Investigation into the circumstances surrounding the death of a man at HMP Woodhill in July 2009

Report by the Prisons and Probation Ombudsman for England and Wales

July 2010

This is the report of an investigation into the circumstances surrounding the death of a man who was found hanging in his cell at HMP Woodhill in July 2009. The man, who was originally from Poland, was 29 years old.

I would like to offer my sincere condolences to the man's wife and son, his wider family, and to others who have been affected by his death.

The investigation was carried out by one of my Assistant Ombudsmen and an investigator. We would like to thank the Acting Governor, the Governor and a senior officer for providing information and arranging interviews to assist the investigation. I am also grateful to Thames Valley Police for copies of some of the witness statements taken as part of the police investigation.

The man, who is the subject of this report, had been in custody for just under seven weeks. Unbeknown to him, it was entirely likely that he would have been bailed the day after he died. The charge against him had been downgraded to the more minor offence of common assault, and a bail hostel had offered him a place.

The man did not appear to staff to be depressed or at risk of self harm. Some of his fellow prisoners did know that he was struggling to cope, but were still surprised by his decision to end his life.

I made five recommendations, including a national recommendation about the issuing of face masks to staff. At draft consultation stage all of the recommendations except the national recommendation were accepted by the National Offender Management Service (NOMS). Their response is shown alongside each recommendation at the end of this report. The clinical review made a further six recommendations which were also accepted by NOMS.

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

Jane Webb
Acting Prisons and Probation Ombudsman **July 2010**

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SUMMARY

The man who died was born in Poland in 1980 but moved to the United Kingdom several years ago and, according to his wife, saw this country as his home. He was married with one son and employed in a supermarket delivery organisation. The man had a problem with alcohol in that sometimes he would drink very heavily and his personality would change. On one of these occasions the man threatened his wife with a knife in front of their son and was arrested by the police. He was charged with affray and remanded into custody at HMP Woodhill on 5 June 2009. This was his first time in prison.

Another charge - that of rape - was not proceeded with at court, but was still showing on the printout from the Police National Computer as an impending prosecution. The man's probation team told him that he would not be eligible for bail to a hostel because of this. At court on 24 June, the man was told the charges were so serious that his case could only be heard at Crown Court. (Magistrates have more limited sentencing powers and can only sentence someone to a maximum of six months in prison.) His solicitor felt that this had a big impact on the man. Foreign national prisoners who are sentenced to more than 12 months in custody are assessed for deportation. The man did not want to be deported and worried about this and being separated from his wife and son.

The man was a private person who only shared his feelings with a few prisoners at Woodhill. Those that did know him said he was tearful a lot of the time and that he missed his wife and son greatly. He struggled to find a way around his problems and went over them again and again in his mind. He applied for several education courses in early July, including Alcohol Awareness and Anger Management. Although cleared for these courses and on the waiting list, nothing was fed back to the man. The only course he had started was Health and Safety.

My investigation found that the personal officer scheme did not seem to work as the prison's policy intended on houseblock 4A. Neither of the man's two allocated personal officers knew much about him and their conversations had been brief and general. No entries had been made in his history file.

The prison was told by the man's solicitor in mid July that the rape charge had been dropped and this was confirmed by the police. An application to a hostel was made and accepted by them two days later. Probation staff faxed the relevant papers through to Crown Court and the man's solicitor the same day.

Over the weekend the man spoke with his wife. She tried to help him to feel better and was encouraging, but he said he did not feel like talking to anyone or doing anything. On the following Monday he started the Health and Safety course in the Education Department. That day, the man's solicitor received a letter (dated three days earlier) from the Crown Prosecution Service indicating that they were going to replace the affray charge with a more minor charge of common assault (this can only be dealt with at Magistrates Court). The letter arrived too late on the Monday to be conveyed to the man.

On the day the man died, his Health and Safety course was cancelled because the tutor was unwell and he went back to his cell. His cell mate remained in education on a different course. An officer saw him around 10.25am whilst carrying out routine cell checks. The man was watching television and said he was okay. At 11.35am, as an officer was unlocking the man's cell for lunch, he saw him hanging from the window bars at the back of the cell. Staff responded quickly, cutting the man down and commencing chest compression only CPR. Medical staff were at the cell within minutes (although there was some confusion about the correct term to use to call for medical help), and resuscitation was continued with breaths, oxygen and a defibrillator (a machine used to shock the patient's heart and restore the heart's normal rhythmic patterns). Paramedics arrived and the man was taken to hospital where further attempts were made to revive him. Sadly, he was pronounced dead by hospital staff at 12.48pm.

My investigation resulted in five recommendations, including one about the personal officer scheme and the way prisoners are told about the progress of their education applications. I also made a national recommendation that NOMS[1] consider issuing face masks with a non-return valve to staff. This last recommendation was not accepted by NOMS during the consultation period. The clinical review was received after the draft report was issued and so a second period of consultation took place. The six recommendations made by the clinical review were accepted by NOMS.

[1] National Offender Management Service.

THE INVESTIGATION PROCESS

1. I was notified of the man's death in July 2009. I appointed two colleagues, one being an Assistant Ombudsman, as my investigators. An incident report, prison documents, medical records and statements from staff were made available to the investigation team.

2. An opening visit was made on 27 July. The team met with the Acting Governor and representatives from the Independent Monitoring Board and local branch of the Prison Officers' Association. My Assistant Ombudsman also met with the police liaison officer working at the prison. Some initial interviews were carried out by the investigation team during the next few days. The team returned to carry out further interviews over the following weeks.

3. I commissioned a clinical review from Milton Keynes PCT. A clinical reviewer was appointed to carry out the review. Some joint interviews of medical staff were carried out in September. I received the clinical review after I issued the initial draft report. Therefore a second draft was issued to the prison so that they would have an opportunity to comment on the recommendations contained within it.

4. My Assistant Ombudsman wrote to the man's solicitor asking for some further information about the man's court appearances and his bail application. I am grateful to the man's solicitors who replied with useful information about his court hearings.

5. HM Coroner's Office was informed of the Ombudsman's investigation. The post mortem report indicated that the man died as a result of asphyxiation, caused by hanging. There were some traces of an anti-histamine (most likely from the sleeping tablets that another prisoner gave the man to help him sleep the evening before) and atropine (used in the resuscitation efforts). I am grateful for the assistance of the Coroner's officer and for translated copies of the e-mail letters sent to the man by his wife.

6. My Assistant Ombudsman met with the man's wife on 28 July as she had travelled to Woodhill to see the cell where her husband had died. My Assistant Ombudsman explained the role of my office and gave her the name and contact number of one of my family liaison officers. My family liaison officer contacted the man's wife shortly after. My family liaison officer explained her role and provided information about the investigation process. My investigators and my family liaison officer met with the man's wife in September. She said her husband was upset and crying on the telephone when they spoke, and that he told her he was very worried about being deported to Poland and being separated from his family. She felt that her husband had an alcohol

problem and wanted to know what had been done to help him. The man's wife said he had applied for several courses whilst he was at Woodhill, such as anger management, alcohol awareness and family relationships, but that he had never received a response to his applications. As noted, she had visited the prison and seen the cell where her husband had lived, and talked to his cell mate. The prison assisted with the funeral costs in line with national Prison Service instructions. The man's wife will receive a copy of my final report.

HMP WOODHILL

7. Woodhill is a local prison that opened in 1992. It is part of the high security estate holding some category A prisoners as well as some of the most disruptive prisoners in the system in the close supervision centre. It also has a protected witness unit. The vulnerable prisoners are located in Houseblock 4B, with standard prisoners being kept on Houseblock 4A, the side that the man lived on. There is also a First Night Centre and separate induction unit, on both of which the man spent short periods of time. Woodhill serves courts in Northamptonshire, Hertfordshire, Buckinghamshire and Bedfordshire.

8. An inspection by HM Chief Inspector of Prisons in 2005 led to a description of the prison as 'depressing and disappointing'. However, following a subsequent inspection in 2007, HM Chief Inspector of Prisons found 'a very different prison'. Safety at Woodhill was said to have 'improved considerably, with extremely good reception and first night procedures'. The main issue within Woodhill was the lack of activity. At the time of the inspection, Woodhill could only provide work or education for 30 per cent of its prisoners. However, HM Chief Inspector of Prisons said that those who were unemployed were out of their cells for considerable periods during the day.

9. Woodhill did not have any self-inflicted deaths for three years leading up to September 2008, but since then has had three (this man being the last of these). My report into the self-inflicted death of a man in September 2008 found that night staff had not been recently trained in CPR (Cardio Pulmonary Resuscitation) and had not carried out resuscitation techniques at the recommended ratio of two breaths to every 30 compressions. I made a recommendation about this.

10. Milton Keynes Primary Care Trust is the responsible commissioning PCT for healthcare at Woodhill. The provider arm of the organisation delivers a nursing healthcare team based in the prison, a Mental Health In-Reach Team, and x-ray, dental, pharmacy and podiatry services. Milton Keynes PCT also commissions a number of other providers to provide healthcare including Resuscitate Medical Services Limited who provide general medical Services, the Seagrave Trust who provide substance misuse services, and Howcroft and Selly who provide ophthalmic services. In addition, Woodhill provides some healthcare staff who support the functions of the healthcare department. Two doctors cover the prison Monday to Sunday. During weekday mornings, one GP stays in the main healthcare department and sees prisoners in two rounds for morning clinic (akin to an appointment with a community GP practice); the other doctor goes to the inpatient unit and the segregation unit. Other clinics are run in the afternoon, and then one GP stays on duty in the prison reception from 6.30pm to 9.30pm.

KEY FINDINGS

Initial period in custody

11. The man was charged with affray. This is normally a public order offence, but in this case he had threatened his wife when drunk on 3 June. Their son had also been present. The charge was laid on 4 June at a police station.

12. The police initially decided to bring a rape charge against the man committed during the previous six months against his wife. However, this was withdrawn at Magistrates Court during the first hearing on 5 June. The man was remanded into custody and taken to Woodhill. After going through reception the man went onto the First Night Centre.

13. The First Reception Health Screen form is a standard form used across all prisons. Nothing of particular note was recorded about the man – the nurse completing the screen ticked “no” to questions about whether the man had seen a doctor in the last few months, took any prescribed medication, had any physical injuries or any other concerns about his physical health. The nurse wrote that he appeared “fit and healthy”. The section of the form that asks about drinking alcohol is ticked, “yes” but the comment added is that the man “drinks socially”. The form advises the nurse to refer to a doctor if the person drinks more than 20 units a day or if they are showing signs of withdrawal.

14. The part of the form about mental health does have one tick – the man answered “yes” to the question about whether he had ever seen a psychiatrist and the nurse has added: “was nervous”. The other questions about in-patient psychiatric care, being assigned a psychiatric nurse in the community, harming himself or receiving medication for any mental health problems are all ticked “no”. The guidance at the bottom of that section states, “If yes to any of the above; refer to the Mental Health In Reach”. The last page of the screening form is where the nurse indicates the planned future actions. The box for the man to be referred to the doctor is ticked but not the box about referring him to the Mental Health In Reach Team (MHIRT). A doctor said during interview that he thought the tick referring the man to the doctor was probably a mistake on the part of the nurse who completed the form. The man had perhaps asked for something to help him sleep and she had ticked the box to see the doctor because of this. The doctor explained that he does not usually see prisoners for this reason. Instead, a standard dose of four days worth of sleeping medication (Promethazine) is written up by the nurse and signed off by the doctor. The doctor explained that Promethazine is an anti-histamine that induces sleep as a side effect.

15. The nurse wrote up an entry in the man's medical record as follows,

> "Seen – first time in prison. Denied self harm / suicidal thoughts. Appears anxious as first time in prison. Doctor prescribed Sominex [promethazine] 40mg IP [in possession]."

I understand that Promethazine is commonly prescribed at Woodhill to help new prisoners get to sleep.

16. The doctor who thought the nurse had made a mistake on the screening form said that the man did not see a doctor that evening because, if he had done, the doctor would have made a separate entry below the nurse entry. There are no other entries in the man's continual medical record (which records all day to day contact with nursing staff or doctors) from 5 June to the day of his death on 21 July.

17. The cell sharing risk assessment form[2] completed on 5 June notes that this was the man's first time in prison custody and that he had abused alcohol in the past. He was given a smoker's pack from the canteen and offered a phone call (which he made on Saturday 6 June). The 'second day interview' section of the induction record form indicates that various aspects about prison life, such as in-cell television and the IEP system,[3] were explained. The man met a member of the chaplaincy team, who noted in the paperwork that he was concerned about his recent marriage breakup.

18. The Secondary Health Screening form was completed on 6 June by a nurse. It notes that the man's father has leukaemia. Under the section asking "Do you have any health concerns?" the nurse has written that the man is "Just stressed that will lose his job as has no family in UK."

19. On 8 June, the man moved onto the Induction Unit (Houseblock 5). Whilst on this unit, the man met another prisoner. The men became friends and would later share a cell on Houseblock 4A.

20. The man appeared at court by way of videolink on 10 June. It was decided he should be given the opportunity to talk to an interpreter as one had not been provided at the police station or court.

21. The man attended a clinic for Foreign National Prisoners on 11 June. An Immigration Clinic is held every second Thursday in the month at Woodhill. From 1 April 2009, all EEA nationals sentenced to 12 months or more are assessed by UKBA[4]. They consider deporting prisoners who have committed a violent, drug related or sexual offence.

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[2] Completed on all prisoners to assess their risk to others if put into a shared cell.
[3] Incentives and Earned Privileges is a scheme whereby a prisoner's good behaviour and compliance with their sentence plan targets can improve the facilities, visits and money that they can access whilst in prison.
[4] United Kingdom Border Agency.

Deportation orders do not carry an expiry date and remain valid unless they are formally revoked. Unless an order is revoked, the deported person may not return to the UK. The relevant form for the man to be referred to UKBA (CCT1) had been automatically completed by an officer on 8 June and sent off to UKBA the following day. No decision about whether to deport the man would have been taken until he was convicted and sentenced. A sentence of less than 12 months would have meant the man could have continued to live in the UK.

22. A legal representative visited on 16 June and the man's wife visited the next day. After this visit his wife sent him a letter by e-mail.[5]

23. The man appeared at Magistrates Court on 19 June. No interpreter had been arranged so the matter was further adjourned to 24 June and the man returned to Woodhill that evening. The man was told his case would be heard at Crown Court because the allegations were so serious that the powers the magistrates had were 'insufficient'.

24. The man's wife and son visited on Tuesday 23 June. The next day the man moved to Houseblock 4A, cell 15 on the two's landing. The man shared a cell with the man he had met on the Induction Unit. He also got to know two other prisoners. My investigator spoke with all three. Each described him as a private man.

25. No entries were made in the wing observation book or the man's history sheet about him whilst he was on 4A. His personal officers did not carry out the personal officer induction interview with him. Both officers said they had conversations with the man but the interaction was on a very general level. I return to the personal officer system later on in my report.

26. Woodhill was under the impression that the man still faced prosecution for the sexual charge and that he was therefore ineligible for release to a bail hostel. This is likely to have been because the PNC[6] printout in the man's core prison record listed the rape charge as an "impending prosecution".

27. The man made a wing application on 24 June to speak to someone about applying for a hostel. A woman from the probation team went to Houseblock 4 to speak to him. She had not met the man before. When she got to the wing she asked an officer to fetch the man for her. The officer called out the man's name and then waved a prisoner over. Another prisoner also came over (as an interpreter). The woman from the probation team assumed that the prisoner was the man. They went into a side room and their conversation began. The woman from the

[5] *E-mail a prisoner.com* is a company that operates in many prisons in England. It allows a prisoner's families and friends to send them e-mail correspondence. The e-mails are printed off by the prison and then distributed in the same way that letters are delivered by staff. The man's wife sent several e-mails to him during his time in Woodhill.
[6] Police National Computer.

probation team said she mentioned the man's name at least three times during their initial dialogue. She went on to explain that he was not eligible for a hostel because of the outstanding rape charge. At this point the prisoner became agitated and said that it was not him and that he was not being charged with rape. The prisoner was not in fact the man who is the subject of this report, but another man.

28. This all appears to have been a genuine mistake on the part of both the officer, the woman from the probation team and the prisoner (who thought he had been 'waved over' to speak with her). There was no deliberate intention to mislead on the part of anyone involved. There were no repercussions on the wing. The woman from the probation team told my investigator that prisoners carry ID cards (with their picture, name and prison number on). They show these for access to activities such as the gym, collecting medication, work and education. The woman from the probation team said she now asks to see prisoners ID cards before starting any interview.

29. The woman from the probation team went on to speak to the 'real' man and explained why the hostel could not accept his bail application. At his videolink hearing he was not given bail. Proceedings were adjourned until 22 July.

30. During the next week the man received several e-mail letters from his wife explaining the day to day things she and their son had been doing. She visited him on 2 July and they talked on the telephone[7] a few days later. The man applied to do five courses on 3 July: Health & Safety, Alcohol Awareness, Anger Management, ESOL[8] and Family Relationships. The man's wife visited on 8 July and he applied again for Health & Safety, Alcohol Awareness and ESOL.

31. The man spoke with his wife on the telephone on Sunday 12 July. During their conversation his wife said she would visit on Wednesday. He told her that staff had asked him if he wanted to go to church. He said he had thought about going but did not do so in the end. His wife encouraged him to go next time as she thought that it would help him. She was encouraging and supportive on the phone and they told each other how they were missing one another. She told her husband she had called someone from Witness Protection and that she wanted to cancel her statement.

32. The man should have gone to education on 13 and 14 July to start the Health & Safety course but the classes were cancelled. A prisoner told the investigator that the man was upset about this.

33. The prison received a letter from the man's solicitor on 15 July. This letter and the attached charge sheets and witness statements showed

[7] Telephone calls are routinely recorded but not routinely listened to at Woodhill. The phone calls that the man made to his wife were in Polish. They were translated after his death.
[8] English as a second language.

that the rape charge had been dropped. This meant that the man would now be eligible to apply to the hostel.

34. The same day, the woman from the probation team interviewed the man on the houseblock regarding the hostel. The man knew that the sexual charge against him had been dropped. The woman from the probation team said the man became upset at times during the interview. She felt that this was because she had to explain to the man that the judge might decide to prevent him seeing his wife during the period leading up to the trial (it might be one of the bail conditions). The woman from the probation team and the man still wanted the bail application to go ahead. She felt that the man was more fearful of losing his wife than he was about the possibility of being deported. (They had discussed the fact that if he received a sentence over 12 months UKBA would assess his circumstances and might decide to deport him back to Poland.) He was blaming himself for what he had done and was very remorseful. She said that the man seemed okay by the end of the interview and they agreed to go ahead and make the application to the hostel. His English was of a good standard and she felt he would understand most things on a day to day basis. She said the man told her he was 'fine' and was due to see his wife soon. She did not think he came across as someone who was depressed. She felt that he had been fairly open with her. The man had a visit with his wife later that day.

35. The hostel accepted the application for the man on 17 July. The woman from the probation team faxed this acceptance to the solicitor (and the Crown Court liaison officer). The solicitor would then have to complete the appropriate court application form and pass everything onto the court, ready for the bail hearing. The woman from the probation team said that normal practice is for the bail application to be considered by the judge within three working days. She is not made aware of when the hearing is scheduled and it would be the solicitor's responsibility to let the man know when the application was being decided. It would appear that the Crown Court planned to hear the bail application on 22 July. The man would not have had to attend.

36. Over the weekend, the man made a telephone call to his wife. He was very down during their conversation. His wife tried to make him feel better and told him that everything would be alright. She asked him to talk to someone but he replied:

> "I do not even feel like talking to anyone. They can see and ask me, 'What is the matter with you?' I do not know … I just do not talk to them … The Polish bloke who is in here asked me what was the matter with me. I do not want to talk about anything. I do not feel like talking to anyone. I do not know. I do not know what happened with me. I do not know."

37. The man went on during the conversation to say to his wife that he did not feel like doing anything. His wife continued to try to encourage him to do things out of his cell, such as go to church. She asked him to be positive and told him that he has her and their son. His wife said she would book a visit for this week. She also asked whether he had received her e-mail yet, but he had not.

38. The following day, the eve of the man's death, he started the Health & Safety course in education. This was the first day of the course. The man was also given the e-mail that his wife had written and sent in. He made further applications for places on the ESOL and Alcohol Awareness courses.

39. In interview, a fellow prisoner said he found a razor blade in their cell. He told my investigators that he had to convince the man to dispose of it. He gave the man his last two sleeping tablets. The man found it hard to sleep and told his fellow prisoner that the tablets helped.

The day of the man's death

40. The man's cell mate thought that the man had woken up "groggy" because of the sleeping tablets. He said the man did not want to get out of bed and wondered about missing the Health & Safety course. The cell mate told him that he would feel better if he got up and went. The two men were unlocked for education at around 9.00am by one of the man's personal officers. The man got to the education department but was then told that his class had been cancelled because the tutor was unwell. She said the man did not appear to be upset or subdued. The man's cell mate said he made a remark like, "that is what you wanted" and patted the man on the back. He did not reply. He returned to Houseblock 4A, only about five minutes after he left and was locked back into his cell by one of the man's personal officers. His personal officer said in his police statement that the man did not say anything to him whilst they were walking to the cell, and he got no impression that he was upset or angry. The man seemed "quite normal".

41. One of the man's personal officers went to the wing office and completed some paperwork. At about 10.05am, both the man's personal officers started doing the AFCs (Accommodation Fabric Checks) which involves each cell being checked for damage to the windows, doors, electrics or lights. It includes a check that the cell call bell system is working. Around 10.25am, one of the man's personal officers reached cell 2-15 (he and the other personal officer were alternating cells on the landing). He said the man was lying on the bed (the top bunk) and that the TV was on. The personal officer asked if he was okay and thinks the man replied, "yes". The personal officer

completed his checks in the cell, which took about one minute, and then left.

42. At around 11.15am, the trolleys carrying lunch arrived on the wing. An officer unlocked the three's landing first and the prisoners collected their lunch. One of the man's personal officers then unlocked the one's landing and supervised the collection of their meals.

43. The officer who unlocked the three's landing then began unlocking the two's landing, starting with cell 20. He reached cell 15 and saw the man hanging from the window. He had used a thin piece of torn green sheet as a ligature. The officer was not carrying a radio, so shouted for help instead, shouting "Staff!" One of the man's personal officers heard him and ran upstairs, shouting for an officer with a radio to call in a medical emergency. As he was doing so he saw the officer who had unlocked the three's landing enter the cell. The officer used his anti-ligature knife to cut the ligature above the knot. He held the man's body. One of the man's personal officers arrived and together the officers lowered the man to the floor of the cell. The personal officer said he remembered the man being "extremely heavy", and as they laid him on the floor he hit his head. They tried to put him into the recovery position but found this difficult because his limbs were very floppy and heavy. The man was then put onto his back, with his head towards the cell door. The personal officer saw marks around his neck and some green sheet wrapped around his throat. He removed this in order to clear the man's airway. He described the man's lips as purple and that his eyes were glazed over. He started to look for a pulse as a further officer arrived. The man's other personal officer went to the cell but did not go in as there were already staff in the cell. She said no one was carrying a radio. She shouted to an officer who was on the one's landing near the servery that they needed medical assistance. At 11.37am, the officer made a Code Red[9] message via his radio. An OSG (officer support grade) in the control room took the Code Red alert over the radio and then put the call out to Hotel 1 (emergency healthcare response), Oscar 1 (the orderly officer) and Victor 2 (the duty governor). The officer who was earlier on the one's landing near the servery went to the cell and passed on more detailed information to the control room via his radio. He told some of the prisoners to go into their cells.

44. A female officer was on the three's landing unlocking for lunch when she heard one of the man's personal officers shout that there was a medical emergency. She ran downstairs and into the cell, joining the man's personal officer and another officer. She also checked for a pulse, but could not find one. She cleared the man's airway and then began chest compressions. She continued compressions until relieved by healthcare staff.

[9] A Code Red is used to indicate that there is a prisoner who has self harmed and that resuscitation may be necessary.

45. A senior officer (SO) went to the cell immediately upon hearing the radio message. He estimated that it took him 20 to 30 seconds to get to cell 2-15. He asked for an ambulance over the net and also for the doctor to attend. The SO asked the officer who was earlier on the one's landing near the servery to run to the treatment room and tell the nurse based there to come.

46. An HCA (health care assistant) had gone onto Houseblock 4 at around 11.35am as she was due to see a patient in the lecture room on the ground floor in connection with smoking cessation support. The ETS (Enhanced Thinking Skills) course was still running and would last for another 15 minutes and so she went towards the treatment room, on the ground floor of the unit, to wait. As she got near the door an officer (the officer who was earlier on the one's landing near the servery) was asking a staff nurse to attend as a prisoner had been found with a ligature around his neck.

47. The staff nurse heard the emergency radio message whilst in the treatment room. In interview, the staff nurse said he is not familiar with the term 'Code Red' but that he heard the words 'medical emergency' over the radio and immediately went to the door of the treatment room. He was directed to cell 2 – 15 by an officer. He thought it might have taken him around two minutes to get to the cell. He saw that staff were attempting CPR. The health care assistant went to the cell as well, arriving about 20 to 30 seconds after the staff nurse, and saw that a female officer was performing chest compressions and a male officer was standing behind her. One of the man's personal officers had left the cell in order to give the healthcare staff some space. The staff nurse checked for a pulse but could not find one. He recalled that the man's extremities were cold. The health care assistant told the female officer she would take over chest compressions when she became too tired to continue.

48. A nursing sister and an HCPO were told of the emergency situation by another sister at about 11.40am. The sister who had alerted them of the emergency was carrying a radio. The staff were in a meeting with the head of healthcare. The sister immediately collected the green emergency bag (on a trolley with wheels) from the duty room and went to Houseblock 4A. The HCPO was slightly ahead of the sister because she had gone to collect the emergency bag. During interview he said the message he had received was that a prisoner had been "found with a ligature", but it was not made entirely clear whether he was hanging or had just been found by staff in the process of putting a ligature around his neck. The HCPO said he was walking very quickly over to the houseblock and started to run when he heard that an ambulance had been requested. An ambulance was called at 11.42am from the control room.

49. The SO who had earlier asked for an ambulance over the net went to the core (the area between sides A and B of the houseblock) to retrieve the resuscitation equipment (defibrillator and oxygen). He gave the equipment to the staff nurse who had earlier heard the emergency radio while in the treatment room. The defibrillator was attached but indicated that no shock should be given. The staff nurse gave oxygen via a face mask. The health care assistant took over doing chest compressions. She said in interview that the man felt quite cold. The HCPO arrived soon after and saw the two healthcare staff attempting to resuscitate the man at a ratio of 30 compressions to two breaths. The HCPO asked the control room to request the doctor. The sister then arrived with the green emergency bag (containing equipment for use in several types of emergency). She assisted the staff nurse in inserting an airway in order to help get air directly into the man's lungs. The staff nurse said during interview that he remembered seeing the man's chest rise and fall so he knew that air was getting into his lungs. The health care assistant continued doing chest compressions until relieved for a period by the sister. The health care officer tried to feel for a radial pulse (in his wrists). She said the man's fingernails were cyanosed (blue colouration of the skin) and that she was unable to feel a pulse. The health care assistant took over the chest compressions again before being relieved a short while later by a doctor.

50. The doctor had been on his way up to the security office when the officer from there had come down the stairs and asked him to go to Houseblock 4 because there was a medical emergency. (The doctor was not carrying a radio and so had not heard of the situation until now.) He estimated that it would have taken him two to three minutes to walk quickly / jog over to the unit. He arrived at 11.55am and directed the nursing staff until the paramedics arrived. The team continued with resuscitation attempts and used the defibrillator again, but it still said not to administer a shock.

51. One of the Governors made his way to the emergency control room (ECR) and asked for an update from a female SO. She confirmed that an ambulance had been called. He made sure that an incident log was started (in the control room) and that the doctor had been asked to go to the cell. He was concerned that there should be no delay with the ambulance getting into the prison. He asked a second female SO to go down to the gate to ensure there were enough staff to escort the ambulance up to Houseblock 4 as fast as possible. He asked a fellow governor to attend Houseblock 4 after speaking with the Acting Governor.

52. The ambulance arrived at Woodhill at 11.58am. Two paramedics arrived at the scene at 12.00 noon and took over CPR straightaway. They got no response. The man was moved from his cell into the corridor, after being placed on a spinal board. This was to give more space for the medical team to work on resuscitation. The paramedics inserted an IV (intra-venous) line and gave the man some adrenaline.

The health care assistant said this was at 12.09pm. The HCPO continued CPR. The staff nurse assisted by holding the bag of fluids that had been set up by the paramedics. The doctor said the paramedics decided to take the man to hospital.

53. The Governor of Head of Operations went to Houseblock 4 to ensure the other prisoners were able to get their lunch and that they were locked back into their cells. Two officers assisted with this.

54. The man's cell mate had arrived back on the unit from education around 12.00 noon and was taken to one side by the Chaplain, the Governor of Head of Operations and a principal officer. They broke the news of what had happened. The man's cell mate told them the man cried regularly about his circumstances and had been worried about being deported. The man had received a letter and photographs on 20 July from his wife. The cell mate said that the man would sit by the window and dream of flying like a bird. He described the man as negative all the time. The cell mate was devastated by the news and was put into a cell with a Listener[10]. He was later to taken to Houseblock 5 and placed in a Listener suite.

55. A man from the IMB said that he was told of the emergency just before midday. He went to the cell and saw that the man was being resuscitated by paramedics and staff. He noted in his memo to the chair of the IMB that two governors, a doctor, the head of healthcare and three nurses were present. The other prisoners had been locked in their cells by this time.

56. The sister left the cell at about 12.10pm, went to the wing office and contacted the duty room. She asked a fellow sister to look in the man's medical record for any underlying medical conditions. The only information of note was that the man had been anxious on arrival because it was his first time in prison custody. This was passed onto the doctor when she returned to the cell.

57. The man was transferred into the ambulance waiting outside Houseblock 4 at 12.15pm. As he was being moved the chaplain said a prayer. The ambulance left the prison for the hospital at 12.24pm. A governor instructed the escort staff that no restraints were to be used. En route to the hospital, the paramedics continued to try to revive the man. There was, however, no change in his condition.

58. At about 12.30pm, the Acting Governor rang the man's wife and advised that her husband was critically ill and that she should make her way immediately to the hospital. The man's wife was with a cousin at the time. She offered to provide a taxi but the man's wife chose to drive herself to the hospital.

[10] Listeners are trained by the Samaritans to provide confidential emotional support to fellow prisoners in distress

59. Once they arrived at the hospital the HCPO stayed with the man. A specialist team of nurses and doctor continued to try to resuscitate him for a further 10 to 15 minutes. The other prison officers remained outside the trauma room. The man was pronounced dead by hospital staff at 12.48pm.

60. The governor who had instructed the escort staff that no restraints were to be used and two officers arrived at the hospital around 2.00pm. The man's wife arrived at the hospital soon after with her son and cousin. The son was taken to a family room by one of the officers. The man's wife was taken into the bereavement room where the governor broke the news of his death.

61. The cell was sealed by a principal officer. The police and HM Coroner's Officer were contacted and attended the prison in due course. There was no suicide note or letter left by the man in his cell.

Events following the man's death

62. All of the relevant people were told about the man's death, including the IMB. A hot debrief was held at 1.30pm and lasted for one and an half hours. Some of the staff told my investigator that there was a bit of a delay in the debrief getting started because another incident was going on at the same time, but that once it did start, staff generally found it helpful. The purpose of the hot debrief was to explore the circumstances around the man's death and to talk through people's feelings and explore what happened with other staff who had been involved. The Acting Governor asked that all Assessment, Care in Custody and Teamwork (ACCT) documents[11] in the prison be reviewed as soon as possible. The HCPO said he was asked questions about the man's medical record whilst at hospital, but that it had not been brought with the escort. It was agreed by the Governor that such documents would be taken in future.

63. The care team provided support and reassurance to those staff who had been involved. The Acting Governor told staff they could speak to their line manager or the care team if they needed further help, including counselling. The SO who had asked for an ambulance over the net ensured that the ACCT documents on Houseblock 4 were reviewed. The Head of Healthcare returned to the healthcare department and offered support to all those staff who had been involved. The health care assistant works part time and had already left for the day. During interview she said that, although she did have a brief chat with her line manager about the man's death, there had been nothing in depth and that she did not feel she had been offered much

[11] ACCT is the system used by NOMS to support prisoners in distress who may be at risk of harming themselves or attempting suicide.

support from work. The Health Care Assistant went on to say that she was okay. She just found what had happened really sad, especially for the man's family.

64. The Governor wrote a letter of condolence to the man's wife on the day of the man's death. She offered the assistance of two family liaison staff, and to pay for funeral arrangements. She also invited the man's wife to visit Woodhill if she wished to do so.

65. The man had been due to appear at Magistrates Court via videolink on 22 July. His solicitor said they received a letter dated 17 July 2009 from the Crown Prosecution Service. This letter, which arrived at the solicitor's offices on 20 July, informed them that the prosecution were going to replace the charge of affray with a summary only[12] offence of common assault. This letter was received too late to be conveyed to the man that day.

66. The Independent Monitoring Board visited Houseblock 4A at around 3.00pm the day after the man's death in order to see how everyone was coping. He recorded in his note to the chair of the IMB that the "Wing was quiet and subdued". He also wrote that one or two prisoners had told the Chaplain that they believed the man had some issues he was concerned about in the days before.

67. An anonymous note was written by one of the other prisoners on the houseblock and passed to staff. The author says that he returned to the wing around 10.35am and on his way back up to the three's landing stopped at cell 2 – 15 in order to speak to the man's fellow prisoner (who was out at education). The author of the note said he saw the man, but did not realise it was him at the time. He said he thought the person was praying. He did not see anything around the man's neck. After the man had been found by staff the author said he was sorry for not raising the alarm.

[12] A summary only offence can only be heard in a Magistrates Court and the defendant can only receive a maximum of six months imprisonment.

ISSUES

Reception health screening

68. Prison Service Order (PSO) 3050 states at 2.6 that, "an initial assessment of the healthcare needs of all newly received prisoners is undertaken within 24 hours of first reception by an appropriately trained member of the healthcare team to identify any existing problems and to plan any subsequent care." If any immediate healthcare needs are identified, then the prisoner must be referred to the appropriate specialist. There is therefore no requirement for a doctor to routinely see all new receptions. The doctor told my investigators during interview that, if the nurse who does the screening identifies any medical problems, either an old problem that needs to be reviewed or a current problem that the prisoner is concerned about, then the doctor will see them to discuss immediate action and treatment.

69. The man's First Reception Health Screen had nothing of note in the sections concerning physical health, alcohol use, drug use or self harm. Within the mental health section there was one "yes" tick, in answer to the question, "Have you ever seen a psychiatrist outside prison?" Although the answers to all of the other questions about mental health were negative, the guidance at the bottom of the form states, "If yes to any of the above, refer to the Mental Health In Reach". The man was not referred to the Mental Health In Reach team.

The Governor should remind all healthcare staff who carry out First Reception Health Screening to refer patients on to other departments within the prison where the form advises.

70. The man's wife wanted to know how the prison might have helped her husband with his alcohol misuse. The guidance on the initial health screening form is for patients to be referred to the doctor if they admit to drinking more than 20 units of alcohol a day or if they are showing signs of withdrawal. The man told the nurse that he "drank socially". During interview, my investigator asked the doctor whether the man was the sort of person who he would expect to have been referred to detoxification services within the prison or put onto an alcohol detoxification programme. The doctor said the man would seem to have been:

> "More of a binge drinking kind of person and once we ask them if they've got any problems when they're not drinking alcohol and they say they are fine, we'll presume that alcohol usage is not very regular and that there's no addiction problem."

71. Thus, even if the man had told the nurse in reception that he drank to excess on occasion, it is unlikely that he would have been put on an alcohol detoxification programme. I will discuss the Alcohol Awareness course that the man applied for later on in my report.

Clinical review

72. The clinical review focused on the man's reception screening when he went into Woodhill for the first time and the resuscitation attempts after he was found hanging in his cell.

73. The clinical reviewer made the following comments about the reception healthcare screening,

> "From the information provided in the first and secondary Reception Screen Forms and that gathered in the interview with the Medical Practitioner (GP) there is no reason to believe that the questions asked of [the man] weren't understood and answered by him. It is difficult to ascertain whether a report from [the man's] GP prior to admission to HMP Woodhill would have revealed what treatment/circumstances led to [the man] seeing a psychiatrist for "nervousness". Also if there was any previous history dependency on alcohol or how this should be treated given that he was on remand for domestic violence which occurred under the influence of alcohol. There would appear to have been no information supplied to HMP Woodhill to indicate that [the man] was suffering with depression, anxiety or stress or had suicidal tendencies or any prior history to indicate that he may be at a higher risk."

74. In line with Root Cause Analysis processes which the PCT follows when investigating Serious Untoward incidents, the National Patient Safety Agency Classification Framework was considered with regards to causal and influencing factors during the clinical review.

75. The clinical reviewer said that the *causal factors* relate directly to the man himself – "Mental/psychological factors: There was no apparent indication of intent to self harm or to commit suicide in [the man's] observed behaviour. It is reported that he was upset when he received a letter and photo from his wife the weekend before his death. [The man] was potentially at risk of anxiety & stress related to the nature of being on remand for domestic violence while under the influence of alcohol; he may also have been worried about his own family as his father was suffering from Leukaemia, plus his own loss of work. These factors and the responses recorded on the two initial health assessment screening should have been sufficient to trigger a

> further screening in to [the man's] psychological status and mental health needs during his time in HMP Woodhill."

76. The clinical reviewer goes on to make the following recommendations:

It is recommended that on admission to prison that any prisoner declaring any statement relating to stress or have been seen previously by a psychiatrist are further assessed, even when the health professional undertaking the screening could form an impression that would indicate a low risk. This further assessment may indicate that a referral to the Mental Health In Reach Team is required.

It should be considered a good practice standard at HMP Woodhill to obtain a GP report /medical history for all newly admitted prisoners, even where the information obtained on the health screening indicates no immediate health care issues.

It should be considered a good practice standard at HMP Woodhill to offer an interpreter where it is known that English is not the prisoner's first language. This is to enable Health Screening staff to obtain the fullest responses to key medical information questions that will enable the prisoner to receive the best possible assessment of their health care needs at Woodhill.

77. The clinical review also considered the record keeping. Although in general the clinical reviewer was content with the standard of record keeping she felt that the health screening forms needed changing:

> "The forms for the health screening process require review. There is currently no information regarding the next of kin/ contact person in an emergency. There is no information regarding the ethnicity, religion and language and any communication needs of the prisoner. The MKPCT records management policy states that the recording of ethnicity should be regarded as mandatory."

78. The clinical reviewer made a recommendation about this,

The Healthcare Screening forms should be revised to include ethnicity, religion, language and need for an interpreter and next of kin /emergency contact person to bring into line with local policy and best practice guidelines.

79. The clinical reviewer commended the resuscitation efforts by staff in her clinical review:

> "Medical opinion was that resuscitation attempts were made effectively and efficiently. A constant theme from the

> interviews was that resuscitation process for [the man] was immediate from the point in which he was found and continued until he arrived at hospital and was pronounced dead. The resuscitation process ran extremely smoothly, everyone was aware of their role, actions took place promptly and efficiently all the equipment needed was available and that nothing more could have been done to try to save [the man].
> Local policy is that all staff employed by MK Community Health Services who have regular patient contact must attend mandatory basic life support training annually. All staff involved in the attempted resuscitation of [the man] had received Basic Life Support Training within the stated period. The doctor who attended stated in interview that he had received Advanced Life Support training within the last year.

80. In justifying a further recommendation, the clinical reviewer said:

> "During an interview a staff member raised a concern that at the hospital the medical team needed to be provided with information to their questions that the prison escort found difficult to fully supply as he did not have [the man's] full medical information with him. It is recommended that whenever possible medical information is taken with the prison escort to the general hospital as a routine standard, but acknowledged that this may not always be possible in an emergency situation."

81. Her recommendation is that:

> **The prison's emergency contingency plans are amended to state that whenever possible on an admission to acute hospital the prisoner's medical record should travel with the accompanying prison escort. This is to enable the hospital staff to be able to obtain vital medical information to ascertain the patients healthcare needs immediately.**

82. Equipment was identified by the clinical reviewer as a potentially influent:

> "Although as a result of a previous clinical review the emergency bag and oxygen cylinder are now on wheels they are heavy and still may be required to be carried up a flight of stairs (as in this case) to a prisoner's room. There still remains an issue regarding the weight of the bag. As part of my review I examined the equipment on a visit to the healthcare centre. All equipment was in situ, replacements

obtained & further monitoring checks had been made and dated."

83. The clinical reviewer recommended that,

The contents of the large emergency green bag based in the prison healthcare centre are reviewed in order to try to reduce its weight and/or explore any other possible mitigating actions to reduce risk of injury and to enable rapid responses to emergencies.

84. In conclusion, the clinical reviewer said:

"There was a missed opportunity for an additional mental health screening in the first few days of admission to prison although the staff carrying out the screening were experienced health care assessors they would not have the additional mental health experience that specialist practitioners have. An interpreter may have been able to help [the man] give a fuller response to his health history and the questions he was asked."

85. It was her opinion that there were no indications raised with healthcare or discipline staff to suggest that the man was intending to commit suicide when he did and that resuscitation attempts were carried out swiftly and efficiently in line with the latest national resuscitation guidelines to attempt to preserve his life.

86. It was the reviewer's opinion that all staff involved in the attempted resuscitation of the man should be praised – "All staff should be commended for their efforts".

Personal officer scheme

87. There is no national Prison Service instruction on how the personal officer system should be run. Prisons are left to develop their own policy. Woodhill's local policy on the Personal Officer Scheme is dated June 2006. A Polish translation of the policy is also available.

88. Section 1 of the policy (Introduction) says:

"The personal officer provides a focal point for the prisoner and a personal relationship through which constructive work can be developed and progress can be discussed … personal officers will provide prisoners with a first point of contact for information and advice.

The personal officer scheme will operate as the vehicle for achieving positive relationships and cultivate a healthy culture

> in which prisoners continue to feel confident about approaching staff with any personal problems, and where staff are responsive to their needs."

89. On Houseblock 4, two staff are given ten cells for which they are jointly responsible to be personal officers. The prisoners in each of these cells should have met each of the personal officers assigned to them.

90. My investigator looked at the initial Personal Officer Interview Sheet contained within the local policy. It is a comprehensive document, some four pages long. The questions cover issues such as sentence length, family contact, deportation, alcohol use, drug use, depression / self harm, work, education, sentence plan aims and courses, adjudications and general interests. There is also another version of this initial interview sheet which was given to the investigator. This form covers very similar issues but looks to have been improved by the addition of the names of staff / departments within Woodhill that the personal officer could refer specific issues on to. A form like this may be one of the means by which a 'real' relationship between officer and prisoner can develop, a relationship that seeks to go beyond a superficial level of interaction. Such a relationship is often difficult to achieve in busy local prisons where prisoners move around houseblocks or transfer to training prisons relatively quickly.

91. Woodhill's policy states that a personal officer will, "Make contact with the prisoner and ensure that an interview takes place asap, ie. when next on duty." It also indicates that a routine entry of good quality should be made at least fortnightly. More frequent entries may be made by the personal officer, should specific issues arise. The senior officer on the wing should, "Check and sign all wing files monthly to ensure that personal officers are completing their fortnightly wing history checks…"

92. The staffing profile on Houseblock 4 is for five staff to work on the unit, morning and afternoon. Four are assigned wing duties and one has designated personal officer time. During this allocated time, the personal officer is expected to see as many prisoners from their ten allocated cells as are on the unit (some will be at work, education or on a visit, for example). The work might also involve liaison with other departments.

93. My investigator asked the SO how he thought the scheme worked on Houseblock 4 and what difficulties there were. He replied,

> "Prisoners come on and off every week, there's other factors like cell changes … if we have to move someone, quite probably he'll change his Personal Officer because they are on a different area of the wing."

94. Commenting on the depth of knowledge that staff had in general about the prisoners on the unit, the SO said:

> "I wouldn't say there was a great deal of depth of knowledge unless they specifically went and asked, which if they are detailed Personal Officer I would expect them to be doing … the first move has to come from staff …"

95. Two officers were the designated personal officers to the man whilst he was on Houseblock 4A. They made no entries in the man's history sheet. Nor was the induction paperwork and interview completed. Both officers wrote to the Governor who had instructed the escort staff that no restraints were to be used, concerning this omission on 25 July 2009. They said in the memo that:

> "… due to unforeseen circumstances we did not make any entries in his wing file … [we] both had conversations with [the man]
> on a regular basis."

96. The two officers said the man was always polite and compliant with the wing routine and that he had not come to the attention of staff. He would spend his free time playing pool and table football and mixing well with others on the wing. Both officers said whenever they spoke with the man he appeared happy and cheerful. His usual question for staff was whether any letters had arrived for him.

97. During interview, one of the man's personal officers (personal officer 1) said that he could not remember a specific reason why the introductory interview or follow up entries had not been made. He said he thought the man had attended education regularly (in fact, he had been only once) and that that meant he would not be on the houseblock during the core day when personal officer time was profiled. He went on to say he could remember three occasions during the time when the man was on 4A that he was scheduled to do personal officer work, but at the last minute he was sent somewhere else – to visits, to education and to the segregation unit. The Senior Officer who accompanied the personal officer said that his estimate was that fifty per cent of the time personal officer work is dropped.

98. Personal officer 1 said he did have some "interaction" with him. He felt the man communicated well with the other prisoners; he remembered him going to education and said he always seemed happy. If he did see a prisoner upset or in a low mood or crying, the personal officer said the first thing he would do would be to speak to them and find out what the problem was. He said the man never came across in this way. The personal officer said the man would normally be playing pool on evening association or chatting with his friend near their cells. He felt his level of English was good and that the man had no problem understanding things.

99. Personal officer 1 went on to say during interview that, when he has had the time to complete the introductory interview, most prisoners will just give one word answers and not a lot will go into depth. He said some prisoners are "not really interested".

100. In a written response to my investigator, the man's other personal officer (personal officer 2) said the man only talked to staff on a few occasions and that his behaviour on the wing was such that he did not come to staff's attention. She said he would come out of his cell during evening association and play pool. Personal officer 2 said they did not discuss any particular issues. She did not have conversations with the man about education or the courses he had applied for, his family situation, being deported back to Poland or feeling low. The man had always appeared cheerful in mood when she spoke with him, although she did indicate that the nature of their interaction was "general and brief".

101. When asked to give her perspective on the Personal Officer Scheme that operates at Woodhill, personal officer 2 said, "it does not work well due to too many tasks being allocated to one officer". She felt that in order for the scheme to be more effective, "we need to be allocated time to carry out this important duty and not be cross deployed at the last minute". Personal officer 2 said that neither the introductory interview nor fortnightly entries were made because personal officer work is usually the first profiled task to be dropped for cross deployment.[13] Her view was that this was a "regular occurrence" in July.

102. The man's cell mate told my investigators that during the time he was on Houseblock 4A with him, their personal officers did not speak with them. He said the man was not the sort of person to make the first move and approach an officer to tell them about his problems. He felt that it would have helped if the man's personal officers had approached him.

103. The report by HM Chief Inspector of Prisons (September 2007) said:

> "The personal officer policy laid down the foundations for an effective personal officer scheme. However, during the prisoner groups we held, and conversations with prisoners, it was evident that some prisoners were unaware of their personal officers and others were not particularly complimentary about them. In our survey, only 16% of prisoners stated they had met their personal officers in the first week, and only 24% found them helpful … The scheme was landing based, usually with two officers per designated

[13] Cross deployment is where staff based on one unit are sent to work on another unit for their shift because of a shortfall in staff on the second unit.

landing. It was not particularly well advertised on landings, or near or in cells. Personal officers were required to make two entries per month in wing files and this appeared to be happening. Levels of written observations were generally good, and some personal officers clearly displayed knowledge of prisoners and presented a balanced view. Many of these entries were based on behaviour and few expanded into resettlement or sentence planning, with minimal references to personal circumstances or family links. Encouragement to take part in activities was not documented. Management checks were regular and were improving levels of entries."

104. The Chief Inspector's recommendations included: "Prisoners should know who their personal officer is, and regular documented meetings should take place," and "Entries in wing files should ensure that resettlement, personal circumstances and family links have been addressed."

105. My investigator looked at a random sample of 30 history sheets, out of a possible 82, for prisoners on Houseblock 4A to see whether the man's experience of the personal officer scheme was typical. She did so on 11 August 2009, just as a changeover from paper documents to electronic records was taking place at the prison. The paper forms were closed during early August. (The names of the prisoners have been shortened to their initial in order to give them anonymity.)

106. Out of the 30 history sheets, 12 prisoners (40%) had been on Houseblock 4A for around two weeks or less before the paper record was closed. This demonstrates how rapid the movement on and off the houseblock can sometimes be, and therefore how difficult it can be for staff to really get to know the prisoners. Of the remaining 18, ten had had the proper induction interview with their personal officer within two or three weeks of being on the unit, and a further four had had interviews but after being on the unit for a month or more (well outside of the policy intention that introductions would happen as soon as the officer was next on duty). In fact, Woodhill promised that personal officer introductions would be carried out within a week of arriving on the houseblock in responding to the recommendation from the Chief Inspector in 2007. Only five prisoners from the sample had their induction interview within a week.

107. In summary, most prisoners who had been on Houseblock 4A for longer than a few weeks, had had a proper induction interview with their personal officer, although some prisoners had lived on the unit for a month or more before it was carried out. The man had been on the houseblock for nearly four weeks. No interview had been conducted with either of his personal officers.

108. The level of regular personal officer entries was disappointingly low. Of the prisoners who had been on the unit for two months or more (12)

and who should have had two entries in their history sheets per month, the actual range was from 0 entries per month to 1.3 per month. The average number of personal officer entries per month was 0.48 per month, meaning that the average was for a personal officer to make an entry in a history sheet once every two months.

109. Although my investigator did not look at all of the history sheets for prisoners on the houseblock, she did look at a reasonable percentage of them. The personal officer scheme on Houseblock 4A does not accord with the policy intentions or timescales. I make no judgement about how the policy operates on other residential areas within Woodhill and note that the Chief Inspector found some positive things about the scheme and how it operated. She commented that, on the whole, regular entries were made by personal officers. My investigator did not find this to be the case on Houseblock 4A.

110. In this context, I do not think it fair to draw attention to the particular personal officers for the man. It is not entirely surprising that there were no personal officer entries in his history sheet during the time he was living on 4A. I think the issues about the personal officer policy are not about individual officers but about the importance and impetus given to it by managers at the prison. I understand the operational necessity to staff areas of the prison that are short, but if personal officer time is always the first to be dropped from a profile, it is inevitable that timescales for introductory interviews slip and that ongoing entries will not happen as often as they should.

111. Whether an effective personal officer scheme would have made a difference to the man's decision to take his own life is impossible to say. On the accounts of his wife and friends on the unit, he was a private man who found it difficult to open up to people, especially those he did not know. However, it is disappointing that after nearly four weeks on the unit, neither of his personal officers knew anything about his personal circumstances, his fear of being deported, his worries about his family life, his alcohol problem, his stalled attempts to get onto courses, or any other concerns he had about his first time in prison. No officer tried to find out how he was settling into life on the houseblock. I acknowledge that the man, like many other prisoners, may have decided not to engage with his personal officer. However, it would seem that because the man was compliant with the prison regime, he largely went about unnoticed and unrecorded by staff.

The Governor should review the personal officer scheme and launch a new system that is workable, audited, supported by staff and promoted by managers.

What other prisoners knew about the man

112. The man's cell mate spoke with my investigators. They had first met whilst in the induction unit. The man had told him he "didn't want to be here any more" and that he had recently tried to hang himself. The man's cell mate moved onto Houseblock 4A about a week after the man and the two men were happy to share. He said the man spoke very good English. The man told him a lot about his problems and asked for advice. He worried a great deal about his family and said this was the longest he had ever been away from them. He also worried about being deported, about his case going to Crown Court, and said he did not want to be separated from his family as they were extremely important to him. The man's cell mate tried to advise the man and told him to start education. The man had been upset when the initial Health & Safety course (on 13 and 14 July) had been cancelled.

113. The man's cell mate described him as "depressed" about 90 per cent of the time. He always wanted to talk to his cell mate, but did not volunteer his problems to others that he did not know. The man's cell mate told my investigators he had suggested to the man that his case might be dropped because his wife did not want to press charges, but the man did not think this would happen. He dwelt on his problems and thought the worst, struggling to find a way forward. The man's cell mate felt it was clear to those who met him that he was constantly feeling upset. He did not socialise much and often sat outside his cell.

114. When the man looked at family photos he would cry. He got upset and said they brought back bad memories. He would kiss the photographs. The man was upset that he had let his wife down and recognised that alcohol changed his personality. His cell mate tried to encourage the man to see the doctor, but he did not want to.

115. In the period leading up to his death, the man had asked his cell mate if he would help him kill himself. His cell mate refused to do this. The man had woken up feeling a big 'groggy' on 21 July because of the sleeping tablets he had taken and thought about not going to education. When the two men arrived in the education block and the man was told his class was cancelled, the man's cell mate said he patted him on the back and told him that he had got what he wanted after all. He had no notion that the man would take his life later that morning.

116. The man's cell mate felt that putting the man on an ACCT might have made things worse as he felt the man would have been irritated at being observed by staff every hour.

117. Two further prisoners were also friends with the man. They knew why he was in prison and recalled how he would get upset and tearful when talking about his family. One of the prisoners said the man would get upset in his cell and not on the landings in front of staff. Both men used words such as "shy" and "private" to describe him. One of the

prisoners said their conversations would often go round in circles and that the man did not know what to do to make things better. He tried to encourage the man to go to the gym with him to keep him busy. One of the prisoners did not see staff talking to the man or engaging him in a proper conversation.

118. In general, the three prisoners to whom my investigator spoke said that they genuinely felt staff would have acted to try to help the man had they known how he was struggling to cope. None voiced any concerns to staff. I can understand why prisoners would choose not to approach staff about the man. Some felt that it would be a betrayal of the man's trust in them and others perhaps felt that it was not their business to tell staff about another person. I do not think there is a certain way of ensuring prisoners talk to staff openly, particularly about other prisoners. As the female officer said, it is often prisoners who are not close to the person feeling low who let staff know that something is wrong. Those closest to the person are more likely to feel disloyal by doing so.

119. The notice to prisoners after the man's death, written by the Acting Governor, included a paragraph saying:

> "I would really like to stress the importance of you sharing information with staff about any prisoner that you may have concerns about, please feel able to approach ANY member of staff if you think that another prisoner is low in mood, or know that they have received bad news or had a problem with their friends or family; as these are key triggers for self harm. Staff do want to support you as prisoners but need to know if people are feeling low in mood, having difficulties and are feeling vulnerable."

120. Woodhill should continue to encourage prisoners to come forward and share information with staff when they are concerned about another person's wellbeing.

How the alarm was raised when the man was found

121. Woodhill's local contingency plan for an act of serious self harm or attempted suicide indicates that staff should raise the alarm using the "Urgent message" protocol. The instruction goes on to say that staff should raise the alarm by telephone or radio, using the words, "Urgent message – medical assistance required [location]". The control room will then put the radio net onto talk through (whereby all radio outstations can hear messages from each other) and ask emergency response staff to attend. Woodhill's Incident Log, started when the man was found at 11.37am, refers to the incident as a "Code Red". The ambulance is recorded as being called at 11.41am.

122. The HCPO explained during interview that the term “Code Red” was brought into use because the healthcare team had responded many times to a radio message relayed as a “Medical emergency”, only to find that the incident was not an emergency in life threatening terms. An example would be something like a prisoner spraining his ankle in the gym. The medical response message was therefore changed to be “Code Red” when it was a true medical emergency, a life threatening situation. This ensured that the medical team would always respond promptly to a “Code Red” call. However, the HCPO said there was some confusion amongst staff as to whether they are meant to use the term “Code Red” or “Medical emergency” over the radio. The system is being looked at with the aim of clarifying procedures.

123. The SO said his understanding of a “Code Red” is that it referred to a life threatening medical situation. He thought the control room automatically called an ambulance in a Code Red situation, but ensured he asked the control room to call one anyway. One of the man’s personal officers said his understanding of “Code Red” was that you needed an ambulance straightaway. He thought the term “Medical emergency” referred to needing medical assistance from within the prison straightaway. The health care assistant thought staff could use the term “Medical emergency” or “Code Red” over the radio to summon help. It is clear from the interviews with staff that there is some degree of confusion over how to call for a medical response in both emergency and routine situations.

124. Many prisons have adopted a system of using “Code Blue” when a prisoner is not breathing, “Code Red” when someone is bleeding, and “Code Green/ Yellow” for any other situation where medical assistance is needed (on a less urgent basis). This colour system seems relatively easy for all staff to remember.

The Governor and Head of Healthcare should review the way in which medical help is summoned across the prison and ensure all staff, both medical and discipline, are familiar with the new terms chosen.

The response to finding the man

125. The officers who first found the man hanging acted appropriately in immediately entering the cell and using an anti ligature knife to cut through the ligature. The staff supported the man’s body and lowered him to the ground. One of the man’s personal officers checked for a pulse and the female officer started chest compressions. No breaths were given. The female officer told my investigator during interview that she had been given refresher training in basic life support about seven years earlier. Nevertheless, she said she felt reasonably confident about what to do.

126. The guidelines issued by the National Resuscitation Council indicate that chest-compression-only CPR is effective for a limited period (about five minutes). However, it is not recommended as standard management of out-of-hospital cardiac arrest. If giving chest compressions alone, a rate of 100 a minute should be carried out. The guidelines acknowledge that giving chest compressions is very tiring and recommend that, if more than one person is present, another rescuer should take over about every two minutes to prevent fatigue and maintain the quality of performance.

127. When carrying out full CPR, the ratio of compressions to ventilations should be 30:2. The speed of starting compressions (and as little a gap as possible whilst giving breaths) is very important.

128. Medical staff were at the cell within a few minutes of the man being found. They were trained in basic life support and began administering breaths and then oxygen. There was therefore only a brief period of time when no breaths were given by staff (certainly within the five minutes that the guidelines indicate compressions alone may be effective). The ideal scenario, however, would be for officers to feel confident and equipped to start full CPR as soon as they found someone. Confidence comes from having received the correct basic life support training (and refresher courses) and having appropriate equipment.

129. Several staff told my investigator that they would feel more able to commence mouth to mouth if they had a face mask with a non-return valve on their person. I know that several prisons issue staff with such a face mask and protective gloves in a small pouch, carried on their belts. My report into the death of a prisoner at Woodhill in September 2008 recommended that the Governor remind all staff about the Resuscitation Council guidance on the ratio of breaths to chest compressions. The prison accepted that recommendation and also said they would issue all first aid trained staff with a one-way resuscitation valve by the end of November 2009.

130. Over the past 12 months I have made local recommendations on seven occasions about the issuing of protective face masks for use in emergency situations for both healthcare and discipline staff. I am of the view that staff would benefit from being issued with a small pouch containing gloves and a face mask. This could be attached to their belt. All staff now carry anti-ligature knives for use quickly in an emergency. The issue of such pouches would complement this measure and ensure that potential life saving CPR could be started as quickly as possible by staff.

NOMS should consider issuing pouches containing gloves and a protective face mask to all medical and discipline staff who work with prisoners.

The courses the man applied for

131. The man made several applications for education run courses. On 3 July 2009, he applied for Health & Safety and Alcohol Awareness. On 6 July, he applied again for these two courses and also for Anger Management, ESOL and Family Relationships. On 8 July, he put in a further application for Health & Safety, ESOL and Alcohol Awareness. On 20 July, he applied for ESOL and Alcohol Awareness. The process at Woodhill is that all job or education applications are first assessed at a Labour Board. The purpose of this board is to ensure that prisoners are suitable for the work or education placement they have applied for from a security point of view (Woodhill holds some category A prisoners who would not be suitable for some education or work places). The Labour Board was held on 7 July and the man was approved for the courses he had applied for.

132. Once the Labour Board has approved the applications they are forwarded to the Education Department. The Education Department then processes the applications and allocates places to the prisoners. My investigator spoke with the Education Department about the man's applications. All of the courses he had applied for are run by them. The man had started the Health & Safety course on Monday 20 July. Alcohol Awareness, Anger Management and Family Relationships are all two week courses running every morning or every afternoon during those two weeks. They are scheduled on a five week rolling basis and so do not run continuously. A maximum of ten prisoners can go on each course and there are often long waiting lists before prisoners are allocated a place, particularly on Alcohol Awareness.

133. The man was due to start ESOL on the day after his death. He would have been told he was due to start via the internal mail system – on the Friday before prisoners are due to start courses they are sent a slip (which has to be handed out by officers) telling them that they are starting the course and which day they are starting it on. The man would have been sent this slip on Friday 17 July. They are usually handed out by staff over the weekend. It would appear that the man did not get his slip about starting the ESOL course over the weekend because he applied for it again (along with Alcohol Awareness) on Monday 20 July. The Education Department told my investigator that the system does not always work smoothly. Sometimes prisoners do not get the slip and so do not know they are starting education until the day their name is called out when prisoners move to their place of work or education. An alternative to staff handing out slips to individual prisoners would be for a list of all prisoners attending education the following week (from a particular houseblock) to be displayed on a prisoner notice board. It would then be the responsibility of prisoners to check if their name is on the list for a particular course. I do not make a formal recommendation about this, but the Head of Education

may wish to consider if the current system of handing out individual slips needs to be supplemented or replaced.

134. The rolling programme courses have a waiting list. There is currently no system for letting prisoners know that they are on the waiting list or an expected start date. My investigator was told that this is in part because a significant percentage of prisoners on the waiting list are released or transferred to a different prison before their anticipated course is run. This means that other prisoners move up the waiting list and get on a course earlier than originally predicted. The downside of not telling prisoners anything about a course is that they do not know where they stand in terms of the applications they have made. They do not know if the Labour Board has cleared them or if they are on the education waiting list. Some prisoners, such as this man, might keep on putting in applications, thinking that their earlier ones had not been acted on. I think it would be better if prisoners' applications for these rolling courses were acknowledged. They could be told that they are on the waiting list and that the Education Department will contact them again once a start date has been confirmed.

The Governor and Head of Education should inform prisoners of the outcome of their applications to the Education Department, where necessary telling them that they are on the waiting list for a course.

The charges against the man

135. The man was initially charged with affray on 3 June 2009 and rape between 31 December 2008 and 1 June 2009. The rape charge was withdrawn at his first court appearance on 5 June 2009. The man was remanded into custody at Woodhill and appeared again via videolink on 10 June. The court decided that he should be given the opportunity of speaking to an interpreter. He appeared again on 19 June. The court had not arranged for an interpreter and therefore the matter was adjourned once more to 24 June.

136. On 24 June, application for bail was made on behalf of the man but he was remanded in custody. Woodhill thought that the man was facing an impending prosecution for rape and explained to him that the hostel would not accept a bail application in these circumstances. The PNC print-out that my investigator obtained from Woodhill did indicate that a prosecution for the rape was pending. It was only when the prison received papers from the man's solicitor on 15 July that they became aware that the rape charge had not been proceeded with.

137. The man's solicitor said that during previous hearings the Crown Prosecution Service had indicated the allegations were so serious that the powers the magistrates had were insufficient (they can only sentence someone for a maximum of six months in prison). The man's case was therefore to be heard at Crown Court. His solicitor is of the

view that this would have had an enormous impact on the man. His case was adjourned until 22 July 2010.

138. As I have reported earlier, on 20 July the man's solicitor received a letter from the Crown Prosecution Service dated 17 July informing them that they were replacing the charge of affray with a summary only offence of common assault. This is a more minor charge and can only be heard at Magistrates Court. The maximum custodial penalty that the man would have faced if convicted was six months. The man's new application to the bail hostel was successful. Given the more minor charge that he was now facing on 22 July, his lack of an offending history, and the offer of a place at a bail hostel, it is reasonable to assume that the man would have been released on bail, pending the hearing date for the offence of common assault.

139. The man had spent 50 days in police or prison custody. This time is offset against any sentence imposed by the court. Even if convicted, it might have been that he would have only a short period of time, if any, left to spend in prison.

140. Issues concerning the accuracy and timeliness of police and CPS charging information and impending prosecutions are beyond the remit of my office. It will be very distressing, however, for the man's wife and family to know that he might well have been released from prison the day after he died. I am aware that the Coroner wishes to explore these issues further at inquest. The Director General of NOMS may wish to consider if there is merit in considering the implications of what happened on this occasion with colleagues in the Police Service and the CPS.

CONCLUSION

141. The man was facing the possibility of a prison sentence for the first time in his life. From the accounts of those few prisoners who knew him at Woodhill, he felt very guilty and remorseful about the actions that had led to his arrest and imprisonment. The man was worried about losing his wife and family and of being deported to Poland. He dwelt on his problems and seems unable to have found any way around them in his mind.

142. The personal officer scheme did not work effectively on Houseblock 4A and his two personal officers did not interact with the man on anything other than a very general level. He made several applications to go on courses in the prison but, with the exception of one course (Health & Safety), had not been told whether he had been accepted onto the waiting list for these courses or when he could expect to begin them.

143. Tragically, the man took his own life the day before he was likely to have been released from prison. The charges against him had, unbeknown to him, been downgraded to a much more minor offence. He would not have faced deportation. His solicitor was told of the substituted charge the day before the man's death but had been unable to tell the man before he was found hanging the next day.

144. Both discipline and healthcare staff at Woodhill worked in a co-ordinated and determined way in their efforts to resuscitate the man.

145. The man did not appear to staff to be depressed or at risk of self harm. Some of his fellow prisoners did know that he was struggling to cope, but told my investigator they were surprised by his decision to end his life.

RECOMMENDATIONS

Recommendations from the PPO

1. The Governor should remind all healthcare staff who carry out First Reception Health Screening to refer patients on to other departments within the prison where the form advises.

At draft stage NOMS accepted this recommendation and said, "First Night Reception Screening is now completed on the Electronic Patient Record System. This ensures prompting for appropriate referral and clear referral pathways are indicated. The Head of Healthcare will issue a notice to staff reminding them of the requirement to refer patients to other relevant services. IDTS will also ensure improved referral work between prison departments on First Night Reception Screening."

2. The Governor should review the personal officer scheme and launch a new system that is workable, audited, supported by staff and promoted by managers.

At draft stage NOMS accepted this recommendation and said, "HMP Woodhill is already reviewing its personal officer scheme. The Governor has issued terms of reference to managers to undertake this review."

3. The Governor and Head of Healthcare should review the way in which medical help is summoned across the prison and ensure all staff, both medical and discipline, are familiar with the new terms chosen.

At draft stage NOMS accepted this recommendation and said, "The Urgent Medical Assistance Protocol is currently in place across the prison. On the advice of HMCIP and the Ambulance Service this replaced the Code Red System some while ago. The Urgent Medical assistance protocol will be reviewed again and staff notices informing of the new procedures will be issued."

4. NOMS should consider issuing pouches containing gloves and a protective face mask to all medical and discipline staff who work with prisoners.

At draft stage NOMS did not accept this recommendation and said, "There are no plans to change the national requirement to issue staff working with prisoners with pouches containing non-returnable valve CPR face masks or rubber gloves. However, PSO 2700, Chapter 11 requires that "Emergency Response Kits must be available in all residential areas and will include the items specified below:

- *1 pair paramedic shears (ligature scissors)*

- ***2 CPR face masks, with non-return valve (for resuscitation attempts)***
- ***2 resuscitation aids with non-return valves***
- ***4 pairs rubber gloves (3 medium** 1 large)***
- *1 spillage kit*
- *2 large ambulance dressing (to stem large bleeds / wounds)*

It is good practice to also have Emergency Response Kits in non-residential areas, based on a local risk assessment. It is the responsibility of each establishment with their PCT to decide on the type of equipment used as well as any necessary training requirements.

Local response: HMP Woodhill has already purchased and issued pouches containing gloves and a protective face mask, to all staff who work directly with prisoners. This will now also be extended to include all nursing staff."

5. The Governor and Head of Education should inform prisoners of the outcome of their applications to the Education Department, where necessary telling them that they are on the waiting list for a course.

At draft stage NOMS accepted this recommendation and said, "All prisoners who apply for any activity including education or work will receive notification informing them of the decision of the labour board."

Recommendations from the clinical review

1. It is recommended that on admission to prison that any prisoner declaring any statement relating to stress or have been seen previously by a psychiatrist are further assessed, even when the health professional undertaking the screening could form an impression that would indicate a low risk. This further assessment may indicate that a referral to the Mental Health In Reach Team is required.

During consultation NOMS accepted this recommendation and said, "The admitting clinician will consider a referral to either the Primary Mental Health Team or the Mental Health In Reach Team dependent on the presentation of the prisoner and information available regarding previous mental health needs and current mental state".

2. It should be considered a good practice standard at HMP Woodhill to obtain a GP report /medical history for all newly admitted prisoners, even where the information obtained on the health screening indicates no immediate health care issues.

During consultation NOMS accepted this recommendation and said, "The Substance Misuse team currently make links with all GP's of prisoners requiring Detox. Where clinical need dictates the GP of a prisoner is contacted for information. However it is anticipated that all GP's will be contacted once there are sufficient staff in post to allow this to happen."

3. It should be considered a good practice standard at HMP Woodhill to offer an interpreter where it is known that English is not the prisoner's first language. This is to enable Health Screening staff to obtain the fullest responses to key medical information questions that will enable the prisoner to receive the best possible assessment of their health care needs at Woodhill.

During consultation NOMS accepted this recommendation in principle and said, "*While it is accepted that the provision of an interpreter for all non English speaking prisoners would be preferable, it is not achievable to provide an interpreter due to the different languages of the prisoners received. Interpretation is achieved via the Big Word telephone translation services and is available to all staff throughout the prison including reception staff. The Head of Safety will remind all staff of the facility via NTS (Notice to Staff)".*

4. The Healthcare Screening forms should be revised to include ethnicity, religion, language and need for an interpreter and next of kin /emergency contact person to bring into line with local policy and best practice guidelines.

During consultation NOMS accepted this recommendation and said, "Healthcare will add to the first stage screening carried out in reception details of the prisoners' next of kin, emergency contact number and the prisoners' religion. The prisoners ethnicity, language and whether able to speak English is already included in that interview following the implementation of SystymOne (TPP)".

5. The prisons emergency contingency plans are amended to state that whenever possible on an admission to an acute hospital the prisoner's medical record should travel with the accompanying prison escort. This is to enable the hospital staff to be able to obtain vital medical information to ascertain the patients healthcare needs immediately.

During consultation NOMS accepted this recommendation and said, "The policy regarding admission into secondary care will be reviewed to ensure that whenever possible a printed copy of the prisoner's medical record from SystymOne (TPP) will accompany the prisoner to hospital. If the admission is an emergency then the records will follow as soon as possible."

6. The contents of the large emergency green bag based in the prison healthcare centre are reviewed in order to try to reduce its weight and/or explore any other possible mitigating actions to reduce risk of injury and to enable rapid responses to emergencies.

During consultation NOMS accepted this recommendation and said, "The Emergency Green bag contents will be reviewed and only essential items will be included. This will be reviewed every 6 months to ensure that the contents are appropriate to the clinical setting. The Green Bags are checked daily to ensure that all equipment is in good working order".