

**Investigation into the circumstances surrounding the
death of a man at HMP Woodhill
in September 2008**

**Report by the Prisons and Probation Ombudsman
for England and Wales**

September 2009

This is the report of an investigation into the circumstances of the death of a man in September 2008 at HMP Woodhill. At approximately 4.48am, the man's cellmate rang their cell bell to tell staff that he had found him hanging. Cardio pulmonary resuscitation was carried out, but at 5.35am, he was pronounced dead. The man was 50 years old and had been in Woodhill for seven weeks. It was his first time in custody.

I would like to offer this public expression of sympathy and condolences to the man's family and friends on their loss. A key objective of all my investigations is to ensure the bereaved family has the opportunity to raise any concerns and contribute to my inquiries. The man's family and their solicitor have raised a number of issues with one of my family liaison officers and with my investigator. I hope this report offers answers to the family's questions. I regret the delay in its completion.

The investigation was led by an investigator who was assisted by a colleague. A clinical review was conducted by a Senior Nurse for Vulnerable Children, of the local Primary Care Trust, and I am very grateful for her assistance. I would also like to thank staff at HMP Woodhill for their co-operation. I should particularly mention the Officer who acted as the establishment's liaison officer with my office.

At the time of his arrest the man had self-harmed and was found with two 'suicide notes' on him. When he went into Woodhill, he was placed on self-harm monitoring. After 17 days in custody, he was thought to be settled. Thirty one days later, he was charged with further offences, but gave no indication to staff or fellow prisoners that he was disturbed by this development. However, he was dead less than two days later.

My report reveals serious failings in the ACCT process at Woodhill, and contains eight recommendations.

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

Stephen Shaw CBE
Prisons and Probation Ombudsman

September 2009

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SUMMARY

The man was arrested on 5 August 2008 for serious sexual offences. At the time of arrest, he was found with a self-inflicted injury to his arm and two suicide notes. Whilst in police custody, he was seen by a Forensic Medical Examiner (doctor) and was deemed to be at high risk of self-harm. The doctor advised that the man be placed on constant observations and reviewed later in the day. No further reviews took place.

The man was charged on 6 August and, the following morning, he was collected by Global Solutions Limited (GSL) to be transported to court. His Prisoner Escort Record identified self-harm/suicide as a risk, but did not give any further information (including what had been found upon his arrest or that he had been on constant observations at the police station). It is thought that the Detained Person's Medical Report, which had been completed by the FME, travelled with him although no one recalled seeing it upon his arrival at HMP Woodhill following his court appearance.

The man went through the reception procedures at Woodhill and was spoken to by at least two prison officers. He talked to both them about his self-inflicted injury but neither deemed him at risk. Once in the First Night Centre, the man completed the First Reception Health Screen with the nurse on duty. Again, he disclosed that he had cut his arm but she did not feel he was at further risk. He was referred to the doctor who was concerned about his low mood and previous self-harm and opened an ACCT during the evening of 7 August.

During the ACCT assessment, the man spoke mainly about practical problems although he did give a detailed history of his various self-harm attempts. However, the assessor felt he presented as stable and he was not deemed to be high risk. At the subsequent reviews, he spoke mainly of practical problems. On 12 August, he moved from the First Night Centre to Houseblock 4, the vulnerable prisoners wing. An ACCT review was not carried out on the day of his move.

Two further reviews took place and eventually the ACCT was closed on 22 August. A post-closure review booked for the 1 September did not take place. The man appeared to be settled. On 24 September, he was visited in the morning by an agent from his firm of solicitors and, in the afternoon, by two police officers who charged him with a further two offences.

He was seen by an officer immediately after the visit and did not give her any cause for concern. Neither his cellmate nor another prisoner he mixed with detected any change in mood.

At approximately 4.48am, one morning in September, the man's cellmate discovered him hanging and rang his cell bell. The officer who attended was unable to enter the cell until other staff arrived a few minutes later. The cellmate burnt through the ligature before staff entered. Cardio pulmonary resuscitation was carried out but the man was pronounced dead at 5.35am.

My report makes eight recommendations in relation to the management of the ACCT and the CPR training of night staff.

THE INVESTIGATION PROCESS

1. The lead investigator conducted a preliminary visit to HMP Woodhill on 2 October 2008 to open the investigation. She visited the cell where the man died and spoke to his cellmate who had discovered him. The lead investigator met with the Deputy Governor and collected all the relevant documentation. She also met representatives from the local branch of the Prison Officers' Association and the Independent Monitoring Board. Neither raised any concerns. The investigating officer from Thames Valley Police was also contacted.
2. Notices were issued to staff and prisoners telling them of the investigation and offering the opportunity to speak with my investigators. No one came forward as a result. Ten members of discipline staff were interviewed on tape and a number were spoken to informally and notes taken. Two prisoners were interviewed on tape.
3. The clinical reviewer, a Senior Nurse at the local Primary Care Trust (PCT), undertook a clinical review of the healthcare provided for the man whilst at HMP Woodhill. Four medical staff were jointly interviewed. The PCT is required, under National Health Services procedures, to carry out its own review of the clinical aspects of the man's care and consequently her remit was broader than my own. The clinical reviewer therefore interviewed some staff alone.
4. The man saw an agent from his solicitor's firm the day before he died and my investigator wrote to him. However, the solicitors declined to provide any information to the lead investigator or discuss the man over the phone. The lead investigator fed this back to the Coroner's Officer and requested that the Coroner be informed. She also asked if a statement could be taken from the solicitors. This was agreed and a copy of that statement has been annexed to this report.
5. The lead investigator contacted the police officer who saw the man on 24 September. By return, she was contacted by the case investigator for the Professional Standards Department for Northants Police. Given that the man had had contact with the police within 48 hours of his death, the case investigator had contacted the Independent Police Complaints Commission (IPCC) and was undertaking an investigation into the conduct of the officers who had seen him the day before his death. It was therefore deemed not appropriate for my investigator to speak with the officer but to rely on the findings of the case investigator's report.
6. The case investigator sent my investigator the man's custody record. Having had sight of this, my investigator asked the case investigator if he would also be able to investigate how much information about the circumstances of the man's arrest and risk assessment had been passed to GSL, the escort contractors. The lead investigator and the case investigator also had a face

to face meeting. The case investigator has shared his investigation report with my office and it is attached as an annex.

7. Contact was made with a Court Services Manager for GSL (now renamed G4S), and he agreed to make enquiries with the staff who collected and escorted the man from the police station to court and onto HMP Woodhill. He has provided a report to my investigator but is currently seeking legal advice about whether it can be annexed to this report.
8. The lead investigator and one of my family liaison officers met with the man's wife and legal representative. The purpose of the meeting was to listen to their concerns about the circumstances surrounding his death. It was also an opportunity to explain the purpose of the investigation and answer any of the family's questions. The main questions raised were:
 - How was the man's risk of self-harm monitored?
 - Why was the severely depressed tone of his letters not picked up?
 - What information was passed to prison staff by police following their prison visit to him on 24 September?
 - Was he bullied by staff?
 - Why did the prison delay passing on his suicide notes to his family?
9. A copy of the draft report was sent to the family, via their legal representative, and the Prison Service. The response by the Prison Service is repeated verbatim in the recommendations section. The concerns of the family were dealt with by way of a letter.

HMP WOODHILL

10. Woodhill is a local prison opened in 1992. It is part of the high security estate holding some category A prisoners as well as some of the most disruptive prisoners in the system in the close supervision centre. It also has a protected witness unit. The vulnerable prisoners are located in Houseblock 4 and there is a First Night Centre.
11. An inspection by HM Chief Inspector of Prisons in 2005 led to a description of the prison as 'depressing and disappointing'. However, following a subsequent inspection in 2007, she found 'a very different prison'. Safety at Woodhill was said to have 'improved considerably, with extremely good reception and first night procedures'.
12. Before the death of the man, there had been no apparently self-inflicted deaths at Woodhill for three years. A second death in April 2009 is currently being investigated by my office.
13. The local Primary Care Trust is the responsible commissioning PCT for healthcare at Woodhill. The provider arm of the organisation provides a nursing healthcare team based in the prison, a Mental Health In-Reach Team, and x-ray, dental, pharmacy and podiatry services. The local PCT also commissions a number of other providers to provide healthcare provision including Resuscitate Medical Services Limited who provide General Medical Services, The Seagrave Trust who provide Substance Misuse services, and Howcroft and Selly who provide Ophthalmic Services. In addition, Woodhill provides some additional healthcare staff who support the functions of the healthcare department.

KEY FINDINGS

14. The man was arrested on 5 August 2008 and taken into custody at Weston Favell Police Station. A case summary says that a suicide note was found on him at arrest and another one in his car. A custody record was opened at 11.11pm which included a risk assessment. It was recorded that the man had an 'injury to the wrist and has had suicidal problems by cutting wrists and was going to try this tonight'. The man himself said that he had harmed himself by 'hanging and cut wrists'. When asked if he suffered from or had received treatment or support for a mental health problem or depression, he replied, 'mental health and depression'. Asked how he was feeling then, he said, 'sound no problems'. He also said that he suffered from a 'tight chest' but that he was not taking any medication for the condition. He was referred to the Forensic Medical Examiner (FME) and put on constant observations at the police station.
15. The man was seen by the FME at 2.15am on 6 August. The FME concluded that he was experiencing 'reactive suicidal thoughts to situation not acutely or severely depressed/mentally ill, infected wound left wrist and mild asthma'. His medical advice was, 'wrist redressed on constant observations until after interview needs wound redressing and mental state reassessing risk, given antibiotics and inhaler' (sic). The man's risk of self-harm was deemed 'high' and a medical review required. He was given doses of antibiotics throughout the day. The FME completed a Detained Person's Medical Form (DPMF).
16. The report provided by the case investigator for the Professional Standards Department states that the FME identified that:

"He had been accidentally found at the place of arrest and it was his intention to take his own life.

"The doctor's assessment was that the man had intended to take his own life and that the intervention of the officers, by arresting him, was the only reason that his intervention failed."
17. In the custody record is an incomplete DPMF indicating that a doctor (FME) was again requested for a 'medical review' at 7.08am on 6 August. The police detention log indicates that a doctor was requested again at 1.51pm for the purpose of changing the dressing. Just after 2.00pm, an entry suggests that the FME had been delayed and it is not clear whether or not the man was further seen by doctor prior to his departure from the police station on the morning of 7 August. He appears to have remained on constant observations for the entirety of his time at the police station.
18. At this juncture, it is worth explaining the process for transporting prisoners from the police station to court and onto prison. The man was collected from the police station by two staff from GSL. The Prisoner Escort Form (PER) (the key instrument for ensuring that information about risk is shared between agencies) accompanied the man from the police station to Northampton Magistrates Court on the morning of 7 August. The risk categories highlighted

were 'conceal weapons' and 'suicide/self-harm'. These categories were identified by a police custody officer.

19. The report provided by GSL, prepared after the man's death, says that GSL asked the police at the station why they had marked the above mentioned risk factors. Based on the information given, GSL staff added the following in the section 'further information about risk':

“*suicidal due to being charged with offence*
* MEDS DUE @ 2pm*
Paperwork @ court”

20. The GSL officers said that they were not told any other information about the man (i.e. not that he was on constant observations at the station, not that he had been found with suicide notes when arrested, not about the self-harm injury). However, based on the information which was provided, GSL's own policy is that a suicide/self-harm warning form should have been completed.
21. According to GSL staff, the man was asked at court about his mood. However, this was not recorded anywhere. The man was further remanded until 22 August. GSL and Woodhill have a local service agreement which means that GSL complete the personal summary sheet of the prison core record. This included recording that the man was a welder and that his wife was his next of kin.
22. The PER indicates that the van left the court around 1.00pm, and that the man arrived at HMP Woodhill at 2.20pm and was received by an Officer in reception at 2.45pm. The officer's entry on the PER says that he received the warrant and core record. There is no mention of the medical form from the FME (nor place on the form to indicate one has been received). When my investigator collected all the man's documents from the prison, a copy of the medical form was included in the paperwork, suggesting that it had been received at the prison at some point. If this had arrived at the same time as the man's PER it should have been handed to reception staff. However, there is nothing to indicate whether or not it arrived at the same time and, if it did, where it went. The expectation is that it would have been passed to healthcare staff.
23. An officer saw the man in reception and completed the property card with him. She also spoke with him about Rule 45 (under which he could be segregated from the main prison population given the nature of his alleged offences). The reception officer wrote in his core record, 'Due to nature of offence accepted Rule 45. Self harmed on Sunday, ACCT not opened due to this being a one off and a cry for help. He states that he is willing to speak to staff if feels like this again.' In interview, the reception officer could not recall the man but was confident that she would have opened an ACCT if she had had any concerns.
24. In reception, section 1 and 2 of the Cell Sharing Risk Assessment (CSRA) was completed by another officer. (This officer was also acting as the camera officer and took the necessary photos for the man's file.) In addition to the

routine information collected, it was recorded that the man had 'self-harmed on Sunday but feels ok now will speak to staff if he intends to self harm again (sic).' He was assessed as a low risk to others.

25. The man was processed through reception and placed in the waiting cells. For reasons unknown, he was not transferred over to the First Night Centre until at least 5.30pm. Once there, an officer there recalled speaking with him that evening. She told my investigator that she completed some documentation with him and spent some time explaining about prison life and the vulnerable prisoners wing. This officer remembered that he communicated well and had made good eye contact with her.
26. A nurse carried out the First Reception Health Screen (FRHS). At the start of the form, the author is asked whether 'health information received from outside source?' She has not ticked this and in interview said that she did not see the medical form from the police station. The first part of the health screen asks the prisoner to provide information about physical health. The nurse recorded that the man had a problem with his right leg in November 2007. He said he was currently taking co-amoxiclov, and on 3 August had cut his left arm which was infected and he was on antibiotics. He also said he suffered from asthma.
27. Under the section about mental health, the man said that he had never seen a psychiatrist and had not received medication for a mental health problem. The nurse recorded that he had tried to harm himself and described the aforementioned cut to arm. The form then instructs the author to refer the prisoner to the Mental Health In-Reach Team (MHIRT) if they answer yes to any of the questions. The nurse did not make a referral to the MHIRT. The man's response to being asked whether he felt like harming himself was recorded by her as no. The nurse indicated that he wanted a referral to the doctor because of leg pains. She concluded that he was fit for ordinary location but not for work because of the wound on his arm.
28. In interview, the nurse could not recall the man in any detail. She explained that, because she was referring him to the doctor, all his needs would be looked at and hence she did not make a referral to the MHIRT. From memory, she assumed that he must have been presenting well and settled at the time and not giving her any cause for concern. The nurse said that she was not ACCT trained.
29. Another task for the nurse was to complete section 3 of the CSRA following the completion of the healthscreen. She assessed the man as a low risk to others. In response to the question, 'Following the self-harm assessment have any concerns been raised?' the nurse ticked no.
30. At Woodhill, new prisoners have to be referred to the doctor and do not see one automatically as part of the induction process as in some prison establishments. A prison doctor was on duty that evening in the First Night Centre. In interview, he was not able to recall the man clearly or whether he had seen the medical form from the police station. However, he explained

that if he does have sight of any additional documentation he usually makes a note of this in the medical record. There is no mention of it in his notes. .

31. The prison doctor made some notes in the man's Clinical Record (CR) and in relation to self-harm/suicide he wrote:

- A few days ago, he slashed his wrist after he heard about the allegation against him
- Presently states no self-harm/suicide thoughts or ideation. However, says he feels low, with poor sleep (2 hours per night) and poor appetite in the past 2 weeks
- Poor eye contact
- Speech monotonous
- Subjectively and objectively low in mood
- States no self-harm/suicide ideation
- No thought disorder

31. The prison doctor decided to open an Assessment, Care in Custody and Teamwork document (ACCT – the mechanism by which prisoners deemed to be at risk of self-harm are monitored and supported by prison staff) at 8.40pm. He indicated that the frequency of observations should be three per session (morning, afternoon and evening period) and five per night. On the 'Concern and Keep Safe' form, he ticked 'suicide attempt or statement of attempt to kill himself' and 'very low mood (e.g. withdrawn, slowed down). In addition, he added 'suicide attempt/self-injury 4 days ago – cut his wrist'. The prison doctor also completed some of the 'Immediate Action Plan'. This is an immediate plan of support for the first 24 hours prior to the in-depth assessment interview being completed. The prison doctor repeated the levels of observations required, and said that the man should have phone access to Samaritans and his family and also to prison Listeners. He also said the man should not have access to in-possession medication.

32. At 8.45pm the unit manager completed the rest of the form which indicated the man's location on the First Night Centre, cell 1-10 (a double cell). In interview, the unit manager said he could not remember him very well and that he would usually have a consultation with the nurse or doctor to discuss the prisoner. He said that the observation level is usually set quite high for the first 24 hours given that this is a very vulnerable time.

33. The following afternoon (8 August) at 3.30pm, the ACCT assessor completed the ACCT Assessment interview. This must be completed within 24 hours of the concern being raised and is a detailed interview to gather risk-pertinent information. In interview, the ACCT assessor said that the man was:

“particularly clear about his intent and his memory of things ... a lot of people we come across are very withdrawn and don't want to talk and he was very open about his thoughts, feelings, his plans, all of these things, he was very open about it and discussing what had gone on and didn't appear to be any sort of withdrawal or any problems there mentally.”

34. In response to the first question of the assessment, 'Individual's perception of the problem related to current distress', the ACCT assessor noted, 'Bills were building up and not much money coming in. Arguments over silly things at home.' The man was then asked about the recent act of self-harm and the ACCT assessor recorded, 'Has made several planned attempts at suicide* Although each attempt was at night, there doesn't seem to be any reason. *over past 10 days. Says that he didn't really know what the outcome would be.' The man was asked about previous acts of self-harm his reply was recorded as, 'Tried to overdose using any medication he could find two years ago. Has attempted suicide several times over past few days, using different methods.' In relation to his current mental state, it was recorded, 'Very conversational and describes thoughts and events in detail. Says that he feels ok now for some reason. Says if financial problems were reduced/removed then this would definitely improve his outlook.'
35. In relation to any current suicidal thoughts and intentions, the assessment reads, 'States he has no thoughts or plans at this time and will discuss any that arise'. Asked about reasons for living and coping resources, the man's reply was recorded as, 'still has daughter. Thinking about daughter, keeps him going.' Under the section 'any other areas of discussion', the ACCT assessor recorded, 'would usually drink to relieve stress. Wants to look presentable – shave etc. States his current situation and charge doesn't concern him much as he didn't do it.' The final section which asks 'agree what is to happen now with the interviewee' has been left blank.
36. In interview, the ACCT assessor said that the man told him about a number of suicide attempts he had made, including trying to throw himself in the river, hanging himself, cutting his wrists, and the final time when he was arrested. However, the ACCT assessor said that to make an assessment he had to balance what he was being told with the way the man was presenting, and he felt that he was presenting well and appeared to be coping. He said that he got the sense that the man felt relieved to be in prison. With regard the nature of the charges against him, the ACCT assessor was not sure whether he had asked the man about them, or whether he would have known prior to seeing him what he was on remand for.
37. A Senior Officer (SO) completed the Action following Assessment (First case review) form and the CAREMAP at 8.30pm with the man. Again this form has to be completed within 24 hours of concern being raised. The ACCT assessor said that following the assessment he would have had a verbal exchange about the prisoner to whoever is in charge. The SO said that he could not recall whether a verbal handover had taken place with the ACCT assessor. According to the ACCT guidance notes, the first case review should be completed by the unit manager identified previously (this was the unit manager). The SO has recorded:
- "The man appears to be agitated about his current situation and is frustrated that he cannot make phone calls. I have explained to him the PPU [Public Protection Unit] process which he now fully understands. He has no thoughts of self-harm at this time and is getting on well with his cell

mate. He has now settled in having not enjoyed police custody. He is happy to talk to staff if he has any further problems and is aware of the availability of Insiders. Obs to be reduced to 1 per session and 5 at night.”

38. The SO ticked low in regard to the current likelihood of further risk behaviours. The next review was scheduled for 11 August. The CAREMAP was also completed by the SO and recorded practical issues about the man’s mobile phone and making arrangements regarding two cars he had left prior to arrest.

39. Between 10 August and 4 September, a number of entries were written in the man’s Record of Events document by staff from the Public Protection Unit within Woodhill. Given the nature of his charges, his mail and telephone calls were monitored until a full risk assessment was completed. Occasionally, his letters were returned to him prior to being sent out to his family. His family did not want contact with him initially, but he had asked to be able to contact his daughter.

40. On 11 August at 3.30pm, the SO carried out a case review with the man. Again, the guidelines recommend at least two members of staff are present. The SO said that other staff do attend if there is a specific need. When asked if staff shortages might have meant there was nobody else available, the SO did not feel that this was the case and said that if he had wanted someone else they would have been available. The SO said that, given that the First Night Centre was a small unit (40 prisoners), all senior officers were familiar with all the prisoners. The level of observations was changed to one per session and three at night. The summary of review said:

“The man states he still has concerns about his car and has been told he should speak to resettlement this evening. He is still adjusting to prison life but feels ok and unlikely to harm himself. He appreciates how he is being treated by staff and will come to staff should his mood deteriorate.”

41. On 12 August, the man was moved from the First Night Centre to Houseblock Unit 4 (HB4) into cell 1-20 and began sharing with another prisoner. The ACCT guidance states that a review should take place following a location move. However, this was not done.

42. An entry in the man’s Record of Events document was completed by one of two personal officers allocated to the cells 11-20 on the first floor landing. In interview, she said that the man was fearful and upset but not overly so. The entry reads:

“Located on HU4B in cell 1-20. Wing rules explained and interview sheet given. Personal officers introduced. It is the man’s first time in prison and he is therefore somewhat fearful. Reassurance given. He states that all his phone numbers are on his mobile which he cannot remember having access to in reception. States that two glasses are at work and without them he has difficulty reading. To contact solicitor to obtain glasses and 3 days wages from work.”

43. In interview, the man's cellmate said that he and the man got on well. He described him as 'a jolly sort of chap, a bit worried about his sentence'. The cellmate said that the man 'seemed to settle in OK. He never gave me any reason not to think any different; he'd got a lot of friends on here and seemed to be OK.'

44. Records indicate that, on 13 August, the man was seen by an Insider (a prisoner trained to offer support to new prisoners) for the purpose of completing the standard form for new arrivals. They spent 45 minutes together but no further details have been given. (This is to be expected as these meetings are confidential.)

45. At 2.40pm on 18 August, a further case review took place with the man and a second SO (who has now retired from the Prison Service and consequently was not interviewed). The level of risk was assessed as remaining low and no changes were made to the level of observations. The second SO wrote:

"Spoke to the man. He is more settled now. First time in prison. Had cut his wrist quite deeply. In court again on Friday this may be a trigger point will review his ACCT again on Friday or Saturday depending on outcome of court appearance. Says doesn't feel like self-harming now and just wants this all over."

46. On 20 August, the man was seen by medical staff in relation to the wound on his wrist. He also had some dental pain, and the nurse planned to submit dental appointment on his behalf and refer him to the medical officer for analgesia.

47. The man went to Northants Crown Court in August for a routine appearance. The risk categories on his PER were identified as self-harm/suicide and it was clearly identified that he was on an open ACCT. He returned to prison at 1.35pm and his core record reports 'no problems'. He had been further remanded until 29 October for trial.

48. On 24 August, the man had another ACCT case review with a third SO and an officer. It reads:

"Although it would seem that none of his outstanding issues have been resolved, he states he is far happier and well settled. Gets on well with cellmate. Has no thought of suicide/DSH. With agreement of all involved, ACCT closed."

49. In interview, the third SO could not recall the man apart from when he conducted the review. As the SO on the wing, he said the task of competing reviews would have fallen to him. He said that if someone was unfamiliar to him it was his practice to speak with staff on the wing to learn more about them. The officer was also present because the third SO always conducts reviews with two members of staff.

50. The form requires that, if the ACCT is closed, a date for the post-closure interview should be given and repeated on the front cover of the ACCT. The date of 1 September was given. The post-closure review did not take place on that day or on any other day.
51. The on-going record of the ACCT records all observations and meaningful conversations throughout the period a prisoner remains on an ACCT. These have been completed and seem to reflect the man as settling into prison life as best he could. One of the last entries prior to the ACCT being closed states, 'spoke with the man at length, tells me he wants to get off his ACCT, he feels fine and the reason he went on his ACCT was because it was his 1st time in prison. He feels now that he has adjusted better to prison life and can come off his ACCT.'
52. On 25 August, the man received a visit from two friends. Two days later (27 August), he was seen by his solicitor and two police officers who conducted a taped interview. In his Record of Events booklet on 29 August there is an entry which reads, 'Resettlement Induction completed. Seen by CAB [Citizens Advice Bureau] regarding mortgage, debts etc. No other issues.'
53. On 9 September, the man was visited again by the same two friends. He also moved into cell 2-18. An officer wrote in his Record of Events document, 'the man is moving into cell 2-18, not sleeping well in 1-20 due to cellmate snoring. The man has requested to move in with another prisoner. I have explained to them that this is a one off and they can't keep requesting cell changes and they were both happy with this.'
54. At about 2.00am on 15 September, the man pressed his cell bell and officer responded. The man said that he had been vomiting all night and was unable to keep any food down. She contacted healthcare staff and was told that he was already down to see them in the morning. The officer relayed this to him and encouraged him to try and get some sleep. His medication chart indicates that he was prescribed some Antacid and anti-emetic (anti-sickness and anti-acid tablet) medication.
55. On 17 September, the man's clinical record indicates that he was seen by a prison doctor and diagnosed with reflux oesophagitis, and that medication was prescribed. He had told the nurse that day that he was suffering from epigastric (abdomen) pain and that he had been diagnosed previously with a hiatus hernia.
56. On the morning of 24 September, the man was visited by a legal clerk from his firm of solicitors. In a statement provided to HM Coroner, the legal clerk said that he was with the man for an hour and 25 minutes and took instructions from him in relation to his case. This was the first time the legal clerk had met him and he said that, 'throughout the time he remained calm and certainly at no time did he give any indication that he may harm himself.'

57. That afternoon, the man had a visit from two police officers and was charged with two further serious offences. From the report provided by the police investigator the police officers stated that:

‘The man was sat in a chair and appeared unhappy. He did not want to engage in any conversation with the police officers ... charged and cautioned ... He made no reply to the charges and refused to sign the charge sheet or to sign the court acknowledgement ... gave him a copy of the charge sheet, which he proceeded to screw up and place on the desk ... The prison officer opened the door and both officers left.’

58. An officer was working on legal visits that afternoon and in interview recalled the visit from the police to the man. In interview, she recalled them telling her that they did not think he would like what they had to say to him. They were with him for a very short time and when they came out they again said he had not liked their news. She said that she asked them if they wanted her to keep an eye on him. The police said that he was ok. (The report by the police officers does not make reference to her asking whether they would like her to keep an eye on the man.)

59. The legal visits officer then had to take the man downstairs to be searched and she asked him if he was ok. In interview, she said that she could not ‘remember what the conversation was about but his mood was light and ... we were having a bit of banter, so ... I can honestly say he was not in any way distressed or depressed or anything like that, he was quite jovial and quite light in mood.’ The officer explained that, had she had any concerns about him, she would have contacted the wing to inform them and, if necessary, opened up an ACCT document. She said that she was not concerned about him.

60. The man’s former cellmate said that the man used to come and see him every morning and have a cup of tea. He said that the man told him he had been further charged, but his mood did not seem any different from other times. He had told the former cellmate that he had previously self-harmed.

61. The man wrote a letter and some poems to his wife that were retrieved from the prison post following his death. He describes being pleased that he has an optician appointment at the end of the month, complains about prison life, but is generally chatty and asks his wife to contact him.

62. An officer, who was familiar with the man and was his personal officer, was giving out toiletries that evening. This usually takes place earlier in the day but for some reason this was not the case. Given it was the evening, razors were not given out as there would not be time to collect them in before evening lock up. In interview, the officer remembered explaining this to him and that he was fine. She had no concerns about him.

63. The man’s cellmate said that on Thursday afternoon he and the man had a cup of tea together and that he was alright. At about 7.15pm, the wing was locked up for the night and the cellmate said that the man was drawing and

writing whilst he watched television. He thought that he turned the television off at about 8.30pm and they then listened to some music before he fell asleep.

64. An officer was on duty alone that night. She had worked on HB4 for three years and knew the man during his time on the wing. When he moved onto the second floor landing, she became one of his personal officers and felt she had a good relationship with him. She said in interview that she looked in on the cell as she noticed the light was on and they were chatting and watching television. She thought this was about 10.00pm. At about 10.40pm, she noticed that the light was out.
65. The cellmate said that at about 4.30 am he got up to go to the toilet. He noticed the man over by the door, looking as if he was sitting down at the end of the bed. The man had moved the cupboard over to the door and his feet were against it. The cellmate tried to shake him as he thought he might have fallen asleep. He then pressed the cell bell.
66. The night officer was on the wing pegging (during the night the officer has to go to certain points on the wing and log their presence) when the cell bell went off. She was coming along the landing and went to the cell door where the red light was on, turned it off and opened the flap. In interview, she estimated this took her a matter of seconds. The cellmate was in the front of the panel saying, 'It's my mate, it's my mate.' The night officer could not see the man at this point until the cellmate moved to one side. Woodhill's Suicide Prevention and Self Harm Management Strategy states that 'staff can enter a single cell alone in order to preserve life (PSO 2710). Staff should wait for assistance when entering a double cell.' The night officer immediately used her radio and called for urgent assistance. At night time, the radios are on talk through so all staff can hear what each other are saying (rather than having to go through the control room, as in the day time). The control room log recorded the call taking place at 4.48am.
67. The night officer then continued to talk to the cellmate as he tried to undo the ligature (made of bed-sheeting). He first used a plastic knife and then burnt through the ligature using a cigarette lighter. The man fell against the cellmate's legs at this stage and onto the floor. The night officer asked the cellmate to try and find a pulse. However, he was not sure how to do this.
68. A Principal Officer (PO) was the night orderly officer and consequently was in charge of the prison that night. He was in the Operations Room with an SO, the assistant night orderly officer. They heard the night officer's message and knew her location. The Operations Room is approximately 60 yards from HB4 and six doors have to be unlocked to get there. The night orderly officer estimated that they reached the cell within a minute. The assistant night orderly officer estimated that it took about two minutes. On arrival, they checked through the flap and entered immediately. The night orderly officer asked for an ambulance over his radio (either as they entered the cell or en route). Records from the control room indicate that an ambulance was called at 4.50am. The cellmate was taken out of the cell by a second night officer

who had been following behind the two other officers and he was taken to the shower block. Eventually he was placed in healthcare overnight and put on an ACCT.

69. In interview, the night orderly officer described the man as red in colour, his tongue sticking out and not breathing. He could not find a pulse. The night orderly officer started mouth to mouth and the assistant night orderly officer did the chest compressions. The night orderly officer felt that there was a chance of saving the man because he was not cold or stiff. However, the assistant night orderly officer made a very different assessment and believed him to be dead at this point because his lips were blue and his feet discoloured. The night orderly officer said they were doing two breaths to four/five compressions and the assistant night orderly officer thought it was five to one. Neither officer had had any further first aid training since their initial officer training over ten years previously.
70. A nurse was the Hotel 1 (the emergency response) nurse that night and was located in the healthcare centre when the call from the night officer came over the radio. Hotel 1 collected the emergency bag and made his way to the wing. In interview, he described the bag as being a very heavy rucksack (containing all equipment needed for any emergency) that hampers running, and that he had to unlock and lock the gates as he passed through. The healthcare centre and HB4 are at opposite ends of the prison. Once he arrived on the wing, Hotel 1 then had to fetch the defibrillator from the wing's emergency box as this was not carried in his box.
71. The night orderly officer thought that Hotel 1 would be there quicker but estimated that the nurse did not get there for ten minutes. He asked again on the radio for an estimated time of arrival of healthcare. Hotel 1 arrived at the cell at 5.00am according to the log. In interview, he said that he checked for a pulse and then attached the defibrillator which instructed them to carry on with CPR. Hotel 1 took over from the assistant night orderly officer to conduct chest compressions. He is CPR trained and said he thought they did 15-30 compressions for each breath. Paramedics arrived at the cell at 5.06am and they moved the man out onto the wing landing. He was pronounced dead at 5.35am by the prison doctor who had been called from home.
72. One of the prison's family liaison officers and Governor Windsor went to break the news to the man's family in the morning. Also, with them was one of the police officers investigating the charges against the man. The Governor reassured the family that the Prison Service would help with the funeral costs, and the prison's family liaison officer confirmed that she would arrange transport for the man's wife to identify his body. The family declined to take up the offer of visiting the prison.
73. The man had left two letters in his cell and these were removed by the investigating police officer following his death. No copies were taken by the prison. One letter was addressed to his daughter and dated and timed. The other is to his wife and it is evident he wrote this prior to the other letter.

Included in the copy of the letters provided to my investigator by the police were two poems and a letter.

74. The prison's family liaison officer had been told by a colleague that there was a 'poem left in the cell' and this information was passed to the family. The family insist that the prison's family liaison officer said that she would provide them with a copy and then kept forgetting to pass it on to them. The prison's family liaison officer said that the prison had not been given copies of the papers retrieved from the cell, and she tried on a number of occasions to obtain these from the investigating police officer. This is confirmed by her liaison log. Copies were not given to the prison until 7 October, the day before the man's cremation, and included his wish to be buried. Understandably, to receive such devastating information too late to be able to change the arrangements caused the family considerable distress.

ISSUES

The Prisoner Escort Record

75. My investigator has tried to answer two questions in relation to the flow of information from the police to GSL to the prison. These are:
- Was all the information regarding risk known by the police passed to GSL so that they could make a full risk assessment?
 - What happened to the Detained Person's Medical Report completed by the FME in the police station?
76. When the man was arrested he had suicide notes on him and had cut his wrist. The police called a FME to examine him and the doctor concluded that he should remain on constant observations as he was a high risk and should be reviewed. This review does not appear to have taken place. The man was handed over to GSL with a completed PER which only had a tick in the box relating to self-harm/suicide. GSL staff said that they asked the police what this meant and were told 'suicidal due to nature of offences'. It is not within my remit to explore this further, but failures in communication between the police, escort service and prisons is far too frequent a factor in my investigations.
77. Although the police and GSL are outside the scope of my remit, I believe that their practice could benefit from having sight of this report. To date they have been very willing to participate and help with my investigator's enquiries. As such, I make the following recommendation:

I recommend that the Governor of Woodhill shares this report with the Northants Constabulary and GSL with the aim of improving the flow of information between the different agencies.

78. Arguably, the Detained Person's Medical Report contained much of the information about the man's perceived risk at the police station, and it is worrying that my investigator is unable to identify if it travelled into the prison at the same time as him and what happened to it then. The medical staff do not recall seeing it at any time, and there does not seem to be a mechanism for recording its arrival in the reception process.

I recommend the Governor gives consideration to providing guidance to staff that any additional documents arriving with a prisoner are recorded in the Record of Events booklet.

The assessment and management of the man's risk

79. On the basis of the information they had, and how the man presented, staff in reception did not deem he was at risk. Nor did the nurse carrying out the First Reception Health Screen. Whilst I would not criticise the nurse for not

opening an ACCT, I am concerned that she told my investigator that she was not ACCT trained. The clinical reviewer, in her clinical review says:

“Not all healthcare staff had received ACCT training. Training records provided to the reviewer suggests only 18 of 50 healthcare staff have had ACCT training. As the ACCT process is a fundamental, centre wide, multi-disciplinary process for protecting prisoners this is a cause for concern. The senior healthcare team has highlighted that there was an issue with lack of availability of ACCT training but that now this is available there is a programme in place to ensure that all staff access this.”

I recommend that the Governor and the PCT ensure that all healthcare staff are ACCT trained with immediate effect.

80. The prison doctor opened an ACCT during the man's first evening. He was aware of the self-harm and felt that he presented as low in mood. Following this, the man underwent an ACCT assessment and four subsequent reviews prior to the ACCT being closed 17 days after it was first opened. I am encouraged by the actions of the doctor as it is sadly rather uncommon for them to take the lead in this way.
81. The assessment of risk is not an exact science and will always be a judgement call based on information known about the prisoner and the way they are presenting. A balance needs to be taken and the level of risk identified correspondingly. The man did tell the ACCT assessor about a number of attempts he had made on his life. However, his presentation was such that the assessor did not view him as a high risk and he was not regarded as high risk during any point in the ACCT process. This may well have been a valid assessment, and certainly the man did not self-harm during the period he was on an ACCT. Indeed, it was nearly five weeks after its closure that he apparently took his own life.
82. However, there are many shortcomings with how the ACCT was managed and this is a cause for concern. Prison Service Order 2700 and Woodhill's own Suicide Prevention and Self Harm Management Strategy outline what is expected of staff. There does not appear to have been any exploration of whether the man should have been referred to the MHIRT, and no consideration at any point of the impact of the criminal allegation he faced and the consequences for him and his outside support network. No consistent case manager was appointed and, with the exception of the last review, there was only one member of staff present (often with limited knowledge of him). None of the staff involved in the reviews, seem to have had any meaningful relationship with him. This is reflected by their inability to recall him in interview. The prison doctor, who had opened up the ACCT, was not included in any reviews nor was his opinion sought at any point. Upon the man's move from the FNC to HB4, no case review was carried out. Whilst acknowledging that the man did not die until five weeks after the closure of the ACCT, I find the lack of adherence to the guidelines both disappointing and unacceptable.

I recommend the Governor ensures that all senior discipline staff are familiar with the ACCT process and have a comprehensive knowledge of the guidance.

83. Finally, the most gaping omission was that of not holding a post-closure review. I understand that this was identified immediately after the man's death, and have been assured that a new system was put in place to ensure that post-closure reviews are not missed. I am not minded to make a recommendation regarding this matter for this reason, although the Governor will wish to ascertain that the new procedure is a robust one.

The man's letters

84. The function of the Public Protection Unit (PPU) is to monitor prisoners' mail and phone calls for inappropriate contact with under-18 year olds. My investigators spoke with two staff from the unit to understand the process more clearly. Wing staff are required to separate letters from prisoners being monitored by the PPU, and these letters are read and any reference made to a prohibited contact are returned to the prisoner. However, it is possible that a prisoner may bypass this procedure by sending a letter via another prisoner or staff may miss one mistakenly. The PPU staff are not ACCT trained, but there is a clear process for them to report any specific and detailed reference to self-harm. Under these circumstances, a Security Information Report is completed and sent to the security office who, in turn, alert the relevant wing staff.

85. The man's family provided my investigator with copies of letters that he had sent, as they were concerned that his sense of desperation was evident and that the prison should have realised that he was suicidal. He was in prison for the first time, charged with very serious offences, and as a result was cut off from his family. The understandable despair was evident from the tone of his letters. However, my investigator has found no overt reference to him taking his own life and therefore can find no evidence to question the effectiveness of the PPU.

86. Additionally, the man's family were concerned that he was being bullied as he made a reference in one of his letters to being spoken to by an officer about wearing the wrong shoes to the servery. For health and safety reasons, prisoners cannot wear certain shoes at the servery. The man complained that the officer was a 'job's worth' and had been quite abrupt with him. However, I am not convinced that this shows that he was being bullied. My investigator found no negative comments about him in the wing Observation Book, and I have no other evidence to suggest that he was being bullied.

The visit by police officers to the man

87. The actions/perceptions of the police officers are beyond the scope of my remit although I am grateful for the sharing of information by the Professional Standards Department. From the account given by the legal visits officer, who saw the man following this visit, he did not give her any cause for

concern. My investigator explored with safer custody staff at Woodhill how best to ensure that visitors (official or otherwise) tell staff of any concern they may have. I am encouraged that staff have developed this idea and have drafted a document which will be handed to all professional visitors. I am, therefore, not minded to make a recommendation and understand that this work is on-going.

The CPR and medical training of officers and healthcare

88. Neither of the officers who performed CPR on the man had had any further training since their initial officer training course (which for both was over ten years previously). These were the two most senior members of staff on duty at night and therefore highly likely to be involved in any emergency situation. Although I accept that it is not feasible to have all staff regularly retrained in basic life saving skills, it is of the utmost important that regular night staff are trained. In addition, my investigator noted that the information posters dotted around the prison did not reflect the latest guidance from the Resuscitation Council regarding CPR. Although the effect it had on the outcome must be uncertain, I note that CPR was not delivered using the currently recommended ratio of two breaths to every 30 compressions.

I recommend that the Governor reviews the training arrangements to ensure that CPR trained staff are always available at night.

I recommend that the Governor issues a notice to staff informing them of the latest Resuscitation Council guidance and update any information posters. In addition, the NOMS Safer Custody and Offender Policy Group may wish to consider if advice to that effect should be shared with all establishments.

89. The clinical review also says that the 'nurse was unclear what ratio of chest compressions to breaths was being performed so it was difficult to ascertain whether the CPR performed by nursing staff met current resuscitation guidance'.

I recommend that the Primary Care Trust ensures that all emergency nursing staff are trained in accordance with the latest Resuscitation Council guidance.

90. The nurse took approximately ten minutes to reach the man's cell, delayed in part due to the excessive weight of the emergency bag. The clinical reviewer understands that a risk assessment has already been completed by healthcare in respect of the weight of the bag and appropriate action implemented.

91. The clinical reviewer observes that, 'at a minimum a discipline member of staff should have collected the defibrillator and had this ready at the scene, but ideally discipline staff would be trained and able to use the defibrillator so that whoever arrived at the scene was able to use it.'

I recommend that the Governor gives consideration to the implementation of mandatory defibrillator training.

Family liaison

92. Unfortunately, the relationship between the prison and the family appears to have been irretrievably broken down as a result of what appears to have been a miscommunication. Too often, letters left in the cell are removed by the police and not treated with the highest priority as a result, and there is a delay in how quickly they are handed to the family. It is essential that the prison attempts to take copies of such letters, as well as the investigating police force facilitating the passing on of them as quickly as possible. I ask Woodhill to reflect upon these unfortunate circumstances. Whilst the conduct of the police is outside of my remit, my Deputy Ombudsman has raised this matter with the Association of Chief Police Officers at one of our regular meetings.

The clinical review

93. As noted, the clinical reviewer undertook the clinical review for the local Primary Care Trust. In addition, her report has acted a Serious Untoward Incident investigation and, in this sense, it very broad in its approach. It is my understanding that the document has been already shared with the PCT and the prison, and that work has begun on a number of areas of concern. However, not all the review is of relevance to the circumstances of the man's death. However, the full clinical review is annexed to this report, and the more pertinent points have been encompassed in the body of my report.

94. The clinical reviewer concludes her report as follows:

“There are a number of areas of good practice which have been highlighted through this report. The reviewer acknowledges that some aspects of this report might be perceived as critical to individuals involved in the man's care but wishes to clarify that whilst particular areas of practice might have been discussed and analysed that the reviewer believes that all staff involved with the man placed a high priority on his welfare and acted in a professional, compassionate and caring manner both during his stay and during their attempts to save his life.”

Conclusion

95. At the time of his arrest, the man was found to have two suicide notes on him and a self-harm wound to his arm. The police were sufficiently worried to place him on constant observations. However, exactly how much information about his risk was passed from the police to GSL and then to the prison is not clear. Later that day, the doctor opened an ACCT and the ACCT assessor gleaned considerable information directly from him about his self-harm actions. The ACCT was eventually closed 17 days later. Just under five weeks after its closure, he hanged himself.

96. It is not possible to say what exactly prompted the man to take his own life. He was of course in prison for the first time, on remand and facing very serious offences, and was cut off from his family. It is perhaps most instructive that, two days before his death, he was further charged by the police.
97. Although my investigation has uncovered serious failures in the way the ACCT process was managed, I do not believe the man's actions could reasonably have been predicted.

RECOMMENDATIONS

1. I recommend that the Governor of Woodhill shares this report with the Northants Constabulary and GSL with the aim of improving the flow of information between the different agencies.

Accepted. A meeting will be convened involving key personnel from both organisations. The meeting will consider current practices and proposals for more effective and efficient methods of communication.

2. I recommend the Governor gives consideration to providing guidance to staff that any additional documents arriving with a prisoner are recorded in the Record of Events booklet.

Accepted. A Governor's Order will be issued informing Reception staff that any additional documents which arrive with a prisoner are recorded in the Record of Events Booklet. A Notice to Staff will be issued providing guidance to all staff in the establishment of the above,

3. I recommend that the Governor and the PCT ensure that all healthcare staff are ACCT trained with immediate effect.

Accepted. Priority ACCT training will be provided to all Healthcare staff. The group consists of 27 individuals of which 15 have received the necessary training. The provision of two months for completion relates to the number of healthcare staff who still require the training (12).

4. I recommend the Governor ensures that all senior discipline staff are familiar with the ACCT process and have a comprehensive knowledge of the guidance.

Accepted. A series of briefings will be convened to ensure that all senior discipline staff receive guidance on the ACCT process. This will be co-ordinated in conjunction with the Training Department. In addition, a Notice to Staff will be issued reminding all staff of the correct procedures to be followed in the event of self-harm/concern for a prisoner.

5. I recommend that the Governor reviews the training arrangements to ensure that CPR trained staff are always available at night.

Partially accepted. All nurses at HMP Woodhill will be CPR trained to ensure that a suitably trained member of staff is always available during both the day and the night. There are 20 nurses and 2 sisters who complete nights – hence the provision of two months for training purposes.

6. I recommend that the Governor issues a notice to staff informing them of the latest Resuscitation Council guidance and updates any information posters. In addition, the NOMS Safer Custody and Offender Policy Group may wish to consider if advice to that effect should be shared with all establishments.

Accepted. Posters relating to the latest Resuscitation Council guidance will be displayed in all staff areas. A Notice to Staff will be issued advising staff of the above information. Additional actions: Sufficient one-way resuscitation values will be ordered to allow every first aid trained member of staff to carry one. A value will be placed into each first response kit also.

7. I recommend that the Primary Care Trust ensures that all emergency nursing staff are trained in accordance with the latest Resuscitation Council guidance.

As per section six above.

8. I recommend that the Governor gives consideration to the implementation of mandatory defibrillator training.

Partially accepted. All nursing staff will be defibrillator trained. During the night, nursing staff will be contactable via the radio network and will be able to attend a medical emergency in a short space of time.