

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# Independent investigation into the death of Mr Michael Green a prisoner at HMP Winchester on 3 May 2017.

**A report by the Prisons and Probation Ombudsman**

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

## Our Values

**We are:**

**Impartial:** *we do not take sides*

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**Fair:** *we are honest and act with integrity*



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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 Green was found hanged in his cell at HMP Winchester on 3 May 2017. He died in hospital shortly afterwards. He was 70 years old. We offer our condolences to Mr Green's family and friends.

We are satisfied that there was little to indicate that Mr Green was at imminent or high risk of suicide and self-harm during the 21 days that he had spent at Winchester and that he did not require special monitoring. We do not believe staff could have foreseen or prevented his actions.

However, staff did not assess Mr Green's disabilities and consider a long-term and structured plan to address his needs. The initial emergency response was confused.

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

**Elizabeth Moody**  
**Acting Prisons and Probation Ombudsman**

**January 2018**

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# Summary

## Events

1. On 12 April 2017, Mr Michael Green was sentenced to two years and three months imprisonment for making indecent photographs and was sent to HMP Winchester. He was 69 years old and this was his first time in prison. His vision was impaired and he said that he could not read or write. Mr Green did not have any history of attempted suicide or self-harm and no history of mental health or substance misuse problems.
2. On arrival at Winchester, Mr Green was held in a dedicated unit for vulnerable prisoners because of the nature of his offence. During an initial health screening, a nurse noted that Mr Green could not see very well and assessed that he was not at risk of suicide and self-harm. At his first night interview, an officer recorded that Mr Green had a disability and learning difficulties but did not refer him for an assessment of his needs. Later, a prison GP assessed Mr Green and recognised that he presented with some risk factors for suicide and self-harm but decided that he did not need monitoring because he was coping well in the prison environment.
3. On 21 April, Mr Green told a careers adviser that he did not know how to read and write. The careers adviser, who noted that Mr Green had a visual impairment, enrolled him on an English course and referred him to a charitable organisation to help him with his reading. The next day, Mr Green approached a nurse with a wound on his elbow. He told the nurse that he had caused the wound when he caught his arm on a rough patch on the wall of his cell. The nurse found no signs of infection and assessed that the wound was not consistent with an act of self-harm. Staff did not record any concerning issues about Mr Green while he was at Winchester and assessed that he was not at risk of suicide and self-harm. His cellmate said that he appeared to be fine and was coping well in prison.
4. 3 May was Mr Green's 70<sup>th</sup> birthday. At around 4.40pm after being told by Mr Green's cellmate that Mr Green was not responding to him, an officer found Mr Green hanging from the window bars with a ligature made from sheets. The officer blew his whistle and entered the cell. Seconds later, other officers arrived, started cardiopulmonary resuscitation (CPR), radioed an emergency code and an ambulance was called. Healthcare staff attended four minutes later and at about 4.56pm, paramedics arrived and continued with CPR. More paramedics arrived nine minutes later and at 5.38pm, moved Mr Green to the ambulance and took him to hospital where a doctor pronounced at 5.58pm that he was dead.

## Findings

5. Mr Green had some risk factors for suicide and self-harm which staff appropriately identified, including being an older and first time prisoner, his vision impairment and learning disability. The nature of his offence, which involved family members, was also a risk factor but Mr Green appeared to be coping well in the prison environment. We are satisfied that staff had no reason to consider Mr Green to be at imminent or high risk of suicide and self-harm or that he

needed to be managed under ACCT procedures. We do not consider that staff could have reasonably foreseen or prevented Mr Green's death on 3 May.

6. However, staff failed to complete a comprehensive assessment of Mr Green's needs in light of his visual impairment and learning difficulties and did not consider making any adjustments to help Mr Green deal with his day-to-day activities in a structured way which might have helped him cope with prison life.
7. The officer who found Mr Green unresponsive did not have a radio with him to communicate the nature of the emergency. There was initial confusion between prison and healthcare staff about when to call an ambulance and who should do so.

## **Recommendations**

- The Governor and Head of Healthcare should ensure that older prisoners and those with physical or learning disabilities have formal needs assessments and receive appropriate and structured support.
- The Governor and Head of Healthcare should ensure that all prison and healthcare staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies as outlined in local notices. In particular, the Governor should ensure that staff carry a radio at all times, when possible, to effectively communicate the nature of a medical emergency, and that there is no delay in calling, directing or discharging ambulances.

## The Investigation Process

8. 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. No one responded.
9. Another investigator, visited Winchester on 15 May 2017, obtained copies of relevant extracts from Mr Green's prison and medical records and spoke to a prisoner on behalf of the first investigator.
10. The investigator interviewed 12 members of staff at Winchester between June and September 2017.
11. NHS England commissioned a clinical reviewer to review Mr Green's clinical care at the prison. She conducted nine interviews jointly with the investigator.
12. We informed HM Coroner for Hampshire Central of the investigation who gave us the preliminary cause of death. We have sent the coroner a copy of this report.
13. One of the Ombudsman's family liaison officers contacted Mr Green's sister and wife, to explain the investigation and to ask if they had any matters they wanted the investigation to consider. They did not raise any specific matters.
14. Mr Green's family received a copy of the initial report. They did not make any comments on the factual accuracy of this report.
15. The prison service also received a copy of the initial report.

## Background Information

### HMP Winchester

16. 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

17. 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 suicide and self-harm prevention strategy.
18. Inspectors reported that processes to identify current and new prisoners in protected groups were inadequate. Wing staff were aware of obvious disabilities but less so about others, such as partial deafness or memory loss. Inspectors saw little evidence of proactive support for prisoners with disabilities. Older prisoners (aged 50 and over) made up 14% of the population, and there were 15 prisoners over the age of 69. Although older prisoners were generally more positive than others in the inspectors' survey, provision for this group was limited.

### Independent Monitoring Board

19. 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

20. Mr Green was the eighth 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. There are no significant similarities between Mr Green's death and previous deaths.

## Key Events

21. On 12 April 2017, Mr Michael Green was sentenced to two years and three months imprisonment for making indecent photographs of his stepdaughter, who was a child, and was sent to HMP Winchester. This was his first time in prison and his expected date of release was 27 May 2018. For his pre-sentence report, Mr Green told a probation officer, that he did not have any mental health issues but was dyslexic and unable to write. Mr Green had had an accident the year before which caused him to lose the use of his right eye and was on a hospital waiting list for surgery to remove his eye completely.
22. At reception, a Supervising Officer (SO) spoke to Mr Green and assessed he was suitable to share a cell. Because of the nature of his offence, the SO asked Mr Green whether he wanted the prison to consider him for vulnerable prisoner status, which meant that he would be kept separately from the general population for his own protection. Mr Green agreed to this.
23. At his initial health screening, Mr Green told a nurse that he did not have any history of substance misuse, no mental health problems and no history or current thoughts of suicide and self-harm. She noted that Mr Green was on the waiting list for surgery to remove his right eye. She said that although Mr Green had problems with his vision he did not appear to be anxious or concerned. She was not clear about the scope of Mr Green's visual impairment and did not carry out or refer Mr Green for an assessment of his needs. She recorded that this was Mr Green's first time in prison and she was aware that he had requested vulnerable prisoner status. She assessed that Mr Green did not present as being high risk for suicide and self-harm.
24. At his first night interview, Mr Green told an officer that he did not have any mental health problems and no drug or alcohol misuse issues. Mr Green told her that he could not see well, as he could not use his right eye, and that he found it difficult to read and write. She recorded that Mr Green had a disability and that he had learning difficulties. She said that Mr Green was nervous as he did not know what to expect but did not have any specific concerns about prison life and was not disturbed about his visual impairment. She read and explained to him the relevant reception compacts, which he signed, but she did not refer him or carry out an assessment of his needs. Mr Green was allocated a shared cell on the unit for vulnerable prisoners.
25. On 13 April, a prison GP reviewed Mr Green who said that he did not have any thoughts of suicide and self-harm. He noted that this was Mr Green's first time in prison and recorded that he was going to be admitted to hospital for the removal of his right eye, which he had injured a year earlier (the hospital had not provided Mr Green with a specific date). He noted that Mr Green had glaucoma in his left eye for which he prescribed eye drops. He prescribed inhalers for asthma and medication for indigestion. He arranged to contact the hospital to confirm Mr Green's appointment. Although he recognised that Mr Green had some risk factors for suicide and self-harm (old age, first time in prison and recent medical issues, with his eye), he did not think that he needed monitoring or management through ACCT procedures as he was fine, appeared to be coping well and had no history of attempted suicide or self-harm. He was not sure about the extent of

Mr Green's visual impairment but knew that there was a problem. He did not refer Mr Green for an assessment of his needs. He told the investigator that he believed that Mr Green did not need any particular adjustment on the unit.

26. On 15 April, Mr Green told a nurse that he had not taken drugs and that he had never had mental health problems. He noted that this was Mr Green's first time in prison but he was coping well. He recorded that Mr Green could not read or write. Two days later a nurse reviewed Mr Green, and recorded that there were no concerns about his presentation and assessed that he was not a high risk of suicide and self-harm.
27. On 21 April, Mr Green told a resettlement worker and careers adviser, that he did not know how to read and write. Mr Green said that he wanted to focus on learning and asked to be enrolled on an English course. She enrolled Mr Green and referred him to an organisation that provides peer mentor support to prisoners in their reading skills. She noted that Mr Green had a visual impairment but told the investigator that she was not sure what the scope of the impairment was, because a prisoner, who was Mr Green's education mentor, told her that Mr Green was able to complete a gym application without help. Ms Simons assessed that Mr Green was not a high risk for suicide and self-harm.
28. On 22 April, a nurse saw Mr Green to replace a dressing on a wound on his arm. She said that the wound was on his elbow and approximately 1.5 centimetres in length. Mr Green had a dry dressing on top of it, which he said another nurse had placed on the wound the day before (although there is no record of this). He told her that he had caused the wound when he caught his arm on a rough patch on the wall in his cell. She found no signs of infection and the wound was not consistent with an act of self-harm. She said that Mr Green was bright and cheerful and interacted very well with her. Healthcare staff re-dressed the wound on two other occasions on 24 and 27 April. The investigation found no evidence that Mr Green had self-harmed while at Winchester.
29. On 27 April, an offender supervisor went to speak to Mr Green to introduce herself. Mr Green told her that he wanted to remain at Winchester until he was released and she explained that it might not be possible because Winchester did not offer any relevant courses to address his offending behaviour. She told the investigator that Mr Green accepted this. She planned to speak to him again in two weeks time to discuss his offending behaviour, family circumstances and accommodation on release. She told the investigator that Mr Green appeared to be fine and he did not raise any concerns with her. She said that Mr Green did not present as having a major visual impairment or disability.
30. During the next five days, staff did not record any issues about Mr Green in his prison records or in the unit's observation book. Staff did not submit any security intelligence reports about Mr Green while at Winchester. Mr Green's cellmate, said that on 2 May, Mr Green appeared to be fine and he did not notice anything unusual that day.

### **3 May 2017 (Mr Green's 70<sup>th</sup> birthday)**

31. At approximately 7.00am, his cellmate woke up and noted that Mr Green was doing some word searches. He did not note anything unusual and went back to

- sleep. He told the investigator that at about 9.30am, he woke up again, had a coffee and watched television with Mr Green. They had lunch at 11:45am and he went to sleep again. At about 1.30pm, he woke up and noted that Mr Green had received some letters. He did not know the content of these letters but the police later confirmed that they were three birthday cards. He said that Mr Green did not mention anything concerning to him but said that he planned to sleep all afternoon. At about 2.30pm, he went to his education classes and Mr Green remained in his cell.
32. Close Circuit Television (CCTV) showed that at 4.40pm the cellmate returned from his classes and arrived at Mr Green's cell door. He told the investigator that he noticed that Mr Green had closed the observation flap on the door and when he opened it, he saw that Mr Green was standing by the sink facing him. Mr Green arms were by his side and his head was flopped forward. He banged on the cell door but got no response. He walked down the landing and found Officer A. The officer said that the cellmate told him that Mr Green 'had stood at the sink and was not talking to him'. The officer went to Mr Green's cell. He told the investigator that when he was on his way to Mr Green's cell, he stopped on another landing, as a prisoner spoke to him. He also opened another cell for another prisoner.
  33. At 4.41pm, Officer A arrived at Mr Green's cell. He told the investigator that he looked through the observation panel and saw Mr Green hanging from the window bars with a ligature around his neck, made from bed sheets. He blew his whistle immediately because he did not have a radio with him (although he said that there were radios available on the unit) and opened the door and entered the cell. Seconds later, Officer B and a Supervising Officer (SO) arrived, followed by three other officers, C, D and E. Control room records show that Officer D radioed a code blue (indicating that a prisoner is unconscious, not breathing or is having breathing difficulties) and the control room officer called an ambulance immediately.
  34. At 4.42pm, Officer B and the SO entered the cell and assisted Officer A to cut the ligature around Mr Green's neck. They placed Mr Green on the bed. Officer A said that he saw that Mr Green had his tongue out and his eyes closed. His neck felt cool but his abdomen was warm. Officer A then checked for Mr Green's pulse but found none and started cardiopulmonary resuscitation (CPR).
  35. At 4.44pm, Nurse's A, B and C arrived at the cell in response to the emergency call. Nurses A and B took over resuscitation procedures and asked the officers to place Mr Green on the floor. Nurse A told the investigator that Mr Green was cold and his lips looked blue. Nurse B said that on her arrival, Mr Green was pale and appeared to be dead.
  36. At 4.56pm, the first paramedics arrived at the cell. They took over resuscitation procedures from the officers. More paramedics arrived nine minutes later and at 5.38pm, moved Mr Green via a stretcher to the ambulance and took him to hospital where a doctor pronounced at 5.58pm that he had died. Mr Green did not leave a suicide note but left a handwritten note asking staff to contact his sister.

### **Contact with Mr Green's family**

37. At 6.35pm, the Head of Security and Intelligence, and the Governor attended the address of Mr Green's sister, his nominated next of kin, but she was not at home. At 7.15pm, they went to the address of Mr Green's niece with the son-in-law of Mr Green's sister, who lived nearby. The Head of Security and Intelligence and the Governor broke the news that Mr Green had died. Mr Green's niece immediately called Mr Green's sister over the phone, the Governor spoke to her and offered support.
38. The next day, at 3.25pm, the Head of Security and Intelligence and the Governor visited Mr Green's sister in person. Her partner and two daughters were present. The Head of Security and Intelligence and the Governor accompanied her to speak to Mr Green's wife. They offered support to both Mr Green's sister and wife and answered their questions. Mr Green's funeral was held on 23 May 2017. The prison offered to contribute to the funeral costs in line with national guidance.

### **Support for prisoners and staff**

39. After Mr Green's death, an operational manager debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.
40. The prison posted notices informing other prisoners of Mr Green's death, and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Green's death.

### **Post-mortem report**

41. The post-mortem examination found that Mr Green died as a result of ligature suspension. The toxicology examination found no drugs (including NPS) or alcohol in Mr Green's body.

# Findings

## Identifying Mr Green's risk of suicide

42. Prison Service Instruction (PSI) 64/2011 on safer custody requires all staff in contact with prisoners to be aware of the triggers and risk factors that might increase prisoner's risk of suicide and self-harm, and to take appropriate action, including starting ACCT procedures, if necessary. Mr Green's risk factors included being an older and first time prisoner, his vision impairment and apparent dyslexia and learning disability. Mr Green, who spent only 21 days in prison, had vulnerable prisoner status, and lived on the vulnerable prisoner's unit because of the nature of his offence.
43. As part of the reception process and through interaction in the unit, staff asked Mr Green on a number of occasions if he had any thoughts of suicide and self-harm but he said that he did not. He appeared to be coping well with prison life, did not have any history of mental health or substance misuse problems and did not display any troubling behaviour. Mr Green was positive about the future and said that he wanted to learn how to read and write.
44. The Officer who was Mr Green's personal officer, told the investigator that Mr Green was a confident man who did not raise any concerns about prison life. Officer A, who interacted often with Mr Green, said that although Mr Green did not have many friends and often kept himself to himself, he appeared to be fine and never expressed any concerns. Mr Green's cellmate, told the investigator that he was coping well in prison, did not have any problems with staff or other prisoners and did not mention having any troubling issues.
45. Mr Green did not give any indication to staff that he was going to kill himself or self-harm. We do not consider that staff could have reasonably foreseen or prevented his actions on 3 May.

## Assessing Mr Green's disabilities

46. Prison Service Instruction (PSI) 32/2011, covering equality issues, requires prisons to make reasonable adjustments to enable prisoners with disabilities to take full part in the normal life of the establishment. Prison Service Order (PSO) 3050, continuity of healthcare for prisoner, states that staff should contribute as appropriate to the prisoner's needs and inform the establishment's Disability Liaison officer, when necessary, to ensure that the prisoner receives adequate assistance to cope with his disability in prison. It also says that staff need to be clear about the tasks a disabled prisoner may need assistance with and that it is helpful to perform an assessment of their abilities on reception into prison. Winchester's local disability policy places responsibilities on all staff to protect prisoners with disabilities and make appropriate referrals for the assessment of prisoners' needs, when necessary.
47. Prison and healthcare staff knew from the records and their interactions with Mr Green that he had a visual impairment but staff did not refer him for an assessment of his needs or seek to put long-term and structured support in place for him.

48. A formal assessment would have established the level of support, if any, Mr Green required with tasks such as collecting his meals, cleaning his cell, understanding processes, completing forms and identifying sources of support.
49. Although we do not know whether such support would have made a difference to Mr Green's actions, it may have helped him make the adjustments needed to cope with prison life. We make the following recommendation:

**The Governor and Head of Healthcare should ensure that older prisoners and those with physical or learning disabilities have formal needs assessments and receive appropriate and structured support.**

### **Clinical Care**

50. The clinical reviewer found that the clinical care that Mr Green received at Winchester was equivalent to that which he could have expected to receive in the community. Mr Green received appropriate treatment for his medical conditions and he was on the waiting list for the removal of his right eye. Healthcare and prison staff contacted the hospital and proactively followed up this appointment. Mr Green died before a date for his hospital appointment was confirmed.

### **Emergency Response**

51. PSI 03/2013, Medical Emergency Response Codes, contains mandatory instructions for efficiently communicating the nature of a medical emergency, ensuring staff take the relevant equipment to the incident and that there are no delays in calling an ambulance. It explicitly states that all prison staff must be made aware of, and understand, this instruction and their responsibilities during medical emergencies. It requires prisons to have a two level code system, which differentiates between a blood injury and all other injuries, usually code red and code blue.
52. When Officer A discovered that Mr Green was hanging, he blew his whistle to call for assistance but did not have a radio with him. He told the investigator that there were radios available in the unit but he did not draw one after lunch. He said that he was probably the only member of staff on the unit at the time and did not foresee leaving the unit and needing the radio because most of the time, staff only use the radio for the movement of prisoners to and from the units.
53. Prison Service Instruction (PSI) 13/2011, Management and Security of Communication, Control Rooms and Internal Prisoner Movement states that each separate residential unit must have at least one member of staff on duty, who has drawn a radio which is logged onto the radio network. This will allow the prison to coordinate an effective response to a variety of incidents, including emergencies. As the only member of staff on the unit, Officer A should have had a radio.
54. Officer A attracted staff attention by blowing his whistle. However, there was a delay of approximately two minutes in summoning healthcare assistance and calling an ambulance. The investigation found that staff were unclear about their responsibilities during emergencies. Officer A told the investigator that officers have to tell control room officers expressly that an ambulance is required, even

after an emergency code has been radioed. Some healthcare staff told the investigator that officers expect them to assess whether an ambulance was required at all times.

55. Winchester's local notices correctly state that the control room should call an ambulance automatically as soon as any emergency code is radioed. We make the following recommendation:

**The Governor should ensure that all prison and healthcare staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies as outlined in local notices. In particular, the Governor should ensure that staff carry a radio at all times, when possible, to effectively communicate the nature of a medical emergency, and that there is no delay in calling, directing or discharging ambulances.**

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