. He said he was urinating in the sink when he saw something unusual out of the corner of his eye. He pulled back the privacy curtain and found Mr Plumstead hanging from the window bars, with a ligature made from a bed sheet.

42. The cellmate went to the cell door and pressed the emergency cell bell at 6.39pm. He returned to Mr Plumstead and tried to lift him. He noticed Mr Plumstead's lips were blue and there was a cut to the right side of his neck. He kicked the cell wall while he tried to hold up Mr Plumstead. Other prisoners shouted at him to be quiet. When he heard an officer approaching the cell, he put Mr Plumstead down, went to the cell door, and banged on it.

43. At around 6.40pm, two officers separately began unlocking servery workers for their showers and answering cell bells. Officer A told the investigator that the wing was very noisy and there seemed to be a lot of cell bells and prisoners kicking their doors.

44. Officer A met Officer B at Mr Plumstead's cell, and Officer B switched off the cell bell at 6.50pm. He looked into the cell and saw Mr Plumstead hanging from the window at the back of the cell. The cellmate was in the cell close to the door. Officer B radioed a medical emergency code blue (indicating a prisoner is unconscious, not breathing or having difficulty breathing). The control room called an ambulance at 6.51pm

45. Officer A opened the door and asked the cellmate to leave the cell. He went into the cell and lifted Mr Plumstead's body while Officer B cut the ligature away from the window. Officer A hit his head on the toilet as he lowered Mr Plumstead's body. As he was lowered to the floor, Mr Plumstead's head hit the wall and became wedged between the toilet and the privacy screen.

46. Another prisoner helped Officer A move Mr Plumstead to the middle of the cell floor. Officer A loosened the ligature so that Officer B could remove it. The

ligature broke and Officer A saw that Mr Plumstead had made cuts to his neck. Another officer and a custodial manager arrived and started cardiopulmonary resuscitation. Nurses then joined them. They attached a defibrillator (a device that gives the heart an electric shock to restart the heart rhythm in some cases of cardiac arrest). The defibrillator did not detect a shockable heart rhythm (over three cycles) and advised to continue resuscitation efforts.

47. Paramedics arrived at 6.56pm, assessed Mr Plumstead and took him to hospital. He was moved to the intensive care unit at 8.45pm and placed on a life support machine. Over the course of the next three days, two prison officers monitored Mr Plumstead hourly at the hospital. As they were outside the unit and not at his bedside they conducted hourly visual checks. The officers were visited on a daily basis by a prison manager. Mr Plumstead did not regain consciousness and died on 18 September.

Contact with Mr Plumstead's family

48. Mr Plumstead's mother was his next of kin but staff were unable to access the prison's computer systems and her telephone number was not recorded in the paper version of Mr Plumstead's prison record. The Head of Safer Prisons therefore asked the police to inform Mr Plumstead's mother about his admission to hospital. When the police visited, Mr Plumstead's sister was at home. As Mr Plumstead's mother was not at home, his sister contacted her to break the news. At around 9.10pm, a governor and the family liaison officer met Mr Plumstead's family at the hospital and offered support. The family liaison officer continued to support the family and met with them on a daily basis after Mr Plumstead was admitted to hospital. The prison contributed to the cost of Mr Plumstead's funeral in line with national instructions.

Support for prisoners and staff

49. After Mr Plumstead was taken to hospital, the Head of Residence and Safety debriefed the staff involved in the emergency response. The staff care team offered support.

50. On 19 September, a governor issued notices to staff and prisoners, informing them of Mr Plumstead's death. The chaplaincy team supported prisoners. Staff reviewed prisoners who had been assessed as at risk of suicide and self-harm in case they had been adversely affected by Mr Plumstead's death.

Post-mortem report

51. A post-mortem examination established the cause of Mr Plumstead's death as hypoxic ischaemic brain injury, bronchopneumonia and myocardial infarction, caused by prolonged cardiorespiratory arrest and compression of the neck due to ligature suspension.

Information received after Mr Plumstead's death

52. The solicitors representing Mr Plumstead's family told us that the family found the conduct of the two prison officers from HMP Portland and HMP Verne who monitored Mr Plumstead on 18 September to be disrespectful. They said that

the officers had eaten food and looked at electronic devices while on bedwatch, and had made insensitive comments about Mr Plumstead.

53. The family told a prison manager about the officers eating food while on bedwatch, but had not reported their other allegations. The two prison officers denied making insensitive comments about Mr Plumstead. They said that the manager had not told them about the family's complaint about them eating but apologised for the offence caused.

54. An ex-cellmate, who had also worked for the clothing exchange store, told Mr Plumstead's family that he had found him making a ligature out of tracksuit trousers in their cell a few weeks before he had died. He said that he told an officer what he had seen. She told him that staff would monitor Mr Plumstead. Mr Plumstead's ex-cellmate declined to speak to the investigator.

55. There was no information about this in Mr Plumstead's prison record or the wing observation book. The officer said that the ex-cellmate had not told her about Mr Plumstead's attempted self-harm. Had he done so, she would have spoken to Mr Plumstead and might have started ACCT procedures. Other wing staff also told the investigator that Mr Plumstead's ex-cellmate had not told them of his concerns about Mr Plumstead.

Findings

Identifying Mr Plumstead's risk of suicide and self-harm

56. Prison Service Instruction (PSI) 64/2011 on the management of prisoners at risk of harm to self, to others and from others, lists a number of risk factors and triggers for suicide and self-harm. Mr Plumstead had some factors that increased his risk including a history of alcohol misuse, he had committed a violent offence against his ex-partner and he had spoken about suicidal ideation.

57. Mr Plumstead had no history of attempted suicide or self-harm, and when he returned to prison in January 2016 he told staff that he had no thoughts of suicide or self-harm. It was therefore reasonable that staff did not start suicide and self-harm prevention procedures when he arrived at Winchester.

58. An ex-cellmate told Mr Plumstead's family that he had raised concerns with staff that Mr Plumstead was at risk of suicide and self-harm. There is no record of this happening and prison staff say that no such concerns were raised. The ex-cellmate declined to speak to our investigator. In the circumstances, we cannot conclude whether or not the alleged incident happened or whether staff were made aware of it.

59. The store clerk who was asked by Mr Plumstead about the "best way to kill yourself" and another clerk who was aware of a change in his general demeanour failed to note the conversation in Mr Plumstead's record or take further action, considering the comment to be general banter. Neither of them had received training in operating ACCT procedures. Winchester has since addressed this issue.

60. Prison Service Instruction (PSI) 64/2011 on safer custody says that any staff who receive information indicating a risk of suicide or self-harm must start ACCT procedures. While we recognise that some training has now been provided, we consider that these interactions with Mr Plumstead should have at least have been recorded and discussed with managers or wing staff, and that ACCT procedures could then have been considered. We recommend that:

    The Governor should ensure that all staff understand the circumstances when they should consider whether to start ACCT monitoring, including when a prisoner has expressed suicidal intent.

61. When Mr Plumstead telephoned his mother on 14 September, he gave no indication that he was distressed or at risk of suicide or self-harm. Similarly, the next day, Mr Plumstead showed no signs to staff or prisoners that he was struggling to cope or was at risk of suicide, and appeared to be looking forward to his family visiting him that week and looking ahead to his impending release from prison. We saw no evidence that there was anything on 14 and 15 September to indicate that Mr Plumstead's risk of suicide and self-harm was raised, and we do not consider that staff could reasonably have anticipated his actions.

Response to the emergency cell bell

62. We understand that the Governor issued local instructions on 10 May 2016 which said that staff should respond to emergency cell bells within five minutes. We also understand that B wing had been particularly busy and unsettled on 15 September

with a number of emergency cell bells ringing and a lot of prisoners banging and shouting.

63. When the cellmate rang the cell bell at 6.39pm after he found Mr Plumstead hanging, he tried to hold Mr Plumstead up while he kicked the cell wall and shouted for assistance. It was not until 6.50pm when two officers responded to the cell bell. Staff took over ten minutes to respond. We recommend that:

    The Governor should ensure that all cell bells are answered promptly, in line with HMIP expectations.

Monitoring Mr Plumstead in hospital

64. Mr Plumstead's family were concerned about how prison staff had behaved while monitoring him in hospital, and alleged that they made insensitive and unprofessional comments. Both officers apologised for any offence caused but denied making inappropriate comments.

65. In the circumstances, we have not been able to reach a conclusion about what happened. However, we shared the family's concerns with Portland and The Verne, where the officers concerned work. They decided not to take action.

Clinical care

66. The clinical reviewer reviewed the clinical care Mr Plumstead received at Winchester. He was satisfied that Mr Plumstead's care was equivalent to that which he could have expected to receive in the community.

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