

**Investigation into the circumstances surrounding the
death of a man
at HMP Winchester in January 2009**

**Report by the Prisons and Probation Ombudsman
for England and Wales**

August 2009

This is the report of an investigation into the circumstances surrounding the death of a man in January 2009 at HMP Winchester. He had been found hanging in his cell.

I offer my sincere sympathy and condolences to the man's family and all those affected by his passing.

The investigation was carried out by one of the Ombudsman's investigators. I am grateful to the clinical reviewer and his team at the PCT, who reviewed the primary medical care which the man received whilst in custody. The primary care review team makes three recommendations, which I fully endorse.

I would like to thank the Acting Governor of HMP Winchester, the Governing Governor (the governor at the time of the man's death) and staff for their full and ready cooperation during the course of the investigation.

The man was serving an Indeterminate Sentence for Public Protection (IPP). He was a foreign national prisoner. It is believed that soon after his imprisonment, his wife's mother took his daughter to live abroad. He felt frustrated at the possibility of not seeing his daughter again, which may have been a factor in his death.

Prior to the man's death, there have been 11 other deaths at Winchester since the Ombudsman began investigating deaths in prison custody in 2004. Five of the deaths were self-inflicted, although there are no specific similarities to the man's circumstances.

This report makes seven recommendations.

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SUMMARY

The man arrived in the UK in 1999 having left his home country because of the conflict. He was granted entry as an asylum seeker. He later formed a relationship with a Ukraine national, and they had a daughter together in February 2007. During his relationship with his partner, the man abused alcohol.

On 26 July 2008, the man was arrested for a violent offence against his partner and was remanded into prison custody at HMP Bullingdon two days later. He was identified as a foreign national. No concerns were noted in respect of him harming himself and his cell sharing risk assessment was rated as "Low".

An Assessment, Care in Custody and Teamwork (ACCT) document (which enables staff to monitor individuals at risk of harming themselves) was opened on 21 September. The man said he wanted to cut his wrists because of the distress caused by losing his family in the bombings in his home country. (Members of his family, including his son had fled his home country to India seeking safety.) He was also worried about his 20 month old daughter, who he had not seen since his imprisonment and who had been taken to the Ukraine by his mother-in-law. Prison staff took steps to monitor his well-being and offered support, including a referral to the Mental Health In-Reach Team.

The man's ACCT document was closed on 5 October. He said that he had no more thought of wanting to harm himself or commit suicide, despite his daughter being at the forefront of his thoughts. He was looking forward to the future, after his release from prison, when he would be with her again. At the post closure ACCT review on 14 October, no concerns about his well being were identified. A psychiatric mental health assessment completed later said that, despite his risk to himself being "Low", he said he would consider ending his life if unable to see his daughter.

On 10 November, the man appeared in court and pleaded guilty to the charges. He was given an IPP sentence of two and a half years imprisonment. The judge also recommended deportation after his prison sentence.

The man was transferred to Winchester on 2 December 2008. No concerns were noted on his prison records about his well-being during his stay at Winchester. He started an education class, "English for Speakers of Other Languages", and was described by the teacher as a good communicator and fluent speaker, but less advanced in reading and writing.

The man had contact with the prison probation officer on four occasions, the last on the day of his death in January 2009. No concerns were noted about any risk to himself. He also had contact with an immigration officer on the same day. It was an introductory meeting and the man was advised that he might be deported. He did not appear distressed by the information and did not raise the issue as a significant concern with staff later that day.

The evening roll check was carried out between 7.40pm and 7.50pm. The man, when checked, was seen standing in his cell. When the roll check was completed, a

recount was ordered. During the second roll check, about ten to 15 minutes after the first, he was discovered hanging by a ligature from the window bar in his cell.

The alarm was raised immediately and staff attempted to resuscitate the man. They continued for around 40 minutes until an emergency ambulance crew arrived. The paramedics continued to check for signs of life but his death was pronounced at 8.46pm.

THE INVESTIGATION PROCESS

1. One of the Ombudsman's senior investigators was appointed to lead the investigation into the man's death. A governor arranged for the man's records to be copied and sent to him. The investigator sent notices to the prison, inviting staff and prisoners to contact him with information that was relevant to the investigation. The investigator subsequently interviewed a number of staff. A nurse, who had contact with the man in the prison reception, was unavailable to be interviewed as she was no longer employed by the prison. The officer who discovered him in his cell, was also unavailable to be interviewed, due to a period of sick leave. No prisoners came forward with any information. The investigator also interviewed the officer the UK Border Agency (UKBA), who spoke with the man on the day of his death.
2. One of the Ombudsman's family liaison officers tried to contact the man's partner, but was unsuccessful. My report will be available should she or their daughter wish to see it in the future.
3. The local NHS identified a clinical review team to carry out a review of the man's healthcare during his stay in Winchester. The investigator also shared his interview transcripts with them. I am grateful to the primary care integrated governance development manager, and the doctor who lead the team, for undertaking the review.

BACKGROUND

HMP Winchester

4. HMP Winchester is a category B local prison built in 1846 to a Victorian radial design. Winchester is currently undergoing major refurbishment with a build programme lasting five years. Work which has already been completed includes safer custody changes to the healthcare centre, first night centre and detoxification unit, a new electrical system, renewal of the fire and general alarms, a new visits complex and pedestrian access at the main gate.
5. The rebuild of C wing has recently been completed and the prison now has a maximum capacity of 707. The accommodation is mostly double cells with all prisoners being in security category B or below. Winchester holds both remanded and convicted prisoners. In July 2009, Winchester held 55 foreign national prisoners.

Assessment, Care in Custody and Teamwork (ACCT)

6. The ACCT process monitors and supports prisoners assessed as at risk of suicide or self harm. (The previous system was known as the F2052SH procedure.) Once an ACCT is opened, the prisoner is observed at intervals determined by their perceived level of risk.
7. Each prisoner is assessed within 24 hours of the ACCT being opened and is reviewed again at intervals determined by their circumstances. The ACCT guidance says that, to be effective, the review should involve the people who know the person at risk and are involved in their care.

Cell Sharing Risk Assessment (CSRA)

8. In order to make sure that unsuitable prisoners do not share cells (for example, a racist prisoner and one from a visible ethnic minority), a cell sharing risk assessment is completed by reception staff when a prisoner first arrives at the prison.

Multi Agency Risk Assessment Conference (MARAC)

9. The goal of these conferences is to share information and take action to reduce future harm to victims of domestic abuse and their children.

Roll check

10. The roll check is the count of the number of prisoners on each wing within a prison. Roll checks occur on a number of specified occasions during the day and night, and staff sign that the roll is correct.

Indeterminate sentences for public protection (IPP)

11. No IPP prisoners can expect release before their tariff expires and, even then, the Parole Board must be satisfied that the risk of harm posed to the public is reduced and manageable. This means that some prisoners remain in prison for lengthy periods beyond their tariff to prevent further harm to the public.

HM Chief Inspector of Prisons (HMCIP) inspection 2007

12. HM Chief Inspector of Prisons last inspected Winchester in April 2007. She published her report in June 2007 and commented:

“Like all local prisons it faces considerable pressures and increased demands. There was some evidence, at this inspection, that this combination was testing the prison’s ability to sustain and continue improvements.

“Winchester remains a reasonably well performing local prison, in spite of the pressures in the prison system as a whole. However, there are some warning signs – the lack of sufficient activity spaces in the main prison, the somewhat dislocated resettlement places and, in particular, the fact that residential staff are not fully engaged in the support and rehabilitation of prisoners. These are all matters that prison managers, and the National Offender Management Service, will need to monitor closely.”

13. The Chief Inspector wrote:

“There were 24 prisoners serving indeterminate sentences for public protection (IPP) and 23 mandatory and discretionary lifers, of whom seven were recalls. Multi agency lifer risk assessment panels were organised after sentence and were well attended and documented. The lifer systems were good but communication with prisoners was poor.

“Offender supervisors reported difficulty in forging positive links with offender managers in the community. Communication links could have been improved by the involvement of probation staff working in the prisons.

“IPP prisoners frequently did not understand the implications of this type of sentence and were not issued with any relevant information. Three prison staff had completed the relevant lifer training, although only the lifer officer presently had any ongoing contact with lifer prisoners.

“Life-sentenced prisoners and those subject to indeterminate public protection sentences should be assigned lifer officers who have received appropriate training.

“Arrangements for clinical information-sharing within the prison and the guardianship of confidentiality were unclear and there were no appropriate policies and some evidence of inconsistent practice.”

The Independent Monitoring Board (IMB) Annual Report 2007/08

14. The Prisons Act 1952 requires every prison to be monitored by an independent board appointed by the Secretary of State for Justice from members of the community in which the prison is situated. The IMB must satisfy itself as to the humane and just treatment of those held in custody within the prison it monitors.
15. The IMB's most recent annual report was published in May 2008. The section on safer custody says:

“Over the past year, the prison has taken a number of positive steps forward in terms of safer custody. There was a noticeable increase in “ownership” of this aspect of prison management, much of it owed to the efforts of a new Suicide Prevention Coordinator, and the close interest taken by the supervising Governor.”

KEY FINDINGS

Prior to the man's transfer to HMP Winchester

16. The man was arrested in July 2008 for an offence committed against his partner. He appeared in court where he was charged with wounding with intent. He was remanded into prison custody and taken to HMP Bullingdon.
17. During his prison reception health screening and induction programme, the man was recognised as a foreign national. No concerns were noted about the risk of him harming himself. His cell sharing risk assessment (CSRA) was rated as "Low".
18. On 21 August, a Multi Agency Risk Assessment Conference (MARAC) meeting took place. Amongst other issues, members of the meeting reported that they had been in contact with the man's partner. She had explained that there had been tensions in their relationship, which derived from his gambling and abuse of alcohol. She had recently told the man that she would leave him. Following the incident for which he was imprisoned, his partner said that she did not intend to return or maintain any contact with him.
19. Around 8.00pm on 21 September, an ACCT document was opened. Staff reported that the man had said he wanted to cut his wrists because he had:

“ ... fallen out with his daughter. The rest of his family have been killed in a bombing by the US Forces. All of this has become too much for him to bear and he is finding it difficult to come to terms with.”
20. The man was placed in a shared cell and monitored every hour. Staff were also required to have at least one conversation with him each shift. He was offered access to a Listener (prisoners trained by the Samaritans to offer support to other prisoners) who spoke the same language.
21. An ACCT assessment was conducted the following morning. The man said that he was worried about his 20 month old daughter, who he had not seen since his imprisonment. He believed that his mother-in-law (who he did not get on with) had taken her to the Ukraine. He said his life revolved around his daughter and he felt like harming himself, but did not want her to be fatherless.
22. Staff offered the man support and told him that he could speak to staff and Listeners whenever the need arose. He was referred to the Mental Health In-Reach Team.
23. The man, the Listener and three members of staff attended an ACCT case review on 26 September. He said he had no current thought of harming himself, despite his mood being low at times. His level of risk to himself was considered low, although the ACCT document remained open and irregular hourly observations continued. As part of his support, it was arranged for him to be allocated a job on the wing, and he also went to education classes.

24. On 2 October, during his education class, the man told the teacher his concerns regarding his daughter. He had written to his solicitor and the social services, but had no confidence in their ability to help. Wing staff spoke to him later that evening and he said that, despite his concern for his daughter, he was okay.
25. A second ACCT case review took place on 3 October. As well as the man and the Listener, two officers and a member of the Mental Health In-Reach Team were present. A member of the Public Protection team was able to contribute to the meeting via a telephone conference call. The man said he was still worried about his daughter. However, he said that he had no current thoughts of harming himself, and that his solicitor's help to find his daughter improved his mood. The ACCT document remained open and he was reminded again about the support available to him.
26. Two days later (5 October), a further ACCT case review was held. Two members of staff, the man and a translator attended. He said that he had no thought of harming himself or to commit suicide. His daughter was at the forefront of his thoughts and he was looking forward to the future, after his release from prison, when he would be with her again. His risk of self harm was again assessed low, and staff felt that the ACCT document could be closed. His interaction with his peers and staff was considered good. He was reminded that he could approach staff for help and support whenever he needed it. A post closure ACCT review date was arranged.
27. The post closure review took place on 14 October. The man said he no longer felt suicidal and had settled well into the prison. His daughter's move to the Ukraine was still an issue, although he was writing to her and maintaining contact with other friends. As no concerns about his well being were identified, the ACCT document remained closed.
28. The man was seen by the Mental Health In-Reach Team's clinical psychologist on 16, 21 and 28 October. He talked a lot about the trauma he had experienced in the past. He also referred to his worries about his family situation, and particularly being unable to see his daughter. Although he said he kept himself busy in prison, his body was there but not his mind. He repeated that he had no current thoughts of harming himself.
29. On the instruction of the Crown Court, a psychiatric assessment of the man was made by a doctor on 31 October. Amongst his findings, the doctor reported:

"From the available information, I am of the opinion that [the man's] current risk to himself is low. However, he told me that he would consider ending his life if he were unable to see his daughter."
30. A pre-sentence report written by the man's probation officer on 6 November was submitted to the Crown Court. The report included the following statement:

"During the course of the assessment it has been identified that there are concerns about suicide and coping in custody. This is due to [the man] saying he would kill himself if he lost his daughter. He also raised

concerns that he believes his daughter is no longer in the country. He did not expand on why he believed this.”

31. The man appeared at the court hearing in November and pleaded guilty to the charges laid against him. He was given an indeterminate sentence for public protection (IPP) of two and a half years imprisonment. He returned to Bullingdon where he remained for approximately three weeks. No concerns were noted about his well-being.

The man’s transfer to HMP Winchester

32. On 2 December, the man transferred to HMP Winchester. He arrived at around 12.25pm and repeated the normal prison reception process. A senior officer completed a CSRA document and noted “no immediate issues, ACCT closed 5/10/08”. She told my investigator that she had no concerns about the man. He was also seen by a nurse from the healthcare team, and she noted on the CSRA that no suicide or self harm issues were expressed.
33. All new prisoners should receive a health screening on their arrival at a prison. Despite the man’s contact with the healthcare nurse, there is no evidence in his file to indicate that she conducted a healthcare screening and neither were there any entries on the computer.
34. When the man arrived at Winchester, the healthcare nurse worked as an agency nurse who covered staff absences. She had previously worked permanently at the prison and should have been familiar with the reception process. My investigator was unable to trace the healthcare nurse to interview her.
35. Another nurse told my investigator that she had worked in Winchester for over 15 months. She carried out general nursing duties in the reception area and on the wings. She said the average reception health screen should last approximately 15 minutes, and include questions about the prisoners medical history. The prisoner would also be asked about any past and present self harm tendencies, mental health and drug or alcohol addictions. Their needs would be assessed and the information be recorded on the healthcare computer system, Vision. A secondary health screening would also take place within a week.
36. The nurse who carried out general nurses duties said that the nurse who completes the CSRA also carries out the initial health screen. As she was not present on the day the man arrived, she was unable to explain why the healthcare nurse did not complete his health assessment, or if she had, why it had not been recorded on the computer.
37. The man was issued with Winchester’s information booklet for foreign national prisoners and allowed to telephone his partner. Although his offence was against his partner, no restrictions had been placed upon contact with her. He was located on A wing where he received his prison induction. He confirmed

that, although he could speak English, he could only read and write a little. He expressed no thoughts of harming himself.

38. The following day, 3 December, the man completed his induction and moved to B wing. The investigator found very few entries on his wing history sheet denoting how he spent his time there. Indeed, the history sheet contains only one significant entry made by his personal officer (this is referred to later in the report).
39. His probation officer, introduced himself to the man on 4 December. At interview with the investigator, the probation officer said that he provided an information leaflet on IPP and they discussed his sentence and sentence plan. The main objective of the meeting, other than to check on his general welfare, was to encourage him to use his time in prison constructively.
40. The probation officer had a second meeting with the man on 18 December. He said he had no problems on the prison wing. His partner would visit him in a week's time (my investigator found no evidence to support this) and he intended to talk about their daughter. His conversation with the probation officer included a discussion about self harm issues as the probation officer had read that the man had been placed on an ACCT whilst at Bullingdon. His explanation was that it had been a mistake. He had asked to see somebody because he was concerned about his daughter. He said prison staff misunderstood him, believed he was depressed and possibly suicidal and suggested he speak to a Listener. The man told the probation officer that he had not felt suicidal and the ACCT document should not have been opened.
41. The man also told the probation officer that he had applied for education and they discussed various courses he could do. A sentence planning meeting would be arranged in due course and they agreed that an interpreter would provide assistance.
42. At interview with the investigator, an officer confirmed that he was appointed as the man's personal officer. He said that he would normally make entries in the history sheet every two to three weeks about a prisoner's well being. He would also speak with prisoners when he was on duty to make sure they were well.
43. The personal officer introduced himself to the man on 20 December. He had no problems communicating with him and recorded that he had no concerns about him. He described him as quiet, introverted and someone who did not mix with other prisoners. The personal officer could not fully explain why he had made only one significant personal officer entry, but believed it to be a consequence of working different shift patterns, included nights.
44. The man met with the probation officer again on 22 December and told him that he had started education, taking English as a second language. No concerns were noted.
45. The following day, the man went to his education induction. His teacher told the investigator that she took the class "English for Speakers of Other

Languages” (ESOL). She worked at the prison on Monday, Tuesday all day and Friday mornings, delivering two and a half hour classes. The teacher described the man as a good communicator and a fluent speaker, but a beginner at reading and writing. He was allocated to the afternoon beginner classes, where the teacher was assisted by two volunteer retired teachers.

46. There are no entries on the man’s wing history sheet over the Christmas and New Year period, and it is not clear how he spent the time. However, amongst his prison records provided to the investigator was a copy of his telephone log. The log showed that during the period 2 December 2008 to 4 January 2009, he made approximately 124 telephone calls to his partner’s home and mobile telephone number. Of these, only eight calls were accepted.

Events on 5 - 6 January 2009

47. The man went to his education class in the afternoon on Monday 5 January. The teacher said that he arrived before the other prisoners. He talked to her about his frustration with getting legal help to bring his daughter back to the UK from the Ukraine. He told her that his partner had taken his daughter and he would never see her again. He said he was trying to find a solicitor to take on his case, but did not understand the paperwork. The teacher said that if he brought the papers to their class the following day, she would ask one of the assistants to explain what was written and help him to compose a letter.
48. For the remainder of the class, the man was “upbeat and chatty”. He talked about how he intended to use his time in prison to improve his English and participate on other courses, including an alcohol awareness course.
49. The next day (Tuesday 6 January), just before 2.00pm, the man again arrived at his English class a few minutes earlier than other prisoners. He showed some pictures of his daughter to the teacher and talked about her and his partner. He had brought the papers mentioned the previous day and the teacher said she would ask one of her assistants to help him later.
50. Part way through the man’s English class, he was visited by an immigration officer from the UK Border Agency. At interview, the immigration officer told my investigator that one of her roles is to act as a link between prisoners and UKBA caseworkers. Winchester was one of the prisons that she dealt with and UKBA staff conducted weekly surgeries in the prison. Officers would speak to prisoners to confirm their identity and deal with problems regarding their immigration status. The role was primarily liaison, and the immigration officer said she did not serve deportation papers on prisoners.
51. The man was listed as a foreign national according to information the immigration officer received from the prison’s foreign national administrative team. She checked the list to see where he was located and was directed by staff to his education class. She asked the teacher if she could speak with him outside the classroom.

52. The immigration officer introduced herself to the man and said that she had asked to see him because he was a foreign national prisoner. It was customary for foreign nationals to be served with forms that required information from themselves and UKBA. The immigration officer wanted to ensure that the man understood that he would soon receive the forms and that she would be available if he needed any help completing them. As his sentence was more than a year, the court had recommended his deportation. One of the forms which he was likely to receive was a form called an AC350, which states that the prisoner has been recommended for deportation. They are invited to submit any representations as to why they should not be deported. In response the man told the immigration officer that he had indefinite leave to remain in the UK and was applying for naturalisation. She said that the authorities can withdraw indefinite leave status if a judge recommends deportation. For this reason, she told the man to ensure he dealt with any paperwork as soon as it arrived.
53. The immigration officer told my investigator that the man's English was of "a reasonable level" and he did not object to talking to her. He confirmed that he had not yet received any immigration documentation. They discussed his prison sentence which the immigration officer had previously been unaware of.
54. Throughout their conversation, the man was more interested in talking about his daughter and had engaged a solicitor to assist him gain access. The immigration officer listened to him but told him that it was not an immigration matter and so she would not be able to advise him. She told him to continue to pursue matters with his solicitor and talk to prison staff. During their five minute conversation, she considered that the man appeared not to be distressed.
55. The immigration officer explained that she regularly moved around the prison to find and talk to foreign national prisoners but did not routinely record her contacts. The prison administrative team who dealt with correspondence for foreign nationals would be aware that she had made contact with prisoners, but it would not necessarily be recorded in their prisoner wing history record or wing log book. She did not normally have any information in advance about any of the prisoners. For example, the immigration officer said she was unsure whether or not the man would have needed an interpreter. If she had found this to be necessary, the meeting would have been rescheduled in order to arrange an interpreter.
56. When asked by the investigator, the immigration officer said she was unaware of the ACCT procedures used in prisons. She was unaware that he had previously been on an ACCT. She said that if she had any concerns about a prisoner, she would pass them to the administration team. There was no procedure that contacts had to be reported to the team. She did, however, let them know who she had seen.
57. At interview with Winchester's Safer Custody Officer, the SO told my investigator that she was aware that UKBA staff did not always note their contact with prisoners in the wing observation book. She thought that it should

be done, especially as it could assist gauge a prisoner's mood if there were concerns following the immigration contact.

58. The man spoke with the immigration officer for around five to ten minutes, after which he returned to the classroom. There were no concerns about his mood and he was not "agitated". The teacher said he mentioned that deportation had been discussed. He felt confident that he would not be deported as he had British nationality. He then spent the next 30 to 40 minutes composing a letter, with the help of the volunteer, to engage a new solicitor. He then joined the rest of the class and finished a reading with them.
59. The teacher said that the man was thinking about his daughter a lot, although he still interacted with the group. She described him as "a quiet man, but able to express his feelings well and although preoccupied, [he] did not give the impression of being suicidal or severely depressed".
60. The probation officer said he went to the education class at around 3.00pm to see the man. They talked in a nearby private room for about 30 minutes. The probation officer said that the man's mood did not concern him. He talked again about his daughter and said he did not get on with his mother-in-law, which limited his contact with his daughter. He intended to write to a family solicitor for advice and was preparing a letter in the education class.

The evening of 6 January

61. The principal officer (PO) was the Orderly Officer (meaning that he was the officer in charge of the prison) on this day. He told my investigator that he began to lock up the prison about 7.45pm.
62. An officer told my investigator that he recalled checking the man's cell during the evening roll check between 7.40pm and 7.50pm. He saw him standing up and looking into the right hand corner of the cell. It appeared as if he was either watching the television or waiting for the kettle to boil.
63. At about 8.00pm, staff started to come into the centre office to report their roll count numbers to the PO. The figures for B wing were different to those he expected and so he asked the officer who did the roll check and his colleague to recount the numbers on B wing. (the colleague was on sick leave during the course of the investigation and has not been interviewed.)
64. The officer who did the roll check said the second roll count check was carried out immediately after the discrepancy was found. It was about ten to 15 minutes since he first checked the man's cell. His colleague assisted him re-check the roll on the fourth landing. As she arrived at the man's cell, the officer that did the roll check checked the opposite cell. His colleague looked through the observation panel and saw the man hanging by a ligature from the window bar. She immediately raised the alarm by shouting and calling for assistance.
65. The officer who did the roll check said that he rushed to the cell, and he too saw the man hanging. He unlocked and went into the cell and used his ligature

knife to cut the ligature, holding the man up as he did so. He said the ligature was “dug right into his neck”. His colleague continued shouting for assistance whilst the officer who did the roll check supported the man’s body. (Although he had been first aid trained, the officer who did the roll check told my investigator that his first aid certificate had expired.)

66. Having heard the shout for assistance, the PO immediately ran to the fourth landing on B wing, instructing a number of staff to come with him. He arrived at the cell in about 30 seconds and saw the officer who did the roll check lowering the man to the floor. He immediately used his radio to contact the Control Room and alerted them to a Code 1 situation (Code 1 is a radio code which denotes a life threatening situation). An ambulance was requested. The PO said that the officer’s colleague was in a state of shock so he asked an SO (a Care Team member) to come to B wing to offer support.
67. Two further officers both responded to the loud shouts for staff assistance at about 8.00pm. One arrived at the cell in seconds and helped the officer who did the roll check, lower the man to the floor slightly outside on the landing, where there was more room for staff to attend to him.
68. The other responding officer told my investigator that he arrived at the man’s cell approximately 45 seconds after hearing the shouts. The first responding officer and the officer who did the roll check were in the midst of lifting the man down from the wall. The other responding officer said it was obvious to him that he had been hanging as the ligature was still around his neck. He assisted his colleagues to lift the man down and laid him on the floor.
69. The other responding officer is an experienced first aider, although his first aid certificate had recently expired. The man was unconscious. The officer checked for signs of life, and believed that he was breathing, albeit very shallowly. He also thought that he could feel a very rapid and weak pulse. Because it was thought that there were signs of life, the officers decided to put him in a recovery position. The other responding officer was aware that healthcare had already been alerted and he said it took about two minutes for healthcare staff to arrive. They arrived as the man was placed in the recovery position.
70. The healthcare nurse told my investigator that she was about to finish work for the day. She responded to a radio Hotel One emergency call (an emergency request for a member of healthcare) to go to B wing, fourth landing. She immediately went to the wing, whilst another nurse went to collect the emergency bag. (A Code One call requires healthcare to take the emergency bag to the incident.)
71. On her arrival at the man’s cell, the healthcare nurse saw him lying on the floor in a recovery position. She examined him quickly to look for signs of life, but found none. The second nurse then arrived with the emergency bag.
72. The second nurse told my investigator that he too checked the man for signs of life. He found no pulse and could see no chest movement indicating that he

was breathing. He decided to reposition him onto his back and take him back into the cell where he could insert an airway, and attach an ambi-bag (an oxygen delivery device) to give him oxygen. The healthcare nurse carried out cardio pulmonary resuscitation (CPR) compressions with the help of the other responding officer.

73. The second responding officer said that CPR continued for approximately 40 minutes, which was the time it took for the ambulance to arrive. During this time, healthcare staff asked for the defibrillator (a machine which detects electrical activity in the heart and advises the user whether there is a shockable rhythm) to be collected from healthcare and brought to the cell. The defibrillator was used to assess the man and it repeatedly instructed that CPR should continue.
74. The safer custody officer was also alerted to the emergency on B wing. When she arrived she saw staff carrying out CPR. She assisted by keeping a count of the number of compressions the staff were doing. She told my investigator that she last had first aid training in 1999.
75. The safer custody officer said it was tiring for the staff carrying out CPR as the ambulance took a long time to arrive. Staff repeatedly asked where the ambulance was. After about 20 minutes, the PO asked the Control Room to contact the emergency services again. The message from the ambulance station was that there was no available ambulance or emergency response at that time, and one would be there as soon as possible. The PO contacted the duty governor, to inform him about the evening's events.
76. When the paramedics arrived (approximately 40 minutes after the alarm was raised), they continued to try and resuscitate the man. The ligature around his neck was described by the other responding officer as thin and had caused a deep groove in his neck. The nurses and paramedics were unable to insert an airway. Having gained no response, the paramedics declared the man had died around 8.46pm.

After the man's death

77. The duty governor arrived at the prison at 8.46pm, just as the paramedics had confirmed the man's death. He immediately invoked the death in custody contingency plans and ensured that all the necessary agencies, including the police, were contacted. The man's cell was sealed and staff were instructed to obtain the details of his next of kin. The care team were deployed to offer care and support to any member of staff.
78. The duty governor spoke to all the staff involved when the man was discovered and ensured they received support from the care team SO. He also held a hot debrief at 9.30pm where staff were given the opportunity to discuss their involvement. The governing Governor at the time, also attended.
79. A letter written by the man and addressed to his partner was found in his cell. The letter was written in Russian and the police subsequently arranged for it to

be translated. He professed his love for his partner and child, said that he missed them and could not live without them. He repeatedly asked for his partner to answer the telephone when he called, to visit him and send pictures of his daughter. He also mentioned that he was told he could be deported. Although he referred to wanting a last visit from his partner, he did not indicate that he had any intention of taking his own life.

80. An SO was appointed as the prison family liaison officer (FLO). The duty governor said that the staff worked through the night checking the man's records and confirming his next of kin. The following morning, the prison FLO and the chaplain visited the man's partner to inform her of his death. She was provided with information and relevant contact numbers for the prison. Financial assistance towards the funeral cost was offered. His partner informed members of his family in the UK about his death. They arranged for his body to be repatriated back to his home country.
81. As well as informing the Samaritans of the death of a prisoner, all prisoners who were on an open ACCT were reviewed and reminded of the availability of the Samaritans should they need any support.

ISSUES

Clinical care

82. It was evident from my investigation and the clinical review that the medical records for the man were virtually non-existent, with the first and only record being that of the attempt at resuscitation on 6 January 2009. The first reception health screen was not completed nor had the secondary health screen (which should be completed within 72 hours) been undertaken. The man had no contact with healthcare in the time that he was detained at Winchester.
83. Furthermore, the man's medical record from HMP Bullingdon should have been transferred with him to Winchester. There is no evidence whether this had happened. If it had been reviewed by Winchester healthcare staff, they failed to make an appropriate entry in his medical record.
84. The clinical review team makes the following recommendations regarding healthcare assessments and continuity of care. I fully endorse them and believe that they are necessary to ensure that prisoners receive an adequate level of healthcare.

The head of healthcare should ensure that all prisoners' healthcare is assessed at reception and recorded in their medical record. A general health assessment should be completed for all new admissions within a week of the prisoner's arrival as per the prison's policy.

The head of healthcare should review healthcare policies, procedures and protocols in line with PSO 3050 Continuity of Healthcare for Prisoners.

85. The emergency response from staff was timely. The clinical review team concluded that every effort was made to resuscitate the man. However, when staff responded to the emergency Code 1 call, they did not bring a defibrillator with the emergency bag. It is essential that all necessary equipment is immediately taken to a life threatening situation

All emergency equipment should be brought to the scene as soon as a Code 1 call is made.

86. Furthermore, staff found themselves in the unfortunate position of having to carry out CPR for a prolonged period (approximately 40 minutes) because there was no emergency ambulance service available in the area. The clinical review panel contacted the Hampshire Ambulance Service to enquire about the delay. Following this, the clinical review panel commented in the clinical review that:

"It is clear that the Ambulance Service was very busy at the time that the first call was received at 20.00hrs. No unit was available to respond in the Winchester area, and so a message was passed to the nearest available vehicle, which was in Andover Ambulance Station, at 20.03hrs. Due to equipment failure, the crew did not respond, as they were unaware of the call. The Ambulance Service only became aware of this when a further call

was received at 20.24hrs requesting estimated time of arrival. A further ambulance had logged on duty at Winchester Ambulance Station at 20.26hrs, and was dispatched at 20.27hrs, arriving on scene at 20.29.”

87. I would suggest that the Governor and head of healthcare raise this issue directly with the Hampshire Ambulance Service.
88. Carrying out CPR is a demanding task and I commend those staff for their extended efforts in trying to revive the man.

The Governor should commend the staff for their sustained efforts to try to resuscitate the man.

First aid training

89. Three of the officers who responded to the emergency had not had recent first aid training. The Ombudsman has previously recommended in other investigations that first aid training is provided for all staff in contact with prisoners. I suggest that basic life support or first aid training should be reviewed for frontline staff to ensure that their knowledge of resuscitation procedures is up to date. However I acknowledge that it is doubtful that it would have made a difference in this case, as healthcare staff arrived promptly.

The Governor should review the need for first aid or basic life support training for staff on frontline duties.

Personal officers

90. The man was assigned a personal officer. However, only one contact is recorded on his wing history sheet. I believe that the lack of contact reduced the opportunity for staff to be aware of any thought of harming himself. It also meant that no regular reports about his well-being were noted in his prison records, and in particular his concern about future access to his daughter. The personal officer scheme is a fundamental part of caring for prisoners. Every prison should have proper arrangements in place. Needless to say, recording of any significant contact by other staff is also essential.

The Governor should ensure that the personal officer scheme is operational and effective throughout the prison.

The man’s contact with the Probation Service and UKBA

91. The immigration officer was familiar with the prison and regularly visited foreign national prisoners. She had a good relationship with the prison administration department and received information about foreign national prisoners in custody. She was allowed to move around the prison in order to interview prisoners. She had not received any ACCT training.
92. The clinical review team comments that they would expect any prisoner whose status had changed or who had experienced a significant event, such as a visit

from an immigration officer, be reviewed by the healthcare team. It would have been helpful for the immigration officer's contact to be recorded in his wing history sheet or the wing observation book. If staff had any concerns, they could then be relayed to healthcare staff.

93. The immigration officer had no concerns about the man's well-being and he did not seem distressed when he returned to his education class. Nonetheless, deportation is a serious issue and it was not documented that it had been raised with him. No precautions were put in place to routinely check his well-being and they did not know what had happened.
94. The same principles apply to recording the contact with the probation officer. Although the probation officer recorded his meetings on probation records, they were not recorded on the man's wing history sheet or the wing observation book.
95. I have already mentioned the importance of recording information. The Ombudsman made a recommendation previously that the management arrangements for sharing appropriate information across all disciplines in the prison should be reviewed. I take this opportunity to remind the Governor of Chapter 8.11 of Prison Service Order 2700 which says: "Good care can only be achieved through effective communication and teamwork."
96. It is important to ensure that when prisoners have significant contact with staff or any other official, which may have a negative impact on their well being, that the information is recorded. At interview the safer custody officer told my investigator that a recent Governor's Order had been issued reminding staff that they should make regular and quality entries on prison documents. I make the following recommendation.

The Governor should remind staff from other agencies of the importance of providing feedback (written in prison logs and verbal) about their contact with prisoners.

CONCLUSION

97. The man's reception health screen was omitted when he transferred to Winchester. He did not report any health problems although it was highlighted that suicide could be a risk if he was deprived of seeing his daughter. This information was not recorded.

98. The man lost contact with his partner and child whilst in custody, but no one recognised that he might go on to harm self. The large number of telephone calls to his partner – most of which went unanswered - shows a high level of frustration. He spoke about his difficulties to the probation officer, teacher and immigration officer but did not say he was going to harm himself. None of them reported his worries to wing staff. They did not notice any distress so could not have predicted that he would harm self. Sadly it seems that the end of the relationship and the loss of his daughter were the triggers that led to him taking his life. Every effort was made to resuscitate him but the prison and healthcare staff were unsuccessful.

RECOMMENDATIONS

1. The head of healthcare should ensure that all prisoners' healthcare is assessed at reception and recorded in their medical record. A general health assessment should be completed for all new admissions within a week of the prisoner's arrival as per the prison's policy.

The Prison Service has accepted this recommendation.

2. The head of healthcare should review healthcare policies, procedures and protocols in line with PSO 3050 Continuity of Healthcare for Prisoners.

The Prison Service has accepted this recommendation.

3. All emergency equipment should be brought to the scene as soon as a Code 1 call is made.

The Prison Service has accepted this recommendation.

4. The Governor should commend the staff for their sustained efforts to try to resuscitate the man.

The Prison Service has accepted this recommendation.

5. The Governor should review the need for first aid or basic life support training for staff on frontline duties.

The Prison Service has accepted this recommendation.

6. The Governor should ensure that the personal officer scheme is operational and effective throughout the prison.

The Prison Service has accepted this recommendation.

7. The Governor should remind staff from other agencies of the importance of providing feedback (written in prison logs and verbal) about their contact with prisoners.

The Prison Service has accepted this recommendation.