Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Ruslan Voitkun, a prisoner at HMP Bullingdon, on 10 March 2023

A report by the Prisons and Probation Ombudsman

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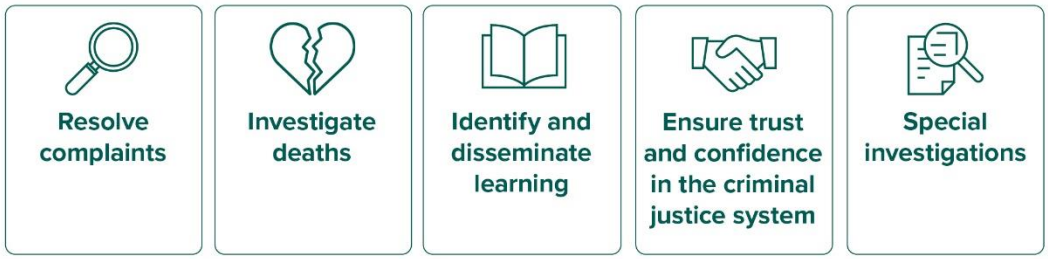
OUR VISION

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

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.

If my office is to best assist HM Prison and Probation Service in ensuring the standard of care received by those within service remit is appropriate, our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.

Mr Ruslan Voitkun died after he was found hanged in his cell at HMP Bullingdon on 10 March 2023. He was 45 years old. I offer my condolences to Mr Voitkun's family and friends.

Mr Voitkun had been at Bullingdon for around four months when he took his own life, the day after he had been sentenced. He consistently denied having any thoughts of suicide or self-harm and hid the level of his distress from staff. The clinical reviewer concluded that Mr Voitkun's healthcare was of a good standard. I make no recommendations.

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

Adrian Usher
Prisons and Probation Ombudsman **April 2024**

Contents

Summary

Events

1. Mr Ruslan Voitkun was remanded into custody in October 2022, charged with harassment and breach of a restraining order against his partner. It was not his first time in prison. In November, he transferred to HMP Bullingdon. He had shoulder pain, high blood pressure and a history of anxiety and depression.

2. During his four months at Bullingdon, Mr Voitkun's key worker met him once. Mr Voitkun's adult son was his main support, and he was worried about him. He tried to maintain contact with his son by telephone, but most of his calls were unanswered.

3. On 9 February 2023, Mr Voitkun was prescribed antidepressant medication due to his low mood and poor sleep.

4. On 8 March, Mr Voitkun phoned his friend, who had spoken to Mr Voitkun's son. His friend told him that Mr Voitkun's son did not want to speak to him.

5. The next day, Mr Voitkun was sentenced to two years imprisonment. Staff assessed him afterwards and had no concerns. Mr Voitkun tried to contact his son, but he did not answer his phone.

6. On the afternoon of 10 March, a prison officer found Mr Voitkun hanged in his cell. Prison and healthcare staff provided emergency care. At 1.50pm, healthcare staff confirmed that Mr Voitkun had died.

Findings

7. Mr Voitkun had several risk factors for suicide and self-harm. He was a foreign national prisoner, he had been charged with an offence against his partner, and he had a history of anxiety and depression. During his time at Bullingdon, he consistently denied having any thoughts of suicide or self-harm and both staff and prisoners did not observe any obvious signs he was in crisis. It is clear from the note that Mr Voitkun left that he felt he had let his son down. However, we have concluded that he hid his distress, and it was reasonable that staff did not identify an imminent risk of suicide.

8. The clinical reviewer concluded that Mr Voitkun's healthcare was of a good standard and at least equivalent to that he could have expected to receive in the community.

The Investigation Process

9. The PPO was notified of Mr Voitkun's death on 10 March 2023. The investigator issued notices to staff and prisoners at HMP Bullingdon informing them of the investigation and asking anyone with relevant information to contact him.

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

11. NHS England commissioned a clinical reviewer to review Mr Voitkun's clinical care at the prison. The investigator and clinical reviewer jointly interviewed ten members of staff. The investigator also interviewed one prisoner.

12. We informed HM Coroner for Oxfordshire of the investigation. He gave us the results of the initial post-mortem examination, but the full post-mortem report was not available at the time of writing. We have sent him a copy of this report.

13. The Ombudsman's family liaison officer contacted Mr Voitkun's next of kin, his son, to explain the investigation and to ask if he had any matters he wanted us to consider. He did not respond.

14. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out two factual inaccuracies, and this report has been amended accordingly.

Background Information

HMP Bullingdon

15. HMP Bullingdon is a local and resettlement prison, serving the courts of Oxfordshire and Berkshire' to 'Oxfordshire, Berkshire, Buckinghamshire and Wiltshire. It holds approximately 1,000 prisoners. Practice Plus Group provides healthcare services and Cotswold Medicare Ltd provides GP services.

HM Inspectorate of Prisons

16. The most recent inspection of HMP Bullingdon was in November 2022. Inspectors reported that, as with many prisons across England and Wales, Bullingdon had a chronic shortage of staff, many of whom were inexperienced. Staff-prisoner relationships were impeded by the limited regime. The delivery of key work to develop relationships and provide more meaningful support to prisoners, had been consistently low over the past 12 months. The prison was short of frontline staff on the wings and specialist staff in almost every department.

Independent Monitoring Board

17. 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 June 2022, the IMB reported that between 1 July 2021 and 30 June 2022, 76 prison officers out of 274 had left the prison. Retention issues and the proportion of inexperienced officers had had an impact on the effectiveness of the prison. The IMB found that healthcare provision was generally good.

Previous deaths at HMP Bullingdon

18. Mr Voitkun was the seventeenth prisoner to die at Bullingdon since March 2020. Two of the previous deaths were self-inflicted. None of our investigations following these deaths raised issues relevant to the death of Mr Voitkun.

Key worker scheme

19. The key worker scheme provides prisoners with an allocated officer that they can meet regularly to discuss how they are and any day-to-day issues they would like to address. Improving safety is a key aim of the scheme. All adult male prisoners should have around 45 minutes of key work each week, including a meaningful conversation with their allocated officer.

20. In 2023/24, due to exceptional staffing and capacity pressures in parts of the estate, some prisons are delivering adapted versions of the key work scheme while they work towards full implementation. Any adaptations, and steps being taken to increase delivery, should be set out in the prison's overarching Regime Progression Plan which is agreed locally by Prison Group Directors and Executive Directors and updated in line with resource availability.

Key Events

21. On 31 October 2022, Mr Ruslan Voitkun was remanded to custody and taken to HMP Wormwood Scrubs on charges of harassment and breach of a restraining order. It was not his first time in prison. He had last been released from HMP Bullingdon in July 2022. Mr Voitkun was a Lithuanian national. All staff we spoke to said he spoke reasonable English.

22. Mr Voitkun told healthcare staff that he had no history of attempted suicide or self-harm, no mental health issues and was not prescribed any medication. He said he had taken prescribed medication for stress in the past. Staff noted that Mr Voitkun had shoulder pain and high blood pressure. Healthcare staff prescribed him pain relief for his shoulder and planned to monitor his blood pressure.

HMP Bullingdon, 1 November onwards

23. The next day, 1 November, Mr Voitkun transferred to Bullingdon. His Person Escort Record (PER – records information about a prisoner including known risks) noted that he had no history of attempted suicide or self-harm, no issues with alcohol or drugs and was not taking any prescribed medication.

24. During Mr Voitkun's reception health screen, Mr Voitkun told a nurse that he had no current thoughts of suicide or self-harm and had no mental health concerns. Mr Voitkun said that he felt stressed by his return to prison, had high blood pressure and shoulder pain. He said he had previously been prescribed sertraline (an antidepressant) for stress. The nurse checked Mr Voitkun's blood pressure which was high. The nurse referred him to the GP to assess his shoulder pain and stress. A prison GP prescribed a one-off dose of amlodipine (to treat high blood pressure) and diazepam (used to treat anxiety).

25. An officer completed Mr Voitkun's first night interview. He noted that Mr Voitkun had no thoughts of suicide or self-harm, and he raised no concerns during the assessment other than that he wanted to make a phone call to his son. The officer told Mr Voitkun that he would contact his son on his behalf. (Mr Voitkun was not allowed to immediately make calls himself, as staff needed to make checks due to his offence.) The officer reminded Mr Voitkun of the support available to him at Bullingdon. Later that night, healthcare checked Mr Voitkun's blood pressure again which was normal.

26. On 2 November, a prison GP examined Mr Voitkun. Mr Voitkun told her that he was stressed but was not depressed and had no thoughts of suicide or self-harm. She checked his blood pressure which was high again. Mr Voitkun declined medication to treat this. She decided not to prescribe antidepressants but noted that she would continue to monitor Mr Voitkun. She prescribed ibuprofen gel for his shoulder pain.

27. That day, a nurse completed Mr Voitkun's secondary healthcare screening, which included an assessment of his mental health and well-being. Mr Voitkun said that he had a history of mixed anxiety-depressive disorder (MADD – when a person suffers from both anxiety and depressive symptoms of limited and equal intensity). She offered to refer Mr Voitkun to the mental health team, but he declined. She

discussed his personal well-being with him and provided him with information on healthy lifestyles.

28. On 8 November, a nurse saw Mr Voitkun after he reported that he was stressed. Mr Voitkun said that he had no thoughts of suicide or self-harm and was coping. Mr Voitkun was concerned that he had not spoken to his son. She offered him support and provided him with distraction packs and information on the Samaritans, healthy eating, and the library.

29. On 11 November, Mr Voitkun was authorised to use his in-cell phone. During his time at Bullingdon, his phone record showed that he made approximately 1,400 calls to his son. While he spoke to his son sometimes, many of Mr Voitkun's calls were unsuccessful either because his son did not answer and/or the calls went to voicemail.

30. On 15 November, a prison GP conducted a telephone consultation with Mr Voitkun. He referred him to the physiotherapist for his shoulder pain.

31. On 2 December, Mr Voitkun applied to see to the mental health team stating that he was stressed and had difficulty sleeping. While he was waiting to be assessed, the mental health team provided him with self-help guides for support.

32. On 13 December, a nurse from the mental health team assessed Mr Voitkun. Mr Voitkun engaged well although he was tearful at times. Mr Voitkun said that his mood was low, he had problems sleeping but no thoughts of suicide or self-harm. The nurse advised Mr Voitkun to contact the Samaritans, chaplaincy, Listeners (prisoners who are trained by the Samaritans to offer confidential, emotional support to other prisoners) or the mental health team if he needed support. The nurse assessed that Mr Voitkun's risk of suicide and self-harm was low, discharged him from the mental health team and referred him to the GP due to his low mood.

33. On 21 December, the physiotherapist saw Mr Voitkun and provided him with advice on how to manage his shoulder pain.

34. On 5 January 2023, Mr Voitkun attended court via video-link. The court adjourned his case until March. A clinical support worker completed a post court assessment with Mr Voitkun. He said he had no thoughts of suicide or self-harm. Although the clinical support worker had no particular concerns about Mr Voitkun's mood or mental state, Mr Voitkun appeared upset at being in prison and said he was struggling. He referred Mr Voitkun to the mental health team.

35. On 17 January, a nurse from the mental health team, attempted to assess Mr Voitkun but could not do so as he was at his prison job.

36. On 21 January, a nurse assessed Mr Voitkun. He told the nurse that he felt stressed. He thought that his limited command of English meant that he was unable to express himself the way he wanted to. He had had no contact with his son or his friends, was worried about his home and was struggling to sleep. He said he had no current or previous thoughts of suicide or self-harm. He explained that his son was his protective factor. The nurse noted that Mr Voitkun had a prison job which he enjoyed and was attending English classes. Mr Voitkun said he spoke to other prisoners in English, and this had helped him a lot. The nurse assessed that Mr

Voitkun's low mood was due to him not having contact with his family and being in prison. Mr Voitkun told the nurse that he did not want to take antidepressants and declined further support from the mental health team. The nurse advised Mr Voitkun that if he wanted antidepressants in the future, he should speak to healthcare staff. He was discharged from the mental health team.

37. On 26 January, an officer completed a key work session with Mr Voitkun. Mr Voitkun told the officer that he was worried about his son, who was due to be evicted from their home that day, making him homeless. He said that their rental agreement had been terminated because the landlord had found out about his (Mr Voitkun's) offence. Mr Voitkun said he normally spoke to his son on Thursdays but had last spoken to him on 1 January (records show that he spoke to his son for over 11 minutes on that day).

38. Since then, Mr Voitkun said he had repeatedly tried, without any success, to contact his son. His phone calls had gone straight to his son's voicemail, which was now full and meant that Mr Voitkun was unable to leave any messages. An officer checked Mr Voitkun's phone records and confirmed that Mr Voitkun had made several unsuccessful attempts to phone his son. She tried to call Mr Voitkun's son herself and confirmed that the calls were being directed straight to his voicemail. She therefore referred Mr Voitkun to the chaplaincy service to see if they could offer him any further support.

39. A member of the chaplaincy team regularly spoke to Mr Voitkun about his son, as he attended Roman Catholic services. Around this time, Mr Voitkun told the chaplain that he had not recently been in contact with his son who was due to be evicted. Mr Voitkun said their lack of contact was unusual and he was worried that his son was upset and that he may have come to some harm. Mr Voitkun told the chaplain that he had asked wing officers for assistance in contacting his son, but they had not been helpful.

40. The chaplain phoned Mr Voitkun's son at his workplace, a casino. He spoke to the casino manager, who said that Mr Voitkun's son was safe and well but had taken some time off to move house. The chaplain told Mr Voitkun, who was relieved that his son was okay.

41. On 31 January, Mr Voitkun asked healthcare staff for antidepressant medication. On 5 February, a nurse reviewed Mr Voitkun. Mr Voitkun told the nurse that because of his low mood and poor sleep, he wanted to be prescribed antidepressants. He denied any thoughts to harm himself. The nurse completed a Patient Health Questionnaire 9 (PHQ-9 - measures the severity of depression) for Mr Voitkun and he scored 17 (15-19 points indicates moderately severe depression). The nurse discharged Mr Voitkun from the mental health team and referred him to the GP to be prescribed mirtazapine (an antidepressant) and for the management of his depression.

42. On 9 February, a nurse conducted a welfare check on Mr Voitkun. Mr Voitkun said that he was coping well. He said that he regularly spoke to his son on the phone and hoped that he would visit him soon. (Mr Voitkun had not spoken to his son since 1 January and his son had not visited him in prison.)

43. The same day, a prison GP saw Mr Voitkun, prescribed him mirtazapine and agreed to review him in four weeks' time. Mr Voitkun started the medication the next day and was allowed to keep it in possession.

44. An E Wing officer described Mr Voitkun as a model prisoner who was quiet, adhered to the prison regime and did not raise any concerns. He said that Mr Voitkun had a good command of English. Mr Voitkun also continued to regularly attend the Roman Catholic Service and chaplaincy staff raised no concerns about him.

45. On 3 March, Mr Voitkun phoned his friend. Bullingdon provided details of the content of this and subsequent conversations to the investigator. (Bullingdon did not listen to Mr Voitkun's telephone calls when he was at the prison and so were unaware of his conversations.) During their conversation Mr Voitkun asked his friend to speak to his son for him. Mr Voitkun told him how important it was for him to have contact with this son. His friend had found out where Mr Voitkun's son worked and planned to speak to him there that night. He said he would ask Mr Voitkun's son to write a letter to his father. Mr Voitkun wanted his son to know that his court date was 9 March, and that his solicitor had told him that he should expect to receive a sentence of around two and a half years. Mr Voitkun said he would phone his friend the next day for an update.

46. On 4 March, Mr Voitkun called his friend twice. At 1.13pm, Mr Voitkun's friend told him that Mr Voitkun's son had not attended work the previous night and so he did not speak to him. Mr Voitkun asked his friend to go to the casino at 10.30pm. Mr Voitkun said he would call him when he was there so that he could speak to his son. His friend agreed to this.

47. At 10.28pm, Mr Voitkun called his friend again. His friend said that he had phoned the casino and spoken to the manager, who told him that Mr Voitkun's son was not due at work until Tuesday (in three days' time). He said he would try to contact him again on 7 March and told Mr Voitkun to contact him the next day for an update.

48. On 8 March, Mr Voitkun called his friend who said he had been unable to go to the casino. He had phoned the casino, but no one had answered. He said he would definitely visit the casino that night and told Mr Voitkun to phone him the next day for an update. Mr Voitkun said he would phone his friend at 10.30pm that night as he wanted to speak to his son.

49. At 10.29pm, Mr Voitkun phoned his friend, who told him that he had spoken to his son on the phone. Mr Voitkun's son was upset with Mr Voitkun and did not want to speak to him. Mr Voitkun's son said that it was his father's fault that he had almost been made homeless, that his father had scared his girlfriend and he now needed to concentrate on himself. He said he would speak to his father when he was ready. Mr Voitkun was unhappy about his son's response and said that he was due to attend court the next day. He asked his friend to speak to his son again as he needed his new home address in case the court gave him a suspended sentence, so that he could show that he had somewhere to live. Mr Voitkun's friend agreed to try and speak to Mr Voitkun's son again. They arranged that Mr Voitkun would ring him back in ten minutes.

50. At 10.34pm, Mr Voitkun phoned his friend. His friend confirmed that he had spoken to his son, who had refused to give him his new home address or assist his father. Mr Voitkun repeated that he just needed an address for release purposes should he receive a suspended sentence. Mr Voitkun's friend discussed the possibility of Mr Voitkun being bailed to a hostel. Their conversation ended with Mr Voitkun thanking his friend for trying to help him. They agreed to meet when he was released from prison.

51. On 9 March, Mr Voitkun attended his court hearing via video link and was sentenced to two years imprisonment. A Healthcare Assistant (HCA), who was based in the video-link suite, assessed Mr Voitkun after his court appearance. She told us that Mr Voitkun appeared to have accepted his situation and she had no concerns about him. Mr Voitkun denied any thoughts of suicide or self-harm. However, he wanted to know how much of his sentence he had left to serve, taking into account the time that he had already spent on remand. The HCA referred this question to the officer on duty in the video-link suite. The officer explained to Mr Voitkun how his sentence would be calculated, including how long he had left to serve in prison. The officer told him that the Offender Management Unit would confirm this information to Mr Voitkun in a couple of days. Neither the HCA nor the officer had any concerns about Mr Voitkun, and they reminded him of the support services available.

52. While being sentenced, Mr Voitkun missed his telephone appointment with the prison GP for review following his prescription of antidepressants. This was rebooked for 10 March.

53. Mr Voitkun's cellmate told us that Mr Voitkun was happy with his sentence length. Mr Voitkun's main concern was that his relationship with his son had broken down. He said Mr Voitkun had expressed suicidal thoughts on more than one occasion and he thought he was being supported by staff and was prescribed medication. The cellmate did not speak to staff about Mr Voitkun himself.

54. At 4.45pm, staff recorded in the wing observation book that Mr Voitkun had been sentenced to two years imprisonment. Staff noted that Mr Voitkun appeared "fine with this" and they had no concerns.

Events on 10 March

55. Around 8.00am on 10 March, Officer A unlocked prisoners on E Wing. At this point, the cellmate told us that he left to go to work. He said Mr Voitkun had already woken up and he had no concerns about him when he left their cell.

56. Shortly afterwards, Mr Voitkun went to the wing office and asked staff for a razor blade to shave. Officer A told him that none were available, but he would try and get him one later. The officer told us that he had no concerns about Mr Voitkun.

57. At 9.59am, Mr Voitkun phoned his friend. He said he felt "fucking shit", and had received a two-year sentence, of which he thought he had eight months left to serve. He was worried about his son and their relationship and urged his friend to contact him again on his behalf. His friend reiterated that his son did not want to speak to him. However, he agreed that he would contact Mr Voitkun's son again

and try to persuade him to talk to his father. The call ended with Mr Voitkun thanking his friend for helping him and they agreed to speak soon.

58. Around 11.45am, prisoners started collecting their lunch. Officer A saw Mr Voitkun return to his cell after he had collected his lunch. At 12.00pm, he completed the lunchtime routine check. He had no concerns about Mr Voitkun, who was sat on his bed eating his lunch.

59. We were informed by the IMB that a prisoner, who wanted to remain anonymous, had told them that Mr Voitkun's cell bell had been left unanswered over the lunch period. Officer B, who was on patrol duty over the lunch time period, told us that Mr Voitkun did not ring his cell bell. There is no CCTV on the wing nor does the prison keep cell bell records and so we are unable to corroborate whether Mr Voitkun had rung his cell bell.

60. At 1.39pm, Officer B, while unlocking prisoners on E Wing, looked through Mr Voitkun's observation panel and saw that Mr Voitkun was hanging from a ligature made from bedding attached to the bars on the window. Mr Voitkun's feet were hardly touching the floor. He immediately radioed a medical emergency code blue (used when a prisoner is unconscious or has breathing difficulties). Control room staff immediately requested an ambulance.

61. Officer B entered the cell, supported Mr Voitkun, cut the ligature and placed him on the floor. Mr Voitkun was not breathing and was cold to touch. He started cardiopulmonary resuscitation (CPR).

62. A Supervising Officer (SO) and two officers arrived at the cell within 45 seconds and assisted with CPR.

63. At 1.40pm, a senior nurse and a colleague got to Mr Voitkun's cell and took over the management of his care. Further healthcare staff arrived, including the Head of Healthcare.

64. At 1.50pm, the senior nurse decided to stop CPR as resuscitation attempts had been futile and were inappropriate. Healthcare staff noted that hypostasis (a pooling of blood that occurs after death) was present. At 1.53pm, paramedics arrived and assessed Mr Voitkun. At 1.55pm, the Head of Healthcare and the senior nurse verified Mr Voitkun's death.

65. Staff found a letter written in Russian addressed to his son in Mr Voitkun's cell. This was later translated. In the letter, Mr Voitkun stated his intention to take his own life, he felt he had let his son down and asked for his forgiveness.

Contact with Mr Voitkun's family

66. Bullingdon appointed two family liaison officers (FLOs). Mr Voitkun's son was his next of kin. The prison had no home address for Mr Voitkun's son, and one FLO tried several times, without success, to contact him on his mobile and work phone numbers. After further enquiries, the police provided a home address for Mr Voitkun's son, in Reading. The FLOs attended the address around 6.00pm, but no one was in.

67. The FLOs again tried to contact Mr Voitkun's son by phone. After several attempts, he answered his phone. He explained that he longer lived at the address that the FLOs had attended. He also refused to tell the FLOs where he now lived, as he did not want his father to know where he was. One FLO therefore broke the news of Mr Voitkun's death to his son. Upon hearing this, Mr Voitkun's son agreed to meet the FLOs in person that evening. They met Mr Voitkun's son, offered their condolences and provided ongoing support. In line with Prison Service instructions, the prison contributed towards the costs of Mr Voitkun's funeral.

Support for prisoners and staff

68. After Mr Voitkun's death, a prison manager debriefed all 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 and the TRiM manager (trauma risk management for staff) also contacted prison staff.

69. The prison posted notices informing other prisoners of Mr Voitkun'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 Voitkun's death.

Post-mortem report

70. The initial post-mortem examination concluded that Mr Voitkun's death was due to external neck compression caused by hanging. The final post-mortem report and toxicology results were not available at the time of writing.

Findings

Identifying the risk of suicide and self-harm

71. Prison Service Instruction (PSI) 64/2011, *Safer Custody*, lists risk factors and potential triggers for suicide and self-harm. It says all staff should be alert to the increased risk of self-harm or suicide posed by prisoners with these risk factors and should act appropriately to address any concerns. Any prisoner identified as at risk of suicide and self-harm must be managed under Assessment, Care in Custody and Teamwork (ACCT) procedures.

72. When Mr Voitkun arrived at Bullingdon in November 2022, he had a number of risk factors: he was a foreign national prisoner, he had been charged with an offence against his partner and he had a history of anxiety and depression. During his reception interviews, Mr Voitkun said he was stressed at his return to prison. Reception and healthcare staff raised no concerns about Mr Voitkun but referred him to see the GP who reviewed him and prescribed antidepressants.

73. The day before Mr Voitkun's death, he was sentenced to two years imprisonment. Prison and healthcare staff assessed his risk of suicide and self-harm and his well-being immediately after his hearing. They had no concerns.

74. In the four months that Mr Voitkun spent at Bullingdon, his main concern was his lack of contact with his son. Prison and mental health staff identified that this affected his mood, and he was offered appropriate support. He repeatedly said he had no thoughts of suicide or self-harm. The clinical reviewer noted that there was no evidence that staff should have opened an ACCT during Mr Voitkun's time at Bullingdon. We conclude that staff could not reasonably have foreseen that Mr Voitkun was an imminent risk of suicide in the days leading to his death.

Clinical care

75. The clinical reviewer concluded that the healthcare that Mr Voitkun received at Bullingdon was of a good standard and was equivalent to that which he could have expected to receive in the community.

Good practice

Emergency response

76. The emergency response when Mr Voitkun was found was quick and effective. The clinical reviewer recognised positive changes which had been implemented in emergency care at Bullingdon. They had an urgent and emergency care team led by a highly skilled senior nurse, a comprehensive training package for healthcare staff and robust procedures for checking emergency equipment. The clinical reviewer concluded that Bullingdon should be commended for this patient-centred approach to improving prisoner safety.

Governor to Note

Key Work

77. Under the Offender Management in Custody (OMiC) model, every prisoner should have a dedicated key worker with whom they have weekly contact. The purpose of the model is to improve safety by building better relationships between staff and prisoners.

78. During the four months he was at Bullingdon, Mr Voitkun had one key work session with an officer on 26 January. She told us that she was unable to fulfil her key working duties because she had been deployed to other areas of the prison due to staff absences. This meant that Mr Voitkun did not have a key work session for over six weeks before he died, during the period when he was sentenced and his contact with his son declined.

79. We found that, at the time, the key worker scheme at Bullingdon did not comply with the OMiC model, due to staffing shortages. It is difficult to measure the impact on Mr Voitkun. During his time at Bullingdon, he was supported by healthcare staff. However, we know that regular key work sessions with a consistent officer can help to improve wellbeing and safety.

80. The prison told us that key working had improved since Mr Voitkun's death, and work continued to be completed to ensure its ongoing full delivery. A local keyworker strategy had also been produced to further direct how key work resources were being utilised included having a priority list of prisoners identified as needing additional support, for who staff are identified and allocated to provide support to them.

Governor and Head of Healthcare to note

81. Postvention is a joint HMPPS and Samaritans initiative that aims to ensure a consistent approach to providing staff and prisoners support following all deaths in custody. Postvention procedures should be initiated immediately after every self-inflicted death and on a case-by-case basis after all other types of death. Key elements of postvention care include a hot debrief for staff involved in the emergency response and engaging Listeners (prisoners trained by the Samaritans to provide confidential peer-support) to identify prisoners most affected by the death.

82. Prison and healthcare staff told us that they received post incident debriefing and support. This was delivered in a group setting and staff told us that they did not feel that this was very effective. They felt there should have been a more robust de-briefing process and staff should have been offered individual 'TRIM' (Trauma Risk Management) sessions. (This is where individuals take part in a carefully structured conversation about the event itself, known as a trauma risk assessment.) The Governor and Head of Healthcare may wish to consider whether there is more that could be done to follow up on individual TRIM sessions.

Inquest

83. An inquest was concluded on 23 April 2024, that the cause of Mr Voitkun's death was suicide as a result of external neck compression, due to hanging. The coroner found that Mr Voitkun had telephone conversations on 8 and 10 March. Transcripts of these calls revealed a loss of significant protective factors in his life, which aligned with the contents of his suicide note. These losses were identified as contributing to a sudden and significant deterioration in Mr Voitkun's mental health, ultimately leading to him taking his own life.

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