

**Investigation into the circumstances surrounding the death of
a prisoner at HMP Woodhill on 28 April 2004**

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

December 2004

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1. Introduction

The sad death of a prisoner on 28 April at HMP Woodhill was one of the first apparently self-inflicted deaths in prison to have occurred after I took responsibility for investigating all such deaths at the beginning of that month. Under transitional arrangements agreed with the Prison Service, a senior investigating officer is appointed by the Prison Service to conduct each investigation. He or she works directly to me for the purposes of the investigation and submits a draft report that I then review and amend as necessary.

In this case, the senior investigating officer and his assistant were from HMP Belmarsh. I am grateful to them for their diligent and thoughtful work. I have structured this report so that their investigation can be separately identified. I have made only minor amendments for reasons of clarity and typographical consistency. However, the description of the cell (para G1.25) is my own as are a number of the other details.

The senior investigating officer visited the deceased prisoner's brother and sister-in-law at their home during the course of the investigation. A Family Liaison Officer from my office has also been in contact. I know they have both offered their condolences, but I should like in addition to offer mine. I fear the family will take little comfort from some of the details revealed in this report. It makes very unhappy reading.

I personally liaised with the senior investigating officer during this investigation and visited HMP Woodhill a few days after the prisoner's death. It was immediately apparent that, while the response by many of the staff at Woodhill was excellent - and I pay testimony here to their professionalism - some things had also gone badly wrong. Information about risk of self-harm was not identified or not acted upon. The prisoner was almost certainly able to hoard prescription drugs despite procedures designed to avoid this. Worst of all, there had been delay and confusion at the gate with senior staff in effect preventing the ambulance from leaving the prison. This investigation has revealed a catalogue of poor decision making by two Governor grades that ultimately prevented the prisoner being taken to hospital for more advanced resuscitation. It gives me no pleasure that one of my recommendations is that their actions must be investigated under the Prison Service Code of Conduct and Discipline.

For this published version of my report, I have amended one detail in light of what emerged at inquest.

I should record here my thanks to the governing Governor and his staff for the help and hospitality the investigators received during

the investigation. Every assistance was made available and all staff co-operated fully and readily with the inquiry.

STEPHEN SHAW
PRISONS AND PROBATION OMBUDSMAN

2. Summary

This is the report of an investigation into the death on 28 April 2004 of a prisoner at HMP Woodhill.

The man had been in prison since 29 July 2003. The offence of which he had been convicted was a most unusual one. He had held two doctors hostage, apparently because of his anger at the medical profession's failure to cure his chronic back pain. He subsequently confided that he had hoped that the hostage-taking would end with his being shot by the police, thereby bringing his pain to an end.

Although an early Prisoner Escort Record (PER) indicated that he was at risk of suicide and self-harm, and despite a number of references by him to a previous suicide attempt and his wish to die, he was at no stage identified by the prison as a suicide risk. As a result, he was not subject to any special measures.

The man was found in bed in his cell at about 8.00 am on 28 April 2004, clearly in need of urgent medical attention. This arrived promptly and various staff and paramedics administered cardio pulmonary resuscitation (CPR) and advanced life support for about 45 minutes. These proved fruitless, however, and the man was pronounced dead at 9.00 am. A post-mortem revealed that death was caused by an overdose of Tramadol, a medication prescribed to the prisoner to alleviate back pain.

The man's back-pain is the key to his apparent decision to take his own life. There is evidence of staff concern about the degree of pain experienced by him during his period in custody.

This report reviews the various points at which the man might have been identified as a suicide risk. I am critical of a number of shortcomings both in completing paperwork and in communication between different agencies.

While I commend staff for their prompt and professional responses to the incident, I raise concerns about the availability and adequacy of life saving equipment. An oxygen bottle was brought quickly, but found to be empty.

A defibrillator had to be collected from the Healthcare centre and took some time to arrive. I also consider the way the incident was communicated which led to confusion over whether death in custody or medical emergency procedures should have been invoked. The number of people involved may also have added to the muddle.

The report explores in detail the sequence of events that led to a delay, and ultimately failure, in removing the man to hospital. This related to

questionable decision-making by two governors on the need for a clinical assessment by a doctor and whether the man should be allowed to leave the prison. The report also highlights other concerns about the performance of one of the governors in particular. Finally, I am critical that the ambulance was retained at the prison for some considerable time after it was deemed that the man should not be removed to hospital.

The report makes over 20 recommendations.

3. Key Findings

- * The man pleaded guilty on 8 August 2003 to charges of kidnap, false imprisonment, possession of drugs (cannabis) and possession of an offensive weapon. On 31 October 2003, he was sentenced to five years imprisonment. The offences had been committed during the course of a protracted incident at a doctor's surgery.
- * He subsequently explained that the motivation for the offence was his chronic back pain and his desire to be shot by the police.
- * The PER form completed by the police stated that the man was at risk of suicide/self-harm. This was overlooked on reception at Woodhill. No special resources were invoked in relation to his care, other than an instruction to 'locate flat' because of a chronic back condition.
- * The man had lost contact with his wife and daughter. He had served for nine years in the army, after which he was employed as an HGV driver. It was during this period that he said he sustained the injuries leading to his back condition. He had admitted in the past to using large quantities of cannabis to alleviate the pain.
- * The man confided information relating to suicidal ideation in an interview for his pre-sentence report. However, while the report was placed in both his core record and sentence management dossier, it does not appear that the information was passed to the prison in any other form.
- * It appears the man had only one social visit during his 20 months in custody. There were no letters and few personal possessions in his cell.
- * In December 2003, the man complained that his evening medication had been given to another prisoner.
- * On 4 March 2004, the man shared details of his suicidal ideation with the facilitator of a Restorative Justice project. This information was not shared with Woodhill.
- * On 26 March 2004, the senior officer on the man's wing wrote to the prison doctor regarding her concerns about the amount of pain from which the man appeared to be suffering. On interview, the senior officer said she had received no reply.

- * The man submitted a canteen form on 23 April requesting a number of consumable items. These would have been delivered on 29 April. This and other evidence indicates that the man gave no indication to staff or fellow prisoners of his intention to take his own life on 28 April.
- * At the time of his death, the man was prescribed Baclofen and Tramadol on a twice-daily basis. Both medicines were administered on a 'see to take' basis. Tramadol is a sustained release medicine and, to ensure full benefit of the pain relief it offered throughout the night, there were good clinical reasons for it to have been taken later than the time at which it was dispensed.
- * The man was unlocked at approximately 8.02 am on 28 April. A call to the Control Room by another officer informed them that "the inmate appears to be dead". The Control Room informed relevant staff including the Healthcare Senior Officer and medical assistance was called. CPR and mouth to mouth resuscitation was commenced. There was a delay in supplying oxygen and in use of a defibrillator. There was also a delay in calling an ambulance. It is suggested that the demeanour of a governor hindered the smooth running of the incident.
- * A note was found indicating that the man had tried to kill himself. The note referred back to the motivation for his offence.
- * The ambulance arrived between 08.21 and 08.26 (depending on which log is accurate). Ambulance staff said the man had good colour and was warm. He was removed to the back of the ambulance within nine minutes of it arriving. Advanced life support was offered. The ambulance reached the gate at 08.45.
- * The exact order of events in and around the gate is confused but among other things:
 - (i) The officer asked to escort the man to the hospital packed and then unpacked the escort bag.
 - (ii) Two governors discussed the appropriateness of allowing the ambulance to leave.
 - (iii) Two doctors entering the prison were subject to the usual staff search before being permitted on to the ambulance.

- (iv) The ambulance entered the gate lock, was reversed into the prison, then entered the gate lock again. It was finally reversed back into the prison after the man had been declared dead.
- * This investigation has revealed great and understandable concerns on the part of medical and non-medical staff as to the circumstance surrounding the man's death, in particular the events at the gate. There was though good practice on the part of other staff - in particular in the careful way in which prisoners on the house unit were told of the death.

4. Senior Investigating Officer's report

SECTION A – INTRODUCTION

- A.1 On 28 April 2004 at approximately 08.02hrs, an Officer unlocked the prisoner for an early breakfast. He found the man in bed and quickly established he required urgent medical attention.
- A.2 Staff attended the scene and commenced CPR, an ambulance was called and paramedics along with Prison Service nursing staff continued with advanced life support for approximately 45 minutes.
- A.3 A doctor declared the prisoner dead at 09.00hrs after a period of consultation with the ambulance staff.
- A.4 On 30 April 2004, instructions were given for the conduct of an investigation into the circumstances of the man's death, in keeping with the provisions of the transitional arrangements for the investigation of fatal incidents agreed between the Prisons and Probation Ombudsman and the Prison Service.
- A.5 A full post mortem was carried out. The toxicology results showed that the man had died of an overdose of Tramadol, a prescription medication he was receiving to alleviate chronic back pain.

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SECTION D – GLOSSARY OF TERMS

Term	Description
IMB	Independent Monitoring Board.
CPR	Cardio pulmonary resuscitation.
Duty Governor	A governor grade who is responsible to the Governor for the smooth operation of the prison during a 24hr period of duty and is available during unlock periods to deal with any contingencies or emergencies.
F2050	Prisoner's core record.
F2052SH	Suicide/Self Harm at risk document.
ACCT Form	A form intended to replace the 2052SH document that is being piloted at Woodhill.
F2169	Initial Reception Health Screening form.
HCC	Healthcare Centre.
HCO	Healthcare Officer.
HCSO	Healthcare Senior Officer.
HMP	Her Majesty's Prison.
IMR	Inmate Medical Record.
IRS	Incident Reporting System.
LIDS	Local Inmate Database System.
MO	Medical Officer.
Orderly Officer	Operational Manager at Principal Officer rank responsible for the day-to-day smooth running of the establishment.
Oscar 1	Radio call sign designated for use by the Orderly Officer.
Oscar 2	Radio call sign designated for use by the Assistant Orderly Officer (a Senior Officer).
OSG	Operational Support Grade.
PER	Prisoner Escort Record.
PO	Principal Officer.
POA	Prison Officers' Association.
PSN	Prison Service Nurse.
PSO	Prison Service Order.
PSR	Pre Sentence Report
SAT	Suicide Awareness Team.
SO	Senior Officer.
Victor 1	Radio call sign designated for use by the Duty Governor.
Locate flat	Prisoner to be located in a cell on the ground floor that ensures there is minimal need to use stairs.

Cell Sharing Risk Assessment	A document raised on first reception, by trained staff, to assess the needs of all prisoners with regard to suitable location.
F2052A	Prisoner's History Sheet, record of events and observations.
House Unit	Secure accommodation area for prisoners.
PIN Phone	Telephone for use by prisoners. PIN refers to their personal number to access the phone.
PSR	Pre-Sentence Report.
PNC	Police National Computer.
Term	Description
DCR	Sentence Management Dossier.
F35	A prison form used to list applications.
MDT	Mandatory Drug Test.
Observation Book	Book used to record occurrences, normally on House Units, in order to inform on-coming staff of previous noteworthy events.
Hotel 1	Duty healthcare nurse detailed responsibility to attend incidents and alarms.
Orderly Office	Office used by the Orderly Officer.
ECG	Electro Cardiogram.
Gate Pass	Official document used to record and authorise the release of all prisoners from prison. No prisoner should leave the prison without one.
Route Form	Official document authorising and recording the times that staff leave the prison. Staff should not leave a prison whilst on duty without one.
Hot Debrief	An operational debrief immediately after an event or incident.
Scene Log	Record kept at the scene of an incident showing times of all events. Kept by the designated log officer.
Contingency Plans	Set of plans used to assist and guide staff in the management of incidents.
Care Team	A mandatory team set up in all establishments for the care and support of staff. All members are volunteers but adhere to general counselling guidelines.
Gate Lock	The area between the inner and outer gates. All staff and vehicles have to enter one gate, which is then shut before the next can be opened, thus the term 'lock'.

Sterile Area	A controlled area, directly inside the prison gate to which prisoners are not given free access.
Control Room	Similar to the 'bridge' of a ship. The Control Room contains the controls for commanding a prison. Systems such as electronic locks, radios, CCTV and communication are managed from there.

SECTION E - BACKGROUND

E.1 Prisoner's details

Date of birth	06/05/60
First reception into custody	31/07/03
Status	Sentenced-5 years
Offences	Kidnap, False Imprisonment, Possession of Drugs (Cannabis) and Possession of an Offensive Weapon.

E.2 Next of kin Brother

E.3 Personal History

E3.1 The prisoner was born on 6 May 1960 in London. He was the youngest of eight children and moved with his family at the age of 14 to Milton Keynes.

E3.2 He joined the army in 1979 and served for nine years. He married during this period and had a daughter with whom he had had no contact for some years despite his efforts to contact her. The marriage ended in divorce. His brother is still making attempts to make contact with the ex-wife and daughter.

E3.3 Following his service in the army, the man was employed as an HGV driver and during that period he claimed to have sustained the injuries which led him to suffer a prolapsed disc and sciatica ever since. At the time of the man's arrest, he was residing in rented accommodation in Kettering and was in receipt of Incapacity Benefit.

E3.4 The man had admitted in the past that he used large quantities of cannabis to alleviate his back pain.

E.4 Criminal History

E4.1 The prisoner had a number of previous convictions but none since 1993. He had served a 12-month prison sentence following one of these convictions in 1989.

E4.2 The man admitted the offences for which he was imprisoned at the time of his death in that he had held two doctors hostage at knifepoint. The man had gone to the doctor's surgery armed with a kitchen knife and a combat knife. He had said during interviews in custody that he was in great pain at the time of the offence and that

he had committed the offence in the hope that he would be shot by the police, thereby ending it all for him.

E4.3 The first doctor whom the man took hostage managed to escape and the second doctor was taken hostage when he entered the room after hearing a commotion. The second doctor said that he feared for his life during the incident. After some hours had passed, the man, who was in great pain, lay down and told the doctor that he should leave the room. The doctor took his opportunity and left. The man was then overpowered by the police and arrested.

E4.4 On 31 October 2003 at Northants Crown Court, the man pleaded guilty to Kidnap, False Imprisonment, Possession of Cannabis and Possessing an Offensive Weapon in a public place. He was subsequently sentenced to five years imprisonment.

E.5 Woodhill Prison

E5.1 HMP Woodhill was opened in July 1992, with a new unit added in April 1996. HMP Woodhill is a Category A prison and in 1998 one wing was designated as a close supervision centre, which holds a small number of prisoners who are amongst the most difficult and disruptive in the prison system.

E5.2 The CNA is 680 with an operational capacity of 789.

E5.3 The regime includes full and part time classes in education. There are offending behaviour groups e.g. Sex Offender Treatment Programme, and courses on: Enhanced Thinking Skills, drug management, developing your potential, relationships, life skills and specific drugs life skills and development courses for young offenders. Other features include an Offending Behaviour Club and Listener Schemes. There are also various projects linked with local schools e.g. "Prison Me No Way?"

E5.4 All prisoners received into Woodhill Prison currently undergo an induction process that lasts up to five days. At the time of the man's reception, the induction process available was scheduled to last three days.

E5.5 The Justice Research Consortium is currently carrying out a study into the effects of restorative justice on the level of re-offending. HMP Woodhill is actively involved in this study and prisoners identified as having received a sentence for violent crime are invited to take part in this study.

- E5.6 The process involves convicted prisoners meeting the victims of their crime in an informal yet controlled setting. The prisoner is given the opportunity to explain why the offence occurred, why the victim was chosen and to describe the thought process surrounding the offence. The victim is given the opportunity to explain the impact of the offence on their lives and the lives of their families.
- E5.7. Following an earlier incident at Woodhill where a prisoner had attempted suicide by an overdose of prescribed medication, an investigation was commissioned. The report from this investigation recommended that a review should occur regarding analgesics and all medications with a potential for misuse. The Medicines and Therapeutics Committee would be responsible for implementing this recommendation.
- E5.8 HMP Woodhill underwent a full inspection by Her Majesty's Chief Inspector of Prisons in February 2002. The establishment was last subject to a Prison Service Standards and Security audit in October 2002 during which they were marked as 85% for standards and 91% for security.
- E5.9 HMP Woodhill is currently taking part in the Assessment, Care in Custody and Teamwork (ACCT) pilot programme. The programme is intended to improve the way the Prison Service manages prisoners who are in a period of crisis and are at risk of self harm or suicide.

SECTION F – INVESTIGATION PROCESS

F.1 The Team

The investigation team comprised a Senior Investigating Officer and Investigating Officer, both from HMP Belmarsh.

F.2 Process

- F2.1 The investigation began on 30 April 2004 and was completed on 13 September 2004. The investigation team relied upon the evidence of interviews and statements, supported by documentary evidence to reach its findings.
- F2.2 The Commissioning Authority has been kept apprised of any emerging issues throughout the course of the investigation. The Deputy Director General of the Prison Service requested an initial verbal report to enable him to address any immediate concerns that the investigators had identified.
- F2.3 An independent professional assessment was conducted into the quality of healthcare provided to the man during his period of custody.
- F2.4 During the course of the investigation, an audit was completed on Prison Service Performance Standard 60, Suicide Self Harm Prevention.
- F2.5 During the incident the ambulance that was carrying the man was unable to leave the prison. Because of the complexities surrounding this issue, it has been separated from the main narrative of the report. The main narrative regarding the incident can be found at Section G2, with a closer examination of the issues surrounding the events at the gate in Section G3.
- F.3 The list of those interviewed and the documents relied upon is not being published.
- F.4 The Investigation Team returned original copies of the man's IMR and F2050 for forwarding to the Coroner's Officer.
- F.5 The man's brother was contacted by the senior investigating officer on the evening of Friday 7 May and invited to contribute to the investigation process. He and his wife were visited at their home on the evening of 17 May 2004. The family was informed of initial findings and the investigation process.

- F.6 The team used the facilities afforded by HMP Woodhill, including interview rooms, tape recording equipment and offices. They were also kindly loaned a transcribing machine for the duration of the investigation.
- F.7 The establishment appointed investigation liaison officers. The team would like to thank them both, as well as two other staff for their help and assistance throughout the course of the investigation.
- F.8 The team visited Bletchley Ambulance Station and the Coroner's Office to conduct interviews with non Prison Service personnel. They would like to thank the respective managers for their help and assistance in facilitating these interviews.
- F.9 The investigation team briefed the then Governor and Deputy Governor regularly on emerging issues whilst they were in the establishment.
- F.10 A draft report was passed to the Commissioning Authority on 7 July 2004 with the final report being submitted on 14 September 2004.

SECTION G1 – EVENTS LEADING UP TO THE DEATH

- G1. 1 The man was arrested on 29 July 2003 following a protracted incident where he had kidnapped two doctors. During the course of the police investigation, the man appears to have stated that the offence was committed in an attempt to get himself shot by the police. This is supported by the fact that the police have recorded him as a suicide/self harm risk on the PER.
- G1. 2 Whilst in police custody at Corby Police Station on 30 July 2003, a warrant for non-payment of Council Tax was served on the man. On this case, the man was bailed to appear before Corby Magistrates on 31 July 2003. However, he remained in custody on the more serious charges that he had been arrested for on the previous day. There is no evidence available to establish how this matter was finally concluded.
- G1. 3 The man attended Corby Magistrates Court on 31 July 2003 in regard to the offences committed on 29 July. During this court appearance, he was remanded into prison custody to appear at Northants Guildhall Crown Court on 8 August 2003. The man was then escorted by Group 4 Custodial Services to Woodhill prison. The PER Form completed by the police for this appearance clearly states the man was at risk of suicide/self harm.
- G1. 4 On reception at HMP Woodhill, the man was subject to the normal reception procedure including the listing of his property, seeing a nurse, and completion of a Cell Sharing Risk Assessment.
- G1. 5 The Cell Sharing Risk Assessment resulted in the man being assessed as a medium risk. The boxes for past abuse and and present dependence upon drink or drugs have been ticked and a note on the form reads: "Due to medical condition, inmate says he gets angry/frustrated quickly". However, it was recommended that he went into a 'single cell if possible due to his medical condition. LOCATE FLAT'. This recommendation has not been signed and dated. The boxes for abuse of alcohol/drugs and current dependence are ticked (the box for previous convictions for Schedule 1 offences has been wrongly ticked 'no').
- G1. 6 A revised F2169 (First Reception Health Screen form) was completed by a nurse. A copy of the warrant was present for this assessment, however there was no copy of the PER and according to the F2169 it appears this document is not required.

- G1. 7 When the man was asked during the first reception health screen interview 'Have you ever tried to harm yourself?' he appears to have responded 'Tuesday 29/07/03'. This has been crossed out. A note is then entered stating 'One year ago, attempted overdose'. On the following question, 'For some people, coming into prison may be difficult, and a few find it so hard that they may consider harming themselves, Do you feel like that?' the man answered 'No'.
- G1. 8 During interview, the nurse could not remember what had been said to cause her to write 'Tuesday 29/07/03'. She was adamant, however, that she did not believe it was a reference to a self harm incident which is why she would have disregarded the information. It has become clear during the course of the investigation that the man said the index offence was committed with the intention of getting himself shot. The discarded information was therefore vital for an accurate assessment to be made on the level of risk he posed regarding self harm or suicide. Unfortunately, no 2052SH/ACCT form was opened following the First Reception Health Screen Interview.
- G1. 9 The planned action required following completion of the F2169 is refer to doctor and mental health. In fact, there was no referral to the Mental Health Inreach Team as the form requires when there has been a previous history of self harm. It has been established that the Mental Health Inreach Team was not in place at the time of the man's reception. This has now been rectified.
- G1. 10 The prisoner consent form, included in the F2169, regarding the sharing of information with outside agencies was unsigned by both the prisoner and the nurse. The nurse stated on interview that when she had discussed this part of the form with the man, he had said that he could not see any point in completing it in consideration of the offence for which he was in custody.
- G1. 11 On 1 August 2003, the man first saw the doctor at HMP Woodhill. It should be noted that he was not placed on a 2052SH following this meeting with the doctor. He was, however, placed on pain relief medication at this stage following consultation with Kettering General Hospital.
- G1. 12 At the time of his death, the man was prescribed Baclofen and Tramadol. The man received this medication on a twice daily basis. Tramadol is a sustained release medication and, to ensure full benefit of the pain relief that it offers throughout the night, there were clinical reasons for it to be taken later than when it is issued.

- G1. 13 A History Sheet F2052A seems to have been opened in Reception. There are a number of pre-prepared questions on the first page of the 2052A, but there is little evidence that many of the questions have been posed. Included are a number of questions specifically about self harm, none of which has been answered. We were informed that the record used was from old stock and these questions were not asked as they were covered by the introduction of the First Reception Health Screen Interview. We have checked and can confirm that records no longer contain these questions.
- G1. 14 On 1 August 2003, the man should have received induction. However there is little or no evidence that this actually happened. A second F2052A has been opened on House Unit 2A. However, the first comment in the document is dated 14 August 2003 when he was received onto House Unit 4. This entry reads 'Rec'd on HU4A. Rules and regs explained. Located 1-14'. We have established that it was not uncommon for induction to be cancelled at this time due to the chronic staff shortages that the establishment was experiencing.
- G1. 15 Attached to the F2052A are a number of local forms including the Cell Sharing Risk Assessment mentioned in G1.5 and a Pinphone System Terms and Conditions of Use by Prisoners form which was completed by the man on 6 August 2003. The team has been unable to establish in which location this form was signed. Additionally there is an Incentives and Earned Privileges 'in cell' television form, House Unit 4 Wing Rules Form and an HMP Woodhill Incentives and Earned Privileges Compact. These were all signed by the prisoner on 14 August 2003 when he arrived on House Unit 4. It would be expected for these forms to be explained and signed on induction.
- G1. 16 On 8 August 2003, the man was produced at Northants Guildhall Crown Court where he pleaded guilty to the offences committed on 29 July. The PER raised by the establishment for that court appearance does not indicate that he was at risk of suicide/self harm, as he was not being managed under 2052SH/ACCT.
- G1. 17 On 19 September 2003 and 23 October 2003, the man attended the Pain Management Clinic at Kettering General Hospital for outpatient appointments. He was returned to the establishment on the same day on each occasion.
- G1. 18 On 30 October 2003, a probation officer visited the man for the purpose of completing the Pre-Sentence Report. During this interview the man stated: 'He was totally disillusioned with the medical profession, although he had no axe to grind with [two named

doctors, his victims].’ He was determined to make his point and said, ‘the only way he could do so was to bring things to a head by getting himself killed.’ The PSR continues: “He was in great pain and stated that he wanted it all to end and to be shot by the police because he was unable to put up with the pain ... any longer.” The man further maintained that he had tried to commit suicide on a number of occasions, although the probation officer was unsure as to whether these attempts had resulted in hospital admissions. The probation officer wrote that: “[The man] says he had a death wish ... his risk of self-harm would have to be considered high.”

G1. 19 Whilst there is a copy of the PSR in both the man’s F2050 Core Record and the Sentence Management Dossier, the probation officer did not separately inform the establishment about the self harm/suicide information contained within.

G1. 20 On 31 October 2003, the man was produced at Northants Guildhall Crown Court where he was sentenced to five years imprisonment. The PER raised by the establishment for that court appearance does not indicate that he was at risk of suicide/self harm.

G1. 21 Following sentence, a Sentence Management Dossier was raised by the establishment. This dossier includes a DCR1 Sentence Plan Form, a copy of the Pre Sentence Report, a copy of the PNC Record, and a Categorisation and Allocation form. The ICA1, allocation form, appears to have been raised on 3 November 2003. The DCR Sentence Plan document had not been started except for front-page details prior to the man’s death.

G1. 22 Attached to the 2052A are two F35’s, both of which have been signed by the prison doctor on 6 November 2003. The first records the man as unfit for labour, the second records that he should receive an extra mattress. These F35’s were completed after the man attended a sick parade that day.

G1. 23 On 25 November 2003, the man received a mandatory drug test result that showed positive for Benzodiazepines. A confirmation test showed that the result was due to prescribed medication. On 15 December 2003 he received a second drug test result, which proved negative.

G1. 24 On 7 December 2003, the man applied for a Visiting Order to be issued to two visitors. This visit took place on 14 December 2003. He applied for a further Visiting Order on 15 December 2003 for the two visitors to visit again; this visit never took place. He received no further social visits whilst he was in custody. Fellow prisoners have

informed us that the man may have chosen not to receive further visits because of the difficulty he had in getting across to visits because of the amount of pain he was in.

- G1. 25 When I inspected the man's cell, it contained no letters and few personal possessions (the police told me they had taken away just one letter from a lawyer). I note he had no radio and am told that one was in store, waiting to be given in possession, having been order by another prisoner. There was a three-day-old Sunday newspaper and a TV guide opened at Tuesday, the day before the man's death.
- G1. 26 On 22 December 2003, the man submitted a Request/Complaint Form regarding his evening medication, which is bagged up, being given to another prisoner. In the complaint, he stated that this was the sixth time that this had occurred. He did not receive a substantive response to his complaint. There is no evidence to suggest that this complaint has ever been properly investigated or that safeguards were put in place to ensure that there was no further recurrence.
- G1. 27 On 12 March 2004, the man submitted a resettlement application regarding accommodation, financial management, employment, training and health matters. On 13 April 2004, a member of the Resettlement team at Woodhill discussed with him issues regarding his resettlement, and completed a resettlement action plan on his behalf.
- G1. 28 On 26 March 2004, a Senior Officer wrote a memorandum to the prison doctor regarding the concerns she had about the amount of pain that the man appeared to be suffering. She also made an entry on the same day in the Wing Observation Book: "I am seriously concerned about the inmate's quality of life." During interview, the Senior Officer informed us that she had not received a reply from this memorandum up to the date of the man's death.
- G1. 29 The team established from staff and prisoners on interview that the prisoner was a quiet man who kept himself much to himself. Staff described how he spent long periods in his cell, as he could not get around much because of the pain. Prisoners said he was in chronic pain and, on occasions, other prisoners would collect his meals for him, as he felt unable to make the walk to the hotplate despite his cell being fewer than ten yards away.
- G1. 30 On 27 February 2003, the Restorative Justice facilitator sent the man a letter informing him of a visit on 3 March 2004. The purpose of the visit was to explain more about the Restorative Justice project and

to ascertain if he was prepared to participate in the scheme. This visit actually took place on 4 March 2004.

G1. 31 During the initial visit, the man expressed remorse towards one of his victims but was less positive in his attitude towards the other. He described the pain he had been in and explained why he had taken such a course of action against the doctors. He said his sole intention was to take a hostage so that he would have to be shot by the Police Armed Response Unit to end the pain that he was suffering. He further stated that he had taken overdoses in the past but without success. The man said that he wished to apologise to the first victim and his family. The facilitator, an experienced probation officer, did not inform Woodhill about the self harm/suicide information that came to light during the interview.

G1. 32 On 30 March 2003, the facilitator and a colleague met with the man to prepare for the conference. During this meeting, the man described an incident with the prison doctor where he felt she had failed to act properly and he had responded by being verbally abusive. He reiterated that he wished to meet with the first victim, but said that he did not want to see the second victim and he went on to make clear threats towards him. He threatened physical injury and stated that he wanted him to be scared of what he might do to him on release. He admitted that he was not capable of inflicting physical harm but was not retreating from the idea of psychological harm as he wanted the second victim to suffer 'for as long as he himself had'. He also made threats against the solicitor who had acted for him in his personal injury case.

G1. 33 Following the meeting on 30 March 2003, the Restorative Justice Project Manager had such concerns over the man's intentions that he contacted a psychiatrist attached to HMP Woodhill to obtain a psychiatric assessment of the man's suitability to participate in the conference. On 8 April 2004, the Manager wrote to the psychiatrist following a conversation that they had had regarding the man's suitability. In the letter, the Manager outlined his main concerns.

G1. 34 On 20 April 2004, the psychiatrist wrote to the Manager. In his letter he indicated that, whilst the man had come to see him, date unknown, he had declined to co-operate with the interview stating he was prepared to apologise to the first victim but not to anyone else.

G1. 35 The facilitator arranged to visit the man on 29 April 2004; this meeting did not go ahead.

- G1. 36 On 23 April 2004, the man submitted a canteen form requesting a number of consumable items. This would have been delivered on 29 April 2004.
- G1. 37 A fellow prisoner said that he had seen the man on the evening of 27 April 2004, and that there was nothing at all to indicate that anything was wrong.
- G1. 38 The night officer for HU4 on the night of 27 April 2004 stated that, as he did his check when coming on duty that evening, the man was laying on his back in bed. The man looked at the officer but did not acknowledge him. The officer had no further reason to check the man during the night period, as he was not on an ACCT form. When he did his early morning count at approximately 06.00hrs, he observed that the man was in his normal sleeping position on his back and there was nothing to indicate that anything was wrong so he did not attempt to gain a response from him.
- G1. 39 The early morning count officer for HU4 stated that she arrived on the unit at approximately 07.10hrs and after a hand-over she proceeded to do the early morning count. She said that when she checked on the man he was lying on his back, as he always did, and appeared to be asleep.

SECTION G2 – THE INCIDENT

- G2. 1 At approximately 08.02hrs on 28 April 2004, a Cleaning Officer called down to another Officer to awaken the man as he had an early appointment at the Healthcare Centre.
- G2. 2 The Officer unlocked cell 1-02 and attempted to awaken the man. He instructed him to 'get up, get dressed and get his breakfast'. When there was no response, he entered the cell and found that the man appeared unconscious and was in need of immediate medical attention.
- G2. 3 The Officer left the cell and immediately called for an urgent message to be sent over the prison radio net, requesting urgent medical assistance. Another Officer made this call which was subsequently logged in the Control Room at 08.03hrs.
- G2. 4 At about the same time, a telephone call was made to the Control Room from a third Officer who was working on the Unit at the time. She informed them 'that the inmate appears to be dead'. During interview, this Officer was unable to say what caused her to give this information other than she was aware that there was no response from the man. She accepted that this information was given in a lay person's terms. It appears that this call influenced the way the incident was reported to outstations from this early stage in the incident.
- G2. 5 On receiving the urgent message, the Control Room informed Hotel 1, Oscar 1 and Victor 2 of the situation. Following these calls, a Principal Officer (PO) and a Governor grade immediately made their way to the scene.
- G2. 6 At the time of receiving the call, the Principal Officer was in the area of the Orderly office. During interview, two Senior Officers stated that the PO received a telephone call apparently from the Control Room, following which he informed them that there was a death on HU4 and that he was going over to deal with it.
- G2. 7 During interview, the PO stated that en route to the scene he informed another Governor grade that there was an apparent death on House Unit 4 and asked him to attend the scene with him. When interviewed, this Governor grade's recollection was different; he believed that a dog handler had told him that there was an incident on HU4. The Principal Officer and the Governor grade are recorded

as having arrived at the scene at the same time; it appears therefore that the PO's recollection is the more accurate.

- G2. 8 During interview, the Healthcare Senior Officer who was Hotel 1 stated that, on receipt of the call from the Control Room, he instructed two nurses to attend House Unit 4 to assist in a medical emergency and that both nurses left the Healthcare Centre taking with them the emergency bag and oxygen. The Healthcare SO then contacted the Control Room immediately and informed them that Healthcare staff were already on HU4 issuing medication.
- G2. 9 The radio log records a call at 08.05hrs to Bravo 7 during which he was informed that there were medical staff on the Unit. The Officer confirmed this on interview. As a result of this call, the Officer went to the Treatments Room and called two other nurses to the scene immediately.
- G2. 10 On hearing the call for urgent medical assistance, another Officer had gone to the cell. He described the man as lying in his bed appearing 'quite lifeless'. He felt for the carotid artery and placed a mirror near to the mouth to see if he could see signs of breathing.
- G2. 11 Two more Officers entered the cell. The first Officer realised there was little he could do as other staff were already checking for signs of life. The second Officer, who is first aid trained, continued into the cell and commenced checks for pulse and respiration. At this stage the first Officer left the cell.
- G2. 12 As this Officer was leaving the cell, the two nurses from the Treatments Room entered the cell and were apprised of the situation by his colleague. One of the nurses returned to the Treatments Room to collect a face-mask. The nurse has stated that there was not one available in the Treatments Room but he used one of his own that he kept on his house keys. He returned to the cell and they commenced CPR and mouth to mouth resuscitation immediately whilst the man remained on the bed. One of the nurses described the man as 'warm to touch' in both his memo and during interview. The evidence supports the fact that resuscitation was started within a couple of minutes of the initial discovery.
- G2. 13 Whilst carrying out CPR, one of the nurses requested that defibrillator and emergency equipment be brought over from the Healthcare. The Control Room log records at 08.07hrs that "a defibrillator was requested by the Healthcare staff on scene".

- G2. 14 When the other two nurses arrived at the scene, one of them took the oxygen out and found the cylinder to be empty. She then left the cell and telephoned the 'duty room' requesting more oxygen and a defibrillator. The Control Room log records the request for additional oxygen at 08.11hrs. This delayed the delivery of pure oxygen.
- G2. 15 On returning to the cell, she found that the Governor grade who had been informed of the incident by the Principal Officer had just arrived. He asked her why a student nurse (one of the two who had been in the Treatments Room) was doing CPR. There is no evidence to suggest that the Governor grade enquired about the man's condition. He appears to have been wholly concerned about how it would appear in Coroner's court if a student nurse had been involved in the resuscitation.
- G2. 16 The nurse went back into the cell and immediately took over mouth to mouth resuscitation from her colleague who in turn took over the CPR from the student nurse. The student nurse played no further part in the resuscitation despite the fact that he had completed his A+E training and was probably as competent in the delivery of CPR as any other person on scene.
- G2. 17 Once the student nurse had been relieved, the Governor grade called him from the cell and explained why he had taken him off CPR. The PO has described that, following this conversation, the student nurse appeared disheartened having done a very good initial job.
- G2. 18 During interview, a Senior Officer stated that the Governor grade had required that the student nurse was removed from CPR. He was of the opinion that this had interrupted CPR being delivered. A number of other staff have stated that CPR was not interrupted. Whilst the Governor grade's actions regarding the removal of the student nurse from CPR were unnecessary and unprofessional, it seems likely that the delivery of CPR was not interrupted.
- G2. 19 The Principal Officer who arrived at the scene at the same time as the Governor grade made an assessment of the situation and instructed a Senior Officer to commence a scene log immediately. He also contacted the Control Room to ensure an ambulance had been called. Despite having been informed that the incident was a Death in Custody, the Principal Officer appears to have managed it as a medical emergency from the outset.
- G2. 20 While observing Healthcare staff carrying out CPR, the Principal Officer noticed a letter on the top of the television set. He asked

one of the Healthcare staff to pass him the letter. On opening the letter he found that it appeared to be a suicide note. The Principal Officer made arrangements for the letter to be photocopied and sealed in an evidence bag.

- G2. 21 In the apparent suicide note there is the following statement, “You might want to know why? Pain constant chronic pain for five and a half years. Nobody will do a thing about it, so I have. There’s a rage building inside me, eating me away, I know if I get out I’ll kill the Doctors, those quack bastards that have made me this way, but deep down I know they ain’t worth it, but I know that won’t stop me. Sorry Bruv.”
- G2. 22 At 08.12hrs, the Control Room log records a request from Healthcare staff for an ambulance to be called. The Control Room radio log shows a separate request from Oscar 1 for an ambulance at 08.15hrs. Two Shires Ambulance have recorded a call received from the establishment at 08.14hrs. There is no doubt there was a delay of around 15 minutes in calling the ambulance.
- G2. 23 A Healthcare Senior Officer stated on interview that, when he became aware that an ambulance had been called, he immediately telephoned the on call doctor at home and asked her to attend the prison as soon as she could, as there was an ongoing incident. The doctor stated on interview that she understood the call was for information only. It is impossible to say what the nature of the call was. However, there is no reason whatsoever why the doctor’s arrival should have delayed the ambulance leaving the establishment.
- G2. 24 The scene log records that the Duty Governor arrived at the scene at 08.13hrs. The Principal Officer briefed him on the situation. The Duty Governor then spoke briefly to the Senior Officer and it became immediately apparent that the Governor grade, in his anxiety to ensure that procedures were being followed, was hindering the smooth running of the incident. The Senior Officer then asked the Duty Governor to get the Governor grade out of the way. A number of staff during interview confirmed that the Governor grade’s demeanour was unhelpful with others describing him as panicking.
- G2. 25 Following a short conversation with the Duty Governor, the Governor grade left the immediate area of the scene and went upstairs on the Unit.
- G2. 26 The Control Room log records that another Governor grade was informed of the incident at 08.15hrs and was asked to attend the scene. The scene log records him as having arrived at the scene at

08.15hrs. On interview, this Governor grade said that he was informed that there was a death on House Unit 4. The Duty Governor has confirmed that, prior to going to HU4, he informed the Governor grade that there was a death after being informed of the same by the Control Room.

- G2. 27 On arrival at the scene, the Governor grade said that he found contingency plans to have been activated with the scene effectively cordoned and managed by the Senior Officer and Principal Officer. He went on to say that he spoke briefly to the Principal Officer who showed him a letter 'supposedly written by [the prisoner]'. He noted, 'Healthcare staff of which at least one, was still administering CPR'. There is no evidence that he asked Healthcare staff about the prisoner's condition and he himself on interview has confirmed this.
- G2. 28 The Governor grade then went upstairs and met the other Governor grade. In his memorandum, he says that the other Governor grade informed him that the prisoner was dead and he was awaiting confirmation from the Medical Officer who had at that time not arrived. During interview, the second Governor grade maintained that he did not know the prisoner was dead as only a doctor can make such a decision. He went on to suggest that the first Governor grade might have misconstrued his comments. It is clear however, that both Governor grades managed this incident as a death in custody from this point on.
- G2. 29 The Governor grades have confirmed on interview that they left the Unit and returned to the administration block to activate Death in Custody contingency plans. From the time they left the unit until the pronouncement of death, neither sought or received any update on the prisoner's condition. They therefore acted solely on the information they had gleaned from their short visit to HU4.
- G2. 30 At 08.17hrs, Officers from the Staff Care Team arrived on scene and commenced care team duties that included supporting staff who had been involved in the incident thus far.
- G2. 31 At 08.18hrs, a Healthcare Senior Officer arrived with the oxygen along with a nurse who had the defibrillator. These items of equipment were passed into the cell and used immediately. The nurse entered the cell and assisted where necessary in the ongoing resuscitation attempts.
- G2. 32 When the defibrillator was attached it advised not to shock and to continue with CPR.

- G2. 33 The Governor grades passed the ambulance as they were leaving the House Unit. One of them spoke briefly to the ambulance staff and said that the patient was in cardiac arrest before proceeding on their way to the Administration Block.
- G2. 34 The Scene Log records the ambulance arriving at the scene at 08.21hrs. The Control Room Incident Log records this arrival at 08.26, with ambulance staff recording their arrival on scene at 08.23. On arrival, the paramedics were given immediate access to the unit.
- G2. 35 The ambulance staff said that, on arrival in the cell, they found the patient had good colour, was warm and that there was good CPR in progress. The patient was in asystole and they heard the prison defibrillator advise not to shock. Ambulance staff put the prisoner onto their own monitor, canulated him and commenced drug therapy prior to moving him on to a trolley and into the ambulance. The Patient Report Form notes that the patient was on the trolley within seven minutes and in the back of the ambulance within nine. A Senior Paramedic confirmed that the ease with which they canulated the prisoner was a strong indication that good quality CPR had been offered as his circulatory system was still working well.
- G2. 36 Once the prisoner had been moved to the ambulance, two nurses got in to the back of the ambulance and assisted the paramedics with advanced life support. Both nurses had prison security keys on them at this time.
- G2. 37 At 08.33hrs, the Duty Governor contacted the Control Room by UHF radio and asked that an escorting officer meet the ambulance at the gate. The Duty Governor maintains that this call was acknowledged. However, there is no evidence to support this. The Senior Paramedic confirmed in his memo that he was asked by a 'warden' if they were going to transport the 'prisoner' to hospital. When he replied 'yes', the 'warden' immediately radioed his control that they were going to hospital and to have an escort ready.
- G2. 38 At 08.43hrs, the Control Room incident log records that the ambulance was leaving House Unit 4. An Officer Support Grade (OSG) escorted the ambulance to the gate. On interview, the OSG confirmed that all vehicle gates between House Unit 4 and the main gate were staffed and opened in preparation for the ambulance to pass through without delay.
- G2. 39 The Gate Keepers Book records the ambulance returning to the gate for departure from the establishment at 08.45hrs. On entry into the gate lock it was quickly established by the OSG that the nursing staff

in the rear of the ambulance were still in possession of security keys. She opened the rear of the ambulance and removed the keys from the staff and deposited them in the key chute.

SECTION G3 – THE DELAY AT THE GATE

- G3.1 Both Governor grades stated on interview that they returned to the Governor's office in the main administration building where they drew the Death in Custody Contingency Plan and started working through it in preparation for the possibility of a death in custody. At this time the ambulance was still on House Unit 4 where the Duty Governor and the Principal Officer were dealing with the incident as a medical emergency.
- G3.2 At 08.30hrs, the first Governor grade made a call to the Deputy Governor of the establishment (the prison's Senior Management Team were meeting for an Away Day some ten minutes drive from the prison). During this call, he informed the Deputy Governor that they had a probable death in custody.
- G3.3 The second Governor grade instructed a Senior Officer to inform the police of the situation in accordance with the Death in Custody Contingency Plan. The Senior Officer informed the prison's Police Liaison Officer who in turn informed the local police. This was done prior to the ambulance leaving the House Unit. This early call to the police resulted in the police and Coroner's Officer arriving at the establishment within five minutes of the prisoner being pronounced dead.
- G3.4 At 08.32, the Control Room contacted the Orderly Office by telephone and requested one officer to escort the ambulance to Milton Keynes Hospital. A Senior Officer confirmed during interview that he had received this call.
- G3.5 The Senior Officer was carrying out Oscar 2 duties and immediately contacted a Principal Officer in Reception and requested that an officer who had not been required for escort that morning attend the Orderly Office to be briefed prior to escorting the prisoner to outside hospital.
- G3.6 In his memo, the Principal Officer stated that an Officer had left Reception to return a prisoner to HU2. He went on to say that he contacted HU2 only to find the Officer had already left and was returning to the Orderly Office. There was a delay of up to ten minutes in the Officer attending the office. However, the Officer stated on interview that he had arrived in the Orderly Office and could have been ready to go out on the escort prior to the ambulance leaving House Unit 4, as the bag had been packed and was ready before the ambulance passed the office window on its way to the gate. The Senior Officer supports this view.

- G3.7 On arrival at the Orderly Office, the Officer began to prepare the escort bag and the Senior Officer began to raise the necessary documentation for the escort. The Senior Officer said on interview that he went from the Orderly Office to the Security Office next door to obtain a Governor's signature on the Route Form. He is quite clear that the first Governor grade signed this form. The first Governor grade was unsure but he believes he may have signed the Route Form.
- G3.8 The Officer said during interview that he attended the Orderly Office and a bag was prepared for him to go on escort. Whilst he was preparing to go on escort, the second Governor grade entered the room and asked what was happening. When he was informed that the prisoner was being escorted to outside hospital, he is reported to have said, 'He is not going anywhere, he's dead'. During interview, the Governor grade denied having made this comment and suggested that any comment he had made had been misconstrued. Whatever was said, the comment made by the Governor grade caused the Officer to unpack the escort bag.
- G3.9 The Governor grade then went to the Security Office next door where he discussed with the first Governor grade the appropriateness of moving 'the body'. Present in the office at the time were two Senior Officers. Whilst this conversation was going on, the ambulance was noticed to have passed the office en route to the gate from House Unit 4.
- G3.10 When the Officer who had been asked to go out on escort became aware of the ambulance moving to the gate, he took it upon himself to re-pack the bag as he thought he would be going out on the escort. There were then a number of phone calls made and a period of considerable indecision caused by the two Governor grades procrastinating over the best way to continue. During this time, the Officer waited for an instruction to go on the escort. During interview, the second Governor grade was unable to give a reason why he did not merely dispatch the Officer to the gate thereby allowing the ambulance to leave immediately.
- G3.11 The ambulance is recorded in the Gate book as having arrived at the gate ready for departure at 08.45hrs. On arrival at the gate, the ambulance staff contacted Milton Keynes General Hospital to give them an estimated time of arrival. This was estimated at 08.55hrs. Shortly after the ambulance had arrived, a Senior Officer in the gate realised that there was no Escort Officer on the ambulance

and called the Orderly Office to find out where the escort was. He has stated on interview that he was informed they were on their way.

G3.12 The Governor grades continued their discussion on the appropriateness of moving 'the body'. There were also a number of phone calls made. The two Senior Officers who were present both stated on interview that they felt so uncomfortable with the way the conversation was going between the two Governor grades they felt the need to leave the room. Both Senior Officers were surprised and frustrated by the Governors grades' reluctance to allow the ambulance to leave and their insistence to get a doctor onto the ambulance to declare death. During interview, the second Governor grade maintained that his only reason for wanting to get the doctor on to the ambulance was to ensure that the prisoner received 'the best possible care'. The evidence supports the view that the intention was to get the doctor on the ambulance to declare the man dead.

G3.13 The Gate book records that two doctors arrived at the gate at 08.50hrs, some five minutes after the ambulance had first arrived at the gate ready for departure. Both doctors were subject to the usual staff search on entry to the prison. This would have delayed their entry by at least two or three minutes, possibly longer if there was a large number of staff passing through the gate at the time.

G3.14 The Control Room Incident Log records that the on-call doctor contacted the control room at 08.49. It appears that either of the Governor grades was informed of this as the first Governor grade gave a clear instruction that the ambulance was to be reversed from the gate to allow the doctor on board.

G3.15 Throughout the period that the ambulance was held up in the gate, paramedics and Prison Service nurses continued to carry out advanced life support on the prisoner. One of the paramedics described in his interview how they were running out of drugs to continue their efforts. His colleague contacted the Ambulance Control Room and explained that there was a delay with the ambulance leaving the prison. The Ambulance Control Room in turn contacted the Prison Control Room to enquire as to the reason for the delay. This call is recorded at 08.53hrs in the Control Room Incident Log. At no time during this delay were staff on the ambulance asked for an update on the prisoner's condition.

G3.16 The Control Room Incident Log records a call from the second Governor grade at 08.52hrs instructing that 'the ambulance is returned to the sterile area from the vehicle lock to be seen by doctor'. The Control Room Senior Officer has submitted a memo

stating that this entry is incorrect and in fact it was the first Governor grade who made the call. She also confirmed during interview that she is absolutely sure that the first Governor grade actually made the call.

G3.17 The Gate Book records that the ambulance was reversed from the gate at 08.55hrs.

G3.18 Once the ambulance had been returned to the sterile area, the two doctors relieved the two nurses and took over CPR believing that the ambulance had not been allowed to leave because the nurses were in possession of keys. The on-call doctor gave a clear instruction that the ambulance was to leave the prison; the ambulance is recorded as re-entering the gate lock at 08.57hrs.

G3.19 Once the ambulance had returned to the gate lock, the Senior Officer in the gate received a phone call from the second Governor grade who instructed him to ask 'if she was pronouncing the prisoner dead?' The Senior Officer stated on interview that the Governor grade remained on the telephone awaiting an answer.

G3.20 On interview, the Senior Officer said that as a result of this phone call he called the doctor from the ambulance so that he could pass on the Governor grade's instructions. The doctor was asked "is that inmate dead? [The Governor grade] wants to know if that inmate is dead?" The on-call doctor's recollection of this is that the other doctor left the ambulance first and went to the window at the gate, returning after a short while to ask her to go and speak to the Gate SO. The on-call doctor's understanding of the conversation with the Senior Officer in the gate was that she was required to make a clinical assessment of the prisoner's condition as a prerequisite to the ambulance leaving the establishment.

G3.21 The on-call doctor returned to the ambulance and discussed with the other doctor and the paramedic staff the position they were in. They then carried out an assessment on the prisoner taking into account the fact that he had been in cardiac arrest for over 45 minutes and in asystole with no changes in his ECG. They then declared the fact of adult death; both the paramedic and the on-call doctor time this at 09.00hrs. Although declaring the fact of adult death whilst still in an ambulance is outside of the Two Shires Ambulance Service protocol, both the ambulance staff and the doctors felt that in the circumstances this was an appropriate action to take.

G3.22 The Senior Officer in the gate then informed the second Governor grade immediately as he had remained on the phone. The Governor

grade instructed that the ambulance once again be reversed from the gate and held in the sterile area to await the arrival of the police and the Coroner. The Gate book records that the ambulance reversed out for the second time at 09.10. This is some 25 minutes after it had first arrived at the gate on its way to the hospital.

G3.23 Having been relieved by the doctors, the two nurses returned to HU4 to retrieve the emergency equipment. The Duty Governor was standing outside of the unit with an Officer. Both nurses confirmed on interview that they spoke to the Duty Governor and voiced their concerns regarding the delay in the gate caused by the absence of an escorting officer. One of the nurses said she was particularly vocal when voicing these concerns. The Duty Governor has also confirmed that both nurses were extremely frustrated and angry.

G3.24 On hearing of the delay at the gate, the Duty Governor instructed an Officer to proceed directly to the gate and escort the prisoner to outside hospital. Unfortunately, the prisoner had been declared dead by this time and the services of the Officer were not required.

SECTION G4 – POST INCIDENT RESPONSE

- G4.1 During the CPR, the Principal Officer became aware of a letter that was on top of the television in the cell (see above, para G2.20). The Principal Officer read this note and quickly established that it appeared to be a suicide note. He then arranged for it to be photocopied and the original note sealed in an appropriate evidence bag.
- G4.2 Following the prisoner's removal from the cell, the Principal Officer instructed an officer to apply a cell isolator lock to cell HU4 A1-02. This lock remained in place until both the police investigation had been completed and the Ombudsman's investigator had visited the scene.
- G4.3 After the ambulance had left House Unit 4, the Duty Governor carried out a hot de-brief with the staff on that unit. The Officers from the Staff Care Team were present at this de-brief.
- G4.4 Following the hot de-brief, the Duty Governor personally informed the man's friends on the Unit of his death. He also arranged that all other prisoners were informed of the situation individually when being unlocked for breakfast.
- G4.5 The Duty Governor contacted the Nights Principal Officer to inform him of the situation. He was unable to contact HU4 Night Officer but arranged for a Senior Officer to speak to him later that day. It is clear therefore that night staff were aware of the position prior to coming on duty that evening.
- G4.6 The Duty Governor and Principal Officer attended the Healthcare Centre to run a hot de-brief for the staff who had been involved. The Duty Governor has stated on interview that the delay in providing an escort for the prisoner had understandably upset the nursing staff. The on-call doctor also raised her initial concerns about being required to carry out a clinical assessment of the prisoner at the gate.
- G4.7 Following this hot de-brief, the Duty Governor met with the two Governor grades and informed them of his actions and the feelings of the nursing staff. It was then decided by the first Governor grade to hold a further de-brief between all three governors and the doctor so that any misunderstandings could be addressed. This de-brief took place at approximately 12.00hrs.

- G4.8 At the de-brief involving the doctor, the Duty Governor and the two Governor grades, the doctor expressed her dissatisfaction that she had been called off the ambulance and asked to assess a situation that she had only just become involved in. During interview, the doctor was of the view that the second Governor grade was attempting to convince her that she had misunderstood his request to carry out a clinical review of the prisoner, and that it was not a pre-requisite to the ambulance being allowed to leave the establishment.
- G4.10 During the course of the incident, whilst advanced life support was still being offered to the prisoner, the death in custody contingency plan had been activated by the two Governor grades. As a result of this, the Independent Monitoring Board, Chaplaincy, Police and the Coroner had been informed of the prisoner's death prior to the doctor's final pronouncement of death.
- G4.11 The Control Room Incident Log records that at 09.02hrs a call was received from the Coroner's Office for the second Governor grade. During interview, the second Governor grade stated that he never took this call and that it would have been in reference to something other than the ongoing incident, as he had not had contact with the Coroner's Office that day. A member of the Coroner's Office stated on interview that she made the call at 09.02hrs. She said that it was a return call following an earlier call from the second Governor grade regarding moving the prisoner if he were dead with rigor mortis having set in.
- G4.12 Shortly after the prisoner had been declared dead and the ambulance reversed into the sterile area, the Police Liaison Officer accompanied by three other police officers and the Coroner's Officer attended the ambulance.
- G4.13 Ambulance staff discussed with the doctor the likelihood of removing the prisoner from the ambulance into the Healthcare Centre. The Police Liaison Officer made it quite clear that the body was not to be moved from the ambulance, as it had become the responsibility of the Coroner. He said that he could have a hearse on scene within a reasonably short period of time. This decision was somewhat surprising considering the Coroner's Officer was in the establishment at the time and does not seem to have been consulted on this matter.
- G4.14 At 10.15hrs, it is recorded in the Gate Book that the hearse arrived at the establishment. The prisoner's body was then transferred from the ambulance to the hearse. The hearse left the establishment at 10.33hrs.

G4.15 At 10.35hrs, the ambulance is recorded in the Gate Book as having finally left the establishment.

G4.16 A request for a Critical Incident Debrief was made by the establishment. As of 7 July 2004, no Critical Incident Debrief had taken place.

SECTION H – LEVEL OF COMPLIANCE

- H.1 As part of the investigation process, an audit of Prison Service Standards 60 Suicide Self Harm Prevention the Assessment, Care and Custody Treatment (ACCT) pilot project and Safer Custody policies in place at HMP Woodhill was carried out.
- H.2 The audit produced an overall rating of 82 %.

SECTION I – CONCLUSIONS

- I.1 The PER Form completed by the police that accompanied the prisoner who died to HMP Woodhill stated clearly that he was at risk of self harm. The establishment failed to take account of the information provided and carry out the necessary follow up actions.
- I.2 During the completion of the revised F2169 by the nurse on the man's first reception, something had been said by him that has caused her to make the entry (Tuesday 29/07/03) following the question 'Have you ever tried to harm yourself?' It appears that the nurse has disregarded this information not realising how vitally important it would prove to be. It appears from the man's comments in the apparent suicide note that the motivation for his death was the same as that stated by him as the motivation behind his index offence.
- I.3 As the PER is one of the few pieces of information available to the Prison Service when a prisoner first comes into custody, we are surprised that there is no requirement within the F2169 for a copy of the PER to be available at the time of interview.
- I.4 The F2169 requires that where a prisoner has attempted suicide in the past they should be referred to the Mental Health Inreach Team. This was not done in this case and, considering the comments in I2, and the fact that the prisoner had been identified as being at risk of suicide on the PER form, the entire focus of the Reception Health Screen process with regard to self harm has been missed.
- I.5 The prisoner had a number of contacts with the prison doctor. He was on pain relief and anti-inflammatory medication at the time of his death. HMP Woodhill operates a policy where most medication that can cause injury or death if taken in excessive doses is issued on a 'see to take' basis.
- I.6 On 22 December 2003, the prisoner submitted a Request/Complaint form regarding the incorrect dispensing of his evening medication. The response to his complaint was hollow and lacked substance. We are surprised that the complaint was dealt with in such a lacklustre way.
- I.7 The History Sheet contained a section of pre-prepared questions concerning self-harm, none of which were completed during the reception process. We feel that there has been a failure during the entire reception process to assess the prisoner appropriately regarding his self harm intentions.

- I.8 At the time the prisoner was received into HMP Woodhill, a three day induction programme was offered to prisoners. There is no evidence that the man who died received such a programme. It is well documented that prisoners are at an increased risk of self harm on first reception into an establishment. Given that the man who died was not suitably assessed in Reception about his self harm intentions, and the apparent failure to offer an induction programme, suggests that the establishment's entire approach to the management of new receptions lacked the importance that it requires.
- I.9 The man's second 2052A has a total of three entries during the eight-month period that he was held at HMP Woodhill. This is an unacceptable level of reporting of contacts during this period of custody.
- I.10 The Pre-Sentence Report contained information that suggested the man was at risk of self harm. The probation officer did not pass this information on in any way, other than in the completed PSR, despite there being an agreed procedure for the passing of such information. Whilst a period of time had elapsed between the offence and this interview, we are of the view that the probation officer failed to treat the prisoner's comments seriously and notify the establishment accordingly.
- I.11 Whilst the establishment was in possession of two copies of the completed PSR, the Sentence Planning process - which would require the reading of the PSR - had not been completed. As the establishment had not been alerted to the importance of the contents within the PSR, it had not been read and was simply filed for future reference.
- I.12 The man who died was sentenced to five years imprisonment on 31 October 2003. A Sentence Management Dossier was opened for him three days later. Considering the role of the establishment, we are concerned that almost six months after being sentenced the Sentence Plan had not been completed.
- I.13 On 12 March 2004, the man submitted a resettlement application regarding accommodation, financial management and employment upon release. This would indicate that he was looking to the future at this time and making plans for his final release.
- I.14 The man had agreed to take part in a Restorative Justice Conference. During pre-conference interviews, it is clear from the facilitator's notes that the man had said that his offence came about because he

wanted to be shot by the police. The facilitator is a probation officer currently on secondment to the Justice Research Consortium. We are surprised that once again a probation officer appears to have failed to pass on information that should have clearly been shared with the establishment as a matter of urgency.

- I.15 The Senior Officer on the man's houseblock submitted a memo on 26 March 2004 to the prison doctor regarding the amount of pain the man appeared to be suffering. During interview, a number of staff also commented on how the man appeared to be in constant pain. Fellow prisoners also described how on occasions they would collect his meals and help him wherever possible. Clearly the man felt that he was in a considerable amount of pain and cited this explicitly as the reason for him taking his own life.
- I.16 Whilst the man complained about the level of pain he felt he was in, he was seen by the doctor on a number of occasions. The doctor had contacted the Pain Clinic at Kettering General Hospital and there were a number of out patient's appointments at the Pain Clinic at Milton Keynes General Hospital. Considering the amount of pain the man felt he was in, we are surprised that he failed to attend a number of sick parades and had walked out on others.
- I.17 A fellow prisoner said that he had seen the man on the evening of 27 April 2004, and had noticed nothing to indicate that anything was wrong. No staff on duty that evening noticed anything untoward. The man submitted a canteen form on 23 April 2004; the canteen would have been delivered the day after he had died. We feel, therefore, that it is unlikely that the man had displayed behaviour in the days prior to his death that should have alerted staff or fellow prisoners to his intentions.
- I.18 On the night before his death, staff carried out checks of all prisoners on the Unit. On the morning of the incident, an Officer completed an early morning count of all prisoners and noticed nothing unusual when she checked the man's cell. We are satisfied these checks were completed appropriately in accordance with the required procedure.
- I.19 We are content that the staff who arrived first on the scene acted appropriately and CPR was commenced as soon as trained staff had arrived.
- I.20 The telephone call that an Officer made to the Control Room saying that 'The inmate appears dead' appears to have influenced the way the incident was communicated to Oscar 1 and Victor 2 and may

have played a part in the way the incident was approached and managed by a number of individuals.

- I.21 Additional Healthcare staff attended the scene with the emergency bag and an oxygen bottle within an acceptable period of time. However, on arrival they found that the oxygen bottle was empty. This caused an unacceptable delay in the delivery of pure oxygen to the man who died and is likely to have affected the quality of the initial CPR.
- I.22 The defibrillator is held in the Healthcare Centre and it took a significant length of time for it to arrive on scene. Had there been an appliance on the Unit this delay could have been avoided.
- I.23 There are a number of references to staff calling for an ambulance, the first being recorded at 08.12hrs with the Control Room recording that they placed the call to the Ambulance Service at 08.15hrs. Considering the man's condition, we are concerned that the call for an ambulance was not made earlier. This concern is further heightened by the fact that a similar finding was made in a recent death in custody report.
- I.24 On arrival at the scene, one Governor grade was so concerned about the possibility of staff having to answer for their actions at the Coroner's Court that it appears to have clouded his judgement and affected his interactions with the staff around him. We understand why staff felt the need to request that the Duty Governor remove the Governor grade from the scene.
- I.25 The Principal Officer and Duty Governor appear to have arrived at the scene under the impression that they were dealing with a probable death in custody. However, on arrival they quickly established that it was a medical emergency and we are content that they managed the incident as such.
- I.26 The Governor grade informed a fellow governor on his arrival at the Unit that the prisoner 'appears to be dead'. Neither Governor grade enquired with Healthcare staff as to the man's condition. We understand that a governor would keep in the back of their mind the possibility that the incident could become a death in custody and record their actions accordingly. We are of the opinion, however, that both Governor grades dealt with this incident from the outset as a death in custody.

- I.27 The ambulance arrival at the prison was dealt with appropriately and we are content that paramedic staff were taken to the Unit as speedily as is reasonably possible.
- I.28 Shortly after arriving on scene, paramedic staff moved the prisoner from the bed to their own trolley outside the cell. Paramedic staff have recorded that he was of good colour and warm on arrival with good quality CPR being carried out. Evidence at the inquest confirmed that that good quality CPR was taking place, although best practice is for CPR to be conducted on a firm surface not on the bed. When paramedic staff arrived they had no difficulty in cannulating the man, which would indicate that the quality of the CPR had not been adversely affected.
- I.29 As soon as it became apparent that paramedic staff intended to take the man to outside hospital, the Principal Officer and Duty Governor made arrangements for an escort to be provided. We understand that staff at the scene are normally identified by the person in charge to go out on escort. In this case, this clearly did not happen. We are content, however, that the actions taken were clear enough that both the Principal Officer and the Duty Governor could have a reasonable expectation that the request would be carried out.
- I.30 The ambulance was escorted to the gate in a speedy fashion. Considering Woodhill is a high security prison, it is commendable that staff made every effort to ensure the ambulance had free passage from House Unit 4 to the gate.
- I.31 Paramedic staff and Prison Service nursing grades continued advanced life support in the ambulance. Whilst the keys should have been removed from the prison staff at this stage, we are content that gate procedures identified this oversight and the keys were appropriately removed soon after the ambulance arrived at the gate.
- I.32 Following the request from the Duty Governor for escorting staff to be sent to the gate, we are content that appropriate actions were taken that would have enabled an Officer to have been waiting at the gate ready to escort the ambulance as it arrived.
- I.33 After a ten minute wait, the ambulance was reversed from the gate on the instructions of the Governor grade to allow the doctor to board. The doctor arrived at the gate some five minutes after the ambulance had been allowed in to the vehicle lock. On interview, the Governor grade stated that he had taken this course of action to get the 'best possible care' to the prisoner. We find it astounding that, if this were

the case, both doctors were subject to the normal search criteria prior to entry thus causing further delay.

- I.34 The ambulance was delayed at the gate for a period of 20 minutes. On interview, the Governor grade repeatedly said that he wanted to get a doctor on the ambulance 'to give [the prisoner] the best possible care'. Paramedic staff had made the decision that the best place for the prisoner to receive the best possible care was hospital. We are firmly of the opinion that he should have been allowed to leave the establishment as quickly as possible to give him the best possible chance of survival. We conclude therefore that the Governor grade's main aim was to have the man declared dead within the establishment because both his and his fellow Governor grade's understanding was that they should not move 'the body'.
- I.35 The events that occurred in the Orderly Office and the Security Office involving the two Governor grades are somewhat confusing. However, there is clear evidence that an Officer was ready and prepared to go on escort prior to the ambulance leaving House Unit 4. A number of staff in the area were so uncomfortable with the way these governors were discussing the movement of 'the body' that they felt the need to leave the room. We therefore conclude that the delay of the ambulance at the gate can be wholly attributed to the two Governor grades' unnecessary involvement in what should have been a simple procedure.
- I.36 Whilst the majority of the evidence regarding the causes of the delay at the gate points to one of the Governor grades, we are content that the other, the Senior Governor in charge of the prison that day, was present in the Orderly Office and Security Office at the time crucial decisions were being made. We find it inconceivable that he could not have been aware of the course events were taking and as such should bear an equal share of responsibility for the unacceptable delay in the ambulance leaving.
- I.37 During interview, one of the Governor grades stated that the call received in the Control Room from the Coroner's Office was on an unrelated matter. He was adamant that he had not been in touch with the Coroner's Office that morning. There is clear evidence that he had, and that he had told the Coroner's Officer that rigor mortis had set in. We can find no reason why the Coroner's Officer would wish to mislead the investigation team and therefore conclude that, on the balance of probabilities, the Governor grade did in fact call the Coroner's Office which is contrary to what he stated on interview.

- I.38 Following the declaration of the prisoner's death, the ambulance was delayed from leaving the establishment for approximately one and a half hours. Paramedic staff had requested that the man's body be moved to an alternative location to enable them to become available to respond to further emergency calls. The Police Liaison Officer would not allow this to happen, stating that the body was the responsibility of the Coroner and as such should not be moved. It is difficult to understand why this decision was made as the Coroner's Officer was present in the establishment within five minutes of the man being declared dead. We therefore feel that the decision not to allow the ambulance to leave was a poor one, which left the Two Shires Ambulance Service without an operational vehicle for an unacceptable period of time.
- I.39 There were two separate de-briefs held. We feel that this will have diminished the quality of the de-brief and therefore reduced any benefit staff may have gained from attending.

SECTION J – RECOMMENDATIONS

- J.1 I accept the recommendations contained in the clinical review.
- J.2 I recommend oxygen is made available on each residential unit and the gymnasium area and a robust system for ensuring it is in a constant state of preparedness is introduced.
- J.3 I recommend that a defibrillator is available on each residential unit and within the gymnasium area and additional staff are trained in its use.
- J.4 I recommend a full review of emergency boxes and first aid kits held within the establishment. All emergency boxes should contain a minimum of cut down scissors and facemasks.
- J.5 I recommend that an emergency aid point be established within each residential unit. The equipment mentioned in the recommendations above should all be stored in this area with immediate access available to all staff. Management checks should be introduced to ensure that all this equipment remains in a constant state of preparedness.
- J.6 I recommend that all staff trained in first aid are additionally trained in the use of the defibrillator.
- J.7 I recommend that a system is introduced which ensures an ambulance can be called by the first on scene in the event of what is considered a serious situation.
- J.8 I recommend that the establishment reviews its procedure for the staffing of emergency escorts and ensures that any procedure adopted is well published and that operational managers are informed individually of any change.
- J.9 I recommend that consideration is given to including PER information when carrying out the First Reception Health Screen interview.
- J.10 I recommend that all staff involved in the carrying out the First Reception Health Screen interview receive additional suicide refresher training and are retrained on an annual basis.
- J.11 I recommend that all prisoners that give an indication of a history of self harm outside of the custodial environment are referred to the Mental Health Inreach Team, as the form requires.

- J.12 I recommend a full review of the practices involved in issuing potentially harmful medication.
- J.13 I recommend that a simple enquiry be carried out with regard to the issues raised in the man's Request/Complaint Form. Any findings and recommendations resulting from the enquiry should be passed to the Medicines and Therapeutic Committee for action as necessary.
- J.14 I recommend a review of the Personal Officer scheme. Staff should be required to make tangible entries on interactions with prisoners on at least a weekly basis.
- J.15 I recommend that the induction process is reviewed with the emphasis on self harm being prioritised within the process. This process needs to be fully documented in the prisoner's 2050A.
- J.16 I recommend a protocol is agreed between the establishment and the Northamptonshire Probation Service with regard to the sharing of information concerning any knowledge of a prisoner's self harm intentions.
- J.17 I recommend a protocol is agreed between the establishment and the Justice Research Consortium with regard to the sharing of information concerning any knowledge of a prisoner's self harm intentions. We are aware that such a system exists following concerns raised at conferences; this should be extended to include the entire process.
- J.18 I recommend that during the course of a protracted incident consideration be given to providing additional staff to the Control Room to ensure that logs are more accurately completed.
- J.19 I recommend the entry in the Death in Custody Contingency Plan, Duty Governor Victor 2 Section 'Ensure Medical Officer has certified death before pursuing further contingency plans' be changed to 'Ensure death has been certified by an appropriate person before pursuing this contingency plan further.'
- J.20 I recommend that the Death in Custody Contingency Plan is amended to require the Orderly Officer to obtain Serious Incident Report Forms from all staff involved in the incident. This should include staff that have managed the incident.

- J.21 Currently HMP Woodhill is part of the ACCT pilot, which is under constant review. We have therefore made no recommendations with regard to the local suicide prevention policy.

SECTION K - GOOD PRACTICE

- K.1 The Duty Governor made arrangements for all prisoners on the House Unit to be informed individually of the man's death. He personally informed prisoners who were close to the man who died. This is good practice and consideration should be given by the Prison Service to adopting this approach nationally.

SECTION L – RECOMMENDATIONS RE: STAFF PERFORMANCE

- L.1 Two nurses continued to carry out CPR for a period of approximately 45 minutes despite numerous frustrations caused by the delay at the gate. We feel that this dedication should be recognised by the Governor.
- L.2 I recommend that consideration be given by the Director of High Security Prisons to commission an investigation under the Prison Service Code of Conduct and Discipline into the actions of the two Governor grades during the course of the incident.