Investigation into the circumstances surrounding the death of a man at HMP Woodhill in August 2005

Prisons and Probation Ombudsman for England and Wales

May 2006

This is the report of an investigation into the death of a man. The man was found hanging in his cell in the Healthcare Centre in HMP Woodhill on 1 August 2005. He was 33 years old when he died. He came from a close knit family, and leaves a wife and two children. He had been in prison for just two weeks, and was known to be at risk of suicide. The loss of a loved one is always distressing, but especially so in these tragic circumstances. I offer the man's family my most sincere condolences for their loss.

The assistant Ombudsman, and an Investigator, undertook the investigation, a key part of which was to make sure that the man's family had an opportunity to raise any concerns about his death. My colleagues were able to meet with the family, and I very much appreciate their willingness to discuss the man's death so soon after their bereavement. I do not underestimate how difficult this must have been for them.

I would also like to thank the Governor of Woodhill and his staff, for their assistance in the investigation.

The Milton Keynes Primary Care Trust undertook a review of the man's medical care. Unfortunately, the outcome of this review was not available at the time my draft report was published, but it has been incorporated into this final version. There were also difficulties in interviewing two locum medical staff. It may be that the Coroner will want to consider calling a representative from the Primary Care Trust to the inquest to explain the position on these interviews, and to call the two locum medical staff.

My report includes a significant number of recommendations. I hope these will go some way towards preventing a tragedy such as the death of the man from happening again.

This investigation has revealed significant failings in the care that Woodhill offered to the man. As I say on page.5, I have concluded that there is a possibility his death could have been avoided.

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PRISONS AND PROBATION OMBUDSMAN **May 2006**

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Summary

1. The man was 33 years old when he died on 1 August 2005. He had been in Woodhill for just two weeks, but he was not new to prison life having served a number of previous sentences. On 18 July, he had received a 15 month sentence for possessing stolen property and dangerous driving.

2. The man had by then been diagnosed with severe to moderate clinical depression, for which he was receiving 150mg daily of the anti-depressant Venlafaxine, and regular home visits from the Community Mental Health Team. At court, the man was identified as a possible suicide risk, and a suicide warning form was raised. The man's probation service officer also wrote a note that day to the prison explaining the anti-depressant medication he was taking, and enclosing some other documents about the man's medical history. The clerk to the court also enclosed the psychiatric reports about the man, and identified the package as containing medical reports for the urgent attention of the Governor.

3. The man arrived at Woodhill at just after 4pm. It seems likely that the documents marked for the Governor's attention were sent to the discipline office and were then put in the internal mail to healthcare, where they arrived on 20 July. As a result, the nurse and the doctor who saw the man on the evening of 18 July did not have access to them. The nurse opened an ACCT suicide warning form, and at 9pm the man was admitted to the Healthcare Centre and placed in a single cell.

4. Because the man was admitted straight into healthcare, he missed out on some of the prison's standard induction arrangements. On 19 July, he was seen by the Mental Health Inreach Team (MHIRT). A review of the ACCT arrangements to support the man should also have been carried out on 19 July, but did not take place until 21 July. Also on 21 July, a prison doctor prescribed the man 75mg of Venlafaxine daily for his depression. On 25 July, the man was again assessed by the MHIRT, on the mistaken understanding that this had not already been done.

5. On 26 July, the man's ACCT was reviewed, and he was discharged from healthcare and moved to a shared cell on House Unit 1A. His ACCT caremap was not updated to say how he would be looked after on the residential wing.

6. Also on 26 July, the prison received a letter from his stepfather. This said that the family had visited the man on 24 July, and were concerned about his physical and mental condition and that he was not getting the medication he had been prescribed. The man's stepfather asked for a watch to be kept on him. The letter was treated as routine correspondence, with a reply due by 5 August. Its contents were not considered before the man's death.

7. On 22 July, the man's family sent him a postal order, letter and some photographs. On 29 July, as the man had not received this, he asked staff

about it. He asked again on 30 July, 31 July and 1 August. The package was located and returned to his wife after his death.

8. On a family visit on 31 July, the man had found out that his father was ill. On the morning of 1 August, he talked to a chaplain about this.

9. At about 1.45pm on 1 August, the man told staff that he wanted to hang himself. Healthcare staff decided that he should be readmitted to healthcare, but there was no proper clinical assessment of his condition to inform this decision and no review of his ACCT document. The man was reluctant to be moved, but eventually agreed. At about 4.30pm, he was put alone in a double cell, with bunk beds, in healthcare. There was no clinical assessment of his condition when he arrived in healthcare, and no admissions process was followed. He was seen by a chaplain at 5.12pm, and observed three times that evening by the officer on the wing. He was found hanging from the bed at about 8.15pm. Staff were unable to revive him, and he was pronounced dead at about 8.30pm.

10. I conclude that there is a possibility that the man's death could have been avoided. I make a number of recommendations about what the prison should do to prevent such a tragedy from recurring.

The investigation

11. The assistant Ombudsman, and one of my investigators, carried out the investigation into the man's death. Notices were issued to staff and prisoners telling them of the investigation and its terms of reference and offering them the opportunity to participate. In the event, only one prisoner came forward of his own accord, although almost all staff, and all prisoners, willingly co-operated in the investigation.

12. The deputy Ombudsman, first visited Woodhill on 5 August 2005 to open the investigation and obtain the paperwork. The assistant Ombudsman and the investigator then visited the prison on 12 August to start the detailed work on the investigation. They saw the Healthcare Centre, the residential wing where the man stayed for a while, and the cell where he died. They met the governing governor, the deputy governor, various members of staff, and representatives from the Prison Officers' Association and the Independent Monitoring Board. They reviewed all the documentation they had been given, asked for much more, and interviewed a number of staff and prisoners.

13. The second governor and subsequently another governor ably acted as liaison officers for the investigation. They were open and honest about what might have gone wrong in the time leading up to the man's death, receptive to feedback during the course of the investigation (as was the governing Governor), eager to take steps to make procedural improvements, and did all that they could to facilitate the task of my investigators. I am sure that their positive approach to the investigation helped to ensure the co-operation of staff within the prison in what, for some, was a difficult, painful and worrying process, during which their actions were put under close scrutiny.

14. One of my Family Liaison Officers made contact with the man's wife. The family liaison officer and assistant Ombudsman visited the family on 24 August and met the man's wife, her mother and the man's stepfather. The family's solicitor was also present at the meeting. I am grateful to the family for contributing to the investigation at what must have been the most difficult and devastating time, as they came to terms with the death of a much loved husband, son and father. The family raised a number of concerns about the way The man was dealt with by the prison. I believe that all these issues are covered in this report. The family liaison officer kept in touch with the man's wife during the course of the investigation.

15. My investigators also liaised with the Coroner's office and the police during the course of the investigation. Once the police had decided that there were no suspicious circumstances surrounding the man's death (which was not until 20 October), they allowed my investigators access to the police documentation. My investigators also eventually obtained a variety of documentation from the Coroner's Office, although there were long delays in receiving this. For example, they telephoned the Coroner's Office on 15 August, but were not able to speak to the Coroner's Officer until 14 September, and documents vital to the investigation did not start to arrive until 29 September and beyond.

16. The assistant Ombudsman also spoke to the probation service officer who had been supervising the man prior to his imprisonment, and had spent some time with him after he was sentenced, but before he arrived in Woodhill.

17. Since April 2004, Milton Keynes Primary Care Trust (PCT) has been responsible for the clinical care provided to prisoners in Woodhill. The PCT is required, under National Health Service procedures, to carry out its own review of the clinical aspects of the man's care while in prison. The assistant Ombudsman wrote to the Chief Executive of the PCT on 3 August to ensure that the PCT investigation and my own investigation dovetailed as far as possible. Unfortunately, it was not until 1 September that the PCT told my investigators that a clinical reviewer had been appointed to conduct the review. By that time, my investigators had interviewed most of the clinical staff. Had the reviewer been appointed earlier, it would almost certainly have been beneficial for the interviews to be conducted jointly. However, the assistant Ombudsman liaised closely with the clinical reviewer during the course of the investigation, including meeting with her to brief her on the key clinical questions which my investigators considered needed to be answered. One joint interview was conducted towards the end of the investigation with one of the three medical officers who dealt with the man while in prison. The Head of Clinical Governance at the PCT, was also present at this interview. Of the other two doctors, I understand that the second of the locum staff failed to attend the interview with The Head of Clinical Governance at the PCT, the Clinical reviewer and the assistant Ombudsman, and the doctor that worked on C wing healthcare was reluctant to attend an interview and he no longer works at the prison. I understand that the PCT is continuing to try and arrange for these interviews to take place.

Woodhill prison

Background to the prison

18. Woodhill was opened in 1992 and was the last prison to be built with public money. There is spacious residential accommodation, broken down into five house units. There are large grassed areas between each house unit and other buildings used for healthcare, administration, and the like. The prison is located on the outskirts of Milton Keynes. It serves four Crown Courts and magistrates' courts within the Milton Keynes, Buckinghamshire, Bedfordshire and Northamptonshire areas. The maximum operational capacity of the prison is 762.

19. In her 2002 report, Ms Anne Owers, Her Majesty's Chief Inspector of Prisons (HMCIP), wrote that Woodhill is an extremely complex prison. *"As a core local, it holds all categories of prisoner from high risk category A prisoners awaiting trial or sentence, to remanded young prisoners and fine defaulters. In addition, it is one of only two prisons with Close Supervision Centres designed to hold the most dangerous prisoners in the prison system."*

20. The residential wing – House Unit 1 – where the man was located for a few days, is bright and airy. In contrast, C wing in healthcare, where the man was placed when he arrived in the prison and where he died, is a rather dark and dismal place. Healthcare cells in Woodhill do not have in cell electricity, so it is not possible for prisoners to have a television. There is a television room, but prisoners can only use this when they are out on association. Cells do have access to radio, but reception is poor, and the programme is controlled centrally, so prisoners cannot tune in to the station of their choice. Prisoners are, however, allowed to smoke in the cells.

21. There is some evidence of an impoverished regime operating in healthcare. Although the core day is intended to be the same in healthcare as in other parts of the prison, staff told my investigators that lack of staff, and the variety of regimes that could apply in healthcare (for vulnerable prisoners, young prisoners and so on) could mean prisoners spending a lot of time behind locked doors. They spoke of a time when prisoners on healthcare were given their evening meal by passing the food through the observation hatch. There is no evening association, and prisoners are locked up from about 4.30pm onwards. One member of healthcare staff told my investigators that there was a view amongst some officers that the regime needed to be harsh to make it easier to encourage prisoners back to the residential wings.

22. There was also some evidence of a reluctance to provide support beyond a certain level to prisoners on an open ACCT (a suicide watch procedure) on the residential wings. My investigators were told that there was a view that prisoners should be moved to healthcare if the level of observations required was more than three per shift, because of the staffing resources that were required on the residential wings to achieve this. A member of healthcare

staff told the investigation team that a higher staff prisoner ratio in healthcare meant that it was easier there to manage a higher level of observations. But the consequence is that there may be prisoners in healthcare who have no clinical need to be there, and for whom better care could actually be provided on the residential wings.

23. Concerns about both the quality of the regime in healthcare and over reliance of supporting potentially suicidal prisoners in healthcare were identified in the 2002 HMCIP report.

24. Newly arrived prisoners at Woodhill are normally located on House Unit 5. On their first night, prisoners receive an individual induction briefing, lasting 20 to 30 minutes, from a member of staff. They are given a smoker's pack (if appropriate), and offered a three minute telephone call. The next day, they are given a more detailed group introduction to the workings of the prison, and about resettlement arrangements. There is subsequently a day of introduction to education in the prison, and a further day dedicated to the use of the gymnasium.

Previous deaths

25. Between April 2004 and August 2005, there have been six other deaths at Woodhill. Three of these were apparently self inflicted. In April 2004, a prisoner who should have been identified as at risk of suicide or self harm, but was not, took an overdose of medication which had been prescribed to him to alleviate back pain. In June 2004, a prisoner who had been charged with two counts of murder tied a ligature around his neck and made very deep cuts to his neck with razor blades. He was found in his cell in the Segregation Unit by the prison chaplain. There were no signs of life, no pulse and significant blood loss, and an appropriate decision was made that attempts to revive him would be futile.

26. The circumstances of each of these two deaths were quite different from the man's death. However, there are two specific recommendations arising from the April 2004 investigation, the implementation of which my investigators have checked during the course of the investigation into the man's death. These are set out below.

   - I recommended that all staff involved in carrying out the First Reception Health Screen interview should receive additional suicide refresher training. A nurse carried out the man's First Reception Health Screen. She has been trained to a high level, as an assessor under the ACCT procedure, in suicide awareness and prevention.

   - I recommended that all staff trained in first aid were additionally trained in the use of the defibrillator. The nurse first on scene arrived in the man's cell with the defibrillator when he was found hanging. She has completed immediate life support training, which covers the use of the defibrillator.

27. The third apparently self inflicted death occurred on the morning of 20 July 2005. This prisoner had arrived in Woodhill the previous day. My report of this investigation is not yet finalised, but again the circumstances appear to be quite different from those of the man. The prisoner was found in his cell on a residential wing with a ligature around his neck. Strenuous and skilled efforts were made to save him, but to no avail. Nonetheless, there are a number of recommendations relevant to the man's death. Specifically, I expect to recommend:

   - The introduction of a coding system at Woodhill so that staff, and especially medical staff, can respond appropriately to a medical emergency.

   - A review of reception processes, with a view to minimising waiting times for prisoners.

   - A review of existing arrangements for ensuring that sufficient members of staff retain their First Aid training qualification.

28. The two other deaths in Woodhill since April 2004 were apparently from natural causes. My report into the first of these, which occurred in February 2005, contains a number of criticisms of the healthcare the prisoner received and made a number of recommendations which included:

- That healthcare professionals be reminded of the importance of obtaining medical records from the prisoner's General Practitioner (GP).

- That healthcare professionals were reminded of the importance of legible, accurate and through documentation, particularly in relation to record keeping.

29. My investigation into the second death, in March 2005, concluded that the prisoner received timely and appropriate medical care, and made no recommendations.

30. I shall return to some of these recommendations from my previous reports in my conclusions to this report.

Assessment, Care in Custody and Teamwork (ACCT) process

31. Since January 2004, Woodhill has used the Prison Service's new ACCT process for caring for suicidal or self harming prisoners. Prison Service Instruction 18/2005 sets out what needs to be in place to run an effective ACCT system, while Prison Service Order 2700 sets out arrangements more generally for supporting suicidal or self harming prisoners.

32. The starting point is that all staff are responsible for the prevention of suicide or self harm. Therefore, all staff in contact with prisoners are required to have training at least to ACCT foundation level (a three hour course), and there should be arrangements in place to ensure the training of all new staff. In Woodhill, as part of the implementation process, 246 staff received basic ACCT training, with a further 77 trained during 2005. In August 2005, there were 334 officers in post.

33. Any member of staff who is concerned that a prisoner is at risk should open an ACCT plan, stating the reasons for their concern. The Unit Manager or Night Orderly Officer is then responsible for drawing up an immediate action plan to support the prisoner. Within 24 hours of the concern being raised, a trained ACCT assessor must conduct an assessment interview with the prisoner. A case review is then held, ideally immediately after the assessment interview. The Unit Manager must chair the first review, and appoint a Case Manager (who must be a minimum grade of Senior Officer or Nurse Grade F). The case review team must draw up a care and management plan which sets out how the prisoner will be supported. Further case reviews are then held as required.

34. In November 2005, Woodhill had 30 staff trained as ACCT assessors.

35. The role of the Case Manager includes organising and chairing case reviews, and ensuring care maps are actioned and updated. All Case Managers are required to have attended the one day ACCT Case Manager training course. During 2005, the prison trained 24 staff as Case Managers. It is not able to say how many staff were trained during the ACCT implementation process. In August 2005, there were 69 Senior Officers and 18 Principal Officers in post.

36. Before a prisoner is returned from healthcare to ordinary location, there must be a pre-discharge case review. The case review team must, amongst other things, review the level of risk and update the care map, and arrange a follow-up healthcare appointment.

37. When a prisoner moves units the receiving Unit Manager must appoint a Case Manager.

Woodhill's suicide prevention procedures

38. The suicide prevention policy in operation at Woodhill at the time of the man's death is dated May 2004. An updated version dated July 2005 is available in draft. The points set out below relate to the May 2004 policy.

39. The policy says that a full time Safer Custody Co-ordinator (SCC) will co-ordinate suicide prevention across the prison. This was taken over by a senior officer in February 2005. The senior officer has some other duties as well as being SCC.

40. Woodhill's Safer Custody Committee is chaired by the Deputy Governor. The prison says it meets monthly to consider strategic issues. A Suicide Prevention and Anti-Bullying Sub-Committee also meets monthly, with a focus on the day to day management of individual prisoners at risk.

41. The suicide prevention policy says that at risk prisoners in normal accommodation should routinely be allocated to shared accommodation, unless the prisoner represents a risk to others or their behaviour is too disturbing. If they are placed in a single cell, the reason should be recorded in the ACCT document.

42. The policy says that, following a deterioration in a prisoner's state of well being, the decision may be taken to place the prisoner in healthcare. This can only be done following consultation with healthcare staff. The level of supervision required must be established and specified on the case review form, including whether the prisoner is at acute risk and therefore requires constant observation, or whether the prisoner requires intermittent supervision (where the prisoner is checked at least five times an hour). Staff are required not just to observe the prisoner, but to interact with him.

43. Constant and intermittent observation can only be authorised by a doctor or nurse, in consultation with the duty governor, or the duty governor, in consultation with a doctor or nurse. The decision to locate the prisoner in

healthcare will be based on the assessment made by the assessor and in consultation with the doctor or nurse and/or duty governor. (This is not in line with Prison Service national healthcare standards, which state that admission to healthcare is 'at the sole discretion of the clinical head of healthcare (or doctor/health care worker, deputised by him/her) and is based on clinical needs, recorded in the patient's clinical record.')

44. A case review must be held prior to a prisoner being discharged from healthcare following an in-patient stay. Staff from the unit to which the prisoner is discharged must attend a pre-discharge case review to ensure the care plan is amended to help the prisoner adjust to life on a normal residential unit.

45. The suicide prevention policy also sets out emergency procedures for action following self harm. It says that staff may enter a single cell alone in order to preserve life. The safety of staff and the prison is also paramount, and must be taken into account when deciding to enter a cell.

Woodhill's contingency plans

46. Woodhill's most recent contingency plans for handling a death in custody expired in May 2005 and were reissued in July 2005.

47. The plans require that the person first on the scene should raise the alarm by radio, telephone or alarm bell. A log keeper should be delegated and a note kept of all staff and prisoners who were in the vicinity of the body. A note should be made of the time each action is taken.

48. During the day and evening, the control room should tell healthcare staff (radio call sign Hotel 1) to attend the scene. During the night, the plans do not require a call to Hotel 1. The tasks of Hotel 1 during the day and evening include collecting the emergency equipment required for the incident, reporting to the scene and assessing the situation, asking the control room to call for an ambulance if required, summoning the medical officer and providing medical assistance to the prisoner. There are no actions set out for Hotel 1 in the night state.

49. The control room is also required to:

- Call an ambulance when asked to do so.
- Tell the orderly officer, who is in charge of the day to day running of the prison (radio call sign Oscar 1). The orderly officer should attend the scene. At night it is the job of the orderly officer to request an ambulance.
- Tell the duty governor (radio call sign Victor 2) of the situation.
- During the night state, tell the duty doctor.

50. Once a doctor has certified death, the cell should be sealed until directed otherwise by the police, the Coroner or the Coroner's Officer.

51. During the day and evening, it is the responsibility of the orderly officer, in consultation with the death in custody liaison manager, to arrange for a case review for all prisoners on an open ACCT to identify what extra support or vigilance is needed. The plans say that, day or night, it is also the responsibility of the duty governor to ensure that all ACCT forms are reviewed.

Events leading up to the man's death

Offences and sentencing

52. In January 2005, The man stole a mini digger, valued at £17,000, from a building site. He put it in a van and drove off. He was pursued by the police who tried to stop him. The van eventually overturned on the hard shoulder of the motorway, and the man ran off but was quickly caught. On 9 May, he pleaded guilty to possession of stolen property and dangerous driving. The case was adjourned for pre-sentence reports.

53. In early June, the man went to see his GP complaining of depression. His GP arranged for him to be seen that day by a consultant psychiatrist, and various other appointments followed. The man said that he was suicidal, had not been going out and thought other people were watching him. He was diagnosed with clinical depression of severe to moderate intensity, and provided with medication and support in the form of regular home visits from the Community Mental Health Team.

54. On 5 July, the man's health was reviewed by a doctor at a Community Mental Health Centre. The man was still feeling suicidal. The doctor decided that his medication should be increased – to 150mg of Venlafaxine – and the home visits were to continue. The man was to be reviewed in the out patient clinic in four weeks' time. An arrangement was also made for the man to have a CT scan of his brain, to rule out any boxing injury as the cause of his depression.

55. On 18 July, the man returned to court for sentencing. The pre sentence report said that the man was in contact with his GP about his mental health and it was important that this continued. It said that the man was at high risk of self harm or suicide, and asked that this information be passed to the prison if he was given a custodial sentence. However, the probation officer's view was that a prison sentence would do little to address the man's offending behaviour and would be highly likely to have a negative effect on him and his family. She did not consider him to pose a serious threat to the public, and she thought that, in light of the man's view that he would not be able to cope while in custody, and his current mental health and suicidal thoughts, a prison sentence was not suitable. She recommended that he be given a Community Rehabilitation Order to address his offending behaviour and provide support for changes in his lifestyle. He could be required to undertake tuition to develop his literacy and numeracy skills, and increase the chances of obtaining employment, while being the subject of an electronic curfew order requiring him to be at home between 7.00pm and 7.00am each day.

56. In the event, the court sentenced the man to 15 months in prison.

57. During the time leading up to 18 July, the man had been supervised by a probation service officer. She was worried about the effect on the man of a prison sentence, and made sure that the details of the man's medical history

were available to the judge before sentencing. After the man was sentenced but before he was taken to Woodhill, she spent some time in the cells with him. She wrote a hand written note to the prison that afternoon expressing her concerns. She said that the man was currently prescribed 150mg of Venlafaxine daily for clinical depression, and had not brought any medication with him. She asked that the information on the man's mental health be found. She also said that the man was terrified about being in Woodhill as he believed that two men whom he said had assaulted him were in the prison. She said that she thought the man should be kept in healthcare, and that he had told her that he did not think he would make it through his sentence. She put this note and the relevant papers, including the pre-sentence report and a prescription confirming the man's medication, in an envelope addressed to healthcare, and handed it to the prison escort. She says the court clerk told her he would also send the prison all the psychiatric reports about the man.

58. The man's barrister recommended that the man be put on a suicide watch, and a suicide/self harm warning form was duly opened at the court. It was also noted on the form that the man said he had concerns about other prisoners at Woodhill and feared for his safety.

The man's time at Woodhill

18 July

59. The man arrived at Woodhill at 4.18pm, and was received in reception at 5.07pm. When a prisoner arrives, the paperwork that accompanies him is taken to the front desk and dealt with by the Senior Officer on duty. The evidence suggests that the clerk to the court did put the man's medical records together, including those from the man's probation service officer, and send them to the prison, as a handwritten note on the order of imprisonment says:

> "Urgent * P[re]S[entence]R[eport] attached plus medical reports for the urgent attention of the Governor."

60. A senior officer was on duty on the reception desk on 18 July. Understandably, he cannot recall the man, or what happened to his records from the court. He says that if an envelope addressed to healthcare arrived with a prisoner's documents, he would put it in the tray for the healthcare officer on reception. If the documents were addressed to the Governor, he would put them in a drawer for the discipline office where they would be delivered the next day.

61. Certainly, the documents sent by the court and the probation service officer - which included correspondence from the Community Mental Health Centre to the man's GP setting out the outcome of the review of the man's case on 5 July, and a copy of a prescription of that date for the anti depressant Venlafaxine at a strength of 150mg - were not available to medical staff who saw the man on 18 July. By 20 July, the man's handwritten note had arrived in the healthcare wing office by internal mail and the medical documents

were, at an unknown subsequent date, linked to the man's medical records. The most likely explanation is that the documents marked for the urgent attention of the Governor (which will have included those from the man's probation service officer) were sent to the discipline office and from there on to healthcare in the internal mail.

62. At reception, prison staff completed various documents about the man. The man's core record gives his address as that of his wife. There is also a note that he could not read or write. A cell sharing risk assessment concluded that the man was a medium risk of harm to others. There is a note on the form that says that the man was very worried about another prisoner, that his barrister had said he should be put on the ACCT procedures, and that he had been talking of a hunger strike.

63. The ACCT assessor carried out the first reception health screen. She says that, if she had had the medical information from the court about the man, she would have ticked the box on the form saying she had received information from an outside source. The box on the form is blank. The section of the form for details of the man's GP has question marks in it. The man told the ACCT assessor that he saw a psychiatrist regularly for severe depression, and that he had an outstanding appointment at the Community Mental Health Centre on 22 July. He explained that he had daily visits from a care worker, and was taking medication for his mental health, although the section of the form for details of the medication is blank. He said he had previously tried to harm himself both inside and outside prison - the most recent occasion being two years ago when he had taken an overdose - and that he felt like harming himself now that he was coming into prison. He said he had been treated on 16 July at the local accident and emergency department for injury to his ribs, and that he wanted to see a doctor. The man's answers to the ACCT assessor's questions meant that he was required to be referred to the Mental Health Inreach Team (MHIRT) and to a doctor. The ACCT assessor noted that the man was very nervous. The first reception health screen was completed by 6.35pm.

64. At 6.45pm, The ACCT assessor opened an ACCT form. She said that the man had attempted an overdose in the past and 'could do something now although he doesn't want to'. She noted that he was extremely low in mood, suffered from severe depression, and was vulnerable due to mental health problems. The ACCT assessor, a nurse and healthcare officer agreed an immediate ACCT action plan to support the man. (Neither the nurse or healthcare officer have had formal training in the ACCT process.) They decided that he should be admitted to the Healthcare Centre, spoken to or observed twice an hour day and night, and given Listener access as required. (Listeners are prisoners trained by the Samaritans.) The form says 'Will require telephone call' which was to be the responsibility of the wing staff. The man was also to be referred to the MHIRT. A note was made that the next case review, due within 24 hours, should take place on 19 July.

65. There is a section on the inside cover of the ACCT form that asks for details of the triggers or warning signs to prompt an immediate review, and the

person or department to be called. The instructions say that this should be considered as part of each case review. This part of the man's form says, 'Has problems with another prisoner who he is sure is in the prison. If he finds out that he is this may cause problems for him.' There is no indication of who should be called if an immediate review is required.

66. The man also saw the prison doctor that evening. The prison doctor noted the problem of depression, two previous suicide attempts, and that the man was being treated at the Community Mental Health Centre. The man said he currently had thoughts of self harm, but would not do anything because of the children. He said that he was taking three tablets, an anti-depressant, a sleeping tablet and one other. The doctor said that the man should be admitted to healthcare for observation, an ACCT form should be opened, and there should be a discussion with his GP the next day about his medication. Meanwhile, the doctor prescribed a sleeping draught (Sominex) for a period of four nights. The man's treatment chart shows that this medication was administered nightly from 18 to 21 July.

67. The prison doctor said at interview that it was normally the MHIRT or the doctor who were responsible for getting the GP records, but sometimes the task could fall between the two. He would have expected the healthcare wing doctor, to make sure the records were obtained the next day.

68. At 9pm, the man was admitted to the Healthcare Centre, wing C, and put alone in cell 1-21A. He was said to be tearful and anxious due to family concerns. There is a note that the escorting officer tried to ring his family, on the authorisation of the duty governor, but that there was no answer. At 10pm, the man was given a Samaritans' telephone while staff made a further unsuccessful attempt to contact his family. By 11pm, the man was asleep. He was checked regularly throughout the night.

19 July

69. The next day, the man seemed more settled, and staff invited him into the office for a brief 15 minute induction to the prison. A prison officer telephoned the man's wife on his behalf, and arrangements were made for the man to make a telephone call himself the next day, 20 July. To do this, a PIN number had to be obtained from reception. (A new generic PIN number is created each day which staff can use to give new prisoners their first night telephone call.) The man was also asked to provide details of the telephone numbers he wanted to be able to ring in due course from his own personal PIN number. The man gave the numbers of his wife, mother and father.

70. There is a note in the wing observation book about the man's smoker's pack. It says that the pack was issued to another prisoner who claimed to be the man. The other prisoner refused to hand over the tobacco after the mistake was identified, and he was placed on a disciplinary charge. The note does not make it clear whether or not the man was issued with a new pack.

71. That afternoon, just before 3 o'clock, the man was seen by the healthcare wing doctor. The man said that he had been taking anti-depressants under the direction of a psychiatrist, and he wanted to take the same medication. The doctor referred the man to the MHIRT. There is no record of any conversation with the man's GP.

72. An officer from the MHIRT saw the man just after the doctor. The officer from the MHIRT noted that the man was tearful and distressed, and had a long history of anxiety and depression, together with a family history of suicide. It was not clear what medication the man was taking, and the officer from the MHIRT was to contact the man's GP and obtain his past history. The officer from the MHIRT suspected that the man would not meet the criteria of the MHIRT - that the prisoner has acute, or severe and enduring, mental health problems - although each case is considered on its merits. He noted that the man had suicidal thoughts but no intent to carry them out. He did not think the man was currently at risk of suicide. The officer asked the MHIRT secretary to request the man's past medical history. He told my investigators that, when he interviewed the man, the information from the court about the man's medical history was not with the records.

73. At about 7.30pm, the man asked to see a Listener to whom he spoke for some time. Later that evening he was again given the Samaritans' phone.

20 July

74. On the morning of 20 July, another prisoner died. That should have prompted a review of all prisoners on an open ACCT. The man's ACCT was not reviewed.

75. During 20 July, the man asked about arrangements to phone his family. He was told that staff were trying to sort out a PIN number for him. He is reported to have been rather tearful, and said that it was his wife's birthday. He was able to make the telephone call at 1.45pm. His wife confirms that the man did indeed ring her on her birthday.

76. At 3.20pm that day the man's probation service officer, telephoned the prison. The probation service officer says she rang to see how the man was, and she was told that he was in healthcare. She asked the person to whom she spoke to send the man her best wishes. One of the prison staff who works on C wing in healthcare, says that the probation service officer's hand written note arrived on the wing in the internal mail and she brought it to a nurse on the wing's attention. The nurse on the wing made a note in the man's medical record that the probation service officer had telephoned, and copied into the medical record the text of the probation service officer's note. This included the information that the man was being prescribed 150mg of Venlafaxine daily.

77. A note was also made in the wing observation book and the man's history sheet that the prisoners of whom the man was scared were the two men that assaulted him.

78. At about 4.20pm, the prison officer from C wing healthcare noted that the man was seen by the healthcare C wing doctor. There is an unsigned note in the medical record at 4.30pm that says: ‘Note the above [ie the record of the conversation with the probation service officer]. Called away.’ It has not been possible to interview healthcare C wing doctor to find out the meaning of this note, and what action he proposed to take. A note in the C wing observations book says that, due to a death in the prison, healthcare C wing doctor did not arrive until 4.20pm and then got called away to the segregation unit at 4.30pm. The note continues, ‘Yet another day when C wing’s sick parade wasn’t done.’

79. Later that day, the prison officer from C wing healthcare noted that the man’s ACCT assessment was two days overdue, and that they had been asking for it to be done since the morning.

21 July

80. An officer is a trained ACCT assessor. He carried out the ACCT assessment with the man the following day, 21 July, at 9.45am. The man said that he had been diagnosed with depression since 1999, and had lost three relatives, two of whom took their own lives, and his son who had been still born. He said that having a prison sentence had intensified his anxiety and depression. In addition, there had been problems with people making threats against him, and these individuals were now at Woodhill. He said that his last self harm attempt was two years ago when he had taken an overdose. Although he felt much better than when he first arrived at Woodhill, he still felt low most of the day. He said he was unable to sleep even with the help of sleeping tablets, and was not eating much. The ACCT assessor officer noted that the man was very tearful during the interview when talking about his family, but that he said he did not want to die and had not planned a suicide attempt. He had a good relationship with his wife and two children, who would be visiting, and good support from other family members and friends. The ACCT assessor officer noted that the things that might help the man were proper medication to help him sleep, and the possibility of him helping the cleaner.

81. The assessment was followed, at 10am, by an ACCT case review. The prison officer from C wing healthcare (who has been trained in ACCT to foundation level), the ACCT assessor officer, and the man were present. The man said that although he thought about it, and felt very low, he had no intention of killing himself as he had too much to live for and needed to support his family. The review team concluded that the man remained a ‘raised’ risk, and that he should be observed three times each session (that is, each morning, afternoon and evening shift), and five times at night.

82. An ACCT caremap was also agreed. This identified the following issues and action:

- Highly depressed. To deal with this, the man had been referred to the MHIRT on 19 July. There is no note about the outcome of this referral.

- Suicidal thoughts. To deal with this, the man was to ask for access to Listeners, Samaritans, Chaplaincy and wing staff when he needed it.
- Unable to relax. To help the man with this, he was to use the therapy unit. The ACCT assessor officer was to refer him to the Occupational Therapist.
- Physical problems – deafness and sore ribs. To help resolve this, the man was to see the doctor, and The ACCT assessor officer was to place him on sick parade.

83. No action was agreed with regard to the question of the medication the man was taking to help him sleep, or helping with the cleaning.

84. The man saw the healthcare C wing doctor again at 11.35 that morning. There is a note in the medical record that the man wanted to go back on Venlafaxine, as set out in the letter from the psychiatrist, and that Sominex was not helping him to sleep. The man also mentioned the problems with his ears and his ribs. The doctor prescribed 75mg of Venlafaxine daily, and eardrops. He noted in the medical record that the man was due to be seen by a psychiatrist, and was fit for ordinary location. It has not been possible to interview the healthcare C wing doctor to find out why he prescribed 75mg of Venlafaxine, when the medical record suggested he had been getting 150mg, and whether any other medical information was now available. Nor has it been possible to ask him about the reference to the psychiatrist (there is no other evidence to suggest that the man was to be seen by a psychiatrist). It was agreed that the man would remain in healthcare until after the weekend. The man's treatment chart shows that he was issued with 75mg of Venlafaxine on the afternoon of 21 July, and every subsequent morning up to and including 27 July.

85. Also on 21 July, and as agreed in the officer from MHIRT's assessment of 19 July, the MHIRT asked the Hertsmere Community Mental Health Team for psychiatric information about the man. No request was made of the man's GP.

86. The man's personal PIN telephone number was set up on 21 July, allowing him to make telephone calls if he had the money to do so. He came to the prison with no money at all, and was given 50 pence a day 'unemployed pay' by the prison, together with an advance of £2.50. Thus on 21 July he had £3.50 in his account. He spent £2.00 on 21 July, and again on 26 July. The man's wife says that on 22 July she sent him a letter and postal order for £20 so that he could buy things while in prison, but this never reached him.

22 – 24 July

87. During the night of 21 to 22 July, the man threw his chair around his cell because he could not sleep. The prison officer from C wing healthcare told him this was not acceptable behaviour. However, there were no other reported problems with the man, either later that day or on 23 July.

88. On 22 July, while the Occupational Therapist from the MHIRT, was on the wing, the man asked if he could speak to her. The occupational therapist said that she did not know about his care, but that she was happy to talk. The man was concerned about a conversation he said he had had with the healthcare C wing doctor suggesting that he had alcohol or drugs problems, which he strongly denied. The occupational therapist says that the man was shaking when he spoke to her. He told the occupational therapist that he had a diagnosis of depression, and that he had not had a MHIRT assessment. The occupational therapist arranged for an assessment to be done on 25 July. Meanwhile, she advised staff that, as the man seemed agitated, he should stay in healthcare until the assessment was complete.

89. The prison officer from C wing healthcare made a note in the man's history sheet dated 23 July, saying that he had been interviewed by the MHIRT and he was to remain on healthcare. As 23 July was a Saturday when the MHIRT do not work, it seems likely that the entry should have been dated 22 July.

90. On 23 July, the healthcare officer drew up a nursing care plan for the man. He identified the main issue as depression, which was to be overcome by a positive response to his prescribed medication. The man was to be assessed while in healthcare and to remain on ACCT. Staff were to interact with him to determine his mood.

91. Also on 23 July, another prisoner moved into the man's cell. Both the man and his new cell mate confirmed to staff that they were happy with this.

92. On Sunday 24 July, the man saw a second prison doctor who prescribed Ibuprofen for the pain in the man's ribs.

93. Later that day, the man had a visit from his wife, mother and son. Before the visit, the man told prison staff that he was looking forward to the visit, and that he had no concerns about it. The man told his family that he had not received the postal order they had sent him, and that he was reduced to smoking tea leaves or begging dog-ends off other prisoners.

25 July

94. On Monday morning, 25 July, the man said he wanted to be relocated onto a normal wing. He was told that this was not possible until he had been assessed by the MHIRT.

95. The occupational therapist undertook the MHIRT assessment that afternoon. She did not know that the officer from MHIRT had already conducted an assessment. However, she later saw the man's name in a referral book, realised he had already been assessed, but was not able to find the record of the assessment.

96. The occupational therapist says that she spent about two hours with the man that day, and he was much happier than he had been the previous week.

Although the man did not strictly meet the criteria for help from the MHIRT, she thought that he needed support. She invited him to attend various Occupational Therapy groups, including art therapy, relaxation, leisure and cookery. The first session - of art therapy - was to be Thursday 28 July, and he was to attend three sessions the following week. She arranged to see the man on Friday 5 August for a one to one session. In her assessment, she said that she thought the man was at high risk of self harm. She planned to obtain further information about him from his GP. She suggested he might need a CT scan to rule out the risk of physical problems, and noted that a psychiatric appointment would be made if necessary. She considered that one of the triggers that might increase the man's risk was not receiving his medication. As part of the risk plan, she said that the man's medication should be reviewed, as required, by the doctor or psychiatrist. She told my investigators that the man was not able to say what medication he was taking, and could only describe the size and colour of the tablets. She said that if the man had been worried about his medication, she would have put this in her notes, but her recollection was that the man's main concern was his family.

97. Although the occupational therapist's note in the man's medical record says that the man was to be reviewed by the MHIRT on 27 July, she says this was not the correct date. The intention was to see the man weekly, and this is what she wrote on the assessment form. She also intended to see him on Thursday 28 July at the art therapy class.

98. At the time of the assessment, the occupational therapist did not have the information that had been requested from the Community Mental Health Team. This arrived by recorded delivery later that week. Nor did she have access to the medical documents that had arrived in the prison with the man, but not been linked to his medical records.

99. The man also told the occupational therapist about the other prisoners that he thought might be a threat to him. She passed this information on to a Senior Officer.

26 July – healthcare

100. On the night of 25 to 26 July, wing staff noted that the man was awake until after 2am talking to his cell mate. At 10am on 26 July, there was a review of the man's ACCT case with a view to discharging him from healthcare. The review was conducted by a senior nurse, the ACCT case manager, the prison officer from C wing healthcare and the man. The man was considered to be settled in mood and behaviour, with no evidence of ideas of self harm or suicide. The man said he was well enough and confident enough to be moved to a normal wing. The level of risk was now identified as low. It was subsequently decided that the case was to be reviewed on 2 August. There is an indication on the ACCT form that the caremap was updated, but the only caremap completed was the one dated 21 July. The senior nurse says that additions would only be made to the caremap if there were specific things that needed to be done. No-one from the residential wing where the

man was to be located attended the review, as the prison's procedures require. Nor was anyone from the wing identified as the new ACCT case manager. There is a note that a follow-up healthcare appointment was to be made by the treatments nurse on the wing, but no evidence that this was done.

26 July to 1 August - the man's time on a residential wing

101. At 10.45am on 26 July, the man arrived at House Unit 1A. He was given an outline about the way the unit worked and an explanation of the ACCT arrangements. The man said he was more positive about the future and would approach staff if he had any problems. Later that day he asked for a transfer application. A member of staff offered to write it for him but he said he had a friend to do it.

102. By 8.30pm, the man appeared less positive. A member of staff asked him if he was alright, and the man said he wanted to be but simulated hanging himself. Wing staff told the Assistant Orderly Officer about this.

103. Also on 26 July, prison staff looked into the man's concerns about risks from fellow prisoners. Security staff spoke to the man, and confirmed that there was a prisoner of the name given by the man on another wing. A note was made on the man's history sheet to say that he must not come into contact with this prisoner. A note was also to be made in the wing observation book, but this was not done.

104. That same day, the prison had received a letter from the man's stepfather, written the previous day. Attached to the letter was an appointment for the man's CT brain scan on 15 August. The letter said:

> "I am the man's stepfather and am sending on this hospital appointment regarding a CT scan at hospital. His wife and mother visited him yesterday, Sunday 24th @ 3.10, and are very concerned about his physical & mental condition. He is <u>not</u> receiving the medication prescribed by his doctors & the judge at his trial, he is very depressed, not sleeping & we fear for his wellbeing. His solicitor has been advised and will no doubt be enquiring.
>
> "Please keep a watch on him & help him as there is so much going on that he is worried about that he says he can't cope with it."

105. The prison secretariat passed the letter to healthcare for a reply by 5 August. The Head of Healthcare says she received the letter on 27 July and looked at the deadline for a reply. She was due to go on holiday the next day. As the deadline for a response was some time after her return from holiday, and she had other correspondence where the deadlines were approaching, she did not deal with the man's step father letter that day. She told my investigators she thought it unlikely that she read the letter, and that she only checked the deadline. She returned to work on 1 August but, because of pressure of other work, she did not look at the man's step father's letter until the following

day. She told my investigators that there was no mechanism within the prison for identifying urgent correspondence.

106. The ACCT document suggests that the man gave prison staff no cause for concern on either 27 or 28 July. The man was due to be at the art therapy class on 28 July but he did not attend. The occupational therapist made a note that she would chase him up about this the following week.

107. Also on 28 July, the man's treatment chart shows that he was not given his Venlafaxine. There is no note in the medical records to explain why the medication was not administered and it seems likely that this was an error.

108. During the evening of 28 July, the man made a telephone call to his family to whom he spoke for over six minutes. During the conversation he told his wife that the money he had been expecting still had not come. She said she still had the post office slip, and that she would go back and check with the post office. She asked the man if he was getting his medication. He said no, and that the staff kept 'fobbing him off'. He said he had been given one dose of 75mg of the anti-depressant, and that had been two days ago.

109. The next day, 29 July, the man told wing staff that he was waiting for a letter with some photographs and a postal order. The officer on the wing asked healthcare to check if they had received it. Later that day, the man enquired again, and was told that healthcare had been asked to check and that he should chase this up the next day. He did so the next morning, 30 July, and the officer on the wing said he would look into it. The man asked again that afternoon. By 5pm, the man appears to have lost his patience as he talked about smashing up his cell and going to the segregation unit. Staff calmed him down, but later that evening he said he was still waiting for his letter to be sent over from healthcare. Wing staff once again said that he should raise this the next day, 31 July.

110. On the morning of 31 July, the man refused his Venlafaxine and said he was going back to bed. The man's mother visited in the afternoon and told him that his father was ill.

111. That evening, there is a note that the man was once again asking for his post, and was again told the matter would be looked into in the morning. Later on, there is a note that he was talking to his cell mate, and that they really seemed to get on well.

Events on 1 August – the move from House Unit 1 to the Healthcare Centre

112. On the morning of 1 August, the man asked a prison officer about his letter, photos and postal order for £20. She checked his account and confirmed that the postal order had not been credited. She telephoned healthcare, who could not see the postal order in their cash book. The man also asked the prison officer about his smoker's pack, which he said he had not received. She told him she would ring House Unit 5 to find out what had happened to it. The prison officer later went back to the man to tell him she was waiting for a

call back from House Unit 5, and that she would try the other healthcare wing (A wing) about his letter.

113. At about 11am, the man spoke to staff about his father being in hospital. Someone from the chaplaincy team came over to speak to him, after which he seemed happier. But at lunchtime, although he ate some food, the man was reported to be very low and asked to speak again to the prison officer. At about 1.45pm, he approached her on the stairs and told her that he wanted to hang himself. She sought advice from a more experienced member of staff. The more experienced officer telephoned the healthcare officer, who was in charge of the duty room in healthcare that afternoon. The healthcare officer said that she should check with the nurse, who was the nurse regularly assigned to distribute treatments to prisoners on House Unit 1. However, the House Unit 1 nurse could not be found, and so the more experienced officer again telephoned the healthcare officer and then went back to speak to the man. She found him in a low mood and again asking to speak to the prison officer. The more experienced officer telephoned the healthcare officer for a third time, saying that the man was low and speaking of hanging himself. She said that she thought he needed to be assessed by healthcare. The healthcare officer again advised speaking to the House Unit 1 nurse who was on his way back to the Unit.

114. The more experienced officer then went to seek the advice of the principal officer, taking the man's ACCT document with her. She says that the principal officer said that she needed to get the advice of healthcare, and if necessary to move the man to healthcare where he might be put on a constant watch. She waited about ten minutes, but the House Unit 1 nurse had still not arrived on the Unit so she telephoned the healthcare officer a fourth time. She says she explained that she had spoken to the principal officer, that the man was threatening to hang himself, and that he might have to be moved to healthcare and put on a constant watch. The House Unit 1 nurse then arrived on the Unit.

115. Up to 1 August, The House Unit 1 nurse's involvement with the man had been to administer his medication on the wing. (The man's treatment chart shows that the House Unit 1 nurse administered the man's medication from 29 July to 1 August.) The House Unit 1 nurse told my investigators that the man had said his medication should be at a higher dose, and he agreed to speak to a doctor to sort this out. He checked the man's medical notes and there was some indication that the man was right. He says he also received a call on 1 August from staff on House Unit 1 expressing concern about the man. The House Unit 1 nurse says he was in healthcare at the time, so he went to see the prison doctor with the medical notes. The prison doctor agreed to increase the dose of Venlafaxine to 150mg daily. The House Unit 1 nurse says he also explained to the prison doctor that the man was currently distressed, and they agreed that it might be best to readmit the man to healthcare on the grounds that it was better to be safe than sorry. I note that, according to the House Unit 1 nurse's account, the decision to admit the man was taken by the prison doctor and the House Unit 1 nurse without seeing the man, and without access to his ACCT document.

116. In contrast, the prison doctor says that the House Unit 1 nurse only approached him about the man's medication. On the basis of seeing the man's prescription for Venlafaxine before he came into prison, the prison doctor agreed to increase the dose. He thought this conversation took place at about lunchtime. He is adamant that there was no discussion at all about anything other than the Venlafaxine. He says that the House Unit 1 nurse told him nothing about any concerns about the man's mental health or his threats to kill himself. Had he known this information, he says he would have asked the duty room to arrange for the man to be brought over for a consultation with him.

117. The House Unit 1 nurse says he took the new medication chart to pharmacy because he wanted to make sure that the new dose of Venlafaxine was available when the man was readmitted to healthcare. The prison's records show that the 150mg Venlafaxine tablets were dispensed at 3.19pm on 1 August.

118. The House Unit 1 nurse says he also went to the duty room and said the man should be admitted, asking if a bed was available. He told my investigators that it was the responsibility of staff in the duty room and those in charge of healthcare to decide where the man should be located. He said he and the prison doctor in deciding that the man should be admitted to healthcare, did not make an assessment of the sort of cell into which the man should be placed or of whether or not he needed to be on constant watch.

119. The healthcare officer confirms that the House Unit 1 nurse spoke to him about admitting the man to healthcare. He says he told the House Unit 1 nurse that, if he was concerned about the man and thought he should be admitted, then healthcare would admit him.

120. The House Unit 1 nurse then went to House Unit 1, where he spoke to the man who was standing outside his cell door. The prison officer and a second prison officer were also present. The House Unit 1 nurse says the man seemed alright, but it was difficult to tell and staff were concerned about him. He thought the man needed to be observed more closely and his condition reassessed. He had access to the man's ACCT document on House Unit 1, but he did not read it, and did not consider it was his responsibility to reassess the man's care. The House Unit 1 nurse has not received any formal training in the ACCT process.

121. The House Unit 1 nurse says that he told the person in charge of the duty room that the man was on his way over. He could not recall who was in charge that afternoon (in fact, it was the healthcare officer) or whether he telephoned or went over to the duty room to say that the man was arriving. Once the man was escorted to healthcare, the House Unit 1 nurse says his involvement ceased. In effect, he says his task was only to make the decision (according to his account, jointly with the prison doctor) that the man should be admitted to healthcare. He says it was the responsibility of staff in healthcare to interview and assess the man when he arrived. He says he

would have expected the duty room to tell the ward staff that the man had arrived, and for the ward staff to do the assessment and arrange for the man to be seen by a doctor if necessary.

122. The House Unit 1 nurse made no note of his discussions with the prison doctor, his assessment of the man, or of the decisions he made that afternoon, either in the man's medical records or in his ACCT document. Nor did the prison doctor make any note of his decision to increase the man's medication, other than on the man's treatment chart, or the reasons for it.

123. The more experienced officer says that the House Unit 1 nurse told her that he had contacted healthcare and there was a double cell available on C wing. The more experienced officer told the man that he was being admitted to C wing, but he said that he did not want to go. She tried to explain that it was the best place for him, and that he might be put on constant watch, but the man remained reluctant and eventually walked off and went back to his cell. The House Unit 1 nurse and the two prison officers also spoke to the man. The prison officer had a long conversation with him, when he talked about the problems with his medication and his missing letter and about going on hunger strike. The prison officer said he could speak directly about these issues to healthcare. She says that the man seemed very down and confused about what he wanted, and she told him he would probably only need to be in healthcare for two or three nights for assessment. By the end of their conversation, he seemed more settled and agreed to go to healthcare.

124. The two prison officers took the man to healthcare. They say he seemed in better spirits on the walk over. When they arrived at C wing in healthcare, they passed his ACCT form over to a third prison officer. The prison officer says she fully explained the situation, and the second prison officer confirms this.

125. The notes in the ACCT document written by the prison officer for 1 August say:

> "13.45 Whilst I was on my way to commence main moves the man approached me to say he is feeling very low and he has a lot of things on his mind he said he does not mind going to the block then he stated he would hang himself. Told him I would speak to him when I get back off moves he said thanks miss."
>
> "16.00 Spoke to the man who was refusing to go to Healthcare saying he would rather go to the block told him it was for his best interest to go so he could be assessed by Healthcare. Said he would go but he would go on hunger and liquid strike. He also kept saying he would not be back."

126. The prison officer on C wing healthcare and the third prison officer were both on duty on C wing in healthcare that afternoon. During the course of the afternoon, The prison officer on C wing healthcare says the healthcare officer

in the duty room told them that the man might be arriving, and thus they had been expecting him although they were not entirely sure he was coming. At about 4.30pm, the third prison officer received the man in healthcare and placed him in cell 20, the only vacant cell on the wing. This was a double cell, with bunk beds, but the man was placed there alone. The hand-over from staff from House Unit 1 took place in the C wing office. The third prison officer dealt with the hand-over, and the prison officer on C wing healthcare was present in the office. The third prison officer says the House Unit 1 staff told him that the man had said he would kill himself, so he rubbed him down and took his shoelaces from him as a standard precaution. The third prison officer's shift was due to finish at 5pm, and he left the wing at about 4.50pm. The prison officer on C wing healthcare remained on the wing alone, as she was on duty that evening.

127. The prison officer on C wing healthcare says she understood the concerns about the man were that he was going on a hunger strike, and that she was not aware that he was threatening to hang himself. She accepts that that information is in the ACCT document, and that she did not read this sufficiently thoroughly. In relation to the cell in which the man was placed, she says she told the duty room that cell 20 was the only one available.

128. All the discipline officers who dealt with the man that day have received ACCT training to at least foundation level.

129. When the man arrived on the wing, the prison officer on C wing healthcare says she put him on the roll, and telephoned the duty room to say that he had arrived. She believes she spoke to the healthcare officer, who expressed surprise that the man had come over as he thought the problem had been resolved.

130. The healthcare officer does not recall being told that the man had arrived on the wing. He went off duty at 5.45pm, and he said at interview that he thought he had gone home by the time the man was brought over. When my investigator pointed out that the man had arrived before 5pm, the healthcare officer said that he was not aware of that.

131. The duty room log shows that at 4.57pm the roll was correct. This means that the count of the prisoners from the wings matched the roll board in the duty room. This entry is initialled by the healthcare officer.

132. Healthcare staff made no arrangements for the man to be formally admitted into healthcare, or for any assessment to be made of his mental health, what accommodation was safe for him, and what care he needed. The prison officer on C wing healthcare on House Unit 1 did not see it as his job to arrange this. The healthcare officer in the duty room told my investigators that, once the man had been placed in the cell in healthcare, he should have been seen by a doctor and a decision made about changing the frequency with which was observed. He said he did not know how that would be arranged or who was responsible for organising it, and had no idea why it had not been done. He said there might be a procedure for admission to

healthcare, but he was not familiar with it. The healthcare nurse was the nurse responsible for A and C wing on healthcare that afternoon. He says he could have been on either wing at about the time the man was brought over. He would have conducted an assessment of the man and drawn up a care plan, but no one told him the man had arrived or passed him the man's medical records to enable him to do this. He said the discipline staff on C wing should have told him the man had been brought over, by telephoning him on A wing if necessary. The healthcare nurse went off duty at 5pm. He told my investigators that he was not aware of any standard arrangements for admitting prisoners from a residential wing to healthcare.

133. An agency nurse appears on the daily staffing rota as taking over responsibility for the duty room from the healthcare officer from 5.45pm to 6.30pm. However, the healthcare officer recalled handing over to a different second agency nurse. The second agency nurse is shown on the rota as assisting in the duty room. The agency nurse confirmed to my investigators that, although she was down on the rota, she did not in fact cover the duty room as the healthcare manager was around, and the agency nurse was needed for treatments.

134. The healthcare officer says that he told the second agency nurse during the handover that there was a problem with two prisoners from the main prison, and that the doctor had gone to assess one of them. He says he told the second agency nurse that he had spoken to the House Unit 1 nurse and told him that, if he was concerned about the other prisoner (who was in fact the man), that prisoner should come over to healthcare.

135. The second agency nurse says she arrived in the duty room some time after 5pm. She says she did not take charge of the duty room because the healthcare manager was there, and it was the healthcare manager's responsibility to take charge. The second agency nurse says that she was just assisting. The healthcare manager told my investigators that she did not take over the duty room, but that from about 5.45pm she based herself in the back of the duty room for support.

136. The second agency nurse says that, when she arrived, the healthcare officer was in the duty room. She says she did not get a handover, although she would have expected to have done so. At the time, she says the duty room was in turmoil with lots of phone calls and prisoners being moved about, although this was not unusual. The second agency nurse says she does not recall anything about the man being admitted into healthcare. If he was admitted at about 4.30pm, she would not have been in the duty room at that time. She says no one mentioned him to her when she came on duty. The healthcare manager also says that she was not aware that the man had been admitted to healthcare.

137. The nurse that was first on scene arrived at about 6.30pm to take over responsibility for the duty room. The second agency nurse says the nurse first on scene was given a handover, although she was not sure whether she did this herself or whether the healthcare manager did it. The second agency

nurse says she remained on duty, assisting the nurse that was first on scene, until about 8pm.

138. The nurse that was first on scene confirms that she was given a handover by the second agency nurse. She says she was told (but she was not sure whether by the second agency nurse or the healthcare manager) that the man had been brought over that afternoon because there were concerns about him, that he was on an open ACCT, and that he was to be in healthcare for observations overnight. She told my investigators that any assessment of the man should have been done before she came on duty.

Events on 1 August – Healthcare Centre

139. Once the man had been placed in the cell in healthcare, he would have remained locked up for the whole evening apart from contact over the evening meal. When the meal was served, he would have been unlocked, allowed to chose his meal from the door of his cell, and then been locked up again to eat it.

140. At 5.12pm, a chaplain spoke to the man through the cell hatch and said they had been unable to find out in which hospital his father was a patient. They were to try and contact his mother. The chaplain noted that the man seemed in good spirits. He went to the wing office and about five minutes later saw the man again. To his surprise, the man's mood had changed dramatically. He made a note in the ACCT document that the man was now tearful and said he wanted to transfer to a mental hospital.

141. At 6pm, the prison officer from C wing healthcare noted that the man did not eat his supper. He told her about his father being in hospital, and that he could not cope in House Unit 1A. At 7.30pm, the officer from C wing healthcare noted that the man said he was alright, and did not want any water. At 8pm she looked through the hatch and saw him lying on the bed. He said that he was okay. These three observations were the ones the officer from C wing healthcare was required to make under the ACCT document (which specified three observations per session). The officer from C wing healthcare said in her statement after the man's death that the man had stood at his door for most of the evening, smiling and talking every time she passed. The officer from C wing healthcare told my investigators that she recalled talking to the man about some photographs and money that were supposed to have been sent to him. She looked on the computer and found there was a parcel for him in reception. She told the man she would try and get it for him the next day.

142. At about 8.15pm, a nurse started doing his rounds. He started at cell 13 and worked his way round to cell 20. He looked through the hatch of cell 20 and saw the man hanging from the bed. He knocked on the cell door to try and attract the man's attention, and then went to the main office which was a few feet away to alert the officer from C wing healthcare. The nurse doing the rounds and the officer from C wing healthcare returned to the cell, and the officer from C wing healthcare radioed the control room with an urgent

message to say that someone was hanging. In her written statement, the officer from C wing healthcare said that she was not allowed to enter the cell alone and that the policy on this was very strict. She told my investigators that she did not want to enter the cell alone. She said she would not have felt safe to do so as the man could have been faking a hanging. She went to the office to get scissors. She heard the control room radio an urgent message, but not contact the radio call sign ‘Hotel 1’. The nurse that was first on scene in the duty room was Hotel 1, and so the officer from C wing healthcare rang her directly. The control room log has no record of a call to ‘Hotel 1’.

143. An officer from A wing was handing over to a third agency nurse on healthcare’s A wing when she heard the urgent message about a hanging on C wing. She and the third agency nurse went immediately to C wing (the nurse doing the rounds says that help arrived in about one minute) and tried to open the cell door, although the man’s feet at first wedged the door. After a few seconds, she managed to get the door open. The officer from A wing, the officer from C wing healthcare and the third agency nurse entered the cell. The officer from C wing healthcare cut the ligature, while the officer from A wing supported the body. The officer from A wing and the third agency nurse checked for a pulse. The officer from A wing then started chest compressions, while the third agency nurse started mouth to mouth resuscitation. This life saving procedure is known as CPR.

144. The nurse first on scene then arrived at the cell. She did not bring any equipment, on the grounds that she wanted first to check what was happening. She then went to fetch the oxygen, which was in the treatment room on C wing, and the defibrillator, which was in the main treatment room downstairs from C wing with the rest of the emergency equipment. (A defibrillator is a machine which can administer an electric shock intended to restore heart rhythm.) The second of the locum staff then entered the cell, although it is not clear exactly when this was. The nurse that was doing the rounds says CPR was carried out for five to ten minutes before the doctor arrived. The second of the locum staff checked for a pulse, while CPR continued. After the nurse first on scene returned with the defibrillator, they attached it to the man but the machine told them not to shock him. The nurse first on scene then took over chest compressions from the A wing officer, who went to C wing to fetch the ambubag which contains oxygen and equipment to administer it. The second of the locum staff then asked for a canula and adrenaline. The officer from A wing went back downstairs to the main treatment room to get the emergency bag which contains this, and returned to C wing with a nurse. Throughout this time, the nurse first on scene and the third agency nurse continued CPR.

145. On instruction from the second of the locum staff, the nurse first on scene and the third agency nurse then stopped CPR, and at about 8.31pm the doctor pronounced the man to be dead. The second of the locum staff appears to have made no record of the actions he took or of the death. He failed to attend the interview that had been arranged, and so it has not been possible to put this to him or to obtain his account of the actions he took that evening.

146. Meanwhile, an orderly officer received the urgent message at about 8.15pm. He arrived at healthcare and found staff trying to revive the man. At 8.18pm, he asked that an ambulance be called, and this was done at 8.19pm. The ambulance arrived at the healthcare centre at 8.29pm. The nurse from the rounds says that by the time the ambulance arrived the doctor had pronounced death. At 8.36pm, the orderly officer told the control room that the man had died. The police were told at 8.37pm, and the ambulance left the prison at 8.39pm.

147. There is no contemporaneous log, and so no timings, of who arrived and left the man's cell from the time he was found until the cell was secured.

148. The man's cell was secured at 8.51pm. The police arrived at 9.09pm. Governor and a second governor arrived on the unit at 9.44pm, and talked to the night staff and the police. The police scenes of crimes officer arrived at 10.27pm and examined the cell. The Coroner's Officer arrived at 11.05pm. Shortly after this, the undertakers arrived and took away the man's body.

149. The second governor and the healthcare manager made sure that all the cases of all the prisoners in healthcare on an open ACCT were reviewed that night.

150. The Governor had the responsibility for contacting the man's family. He arranged for a chaplain to accompany him, and asked the police to check the next of kin details. Once this was done, the governor and chaplain visited the house with the police, but it turned out to be the man's wife's sister's house. They were directed to a neighbouring house, where the man's wife, their children, and the man's mother in law were found. They broke the news at about 2am on 2 August. The man's son was so distraught on learning of his father's death that he punched the wall and damaged his arm. The police officers were invited in and helped administer first aid. The man's son was later taken to hospital.

151. Arrangements were also made for the police to break the news to the man's mother and stepfather, who were due at work at 3am. The Governor and chaplain subsequently checked that this had been done. They were told that The man's mother would tell his father. The Governor and chaplain remained with the family until about 5am.

152. Later that day, notices were put up in the prison telling staff and prisoners of the man's death. That afternoon, the second governor spoke to all the prisoners on C wing to check how they had been affected by the man's death.

153. At 8pm that evening, a critical debrief was held for night staff involved in finding the man and trying to save him. Those staff who spoke to my investigators said that the prison had offered them support, and those who had taken advantage of it had found it helpful.

154. The second governor was appointed the prison family liaison officer. She got in touch with the family, and also wrote to them to confirm her role and to offer any assistance. She also offered, on behalf of the prison, to pay the family's funeral expenses.

155. After the man's death, the prison located the letter, photographs and postal order about which the man had been enquiring, and returned them to his wife. The second governor told my investigators that the letter had been found in reception. She said it was marked as having been sent to House Unit 1, and then on to healthcare, and finally back to reception. The man's wife arranged for the correspondence to be buried with him.

156. When the police searched the man's cell, they found a brief suicide note, in which the man sent his love to his wife and children and said sorry.

157. The man's wife has raised concerns about the man's clothes, which she says were incinerated by the prison. However, after the cell was sealed the responsibility for what happened to the man lay with the police and the Coroner. I believe that the man's clothes may unfortunately have been incinerated after he was taken to the mortuary, but there is no evidence that this was a matter in which the prison was in any way involved.

Views of other prisoners who knew the man

158. On 22 July, another prisoner who was a close friend of the man, moved from healthcare wing A to wing C. While they were on the wing together (which was from 22 July to 26 July), he says the man told him that he was not getting the medication that he needed. When the man asked staff about this, they refused to help. He particularly heard the man asking a doctor for medication, and saying that he needed something to help him sleep.

159. The man's friend says that while the man was in healthcare he was given a letter confirming that he would be released on a 'tag' on 10 or 11 November. He was very happy about this, as it meant that he would see his wife and children again before too long.

160. The man's cell mate on House Unit 1 says he and the man got on well, although the man was depressed and talked of taking his own life. The man's cell mate read out to the man the papers about his release in November, and pointed out that he only had 12 weeks to serve in prison. He did his best to look after the man, and made it clear that he would do what he could to stop him from committing suicide. He says that the man did not have any problems on the wing, and that staff treated him well. The man did not mention to him problems with his medication or his post.

Post Mortem

161. The post mortem was not available to my investigator at the time that this report was issued in draft.

162. A toxicology report shows that there was no Venlaflaxine in the man's blood at the time of his death. The toxicologist notes that, when taking Venlaflaxine, it may be several weeks before an anti-depressant effect is observed. If it is taken on an irregular basis, the therapeutic benefits may not be fully achieved. The toxicology report does not say how long Venlaflaxine might be expected to remain in the body. The clinical review points out that the man could have suffered some side effects from reduced and missing doses of Venlaflaxine, but that there is no evidence that he complained of these effects. The review also notes that there is no evidence to suggest that a decrease in dosage is linked to increased risk of suicidal ideas.

163. The toxicology report notes that no other drugs or alcohol, apart from the possible presence of a low concentration of cannabinoids, were detected.

Clinical review

164. The clinical review was not available at the time my report was issued in draft. It makes a number of recommendations, which the Governor and the PCT will no doubt want to work together to consider from a clinical perspective:

- There are several systems of recording information – in particular in relation to medical notes and ACCT – and notes system should be streamlined.
- The PCT policy on record keeping should be followed.
- There are gaps in the reception admission notes and subsequent assessments, and the policy on admission assessment to prison should be reviewed or developed.
- The policy on admission to healthcare should be reviewed or developed.
- There is a need for a clearer definition of the roles and responsibilities of clinical and medical staff.
- There should be a policy for how to deal with non attendance at Occupational Therapy groups, which should be outlined in the care plan.
- A protocol is required for the procedure to be followed when prisoners refuse prescribed medication.
- Visiting protocols should be reviewed to include some structures for support when prisoners receive bad or distressing news.
- Clear roles and responsibilities should be determined for the Duty Room, outlining the level of skill or qualification required to undertake the role of the duty officer and the support mechanisms in place.
- Ligature knives should be placed in strategic places to ensure a rapid response.
- A protocol should be developed on resuscitation procedures.
- Attempts should be made to ensure that all staff have up to date basic or intermediate life support training dependent on their qualification.
- A protocol should be developed on Serious Untoward Incidents.

Consideration of the some of the issues surrounding the clinical care that the man received

165. It is clear from this investigation that the prison failed to arrange for the man to be fully assessed and properly admitted into healthcare on 1 August when he was brought over from House Unit 1. My investigators therefore looked in some detail as to what happened that day in healthcare, and how this might have come about. The intention was not to try and identify individuals to blame, but to see if there were fundamental failings in the system that lead to the tragedy of the man's death.

166. There are two wings in healthcare, A wing, on the ground floor, where more seriously ill prisoners are generally located, and C wing on the first floor. There is a duty room on the ground floor.

167. Staffing cover in healthcare is split into four shifts. There is a morning shift (up to lunchtime), an afternoon shift (up to about 5pm), an evening shift (up to about 8pm) and a night shift. The staffing rota for 1 August shows that, for the discipline staff, two prison offers were covering the afternoon shift for C wing, and two other officers were covering the same shift for A wing. One officer then continued to cover C wing for the evening shift, and another officer continued to cover A wing.

168. There were 16 healthcare staff on duty that day (excluding managers) to cover all the shifts. Ten of these were agency nurses. Three permanent staff were off sick, and three were on annual leave.

169. As well as nurses, Woodhill employs Healthcare Officers who are not registered nurses but who have some clinical qualification. Prison Service Standing Order 13 (Health Care) outlines the general role of the Health Care Officer:

- Carrying out basic nursing care and such specialist nursing care as is within their competence.
- Observing patients in their charge and alerting a Medical Officer to any matters relating to the health or treatment of a patient which are considered to warrant medical attention.
- Keeping accurate records of medication administered and other significant nursing duties undertaken.

Were duty room staff aware that the man had been brought to healthcare?

170. The officer from C wing is certain that she told the duty room that the man had arrived on C wing. She believes she spoke to the healthcare manager, and that he expressed surprise that the man had come over. The healthcare officer does not recall being told that the man had arrived before he went off duty at 5.45pm. However, at 4.57pm the duty room log shows that the healthcare manager signed to confirm that the count of prisoners on the wing matched the roll board in the duty room. Accordingly, it seems likely that at that time he was aware that the man was on the wing, even if he did not

attach any significance to this information, or know what he needed to do with it.

171. There is some lack of clarity about the duty room handover arrangements during the course of that evening. The healthcare officer says he handed over to the second agency nurse and told her that, if House Unit 1 nurse was concerned about the man, the man should be admitted to healthcare. The second agency nurse says she did not receive a handover, and did not know anything about the man. The duty room log, which should be updated before a handover, does not have a record of the man being one of the prisoners on an open ACCT.

172. The second agency nurse is not sure whether she or the healthcare manager formally handed over to the nurse that was first on scene, but this nurse confirms it was the second agency nurse who did the handover. The nurse that was first on scene said she knew – although she was not sure whether from the second agency nurse or the healthcare manager – that the man had been brought over, was on an open ACCT, and was in healthcare for observations for the night. She assumed that any assessment that the man required would have been done before she came on duty at 6.30pm.

173. In my view, there is little doubt that the duty room knew that the man had been brought over to C wing. I think it likely that this information was conveyed to the healthcare officer before the 5pm roll check.

Was the duty room adequately staffed?

174. The Healthcare Centre has a document that sets out the tasks of the duty room. This says that the person in charge of the duty room is the first point of call for all Healthcare Centre enquiries, and that the person in charge must act accordingly. Specific activities include, amongst other things:

- Making sure that the duty room roll board is accurate and up to date at all times, so figures for available spaces are always at hand.
- Having an up to date knowledge of the client group on healthcare to ensure safe transition of any moves that take place.
- When locating new admissions to the Healthcare Centre, making sure that wing staff are adequately briefed on any information about that prisoner.
- Ensuring that each prisoner is as safely located as resources will allow, but being prepared to make moves within the healthcare wings as necessary to maximise safety. This must be done in conjunction with wing staff, the Senior Management Team and the Duty Governor.

175. The paper says that the person in charge of the duty room should be flexible in their approach to duties and be prepared to carry out any reasonable requests. If unsure, the person in charge should consult a senior manager.

176. The senior nurse for inpatient care in healthcare, is also one of the Healthcare Centre managers. He has worked in the prison for several years

and became a 'G' grade nurse in January 2005. He told my investigators that the role of the person in charge of the duty room was basically to manage healthcare – dealing with queries about medication, assessing whether prisoners are fit for transfer or for work and so on. He said it is a very busy post, the first point of contact, and in effect the hub of the Healthcare Centre. So, for example, if wing staff were not sure about a prisoner with regard to self harm, the duty room would be the first point of contact. Other staff to whom my investigators spoke confirmed that the duty room 'drives' healthcare. The duty room was said to be a communication point, involving asking questions so that the right people can be updated with the right information.

177. On 1 August, the senior nurse covered the duty room for the morning shift. The healthcare officer was in charge of the duty room that afternoon, assisted by a Healthcare Assistant. The second agency nurse arrived in the duty room some time after 5pm, and the healthcare officer left at 5.45pm. The healthcare manager says that she based herself in the back room at about 5.45pm so that she was available for support. The nurse first on scene took charge of the duty room at about 6.30pm.

178. The senior nurse said at interview that he had been seriously concerned about the staffing levels on healthcare that day, as too many people had been allowed leave, or were off for other reasons. In particular, the healthcare officer was not sufficiently qualified or experienced to be in charge of the duty room. His view was that the healthcare officer had neither the experience of managing the duty room nor any experience of clinical assessment. He said it was not so much a matter of grade as a matter of experience. He raised this with the healthcare manager at about midday on 1 August. He said that, when he was explaining the problem, the healthcare manager came in and said that he was not sufficiently experienced, prepared or confident to cover the duty room. He said the healthcare manager told the healthcare officer that all he needed to do was be in the duty room, and she would make any management decisions. Thus, the healthcare officer's role in the duty room was to answer telephone calls, enquiries and so on.

179. The senior nurse told my investigators that he himself had been at work the previous Friday afternoon, throughout the weekend, and on the Monday morning. Normally, he would have stayed to cover the shortfall in the duty room that afternoon. But he had already worked all weekend, and the previous weekend, to cover a shortfall, and he was not prepared to do so again.

180. The healthcare officer has worked at the prison for about eight years as a discipline officer, and for the last five years on healthcare. He has an NVQ level 3 healthcare qualification, which he obtained in the last 12 months, having started to work towards it about six months after he started in healthcare. He said at interview that he was supposed to be a hospital officer (this is the old term for a Healthcare Officer), but he had not yet got his certificate and was not being paid the extra money. He said he was covering the duty room that afternoon against his will, having told the healthcare

manager earlier that he was not paid enough to be in charge of the duty room and he did not want to be there. He said the phone never stopped ringing, and he was under immense pressure for which he was not appropriately paid. He did have the assistance of the healthcare assistant, but she was in and out, was not up to the task, and he had not found her of any help at all. He said he had essentially been left on his own to cope. He had previously assisted in the duty room from time to time, but not very often, and had never before been in sole charge. He said he normally worked on the wings and administered treatments.

181. The healthcare manager said at interview that the healthcare officer was an experienced healthcare officer, and although he did not normally work in the duty room, he had done so previously. He had raised some concerns with her about covering the duty room, but it was mainly about being on his own. He also said he did not feel able to make managerial decisions. The healthcare manager arranged for someone to assist him, and said that she would be available to help with any managerial or clinical issues. She said that at no point that afternoon did the healthcare officer tell her he was not coping, although she had invited him to call her as she was around all afternoon. She says she checked several times, and the healthcare officer said he was busy but did not have any problems.

182. The senior nurse also said that the second agency nurse had never before been in charge of the duty room. The second agency nurse is a Registered Mental Nurse, and has worked as an agency nurse in Woodhill for about five years. The second agency nurse said at interview that she did not consider that she took charge of the duty room, but was simply assisting, since the healthcare manager was there. The healthcare manager told my investigators she did not consider herself in charge of the duty room, as she was just available for support.

183. I conclude that there can be little doubt that the duty room was not adequately covered on the afternoon and early evening of 1 August, by staff of sufficient experience, confidence or competence to undertake the task. The senior nurse had raised concerns earlier that day. The healthcare officer had explicitly expressed his lack of confidence. And there was lack of clarity as to who was in charge once the healthcare officer left and before the nurse first on scene arrived. The problem was, it seems, not so much a matter of grade as of familiarity with the task, although there was clearly also an underlying dispute about pay. The list of duty room tasks is not comprehensive, and my investigators have not been able to obtain any clear description of the tasks that an healthcare officer in general is normally expected to perform, or the tasks that the healthcare officer in particular was assessed as competent to perform. In light of the healthcare officer's limited previous experience, the lack of clarity about the task, and the lack of written procedures of which staff were aware (which I consider below), my view is that the healthcare officer was not competent, or given the necessary tools, to be in charge of the duty room that afternoon. It cannot be right that he was left in charge of such a vital function without, at the very least, close and active supervision of his performance, and clear instructions about the task.

184. In coming to this view, I have also considered the Nursing and Midwifery Council's Code of Professional Conduct. This requires a registered nurse, midwife or health visitor to be personally accountable for their practice. This means that they are answerable for their actions and omissions, regardless of advice or directions from another professional. I am told that fully qualified and paid Healthcare Officers, although not registered nurses, are normally required by the Prison Service to be bound by the Code. My investigators have not been able to gain sight of healthcare officer's employment documentation which might clarify whether or not he was signed up to the Code. If he is bound by the Code, then he must take some responsibility for taking charge of the duty room despite his own view of his ability to undertake the task. But either way, it cannot be right that he was allowed by two senior managers – albeit one under protest – to undertake a task that a signatory to the Code would have been duty bound to refuse.

Were staff aware of arrangements for admitting prisoners to healthcare?

185. The house unit 1 nurse is a Registered Mental Nurse, and has worked at Woodhill on an agency basis for over five years. He saw his task as only to make the decision that the man should be admitted to healthcare. He did not think it was his responsibility to undertake any further assessment of the man, or decide on the type of cell in which the man should be located. He thought it was the responsibility of the duty room to tell ward staff that the man had arrived, and for the ward staff to assess the man and arrange for him to see a doctor if necessary. The house unit 1 nurse did not think it was his task to make sure that happened.

186. The healthcare nurse was the nurse responsible for covering both A wing and C wing on the morning and afternoon of 1 August. The healthcare nurse is a Registered Mental Nurse, and has worked at Woodhill on and off since 2003. He told my investigators he thought the discipline staff should have told him that the man had been brought over. Had they done so, the healthcare nurse would then have assessed him. He was not aware of any standard arrangements or procedures for admitting prisoners from a residential wing to healthcare.

187. The healthcare officer was in charge of the duty room when the man was brought over to healthcare. He thought that when the man arrived he should have seen a doctor, who would make a decision about the level of observations required. He did not know who was responsible for arranging this. If there was a procedure for admission to healthcare, he was not aware of it.

188. The head of healthcare told my investigators that a doctor should have assessed the man, either on the wing or in healthcare, unless it was out of hours in which case the most senior clinician in healthcare should have conducted the assessment. She said this was usually co-ordinated by the duty room, and it was the duty room's responsibility to make sure the doctor knew the prisoner had arrived. She would have expected the nurse referring

the prisoner to healthcare (in this case the house unit 1 nurse) to have a conversation with the receiving doctor or other clinician about the admission and the prisoner's future care. She said that discipline staff should also have told the nurse on the hospital wing, or the duty room, or some other clinician, that the prisoner had arrived. She said it would be a joint decision between discipline staff and healthcare staff as to which cell was suitable for the prisoner. She would have expected house unit 1 nurse to tell the duty room about the prisoner's problems, and for the duty room to see what space there was. It was the responsibility of the duty room to co-ordinate spaces, and to move prisoners around if necessary to obtain a suitable vacant cell. On this occasion, she thought that the cell in which The man was placed was the only one available, and all the constant watch cells were full.

189. The head of healthcare accepted that, if the duty room expected a prisoner and it seemed he had not arrived, she would anticipate the person in charge of the duty room to check what had happened to him. She said that they had identified the lack of adequate written procedures as a problem, and were taking steps to put that right.

190. Towards the end of the investigation, on 16 November 2005, the prison sent my investigator the prison's policy for admission to healthcare that had been agreed in September 2004. This says that when the prisoner arrives, they should be shown to their new accommodation by a member of healthcare staff. As soon as practicable, a duty doctor should review the prisoner and a plan of care established. It says that healthcare staff will determine the location of the prisoner within healthcare. None of the healthcare staff interviewed in the course of the investigation mentioned this document.

191. I conclude that there was a general lack of understanding about the healthcare admission arrangements when the man was brought over. I am not convinced by arguments put forward by some staff that the confusion arose, in part, because of the large number of agency nurses being used by the prison. None of the agency nurses interviewed or spoken to during the course of this investigation was by any means new to Woodhill. But in any event, if there is a large number of transient staff, that is even more reason to have clear, simple, practical written procedures, of which agency staff are aware, and which they can be expected to follow.

192. My investigators were told by various healthcare staff that there were other events on the day of the man's death which may have caused things to go awry. In particular, the man was brought over to healthcare at about the time of the changeover from afternoon to evening shift. It had been a busy afternoon, and another prisoner had also been identified as potentially suicidal. A doctor had been called over to the wing to assess him that afternoon, and he was subsequently admitted to healthcare later that evening. There was no bed available for him in healthcare, and he had to be put in a holding cell while prisoners were moved around to make space for him. While I appreciate that this will have put extra strain on staff, and none of the people my investigators spoke to was using this as an excuse, it is

disappointing that healthcare arrangements were insufficiently robust to cope with both predictable and unpredictable crises.

Conclusions

193. The man was on an open ACCT document when, on 1 August, he said that he intended to hang himself. Staff on the residential wing where the man was located took his concerns seriously, and asked for some clinical input into how the man should be dealt with. Healthcare staff decided that he should be admitted into the Healthcare Centre. As a consequence, the man was moved from the relative comfort of the residential wing, and the care of his cellmate, and put alone in a cell in healthcare. This cell contained an easy ligature point, was without a television or access to any company, and was in far less pleasant surroundings. Yet there was no change in the level of observations that had been agreed for the man some days before on his ACCT review, and no proper clinical assessment of his condition or the care that he might now need. A few hours later he was dead. How did this tragedy come about?

194. My view is that a number of things went wrong. First, when the man was on the residential wing and said that he wanted to commit suicide, there should have been a proper ACCT case review, involving house unit nurse 1, wing staff, the case manager and the man. A comprehensive assessment should have been made of the man's state of mind, and the best course of action to support him (including the best location) should have been made. Instead, there was no nominated case manager on the wing to take charge of the case, no real assessment of any kind was made, and there is no evidence that any other options were properly considered apart from an admission to healthcare.

195. **I recommend that the Governor reminds staff to ensure that, when a prisoner who is on an open ACCT clearly deteriorates, there is an urgent ACCT case review to decide on the best course of action, and that this is properly documented in the ACCT record.**

196. **I also recommend that the Governor ensures that, when a prisoner on an open ACCT moves location, a new, properly trained case manager from the new location is always appointed, and that there is a process for monitoring this to make sure it is done.**

197. The second thing to go wrong that day was that cover in the duty room that afternoon and early evening was inadequate, and so no-one made proper arrangements for the man to be admitted. Third, the formal arrangements for admission to healthcare, and the role to be played by different members of staff, were not properly documented, and staff were not clear what they were. Fourth, I do not believe that the house unit 1 nurse's assessment of the man on the residential wing was adequate. He simply decided that the man needed closer observation (but did not feel that it was his task to specify what this meant) and to be reassessed. He did not make a single note of his decisions, or the reasons for them, in either the man's medical records or his

ACCT document. Thus, even if there had been a proper admissions process, clinical or medical staff reassessing the man would have had very little information about why he had been admitted. A clearer briefing to the person in charge of the duty room might, despite the lack of procedures, have brought The man higher up the priority list for hard pressed staff in and around the duty room that evening.

198. Although it is impossible to be sure what might have happened had things not gone wrong, there is at least a possibility that the man's death could have been avoided. I therefore urge the Governor and the PCT to take urgent steps to ensure that duty room staff are up to the task, that there are proper handover arrangements when the shifts change, that proper admissions procedures are in place and understood by staff, and the nurses on the residential wings fully understand the extent of their clinical responsibilities when deciding that a prisoner should be admitted to healthcare.

199. **I recommend that the Governor and the PCT work together to ensure:**

- **That the role and responsibilities of the person in charge of the duty room are clear, and that staff put in this position are competent to undertake the task.**
- **That handovers always take place when shifts change, and that all staff know it is their individual responsibility that they both give and receive handovers, irrespective of their position in the management structure.**
- **That proper procedures are in place for admission to healthcare, and that all staff are aware of them and understand them.**
- **That nurses on residential wings fully understand the extent of their clinical responsibilities when deciding that a prisoner should be admitted to healthcare.**
- **That staff are once again reminded of the vital need to keep proper records of clinical decisions, and to update both medical records and ACCT records appropriately. The Governor and the PCT may want to consider disciplinary action for those that still fail to do so.**
- **That the clinical audit process reflects compliance with healthcare policies and procedures.**

200. I am also concerned that there may be a lack of clarity regarding the role of a Healthcare Officer, the duties they are expected to undertake, and the specific competencies of individual members of staff.

201. **I recommend that the Governor and the PCT jointly review the role of a Healthcare Officer and other healthcare staff, and the duties they are expected to undertake according to grade. They should ensure that roles are clearly defined, and that there is an adequate system in place to measure the competency of individual members of staff against the agreed standard.**

202. There is some evidence that a low level industrial dispute may underlie some of the questions about who can and should take charge of the duty room. I do not know the details of this, but it seems to me it is something that needs to be resolved urgently: for the benefit of a better run Healthcare Centre and a better service to vulnerable and unwell prisoners.

203. **I recommend that the Governor and the PCT investigate the question of who is paid as a Healthcare Officer, and ensure that the duties and responsibilities of all healthcare staff are clearly laid out according to grade.**

204. I do not know whether the healthcare officer was bound by the Nursing and Midwifery Council's Code of Conduct, and therefore whether he was in breach of it.

205. **I recommend that the Governor and the PCT conduct a local investigation to establish whether the healthcare officer was bound by, and in breach of, the Nursing and Midwifery Council's Code of Conduct, as a result of his actions on 1 August 2005 in agreeing, albeit under pressure, to take charge of the duty room. I also recommend that consideration is given, if appropriate, to whether healthcare managers knowingly allowed the healthcare officer to breach the Code.**

206. Although the shortcomings set out above were by far the most serious, my investigation has suggested a number of other areas where I take the view that the prison did less than it should to care for the man.

Separation of court correspondence from the man's medical records

207. It is clear that staff at court did their very best to ensure that information about the man's medical history and his medication reached the prison. There is little doubt that the information arrived. But because it was marked for the urgent attention of the Governor, it seems likely that it ended up in the internal mail, and actually took longer to find its way to medical staff than if it had simply been marked for the attention of healthcare. As a consequence, when the man arrived at Woodhill, he did not get the medication he had been receiving before he was sent to prison. This need not have happened if the records had been kept together.

208. Even when part of the correspondence – in particular the note from the probation service officer – was linked up to the man's medical record, it seems that other documents were not. Certainly, they had not been linked up at the time of the man's second MHIRT assessment.

209. **I recommend that the Governor reviews arrangements to ensure that, if correspondence is marked for his urgent attention, it does in fact reach its destination urgently.**

210. **I recommend that the Governor and the PCT work together to ensure that the administration of medical records is up to the task, and that**

documents that arrive at a later date are linked up promptly, and an assessment made of the action that needs to be taken in the light of their contents.

Induction process

211. If the man had not needed to be placed in healthcare when he arrived in prison, he would have received a full induction programme with all the benefits that that would bring. He would in addition have been assured of receiving his smoker's pack, and a first night telephone call home. Instead, it was two days before he was able to speak to his wife, and there is some doubt about whether he ever received his smoker's pack. The lack of proper induction arrangements for prisoners who arrive in healthcare means, in effect, that some of the most vulnerable prisoners are likely to receive he least support when they arrive in prison.

212. **I recommend that the Governor reviews the arrangements for induction of prisoners placed in the Healthcare Centre, to ensure that they have the benefit of the same facilities as prisoners placed straight onto a residential wing.**

Reception process

213. My investigation into the death of another prisoner, in July 2005, has identified lengthy delays in reception as likely to increase the stress of imprisonment for newly arrived prisoners. The man, too, spent a considerable amount of time waiting around on his first evening in prison. He arrived at 4.18pm, was received on reception at 5.07pm, had his first reception health screen completed by 6.35pm, saw a doctor, and was finally admitted to healthcare at 9pm. Such long delays are likely to have exacerbated the man's sense of despair.

214. **I recommend that the Governor reviews reception processes with a view to minimising waiting times for new prisoners.**

Regime in healthcare

215. Evidence from this investigation suggests that the physical surroundings and the daily regime for prisoners in the Healthcare Centre are far inferior to those provided on the residential wings. In addition, it may be that Woodhill is too ready to move prisoners at risk of suicide or self harm to healthcare, rather than support them on a residential wing.

216. **I recommend that the Governor considers whether action can be taken to improve the environment and regime in healthcare, and whether more could be done to support suicidal or self harming prisoners on the wing, if there is no clinical need for them to be located in healthcare.**

ACCT arrangements

217. I have a number of concerns about the way Woodhill administered the man's ACCT document. The ACCT document was correctly opened on 18 July, although there was no information given as to who should be called if an immediate review was required. There should have been a proper assessment and case review of the man's ACCT within 24 hours. Nothing was done on 19 July. On the morning of 20 July, another prisoner died. This of itself should have prompted an urgent review of all open ACCT documents, to make sure that vulnerable prisoners were protected. But it was not until the morning of 21 July that the man's case was reviewed.

218. When the man was moved from healthcare to a residential wing on 26 July, a full case review was carried out. However, no-one from the residential wing where the man was to be located attended the review, no new case manager was appointed, and the caremap was not updated to take account of what support the man needed on the residential wing. In fact, only one caremap was ever completed, and that was the one on 21 July. Nor is there evidence that a follow-up healthcare appointment was made, as procedures require.

219. I am also concerned that, although prisoners on an open ACCT located on residential wings should normally be located in shared cells, unless there is a documented reason not to do so, there is no similar requirement for prisoners placed in healthcare. I recommend that this be reviewed.

220. Finally, this investigation has identified some evidence that, although a large number of staff have received ACCT training, key healthcare staff dealing with the man had no ACCT training – in particular the healthcare officer, a nurse and the house unit 1 nurse. I also believe that it is important that the Safer Custody Co-ordinator is allowed to focus on his task full time.

221. **I recommend that the Governor ensures that:**

- **The first ACCT assessment is always done within 24 hours, and that arrangements are in place to make sure that all open ACCT cases are reviewed urgently in the event of another prisoner's death.**
- **A member of staff from the residential wing attends the case review when a prisoner is discharged from healthcare.**
- **Caremaps are regularly reviewed and updated.**
- **Follow up healthcare appointments are always made when a prisoner is discharged from healthcare.**
- **The arrangements for placing prisoners on an open ACCT alone in a cell in healthcare are reviewed, particularly those cells with bunk beds which provide an all too easy ligature point.**
- **All healthcare staff are trained in ACCT to at least foundation level.**
- **The Safer Custody Co-ordinator is allowed to focus full time on his task.**

Dealing with the man's stepfather's correspondence

222. Woodhill received a letter from the man's stepfather on 26 July, saying how worried his family were about his wellbeing and about the fact that he was not getting the medication he had previously been prescribed. It is a matter of great concern that that letter was dealt with as routine correspondence, and that there is no mechanism within the prison for identifying and acting on letters that raise urgent issues. I understand that Woodhill has now taken some steps to identify urgent correspondence when it is received in the prison. My view is that there must also be an onus on the unit receiving the letter to make their own assessment of urgency, and not simply to rely on a decision by staff in a central secretariat.

223. **I recommend that the Governor takes steps to ensure that urgent correspondence is identified either on receipt by the prison, or by the receiving unit, and is dealt with appropriately.**

Correspondence sent to the man by his family

224. On 22 July, the man's wife sent him a letter, photographs and a postal order. It seems that this package travelled around the prison, and the man certainly never received it. A package from home is likely to be of great comfort to a vulnerable and potentially suicidal prisoner. The man was understandably very agitated and distressed about its failure to arrive. It is of some surprise that, when the man raised the problem several times over, it was not a simple matter for staff to resolve. It seems that it was not until 1 August that staff established that the package was in reception. Sadly, it is possible that the man could have been given it the next day.

225. **I recommend that the Governor reviews arrangements for receiving correspondence for prisoners, to make sure it is properly tracked, gets promptly to the prisoner, and that staff understand how to locate anything that may go astray.**

Obtaining information from the man's GP

226. Although it was identified when the man arrived at Woodhill that there needed to be a discussion with his GP about his medication the following day, this did not happen. The prison doctor thought it was either the responsibility of the doctor or the MHIRT team to make sure this happened, but that there was some scope for confusion as to who was responsible. In my report following the death from natural causes of a prisoner at Woodhill in February 2005, I also pointed out the importance of obtaining a prisoner's medical records from his GP.

227. **I recommend that the Governor and the PCT work together to ensure that healthcare professionals obtain information from a prisoner's GP (or indeed any other relevant healthcare providers), and that there is no room for doubt as to whose responsibility this is.**

Ensuring prisoners receive their medication

228. There was one day when the man did not receive his medication. It seems likely that this was an error. This investigation has not looked at how this might have come about, but the prison will no doubt want to find out and make sure that such an error cannot recur.

229. **I recommend that the Governor and the PCT work together to check that the arrangements for administering medication to prisoners are adequate, and that the error in the man's case will not recur.**

Operation of contingency plans

230. The prison's contingency plans in the night state do not make reference to the function of the staff member in healthcare holding radio call sign 'Hotel 1'. That may be why, when the prison officer from C wing healthcare sent the emergency radio message, she did not hear a call for Hotel 1. Luckily, she was sufficiently quick thinking to make the call herself.

231. The contingency plans required a log keeper to be appointed and a note kept of all staff who entered or left the cell. There were enough staff around shortly after the man's cell was entered to allow this to happen, but it was not done. It is difficult now to be sure of the times that staff arrived at the cell to try and save the man's life.

232. I think the Governor may also want to remind staff that they can enter a cell alone in order to preserve life, if they think it is safe to do so.

233. **I recommend that the Governor ensures that the contingency plans are updated, and that the role of Hotel 1 in the night state is clarified and communicated to staff.**

234. **I recommend that the Governor ensures that staff are reminded to delegate a log keeper, if one is available, as soon as possible after an emergency is declared.**

235. **The Governor should remind staff that they can enter a cell alone in order to preserve life, if they think it is safe to do so.**

The efforts to save the man's life

236. The evidence suggests that staff acted promptly and professionally to try and save the man's life. I recommend that the Governor makes sure that all staff involved are aware of my finding on this matter.

237. I do, however, have some concerns that the nurse first on scene did not bring emergency equipment with her to the cell, and that there were in fact three journeys from the cell to obtain all that was needed. It may be that this was caused by some initial lack of clarity about the nature of the emergency.

238. **I recommend that the Governor and the PCT work together to ensure that staff always bring all appropriate emergency equipment with them to an emergency.**

239. **I also repeat my recommendation, made following the July 2005 death, that the Governor considers the introduction of a coding system so that staff can respond appropriately to a medical emergency.**

240. **I recommend that the Governor draws the attention of staff involved to my view that, once the man was discovered, staff worked promptly and professionally to try to save his life.**

Training in first aid and use of emergency equipment

241. The prison has not been able to confirm whether or not the discipline officers involved in saving the man's life were trained in first aid.

242. **I recommend that the Governor checks that staff involved in saving the man's life had adequate training, and if not, that he reviews training arrangements to make sure that trained staff are always available in an emergency.**

Clinical care

243. The lack of a timely clinical review, and the fact that it has not been possible to interview two of the doctors involved in the man's care, means that I have not been able to answer additional questions about the clinical care the man received. I do not know why the healthcare C wing doctor apparently did not speak to the man's GP and did not prescribe the man medication of the same dosage as he was getting in the community, and whether he got other appropriate medication such as sleeping tablets. Nor can I say what effect any failure to prescribe the correct medication may have had on the man. Similarly, I do not know what action the second locum doctor took after the man was discovered hanging in his cell, and what record he made, if any, of the man's death.

244. Now that there is a clinical review, the Governor and the PCT will not doubt want to work together in considering these issues, and anything else not already covered in my investigation.

Care of staff and prisoners

245. The evidence suggests that the prison took good care of staff and prisoners after the man's death, and took all appropriate steps to make sure that everyone was appropriately supported.

Liaison with the family

246. I can appreciate how angry the man's family will be with the prison about the man's death. Nonetheless, I take the view that the prison has taken all reasonable steps to liaise with the family, both in breaking the bad news and in subsequent interactions. I believe that the prison has handled matters carefully and sensitively.

Recommendations

1. **I recommend that the Governor reminds staff to ensure that, when a prisoner who is on an open ACCT clearly deteriorates, there is an urgent ACCT case review to decide on the best course of action, and that this is properly documented in the ACCT record.**

2. **I also recommend that the Governor ensures that, when a prisoner on an open ACCT moves location, a new, properly trained case manager from the new location is always appointed, and that there is a process for monitoring this to make sure it is done.**

3. **I recommend that the Governor and the PCT work together to ensure:**

- **That the role and responsibilities of the person in charge of the duty room are clear, and that staff put in this position are competent to undertake the task.**
- **That handovers always take place when shifts change, and that all staff know it is their individual responsibility that they both give and receive handovers, irrespective of their position in the management structure.**
- **That proper procedures are in place for admission to healthcare, and that all staff are aware of them and understand them.**
- **That nurses on residential wings fully understand the extent of their clinical responsibilities when deciding that a prisoner should be admitted to healthcare.**
- **That staff are once again reminded of the vital need to keep proper records of clinical decisions, and to update both medical records and ACCT records appropriately. The Governor and the PCT may want to consider disciplinary action for those that still fail to do so.**
- **That the clinical audit process reflects compliance with healthcare policies and procedures.**

4. **I recommend that the Governor and the PCT jointly review the role of a Healthcare Officer and other healthcare staff, and the duties they are expected to undertake according to grade. They should ensure that roles are clearly defined, and that there is an adequate system in place to measure the competency of individual members of staff against the agreed standard.**

5. **I recommend that the Governor and the PCT investigate the question of who is paid as a Healthcare Officer, and ensure that the duties and responsibilities of all healthcare staff are clearly laid out according to grade.**

6. **I recommend that the Governor and the PCT conduct a local investigation to establish whether the healthcare officer was bound by, and in breach of, the Nursing and Midwifery Council's Code of Conduct, as a result of his actions on 1 August 2005 in agreeing, albeit under pressure, to take charge of the duty room. I also recommend that**

consideration is given, if appropriate, to whether healthcare managers knowingly allowed the healthcare officer to breach the Code.

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10. **I recommend that the Governor reviews reception processes with a view to minimising waiting times for new prisoners.**

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