Investigation into the circumstances surrounding the death of a man at HMP Woodhill on June 2004

Prisons and Probation Ombudsman for England and Wales

October 2005

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The death of a man on Father's Day, 20 June 2004, at HMP Woodhill was the second death at that prison I have investigated since taking on the responsibility for investigating deaths in prison custody in April 2004.

Under transitional arrangements agreed with the Prison Service, a senior investigating officer was appointed by the Prison Service to conduct the investigation. He was the Governor of HMP Wakefield. I am most grateful to him for the investigation. I have structured this report so that the Governor's investigation can be separately identified.

The man who died was on remand but the circumstances of his arrest leave no doubt that he had murdered his estranged wife and his sister-in-law, and seriously injured his mother-in-law, using a shotgun. The man had two young children. The police family liaison officer has informed my office that a copy of this report will be placed into 'memory boxes' for them when they are older. I should like to offer my sincere condolences to them for the tragic deaths of their parents and aunt.

The Deputy Ombudsman met with the man's mother and his other sister, along with their legal representative to talk about the investigation and the findings.
A family liaison officer from my office, and the Deputy Ombudsman, met with the man's sister at her home. They have also spoken over the phone. I hope that this report is able to provide the family to answers to the questions they have about the man's short period in custody. I wish to extend my sincere condolences to his parents, sisters and their families on their tragic loss.

The Deputy Ombudsman BSc RGN carried out a clinical review into the medical care and treatment that the man had received in prison custody. Her report makes four recommendations and is reproduced in full at Section 5.

The death of the man was the first of a person who had been recently removed from the new suicide prevention procedures (the ACCT form) that the Prison Service was piloting at five establishments. Two of the recommendations from this investigation relate to the policy on ACCT procedures.

Finally, I would like to express my thanks to acting governor of Woodhill at the time, and his staff for the help and active co-operation that the investigators received during the investigation.

STEPHEN SHAW CBE **October 2005**
PRISONS AND PROBATION OMBUDSMAN

SUMMARY

This is the report of an investigation into the death on 20 June 2004, at HMP Woodhill, of a man. A chaplain at the prison found the man in his cell just after 11.10am on that Sunday morning. He had made very deep cuts to his neck that resulted in him losing over two litres of blood. He had also tied a ligature around his neck. He was 39 years old at the time of his death.

Oxford Magistrates Court had remanded the man into custody at HMP Bullingdon on 9 June 2004. He had been charged with two counts of murder and one count of attempted murder. The offences involved extreme violence and had received significant media coverage. Because of the seriousness of the charges, the man was classified as a potential category A prisoner (the highest security classification). He therefore needed to be accommodated in a high security prison and was transferred to HMP Woodhill near Milton Keynes on 11 June.

At both HMP Bullingdon and HMP Woodhill, the man was assessed on reception as a possible suicide risk. Staff at Bullingdon instigated suicide and self-harm prevention procedures appropriately. Woodhill was piloting new suicide and self harm prevention procedures (known as Assessment, Care in Custody and Teamwork (ACCT)). The Prison Service plans to roll these out nationally in due course the man transferred onto the ACCT system from the F2052SH system used at Bullingdon on the day of his arrival at Woodhill.

Action plans, assessments and reviews were carried out in accordance with ACCT guidelines. On 16 June, the man moved to the segregation unit for a period of assessment to determine whether he could be accommodated on a normal residential unit. The following day his ACCT form was closed after a case review. The man did not express any suicidal thoughts to staff at any point, although his mood was noted to be low and he was struggling to accept the impact of his actions.

On Saturday 19 June, the man spent some time talking to other prisoners during the exercise period and whilst associating with them on the unit. One of these prisoners told the investigation team that he did talk about suicide, whilst another thought he seemed ‘fine’. No concerns were brought to the attention of staff and so no additional monitoring was instigated.

The next day, he asked for and was given razor blades to shave with. The category A monitoring book has been completed for 10.00am indicating that a member of staff had observed him. During the investigation it has come to light that this did not occur. The Prison Service have carried out their own internal disciplinary investigation into why an officer signed a monitoring book stating that he had observed the man when in fact CCTV evidence clearly showed this did not occur.

The man who died was found shortly after 11.00am by the Chaplain on a routine visit. He was hanging from the bed frame in his cell, surrounded by a large amount of blood. I commend the staff who responded in a prompt and professional manner to the very distressing and disturbing sight that faced them upon entering the cell that Sunday morning. Prison healthcare staff were summoned immediately and were en-route to the cell very quickly. The ambulance arrived at the segregation unit within

10 minutes of being called. Unfortunately, the man had no pulse and had lost a very significant amount of blood so neither prison staff nor the arriving paramedics attempted resuscitation. This was appropriate given the circumstances.

On reception into custody, the man was correctly screened and admitted to healthcare for a period of assessment and management of his alcohol withdrawal and mental state. At Woodhill, he was also located in the healthcare centre due to his low mood. However, there is no documentary evidence to show whether his mental state stabilised or improved during this period. He was subsequently transferred to the segregation unit where again there is no evidence to show any out-reach care or healthcare input into his support and management planning.

There is no way to know for certain why the man chose to take his own life. There was no suicide note and there is no knowing exactly what he was thinking. Sunday 20 June was Father's Day – and this day may have been significant in his decision. In retrospect, he had a number of risk factors including being in the first month in custody and the nature of his alleged offences.

There is also some indication from a prisoner who was interviewed by the investigation team that the man had thought about committing suicide and that he was worried about facing a long prison sentence. He had told staff, however, that he did not have any suicidal thoughts. No concerns had been raised about his behaviour by staff after his ACCT form was closed on 17 June.

Having met with the family, they have informed my investigators that they communicated their concerns about the man's mental well-being with the prison. However, there is no evidence as to who received this information or what action was taken when it was received.

The report makes a total of six recommendations in all, two of which relate to the ACCT form that is currently being developed and piloted by Safer Custody Group in the Prison Service. A further four recommendations arising from the clinical review make reference to local practices.

Because of the deliberate and extreme way in which the man died, I am in no doubt that he intended his life to end.

KEY FINDINGS

Oxford Magistrates Court remanded the man into custody on 9 June 2004. He had been charged with two counts of murder and one count of attempted murder. The charges were for offences committed against his estranged wife and members of her immediate family. His first night in custody was at HMP Bullingdon.

Whilst at Bullingdon, the man was located in the healthcare centre. He was incorrectly informed on the evening of 10 June that his mother in law had died in hospital as a result of her shotgun injuries. He was told the next morning that this was not true. The prison apologised for having misinformed him about the situation and he seemed to accept this apology and did not want to make a formal complaint. The Governor of Bullingdon immediately commissioned her own inquiry into how this incorrect information had been passed to the man. The findings of this investigation were that improvements needed to be made to both the record keeping within the healthcare centre at Bullingdon and communication between managers.

Because of the seriousness of the charges he faced, the man was classified as a potential category A prisoner (the highest security classification). This classification meant that he needed to be accommodated in a high security prison and he was therefore moved to HMP Woodhill near on 11 June.

Both Bullingdon and Woodhill appropriately assessed the man as a suicide risk on his initial reception due to concerns raised by the police, the high profile of his alleged offences, and his presenting low mood. Staff at Bullingdon, using the F2052SH process, initiated suicide and self-harm prevention procedures appropriately. Woodhill is piloting new suicide and self harm prevention procedures, Assessment, Care in Custody and Teamwork (ACCT). The man was transferred onto the ACCT system on 11 June on his arrival at Woodhill.

The healthcare unit at Woodhill completed an 'Immediate Action Plan' and an 'Assessment Interview' for the man in line with the ACCT guidelines on his first day. These were fully completed and in line with the guidelines.

On 12 June a Case Review was held. The document stated that no concerns had been expressed about the man during the previous evening and night and that he had told staff that he had no thoughts of self-harm. The man also asked to be considered for a move to a normal residential unit in the prison so that he could associate with others. The ACCT form was kept open and another case review was scheduled for 19 June after his next court appearance.

On 16 June, the man was moved to the segregation unit within Woodhill. The purpose of his move to this unit was not for any type of 'punishment' (commonly associated with a segregation unit) but for assessment as to whether he could be moved onto a normal residential unit. This decision was reasonable in light of the notoriety of the offences with which he had been charged and the uncertainty that the prison faced as to whether he would be able to associate freely with other prisoners without risk of harm. The part of the segregation unit where the man was located allowed for a semi-relaxed regime, including exercise and association periods with other prisoners who were held in that part of the unit.

The case review planned for 19 June was brought forward to 17 June. This was because staff trained in the ACCT procedures were available on 17 June, because the man had not expressed any suicidal thoughts to staff and because he had a court appearance the next day. His ACCT assessor felt that it would be in his interests to have a case review on that day. The case review consisted of only three people – the unit Senior Officer (case manager), the man and his ACCT assessor. They decided that he no longer required the additional monitoring offered by the ACCT process and closed his ACCT form. The review notes show that the man said that he had no intention of self-harming. They also note that the man said what he had done had not sunk in yet. This report makes two recommendations about the ACCT procedures that are currently at a trial stage in several establishments.

On Friday 18 June, the man attended the Crown Court and was remanded back into Woodhill. On his return to Woodhill, he went back to his single cell in the segregation unit.

On Saturday 19 June, the man spoke to another prisoner whilst on the exercise yard. This prisoner told the investigation team that the man told him that he was thinking of committing suicide because he would rather be dead than spend 30 years in prison. Prison staff did not hear this conversation and the prisoner did not pass on the information to them. Another prisoner said that he also spoke with the man who died on Saturday during exercise. He reported the man as saying he was “alright at the moment” but that he had been upset when he had started to talk about his wife. A third prisoner spoke to him later on that day whilst playing table football. He told the investigation team that he was chatting normally with people and that he seemed fine and not distressed. Whatever the man may or may not have said to particular prisoners on that Saturday, he did not raise any concerns with staff and no prisoners told staff of any concerns they might have had about him.

The Saturday night passed uneventfully. The man was last seen alive at approximately 9.05am on Sunday 20 June. At this time he was given two razor blades (which he had requested in order to shave) and his prescribed medication.

It is normal practice within the Prison Service for prisoners to be given disposable razors with which they can shave in their cells. Prisoners are usually permitted to shave unobserved by staff and return the used razor to staff later on in the day (or swap it for a new razor for use the following day).

A member of the segregation staff signed a category A movement / monitoring book to say that he had observed the man at 10.00am. This check was not in fact carried out. One of my recommendations is that the Prison Service conducts a disciplinary investigation into this finding.

A chaplain at the prison found the man in his cell just after 11.10am on 20 June 2004. He had made very deep cuts to his neck with a razor blade. This resulted in over two litres of blood loss in the cell. Additionally, the man had attached a ligature around his neck to the underside of the bed.

The alarm was raised very quickly and prison officers and healthcare staff were at the cell within a few minutes. Neither the officers nor nursing staff attempted resuscitation due to the fact that there were no signs of life, no pulse and a significant amount of blood loss. This judgement appears to have been wholly appropriate in the circumstances.

Ambulance paramedics arrived at the scene at 11.29am and found no signs of life. The man was pronounced dead by the arriving doctor around 11.55am.

This investigation commends the actions of staff upon finding the man in his cell that Sunday morning. They all acted in an effective and professional manner in circumstances that must have been acutely distressing.

FINDINGS AND CONCLUSIONS

Policy

The first recommendation is in relation to the multi-disciplinary case conference that meets regularly to discuss how a suicidal person is feeling and what support can be offered to them.

The Prison Service should consider whether the policy should be altered so as to specify a minimum number of members for such an assessment including the attendance of a member of the healthcare team.

The second recommendation relates to the decision of a case conference to close an ACCT form. My objective is to enable an objective viewpoint to be taken by someone removed from the case conference process and the prisoner concerned. It would encourage a 'balancing' of a person's statistical risk of suicide against what they have said during a case conference and/or observations that staff have made whilst being monitored on the ACCT form.

The Prison Service should consider whether the ACCT policy should be amended to include a section for senior management approval of the closure of the ACCT following a case review.

Health

When the man was received at HMP Bullingdon he was assessed by a healthcare worker and appropriately located in healthcare for a period of assessment and management of his withdrawal from alcohol. He was placed on an enhanced level of observation, but the medical record does not make clear what this should have been.

Healthcare staff should be reminded that entries in medical records and nursing notes should be explicit to enable staff to carry out the instructions and ensure that prisoner / patients receive the correct level of care, support and supervision.

The man transferred to HMP Woodhill on 11 June, was seen on reception by healthcare staff and appropriately located in the healthcare centre. He was noted to be low in mood. During his stay in healthcare there are no entries in his nursing notes to indicate an evaluation of his mental state or the risk he posed to himself. There is one entry in the continuous medical records indicating he was associating well when out of his cell.

Staff should be reminded of the importance of making accurate and contemporaneous notes to ensure patients receive appropriate and seamless care.

Healthcare staff did not participate in the ACCT case review on 17 June 2004 despite the man having spent all his time as an in-patient since his arrival in custody.

Healthcare should be invited to contribute to ACCT case conferences, particularly when there has been significant healthcare involvement with the prisoner.

At no time was the man referred for a mental health assessment despite entries indicating his depression, low mood, reaction to events and additionally the serious nature of the charges.

All persons charged with murder or other serious charges should receive a prompt mental health assessment by an appropriately qualified practitioner.

RECOMMENDATIONS

The Prison Service should consider whether the policy should be altered so as to specify a minimum number of members for such an assessment including the attendance of a member of the healthcare team.

The Prison Service should consider whether the ACCT policy should be amended to include a section for senior management approval of the closure of the ACCT following a case review.

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