

**Prisons &
Probation**

Ombudsman
Independent Investigations

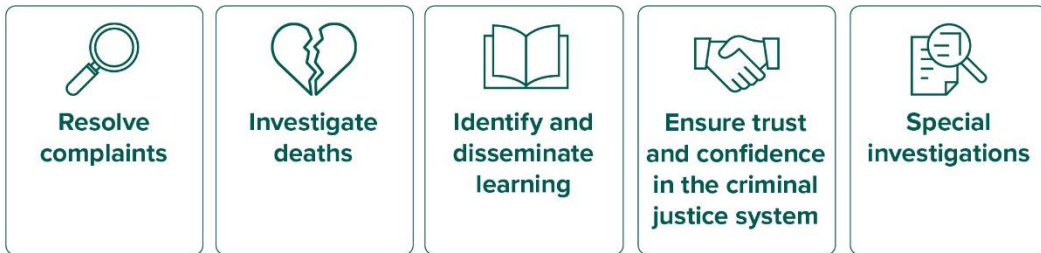
Independent investigation into the death of Mr John Winchcole, a prisoner at HMP Forest Bank, on 10 September 2018

A report by the Prisons and Probation Ombudsman

OUR VISION

To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.

WHAT WE DO



WHAT WE VALUE



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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 John Winchcole died on 10 September 2018 when he was found hanging in his cell at HMP Forest Bank. Mr Winchcole was 36 years old. I offer my condolences to Mr Winchcole's family and friends.

Mr Winchcole had been released from prison on licence but was recalled in May 2018. He had a history of mental health problems and drug misuse.

On his return to prison, Mr Winchcole said he intended to take his own life. He was supported by Prison Service procedures for those at risk of self-harm (known as ACCT) and also spent some time in the healthcare inpatient unit.

I am satisfied that it was reasonable for the ACCT to be closed at the end of June when his mood had stabilised and he seemed to be settling back into prison life. I am also satisfied that staff had no reason to consider that Mr Winchcole was at risk of suicide in the period before he died.

I am concerned that the prison officer who found him did not use an emergency medical code. I am also concerned that toxicology tests showed traces of drugs in Mr Winchcole's system.

Mr Winchcole was serving an indeterminate sentence and as such had no indication of how long he would be in prison. This may have played some part in his decision to take his own life.

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

June 2019

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Summary

Events

1. In 2008, Mr John Winchcole received an indeterminate sentence for public protection (IPP). He had been released from prison on licence but in May 2018 was recalled and returned to HMP Forest Bank after committing further offences. He had a history of substance misuse, self-harm and of mental health issues. As Mr Winchcole had said that he intended to take his own life, on arrival at Forest Bank he was placed under Prison Service procedures for those at risk of harming themselves (known as ACCT).
2. Mr Winchcole declined to engage with healthcare staff in his reception healthcare screening, saying that he had no health or detoxification issues. The nurse referred him for a mental health assessment. Mr Winchcole asked to be located on the vulnerable prisoners' unit, where he had lived on his previous stay at Forest Bank. He was upset at the prospect of spending a long time in prison, and was unsure how much support he would continue to have from his family.
3. Mr Winchcole remained low in mood, expressing thoughts of harming himself and, in early June, moved to the prison's healthcare inpatient unit for further observation. He gradually began to interact with staff more easily and by mid-June he seemed more positive and more confident about expressing his needs. By the end of June, Mr Winchcole appeared to have adapted to being back in prison, and was happy to leave the healthcare unit. ACCT procedures were closed, and in early July Mr Winchcole moved to the vulnerable prisoners' unit.
4. Mr Winchcole seemed to settle on the unit. He had re-opened contact with his family, was on the waiting list to attend education courses, had employment and told staff that he had no specific concerns.
5. On 24 August, the Parole Board wrote to Mr Winchcole and told him that he was not to be released at that stage.
6. There was a report that another prisoner might have been bullying Mr Winchcole, but prison officers did not see any evidence to support this.
7. On the evening of Sunday 9 September, when Mr Winchcole collected his meal, a fellow prisoner and a member of staff both recalled that he seemed in a good mood. When a prison officer conducted a roll check at 5.00am on 10 September, he called to Mr Winchcole, who, he said, responded.
8. At 7.05am, a prison officer unlocking prisoners found Mr Winchcole hanging from the door frame. The officer called for assistance and prison officers and healthcare staff arrived. They agreed that Mr Winchcole was clearly dead so did not attempt to resuscitate him.

Findings

Risk assessment

9. When Mr Winchcole arrived in Forest Bank, staff correctly identified that he might be vulnerable and require support. Staff began ACCT procedures to support him. We are satisfied that Mr Winchcole was well supported under ACCT, although we are concerned that healthcare staff did not attend all of the reviews.
10. We are satisfied that it was reasonable for the ACCT to be closed at the end of June when Mr Winchcole seemed more settled and his mood had improved.
11. Mr Winchcole received good support from his key worker and appeared to be happier in the period before he died. Although a single piece of intelligence became available the week before he died that suggested that Mr Winchcole might be being bullied, there is no other evidence to suggest that he had any specific problems that might place him at risk of suicide or self-harm. His friends said they were unaware of any problems with debt or bullying. Those who knew Mr Winchcole said that his death came as a shock to them.
12. We are satisfied that staff could not reasonably have foreseen Mr Winchcole's death.
13. Mr Winchcole was serving an indeterminate sentence for public protection and, therefore, had no indication of how long he would be in prison. Prisoners serving indeterminate sentences can face additional stress and uncertainty and this may have played some part in his decision to take his own life, although there is no specific evidence to suggest that this was the case for Mr Winchcole.

Use of illicit drugs

14. Mr Winchcole had a history of drug use but staff did not suspect that he was using drugs before his death. After he died, one of his friends told the investigator that Mr Winchcole was used psychoactive substances (PS) most days and that he thought he had done so the night before he was found hanged. Toxicology tests later showed that Mr Winchcole had PS and tramadol (a strong painkiller which he had not been prescribed) in his system, and we cannot rule out the possibility that drugs might have played some part in his decision to take his life.

Mr Winchcole's healthcare

15. The clinical reviewer is satisfied that the healthcare provided to Mr Winchcole in Forest Bank was equivalent to that which he could have expected to receive in the community. She did, however, identify some shortcomings and we are concerned that shortages of healthcare staff affected the service provided to Mr Winchcole in some respects.

Time out of cell

16. The prison was operating a restricted regime at the time of Mr Winchcole's death. This meant that prisoners spent more time locked in their cells over the weekend.

This can be particularly difficult for prisoners, like Mr Winchcole, who are in single cells.

Emergency response

17. Prison Service guidelines require specific emergency codes to be used during medical emergencies. Using the correct codes ensures that an ambulance is called immediately, and that healthcare staff attending emergencies know what equipment to take with them. The prison officer who found Mr Winchcole hanging did not use an emergency code and, as a result, there was a delay of around four minutes before an ambulance was called. Mr Winchcole was already dead by this point, so the omission did not have to serious consequences in his case. It could, however, do so in future.

Recommendations

- The Head of Healthcare should:
 - Ensure that a mental health nurse is allocated to each prisoner in the inpatient unit; and
 - Introduce a more structured risk assessment tool which should be used during the ACCT process and when there is an escalation of risk.
- The Head of Healthcare should ensure that healthcare staff attend ACCT reviews as required.
- The Director should ensure that during a restricted regime staff consider whether any prisoner's risk of suicide or self-harm may be raised by spending a long time in their cell, particularly in the case of prisoners in single cells.
- The Director should remind staff of the importance of using the correct codes in a medical emergency, and the potential consequences of not doing so.

The Investigation Process

18. The investigator issued notices to staff and prisoners at HMP Forest Bank informing them of the investigation and asking anyone with relevant information to contact him. No one responded.
19. The investigator visited Forest Bank on 27 and 28 September. He obtained copies of relevant extracts from Mr Winchcole's prison and medical records.
20. The investigator interviewed two members of staff and four prisoners at Forest Bank.
21. NHS England commissioned a clinical reviewer to review Mr Winchcole's clinical care at the prison.
22. We informed HM Coroner for Greater Manchester West of the investigation. She gave us the results of the post-mortem examination and we have sent her a copy of this report.
23. The investigator contacted Mr Winchcole's mother to explain the investigation and to ask whether she had any matters she wanted the investigation to consider. Mr Winchcole's mother asked about her son's mental health care. Mr Winchcole's mother received a copy of the initial report and made some comments that have been answered in separate correspondence.

Background Information

HMP Forest Bank

24. Forest Bank is a local prison in Salford, serving courts in north west England. It holds 1,460 remanded and sentenced men. The prison is managed by Sodexo Justice Services. Sodexo provides primary health care services.

HM Inspectorate of Prisons (HMIP)

25. The most recent inspection of HMP Forest Bank was conducted in February 2016. Inspectors reported that the prison was well led with a focus on improvement. Drugs, however, were easily available. The substance misuse strategy was well managed and prisoners with substance misuse issues could access a wide range of recovery-focused interventions. Most prisoners received a decent amount of time out of their cells. Drugs were available but there were good strategies in place to reduce supply.

Independent Monitoring Board

26. 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 October 2017, the IMB raised concerns over mental healthcare, and the availability of drugs.

Previous deaths at HMP Forest Bank

27. Mr Winchcole was the thirteenth Forest Bank prisoner to die since 2013. Eight of these deaths were due to natural causes. We have previously raised issues around lack of mental health support, and the availability of drugs.

Assessment, Care in Custody and Teamwork

28. ACCT is the Prison Service care-planning system used to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk, how to reduce the risk and how best to monitor and supervise the prisoner.
29. After an initial assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. Checks should be irregular to prevent the prisoner anticipating when they will occur. There should be regular multi-disciplinary review meetings involving the prisoner. As part of the process, a caremap (a plan of care, support and intervention) is put in place. The ACCT plan should not be closed until all the actions of the caremap have been completed.

Psychoactive Substances (PS)

30. Psychoactive substances, previously known as 'legal highs' are an increasing problem across the prison estate. They are difficult to detect and can affect people

in a number of ways including increasing heart rate, raising blood pressure, reducing blood supply to the heart and vomiting. Prisoners under the influence of PS can present with marked levels of disinhibition, heightened energy levels, a high tolerance of pain and a potential for violence. Besides emerging evidence of such dangers to physical health, there is potential for precipitating or exacerbating the deterioration of mental health with links to suicide or self-harm.

31. In July 2015, we published a Learning Lessons Bulletin about the use of PS and its dangers, including its close association with debt, bullying and violence. The bulletin identified the need for better awareness among staff and prisoners of the dangers of PS; the need for more effective drug supply reduction strategies; better monitoring by drug treatment services; and effective violence reduction strategies.
32. HMPPS now has in place provisions that enable prisoners to be tested for specified non-controlled PS as part of established mandatory drugs testing arrangements.

Key Events

33. In 2008, Mr John Winchcole received an IPP sentence for various offences including robbery, aggravated burglary and driving offences. This means that he was required to remain in prison until the Parole Board was satisfied that he no longer posed a threat to the public. He was released on licence in July 2017 but his licence was revoked in April 2018 when he was suspected of having committed further offences. He was arrested on 25 May and taken to HMP Forest Bank the following day.
34. Mr Winchcole had been in Forest Bank before. He had been transferred there for his own protection when he was under threat from other prisoners in another prison. He had a history of substance misuse, self-harm and of mental health issues, including depression, and his medical record refers to a possible personality disorder.
35. When he arrived at Forest Bank, escort papers that accompanied him noted that he had told escort staff that he was going to take his own life. Prison officers in reception began Prison Service procedures for monitoring prisoners thought to be at risk of harming themselves (known as ACCT). Staff were to check on him at least twice per hour.
36. Mr Winchcole declined to engage with healthcare staff in his reception healthcare screening, saying that he had no health or detoxification issues. The nurse referred him for a mental health assessment. Mr Winchcole asked to be located on the vulnerable prisoners' unit (VPU), where he had lived on his previous stay in Forest Bank. This was because of the nature of a previous offence that involved making threats against children. Staff noted on his records that once he had completed his time on the induction unit, he would move to the VPU. Mr Winchcole's cell sharing risk assessment noted that he presented a high risk to a potential cellmate so should be housed in a single cell. When asked during his first night check whether he felt himself to be at risk of suicide or self-harm, he said that he did not.
37. On 29 May, healthcare staff saw Mr Winchcole to carry out some screening tests, but, again, he declined to engage. No issues had been raised about his mental capacity to make such a decision so he was able to do so.
38. Under his ACCT management plan, he had an assessment interview with Prison a Custody Officer (PCO). He told the PCO that he felt very low in mood. He was facing a long prison sentence, and was tearful thinking about it. He had self-harmed for most of his adult life, with the impulse to do so coming and going as he suffered from feelings that he could not cope with. He said that he had been kidnapped and attacked before being recalled to prison. He was not sure how much support he could continue to rely on from his family.
39. After the assessment interview, Mr Winchcole attended an ACCT review meeting with the PCO, and two Supervising Prison Custody Officer (SPCO). Mr Winchcole reiterated that he was in a low mood because of the possibility of a long sentence. He wanted to make contact with his family, as he had lost touch with them. He said that he had asked to be designated as a vulnerable prisoner for his own protection, both because of the nature of previous offences and because he had ongoing issues with gang members. A SPCO noted that Mr Winchcole remained a high risk

of self-harm, and left the level of observations at two checks per hour. There was an action point in the caremap for Mr Winchcole to speak to a member of the resettlement team to help address his family issues.

40. The SPCO held Mr Winchcole's next ACCT review on 1 June. Mr Winchcole was still feeling low, with ongoing thoughts of harming himself. He was happy to have the support of the ACCT process, and the meeting agreed that the level of observation would remain the same.
41. At the next review, on 4 June, Mr Winchcole said that nothing staff could do would prevent him taking his own life. There were no signs that he had harmed himself but he remained in a very low frame of mind. The SPCO discussed Mr Winchcole with a manager and they agreed that he should be moved to the prison's healthcare inpatient unit, with staff raising the frequency of observations to four times per hour, day and night. His medical record noted that he settled well there that afternoon.
42. On 5 June, a mental health nurse assessed Mr Winchcole. He said that he did not have any mental health issues, that he did not want to engage with the ACCT process, and that he just wanted to be left alone. She noted that he seemed to be hopeless about his IPP sentence. His body language and presentation were negative, and he said that he had no family or friends to support him, suggesting that was his choice. He said he had constant thoughts of suicide and that he was tired of life. He declined an offer to see the doctor to discuss medication. The nurse noted that he should be referred to appropriate agencies, and that staff should try to encourage him to engage with his future planning.
43. On 7 June, a nurse noted on Mr Winchcole's medical record that he was unable to spend time with Mr Winchcole because of other operational demands placed on him. He noted that there had been no evidence of any attempts by Mr Winchcole to harm himself, and prison officers did not express any concerns about him.
44. On 8 June, Mr Winchcole attended an ACCT review. Those present thought his body language had become more positive. He was still struggling with his thoughts, however, and had recently received a letter from his family that had upset him. He also had very little information about his prison planning, including future parole hearing dates. His ACCT caremap was reviewed with a note for this to be addressed. (Staff subsequently did contact the Offender Management Unit to obtain further information.) The review agreed that Mr Winchcole should continue to have the support of the ACCT process, and that staff should check on him at least twice per hour.
45. Mr Winchcole began to interact with staff a little more easily, though only when they approached him. On 10 June he declined to participate in the prison regime or come out of his cell for association, though he asked for a pen and paper as he needed to write to his bank. He was eating and taking care of himself to an acceptable level.
46. On 12 June, Mr Winchcole saw a prison GP. He told the doctor that he had been kidnapped prior to his recall to prison, and believed he had been drugged by a vigilante gang. He said he had woken to find himself in police custody, and had been in low mood since returning to prison. He told the doctor that he had used antidepressants in the past but stopped due to their side effects. The records do

not show that the doctor offered anti-depressants but the conversation recorded suggests that Mr Winchcole did not want to take medication.

47. At an ACCT review on 14 June, Mr Winchcole appeared more positive, with better body language and eye contact with those present. They discussed his future court dates, and he thanked staff for their support. His level of risk remained unchanged.
48. On 15 June, Mr Winchcole spoke to a mental health nurse. He seemed more relaxed and was happy to chat. It had been agreed that as soon as a suitable cell was available he was going to leave healthcare and go back to the VPU.
49. On 18 June, a nurse noted on Mr Winchcole's medical record that he was now more willing to engage, and more confident about making his needs known. He discussed issues around self-harm, his sentence, traumatic experiences and his feelings of hopelessness. He was caring for himself appropriately, and was working with staff to use the ACCT process to identify risks and suitable support. He was to move out of the healthcare centre but was still offered the support of the mental health team if he needed it.
50. On 18 June, Mr Winchcole saw a PCO, who was his keyworker (a prison officer allocated time each week to provide individual support to around six prisoners and to be their first point of contact for queries or problems). Mr Winchcole said that he was trying to access funds from his bank after being the victim of identity fraud. He said that a member of staff was assisting with this.
51. On 20 June, at an ACCT review, Mr Winchcole was noted to be in a positive frame of mind. He said he had no thoughts of harming himself and had been working hard with staff to resolve his issues. He had contacted the Parole Board about his sentencing dates, and was working with the Offender Management Unit to clarify these. He was due to be relocated to the VPU. Healthcare staff had assessed him and considered him fit to be relocated and his risk was now judged to be low. The ACCT process remained in place, with staff to check on him at least once per hour.
52. Following the death of a prisoner on the unit, staff reviewed Mr Winchcole's risk to himself on 23 June. He was settled, and denied any further issues. Staff left his risk assessment and level of observations unchanged.
53. At the next ACCT review on 26 June, Mr Winchcole appeared very positive. He said he had no thoughts of harming himself, and felt that he had the relevant support to help him. He understood the support available to him in prison, was happy about relocating away from the healthcare centre, and was comfortable about the arrangements around his court case. He said he was aware that he could talk to staff if he needed help. All present, including a nurse agreed that his ACCT support could be closed.
54. On 3 July, Mr Winchcole transferred to the VP unit. Also on the unit was a friend of Mr Winchcole. Mr Winchcole told him that since he last saw him, his father had died. Mr Winchcole had been very upset, and said that this had indirectly caused problems for him that led to the circumstances of his recall to prison.
55. His friend told the investigator that, over the following weeks, Mr Winchcole began to perk up. He got his hair cut, began to take exercise and seemed more settled.

56. On 5 July, a SPCO held a post-closure ACCT review with Mr Winchcole. He said that he had settled into the VPU. He had some limited family support and would try to deal with any issues on his own at first but, if necessary, would talk to staff. He was to begin education courses and filled his time watching television, playing cards, and talking to a few other prisoners on the unit. He said he had no concerns at that time.
57. On 16 July, a nurse noted on Mr Winchcole's medical record that he had been assessed as trusted to hold his medication in his own possession.
58. On 2 August, Mr Winchcole told a PCO that a SPCO had put him in touch with his bank and he had received a sum of money into his account. He was pleased with this.
59. On 17 August, a PCO covered the key worker session while he was away. Mr Winchcole said he was happy to be in employment and had no current drug misuse issues. He commented favourably on the key worker system and said that he felt his key worker spent quality time with him and was supporting him to achieve small goals, the first of which was to feel calm and settled on the wing.
60. On 20 August, some intelligence suggested that Mr Winchcole might be in possession of a mobile telephone. There is no further information about this in his records or security files.
61. On 23 August, Mr Winchcole told a PCO that he still had not received all the money from his bank, despite having signed two sets of forms. Other than that, he said that he was settled on the wing and happy to be working, having got a job in a workshop. The PCO noted that it was a very positive interview.
62. On 24 August, the Parole Board wrote to Mr Winchcole. The Board notified him that he was not to be released at that stage.
63. An intelligence report indicated that a prison officer on the wing thought Mr Winchcole might be being bullied by another prisoner. The information was distributed to staff on the wing for them to watch for any signs. There were no further indications of any issues of this sort, and staff noted Mr Winchcole and the other prisoner chatting freely together.
64. On 4 September, a PCO met Mr Winchcole and reported that he had maintained a positive stance in recent months, and that his mood and demeanour had improved 'massively' since their first meeting. Mr Winchcole said that he enjoyed working, that the money was a big help and motivation for him and that he had a good relationship with workshop staff and his fellow workers. The PCO asked how things were on the wing and said that he got the impression that Mr Winchcole was quite popular and had made a lot of friends on the unit. They talked about a new job Mr Winchcole had been offered and the PCO said he would try to resolve Mr Winchcole's concerns about how much it would pay. He also advised him to make an appointment with his offender manager via the self-service kiosk.
65. On 5 September, the workshop manager recorded that Mr Winchcole had had a good month in the workshop and was always polite and helpful.

Events of 9/10 September

66. His friend told the investigator that he had seen Mr Winchcole at lunchtime on Sunday 9 September and he had seemed fine, and in a happy mood. A PCO said in her police statement that she spoke to Mr Winchcole that lunchtime and he seemed fine.
67. Another friend of Mr Winchcole's, who was serving food, saw Mr Winchcole briefly on Sunday evening as he collected his meal. He said seemed fairly upbeat and happy. When he asked whether he was alright, Mr Winchcole replied, "all good" and gave him a thumbs-up gesture. He told the investigator that he suspected that he might have been under the influence of PS at the time because he was so upbeat.
68. A PCO conducted a roll check of the landing at 8.00pm. No problems were noted. The wing observation book does not contain any indication that Mr Winchcole came to the attention of staff during the night.
69. At 5.00am on 10 September, a PCO conducted a roll check of the unit. When he checked Mr Winchcole, he could not see him through the cell's observation panel. He completed his check, then returned to Mr Winchcole's to confirm that he was there. He still could not see Mr Winchcole, so called through the door. He said that Mr Winchcole replied that he was in the toilet area of the cell. (This is not visible from the observation panel for reasons of privacy.)
70. At 7.00am, a PCO began unlocking prisoners and, at approximately 7.05am, unlocked Mr Winchcole's door. He pushed the door but found that something was blocking it. The PCO moved on to unlock the next cell but, concerned that he had not actually seen Mr Winchcole, went back and pushed the door. It partially opened and the PCO could see Mr Winchcole's feet behind it. He forced open the door and found Mr Winchcole hanging by a ligature suspended from the door frame. The PCO used his anti-ligature knife to cut Mr Winchcole down, and used his radio to make an urgent call, requesting the orderly officer (the officer in charge of the day-to-day running of the prison) and the medical emergency responder to come to the unit. This message was sent at 7.07am.
71. Other staff responded to the call and those already on the unit were quickly at the cell. A SPCO cut the ligature from Mr Winchcole's neck. The SPCO said in his statement that Mr Winchcole was unresponsive and not breathing. A nurse arrived and used her radio to call a code blue emergency (meaning a prisoner is not breathing, or having difficulties doing so). This prompted the control room to request an ambulance automatically. The nurse made this call at 7.10am. Ambulance service records show that they received the request for an ambulance at 7.11am.
72. The nurse told the prison officers to begin cardiopulmonary resuscitation in an attempt to revive Mr Winchcole, while she assessed him. They did so but, on examination, the nurse could see that Mr Winchcole was clearly dead, with hypostasis (discolouration of tissue) and extensive rigor mortis. Other nurses arrived, and having assessed Mr Winchcole and discussed him with the nurse and agreed with her assessment. They said that that attempting resuscitation was inappropriate and instructed the prison officers to stop.

Information from Mr Winchcole's friends after his death

73. His friend told the investigator that Mr Winchcole had seemed to be alright in the weeks before he died. On one occasion he had got a bit upset when he received some unwelcome news from his probation officer (presumably the Parole Board letter of 24 August), but that was all. He said Mr Winchcole had no particular problems on the wing, there were no incidents of bullying and he was not in debt. He said he never saw Mr Winchcole under the influence of drugs and that Mr Winchcole denied using drugs. However, he suspected that he was using PS at least occasionally. As far as he was aware, Mr Winchcole did not have any serious issues and his death came as a total surprise.
74. Another friend also said that Mr Winchcole had no problems on the wing, no bullying problems or debt. He liked to play poker but only for commodities such as shampoo or shower gel, which were easily within his means. He said that Mr Winchcole was a frequent user of PS and seemed to be under the influence of it most days, with bloodshot eyes, dilated pupils and unsteady on his feet. He said that when Mr Winchcole was using PS, he was happy and positive, and he tended to be more withdrawn and negative when he was not.
75. An intelligence report submitted to the security department after Mr Winchcole's death recorded that a prisoner thought he might have been under the influence of an illicit substance the evening before he died.

Post-mortem report

76. The post-mortem found that Mr Winchcole died as a result of hanging.
77. The toxicology report showed traces of PS and unprescribed medication (tramadol, a strong opiate-based painkiller) in Mr Winchcole's system at the time of his death.

Contact with Mr Winchcole's family

78. A SPCO was appointed family liaison officer (FLO). He identified Mr Winchcole's mother as his next of kin and travelled to her address to inform her of her son's death. In line with guidance, Forest Bank offered a contribution to the cost of Mr Winchcole's funeral.

Support for prisoners and staff

79. After Mr Winchcole's death, one of the prison's managers 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.
80. The prison posted notices informing other prisoners of Mr Winchcole'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 Winchcole's death.

Findings

Risk assessment and management

81. When Mr Winchcole arrived at Forest Bank on 28 May, staff correctly identified that he was at risk of suicide or self-harm and began ACCT procedures to support him. He remained under ACCT management until the end of June. He was also moved into the healthcare unit for additional support from 4 to 18 June. When he left the inpatient unit, he was appropriately located in the vulnerable prisoner unit.
82. We are satisfied that Mr Winchcole received appropriate support under ACCT and that it was reasonable to close the ACCT on 26 June when he seemed more settled and his mood had lifted.
83. We are, however, concerned that representatives from the healthcare department did not always attend ACCT reviews. The clinical lead said that there had been a low level of staffing in the healthcare department at the time, and it had not always been possible to provide healthcare representation at all ACCT reviews. The healthcare manager said that this has been addressed since Mr Winchcole's death, but we consider that healthcare attendance at ACCT reviews is something that needs to be kept under review.
84. We are satisfied that Mr Winchcole received a good level of support from his key worker, and his entries in Mr Winchcole's prison record show that he had regular quality conversations with him.
85. Mr Winchcole's friends in the vulnerable prisoner unit said that, so far as they were aware, he did not have any specific problems in the prison. Although there was a single piece of intelligence the week before he died that suggested he might be being bullied, staff kept watch on the situation and there were no further indications. Staff observed him and the other prisoner interacting normally.
86. Mr Winchcole's friends said that they were unaware of him having any problems with bullying or with debts. He had been frustrated by a problem with his bank but a member of staff had been helping him with this and he had been making some progress. Those who knew Mr Winchcole said that his death came as a shock to them.
87. Prison Service Instruction (PSI) 64/2011, Management of prisoners at risk of harm to self, to others and from others (Safer Custody) lists a number of risk factors and potential triggers for suicide and self-harm, and that includes Parole Board hearing refusals.
88. In August, the Parole Board told Mr Winchcole that, having considered the circumstances of his recall to prison, he was not to be released at that stage. There were no indications that this was unexpected or that Mr Winchcole was particularly adversely affected by this. It was, however, potentially upsetting news. As a prisoner serving an indeterminate sentence, Mr Winchcole did not have any idea how long he might remain in prison, and we would have expected staff to have considered whether this affected Mr Winchcole's risk to himself, particularly as he had been on an ACCT two months previously.

89. However, we accept that staff had no reason to consider that Mr Winchcole was at risk of self-harm in the period before his death.
90. We make the following recommendation:

The Head of Healthcare should ensure that healthcare staff attend ACCT reviews as required.

Use of illicit drugs

91. HMIP found that drugs were easily available in Forest Bank in 2016 and the IMB has also expressed concern about the availability of drugs. We note that use of drugs is a potential risk factor in self-harm and suicide.
92. Mr Winchcole had a history of drug use. There was no evidence to suggest that he had used drugs since returning to Forest Bank but an intelligence report that was submitted to the security department after his death said that a prisoner thought that he might have been under the influence of an illicit substance the evening before he died. One of Mr Winchcole's friends told the investigator that Mr Winchcole used PS most days and, when he saw him on the evening of Sunday 9 September, he suspected that he might have been under the influence of something.
93. If Mr Winchcole was using PS regularly, it is surprising and disappointing that staff were not aware of this.
94. No drugs or drug paraphernalia were found by prison staff who cleared Mr Winchcole's cell. However, post-mortem toxicology tests showed the presence of PS and tramadol (which had not been prescribed) in Mr Winchcole's system. We cannot rule out the possibility that this affected his mood and contributed to his decision to take his life.

Mr Winchcole's healthcare

95. The clinical reviewer is satisfied that the healthcare provided to Mr Winchcole in Forest Bank was appropriate and at least equivalent to that which he could have expected to receive in the community.
96. She noted that Mr Winchcole was reluctant to engage at times, which resulted in him isolating himself, but that there was no suggestion that he did not have the mental capacity to make this decision. She also noted that there was limited formal risk-assessment during contact with Mr Winchcole on some occasions which might have been a missed opportunity to improve his engagement overall. There was also no risk assessment made of Mr Winchcole following the refusal of parole in August.
97. The clinical lead said that a mental health nurse should be allocated to prisoners in the inpatient unit but that this resource was not available during Mr Winchcole's time there. Moreover, the risk assessment templates that were in use at the time were not completed. We were told that these issues have now been addressed. Nevertheless, we make the following recommendations:

The Head of Healthcare should:

- **Ensure that a mental health nurse is allocated to each prisoner in the inpatient unit; and**
- **Introduce a more structured risk assessment tool which should be used during the ACCT process and when there is an escalation of risk.**

Time out of cell

98. At the end of June, the prison Director put introduced a restricted regime on a temporary basis. Until the end of August, prisoners were not allowed out of their cells for association on Saturday or Sunday afternoons, or on Monday or Friday evenings. There would be additional periods of association instead on Monday and Friday afternoons. On 29 August, the Director extended these temporary regime restrictions until the end of November.
99. This meant that on Friday 7 September prisoners were unlocked for breakfast for an hour, then unlocked again between 2.00pm and 4.00pm for afternoon association. Over the weekend, prisoners would have been unlocked between 8.30am and 10.30am, after which they were out of their cells to collect their meals, attend chapel, exercise, gymnasium or collect their medication.
100. This could be particularly difficult for prisoners like Mr Winchcole who had to spend that time alone in a single cell. Mr Winchcole did have a tendency to isolate himself, through his own choice, and there is no evidence to suggest that this restricted regime played a part in his death. Nonetheless, we make the following recommendation:

The Director should ensure that during a restricted regime staff consider whether any prisoner's risk of suicide or self-harm may be raised by spending a long time in their cell, particularly in the case of prisoners in single cells.

Emergency response

101. Prison Service Instruction 03/2013 requires prisons to have a two-code medical emergency response system. As is usual, Forest Bank use code blue to indicate an emergency when a prisoner is unconscious or having breathing difficulties, and code red when a prisoner is bleeding. Calling an emergency code should automatically trigger the control room to call an ambulance. It also tells healthcare staff what equipment they need to take to the emergency.
102. When a PCO found Mr Winchcole hanging, he called for senior staff and healthcare staff, but did not call a code blue emergency. This meant that a nurse did not know what situation she was about to face and that the control room did not immediately request an emergency ambulance. An ambulance was not summoned until the nurse called a code blue emergency. Between the PCO finding Mr Winchcole and the control room requesting an ambulance there was a delay of approximately four minutes.
103. In this instance, it is fairly clear that Mr Winchcole had already been dead for some time when the PCO found him, and the delay did not affect the outcome. In

emergencies, however, seconds can be vital and in another situation, such a delay could have serious consequences. We make the following recommendation:

The Director should remind staff of the importance of using the correct codes in an emergency, and the potential consequences of not doing so.

Inquest

104. The inquest, held from 19 to 23 February 2024, concluded that Mr Winchcole died by suicide.

**Prisons &
Probation**

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