

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Andrew Goldstraw a prisoner at HMP Winchester on 14 November 2018

A report by the Prisons and Probation Ombudsman

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*



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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.

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

Mr Andrew Goldstraw died on 14 November 2018, having been found hanged in his cell at HMP Winchester. Mr Goldstraw was 43 years old. I offer my condolences to Mr Goldstraw's family and friends.

Mr Goldstraw had only been on remand at Winchester for three weeks when he was found dead. Although he had some risk factors for suicide and self-harm, I accept that he gave no indication that he was at imminent risk of taking his life.

The post-mortem examination found that Mr Goldstraw had taken an excessive amount of his antidepressant medication before he died and I am concerned that Mr Goldstraw had been assessed as suitable to keep his prescription medication in his cell (rather than having to collect it every day). Traces of a psychoactive substance (PS) were also found in his system and it is possible that this contributed to his decision to take his life.

I am also concerned that an officer did not conduct a scheduled roll check on the morning of 14 November, and that the officer who subsequently found Mr Goldstraw hanging was not carrying a radio to call an emergency medical code and did not enter the cell. These shortcomings did not make a difference to the outcome for Mr Goldstraw as he had been dead for a while when he was found, but could make the difference between life and death in other cases.

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

Sue McAllister, CB
Prisons and Probation Ombudsman

September 2019

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Summary

Events

1. On 23 October 2018, Mr Andrew Goldstraw was remanded to HMP Winchester, charged with causing grievous bodily harm with intent. He had been at Winchester before.
2. He had a history of alcohol and drug misuse, asthma, anxiety and depression. He had attempted to take his own life in the past. He was prescribed medication for anxiety and depression and was assessed as suitable to keep his medication in his cell (rather than having to collect it every day).
3. Mr Goldstraw was housed on the detoxification wing and was monitored through his detoxification period. He said that his medication was not working so a GP increased the dosage. He was assessed as not needing the support of the mental health team but was told that he could approach them if he wanted help.
4. On 6 November, Mr Goldstraw saw a psychosocial support worker and told her that while he did sometimes have thoughts of taking his own life, he had strategies to manage this and had no intention of acting on these thoughts.
5. On 9 November, Mr Goldstraw did not collect his medication for the following week. The next day he told a nurse that he was managing his mental health problems with his medication.
6. On 11 November, Mr Goldstraw completed his detoxification programme and moved to a standard wing.
7. On 13 November, one of the prison's Safer Custody managers spoke to Mr Goldstraw on the wing. He did not raise any issues and gave her no cause for concern.
8. Mr Goldstraw did not ring his cell bell or come to the attention of staff during the night of 13/14 November.
9. The night officer did not complete the roll check at 6.00am on the morning of 14 November, and did not check on Mr Goldstraw. Another officer found Mr Goldstraw hanging in his cell at about 7.15am.
10. Staff attempted to resuscitate him and continued until ambulance staff arrived. They confirmed that Mr Goldstraw had died.
11. The post-mortem found that Mr Goldstraw had higher than prescribed levels of his antidepressant medication in his system when he died and also had traces of a psychoactive substance (PS).

Findings

Assessment of risk

12. Mr Goldstraw was not monitored under Prison Service suicide and self-harm prevention procedures (known as ACCT).

13. Mr Goldstraw had some risk factors for suicide and self-harm, including having previously harmed himself and made attempts on his own life. We are concerned that staff may have placed too much emphasis on his presentation and his assertions that he had no thoughts of harming himself, and not enough on his risk factors when they assessed his risk to himself. However, we accept that he gave no indication that he was at imminent risk of taking his life.
14. We are concerned that a nurse assessed Mr Goldstraw as suitable to hold his prescribed medication in his cell, even though he had taken an overdose of prescription medication six months earlier.

Substance misuse

15. Staff recognised Mr Goldstraw's problems with alcohol and drugs and gave him support. Although Mr Goldstraw had traces of PS in his system when he died, staff had had no suspicions that he was using illicit drugs. It is possible that PS use affected his mood and influenced his decision to take his life.

Roll checks

16. The night officer did not complete the full roll check on the morning of 14 November. She is currently subject to Prison Service disciplinary procedures.

Emergency response

17. The officer who found Mr Goldstraw was not carrying a radio. This resulted in a delay of three minutes before healthcare staff were alerted and before an ambulance was called. Although this did not affect the outcome for Mr Goldstraw it could make a critical difference in other cases.
18. We found a similar issue in our investigation into the death of another prisoner at Winchester in May 2017 and made a recommendation about it.
19. The officer who found Mr Goldstraw hanging did not enter the cell until other staff were with him. We are concerned that he believed he should never enter a cell on his own in any circumstances.

Family liaison

20. Mr Goldstraw's daughter said that she and her family sometimes had difficulty in contacting the family liaison officer in the prison. The designated liaison officer did not have his own extension number and the family had to try to contact him through the switchboard, which was not satisfactory.

Healthcare

21. The clinical reviewer was satisfied that, overall, Mr Goldstraw received clinical care of a standard that was equivalent to that which he could have expected in the community. He did, however, have concerns about Mr Goldstraw's diagnosis of hypertension (although this did not contribute to his death); the decision to allow Mr Goldstraw to have his medication in possession; the monitoring of his compliance with his medication; and the fact that healthcare staff continued to try to revive Mr Goldstraw when it was apparent that he had died.

Recommendations

- The Head of Healthcare should ensure that healthcare staff:
 - take all appropriate factors, including a prisoner's history, into account before assessing a prisoner as suitable to hold medication in-possession; and
 - record the reasons for their decisions.
- The Governor should ensure that all staff are familiar with their responsibilities during roll checks.
- The Governor should:
 - review the current provision of radios to ensure that it meets the needs of the prison;
 - ensure that staff comply with local requirements for carrying radios to enable medical emergency codes to be radioed promptly.
- The Governor should ensure that all staff understand that, subject to a personal risk assessment, they should enter a cell at night when there is a potential risk to life, and that local policies and instructions reflect this prominently.
- The Governor should ensure that bereaved families are able to contact their family liaison officer or a deputy, or are at least able to leave a message that will be passed on promptly and acted upon.
- The Head of Healthcare should ensure that there is a process for monitoring the compliance of a prisoner holding medication in their own possession. If a prisoner misses a collection, this should be followed up and clearly noted on his medical record, so that other healthcare staff who see the prisoner are aware.
- The Governor and Head of Healthcare should ensure that staff are aware of the circumstances in which resuscitation is inappropriate.

The Investigation Process

22. 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.
23. The investigator visited Winchester. He obtained copies of relevant extracts from Mr Goldstraw's prison and medical records.
24. The investigator interviewed seven members of staff at Winchester.
25. NHS England commissioned a clinical reviewer to review Mr Goldstraw's clinical care at the prison. The clinical reviewer joined the investigator for interviews.
26. We informed HM Coroner for Hampshire Central of the investigation. He gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
27. The investigator contacted Mr Goldstraw's daughter to explain the investigation and to ask whether she had any matters she wanted the investigation to consider. She asked about risk assessments and about her father's mental health care. She also raised her difficulty in contacting the prison's family liaison officer. We address these issues in the report.
28. Mr Goldstraw's family received a copy of the initial report. The solicitor representing them confirmed that they did not wish to offer any comments.

Background Information

HMP Winchester

29. HMP Winchester is a local prison, serving courts in Hampshire. It holds around 700 adult remanded and sentenced men. There is a separate lower security unit for up to 129 sentenced men nearing the end of their sentence. Central and North-West London NHS Foundation Trust provides healthcare at the prison and 24-hour healthcare cover.

HM Inspectorate of Prisons

30. The most recent inspection of HMP Winchester was conducted in July 2016. Inspectors reported that new prisoners were treated well, although they were let down by some weak first night arrangements, especially for those at risk of self-harm. Inspectors noted that the level of self-harm had increased at the prison but there was little analysis of data or trends to inform a local strategy. There had been five self-inflicted deaths since their previous inspection and inspectors found that insufficient attention was given to previous PPO recommendations.

Independent Monitoring Board

31. 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 2018, the IMB commented on the illicit supply of mobile telephones into the prison. Healthcare provision was improving. Although the report said that there had been issues over prisoners having a restricted regime, the Chair of the IMB told the investigator that this had largely been addressed by the time of Mr Goldstraw's death.

Previous deaths at HMP Winchester

32. Mr Goldstraw was the sixteenth prisoner to have died at Winchester since June 2015. He was the ninth prisoner to take his own life in this period. There have since been three further deaths, two of which were due to natural causes.
33. We have previously made recommendations about the prison's emergency response procedures (most recently in October 2018), and family liaison arrangements, issues we again raise in this report.

Key Events

34. Mr Andrew Goldstraw was remanded to HMP Winchester on 23 October 2018, charged with causing grievous bodily harm with intent. He had been in Winchester before.
35. He had a history of alcohol, drug and psychoactive substance (PS) misuse, and had been under the influence of alcohol when he committed his alleged offence. As well as using inhalers for asthma, he was prescribed medication for anxiety and depression, which had been diagnosed in 2016.
36. Documentation that arrived at the prison with Mr Goldstraw noted that he had previously attempted suicide by trying to hang himself and by taking an overdose of tramadol (a prescription-only painkiller). While in police custody, he had threatened to harm himself by hitting his head against a wall.
37. A nurse carried out Mr Goldstraw's initial reception health screening. Mr Goldstraw said that he had been assaulted two days earlier and had some injuries to his eye, nose and ribs. The nurse noted that Mr Goldstraw had high blood pressure and recorded a diagnosis of hypertension. The nurse also noted his high alcohol use (a litre of vodka a day), his history of depression, and his current prescription of fluoxetine (an antidepressant, also known as Prozac).
38. Mr Goldstraw said that he had no intention of harming himself. The nurse, who is both a Registered General Nurse and a Registered Mental Health Nurse, completed a mental health assessment. He did not consider that Mr Goldstraw needed a referral to the mental health team but did refer him to a doctor in relation to his depression. He also referred him to substance misuse services and to the Phoenix Futures team for psychosocial support. The nurse assessed Mr Goldstraw as being able to hold weekly supplies of his medication in his own possession.
39. Mr Goldstraw's cell sharing risk assessment noted that he had mental health issues of anxiety and depression, and that he required a detoxification programme. The form noted that there was no current risk of self-harm or suicide and that Mr Goldstraw presented a standard risk for sharing a cell. He was allocated a cell on C Wing, which contained the detoxification unit.
40. An officer saw Mr Goldstraw as part of his induction. Mr Goldstraw said that he had been in Winchester before so knew what to expect. The officer noted that Mr Goldstraw declined an offer to make a telephone call. He said that he had no thoughts of self-harm.
41. Because it was his first night in prison, a nurse of the substance misuse team checked on Mr Goldstraw at 5.05am. She noted that there were no issues or concerns.
42. On 24 October, an officer completed Mr Goldstraw's induction process, and a Reverend completed his chaplaincy induction. A prison GP reviewed Mr Goldstraw's medical history and continued his current prescriptions. The prison GP did not check his blood pressure or perform a cardiovascular risk assessment.

43. A healthcare support worker, completed a substance misuse risk assessment. She noted that Mr Goldstraw was very mildly anxious, but had no thoughts of self-harm. When she saw him again later that day, she noted that he no longer displayed any anxiety.
44. Mr Goldstraw was discussed at the alcohol and substance misuse service multi-disciplinary meeting. It was agreed that staff would keep him under observation while he stabilised through the detoxification period.
45. On 25 October, Mr Goldstraw saw a prison GP in the substance misuse clinic. He told the doctor that he smoked cannabis and drank alcohol daily from early in the morning. He said that he felt unwell when he did not drink. He described a history of anxiety and depression and self-harm, including attempting to hang himself two years earlier. He also said he had taken an overdose six months earlier. He said that he had no current thoughts of harming himself. He told the doctor that the effects of his prescription of Librium, used to treat anxiety, usually wore off before the next dose was due, so the doctor increased the dosage.
46. An officer completed a Basic Custody Screening. Mr Goldstraw said that alcohol was a problem for him, and that he might need support for his anxiety and depression. He also wanted help managing his temper and impulsivity.
47. A nurse saw Mr Goldstraw to complete his 'early days in custody' assessment. She recorded that Mr Goldstraw was relaxed, reported a good appetite and energy level, and said that he had slept well. The nurse noted that he was orientated and displayed no abnormalities in his thought processes. He was well-presented and spoke normally. He was under the care of the substance misuse team and the doctor. The nurse told Mr Goldstraw that he did not need any follow-up contact with the mental health team but should contact them if he had any concerns.
48. Substance misuse team staff checked Mr Goldstraw's wellbeing on 25, 26 and 27 October. His doctor in the community contacted the prison to confirm his prescribed medication. On 29 October Mr Goldstraw completed his alcohol detoxification programme.
49. On 30 October an officer went to Mr Goldstraw's cell to conduct his second basic custody screening assessment. Mr Goldstraw was in bed and declined the assessment. He told the officer that he was on remand and did not need any input from the resettlement team at that time.
50. On 2 November Mr Goldstraw collected his medication for the following week.
51. On 6 November Mr Goldstraw saw a member of staff from the Phoenix Futures team for his initial assessment. Mr Goldstraw said that his offending was linked to his alcohol use: when drinking he would become violent but would not remember doing so afterwards. He said that he did not have any physical health concerns but had depression and felt that he would benefit from working with the mental health team. He said that he did sometimes have thoughts of ending his life but that he would not act upon them and used coping strategies. He had self-harmed in the past but said that he had no thoughts of self-harm at the current time. Mr Goldstraw said that his goal was to stop drinking but he had no

intention of stopping using cannabis. He said he would like support from the drug and alcohol teams.

52. The member of staff from the Phoenix Futures agreed a care plan of one-to-one work, as well as independent work for Mr Goldstraw. She told the investigator that she had received ACCT training and suicide and self-harm training and was well aware of the need to look for signs that someone might be vulnerable to self-harm. She saw no such signs in Mr Goldstraw and, when she asked him, he had denied having any such thoughts.
53. Mr Goldstraw's medical record shows that on 9 November he did not collect his medication for the following week as he was supposed to.
54. On 10 November, a nurse carried out Mr Goldstraw's secondary health screening. Mr Goldstraw declined a referral to the smoking cessation service. He reported that he had had mental health issues in the past, but that he was managing them well with his prescribed medication.
55. Having completed his detoxification programme on Sunday 11 November, Mr Goldstraw moved from C wing to B wing.

Events of 13 and 14 November 2018

56. On 13 November, officers conducted a search of the wing in response to intelligence suggesting that a prisoner on B wing (not Mr Goldstraw) had a knife.
57. That afternoon, one of the prison's Safer Custody managers spoke to Mr Goldstraw while conducting a standard search of his cell. She told the investigator that Mr Goldstraw was relaxed and made appropriate small talk while she searched his cell. He did not raise any issues, and she said she had no reason to think that he presented any risk to himself.
58. CCTV shows that Mr Goldstraw collected his meal and returned to his cell at 5.54pm. An officer *conducted* a roll check at 8.21pm, then handed over to the night officer, Operational Support Grade (OSG).
59. There is nothing to suggest that Mr Goldstraw tried to raise any issues during the night. The wing observation book contains no entries relating to him, and the electronic recording system shows that he did not press his cell bell during the night. Police analysis of the CCTV footage does not show anything relevant to Mr Goldstraw during the night.
60. The morning roll check was due to be completed by 6.20am. The OSG began her roll check at 5.55am. While conducting the check, she stopped to answer a cell call bell. Before she resumed the roll check, she answered another cell call bell. Neither of these bells were Mr Goldstraw's. She did not complete the roll check.
61. An officer came on duty at approximately 7.15am and took over from the OSG on B wing. She gave him a handover briefing and did not report any issues about Mr Goldstraw.

62. The officer then conducted a roll check of the wing. When he reached Mr Goldstraw's cell, he saw Mr Goldstraw suspended from the window frame by a ligature made from a torn bed sheet. CCTV footage showed that this was at 7.19am. The officer shouted that there was a code blue emergency, meaning a prisoner was not, or was having difficulty, breathing.
63. A number of staff members who were coming on duty on the landing below heard the shout and ran up the stairs to Mr Goldstraw's cell. One of them, a Supervising Officer (SO), switched on his body-worn video camera. Footage begins at 7.20am. As they reached the top of the stairs another officer shouted to the officer to open the cell door. He did so, and the officers went in. The officer supported Mr Goldstraw's body while the SO cut the ligature. They laid him on the floor and immediately began to perform cardiopulmonary resuscitation (CPR).
64. One of the prison's senior managers, used her radio to broadcast a code blue emergency call across the radio network. This was at 7.22am. This prompted the control room to call for an ambulance, and for any available medical staff to attend.
65. A nurse who was the emergency response nurse, collected the emergency bag and ran to B wing when she heard the code blue. Other nursing staff had responded to the code blue call and to the sight of the nurse running to the wing, and a number of nurses, as well as the prison paramedic made their way to Mr Goldstraw's cell. The first nurse was there a minute after the prison's senior managers radioed the code blue call. They joined the officers in providing emergency aid to resuscitate Mr Goldstraw. They applied a defibrillator (a machine which, in some instances, restarts the heart by delivering an electric shock) but it could not detect a heartbeat and advised them to continue with CPR.
66. They continued attempts to revive Mr Goldstraw until ambulance paramedics arrived at 7.33am. The paramedics assessed Mr Goldstraw and, at 7.35am, pronounced him dead.

Post-mortem report

67. Post-mortem examinations showed that Mr Goldstraw died as a result of hanging. Toxicology tests found levels of fluoxetine in Mr Goldstraw's system higher than the therapeutic range. There were also levels of synthetic cannabinoids (PS) in his system.

Contact with Mr Goldstraw's family

68. Winchester appointed a family liaison officer. She identified Mr Goldstraw's current partner and travelled to her home to inform her of Mr Goldstraw's death. Another family liaison officer subsequently obtained contact details for Mr Goldstraw's ex-wife and their daughter, and informed them.
69. In line with Prison Service guidance, Winchester offered a contribution towards Mr Goldstraw's funeral.

Support for prisoners and staff

70. After Mr Goldstraw's death, the prison's deputy Governor 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.
71. The prison posted notices informing other prisoners of Mr Goldstraw'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 Goldstraw's death.

After Mr Goldstraw's death

72. Mr Goldstraw left a note in his cell apologising to his partner for his actions and saying that he could not live with what he had done and been charged with.
73. A mobile telephone was found in Mr Goldstraw's cell.

Findings

Assessment of risk

74. Mr Goldstraw had some risk factors for suicide and self-harm when he entered Winchester: he was detoxing from alcohol; he was on medication for anxiety and depression; he had previously harmed himself and made attempts on his own life, including taking an overdose of prescription medication six months earlier; and he was facing the possibility of a long prison sentence. He also told healthcare and substance misuse staff that he had occasional thoughts of taking his life, although he said he would not act on these.
75. Although these risk factors could have justified monitoring Mr Goldstraw under ACCT procedures, we accept that risk assessment is not an exact science and that the staff who had contact with him were all satisfied that Mr Goldstraw did not pose a risk to himself. We are, though, concerned that their judgements at the time were expressed in terms of what Mr Goldstraw said and how he presented, and that there is no evidence that they also took his risk factors into account in assessing his risk. Having said that, we consider that this was a relatively finely balanced judgement in Mr Goldstraw's case and we cannot say that Mr Goldstraw should definitely have been monitored under ACCT.
76. However, we are concerned that Mr Goldstraw was assessed as suitable to have his prescription medication in his possession, given his overdose six months earlier. We have more to say about this below.

Substance misuse

Prescription medication

77. Mr Goldstraw had been prescribed medication for anxiety and depression in the community and this was continued in prison. The clinical reviewer is satisfied that this was appropriate.
78. Mr Goldstraw's partner said he had written to her and told her there was an issue with his medication. According to his medical records, the only indication of a problem was when Mr Goldstraw told the doctor that the effects of his Librium wore off before his next dose of medication was due. The doctor raised the dosage in response.
79. Post-mortem toxicology tests found levels of fluoxetine (an antidepressant) in Mr Goldstraw's system higher than the level he had been prescribed. This suggests that he had been stockpiling his medication and had taken a higher dose of it than he should have before his death. We cannot say whether he did so because his mood was particularly low that night or in an attempt to take his life.
80. We are satisfied that healthcare staff had no reason to suspect Mr Goldstraw was stockpiling his medication. We do, however, consider that they should have investigated the reasons why Mr Goldstraw did not collect his medication on 9 November.
81. In addition, given Mr Goldstraw had a history of self-harm and suicide attempts and had taken an overdose of a prescription medication six months earlier, we

are concerned that a nurse assessed Mr Goldstraw as suitable to have his medication in his own possession (rather than having to collect it under supervision from the medication hatch once or twice a day). The clinical reviewer noted that the computerised assessment showed Mr Goldstraw as high risk for holding his medication in possession and the nurse did not record why he came to a different conclusion.

82. We make the following recommendation:

The Head of Healthcare should ensure that healthcare staff:

- **take all appropriate factors, including a prisoner's history, into account when assessing whether a prisoner is suitable to hold medication in-possession; and**
- **record the reasons for their decision.**

Illicit drugs

83. Toxicology tests also found traces of PS in Mr Goldstraw's urine after his death, although not in his blood. The clinical reviewer said that research about PS is developing, and he was unable to say whether the presence of PS in Mr Goldstraw's urine, but not his blood, meant that he had taken PS during his time in prison.

84. There was no intelligence during Mr Goldstraw time in prison to suggest that was using illicit drugs, and nothing was found in his cell to indicate illicit drug use. However, the toxicology results mean that this possibility cannot be ruled out.

85. Prisoners under the influence of PS can be affected in a number of ways including marked levels of disinhibition and the deterioration of mental health with links to suicide and self-harm. The pathologist who completed Mr Goldstraw's post-mortem noted that the drug found in his system is highly potent with effects that may include severe paranoia and other adverse psychological effects. We cannot, therefore rule out the possibility that PS use affected Mr Goldstraw's mood and influenced his decision to take his life.

Cell bells

86. In our report into an earlier death at Winchester, we drew attention to the delays in staff answering cell bells. Following Mr Goldstraw's death, a prisoner alleged that Mr Goldstraw had pressed his cell bell during the night of 13/14 November and it had gone unanswered. Checks on the cell bell recording system show that Mr Goldstraw's cell bell was not activated during the night of 13/14 November. The data does show that other cell bells were activated and answered, so the system was operating. We are satisfied that there is no evidence to support the suggestion that Mr Goldstraw's cell bell went unanswered.

Roll checks

87. The OSG did not complete the roll check that she was due to make at 6.20am on the morning of 14 November. The OSG has admitted that she did not undertake

the check as she was supposed to (although CCTV footage would have confirmed this without her admission).

88. Although we do not know when Mr Goldstraw died, rigor mortis was evident when he was found at about 7.15am which suggests that he had been dead for at least two hours. It is therefore, likely that Mr Goldstraw was already dead at 6.20am. Although it seems unlikely that the roll check would have changed the outcome for Mr Goldstraw, it could be critical in other cases. Mr Goldstraw would also have been found earlier if the OSG had carried out the roll check.
89. Winchester is undertaking an internal investigation into the OSG actions and considering disciplinary action. However, we recommend that:

The Governor should ensure that all staff are familiar with their responsibilities during roll checks.

Emergency response

Radioing the medical emergency code

90. An officer did not have a radio while conducting the morning roll check. He told the investigator that this was common practice because individual radios were allocated to specific areas of the prison. Staff would not know what area they were due to work in until details for the day had been announced. If they took a radio for the morning roll check and were subsequently allocated to a different part of the prison, they would have to return the radio to the gate and collect a different one.
91. When the officer found Mr Goldstraw hanging at 7.19am he had to shout the code blue emergency. This meant that only those staff nearby heard it.
92. CCTV and body-worn camera footage shows that other prison staff reacted immediately to his shout, arrived quickly, cut Mr Goldstraw down and began CPR.
93. However, there was a delay of three minutes between the officer finding Mr Goldstraw and the prison's senior manager, calling a code blue emergency across the radio network. This means that there was a three minute delay before healthcare staff were alerted and before the control room called an ambulance. Although this did not affect the outcome for Mr Goldstraw as it seems he was already dead when he was found, in another emergency situation, this could mean the difference between life and death.
94. We found a similar problem in our investigation into another death at Winchester in May 2017 and made a recommendation about it. The Governor said in response that an audit had been carried out to ensure there were adequate radios for all appropriate staff, and that a notice to staff was published in January 2018 to remind all appropriate staff to carry a radio and how to sign on to the radio net.
95. We are concerned that, although it appears there were sufficient radios available, the officer had chosen not to take one for reasons of convenience. As staff are expected to check the wellbeing of prisoners during roll checks, this is one of

times when they are likely to need a radio to call an emergency medical code. We make the following recommendation:

The Governor should:

- **review the current provision of radios to ensure that it meet the needs of the prison; and**
- **ensure that staff comply with local requirements for carrying radios to enable emergency medical codes to be radioed promptly.**

Entering the cell

96. National policy on entering cells at night is given in Prison Service Instruction (PSI) 24/2011. The PSI says that, under normal circumstances, authority to unlock a cell at night must be given by the night orderly officer and a cell should be opened with a minimum number of staff present, in accordance with local risk guidelines. However, the PSI goes on to say, that the preservation of life must take precedence over this and where there is or appears to be a threat to life, cells may be opened without the night orderly officer being present, and entered by staff on their own if they feel safe to do so, having performed a dynamic risk assessment and informed the control room. The local instructions at Winchester reflect this.
97. The officer did not go into the cell when he saw Mr Goldstraw hanging. Although it is likely that Mr Goldstraw was already dead when the officer found him, the officer was unaware of this at the time. He told the investigator that it was his understanding that he should never open a cell door if he was on his own. The SO said this was also his understanding.
98. Although the officer failure to enter the cell is unlikely to have affected the outcome for Mr Goldstraw, a delay could mean the difference between life and death in other cases. We are concerned that at least some staff at Winchester do not understand that they should enter a cell when there is a risk to life, unless there is a clear threat to their own safety. We make the following recommendation:

The Governor should ensure that all staff understand that, subject to a personal risk assessment, they should enter a cell at night when there is a potential risk to life and that local policies and instructions reflect this prominently.

Mobile telephone

99. A mobile telephone was found in Mr Goldstraw's cell after he died. There was no intelligence about this prior to it being found. Police analysis of the phone showed some messages between Mr Goldstraw and his partner to arrange contact but these were some days before he died. Its presence does not seem to have had a bearing on his death.

Family liaison

100. Mr Goldstraw's daughter said that she and her family sometimes had difficulty in contacting the family liaison officer at the prison.
101. The family liaison officer told the investigator that he did not have an individual telephone extension. This meant that when Mr Goldstraw's family wanted to speak to him they had to go through the main switchboard. The switchboard operators would be unaware of the circumstances in which they were calling and, for security reasons, would be unable to divulge any information about members of staff or take messages. This meant that if the family liaison officer was not available, Mr Goldstraw's family were unable to speak to anyone or leave a message.
102. Bereaved families are going through a very difficult and emotional process and may rely on family liaison officers for support and information. We consider that bereaved families should be given a telephone number or email address that will allow them to contact their liaison officer when they need to. We make the following recommendation:

The Governor should ensure that bereaved families are able to contact their family liaison officer or a deputy, or are at least able to leave a message that will be passed on promptly and acted upon.

Healthcare

103. The clinical reviewer concluded that, overall, Mr Goldstraw received clinical care of a standard that was equivalent to that which he could have expected in the community. He was satisfied that the substance misuse team correctly monitored Mr Goldstraw through the high-risk alcohol withdrawal period, and that his previous mental health history was recorded and his medication reviewed appropriately.
104. The clinical reviewer did, however, have some concerns, which we share.
105. He considered that a nurse diagnosed Mr Goldstraw with hypertension without sufficient evidence to do so. In addition, he considered that Mr Goldstraw's high blood pressure and other physical characteristics should have triggered a cardiovascular risk assessment, which did not happen. Although this did not contribute to Mr Goldstraw's death, the clinical reviewer has made a recommendation which the Head of Healthcare will need to address.
106. The clinical reviewer was also concerned about decision to allow Mr Goldstraw to have his medication in his possession (which is discussed above) and about the monitoring of Mr Goldstraw's compliance with his medication.
107. When Mr Goldstraw saw a nurse on 10 November he told him that he was managing his mental health issues with the aid of his medication. This was the day after he had failed to collect his medication, but the nurse was unaware of this as there was no system in place to monitor this and note it on a prisoner's medical record. The clinical reviewer said that such information should be available to staff assessing prisoners. We make the following recommendation:

The Head of Healthcare should ensure that there is a process for monitoring the compliance of a prisoner holding medication in their own possession. If a prisoner misses a collection, this should be followed up, and clearly noted on his medical record so that other healthcare staff who see the prisoner are aware.

108. Although the clinical reviewer was satisfied that the emergency response was prompt and the appropriate equipment was available, he considered that it was inappropriate to attempt to resuscitate Mr Goldstraw given that rigor mortis was present. He was concerned that nursing staff did not feel confident to stop resuscitation attempts until they were told to do so by someone who was authorised to pronounce death.
109. European Resuscitation Council Guidelines for Resuscitation 2015, which were shared with prison managers in September 2016, say that “resuscitation is inappropriate and should not be provided when there is clear evidence that it will be futile”. The guidelines define examples evidence of futility as including the presence of rigor mortis. The British Medical Association (BMA), the Royal College of Nursing (RCN) and the Resuscitation Council (UK) issued guidance in October 2014 on making appropriate decisions about resuscitation. The guidance says that every decision should be made on the basis of a careful assessment of an individual’s situation.
110. While it is understandable that staff wish to give prisoners the optimum chance in an emergency, it is important that healthcare staff are aware of when resuscitation should not be attempted. Trying to resuscitate someone who is clearly dead is distressing for staff and undignified for the deceased. We make the following recommendation:

The Governor and Head of Healthcare should ensure that staff are aware of the circumstances in which resuscitation is inappropriate.

**Prisons &
Probation**

Ombudsman
Independent Investigations