Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Dylan Woodhead, a prisoner at HMP/YOI Hindley, on 8 January 2021

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.

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 Dylan Woodhead was found hanged in his cell at HMP Hindley on 8 January 2021. He was 22 years old. I offer my condolences to his family and friends.

Mr Woodhead had been in custody for three months when he died, and for only ten days at Hindley. It was his first time in prison. While he had a number of risk factors, prison staff at HMP Forest Bank, his previous prison, should have considered starting suicide and self-harm procedures for him when he arrived, he sought minimal support from prison staff and there were no clear signs to indicate that he intended to take his life, including in the days before his death.

However, I am concerned that roll checks were not properly completed the night and morning before Mr Woodhead was found dead in his cell. I cannot say whether this might have affected the outcome for him.

The post-mortem examination confirmed that Mr Woodhead had used psychoactive substances (PS) before his death. Although this was not found to have caused his death, PS is known to affect mental health adversely. I am concerned that Mr Woodhead was able to obtain PS with apparent ease at Hindley, even though strict restrictions had been put in place during the COVID-19 lockdown. Hindley needs to continue in its efforts to reduce the supply of and demand for drugs and ensure that staff can recognise and are vigilant for signs of PS use.

I am also concerned that healthcare staff tried to resuscitate Mr Woodhead despite the presence of rigor mortis.

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

Kimberley Bingham
Acting Prisons and Probation Ombudsman **October 2022**

Contents

Summary

Events

1. In September 2020, Mr Dylan Woodhead was remanded into custody at HMP Forest Bank, charged with assault, causing actual bodily harm, engaging in controlling/coercive behaviour towards his ex-partner and the damage of property. It was his first time in prison. He was transferred to HMP Hindley on 29 December.

2. His Person Escort Record (PER) noted that he had depression and anxiety. He had a restraining order in place not to contact his ex-partner. A reception nurse assessed Mr Woodhead's mental health and noted his history of attempted suicide. However, he had no current thoughts of suicide or self-harm and there was no evidence that he had tried to harm himself at Forest Bank. Prison and healthcare staff did not identify any acute mental health concerns.

3. Mr Woodhead disregarded the restraining order in place and used the prison's PIN phone system to contact his ex-partner. He made numerous telephone calls to her during his time at Hindley. They argued during their telephone conversations on the evening of 7 January, and Mr Woodhead threatened to take his life.

4. On 8 January 2021, an officer found Mr Woodhead sitting on the floor of his cell, with a ligature around his neck. The officer radioed a medical emergency code blue and staff responded quickly. Staff tried to resuscitate Mr Woodhead until paramedics arrived and took over. They were unable to resuscitate him and pronounced that he had died.

Findings

Assessment of risk

5. Mr Woodhead had a number of risk factors when he arrived at Forest Bank: it was his first time in prison, he had been remanded for a serious offence against his ex-girlfriend, he had a history of attempted suicide and self-harm, he misused alcohol and had anxiety, depression and substance misuse problems.

6. We are concerned that staff at HMP Forest Bank failed to consider opening ACCT procedures or record why they had decided it was unnecessary.

7. When he arrived at Hindley, we are satisfied that staff reviewed Mr Woodhead's risk information, assessed his risk of suicide and self-harm appropriately and made a reasonable decision in the absence of hindsight, based on the facts they were presented with at the time that he was not at immediate risk of suicide or self-harm.

Roll check

8. The officer on night duty failed to properly conduct the evening roll check on 7 January 2021 and the morning roll check on 8 January and therefore did not check on Mr Woodhead. The officer on day duty also failed to conduct a morning roll check on 8 January. Although we cannot say whether this might have made a

difference in Mr Woodhead's case, early intervention in another emergency may save a life.

Drug strategy at HMP Hindley

9. Although Hindley has a comprehensive drug strategy, Mr Woodhead was still able to obtain drugs in the prison. The prison updated its drug strategy in March 2021 but must continue to implement it effectively to reduce supply and demand.

Resuscitation

10. While we recognise that staff wanted to save Mr Woodhead's life, rigor mortis was already present when he was found hanged in his cell. Trying to resuscitate someone who is clearly dead is distressing for staff and undignified for the deceased. Healthcare staff should therefore not have tried to resuscitate him.

Recommendations

- The Governor and Head of Healthcare at Forest Bank should ensure staff consider and record all the known risk factors of newly arrived prisoners when determining their risk of suicide or self-harm, including information from suicide and self-harm warning forms, person escort records and medical records, and consider ACCT monitoring in light of those risk factors.

- The Governor should ensure that roll checks are properly carried out.

- The Governor should ensure that staff continue to prioritise implementing Hindley's drug strategy, and that they can recognise, are vigilant for and address signs of PS use.

- The Governor and Head of Healthcare should ensure that staff are given clear guidance and check their understanding about the circumstances in which resuscitation is inappropriate in line with the Resuscitation Council Guidelines.

The Investigation Process

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

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

13. NHS England commissioned a clinical reviewer to review Mr Woodhead's clinical care at the prison.

14. The investigator interviewed five members of staff jointly with the clinical reviewer. The interviews were completed by video and telephone because of the restrictions imposed due to the COVID-19 pandemic.

15. We suspended our investigation pending the police investigation into the death of Mr Woodhead, the outcome of which was received on 11 March 2022, 14 months after his death. The investigation was further delayed by the COVID-19 pandemic. The police shared information with us to assist our investigation.

16. We informed HM Coroner for Greater Manchester West District of the investigation. He gave us the results of the post-mortem examination. We have sent him a copy of this report.

17. We contacted Mr Woodhead's family to explain the investigation. They wanted to know the full circumstances leading to Mr Woodhead's death, including:

    - whether Mr Woodhead was monitored under suicide and self-harm prevention procedures at HMP Hindley;
    - why he was in a single cell and how often he was checked;
    - whether Mr Woodhead had bipolar disorder and whether he was prescribed any medication; and
    - whether Mr Woodhead was allowed access to a telephone at Hindley.

    We have addressed these concerns in this report and in separate correspondence.

18. Mr Woodhead's family legal representative received a copy of the initial report. The solicitor representing Mr Woodhead's family wrote to us raising a number of questions that do not impact on the factual accuracy of this report. We have provided clarification by way of separate correspondence to the solicitor.

19. The initial report was shared with HM Prison and Probation Service (HMPPS). They identified no factual inaccuracies. All recommendations were accepted. Their action plan is attached as an annex.

Background Information

HMP Hindley

20. Hindley is a Category C training and resettlement prison near Wigan, holding up to 590 adult male prisoners. Nearly a quarter of the population are under 21 years old. About half of the prisoners are serving long sentences of at least four years. Primary healthcare and mental health services are provided by Greater Manchester Mental Health NHS Foundation Trust.

HM Inspectorate of Prisons

21. The most recent inspection of HMP Hindley was a scrutiny visit in December 2020 to inspect the conditions and treatment of prisoners during the COVID-19 pandemic. Inspectors found that the amount of time that most prisoners spent out of their cells had increased since the start of the pandemic to two 45-minute sessions a day when they could shower and exercise outdoors.

22. Inspectors found that the recent reintroduction of mandatory drug tests had yielded a very high positive rate of 59% in the first month. They noted that Hindley was taking steps to reduce the supply of drugs but psychosocial support for prisoners with substance misuse issues was very stretched. Inspectors concluded that the care of those at risk of suicide and self-harm was reasonable. They found that staff checked on the wellbeing of all prisoners regularly, and those with high risks or needs received support through regular key work sessions. They noted that the uptake of video calls and social visits, when they were able to take place, had been low. They noted that all prisoners had in-cell telephones for use 24 hours a day, and this had helped them maintain family contact.

Independent Monitoring Board

23. 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 December 2021, the IMB reported and noted that throughout the year, the prison has been subject to a range of restricted regimes as management tried to maximise out of cell opportunities while protecting prisoners and staff from COVID-19 outbreaks. There were ongoing concerns about prisoners being locked in their cells for 23 out of 24 hours, and on occasion longer. They noted a concerning increase in the incidents of self-harm. They found that cannabis, psychoactive substances (PS) and 'home brewed' alcohol (hooch) were the most available illicit substances used by prisoners during the year. It was thought that many prisoners had illicit mobile phones, used primarily to keep in contact with family as the cost of using the in-cell phones was felt to be prohibitively high. There was also concern about the number of prisoners choosing to self-isolate and remain in their cells. The most common reason given were the prisoners wanting to avoid trouble as their parole/Category D hearing was approaching.

Previous deaths at HMP Hindley

24. Mr Woodhead was the first prisoner to die at Hindley since June 2018.

Key Events

HMP Forest Bank

25. On 15 September 2020, Mr Dylan Woodhead was remanded to HMP Forest Bank, charged with assault, causing actual bodily harm, engaging in controlling/ coercive behaviour towards his ex-partner and the damage of property. It was his first time in prison.

26. His Person Escort Record (PER), which accompanied him to prison, noted his history of attempted suicide and self-harm, he was violent, he misused alcohol and had anxiety and depression. Mr Woodhead had a restraining order in place, preventing him from contacting his ex-partner. He was seen by the Court's Liaison and Diversion (L&D) services (who identify people who have mental health concerns, learning disabilities, substance misuse or other vulnerabilities when they first come into contact with the criminal justice system), due to his self-harm history in the community

27. Prison reception staff interviewed Mr Woodhead when he arrived. His PER and court documentation, which included comments from the L&D team noted no specific concerns about his immediate risk.

28. A reception nurse completed Mr Woodhead's reception health screen. The nurse reviewed the PER, examined Mr Woodhead and recorded his physical observations. It was noted that he had a history of substance misuse, anxiety and depression. Mr Woodhead declined substance misuse support and said that he had no thoughts of suicide or self-harm. He said that he had previously tried to take his life (in July 2020) by taking an overdose of 30 paracetamol/co-codamol tablets due to the stress of possibly receiving a prison sentence. The nurse referred Mr Woodhead to the mental health team.

29. A mental health nurse completed a mental health assessment. The nurse noted that Mr Woodhead had no suicidal ideation but that it was his first time in prison. Mr Woodhead said that at the time that he had taken an overdose, he was depressed. He said that he had been admitted to hospital and the mental health team had seen him but he had subsequently failed to attend any of his follow-up appointments. Mr Woodhead thought that he may have bipolar disorder. The nurse noted that Mr Woodhead was not taking any medication, and she did not identify any immediate risks but agreed to discuss Mr Woodhead at the next mental health multidisciplinary team meeting.

30. On 16 October, a mental health nurse assessed Mr Woodhead by telephone. Mr Woodhead said that he had no thoughts of suicide or self-harm. He believed that he had bipolar disorder and asked for a diagnosis. He said that he had a split personality, low mood, was "easily wound up" and got angry at the slightest thing. He added that he was upset that he was unable to see his baby daughter due to the COVID-19 pandemic. The nurse discussed Mr Woodhead's symptoms with him and explained that they related more to emotional regulation than a clinical mood disorder. She assessed that he presented with no psychotic symptoms and discussed how psychological interventions could help him identify and manage his

emotions. She agreed to refer Mr Woodhead to a psychological wellbeing practitioner to support his emotional regulation and anger management.

31. On 4 December, Mr Woodhead attended court by video link and was sentenced to two and a half years in prison. He also received a five-year restraining order not to contact his ex-partner.

32. On 22 December, Mr Woodhead was prescribed omeprazole (for indigestion).

33. On the morning of 29 December, a nurse saw Mr Woodhead and completed a health screen before his impending transfer to HMP Hindley. Mr Woodhead was assessed as being fit for transfer. The nurse recorded that he had no outstanding health appointments. It was not recorded that Mr Woodhead was waiting to see a psychological wellbeing practitioner.

HMP Hindley

34. On 29 December, Mr Woodhead was transferred to HMP Hindley. His PER noted that he had depression and had committed a domestic violence offence.

35. A prison officer interviewed Mr Woodhead in reception when he arrived. Mr Woodhead had no thoughts of suicide or self-harm, he had not been monitored by suicide and self-harm prevention procedures (known as ACCT) and it was his first prison sentence. Staff offered him emergency PIN credit.

36. A Phoenix substance misuse officer saw Mr Woodhead as part of his induction. Mr Woodhead said that he had not used illicit substances in prison and declined the structured psychosocial support offered to him.

37. A member of the chaplaincy team spoke to Mr Woodhead in reception. He raised no concerns.

38. A nurse completed Mr Woodhead's initial and secondary health screens. She had no concerns about him.

39. She referred him to the prison GP who continued his omeprazole prescription for indigestion. Mr Woodhead told the nurse that he had a history of cocaine misuse. She completed an alcohol screen for him and assessed that he was not a hazardous drinker and did not need support for this. The nurse also assessed Mr Woodhead's mental health. She noted his history of attempted suicide and that he had taken an overdose in July 2020. He had not tried to harm himself in prison and had not seen a doctor in the past few months. Mr Woodhead said that he had no thoughts of suicide or self-harm. She noted that he presented as relaxed and said that he was happy to be at Hindley. She noted that he would not be allowed to keep and administer his omeprazole due to his overdose history.

40. After he completed his reception screen, Mr Woodhead was moved to a single cell on the induction unit. All the cells have in-cell PIN phones.

41. An officer completed Mr Woodhead's first night interview and assessed his risk of suicide and self-harm. She had no concerns about him. Mr Woodhead said that

he was happy to be at Hindley because it was easier for his family to visit him. He said that he was unable to see his daughter because of his offence.

42. Shortly after the officer had completed Mr Woodhead's first night interview, he rang his emergency cell bell and asked for cloth to clean his cell and toilet rolls which an officer gave him.

43. On 30 December, an officer completed an induction follow-up interview with Mr Woodhead. She noted that he raised no concerns.

44. On 3 January 2021, staff noted that when staff refused to give Mr Woodhead emergency telephone PIN credit because he had not applied for it on the appropriate day, he repeatedly threatened to damage his cell. No further information was recorded about this.

45. That day, Mr Woodhead's father left a telephone message for the safer custody team. He was concerned that he had not heard from Mr Woodhead for nearly a week. An officer from the safer custody team picked up the message that afternoon and visited Mr Woodhead to pass on his father's concerns.

46. The officer said that Mr Woodhead was in "good spirits" and joked with him. Mr Woodhead said that he had had problems getting phone credit but this had been rectified. He asked the officer to call his father on his behalf and reassure him that he was "fine". Mr Woodhead said that he would try and call his father the following week. The officer could not make contact with Mr Woodhead's father so left a telephone message for him.

47. On 6 January, prison staff completed a public protection risk assessment, and decided to monitor Mr Woodhead's PIN phone and mail.

Events on Thursday 7 January

48. On the morning of 7 January, it was noted in prison intelligence reports that a prisoner had reported to wing staff that another prisoner on the wing had illicitly used his cellmate's PIN phone credit, and that he wanted these phone numbers removed from his account. The prisoner did not name the other prisoner.

49. Later that morning, immediately after staff unlocked Mr Woodhead from his cell, he walked over to another cell, where two prisoners lived and started threatening them through their cell door. Both prisoners returned the abuse before staff removed Mr Woodhead. Mr Woodhead had threatened to "cave their heads in" if they opened their door. One of the prisoners threatened to "flatten" Mr Woodhead if they were out of their cells at the same time. Staff assumed that Mr Woodhead had been the prisoner who had used one of the prisoner's PIN phone credit. When the security team subsequently checked the prisoner's request to remove phone numbers from his PIN account, the two sets of phone numbers he had selected had the surname "Woodhead". Wing staff were told to monitor the three prisoners.

50. At 12.41pm, Mr Woodhead used his PIN phone and called a mobile telephone number, identified from prison records as belonging to his sister. However, his ex-partner answered. Mr Woodhead told her that he had had an argument with two prisoners that morning about PIN phone credit and had threatened them.

51. At 12.49pm, Mr Woodhead phoned his father and said that he had a phone but was waiting for a SIM card for it.

52. At 2.30pm, 2.49pm, 3.52pm and 4.43pm, Mr Woodhead phoned his ex-partner. They had a general conversation about his family and his release date. His ex-partner then told him that his phone credit would run out if he kept calling her. Mr Woodhead said that he was bored.

53. Mr Woodhead phoned his grandmother at 5.14pm. They talked about money and his bank account.

54. At 5.17pm, CCTV footage shows that staff completed a roll check and raised no concerns about Mr Woodhead.

55. Mr Woodhead called his ex-partner four times between 5.23pm and 6.42pm. They talked about money. Mr Woodhead said that he had tried to ring her twice and accused her of ignoring him. They talked about his ex-partner sending him a parcel and whether she loved him. Mr Woodhead said that he would kill her if she found someone else. Their conversation about their relationship became heated and they swore at each other. Before the phone call ended, Mr Woodhead said that he would call her at 9.00pm as he did not have enough credit. His ex-partner told him to stop wasting his phone credit.

56. Mr Woodhead phoned his father at 6.44pm and his grandmother at 6.49pm. Both conversations were about money and Mr Woodhead's bank account. Mr Woodhead agreed to call his grandmother the next day.

57. CCTV footage at 6.57pm shows that Operational Support Grade (OSG) completed a roll check. She checked that all the cell doors on the wing were locked but did not look through the observation panels to check on prisoners.

58. At 7.06pm, Mr Woodhead phoned his partner. He asked her to apologise to a prisoner for him for the morning's events. Mr Woodhead said that she should transfer £10 to the prisoner.

59. Mr Woodhead made a number of short phone calls to his ex-partner at 7.20pm, 7.26pm, 7.29pm and 7.33pm. They talked about money and the transferring of money into bank accounts. His ex-partner questioned why he had phoned her again as it was not 9.00pm. Their conversation became heated and his ex-partner ended the call. Mr Woodhead then called his ex-partner again. They shouted and swore at each other about not being able to log into each other's bank accounts and money issues. His partner said that she was sick of Mr Woodhead always blaming everyone else for his problems. Mr Woodhead said that he would kill himself if she ended the call. His ex-partner told him to do it. Mr Woodhead responded and said, "I'm fucking paying you back." His ex-partner replied, "You do this every month." Mr Woodhead again told her that he would pay her back. His ex-partner said it was not about that but how he made her feel.

60. In the next phone call at 7.29pm, Mr Woodhead said that he would pay his ex-partner back every penny of the money he owed her. They argued and shouted about trust and money. He asked his ex-partner if he should call her later. She told him that he should do what he wanted to do.

61. When Mr Woodhead called his ex-partner at 7.33pm, he screamed at her and told her not to put the phone down on him again. He told her that she could take her money and then she would not have to speak to him again as she obviously could not "fucking stand" him. He said that he would ring her on Monday and if she did not want to speak to him, she could block the number. Mr Woodhead is then heard shouting (as if to someone else near or outside his cell), "shut your fucking mouth". His conversation then resumed with his ex-partner and he told her how to log in to his bank account. He told her to take all the money and that he would tell everyone else that he had spent it. Mr Woodhead then said his phone credit was going. He told his ex-partner that once she logged into the account, she would see where his money had gone and would "kick off" (be upset).

Events of 8 January

62. CCTV footage shows that at 2.57am, the OSG walked along the landing and opened cell door observation panels but did not look through them. The OSG then failed to conduct the morning roll check between 5.00am and 6.00am, despite signing the roll check sheet and wing observation book at 5.50am to state that she did.

63. The OSG completed a handover to an officer before her duty finished at around 6.00am. At 6.17am, CCTV footage shows that the officer did not conduct the morning roll check after he arrived for his shift. While he checked that cell doors were locked, he did not check on the occupants.

64. Just before 8.00am, staff started unlocking some prisoners.

65. In her police statement, an officer stated that she had just finished the medication round and was walking towards Mr Woodhead's cell to unlock him. As she approached his cell door, she saw a piece of paper pushed out under his cell door. The officer opened Mr Woodhead's cell observation panel and saw him sitting on the floor, with a ligature made from a bed sheet tied around his neck at the end of the bed. Mr Woodhead's face was blotchy and purple/grey in colour and his tongue was protruding slightly from his mouth. The officer saw a second officer nearby and asked him to call a code blue, indicating a life-threatening situation. The control room log recorded that this occurred at 8.07am and an ambulance was called at 8.09pm.

66. In the meantime, the officer tried to open Mr Woodhead's cell door. She found that his feet were obstructing the door and she had to use her shoulder to push it open. The second officer joined her and they entered the cell. In his police statement, the second officer said that Mr Woodhead's skin was grey and his blood was pooling in certain parts of his body.

67. The second officer tried to cut the ligature with his fish knife (cut-down tool) but it was too thick. An officer arrived and helped the officer to support Mr Woodhead's body while an officer removed the ligature.

68. The officer checked Mr Woodhead for signs of life. He had no pulse and his skin was cold and very hard. He started cardiopulmonary resuscitation (CPR) but then noticed that Mr Woodhead's body was stiff so he had to push him flat. An officer helped with CPR efforts.

69. A nurse arrived at Mr Woodhead's cell at 8.08am, with a medical emergency bag. She took over CPR attempts.

70. A second nurse arrived at 8.10am, with personal protective equipment for staff to wear. She helped the nurse who noted in Mr Woodhead's medical record that he had no pulse and was not breathing. His skin was mottled and his pupils were fixed and dilated. The nurses attached a defibrillator to Mr Woodhead but it advised no shock.

71. The nurse told us that Mr Woodhead's skin on his feet, stomach, hands and partially on his calves was mottled and discoloured. She said that his lips appeared blue and rigor mortis was present. She was unable to insert an oral airway because his jaw was clenched so they inserted a nasal airway to administer oxygen. The nurses completed approximately six cycles of CPR before paramedics arrived at 8.21am. They pronounced his death at 8.23am.

Information discovered after Mr Woodhead's death

72. After Mr Woodhead's death, staff found a suicide note in his cell, addressed to his parents, ex-partner, daughter and family. In it, he said that he was "sorry that he did this, don't blame anyone other than me I've been nothing but a complete failure to you all [sic]". He also said that he loved his daughter very much. Staff found a short note, addressed to a prisoner. It said, "Sorry about using your credit, I'll get [my ex-partner] to transfer you £10 and I'll sort you some NEMO…". (It is not clear what 'NEMO' referred to but it is possibly an anti-inflammatory drug used for pain relief.)

73. A wing officer submitted a security intelligence report at around 9.00am to say that while conducting welfare checks, four prisoners who lived on Mr Woodhead's landing, said that they had heard him arguing with his partner on the phone at around 10.00pm the previous night and that Mr Woodhead had told his partner that he would kill himself if she broke up with him. The security team checked Mr Woodhead's PIN phone activity and noted that he did not make any calls from his in-cell phone at this time.

Contact with Mr Woodhead's family

74. After Mr Woodhead died, staff identified his father as his next of kin. The prison appointed a member of the chaplaincy team, as the prison's family liaison officer (FLO). The FLO and the Deputy Governor visited Mr Woodhead's father shortly before 11.00am and broke the news of Mr Woodhead's death. Mr Woodhead's father contacted Mr Woodhead's mother and informed her of his death.

75. Mr Woodhead's funeral took place on 29 January. The prison contributed towards the cost of Mr Woodhead's funeral in line with national instructions.

Support for prisoners and staff

76. After Mr Woodhead's death, a Custodial Manager (CM) debriefed the staff involved in the emergency response to ensure that they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support. The

prison posted notices informing other prisoners about Mr Woodhead'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 Woodhead's death.

Post-mortem report

77. The post-mortem report concluded that Mr Woodhead died from hanging. Toxicology results showed that he had taken psychoactive substances (PS) sometime before his death.

Findings

Risk assessment on arrival at HMP Forest Bank

78. Prison Service Instruction (PSI) 64/2011 on safer custody and PSI 07/2015 on early days in custody list risk factors and potential triggers for suicide and self-harm. The PSIs requires that staff appropriately manage newly arrived prisoners who are at risk of suicide and self-harm. It requires that reception staff examine the PER and any other available documentation to assess a prisoner's risk of suicide, self-harm or harm to or from others.

79. Mr Woodhead had a number of risk factors when he arrived at Forest Bank in September 2020: it was his first time in custody, he had been remanded into custody for a serious offence against his ex-girlfriend, he had a history of attempted suicide and self-harm, he misused alcohol and had anxiety, depression and substance misuse problems.

80. In these circumstances and contrary to national instructions, we are surprised that neither prison nor healthcare staff challenged critical risk information from Mr Woodhead's PER and other related documents and considered opening ACCT procedures or recording why they decided it was unnecessary. However, Mr Woodhead appears to have settled at Forest Bank after this, so if he had been monitored under ACCT procedures, it is likely that monitoring would soon have ended. Although this did not contribute directly to Mr Woodhead's death four months later, it was a missed opportunity to understand his risks and triggers. We make the following recommendations:

    The Governor and Head of Healthcare at Forest Bank should ensure staff consider and record all the known risk factors of newly arrived prisoners when determining their risk of suicide or self-harm, including information from suicide and self-harm warning forms, person escort records and medical records, and consider ACCT monitoring in light of those risk factors.

Risk assessment on arrival at HMP Hindley

81. PSI 07/2015 on early days in custody is clear that staff should assess all newly arrived prisoners and share, review and act on information, including person escort records, where necessary. The National Institute for Health and Care Excellence (NICE) guidelines state that initial health screens in reception should ensure continuity of care for people transferring from one custodial setting (including courts) to another by accessing relevant information from the patient clinical record, PER, cell-sharing risk assessments, medication prescriptions and outstanding medical appointments.

82. In addition to Mr Woodhead's significant risk factors, when he arrived Hindley on 29 December, he had also been recently sentenced.

83. We note that prison and healthcare staff assessed him in reception and determined that his risk of suicide and self-harm was low, he had no current thoughts of self-harm and he did not need ACCT monitoring. His initial reception screen raised no particular concerns about Mr Woodhead's mental health.

84. While Mr Woodhead had taken an overdose in the community in July 2020, this was in response to a social situation that had caused him stress and appeared to have been an isolated incident. Mr Woodhead spent over three months at Forest Bank and there is no evidence that he had tried to harm himself during that time. After he transferred to Hindley, staff had no concerns about Mr Woodhead. Staff followed up on concerns raised by Mr Woodhead's father on 3 January 2021, and a safer custody officer spoke to Mr Woodhead and checked on him. Mr Woodhead expressed no concerns and explained that he had not contacted his father because he had not had enough PIN credit. Although we recognise that Mr Woodhead had a number of significant risk factors, they had not changed since he was at Forest Bank and he had not tried to harm himself or expressed any thoughts of suicide or self-harm during his time in custody.

85. Although it was a finely balanced decision, we consider that without the benefit of hindsight, prison staff's assessment of Mr Woodhead at Hindley was reasonable. We do not consider that prison staff could reasonably have predicted that Mr Woodhead was at imminent risk of suicide when he arrived.

Roll checks

86. The primary purpose of a roll check is to confirm that all prisoners are present. However, roll checks are also an opportunity to check on the wellbeing of prisoners and to identify any obvious signs that a prisoner may be ill or dead. Hindley's roll check procedures state that night duty staff should complete full roll checks at 7.45pm and 6.30am in the morning. The day duty staff are required to conduct a full roll check on handover from the night duty staff in the morning.

87. The OSG signed a formal document to confirm that she had completed the roll check on the evening of 7 January and the morning of 8 January. An officer had also signed a formal document to confirm that he had completed the roll check on the morning of 8 January. However, CCTV footage shows that neither officer had completed the roll check properly. Falsifying documents is a serious disciplinary matter and Hindley subsequently suspended the OSG and an officer from duty and they are subject to disciplinary proceedings. While we cannot know whether the outcome for Mr Woodhead might have been different if the OSG and the officer had conducted their respective roll checks correctly, it may be critical in another emergency. We therefore make the following recommendation:

The Governor should ensure that roll checks are properly carried out.

88. We are pleased that after Mr Woodhead's death, Hindley introduced 'normality' checks in addition to the routine four roll checks completed by staff each day. This instructed night duty staff to check on each cell twice (between 10.00pm and 3.00am with checks at least 3 hours apart) to ensure that there is nothing "out of the ordinary". This check offers prisoners two opportunities to speak to staff at night.

Drug strategy at HMP Hindley

89. It is troubling that Mr Woodhead was able to access PS, particularly during the COVID-19 lockdown when severe restrictions had been put in place on prisoner and visitor movement.

90. There was a national instruction from HM Prison and Probation Service in April 2019 that all prisons should review their drug strategy. HM Inspectorate of Prisons expressed concern about the easy availability of drugs at Hindley in December 2020, and Hindley has since made strenuous efforts to ensure support for prisoners with substance misuse and to reduce the supply and demand for illicit substances. They also revised their Drug Strategy in March 2021, installed a new CCTV camera system across the site and introduced a full body scanner and Rapiscan substance detector equipment. While these are positive measures and work in this area should continue to be prioritised, we remain concerned that Mr Woodhead was able to access PS. We therefore make the following recommendation:

The Governor should ensure that staff continue to prioritise implementing Hindley's drug strategy, and that they can recognise, are vigilant for and address signs of PS use.

Clinical care

91. The clinical reviewer noted that overall, the healthcare that Mr Woodhead received was of a good standard and was equivalent to that which he could have expected to receive in the wider community. She noted that his physical and mental health needs were appropriately assessed on arrival at Hindley and his history of overdose and substance misuse issues were noted.

Mental healthcare

92. Healthcare staff completed a mental health screen when Mr Woodhead arrived at Hindley. They found that he had no diagnosed mental illnesses and was not exhibiting signs or symptoms of mental illness, including depression or anxiety. While at Forest Bank, psychological interventions were identified as being able to help Mr Woodhead's emotional regulation and anger management, but healthcare staff assessed that there was no indication that he needed prescribed medication for his mental ill health. As there was no known change in Mr Woodhead's mental health during his brief time at Hindley, the clinical reviewer considered that Mr Woodhead's mental health was appropriately assessed.

Resuscitation

93. While we understand why staff wanted to try to resuscitate Mr Woodhead, starting CPR in these circumstances was not in line with the national guidelines on when it is appropriate to do so.

94. The Resuscitation Council (UK) guidelines state that staff should consider whether CPR efforts would be successful and in the patient's best interests. It states that, "Resuscitation is inappropriate and should not be provided when there is clear evidence that it will be futile." The guidelines define examples of futility as including the presence of rigor mortis. In Mr Woodhead's case, both prison and healthcare staff noted that rigor mortis was present and that he had and mottled skin so CPR was not likely to be successful as these are clear signs of death.

95. The Head of Healthcare told us that if officers had started CPR, healthcare staff would continue rather than making the decision to stop. A nurse also confirmed this

approach. She told us that if a nurse had been the first on scene, they would have assessed the situation and decided not to start CPR. She said that there have subsequently been discussions with staff about when not to start CPR.

96. While we understand the wish to attempt and continue resuscitation until death has been formally recognised, staff should not carry out CPR in these circumstances. We make the following recommendation:

The Governor and Head of Healthcare should ensure that staff are given clear guidance and check their understanding about the circumstances in which resuscitation is inappropriate in line with the Resuscitation Council Guidelines.

Inquest

97. The Coroner's inquest held on 18 January 2024 determined the medical cause of death to be hanging. The jury returned a narrative conclusion, stating that Mr Woodhead died as a result of suicide and noted that this was an intentional act of self-suspension by use of an improvised ligature.

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