Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Jamie Winfield, a prisoner at HMP Lincoln, on 8 May 2020

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.

Our 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 Jamie Winfield was found hanged in his cell at HMP Lincoln on 8 May 2020. He was 52 years old. I offer my condolences to Mr Winfield's family and friends.

Mr Winfield gave staff no indication that he was at risk of suicide and I am satisfied that they could not have foreseen his actions.

However, I am concerned that no one checked on Mr Winfield between 6.41pm on 7 May, when he was locked in his cell for the night, and 9.46am the next day, when a prisoner saw him hanged in his cell. It is unacceptable that no one checked on Mr Winfield for over 15 hours.

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 **December 2020**

Contents

Summary

Events

1. On 9 December 2019, Mr Jamie Winfield was remanded in custody, charged with grievous bodily harm, and sent to HMP Lincoln. He had been in prison before.

2. Mr Winfield had no ongoing substance misuse issues, no history of self-harm and no mental health concerns. Staff said he was polite and caused no issues.

3. Mr Winfield's key worker told us that she and Mr Winfield often discussed his court case. He told her that he had not committed the offence he had been charged with and seemed confident he would not be found guilty. He was frustrated that he had not been granted bail in February 2020.

4. On 7 May at 6.41pm, Mr Winfield was locked in his cell for the night. An operational support grade (OSG) carried out two roll checks (count of prisoners) at 9.56pm and at 5.54am the next morning, but he missed out Mr Winfield's cell both times.

5. At 9.46am on 8 May, a prisoner went to Mr Winfield's cell to ask if he wanted breakfast. He saw Mr Winfield slumped by his sink with a ligature around his neck. He shouted to staff who ran to the cell, cut the ligature and started cardiopulmonary resuscitation (CPR). However, there were clear signs that Mr Winfield was already dead. He was pronounced dead at 10.06am.

6. Later that morning, a prisoner told staff that Mr Winfield had received legal documentation on 7 May and that he had previously said he would receive a long sentence if found guilty.

Findings

7. We are satisfied that Mr Winfield did not show any signs that he was at imminent risk of suicide and we accept that staff could not have foreseen his actions.

8. Staff failed to check on Mr Winfield between 6.41pm on 7 May and 9.46am the next morning, when a prisoner saw him hanged in his cell. The OSG responsible for the evening roll check on 7 May and the morning roll check on 8 May, failed to check Mr Winfield's cell.

9. When Mr Winfield was found hanged, there was a delay of four minutes before staff radioed a medical emergency code. This caused a delay in the ambulance being called. We are satisfied that it made no difference to the outcome for Mr Winfield, but it is important that staff follow the correct medical emergency procedures.

10. Despite Mr Winfield showing signs that he was already dead when found, the nurse who attended did not feel confident to ask staff to stop CPR. Staff should be reminded of the circumstances in which it is inappropriate to attempt resuscitation.

Recommendations

- The Governor should ensure staff carry out a morning welfare check for every prisoner.
- The Governor should ensure that staff follow the correct emergency procedures, as set out in PSI 03/2013, and radio a medical emergency code immediately when they find a prisoner unresponsive.
- The Governor and Head of Healthcare should give clear guidance to staff about the circumstances in which resuscitation is inappropriate.

The Investigation Process

11. The investigator issued notices to staff and prisoners at HMP Lincoln informing them of the investigation and asking anyone with relevant information to contact her. No one responded.

12. The investigator obtained copies of relevant extracts from Mr Winfield's prison and medical records.

13. NHS England commissioned a clinical reviewer to review Mr Winfield's clinical care at the prison. The investigator and clinical reviewer jointly interviewed staff on 26 May. Due to coronavirus restrictions, all interviews were conducted by telephone or video conference.

14. We informed HM Coroner for Central Lincolnshire of the investigation. We have sent the coroner a copy of this report.

15. One of the Ombudsman's family liaison officers contacted Mr Winfield's family, to explain the investigation and to ask if they had any matters they wanted the investigation to consider. They asked when Mr Winfield had last been checked by staff. This has been addressed in the report.

16. We shared our initial report with HM Prison and Probation Service (HMPPS). They raised no factual inaccuracies.

17. We provided Mr Winfield's next of kin with a copy of our initial report. They did not raise any issues or comment on the factual accuracy of the report.

Background Information

HMP Lincoln

18. HMP Lincoln holds up to 729 remanded and convicted men. It serves the courts of Lincolnshire, Nottinghamshire and Humberside. It has four residential wings, including a Vulnerable Prisoners Unit. Nottingham Healthcare NHS Trust provides health services and there is 24-hour nursing cover.

HM Inspectorate of Prisons

19. The most recent inspection of HMP Lincoln was in December 2019/January 2020. Inspectors reported that Lincoln was a much safer prison since their last inspection in 2017, though there had been two self-inflicted deaths since then. Inspectors said that the prison's approach to prisoners in crisis was good, and they had implemented previous PPO recommendations. Inspectors found that staff-prisoner relationships were very good.

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 31 January 2020, the IMB reported a slight decrease in incidents of self-harm but were still concerned at the high level. The Board found that staff-prisoner relationships were generally positive and supportive.

Previous deaths at HMP Lincoln

21. Mr Winfield was the fifth prisoner to die at Lincoln since May 2018. Of the previous deaths, one was self-inflicted, one was drug-related, and two were from natural causes. We have previously made recommendations about welfare checks and the use of medical emergency codes.

Key Events

22. On 9 December 2019, Mr Jamie Winfield was remanded in custody, charged with grievous bodily harm, and sent to HMP Lincoln. Mr Winfield had been released from HMP Ranby in January 2019 and had also been in Lincoln before.

23. When Mr Winfield arrived at Lincoln, he told staff he had no ongoing substance misuse or mental health issues, and no suicidal thoughts or history of attempted suicide or self-harm. Mr Winfield was allocated a single cell on A Wing.

24. On 19 December, Mr Winfield met his key worker for the first time. They met regularly over the next three months. At interview, the key worker said that she and Mr Winfield often discussed his court case. He was adamant that he had not committed the offence he had been charged with and seemed positive that he would not be convicted. He was frustrated that he had not been granted bail during a court hearing on 8 February 2020.

25. In January 2020, Mr Winfield saw a prison GP about neck pain following a motorbike accident and was prescribed painkillers and gel, and referred to a physiotherapist, who he saw on 18 February and 10 March. Treatment was suspended due to COVID-19 restrictions but was due to restart once restrictions were lifted. Mr Winfield continued with the medication.

26. Mr Winfield met with his key worker for the last time on 11 March. Mr Winfield was in his cell looking through paperwork he had written about his alleged offence. He told her that that more evidence had come to light. Mr Winfield was still frustrated about being in prison and said he would contact his solicitor about applying for bail.

27. On 21 April, an officer recorded that Mr Winfield had had a couple of minor arguments with other prisoners. He noted that Mr Winfield had said it was probably due to the stress of the current restricted regime during the pandemic.

28. A Supervising Officer (SO) and an officer both worked on A Wing. They said Mr Winfield was polite and caused no problems. The SO told the investigator that the prison had run a restricted regime from March due to COVID-19. All prisoners spent longer locked in their cells and were limited to showers and an hour of exercise daily. Landings were unlocked at varying times, to ensure all prisoners had equal access out of their cells either morning or afternoon. An officer told the investigator that wing staff had said that Mr Winfield had been frustrated about the timings changing every day and not knowing when he would get a shower.

Events of 7 and 8 May

29. An officer told the investigator that he had seen Mr Winfield on 7 May, at 4.15pm, while serving evening meals. Prisoners were unlocked to collect their meal from the servery and returned immediately to their cell. The officer completed a roll check before handing over to night staff, and CCTV shows him checking Mr Winfield at 6.41pm. He told the investigator that Mr Winfield was sitting on his bed reading, and that he looked up and nodded at him.

30. Mr Winfield made a telephone call to a friend at 8.40pm. He said his life had "imploded" but there was no point him griping about it. They spoke about someone they knew who died from poison and Mr Winfield said he would end up doing the same thing. The other person challenged this and Mr Winfield responded, "Anyway, let's move on, lift the spirit."

31. The investigator watched the wing's Closed-Circuit Television (CCTV) footage. At 9.56pm, an Operational Support Grade (OSG), can be seen carrying out the evening roll check (count of prisoners). He did not check the cells behind the stairs on the wing, which included Mr Winfield's cell. CCTV shows the OSG occasionally responded to a cell bell during the night, but none were near Mr Winfield's cell. He carried out the morning roll check at 5.54am, but again, he missed out Mr Winfield's cell.

32. On 8 May, a prisoner was unlocked to serve breakfast to prisoners in their cells. CCTV showed he arrived at Mr Winfield's cell at 9.46am, and immediately officers can be seen running to where the prisoner is standing. The prisoner said he had looked into Mr Winfield's cell and saw him slumped by the sink with a bedsheet tied around his neck, so shouted for help. A SO said he heard the prisoner shout that Mr Winfield was hanging and picked up a defibrillator on his way to the cell.

33. An officer arrived first and went straight into the cell. He saw Mr Winfield hanging from a ligature, tied to the sink tap. Mr Winfield's skin looked purple, his tongue was protruding, and he felt stiff. Another officer was immediately behind the first officer. The first officer tried to use his anti-ligature knife to cut the ligature, but it was too tight, so he cut the bedsheet attached to the tap and laid Mr Winfield on the floor. The other officer then untied the rest of the ligature. The first officer told the investigator he shouted out "code blue" a few times as he was not carrying a radio. (A code blue is a medical emergency code used when a prisoner is unconscious or having breathing difficulties. It should be called over the radio so that it alerts healthcare staff and tells the control room to call an ambulance immediately.)

34. Two nurses and a healthcare worker had been on A Wing preparing to dispense medication and went immediately to Mr Winfield's cell. One nurse said at interview that Mr Winfield was unresponsive, his skin appeared blue and he felt rigid. She attached the defibrillator to Mr Winfield's chest, and started chest compressions with the healthcare assistant, while the other nurse ran to collect the emergency bag. The defibrillator advised no shock three times.

35. At 9.50am, an officer called an emergency code blue over the radio and the control room called an ambulance immediately.

36. The paramedics arrived at Mr Winfield's cell at 9.56am. They assessed Mr Winfield and attached their defibrillator, while healthcare staff continued chest compressions. The defibrillator continued to advise no shock, twice. A doctor with the paramedic team pronounced Mr Winfield's death at 10.06am.

37. A prisoner and friend of Mr Winfield told an officer later that morning that Mr Winfield had received legal documentation the night before he died and had previously told the prisoner he would be "lifed off" if he was found guilty.

38. Mr Winfield left notes in his cell. One said goodbye and thank you to friends and discussed financial arrangements. Another note said he did not want to "get old" and sent his love to his family, and a third note said he felt he could not get justice, but he would not have to worry any more.

Contact with Mr Winfield's family

39. A SO was appointed as family liaison officer. She visited Mr Winfield's next of kin at their home address later that day, with a manager and a chaplain.

40. The prison contributed to the cost of Mr Winfield's funeral, in line with national guidelines.

Support for prisoners and staff

41. After Mr Winfield's death, the 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.

42. The prison posted notices informing other prisoners of Mr Winfield'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 Winfield's death.

Post-mortem report

43. The coroner had not provided us with Mr Winfield's post-mortem and toxicology reports at the time of issuing this report.

Findings

Mr Winfield's risk of suicide or self-harm

44. Staff told us that Mr Winfield was polite to staff and caused no issues. Despite Mr Winfield expressing frustration about being refused bail, his key worker told us that he did not seem concerned about his court case as he was adamant he was innocent and seemed confident that he would not be convicted. His trial was not scheduled until July 2020.

45. Mr Winfield expressed frustration about the restricted regime in place since March and blamed some minor arguments with other prisoners on the stress of the regime. However, these appeared to be minor frustrations and there was no indication that Mr Winfield was struggling to cope.

46. Mr Winfield received a bundle of legal documentation on 7 May. He had mentioned this to a prisoner, but staff were unaware. He made a telephone call that evening when he suggested his life had imploded. Again, staff were not monitoring his calls, so were not aware.

47. We are satisfied that Mr Winfield gave staff no indication that he was at imminent risk of suicide and we accept that they could not have foreseen his actions.

Missed roll and welfare checks on 7 and 8 May

48. The night OSG was responsible for carrying out the evening and morning roll checks on 7/8 May. Although CCTV shows that he carried out a roll check at 9.56pm on 7 May and at 5.54am on 8 May, he missed out Mr Winfield's cell both times. No one checked on Mr Winfield between 6.41pm on 7 May, when he was locked in his cell for the night, and 9.46am on 8 May, when a prisoner saw him hanging in his cell.

49. It is unacceptable that Mr Winfield was not checked for over 15 hours and that a prisoner who had been unlocked to deliver breakfast was the one to find Mr Winfield hanging. The PPO has raised concerns previously about prison staff failing to identify that a prisoner has died overnight. Prison Service Instruction (PSI) 75/2011, *Residential Services,* states, *'[Differing] arrangements will depend on the local regime, but there need to be clearly understood systems in place for staff to assure themselves of the wellbeing of prisoners during or shortly after unlock ... Where prisoners are not necessarily expected to leave their cell, staff will need to check on their wellbeing, for example by obtaining a response during the unlock process.'*

50. We accept that Lincoln was operating a restricted regime at the time of Mr Winfield's death and some prisoners were not being unlocked until the afternoon. However, it remains important that staff check on the welfare of prisoners in the morning. Staff at Lincoln told us that the evening and morning roll checks should also incorporate a welfare check, in that the staff member should check for signs of movement or breathing when carrying out the roll check. This was not done in Mr Winfield's case as his cell was missed out completely and he was not checked at all. The prison told the investigator that following Mr Winfield's death, Lincoln has introduced an additional welfare check at 8.00am each morning.

51. We would have normally recommended a disciplinary investigation into the OSG's actions but, as he was an agency member of staff who no longer works at Lincoln, we make no recommendation about him. However, Lincoln must ensure that staff carry out a morning welfare check on all prisoners regardless of whether or not they are being unlocked. We recommend:

The Governor should ensure staff carry out a morning welfare check for every prisoner.

Emergency response

52. PSI 03/2013, *Medical Emergency Response Codes*, sets out the actions staff should take in a medical emergency. It contains mandatory instructions for Governors to have a protocol on 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 says that if a medical emergency code is called over the radio, an ambulance must be called immediately.

53. The prisoner who found Mr Winfield hanging, shouted to staff and they responded immediately. The first officer to go into Mr Winfield's cell said that he shouted code blue to staff but did not hold a radio. No-one called a code blue over the radio until four minutes later. This caused a delay in calling for an ambulance. Although this did not make a difference to Mr Winfield because he was already dead when found, it is important that staff follow the correct medical emergency procedures. We know that in a medical emergency, a delay of a few minutes can be critical. We make the following recommendation:

The Governor should ensure that staff follow the correct emergency procedures, as set out in PSI 03/2013, and radio a medical emergency code immediately when they find a prisoner unresponsive.

54. Mr Winfield had already died by the time he was discovered. He felt cold to touch and there were signs of rigor mortis. Mr Winfield's jaw was clenched, and his tongue was swollen. We are concerned that staff began CPR when Mr Winfield showed clear signs of rigor mortis and lividity.

55. European Resuscitation Council Guidelines 2015 say that, "*Resuscitation is inappropriate and should not be provided when there is clear evidence that it will be futile …*" The guidelines give examples 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) have also issued guidance about making appropriate resuscitation decisions. The guidance says that every decision should be made on the basis of a careful assessment of each individual's situation. Attempting resuscitation when someone is clearly dead is distressing for staff and undignified for the deceased.

56. At interview, a nurse was asked whether, at any point, she thought CPR might not be appropriate. She said that she had not, as she was new to working in a prison and was focused on helping Mr Winfield. She was unsure whether all staff were fully aware of the guidance about decision making in CPR, and when attempted resuscitation is not appropriate, issued by NHS England in 2016.

57. The nurse acted with the best intentions, but we find that CPR should not have been started in this instance. We make the following recommendation:

The Governor and Head of Healthcare should give clear guidance to staff about the circumstances in which resuscitation is inappropriate.

Clinical care

58. The clinical reviewer had no concerns about the management of Mr Winfield's physical health at Lincoln and noted that Mr Winfield's reception health screen was completed in line with NICE guidelines. Although Mr Winfield had a history of illicit drug and alcohol misuse, there was no evidence that this was a current issue and no intervention was required. The clinical reviewer noted that Mr Winfield reported no mental health problems and although he had been prescribed antidepressants while in prison in 2008, he had not continued with this prescription on his release. There was nothing to suggest Mr Winfield was at risk of suicide or self-harm, or that the self-harm could have been predicted or prevented.

59. The clinical reviewer found that Mr Winfield's healthcare was equivalent to that he could have expected to receive in the community.

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