PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent Investigations

Investigation into the circumstances surrounding the death of a man, in January 2012, at HMP Woodhill

Report by the Prisons and Probation Ombudsman for England and Wales

September 2012

This is a report into the death of a man in January 2012, while in custody at HMP Woodhill. He was 37 years old and a post mortem showed that he died from hanging. I offer my condolences to the man's family and friends.

The investigation was carried out by one of my investigators. HMP Woodhill and HMP Birmingham co-operated fully with the investigation. Milton Keynes NHS appointed a clinical reviewer to review the man's clinical care while in custody.

The man was addicted to heroin and started a detoxification programme in prison. However, the clinical review found that this was not appropriately managed at Woodhill. He was not accommodated in a designated detoxification wing with appropriate support and does not appear to have received the level of clinical monitoring expected. Record keeping was also deficient. Recommendations are made accordingly.

The investigation considered whether the man should have been identified as at risk of suicide and self harm. Such assessments are not an exact science and involve balancing the prisoner's demeanour and behaviour against known risk factors. He did not have a history of mental health problems and there was no information to suggest he had previously attempted self harm or suicide. However, he had a number of significant risk factors: he was on an opiate detoxification programme, he was a foreign national prisoner of considerable notoriety facing an extensively publicised double murder charge and, potentially, an extremely long prison sentence. There is little indication that these factors were considered. However, I note that at no time had he given any indication to staff that he intended to take his own life and to that extent it would have been difficult to foresee his actions. Overall, the investigation concludes that these other risk factors should have been taken more fully into account when assessing his level of risk, but whether this would have changed the outcome cannot be known.

This 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 **September 2012**

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SUMMARY

1. The man, a Lithuanian national, was remanded into custody on two charges of murder on 19 January 2012 and sent to HMP Birmingham. He was transferred to HMP Woodhill on 21 January. The man was a smoker and had a history of opiate abuse. He had previously served custodial sentences in the UK and had been deported back to Lithuania in 2009. Due to the seriousness of his alleged offences, he was regarded as a potential Category A prisoner. (A prisoner requiring the highest level of security).

2. On arrival at Birmingham, the man told healthcare staff that this was not his first time in custody, he had no health issues but was heroin dependent. He denied any thoughts of self harm or suicide and was not subject to suicide and self harm monitoring. He began an opiate detoxification programme but was located on a standard wing rather than the prison's detoxification unit or in the healthcare centre as would normally be expected.

3. At 8.52am on a day in January, the man was found hanging in his cell and emergency medical assistance was called. Staff began cardio pulmonary resuscitation (CPR) until paramedics arrived and took over his care. After a period of assessment and emergency treatment, the prison doctor confirmed at 9.30am that the man had died.

4. There was appropriate initial assessment of the man's physical and mental health and suitable treatment identified. However, the subsequent care that was provided to manage his opiate detoxification did not follow the standards set out in Woodhill's own operating procedure or Prison Service guidelines.

5. The man repeatedly stated that he had no thoughts of harming himself. However the assessment of the risk of self-harm or suicide by the man had not adequately considered other risk factors, for example that he was a foreign national prisoner facing a double murder charge of considerable notoriety and he was withdrawing from a dependency on heroin.

6. We make three recommendations, concerning the need for appropriate assessment of the risk of self-harm or suicide, development of a policy for the management of prisoners withdrawing from drugs and alcohol and effective medical record keeping.

THE INVESTIGATION PROCESS

7. The investigation was opened on 31 January 2012 when the investigator issued notices announcing the investigation to staff and prisoners.

8. The investigator visited HMP Woodhill on 31 January. During his visit he was given copies of all documentation relating to the man. The investigator visited HMP Birmingham on 16 February and 13 March to interview six members of staff. He returned to Woodhill on 27 February and 21 March to interview 13 members of staff. Written feedback was given to the Governor of Woodhill on 15 March.

9. Milton Keynes NHS asked a clinical reviewer to carry out a review of the man's clinical care. The investigator and the clinical reviewer discussed aspects of the man's treatment during his time at Birmingham and Woodhill.

10. Her Majesty's Coroner was informed of the investigation and a copy of the investigation report will be sent to the Coroner to assist his enquiries. The Coroner provided the investigator with a copy of the post mortem which showed that the cause of the man's death was hanging.

11. The investigator liaised with police to inform them of the progress of our investigation. The police provided the investigator with translated, redacted copies of a letter, signed and dated 28 January, and an undated note that the man had written which had been found in his cell.

12. One of our senior family liaison officers contacted the man's sister, through the Lithuanian Embassy, to inform her about the investigation and to invite her to ask any questions or raise any concerns about the care her brother received in prison. To date, no reply has been received.

HMP WOODHILL

13. HMP Woodhill opened in 1992. The prison holds some Category A prisoners (the highest level of security) as well as some of the most disruptive prisoners in the prison system in the close supervision centre. In addition to its function as a Category A prison, Woodhill operates as a local prison serving both Crown and Magistrates Courts. The man was regarded as a potential Category A prisoner.

14. Milton Keynes NHS is responsible for commissioning healthcare at HMP Woodhill. The prison has a nursing health care team, a mental health in reach team, also x-ray, dental, pharmacy and podiatry services.

15. The NHS Milton Keynes also commissions a number of other agencies to provide healthcare services at Woodhill including, Resuscitate Medical Services Limited to provide general medical services and the Seagrave Trust, to provide substance misuse services.

HM Chief Inspector of Prisons (HMCIP)

16. The last published inspection report of Woodhill by HMCIP took place between 16 – 20 November 2009. The report of an inspection in January 2012 has yet to be published. In the introduction to the 2009 report the then Chief Inspector said:

> "Woodhill remained a reasonably safe prison, with little use of segregation and sound suicide prevention procedures. Drug use was reasonably low and clinical management of substance users was developing. However, procedures to support prisoners in the early days of custody needed some attention."

Independent Monitoring Board (IMB)

17. Each prison has an IMB who are unpaid members of the local community appointed by the Secretary of State for Justice. Their role is to monitor day-to-day life in the prison and ensure that proper standards of care and decency are maintained.

18. In their annual report for the period ending May 2011, the IMB made the following comments

> "Healthcare interventions and health promotion are provided by a multi-disciplinary team with twenty four hour nursing cover.
>
> "Prisoners are screened in the First Night Centre (FNC) and have a secondary screening. The waiting time to see a doctor compares favourably with the outside and can sometimes be even better.
>
> "The Substance Misuse Service continues to use a range of pharmaceutical treatments for opiate (heroin) and alcohol dependence.

"Medications to ensure abstinence from heroin and alcohol are also prescribed. All patients on treatment are seen regularly on a one-to-one basis for review, motivational interviewing, brief interventions, health promotion and education.

"House Unit 5 is now the Stabilisation Unit and prisoners received in Reception with any form of substance misuse will be placed in this Unit. Much work has been carried out on the Unit to provide the necessary accommodation and special facilities.

"The entire process has been very controlled and brought stakeholders together in a manageable and safe way. It is believed that this will ensure that IDTS will run efficiently and effectively in HMP Woodhill.

Reception

19. Reception staff do not routinely have access to a prisoner's past records, so at this point the prisoner is the main source of information. However, all prisoners will also have a Person Escort Record (PER). This document is used when escorting a prisoner between prisons, courts, and police stations. It includes information, such as a prisoner's risk to others or themselves.

20. Part of the reception process is an initial healthcare screen. This concentrates on the prisoner's immediate well-being, mental health, risk of self-harm or suicide, and any drug or alcohol withdrawal or detoxification issues. A more detailed healthscreen will usually take place in the days after arrival.

Suicide and self-harm monitoring

21. The rules that govern all aspects of running a prison are set out in a series of documents called Prison Service Orders (PSOs) and Prison Service Instructions. PSO 2700 – 'Suicide prevention and self-harm management' the instruction in place at the time (now replaced by PSI 64/2011) detailed prison procedures for looking after prisoners at risk of suicide or self harm. Assessment, Care in Custody and Teamwork (or ACCT) is the system used by prisons to identify, monitor and support prisoners at risk of self harm.

22. Any member of staff can start the ACCT process, by raising a Concern and Keep Safe form, explaining the reasons for their concern. An Immediate Action Plan is written by the manager of the wing where the prisoner is located and within 24 hours an ACCT assessment is carried out by a member of staff who has the required training. Once placed on an ACCT, the prisoner is subject to regular case reviews that will direct observations/conversations to be carried out at intervals determined by their perceived level of risk. The observations continue during the day and the night.

Integrated Drug Treatment System (IDTS)

23. IDTS aims to increase the amount and quality of substance misuse treatment available to prisoners, with particular emphasis on the early days in custody. It

is intended to improve the links between clinical and non-clinical services and reinforce continuity of care from the community into prison, between prisons, and on release into the community. As part of the IDTS programme, prisoners can be prescribed substitute substances to aid detoxification along with integrated clinical and psychological treatments in prison and the community.

KEY EVENTS

24. The man was born in July 1974 and was a Lithuanian national. He was divorced and had two children. He had previously served custodial sentences in the UK and was deported back to Lithuania in 2009. He had illegally re-entered the UK during 2011. He had a history of opiate abuse.

25. On 19 January 2012, the man appeared at a magistrates' court charged with committing two murders. While at the court, the Person Escort Form (PER) document was completed by court custody officers. The form noted that the man was violent and a risk to others and that he was a heroin user. At the magistrates' court, the man was checked by staff on nine separate occasions between 9.10am and 2.00pm and no concerns were identified.

26. Following his court appearance, the man was remanded into custody until his appearance at a crown court on 23 January and was sent to HMP Birmingham.

27. When the man arrived at Birmingham, he was seen in reception by a prison custody officer (PCO) who completed the Prisoner Induction Document. He gave his next of kin as his brother-in-law. The officer also recorded that the man said that he was able to communicate in English, which he could read and write, in addition to his native language. He said that he had been in prison before, was a smoker and was happy to share a cell. He said that he was a drug user and wanted to be put on a detoxification programme. He also said that he had never had any thoughts of harming himself or taking his own life in the past and had no such thoughts now he was in custody.

28. A Cell Sharing Risk Assessment (CSRA) was completed. Due to the seriousness of the charges and the high media interest surrounding the case the man was deemed to be a high risk prisoner requiring maximum security and was placed in a single cell in the prison's segregation unit, the Care and Separation Unit (CSU).

29. A nurse saw the man in the CSU for a reception health screen on 19 January. (A first reception healthscreen takes place every time a prisoner arrives at a prison to determine any immediate physical and mental health conditions that require treatment, substance misuse matters that need to be addressed, and any risk that the prisoner may pose of harming himself or attempting suicide.). The man told the nurse that he had a £40 per day heroin habit and had last injected four days earlier. He also said he had no concerns about his physical health and had no mental health issues and was not taking any prescribed medication before he entered custody. The man told the nurse that he had no thoughts of harming himself or suicide. The nurse recorded that the man spoke limited English but was able to communicate well.

30. The same day, a prison doctor saw the man and began an opiate detoxification programme. He prescribed one 25mg tablet of promethazine hydrochloride (for opiate withdrawal) and recorded that he was to be seen the next day by the specialist substance misuse doctor.

31. Later that same evening a nurse from the mental health team saw the man in his cell to undertake a mental health assessment. The nurse recorded that, despite the man's limited English, he was able to communicate and demonstrated that he understood what was said to him. He told the nurse that he had not had any dealings with mental health services in the community and had no history of mental illness or depression. He reiterated that he had never previously self harmed or attempted suicide and had no thoughts of doing so. The nurse recorded that the man gave no indication of mental illness and that the only health issue identified was drug dependency and that he had already been placed on an opiate detoxification programme.

32. The following morning 20 January a prison substance misuse doctor saw the man in his cell in the CSU. The doctor recorded that the man had limited English but was able to communicate and understand sufficiently for the consultation to continue. He complained to the doctor of being hot and cold, had shivers, pain in the limbs, and difficulty in sleeping. He told the doctor that he first used heroin when he was custody in Lithuania, had become dependant on opiates and had a £30 - £40 daily habit. The substance misuse doctor's assessment was that the man showed no evidence of significant opiate withdrawal as he was not restless, had no tremors, was not yawning or sniffing (all signs of significant opiate withdrawal). The doctor prescribed methadone (opiate replacement) commencing at 30ml a day with the dose to be reduced by 5ml each week over the next four weeks.

33. The same day, the security senior officer at Birmingham completed an escort risk assessment form as the man was to be transferred to HMP Woodhill. The SO recorded on the form that he was a high risk prisoner, a risk to the public and that the charges against him had been publicised in the national media and press. The SO also noted that he had no health concerns other than heroin addiction.

34. On the morning of 21 January, a nurse saw the man to issue him with his prescribed methadone. The nurse recorded that he appeared stable, had no concerns and he was to be transferred to Woodhill later that day. A further PER form was completed which again detailed his high risk status and drug misuse history.

35. On arrival at Woodhill on 21 January, an officer saw the man and completed the First Night Centre (FNC) interview. The man told the officer that he had been in prison before, he was able to speak and write English, was a smoker and he had no concerns or thoughts of self harm or suicide. The officer explained the role of wing Listeners (prisoners trained by the Samaritans, who offer confidential emotional support to fellow prisoners in distress). He was allocated a single cell on the FNC.

36. A nurse saw the man later in the afternoon to conduct an initial healthscreen. The nurse recorded that the man had been placed on a detoxification programme and had been prescribed 30ml of methadone by the doctor at Birmingham. The nurse further noted that he appeared fit and well, had no

mental health issues and was to be seen by the doctor. The man told the nurse that he had no thoughts of self harm or suicide.

37. The same afternoon, the man saw a prison doctor who recorded that he had examined the man and found no concerns and authorised 30ml of methadone to be given for the next two days.

38. On 22 January, the man saw a nurse who conducted a second healthscreen. (A second healthscreen is a more in depth assessment of physical and mental health conditions that require treatment, substance misuse matters that need to be addressed, and any risk that the prisoner may pose of harming himself or attempting suicide.) The man told the nurse that he had no concerns over his health and had no thoughts of self harm or suicide. He said that he was a smoker and did not drink alcohol excessively. The nurse recorded the man's weight as 82.8kg (13st 1lb), height as 1.77m (5' 10") and blood pressure as 121/56 (within the normal range). The nurse also issued the man with his prescribed 30ml of methadone and recorded it on the methadone prescription chart.

39. The officer who carried out the First Night Centre interview also saw the man to complete the second day induction interview. The officer recorded that the man was able to understand English, and that he was able to read and write in English. The man told the officer that he had no concerns and had no thoughts of self harm or suicide.

40. The man also met a prison chaplain. The prison chaplain explained that it was his role to see prisoners who arrive at Woodhill at weekends to ensure that their religious requirements and rights are fulfilled and to make any other contact as necessary. The chaplain said that he could not remember the man precisely, but if he had given any indication of a risk of self harm or suicide an ACCT plan would have been opened.

41. On 23 January 2012, the man appeared at a crown court. A PER was completed that confirmed the man's high security risk and his drug misuse. At this court appearance, it was ordered that he was to remain remanded in custody until his trial at the court on a date to be determined later in the year. Before leaving for court, a nurse recorded in the methadone prescription chart that the man had been given 30 ml of methadone at 7.25am. There was no entry made in the medical records. The man returned to Woodhill later that day.

42. On the morning of 24 January, at 11.47am, a nurse recorded on the methadone prescription chart that the man had been given the prescribed 25 ml of methadone. There was no entry made in the medical records.

43. That afternoon, a prison doctor saw the man in his cell. The doctor recorded that he was opiate dependant and that it was appropriate to continue with the methadone therapy which was to continue on 25ml of methadone for the next seven days, and then to reduce by weekly amounts of 5ml. The doctor recorded that his blood pressure was 116/57 (within normal range).

44. Later that same afternoon the man was moved to cell 2-005 on House Unit 1, which is the induction wing, which he occupied on his own. There is no record of the reason why he had not been allocated to the Stabilisation Unit (for detoxifying prisoners) on House Unit 5 and no one was able to explain to the investigator why this was not done.

45. There were no further entries made in the man's medical records after the prison doctor's entry of 24 January until the day of the man's death. However, over the next three days it was recorded in the methadone prescription chart that he was issued with the prescribed 25ml of methadone on the mornings of 25, 26 and 27 January.

46. An officer based on House Unit 1 said at interview that in the days that the man was on House Unit 1 he interacted well with prisoners and staff, he came out of his cell on association periods and joined in the activities such as playing pool. The officer further explained that at no time did the man raise any concerns or issues with staff. Another officer based on House Unit 1 confirmed at interview that the man settled into life on the unit and that staff had no issues or concerns about his welfare.

47. A roll check of House Unit 1 was conducted at 9.00pm after all prisoners had been locked in their cells for the night. The check on prisoners is carried out by an officer looking through the observation hatch of the cell door to see the prisoners are present. This check is not designed as a check on well being, it is a security measure to check that all prisoners are accounted for. Any concerns have to be reported. The officer on duty completed the role check of prisoners and there were no concerns raised.

48. During the night the prison is in night patrol state. All prisoners remain in their cells and there is a restricted number of staff on duty. Each cell has an alarm bell that a prisoner can press to summon assistance from a member of staff. The timing of each call made on the cell bells, and the time of the response, is logged, and the records showed that the man did not use his cell bell at any time from the evening before through to the following morning.

Events on the day of the man's death

49. During the early hours of a morning in January, an officer was required to check each of the high risk prisoners on the wing. The officer recorded in the Night Patrol Log that the man was checked at 11.00pm, 1.00am and 3.30am and there were no concerns raised.

50. There was a second roll check of the prisoners on House Unit 1 at 5.30am and no concerns were reported. When the night staff handed over to the day staff there was a further roll check carried out and this was conducted at 7.15am by an officer and again there were no concerns raised.

51. As it was a weekend, the prisoners were unlocked at 8.50am. An officer arrived at the man's cell at 8.52am. On opening the cell, the officer saw the man on

the floor with his body suspended from the wall bracket next to the bed, by torn bedsheets around his neck. The officer shouted for assistance and immediately entered the cell and supported the weight of the man's body. A second officer ran into the cell and cut the sheets, both officers began cardiopulmonary resuscitation (CPR – a mixture of chest compressions and rescue breaths to manually circulate oxygen around the body). The alarm was raised to summon immediate healthcare assistance and an emergency ambulance was requested at 8.54am.

52. A nurse and a healthcare assistant (HCA) were in the treatment room on the wing and ran up the one flight of stairs to the man's cell. The healthcare staff, joined by a further nurse, took over and continued CPR, using an airway bag and an automated external defibrillator (AED) (which monitors the heart rhythm and administers electrical shocks to the heart to restore the normal rhythm when necessary) until the paramedics arrived. The AED advised that there was no shockable rhythm.

53. The paramedics arrived at 9.05am and took over the man's care. The paramedics continued treatment until a prison doctor arrived at the scene. At 9.30am, having spoken to the paramedics, the prison doctor pronounced that the man had died.

54. A hot debrief was held for staff involved in the incident later that morning and the services of the care team were made available (hot debriefs should be led by a senior member of prison staff and are intended to offer staff involved the opportunity to discuss the incident. The purpose is to offer reassurance, information and support.)

55. Staff and the chaplaincy were made available to support any prisoners affected by the incident. There were 35 prisoners on suicide and self harm monitoring (ACCT) at Woodhill (although none on the wing where this man was found), and appropriate checks on these prisoners were carried out, in line with Prison Service policy.

56. As with all deaths in custody, the police undertake an initial investigation to establish the circumstances of the prisoner's death to ascertain whether a criminal investigation is necessary. On searching the man's cell, the police found two letters, both written in Lithuanian, one concerning his request for a doctor's appointment, which was undated, and another to his sister which was signed and dated 28 January 2012.

57. The police had the letters translated and provided the investigator with copies, with some information relevant to the criminal investigation removed for legal reasons. In his letter to his sister, the man began by saying "hello and goodbye" and said that he had tried to take his own life for five days but had found it really hard to do. The undated note concerned an appointment with the doctor and his dissatisfaction that he was not able see a doctor until "next week" as he said he had "psychological problems".

58. As the man was a Lithuanian national, Prison Service Headquarters advised Woodhill to contact the Lithuanian Embassy and seek their assistance with informing his family of his death. Three days after his death, the Embassy was able to confirm that the man's sister had been informed of her brother's death. The prison contributed towards funeral expenses in line with Prison Service policy.

ISSUES

Assessment of risk

59. As the man was in custody for just over a week before his death, there were few entries made in his prison record. He stated that he had no mental health history but had a history of drug abuse. When questioned about this on arrival at Birmingham and Woodhill, he said he had never had any thoughts of self harm or suicide. The CSRA and first night assessments were completed with no concerns identified about his risk of self harm or suicide. All those who met him described him as seeming calm and he said he was "fine".

60. The man's mental state and risk of self harm or suicide was assessed by three healthcare staff on his arrival at the Birmingham – by a nurse, a prison doctor and a substance misuse doctor. None thought that he showed any signs of vulnerability. In addition, the man also saw a nurse, a member of the mental health team, who assessed that he gave no indication of mental illness and again said he had no thoughts of self harm or suicide.

61. On his arrival at Woodhill, the man was assessed by three healthcare staff, a nurse, a prison doctor and a further nurse. Again the man reiterated that he had no thoughts of self harm and none of these staff thought he displayed any signs of vulnerability.

62. We have considered whether staff should have opened an ACCT plan on the man's arrival in custody, particularly given the nature and high profile of his offences. Staff judgement is fundamental to the ACCT system. At its core, the system relies on staff using their experience and skills, as well as local and national assessment tools, to determine risk. It is not an exact science.

63. However, it is a concern that little account seems to have been taken of all the risk factors relating to the man, such as being a foreign national, the profile and seriousness of the charges against him and the possible consequences of being found guilty and the fact that he was withdrawing from heroin.

64. Some of these risks and triggers are set out in Prison Service guidance (PSO 2700, replaced by PSI 61/2011 since April 2012) and should always be taken into account when assessing the risk a prisoner might pose to themselves, rather than relying solely on personal presentation.

65. It was an omission not to include these factors explicitly in the assessment that was made in relation to the risk of self harm and suicide. We accept that the man consistently denied any thoughts of self harm or suicide when asked directly about this and his behaviour and demeanour gave no indications otherwise. While this might not have changed the conclusion, staff did not appear to make a fully informed assessment of the man's risk by considering and balancing all the known risk factors when reaching their decision about the risk of him harming himself. We therefore make the following recommendation:

The Governor should ensure that staff take account of all potential risks and triggers in line with PSI 64/2011, when assessing a prisoners risk of self harm or suicide.

Integrated Drug Treatment System (IDTS)

66. The clinical reviewer has carefully considered the care given to the man for his opiate detoxification and made the following comments:

> "[The man] admitted to being a regular user of heroin, which he injected into his veins. The normal treatment for detoxification from heroin is commencement of Methadone, a heroin substitute. Treatment with Methadone is monitored for compliance and suitability and was the appropriate drug to treat [the man].
>
> "[The man] was seen by medical staff trained in the treatment of heroin addiction at both HMP Birmingham and HMP Woodhill. Both doctors involved agreed on his treatment plan: the prescription of Methadone at a certain level with a plan to reduce the amount in line with established treatment protocols for this drug. Urine samples were taken at HMP Woodhill to ensure that [the man] was taking the drug as prescribed and given to him, and these showed that he was complying with treatment.
>
> "Although detoxification from heroin addiction can be a long and difficult process, [the man] raised no concerns about how he was feeling whilst on the medication. He reported no side-effects and at no time did any health or prison officer report any concerns about his general state of health or about his mental state."

67. Prison Service Instruction (PSI) 45/2010 'Integrated Drug Treatment System' details the mandatory requirements for prisons to support and facilitate the delivery of IDTS. In respect of the location of prisoners placed on detoxification programmes the PSI states:

> "Local prisons must be able to offer immediate access to clinical services as described in the Clinical Management of Drug Dependence in the Adult Prison Setting (DH 2006) whenever there is a clinical need. This means that all drug or alcohol dependent prisoners arriving in Reception must always be offered immediate admission to a stabilisation unit."

68. In this man's case, when he arrived at Woodhill on a drug detoxification programme, he should have been allocated to the detoxification unit for ongoing assessment and support. Woodhill's "Local Operating Procedure for the Substance Misuse Service" states:

> "For the first 5 days, prisoners will be located on the 1's or ground level of the Stabilisation Unit; where possible, to allow maximum observations by nursing staff who will be located in the nurses station. Should a prisoner not be suitable for this location; alternative locations will be considered and outreach clinicians will ensure their needs are met."

69. We have been unable to establish why the man was not allocated to the Stabilisation Unit, but it is important that someone in the early stages of detoxification is appropriately monitored and supported. It is not possible to know how this affected the man but we consider the failure to accommodate him in a supported location in the detoxification wing was an omission by staff at Woodhill.

The Governor and Head of Healthcare should ensure that prisoners withdrawing from drugs and alcohol are supported in the prison's stabilisation unit for at least the first five days of their detoxification.

Medical record keeping

70. The importance of maintaining accurate and contemporaneous medical records is a frequent issue raised in our reports. There were no recorded follow up checks of the man after he had been seen by the prison doctor. Woodhill's "Local Operating Procedure for the Substance Misuse Service" details the routine nursing observations for a prisoner placed on opiate detoxification as:

> "That all prisoners as requiring treatment for opiate dependence are titrated and stabilised over a 5 day stabilisation period using either Methadone or Buprenorphine, with clinical observation to include withdrawal and intoxification monitoring at least twice a day.
>
> "Those stimulant users, who report recent stimulant use and who are screened by a toxicology test, have twice daily blood pressure, pulse and pupil light responsiveness testing for the first 72 hours of their custody, or until all observations are within national limits."

71. The man saw nurses once a day to be issued with his prescribed methadone, and the nurses signed the prescription chart to confirm it had been issued. There were no other recorded observations made in accordance with Woodhill's "Local Operating Procedure for the Substance Misuse Service". We make the following recommendation:

The Head of Healthcare should ensure that all healthcare staff accurately and contemporaneously record actions in clinical records, in accordance with the required standards of the General Medical Council and the Nursing and Midwifery Council.

Emergency response

72. The staff response to the man's need for assistance was swift and professional. Staff correctly commenced CPR and an automatic external defibrillator was used. As the man did not have any cardiac rhythm, there were no instructions to shock him during the CPR.

73. Staff continued with CPR until the paramedics arrived and took over the man's care. Following their assessment and treatment, the prison doctor confirmed

that he had died. The clinical review commented on the attempt to resuscitate the man as follows:

> "The prompt response of prison staff to the discovery of [the man] hanging in his cell, backed up by the quick arrival of health staff, ensured that CPR was started as soon as possible. The attempt carried on uninterrupted until a clinical decision was made by appropriately trained professionals to stop the attempt to revive [the man].
>
> "Given the speed of the response to his discovery, it would appear that [the man] had been dead for long enough by then to make any attempts to revive him futile."

74. Even though the man could not be revived, we believe that the emergency response by staff at Woodhill was appropriate and that everything possible was done to try and revive him.

Letter and note found in the man's cell

75. When the police searched the man's cell immediately following the incident, officers found two handwritten documents one signed and dated 28 January, the other undated and not signed. Both were written in Lithuanian.

76. The letter the man had written to his sister ended with him saying that he had tried to take his own life for the previous five days but had found it very hard to do.

77. The other undated note contained a request to see a doctor because the man said he had psychological problems. He went on to explain that he had spoken to a nurse, described only by gender and ethnicity, who had informed him he would be able see the doctor next week.

78. The investigation has not been able to establish whether the man did actually speak to a nurse, when this might have taken place or identify the nurse. There is nothing in his clinical record to indicate such a discussion and no appointment or referral to a doctor had been made.

CONCLUSION

79. The man was in prison for 10 days before taking his life. He gave no indication to staff that he was thinking of doing so. He did not have a history of mental illness and repeatedly stated that he had no thoughts of harming himself. Staff at the prison acted on what the man told them and how he presented. However, they did not adequately consider his other risk factors, for example that he was a foreign national prisoner facing a double murder charge of some notoriety and he was withdrawing from a dependency on heroin. We are not satisfied that the assessment of his risk of self-harm or suicide fully took into account all the information available.

80. After a satisfactory initial health assessment, the care that was provided in relation to the man's drug dependency did not meet the standards set out both by the Prison Service and in Woodhill's own detoxification operating procedure. The investigation concludes that he was not sufficiently supported at a critical time during detoxification.

81. When the man was found hanging, staff responded swiftly and professionally, but it was not possible to revive him.

RECOMMENDATIONS

1. The Governor should ensure that staff take account of all potential risks and triggers in line with PSI 64/2011, when assessing a prisoners risk of self harm or suicide.

   Accepted
   Since the publication of PSI 64/2011 and the introduction of the new Safer Custody training there is an ongoing training plan in place to cover this point. A Staff information notice has been compiled to raise staff awareness of potential risks and triggers, and is due to be published shortly

2. The Governor and Head of Healthcare should ensure that prisoners withdrawing from drugs and alcohol are supported in the prison's stabilisation unit for at least the first five days of their detoxification.

   Accepted
   All prisoners withdrawing from drugs and alcohol are located within the stabilisation unit for at least their first five days with the exception of prisoners located directly to Healthcare, Segregation or prisoners who are classified as Young Offenders and those on Rule 45.

3. The Head of Healthcare should ensure that all healthcare staff accurately and contemporaneously record actions in clinical records, in accordance with the required standards of the General Medical Council and the Nursing and Midwifery Council.

   Partially Accepted
   The issue in the report is regarding the lack of observations carried out – not that they were carried out and not recorded.

   To ensure that observations are carried out as indicated by clinical need a number of actions are being followed through. All prisoners requiring a period of stabilisation have twice daily vital signs and sleep monitoring as a minimum for at least a 5 day period. Other observations are carried out determined by assessed need and documented. All observations are documented on TPP with hard copies of clinical assessment tools available in the event of not being able to access electronic notes (to then be entered onto the system as soon as possible).