PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent Investigations

Investigation into the circumstances surrounding the death of a man at HMP Woodhill in December 2011

Report by the Prisons and Probation Ombudsman for England and Wales

October 2012

This is the report of an investigation into the circumstances surrounding the death of a man, who died by hanging in HMP Woodhill aged 33. I offer my condolences to his family.

The investigation was led by an investigator. A clinical reviewer conducted a review of the man's clinical care at Woodhill, on behalf of the local PCT. Woodhill Prison cooperated fully with the investigation.

The man had been in prison since 2006 and at Woodhill since September 2011, serving an indeterminate sentence for public protection. He was also facing two further charges of grievous bodily harm for incidents in prison. After his death, his family and other prisoners said that he was worried that his prospect of release from prison was poor, but he does not appear to have shared those feelings with prison staff. He also had a history of mental health and substance misuse problems and a history of suicidal behaviour. This background suggests he was at risk of making a further attempt on his life at some point. While there does not appear to have been any obvious sign that he was at increased risk of harming himself in the period leading up to his death, I am concerned that, for various reasons, he had missed a number of mental health appointments in the weeks before he died.

On a number of occasions the man was found to be hiding his medication and, not long before his death, he told prison staff that he had been selling it for tobacco. He had a long history of debt and pressure from other prisoners to swap his medication for illegal drugs at his previous prison. There is no evidence that he was being coerced by prisoners at Woodhill but I am concerned that no one at the prison was aware of this history, and the administration of medicines does not appear to have been well supervised. While it does not appear to have made a difference in his case, the emergency response when he was found hanging was slow and poorly coordinated.

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.

Nigel Newcomen CBE
Prisons and Probation Ombudsman **October 2012**

CONTENTS

Summary

The investigation process

HMP Woodhill

Key events

Issues

Conclusion

Recommendations

SUMMARY

1. The man had a history of substance misuse including cannabis, cocaine and alcohol going back to his teens. He suffered from depression and experienced psychotic episodes. In December 1998, he was admitted to hospital after attempting suicide by hanging. Two weeks later, in January 1999, he took an overdose in another suicide attempt. He was diagnosed as suffering from either drug-induced psychosis or a schizophrenic illness caused by drug abuse.

2. On 7 September 2006, the man received an Indeterminate Sentence for Public Protection (ISPP) for two offences of wounding with intent to cause grievous bodily harm. He was given a tariff of five years – the minimum time he would spend in custody before he could be considered for release. (Release after the minimum term is served requires the prisoner to demonstrate to the Parole Board that he is no longer a risk to the public.) It was not his first custodial sentence.

3. He was transferred to a medium secure mental health unit under Section 47 of the Mental Health Act 1983 between July 2008 and June 2009. In November 2009, he moved to HMP Rye Hill. In February 2010, he cut his neck with a razor. He told prison staff he felt suicidal and wanted to be moved from his wing because he was being bullied for his medication. Staff believed he was being bullied again in April 2010.

4. In June 2010, he cut another prisoner's face with a craft knife. In July, he was found in his cell with a noose around his neck. He told staff he felt hopeless and that he would never be released from prison. He was charged with grievous bodily harm. Between July and November 2010, he spent a second period in a medium secure mental health unit.

5. In February, April and May 2011, staff at Rye Hill suspected that the man was again being bullied. In July 2011, he was involved in a fight with another prisoner and used a tin lid to cut the other man's face. He was charged for a second time with grievous bodily harm.

6. In September 2011, he was transferred to Woodhill. He was described as quiet and spent most of his time in his cell. He worked willingly with the mental health in-reach team although he missed several appointments in the weeks before his death. On three occasions in October, November and December, he was caught not taking his medication. Prison staff suspected he was selling it to other prisoners and in December he admitted he was selling it for tobacco. There is no evidence that he was being bullied at that time.

7. On Christmas Day 2011, the man was involved in a fight with another prisoner. A few days later he was found hanging in his cell. Staff attended promptly but an ambulance was not called for nine minutes and cardio pulmonary resuscitation was not started for some ten to 15 minutes.

8. We make 11 recommendations about emergency response, communication of information, risk assessment and family liaison.

THE INVESTIGATION PROCESS

9. We were notified of the man's death on 27 December 2011. The investigation was allocated to an investigator on 29 December. Notices about the investigation were issued to staff and prisoners at Woodhill, inviting those who wished to see the investigator to make themselves known. She received telephone calls from two prisoners in response to these notices. She spoke to a Detective Constable and to the prison's family liaison officer by telephone on 9 January 2012.

10. The investigator visited Woodhill to open the investigation on 13 January. The visit was delayed to wait till the end of an unannounced inspection by Her Majesty's Inspectorate of Prisons (HMIP). She met the Governor, visited the cell where the man died, spoke informally to two staff present on the day he died and collected copies of his prison record and other relevant paperwork. The investigator also spoke to members of the Independent Monitoring Board.

11. A clinical review of the man's medical care in Woodhill was commissioned from the local PCT. A clinical reviewer was appointed to undertake the review. He interviewed relevant staff at Woodhill. The investigator and clinical reviewer attended a death in custody review panel at NHS Milton Keynes on 1 March.

12. The investigator visited Woodhill on 1 February and 1 March and interviewed seven members of staff and two prisoners. Following the interviews she sent feedback to the Governor about the progress of the investigation and emerging issues.

13. One of our family liaison officers spoke to the man's mother on 2 February to explain the investigation process and asked her if she had any questions or concerns about her son's treatment in prison and the circumstances of his death. She:

    - Was concerned that Woodhill did not seem to be aware of her son's history of mental health problems, or that he had been sectioned twice under the Mental Health Act. She asked whether he had received any mental health assessment and/or intervention at Woodhill.
    - Was not aware until after his death that he had tried to take his own life in summer 2011. She asked whether he was considered an on-going risk of self-harm and subject to additional monitoring as a result.
    - Said he was distressed about his indeterminate sentence for public protection (ISPP) and the uncertainty of his release date. The upcoming trials for charges of grievous bodily harm were playing on his mind and his solicitor had not turned up to a meeting about this. His mother did not know whether he had been told of this in advance and she thought that it might have troubled him further.
    - Was concerned to learn that he might not have been taking his medication and had been punished for hiding it. She asked how his medication was being administered and whether more could have been done to monitor this.

- Usually spoke to him two or three times a week but, unusually, he had not called on Christmas Day or Boxing Day.

14. At draft report stage the man's mother corrected her son's age and commented that she did not feel that the prison had been sufficiently aware of her son's vulnerability despite his two periods in residential secure units.

HMP WOODHILL

15. HMP Woodhill has the dual role of a local prison and a high security prison and holds up to 819 prisoners. It accepts adult male prisoners and young offenders from the Magistrates' and Crown courts in the Milton Keynes area and also holds category A prisoners (prisoners deemed to be of high risk to the public should they escape). It has a Close Supervision Centre housing prisoners whose behaviour is especially complex or challenging. There is also a unit for protected witnesses.

16. Her Majesty's Inspectorate of Prisons inspected Woodhill for an unannounced inspection in January 2012. HMIP found that the mental health in-reach team (MHIT – the team who work with prisoners suffering from severe or enduring mental illness) had a caseload of 100 patients. HMIP found the standard of service was good and that prisoners with mental health issues were appropriately identified and treated. The prison had solid systems to tackle bullying and violence and few prisoners reported feeling unsafe. There was an appropriate personal officer scheme. Emergency resuscitation equipment, including oxygen and automated electronic defibrillators, were available throughout the prison but there were no records to identify that appropriate checks had been undertaken. The supervision of prisoners collecting and taking their medication was of a varying standard and there was the potential for bullying and diversion of medication. HMIP recommended that officers should manage the queues for medication on all house units.

17. Every prison has an Independent Monitoring Board (IMB) made up of unpaid volunteers from the local community who monitor standards to help ensure prisoners are treated fairly and humanely. In the most recent available report for Woodhill covering the period between June 2010 and May 2011, the IMB noted that budget reduction and a continuing shortfall of officers and operational support grades had affected staff morale and resulted in increased levels of cross-deployment and a lack of continuity in staff working on the units. The IMB was particularly concerned with a shortfall in healthcare staff and the limited psychiatric cover. They also reported that the personal officer scheme did not appear to be working as effectively as it should. They had received reports of higher numbers of prisoners asking to speak to Listeners (prisoners trained by the Samaritans to provide support in confidence) because personal officer work was not being completed.

18. The man's death was the first of two apparently self-inflicted deaths to occur at Woodhill in the space of five weeks. The investigation into the subsequent death has not highlighted any of the same issues as this investigation.

19. In previous investigations into deaths at Woodhill, we have made recommendations about emergency response equipment, emergency response calls, the personal officer scheme and training in life support. The recommendations in this report about the personal officer scheme and the emergency code system echo those made in two previous investigations in 2009.

KEY EVENTS

20. On 7 September 2006, the man received an Indeterminate Sentence for Public Protection (ISPP) for two offences of wounding with intent to cause grievous bodily harm. He was given a tariff of five years – the minimum time he was required to spend in custody before he could be considered for release. It was not his first custodial sentence.

21. He had a history of substance misuse including cannabis, cocaine and alcohol going back to his teens. He suffered from depression and had experienced psychotic episodes thought to be linked to his substance misuse. On 24 December 1998, he was admitted to hospital after attempting suicide by hanging. On 12 January 1999, he left the hospital and took an overdose in another suicide attempt. He was diagnosed as suffering from either drug-induced psychosis or a schizophrenic illness caused by drug abuse.

22. In HMP Belmarsh in January 2008, the man began to lose weight and voice concerns about poison in his food. These were thought to be paranoid delusions. In June 2008, he was admitted to Three Bridges (a medium secure mental health unit), under section 47 of the Mental Health Act 1983. He returned to Belmarsh on 13 July 2009. He had regular reviews from the prison psychiatrist and input from the mental health in-reach team (MHIT – the team who work with prisoners suffering from severe or enduring mental illness). He was treated throughout this period with anti-depressant and anti-psychotic medication. On 23 November 2009, he transferred to HMP Rye Hill.

23. On 2 February 2010, he made two large lacerations to the side of his neck and minor lacerations to his wrist with a razor blade. He was admitted to the prison healthcare centre and an ACCT document (Assessment Care in Custody and Teamwork – the system used for monitoring prisoners thought to be at risk of suicide or self-harm) was opened. He said that he was feeling suicidal when he made the cuts because he was in debt to other prisoners over drugs. He said that he used the drugs to help with his depression and that he had harmed himself to be moved from the wing.

24. The man's security file from this period shows that, on 20 April 2010, staff found burnt foil in his cell during a random cell search. On 6 May, staff noted that his canteen consisted of five bags of sugar and a large quantity of orange juice. Staff believed that he was vulnerable to bullying to provide ingredients for making hooch (alcohol). On 1 June, he assaulted another prisoner by slashing his face with a craft knife. He told staff that the prisoner was bullying him. The next day, he asked staff to cancel his canteen order because he owed it all to bullies on the wing. He admitted that he had been taking Subutex (an opiate substitute used in detoxification) and heroin on the wing and drinking hooch. He told healthcare staff that he was hearing voices and these had increased over the previous week because of the stress of being bullied and owing money. He was charged by the police with grievous bodily harm with intent to commit grievous bodily harm (GBH).

25. On 11 June 2010, the man was referred to Three Bridges for assessment with a view to readmission. The Consultant Forensic Psychiatrist at Rye Hill described him as psychotic with persecutory delusions and auditory hallucinations. On 14 July, he was seen standing in his cell with a noose made from a piece of curtain wound around his neck and over the cell door. He was cut down by staff but was uninjured. He said that he felt hopeless and that he would never be released from prison. An ACCT form was opened. On 17 July, staff found some burnt foil and another noose made from a curtain during a search on his cell. He was admitted to Three Bridges under Section 47 of the Mental Health Act 1983 on 28 July 2010. He returned to Rye Hill on 9 November.

26. In February and April 2011, security information reports (SIRs) show that it was suspected that the man was being bullied and forced to hold illegal property for other prisoners. In May 2011, staff suspected that he was being bullied into enforcing debts on behalf of other prisoners. On 24 July, he tested positive for opiates at a random urine screen as part of the prison's mandatory drug testing process. On 26 July, he was involved in a scuffle with another prisoner on his wing. The other prisoner sustained a cut to his face from a lid of a tuna can. Information from other prisoners suggested that he had sold his Playstation to buy heroin on the wing but then refused to pay for it because the quality was poor. The police again charged him with GBH.

27. The man was taken to Crown Court on 12 September 2011 to face the charge of GBH for the incident on 1 June 2010. He did not return to Rye Hill but was taken instead to Woodhill. The Person Escort Record (PER - a form listing risk factors and accompanying property that travels with prisoners between court and prison) recorded that he had a history of being at risk of verbal or physical abuse, involvement in prison drug culture, holding weapons for other prisoners and assaulting other prisoners. It did not specifically record that he had been involved in selling his medication. The box indicating risk of suicide or self-harm records "no history". The box for mental health issues is blank.

28. During his First Night Centre interview with an officer, he answered "yes" to a question about whether he had a history of self-harm. The officer wrote that he maintained good eye contact and had no issues. A staff nurse interviewed him for his reception health screen. He gave a history of anxiety, depression, schizophrenia, substance misuse, self-harm and attempted suicide. She referred him to the mental health team and the substance misuse service. She recorded that he appeared "cool" and denied any suicidal feelings. A doctor continued his prescription for paroxetine (an anti-depressant), olanzapine (an anti-psychotic) and diazepam (for anxiety). The doctor referred him to the MHIT.

29. On 13 September, the man had a second day interview with an officer (signed but illegible). It was recorded that he had no issues and was not concerned about being at Woodhill. He signed all of his induction paperwork to confirm that he understood the prison phone system, TV policy and custody compact. A nurse received the doctor's referral to the MHIT and screened him for evidence of severe and enduring mental illness. She concluded that his long

history of depression and schizophrenia meant that he should be assessed by the MHIT at the next available opportunity. He did not attend a substance misuse assessment but the reasons for this are not recorded. The same day he was allocated to House Unit 2. Each House Unit at Woodhill is split into two wings, A and B, with a centre area where the wing offices are and where prisoners go to collect their medication. He was located on house unit 2B (HU2B).

30. Every new prisoner arriving on a house unit at Woodhill see a communications orderly (a trusted prisoner) as part of their introduction to the unit. The communications orderly tells the prisoner who their personal officers are, explains the personal officer scheme and gives the prisoner a personal officer initial interview form which the prisoner then completes for officers. The man wrote on his form that he had twice been sectioned under the Mental Health Act 1983 while in prison. He said he had a partner and one child and was in telephone contact with his partner, mother, grandmother and sister and they would visit him and send him money. He said he used to drink five pints of lager in an evening before he came to prison and had used heroin, crack cocaine, ecstasy and cannabis at weekends. He said he had never injected drugs and would not comment on when he had last used drugs.

31. The man wrote on the form that he suffered from depression and had been feeling low in spirits recently. He said he had tried to kill himself in the past but was not at risk of doing so now. He said he was due to complete an offending behaviour course and was waiting for a place at Dovegate. He said he had completed the Thinking Skills Programme at Rye Hill. When asked about outstanding issues, he said that his money had not yet been sent from Rye Hill and asked whether the outstanding credit on his prison phone account could be transferred to Woodhill. There is no record of any contact between him and wing staff in response to this form.

32. On 28 September, an occupational therapist from the MHIT assessed him. She reported that he behaved appropriately during the interview and was able to express his needs. He gave an accurate history of his mental health, previous self-harm, attempted suicide and time in prison. He told her that he was concerned about his forthcoming court appearance on 24 October because the psychiatrist writing the report for the court had not yet interviewed him. She encouraged him to talk to his solicitor about this. He told her that he had considered stopping his anti-psychotic medication but after discussion agreed with her that it was important for him to remain stable. He agreed to be referred to the prison psychiatrist. He denied any current active symptoms of psychosis or suicidal feelings. She reminded him of the coping strategies he learned on his Thinking Skills Programme and encouraged him to ask to see members of the MHIT when he needed to. A further appointment was made for the following week. The same day, he moved to a cell on house unit 2A (HU2A).

33. The man had his second appointment with the therapist on 5 October. She reported that he appeared slightly more relaxed and engaged more freely in conversation. He told her that he remained concerned about his court case

as he had still not been interviewed by the psychiatrist. He said he had not yet telephoned his solicitor but would do so on return to the wing. He told her that he felt well.

34. On 7 October, an officer was observing prisoners receiving their medication from the treatment hatch on the house unit centre when he noticed the man appear to move his medication to one side of his mouth before swallowing his water. He then opened his mouth partially to show the nurse that he had swallowed. The officer followed him back to the wing and saw him take the medication out of his mouth. He told another officer what he had seen and both officers stopped him and asked him to give them what was in his hand. He gave the officer a diazepam tablet and a paroxetine tablet and said that he wanted to take the tablets now. The officer told him that he could not and he was escorted back to his cell. He was charged with an offence against Prison Rules by having an unauthorised article in his possession. A security information report (SIR) was completed and a governor (the manager who counter signed the SIR) asked for the matter to be referred to healthcare managers and the pharmacy for a review of his medication.

35. The man attended an adjudication (disciplinary hearing) for this charge on 10 October. The hearing was remanded for seven days because he requested legal advice. As a result of attending the hearing, he did not go to his appointment with the occupational therapist. The appointment was rearranged for the same afternoon but his name was not added to the movements list and he was not called. The appointment was rearranged a second time for 12 October but again he did not go, this time because the movements of prisoners were delayed that day. On 15 October, his mother, grandmother and sister visited him.

36. The man's adjudication resumed on 18 October. He pleaded not guilty and said that he preferred to take his medication at lunchtime. He said he had intended to speak to the MHIT about this at his appointment. He denied intending to sell his medication to other prisoners or being under pressure to give them away. He then changed his mind and pleaded guilty. He was given seven days loss of association, canteen and earnings and three days cellular confinement as punishment, all suspended for three months.

37. He saw the occupational therapist on 19 October. She reported that he appeared bright and talkative. He told her about the incident with his medication on 7 October. He said it made him drowsy and he had not wanted to take it. He did not understand why the officers thought he might be selling his medication or being bullied for it. He told her that he had spoken to his solicitor but had not found out about his psychiatric report.

38. On 21 October, the man attended Magistrates' Court for the charge of GBH from the incident on 26 July. The PER showed a single risk indicator for violence to others and "psychosis" is written in the mental health risk box.

39. He saw the occupational therapist again on 26 October. He told her his court case had been adjourned until January but he was waiting for another case as

well. He said he still felt frustrated that the psychiatrist writing the court report had not interviewed him. He reported feeling well and that he was trying to stay out of trouble.

40. On 3 November, his weekly appointment with the occupational therapist was cancelled due to staff shortages. He was visited by his mother, grandmother and uncle. He missed another appointment with the therapist on 9 November because he was late responding to the call and missed the scheduled time for prisoners to move around the prison. The same day, during a routine search of his cell, an officer found medication that he was not allowed to have in his possession. Healthcare staff confirmed that the medication was that prescribed for him which he should have taken that morning. He was charged with breaking Prison Rules by having an unauthorised article in his possession. A SIR was completed. It was noted that he had previously tried to hide his medication. A referral was made to the pharmacy and it was decided to give him a drug test.

41. The adjudication for this charge was opened on 11 November but adjourned twice – first for the man to obtain legal advice and the second time because the reporting officer was on leave.

42. He missed his appointment with the occupational therapist on 14 November for an unknown reason and the next one on 17 November. The medical record reports that this was because he was sent to the education department instead but he attended Crown Court on 17 November and this is the more likely reason. On 16 November, his mother and grandmother visited him. On 21 November, he missed another appointment with the therapist because a different prisoner with his name was listed in error and he wasn't called by wing staff. Also on 21 November, he gave a urine sample for a test under the Mandatory Drug Testing programme (MDT). This was the test requested as a result of the SIR of 9 November. The result was negative.

43. The man's adjudication for the disciplinary charge laid on 9 November resumed on 24 November. He said in his defence that the medication made him drowsy so he saved it to take at night. The charge was proved because he knew that he should have taken the medication at the hatch. He was given two weeks stoppage of half his earnings and five days cellular confinement as punishment. The three days cellular confinement suspended from his previous adjudication were activated. He served this part of his punishment in the segregation unit. An entry on his electronic prison record (P-NOMIS) during this period of segregation described him as spending most of this time asleep in bed. Staff wrote on his segregation history sheet that he did not participate in the segregation unit regime and did not shower or clean his cell each day. He was reported as quiet and with "no concerns". The duty GP and a member of the chaplaincy visited him daily. No concerns were raised about him. He had a random drug test on 25 November, which was negative. He returned to the unit on 1 December.

44. On 3 December, the man received a warning under the Incentives and Earned Privileges Scheme (IEPS – a national scheme run in all prisons that

grants prisoners privileges as an incentive for reaching and maintaining certain standards of behaviour) for smoking on the yard. On 5 December, he did not go to an appointment with the occupational therapist and he also did not attend at the rearranged times on 7 and 8 December. On 8 December, the therapist wrote in his medical record that wing staff had not raised any concerns about his mental state. They told her that he was keen to go to his appointments but did not appear to hear the calls for prisoner moves. She wrote that, due to him repeatedly missing appointments, she would visit him on the wing.

45. On 19 December, the man's solicitors visited him. On 20 December, in the evening, the wing observation book records that he and another prisoner had to be separated by staff after becoming "argumentative and verbally abusive towards each other". The argument took place near the telephones. There is no other information about the incident.

46. On 21 December, an officer watched the man receive his medication from the treatment hatch. He said he saw him regurgitate his medication from his throat and put it in his hand as he returned to A wing. The officer followed him and saw him gesture to another prisoner to follow him upstairs. The officer intervened and he then swallowed his medication. He received a second warning under the IEPS from the officer for bringing medication onto HU2 that should have been taken at the medication hatch and attempting to sell it. A SIR was completed and the Security Manager asked wing staff to ensure that healthcare staff were informed of the incident.

47. An officer and a Senior Officer (SO) spoke to the man about this incident. The SO said he appeared sheepish and he asked him if he was being bullied for his medication. He said he was not but admitted that he was selling his anti-psychotic medication on the wing in exchange for tobacco. He told them he felt he did not need his medication and wanted to get something useful in exchange. The SO said he told him that it was important that he took his medication in order to remain well. Both the SO and officer believed he was telling the truth. He had been watched more closely since he was first seen hiding his medication and officers had seen no signs of coercion by other prisoners. The officer said he did not give any sign of physical stress. He always approached other prisoners rather than being approached by them. Neither the SO nor the officer were aware that he had sold his medication on several occasions at Rye Hill and had admitted to being put under pressure by other prisoners to do so.

48. The SO reviewed the man's IEPS level and decided to downgrade him to the basic level. The SO wrote that, in the previous eight week period, he had received several negative entries on his P-NOMIS record (electronic prison record) and had not been open when questioned about 'palming' or selling his medication. The SO explained that this was unacceptable and he would be put on basic regime for a minimum period of 14 days. He would be reviewed after seven and 14 days and returned to standard regime if his behaviour improved. The SO told the investigator that prisoners on basic spend more time in their cells and he thought that this might remove some of the

temptation and opportunity for him to sell his medication. The same day, he was charged under Prison Rules for having an unauthorised article in his possession. This charge was dismissed at a hearing on 23 December.

49. As he was on basic regime, staff completed a daily behaviour assessment for the man (known as a basic regime monitoring sheet). The various entries for the period 22-24 December show that he collected his meals from the servery, went to the gym, declined exercise and was polite to staff. No particular issues were recorded.

50. On 25 December, he was involved in a fight with another prisoner. He was seen by the prison doctor and found to have a slight nose bleed. He told the doctor that he did not want to see a nurse. Both prisoners were charged with offences against Prison Rules and he was moved to house unit 1B (HU1B) to keep him apart from the other prisoner. This is the induction wing where prisoners new to the prison stay for the first few days while they learn about prison routines. He was moved there because it was the only available space. His basic regime monitoring sheet for 26 December recorded that he spent most of the day in his cell but collected his meals and was polite to staff.

Day of Incident

51. The man's basic regime monitoring sheet records that he came out of his cell on HU1B for an hour and a half in the morning for association. At 10.40am, an officer took him to the segregation unit for the adjudication hearing for the charge of fighting. He told the investigator that the man appeared fine and was fairly chatty with him. The hearing was adjourned for him to obtain legal advice. He returned to HU1B and came out of his cell to collect his lunch. He declined afternoon exercise (time in the open air) but came out to collect his teatime meal. At interview, staff said that he had not come to their attention for any reason that day and he spent most of it in his cell as a prisoner on basic regime.

52. Officer A was moved from his usual duties as a reception officer to cover staff shortages for evening duty on HU1B. He arrived on the unit at about 5.25pm. He was briefed by a SO and helped unlock the prisoners allowed out for association. He was told that the man was on basic regime and would therefore stay in his cell. He had not met him previously. He came out to collect his teatime meal at about 4.45pm. The officer said he saw him talk to a couple of prisoners and then return to his cell. There was no requirement for staff to check on him during association. The officer did not see anyone go to his door during association.

53. At about 7.00pm, the officer decided to begin locking the prisoners in their cells for the night. He was required to lock each cell door, look through the observation hatch and check that the prisoner was inside. The first cell he went to was the man's because it was the first one on the left. He looked through the observation panel and saw the frame of the bunk beds standing on its end. He saw him apparently standing between the two beds. He did

not see a noose. The nightlight was on and the interior of the cell was quite dim.

54. The officer called Officer B over and they opened the man's cell and went in. They saw that he had tied a noose made from a sheet around his neck and tied it to the frame of the bunk bed. He was suspended with his feet just touching the floor. Officer A supported him around the waist to try to relieve the pressure on his neck while Officer B used Officer's A's personal issue cut-down tool (commonly referred to as a 'fish knife' because of its shape) to cut the sheet. Both officers then lowered him to the floor and put him in the recovery position.

55. Officer A removed the sheet from around the man's neck. He said this was quite difficult because it was very tight. He described a deep mark on his neck and said his first impression was that the man, who was grey in colour, was dead. While he was doing this, Officer B used his radio to call for emergency assistance. The control room log shows that this was received at 7.00pm. The officer said that he told control that the emergency was a 'code blue', which he understood to mean that someone had breathing difficulties. He said he was asked to repeat his call and this time he asked directly for emergency assistance. To reinforce his message he pressed the general alarm bell outside the cell as well (so that other staff came immediately). He said he checked the man's throat and wrist to see if he had a pulse. At first, he thought he had found one. He said the man's eyes were wide open and fixed. Two SOs then arrived at the cell.

56. SO 1 said he was in his office on the centre of HU1 when he heard a call for emergency assistance on HU1B on his radio. He went immediately to the man's cell and saw Officer B kneeling on the floor next to him trying to find a pulse. The man was in the recovery position, his head was bloated and blue and he could see a vivid mark around his neck. At first the SO thought the ligature was still round his neck but Officer B confirmed to him that it had been cut off. SO 2 then went past him into the cell and also tried to find a pulse. Both SOs asked for an ambulance to be called and he was about to do it when another officer in the doorway made the call on his radio. A nurse arrived and asked him to collect the house unit's emergency response bag from his office, which he did. SO 1 said it was difficult to estimate the timings of who arrived and what happened when. He said lots of staff arrived one after the other but it seemed to take longer than usual for healthcare staff to arrive.

57. SO 2 said she was on duty in reception when she heard the 'warble' of a general alarm over her radio at about 7.00pm. She and her two colleagues were the dedicated response officers that evening which meant that they were required to respond to all general alarms. As they left for HU1B, she heard another call on the radio saying the incident was a medical emergency code blue. One of her colleagues shouted out to her that a code blue was a hanging.

58. She went straight to the man's cell while her two colleagues helped lock the other prisoners in their cells. She said that the atmosphere on HU1B was strangely quiet and prisoners were waiting outside their cells. She later found out that the other staff on HU1 did not have radios and were unaware of the emergency. She looked into the cell and her first impression was that the man was dead. She described him as blue in colour with a deep indentation in his neck. She said she could see he needed professional medical help and so she used her radio ask the control room to call an ambulance.

59. Officer B told her that he thought he could feel a pulse and asked her to check. She felt the man's wrist but could not feel a pulse. She stepped outside of the cell and called the control room again to find out where the ambulance was. As she left the cell, a nurse, the emergency response nurse, went in. She said the control room told her that only healthcare staff could ask for an ambulance. She asked the nurse to confirm the need for one and he did. She then called the control room a third time and this time they told her they would call an ambulance. The control room log shows that an ambulance was called at 7.09pm.

60. Two nurses were on house unit 4 giving prisoners their medication when they heard the emergency call. Nurse A left immediately and the other nurse finished giving out the medication before going to the cell. On arrival at the cell, the nurse said the man was lying on the floor with a deep mark around his neck. He could not find his pulse and his pupils were dilated and not responding to light. He was blue. He said he asked the officers to call for an emergency ambulance and the on call doctor. He also asked for the emergency bags to be brought. When these arrived, the nurse gave him oxygen and began cardio-pulmonary resuscitation (CPR). He connected a defibrillator to him and it advised to continue with CPR. (A defibrillator detects heart rhythm and will only advise an electric shock if it detects a suitable rhythm. In all other circumstances it advises CPR is used to try to re-start the heart.) The nurse said he continued CPR until ambulance paramedics arrived and took over.

61. Nurse B and a Healthcare Assistant (HCA) were giving medication to prisoners on house unit 6 (the Close Supervision Centre) when they heard the emergency call. They continued with their task but a few minutes later heard a second call for more healthcare staff. Nurse B locked the medication away and the HCA telephoned an officer and asked him to get the emergency bag from the healthcare centre and meet them on the way to the man's cell. They arrived at about 7.15pm. Nurse B said he saw Nurse A finish assessing him for signs of life and begin CPR. He and the HCA helped him give the man CPR until the paramedics arrived. Nurse C said a few minutes after the original emergency call he heard another call asking for the emergency bag and more healthcare staff to respond. He then stopped what he was doing and went immediately to the cell. At about 7.20pm, he joined both nurses in giving CPR.

62. The incident logs show that the ambulance arrived at the gate at 7.24pm and the paramedics arrived at the man's cell at 7.27pm. They assessed him and pronounced him dead at 7.33pm.

63. At 8.30pm, a member of the Care and Welfare Team spoke to the prisoner in the adjoining cell to ask if he was OK.

64. A hot debrief (a meeting for those staff involved in finding and treating the man that evening) took place at about 9.05pm. Both officers had a separate debrief because the police were interviewing them when the first one took place. The prison Care and Welfare Team and members of the Chaplaincy were present to offer their support.

Family liaison

65. At the time the man died, there were two trained family liaison officers at Woodhill. However, both of them were on annual leave. The Governor, the Duty Governor that evening asked the Chaplain to contact prisons near to the man's family and ask them to provide a family liaison officer to break the news to the family in person. The prisons contacted were unable to do so and so the Governor asked officers from the local police force to visit the family. He followed up this request several times and eventually received confirmation that the man's mother had been informed of his death at 1.15am.

66. The man's mother said the police visited her in the early hours to break the news of her son's death. They gave her the Governor's contact number and she was able to speak to him that night. He telephoned her again the next morning. She spoke positively about the support provided by Woodhill. She was offered financial assistance with funeral costs and the Governor and the prison family liaison officer attended the funeral. The family liaison officer also visited her on another occasion to return her son's property to her.

Other action taken

67. All prisoners with open ACCT forms were reviewed on 28 December. Notices to staff and prisoners were put up around the prison to inform them of the man's death and to remind them of the support available.

68. All beds in Woodhill are supposed to be securely bolted to the floor. A full check of the beds in the main residential units was made on 28 December. A total of seven beds were found to have missing or loose bolts. The report noted that the man's cell had been damaged and set fire to by a previous occupant on 5 December.

69. Officer B did not have a fish knife and there was no record that he had been issued with one. A full inventory was undertaken to establish whether other staff had not received one.

70. The Head of Safer Custody was asked to ensure that more staff were trained to be family liaison officers as soon as possible on a course in January.

ISSUES

Response to finding the man

71. The control room log gives the time of the first emergency call at 7.00pm. There were two radio calls, one for emergency response and one for code blue, and the general alarm was also pressed. These all happened in quick succession. Interviews with staff and staff statements show that different people responded to different calls. Staff had differing recollections of which order the calls came in. Officer B said that he first called a 'code blue' because he understood this to mean a person with breathing difficulties. He was relatively new to Woodhill and code blue was the term used in his previous prison. He thought that the control room did not understand him and so he asked for emergency response instead. He remained worried that no response was forthcoming so he also pressed the general alarm bell.

72. In 2009 we made recommendations in two reports of investigations into deaths at Woodhill that the Governor remind staff of the correct call to make when asking for emergency response. We accept that both prison officers and nurses responded quickly to the radio call or general alarm but there was some confusion. The Prison Service is considering whether to introduce a national code system to help avoid situations like this at Woodhill where officers have to remember different emergency codes in different prisons. In the meantime we make the following recommendation:

    The Governor should ensure that all staff understand the local policy on emergency calls and what actions are expected when one is made.

73. Both officers entered the man's cell immediately and cut him down. Neither they nor the other officers who arrived promptly were first aid trained and they did not attempt to give him CPR. It was clear from the interviews that most of the staff were overwhelmed by the situation and did not feel competent to do so. Officer B said that he did know how to do CPR but for some reason his main focus on the day was to get healthcare staff to the cell as soon as possible. All of the staff interviewed were clearly distressed that they did not attempt to revive the man.

74. Resuscitation attempts are more likely to be successful if they are started as soon as possible and it is officers who are usually first on the scene. In his review, the clinical reviewer comments that the man's presentation when he was discovered suggests that he had been deprived of oxygen for a significant time. This would have seriously have affected the chances of reviving him even had CPR been started immediately. Nevertheless the delay in starting CPR is of concern as in some cases it can save a life.

75. Woodhill's Emergency Response Guidelines tell staff to start CPR unless told by an appropriately trained person to stop. An examination of previous reports into fatal incidents at Woodhill does not show that staff delayed starting CPR on those occasions. The investigation into the death that occurred after the man's, found that the emergency response was prompt and

efficient. It would seem that responses to emergencies are usually appropriately handled at Woodhill. Nevertheless, on this occasion officers did not begin CPR when they should have done. We make the following recommendation.

The Governor should ensure that there are sufficient first aid trained officers on duty at all times who are able to administer CPR in an emergency.

76. The officers who arrived immediately at the man's cell said it took a comparatively long time before Nurse A arrived. It was not possible to interview the nurse because he was on sick leave during the investigation. However, it is the policy at Woodhill that only healthcare staff can ask for an emergency ambulance. The logs confirm that the ambulance was called at 7.09pm. SO 2 said that Nurse A confirmed the need for an ambulance shortly after he arrived. It therefore appears that it took nine minutes for the nurse to get to HU1B. He was on house unit four when he heard the request for emergency response and had to negotiate several locked doors on his way to house unit one. The duty governor wrote in his log that the governor in charge of managing the incident on HU1B told him at 7.10pm that CPR had not started. Nurse B estimates that he arrived at the cell at about 7.15pm and saw Nurse A complete his initial assessment of the man and begin CPR. Nurse A said in his statement that he began CPR once the emergency equipment had arrived.

77. It seems clear that an ambulance was not called for nine minutes and CPR was not started until some 10-15 minutes after the man was discovered. Regardless of whether he was already dead, as seems likely, this is an unacceptable delay which in other circumstances might have made the difference between a successful outcome or not.

78. The system in operation at Woodhill requires a member of healthcare staff to call for or confirm that an ambulance is required. The investigator asked why this was the case and the prison responded that, "HMP Woodhill has a level 3 Healthcare provision and has 24 hour cover, therefore we are able to provide a healthcare response in the first instance who will assess if an ambulance is required". This is contrary to national guidelines. In a number of investigation reports, we have highlighted the issue of requesting an ambulance when a medical emergency has been raised. Department of Health and National Offender Management Service guidance about when an ambulance should be called has been in existence since 2004 and was updated in a letter of 17 February 2011 from the Director of Offender Health at the Department of Health and the Chief Executive of the National Offender Management Service which went to governors of all prisons. This required governors to ensure that a protocol exists at each prison to ensure immediate access of ambulances to prisons and to the individual prisoner. The letter said that it should not be a requirement for a member of the prison healthcare team to attend the scene before emergency services are called. Any member of staff raising the alarm should be able to call for an ambulance. It is unnecessary to wait until a healthcare professional arrives to assess whether one is needed as valuable

minutes can be wasted waiting for them to arrive. If the ambulance is no longer needed when healthcare staff arrive, it can be cancelled.

79. In this case, a member of the healthcare team did not arrive at the man's cell for almost ten minutes after Officer B called for the emergency. When SO 2 called the control room for an ambulance she was told that this could be done only by healthcare staff. This led to an unacceptable delay in the ambulance being called. In other circumstances, this could have made a real difference to the outcome. Whenever a prisoner is found hanging or in any life threatening situation, any member of staff should be able to call for an ambulance. We make the following recommendation:

The Governor should ensure that all staff understand that it is their responsibility to call an ambulance when they find a prisoner in a life threatening situation and that protocols are revised to reflect this.

80. There are emergency bags on every house unit on the centre between wings. Another bag is kept on the healthcare centre. SO 1 said he collected the bag on the house unit when Nurse A asked for it and Nurse B brought the healthcare centre bag with him. We are satisfied with the availability of the emergency equipment. It appears from the note of the hot debrief that some part of the emergency kit was out of date. In their report of an inspection in January, HMIP noted that there were no records to identify that checks on emergency equipment had been made. In light of this we recommend:

The Governor and Head of Healthcare should ensure that there are regular recorded checks of all emergency equipment.

Mental health care

81. The man was identified during his reception health screen as suitable for assessment by the MHIT. The following day a referral was made and he had his first appointment with his occupational therapist two weeks later. He appeared to co-operate willingly with her. The notes from his sessions reflect openness on his part to talk about issues that were troubling him. He consistently raised the issue of a forthcoming psychiatric court report and was appropriately advised to follow this up with his solicitor.

82. The therapist was aware of the incident on 7 October when he was seen 'palming' his medication. She spoke to him about it and reinforced how important it was that he took everything prescribed for him. She appears to have accepted his explanation that it made him drowsy and he preferred to take it later in the day. She was not aware of the two subsequent incidents on 9 November and 21 December because the last appointment that he attended was 26 October. He missed seven consecutive appointments during November and December for various reasons. Wing staff told her that he appeared keen to attend his appointments but did not seem to hear the call for prisoner moves. On 5 December, she wrote on the electronic medical record that she would visit him on the wing to ensure that she saw him. She then made entries on 7 and 8 December that he had not attended

appointments with her in healthcare. There are no other entries on his record between 8 December and his death.

83. In the opinion of the clinical reviewer, the medical record does not indicate that the man was lacking mental stability or finding it hard to cope. The occupational therapist told him that the man showed no signs of low mood and she had no concerns that he would take his own life. No other staff who came into contact with him raised any concerns. There are procedures in place at Woodhill to deal with non-attendance at MHIT sessions, but these were not pursued rigorously. The clinical reviewer concludes that, despite the long gap between the man's last MHIT appointment and his death, there were no signs that should have prompted a different approach to his management and care.

84. The clinical reviewer also concludes that the interventions from the MHIT fulfilled the expectations of the service and the man received care equitable with mental health provision in the community.

85. The man missed a number of appointments with the occupational therapist including seven consecutively in November and December. Sometimes this was for operational reasons, sometimes it was because of mistakes on the prison's part and wing staff said he sometimes did not respond to being called. This cannot be verified but if this were the case the responsibility for non-attendance on those occasions was his. The record shows that the occupational therapist found out the reason for the missed appointment and tried to rearrange them promptly for either later the same day or soon after. It is nevertheless of concern that a prisoner with his mental health history went some two months without attending an appointment, especially as during that time he was twice found not to have taken his medication.

The Head of Healthcare should ensure that mental health in reach patients who miss more than two consecutive appointments are seen personally to establish the reasons and to check whether there are health concerns that need to be addressed.

86. The man suffered from serious mental health problems and needed regular medication to maintain his mental stability. In the circumstances we consider it was very important that the MHIT (and the occupational therapist ideally) should have been made aware that there was evidence he was not taking it and this should have led to further investigation.

87. After the SIR submitted following the incident on 7 October, staff were directed to ask the pharmacy and healthcare managers to review the man's medication. It does not appear from the electronic medical record that healthcare staff were aware of this incident until 19 October, when he told the occupational therapist that he had 'got a nicking' for having spat out his medication. The SIR submitted after the incident on 9 November asked staff to refer him to the pharmacy again. There is no entry on the electronic medical record to show that this happened. An entry for 21 November (entered on 24 November author "M Hirt", ie MHIT) records that he was in the

segregation unit after keeping his medication in his cell. Subsequent entries show that two different GPs visited him daily in the segregation unit and that 'no concerns' were raised. It does not appear that anyone from healthcare questioned him about hiding his medication a second time or that the therapist was informed. Following the SIR completed on 21 December staff were directed to 'ensure HCC [health care centre] are informed'. It is clear from the security record that the intention was that healthcare should be made aware of these incidents but it does not appear that they were and there is no record that anyone challenged him about them.

88. There was a clear failure for the relevant information to be provided by the security department to healthcare. Had this information been transferred appropriately, the man's medication could have been reviewed. We make the following recommendation:

The Governor and the Head of Healthcare should ensure that there is a robust system to pass healthcare related security information about prisoners on the MHIT case list to relevant caseworkers.

Diversion of medication

89. There were two documented occasions that the man attempted to conceal his medication rather than take it at the treatment hatch. We also know that on another occasion, he successfully diverted his medication because it was found during a cell search. In their inspection in January, HMIP found that the supervision of prisoners collecting their medication was of a varying standard and there was potential for bullying and diversion of medication. At interview an officer told the investigator that staff did not routinely observe prisoners on house unit 2. We echo the recommendation made by HMIP:

The Governor should ensure that officers manage and supervise queues for the administration of medication on all house units.

Transfer of Information

90. On several occasions at Rye Hill, the man bartered his medication and property for illegal drugs. He got into debt and came under pressure from other prisoners. A combination of taking illegal drugs, not taking his medication and the stress of being in debt appears to have affected his mental health. He was in this situation when he assaulted another prisoner with a craft knife and put a noose around his neck in July 2010. He was transferred to hospital and returned to prison in November 2010. By June 2011 it appears that he had once again begun to barter his medication for illicit drugs. He assaulted another prisoner with the lid from a tuna can.

91. When he moved to Woodhill, the accompanying PER listed five risk indicators for him. The PER said that he was easily influenced by other prisoners, had assaulted other prisoners, was involved in the drug culture, held weapons and mobile phones for other prisoners and could be abusive and threatening. The PER is one of the documents that should be examined as part of the

reception process. There is no evidence that he was questioned about the information on his PER. Once the prisoner has gone through reception, the PER forms are placed in his main record. It is therefore important that the information about risk they contain is captured when the prisoner first arrives. He did not mention any of the incidents that had occurred at Rye Hill during his reception interview. He did talk about his mental health problems and history of self-harm and these were appropriately identified during his health screen. However, some of the issues listed on the PER reflect problems that occurred while he was at Woodhill and staff were not fully informed of potential problems. We make the following recommendation:

The Governor should ensure that reception staff inform all appropriate departments of risk factors indicated on PERs.

92. Most of the information about the man's history of bartering his medication for illegal drugs, getting into debt and being bullied was contained in his prison security record. When a prisoner is transferred between prisons, the sending establishment is responsible for sending the prison record with them. When the security file arrives a member of staff should collate the information into a single SIR. This then forms the basis of a new security file. If there is information about bullying or self-harm this should be passed to the violence reduction and safer custody teams.

93. When he went to court on 12 September Rye Hill were expecting him to return there but he was sent to Woodhill instead. Rye Hill did not find out where he had gone and did not send on his security file. Staff at Woodhill were therefore unaware of his history. When the first SIR was raised after the incident of 7 October, as far as they were aware, this was the first time he had been involved in hiding his medication.

94. There also seems to have been some confusion at Woodhill about his status. Although the man was serving an indeterminate sentence he was also facing further charges. Because he had come from one of the local courts, the security department believed he was a new prisoner and not a transfer. They were therefore unaware that he had a previous security file. Information that he had come from Rye Hill was contained on the PER, but as discussed above this does not appear to have been looked at in sufficient detail.

95. When a prison sends a prisoner to court but does not receive him back the onus is clearly on the sending establishment to find out where he has gone and to make sure that his records are sent on. They should be able to do this by a simple search on P-NOMIS. We have not seen any evidence that the man was being bullied at Woodhill but the ability of staff to properly assess the implication of his hiding his medication was not helped by the fact that they were unaware of his history. We make the following recommendation to Rye Hill and, in doing so, note the difference between convicted and remand prisoners, who are much more likely to have been released by the court:

The Governor of Rye Hill should ensure that the files of all convicted prisoners who do not return from court appearances are sent to their new prison.

Personal officer initial interview

96. When prisoners are allocated to house units at Woodhill they complete a personal officer initial interview sheet and hand it in to officers. Any issues that they bring up on this sheet should then be followed up as necessary at an actual interview. The man appeared open and honest in his answers and gave information about his mental health and previous history of self-harm. He said he had suffered from depression, had been in low spirits recently and had attempted suicide in the past but was not feeling suicidal.

97. We raised concerns about the operation of the personal officer scheme in a report of an investigation into a death in 2009 and asked the Governor to review it, which the prison did. We note that the IMB raised similar concerns in their most recently published report. A survey completed by HMIP as part of their January inspection found that the scheme in place was generally suitable. However, we are concerned that personal officers do not use the initial interview form as the basis for an actual interview to follow up any issues raised and to ensure that prisoners get appropriate support. There is no evidence that the man's personal officer or any other residential officer spoke to him about the issues identified on his form. Our interviews indicated that personal officers at Woodhill appear to adopt a reactive approach rather than actively seeking out the prisoners for whom they are responsible. We therefore recommend that:

The Governor should ensure that personal officers discuss with prisoners the information provided on the initial personal officer interview sheet, take action as appropriate and record discussions on case notes in P-NOMIS.

The man's bed

98. Daily inspections of all cells, known as Accommodation Fabric Checks (AFCs) should be made. These involve checks of locks, bolts, window bars and cell furniture. Bunk beds are supposed to be screwed to the floor. At interview, SO 1 told the investigator that the security of the bunk bed frame should be checked as part of a routine fabric check and the officer would usually do this by shaking the frame to see if it could be dislodged. The daily log sheets show that the AFCs on landing one were completed at 2.10pm on 26 December and 8.50am on 27 December and no defects were noted. The legs of the bed frame slot into 'feet' bolted to the floor and are then secured with another bolt placed horizontally. This second bolt was missing from the man's bed and allowed him to lever it into an upright position.

99. The investigator examined the bed during her opening visit and it was not obvious that the bolt was missing. It has not been conclusively established whether the man managed to remove the bolt or whether it had been removed

before he was allocated to that cell. It was impossible to tell after the fact how far the bed would have moved if shaken during a search. After his death, his bunk bed was repaired and all of the beds in the main residential units were re-checked. Seven were found to have missing or loose bolts. All have since been replaced.

100. Clearly the missing bolt on the man's bunk was not noticed during daily checks of his cell. Unfortunately, its absence allowed him to use the bed as an effective frame from which to hang himself. However, he was not thought to be at risk of self-harm or suicide and the cell he occupied was not designed to be a 'safer cell'. There were a number of points in his cell that could have been used to attach a ligature, including the frame of the bed in its normal position. His ability to move the bed was not a crucial factor in him being able to hang himself, but we are pleased to see that a full check of all bunks was made after his death and remedial action taken.

Informing the next of kin

101. The man died after Christmas when there was a reduced number of staff on duty. At the time Woodhill had two trained family liaison officers but both were on annual leave. The duty governor was concerned to make sure that the family were told of his death as soon as possible. In the absence of available staff at Woodhill, prisons closer to them were contacted. They were also unable to provide staff. The governor therefore decided that the best available option was to ask the local police to visit the family. A DC told the investigator that the police contacted the Metropolitan Police (the man's mother's local force) but the message was not picked up immediately, again because it was a Bank Holiday and a reduced service was operating. As a result his family were not visited until 1.15am on 28 December.

102. Chapter three of PSO 2710 (which was the Prison Service Order in operation at the time of the man's death) provided the following guidance:

> "The decision on how to inform next of kin should take into account individual circumstances, especially the distance from the establishment. However, unless inappropriate for geographical reasons (ie distance from establishment and time taken to travel), it is recommended that unless there are very good reasons not to do so notification should be made in person by a visit to the next of kin by the governor (or in his/her absence the deputy) and chaplain/other religious leader. Notification of the next of kin must take place as soon as possible after the death."

Woodhill's death in custody contingency plans direct that, in the absence of a trained family liaison officer, a senior manager and another person (for example the Chaplain) should notify the family in person.

103. The guidance in operation at the time of the man's death did not specify that a trained family liaison officer must be present to break the news, but it is important that the family are told as soon as possible. A press release is sent

out as a matter of course as part of the death in custody contingency plans and a delay in telling the next of kin increases the risk that they will find out via the media or that the news gets to them from other sources. We understand that on Bank Holidays staffing levels are lower but contingency plans should allow for that. While the duty governor appears to have tried hard to ensure that the family were told as soon as possible this should have been facilitated by a personal visit from the prison. We therefore make the following recommendation:

The Governor should make contingency plans to ensure that whenever possible the families of men who die in the prison are told in person by appropriately trained and senior staff.

Issues raised by the man's family

104. The man's mother said she was concerned that the prison did not seem to be aware of her son's history of mental health problems, or that he had been sectioned twice under the Mental Health Act. She asked whether he had received any mental health assessment and/or intervention at Woodhill.

105. It is clear that his mental health issues were identified during the reception process at Woodhill. He gave a full history of his mental health and the treatment he had received and was referred to and treated by the mental health in-reach team. Wing staff were also aware of his involvement with mental health staff and that he was receiving medication for mental health problems.

106. The man's mother said she was not aware until after her son's death that he had tried to take his own life in the summer of 2011. She asked whether he was considered an on-going risk of self-harm and subject to additional monitoring as a result.

107. We have not seen any evidence that he attempted to take his own life in the summer of 2011. His prison record shows that he was found with a noose around his neck at Rye Hill in July 2010. He told staff at Woodhill about his history of self-harm and attempted suicide. He did not tell anyone that he felt suicidal and there were no obvious signs that he intended to harm himself. He was not therefore considered to be an on-going risk and was not specially monitored. We are satisfied that that was appropriate.

108. The man's mother said that he had spoken to her about his indeterminate sentence for public protection (ISPP) and was distressed about the uncertainty of his release date. She said his upcoming trial for charges of causing grievous bodily harm was playing on his mind. His solicitor had not turned up to a meeting about this. She did not know whether he had been told of this in advance and she thought that it might have troubled him further. He told the occupational therapist on two occasions that he was anxious that the psychiatrist writing his court report for the charges of GBH had not yet interviewed him. She advised him to speak to his solicitors. His medical

record reports that he was visited by his solicitor in October and did not bring up the issue. His solicitors visited him again on 19 December.

109. The man's mother said she was concerned to learn that her son might not have been taking his medication and had been punished for hiding it. She asked how his medication was being administered and whether more could be done to monitor this. There is no evidence that he missed collecting his medication. On three occasions, he was caught not taking it or hiding it in his cell. From 7 October, staff observed him more closely when he received his medication. It appears that he was able to partially swallow his tablets so that when the nurse checked his mouth it looked as if he had swallowed them. However, it is impossible to be certain whether this was a regular occurrence. We have noted in the report that better supervision of the administration of medication administration is needed. He was not formally punished for hiding his medication (a charge about this was dismissed on 27 December) but it was one of the factors which led to him being placed on the basic regime.

CONCLUSION

110. The man was a man with a number of mental health and substance misuse issues. He had a history of suicidal behaviour that meant he was at a higher risk of making further attempts on his life. It seems also that his prospects of release were playing on his mind. He did not share these with staff. He also admitted that he was selling his medication for tobacco. We are concerned that in the past this was a precursor to him finding himself under stress and harming himself. However, we have seen no evidence that this was the case in Woodhill and we do not believe that there was any obvious sign that he was at increased risk of harming himself in the period leading up to his death.

111. The investigation has identified some concerns about a number of matters at Woodhill. In particular, he was able to conceal and trade his medication when there was information, not passed on, that he had done the same at Rye Hill. He missed too many mental health appointments without this being sufficiently well followed up. It would have been difficult to predict his intentions and it appears that it was too late to resuscitate him when he was found. Nevertheless, the emergency response was poor and it took too long to begin CPR and for an ambulance to be called.

RECOMMENDATIONS

To the Governor of Woodhill

1. The Governor should ensure that all staff understand the local policy on emergency calls and what actions are expected when one is made.

   This recommendation was accepted at draft stage and the prison responded: "A Staff Information Notice will be published describing the actions required on emergency calls. Revised procedure to be included within the Safer Custody Policy for ongoing review."

2. The Governor should ensure that there are sufficient first aid trained officers on duty at all times who are able to administer CPR in an emergency.

   This recommendation was partially accepted at draft stage and the prison responded:
   "Currently there are 84 staff trained in emergency first aid in addition to 24 hour H/Care cover provided by PCT. HM Prison Service does not include First Aid Training as Mandatory training for staff within penal establishments."

3. The Governor should ensure that all staff understand that it is their responsibility to call an ambulance when they find a prisoner in a life threatening situation and that protocols are revised to reflect this.

   This recommendation was accepted at draft stage and the prison responded: "Current agreed protocol for the calling of an ambulance has recently been reviewed in conjunction with Deputy Governor, Head of Healthcare and SMT and published to staff. The protocol has been reviewed and the First on Scene when dealing with a life threatening situation will call a Medical emergency Code Red, the control room will then immediately request a 999 ambulance."

4. The Governor should ensure that officers manage and supervise queues for the administration of medication on all house units.

   This recommendation was accepted at draft stage and the prison responded: "This process has been reviewed as part of the Drug Strategy Meeting. Staff have been reminded of the supervision process via a Staff Information Notice and the supervision area will be improved in conjunction with the Healthcare Managers to ensure adequate administration of medication."

5. The Governor should ensure that reception staff inform all appropriate departments of risk factors indicated on PERs.

   This recommendation was accepted at draft stage and the prison responded: "Risk factors indicated on PERs are taken into account when completing the CSRA. Night Security Officers access incoming information and record any relevant risks onto 5x5.

A Staff Information Notice will be published reminding staff of this requirement to ensure this is completed in a timely manner."

6. The Governor should ensure that personal officers discuss with prisoners the information provided on the initial personal officer interview sheet, take action as appropriate and record discussions on case notes in P-NOMIS.

   This recommendation was partially accepted at draft stage and the prison responded:
   "The use of the initial personal officer sheet is no longer in use at HMP Woodhill. All prisoners on receipt to any unit will be informed of their personal officers and any issues brought to the attention of the Personal Officer will be managed appropriately and recorded on P-NOMIS."

7. The Governor should make contingency plans to ensure that whenever possible the families of men who die in the prison are told in person by appropriately trained and senior staff.

   This recommendation was accepted at draft stage and the prison responded: "Every effort is made for an appropriately trained member staff to inform prisoner's families. Further staff at HMP Woodhill have completed the FLO training course now totalling 5 with a further 3 awaiting training. Access to the FLO network is now available to Managers managing any death in custody."

<u>To the Governor and Head of Healthcare</u>

8. The Governor and Head of Healthcare should ensure that there are regular recorded checks of all emergency equipment.

   This recommendation was accepted at draft stage and the prison responded: "All emergency equipment throughout the prison is checked weekly. Emergency equipment on all house units to be reviewed and revised."

9. The Governor and the Head of Healthcare should ensure that there is a robust system to pass healthcare related security information about prisoners on the MHIT case list to relevant caseworkers.

   This recommendation was accepted at draft stage and the prison responded: "Multi-disciplinary Reviews to be facilitated for prisoners identified to have a serious mental health illness by MHIRT lead and Case workers. Completion of SIR forms following disclosures relating to security."

<u>To the Head of Healthcare</u>

10. The Head of Healthcare should ensure that mental health in reach patients who miss more than two consecutive appointments are seen personally to establish the reasons and to check whether there are health concerns that need to be addressed.

    This recommendation was accepted at draft stage and the prison responded:

"Operating procedure for non attendance at appointments to be formulated and embedded by Head of MHIRT."

To the Governor of Rye Hill

11. The Governor of Rye Hill should ensure that the files of all convicted prisoners who do not return from court appearances are sent to their new prison.

This recommendation was accepted at draft stage and the prison responded: "A system has been established whereby the case administrator will monitor and identify convicted offenders who have not returned to the establishment from an external court appearance. They will confirm on P-NOMIS where the offender is located and ascertain from the holding establishment if the offender is to return to HMP Rye Hill in the immediate future, for those whose return is not imminent the case administrator will co-ordinate the onward communication of any retained documents (Public Protection and Security file for example)"