PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent investigations

A Report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

**Investigation into the death of a man at HMP Woodhill in May 2013**

## *Our Vision*

*‘To be a leading, independent investigatory body,*
*a model to others, that makes a significant contribution to*
*safer, fairer custody and offender supervision’*

This is the investigation report into the death of a man at HMP Woodhill who was found hanging in his cell in May 2013. He was 28 years old. I offer my condolences to his family and friends.

A clinical reviewer reviewed the clinical care the man received at Woodhill. The prison cooperated fully with the investigation.

The man had been recalled to prison on 24 May, after being released on licence from a previous prison sentence. He was also charged with a further serious offence. Prison and healthcare staff did not consider these risk factors when assessing him in reception and concluded that he was not at risk of suicide or self-harm. Several days later, at about 5.00am, his cellmate found him hanging and raised the alarm. The officer who responded did not go immediately into the cell and an ambulance was not requested until ten minutes after he was found. Officers attempted resuscitation, but paramedics pronounced him dead at 5.52am, shortly after they arrived.

I am concerned, as we previously found at Woodhill, that too much emphasis was placed on personal presentation when assessing the man's risk of suicide and self-harm in reception rather than balancing all the known risk factors. The emergency response was delayed and Woodhill did not have a protocol in place as they were required to do, giving guidance to staff about the use of emergency codes to ensure an ambulance is called automatically in a life threatening situation. It is a serious concern that this is a matter I have raised with the prison before, but Woodhill appears to have been reluctant to comply with national instructions about emergency procedures. Sadly, in this case it seems unlikely that a swifter response would have saved him but in other incidents this could be crucial.

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

**Nigel Newcomen CBE**
**Prisons and Probation Ombudsman** **March 2014**

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## SUMMARY

1. The man was recalled to prison on Friday 24 May 2013 and charged with a further offence of armed robbery. He told reception staff at HMP Woodhill that he had no thoughts of harming himself or of suicide and he had no history of self-harm. There is no record that reception staff considered that he was an increased risk of suicide or self-harm as a recalled prisoner and because he was charged with a serious violent offence.

2. The man was interviewed by officers and assessed by healthcare staff in the first night centre, and again the next day when he moved to the induction unit. He repeated that he had no thoughts of harming himself and again there is no record that anyone considered whether his circumstances increased his risk of suicide or self-harm.

3. The man shared a cell with a cell mate, who told the investigator that the man had said he was innocent of the charges against him and that he was upset to be back in custody, but the cell mate did not think he appeared suicidal. During a telephone call to his partner on the evening of 24 May, he told her he was upset and frustrated about being back in prison. He said he could not handle a visit from her and that she would not hear from him again.

4. One morning a few days later, the man's cell mate woke up at about 5.00am and saw him on the floor with a bed sheet around his neck. He immediately pressed the cell bell to call staff. The officer who responded waited for others to arrive before going into the cell at about 5.04am. An ambulance was not called for another six minutes. Resuscitation was attempted, but at 5.52am paramedics pronounced him dead.

5. The investigation identifies some concerns about the assessment of the man's risk of self-harm and the emergency response about which we make three recommendations.

## THE INVESTIGATION PROCESS

6. The investigator issued notices informing staff and prisoners at HMP Woodhill of the investigation and asking anyone who had relevant information to contact her. No one responded.

7. Another investigator visited Woodhill on 28 May and spoke to the man's cell mate, obtained copies of his relevant prison records and medical record. NHS England appointed a clinical reviewer to review the man's clinical care in prison.

8. The investigator visited Woodhill on 10 July and interviewed prison staff.

9. The investigator informed HM Coroner for Buckinghamshire of the investigation. A copy of the report has been sent to the Coroner to assist his enquiries.

10. One of the Ombudsman's family liaison officers contacted the man's mother and partner to explain the purpose of the investigation. The man's mother wanted clarification about how her son had died.

11. The man's partner identified one factual inaccuracy in the draft report. He was released from Dovegate prison in September 2012 and not Sudbury prison. This report has been amended accordingly. The prison did not identify any factual inaccuracies.

12. After the draft report had been issued a prisoner spoke to a member of Her Majesty's Inspectorate of Prisons (HMIP) and offered further information about the man's death. As a result the Coroner was informed and the inquest postponed until the investigator made further enquiries.

13. The investigator carried out a telephone interview with the prisoner on 13 February 2014. He said that he had heard the man tell a prisoner officer that he did not feel safe and might harm himself. He alleged that the officer replied that it was time for him to be locked in his cell, and took no action.

14. The investigator carried out a telephone interview with the officer on 26 February 2014. The officer said that he had not had this conversation with the man, that he had not spoken to him at all and that he did not recall locking him in the cell that afternoon.

15. Given the conflicting accounts given by the prisoner and the officer, the investigator was unable to take the investigation any further.

## HMP WOODHILL

16. HMP Woodhill has the dual role of a local prison and a high security prison and can hold more than 800 prisoners. It takes adult male prisoners and young offenders from the Magistrates' and Crown courts in the Milton Keynes area and also holds category A prisoners (prisoners regarded as a high risk to the public should they escape). It has a close supervision centre housing prisoners whose behaviour is especially complex or challenging. There is also a unit for protected witnesses.

17. Central and North West London NHS Foundation Trust commissions health services at HMP Woodhill.

### Her Majesty's Inspectorate of Prisons

18. The most recent inspection of HMP Woodhill was an unannounced inspection in January 2012. The Inspectorate found that the number of self-harm incidents had risen considerably over the previous 12 months and a number of procedures aimed at supporting those in crisis were just adequate.

19. The Inspectorate reported that all new prisoners went to the dedicated first night centre and their vulnerability was assessed. Prisoners got a free telephone call on their first night, except when there were public protection concerns. The Inspectorate found that first night accommodation was well prepared by appointed prisoners, who were available to talk to new prisoners.

### Independent Monitoring Board

20. Each prison in England and Wales has an Independent Monitoring Board (IMB) made up of unpaid volunteers from the local community who oversee all aspects of day-to–day life in prison to help ensure that prisoners are treated fairly and decently.

21. In its 2012 annual report, the IMB noted that the Safer Custody team at the prison produced in-depth documentation and statistics which were reviewed monthly at combined Safer Custody/Violence Reduction meetings. Trends were investigated and potential solutions put in place.

22. The IMB reported that there had been two apparent self-inflicted deaths at the prison during the reporting period. The IMB considered that prisoners, staff and families were given appropriate support after the deaths.

### Previous deaths at HMP Woodhill

23. Since 2012 there have been five deaths at Woodhill, three were self-inflicted deaths by hanging. The other two prisoners died from natural causes. Following the death of a prisoner in January 2012, we made a recommendation about assessing a prisoner's risk of self-harm, similar to the recommendation we make in this report. In another investigation, we were also concerned about delays in calling an emergency ambulance.

## KEY EVENTS

### Friday 24 May 2013

24. The man was released on licence from Dovegate prison in September 2012. On Friday 24 May, 2013 at about 6.00pm he arrived at HMP Woodhill after being recalled to prison and charged with an offence of armed robbery. His Person Escort Record (PER) for the journey from Crown Court to Woodhill did not identify any risk factors. There is no record that anyone in the prison's reception area asked him about the charges he was facing or noted that he had had his licence revoked and been recalled to prison.

25. At his initial assessment, a nurse noted that the man had no thoughts of harming himself or of suicide, although he appeared sad and had poor eye contact. The nurse only had the PER and reception records, which had no record of what he was charged with and he did not ask him about this. He said he knew that he had been in prison before, but there is no record that he knew he had been recalled or discussed this with him. The nurse told the investigator that he did not have time to look at the man's previous records on SystmOne. He said that he was unhappy about returning to prison. The nurse noted no mental health problems. He would not give his next of kin contact details and declined to see a doctor. The nurse concluded that he was not at risk of self-harm.

26. The man then went to the first night centre where all new prisoners initially stay. As part of routine first night procedures a Listener (a prisoner trained by the Samaritans to provide confidential support to other prisoners) asked him if he wanted to talk to him, but he did not.

27. An officer chatted to the man that afternoon on the induction wing and she jotted down the details of their conversation. An operational support grade (OSG) entered the details into his case history notes retrospectively at 8.38pm. (The notes misleadingly read as if it was the OSG who had spoken to him, which is bad practice.) The entry read:

> "He informed me he was released from HMP Sudbury last year after serving a six year sentence. Seemed shell-shocked to be sent back to prison. Polite and courteous with good eye contact. No thoughts of suicide or self-harm. Seen by a Listener. All support systems explained. Purchased one smokers' pack. Had reception phone call. Declined a shower. No outstanding issues at this time."

28. The man telephoned his partner just before 8.00pm. His partner said she wanted to visit, but he said it was too much and that he could not deal with it. His partner asked for further details about the charges he was facing so they could begin his defence. He said that he had no money and that she would not hear from him again. She told him that she loved him. He again told her not to visit him. (The call was not monitored at the time, but transcribed after his death.)

**Events leading up to the incident**

29. The man completed the second day of his induction in the first night centre. He raised no issues and collected his phone account details. A member of the chaplaincy team saw him and recorded no concerns. An officer spoke to him again and recorded in his case history notes that he was a recalled prisoner with further charges, but there were no additional concerns. She did not indicate whether she had considered this meant he was an increased risk. She said that he was polite during their conversation and said he had no thoughts of harming himself.

30. That afternoon, a nurse carried out a secondary health screen. He told the nurse that he had no intention of harming himself and the nurse recorded that he had no concerns about him or his mental health.

31. An officer spoke to the man that afternoon during his induction. He said he had no thoughts of self-harm or suicide and the officer explained all the support services available to him. He moved to the induction unit, where he shared a cell with another prisoner. When he got to the cell, his cell mate agreed that the man could have the bottom bunk bed because he had a bad back. A little later, he wrote two letters and his cell mate said the man asked him to remind him to post them the next morning.

32. There was little else recorded that day as it was a weekend with a limited regime. The cell mate said they spent the afternoon and evening chatting and watching television. He said the man seemed fine, chatty and normal, except he seemed upset that had been recalled for no reason, and had said that he was innocent of the charges. He said that the man spoke about his partner and his plans for opening a business when he got out of prison.

33. The cell mate said he woke up at about 5.00am as it was beginning to get light. The television was still on. As he sat up, he saw that the man was slumped on the floor, in the corner of the cell below the window, with a ripped bed sheet around his neck. It appeared that the sheet had snapped from around the top bunk. He could see that his eyes had rolled back into his head. He immediately pressed the cell bell.

34. Officer A was the only officer working on the unit that night and responded to the bell. (He said there would normally be two officers on the unit but the officer had been redeployed because of staff shortages.) When he arrived at the cell, he said the cell mate appeared very upset, shouted to be let out and said he thought the man was dead. The officer could see him lying on the floor at the back of the cell, with what appeared to be a piece of material around his neck.

35. The officer immediately radioed for urgent assistance. He did not go into the cell. He said he called an urgent message rather than an emergency medical response code, as he was unsure what to do. He told the investigator that he had not thought it was safe to go into the cell because he was on his own. It took approximately four minutes for other prison staff to arrive. A Supervising

Officer (SO) and a Custodial Manager (the night manager responsible for the prison), arrived at 5.04am, closely followed by another SO.

36. Officer A told the first SO that a prisoner was unresponsive on the floor. The SO looked through the observation panel in the door and then opened it immediately. The cell mate, who was clearly distressed, ran out of the cell and the second SO tried to calm him down.

37. The first SO, who was first aid trained, found the man lying on his side at the back of the cell with a bed sheet around his neck. His legs were bent around the end of the bunk bed, his lips were blue and his eyes were slightly open. He cut the sheet with his anti-ligature knife but could get no response from him. He asked if anyone had a resuscitation mask on them, but nobody did. He asked for a defibrillator to be brought and began cardiopulmonary resuscitation (CPR). A SO radioed for healthcare staff to attend the cell.

38. A nurse said she heard a radio request for healthcare staff to attend House Unit One but there was no emergency code so she did not know what kind of incident it was. She picked up an emergency response bag and hurried to the House Unit. The bag contained a defibrillator (there are also defibrillators on each unit), oxygen and medication.

39. A SO gave another officer, who had responded to the emergency call, the keys to unlock the gates to the unit so the nurse could get to the cell. The SO continued CPR for two cycles until the nurse arrived. The nurse noticed that the man had a cut on the left side of his neck and on his left wrist. The cuts appeared superficial and the blood had clotted. The nurse noted that he was unresponsive, unconscious and not breathing. He had no pulse, his pupils were dilated and he looked blue around his mouth. The SO straightened his legs and cut away his shirt while the nurse inserted an oral airway and administered oxygen.

40. The SO attached the defibrillator to the man's chest, which advised that no shock was required, so he and the nurse continued CPR. The nurse advised that they should stop the resuscitation attempt, because she believed he had died. However, the SO continued until the paramedics arrived.

41. The second SO telephoned a third SO in the prison's control room to confirm that they were dealing with a serious incident and gave him the man's details. The third SO requested an ambulance at 5.10am and then went to the gate area to ensure the ambulance was admitted without any further delays.

42. Ambulance records show that the paramedics arrived at the prison at 5.17am, although the third SO noted in the prison's incident log that this was 5.14am. The paramedics noted that there was a delay entering the prison as they had to go through the security department. They arrived at the cell at 5.20am, between three and six minutes after they arrived. When they got to the cell, the man was lying on the floor with a defibrillator attached to his chest and the first SO was administering chest compressions and breaths.

43. The paramedics assessed the man. He was not breathing and they could not detect a pulse. His pupils were fixed and dilated. The paramedics took over chest compressions, removed the defibrillator and attached their own machine. They also administered adrenaline. Two SOs understood that the paramedics had said that he was alive, so one SO began to make arrangements for him to be taken to hospital. However, he remained unresponsive and, at 5.52am, the paramedics pronounced him dead.

44. Two letters were found in the man's cell, addressed to his partner and his is mother in which he had said that he intended to kill himself.

**Prisoner support**

45. The cell mate was taken to a different cell in the first night centre. He spoke to a Listener and was supported under suicide and self-harm monitoring measures as he was clearly distressed and staff were concerned about him. Prison staff reviewed all prisoners assessed as at risk of suicide or self-harm and reminded them of the support available to them.

**Staff support**

46. Officer A continued with his duties and completed a roll check of the unit that morning. A residential manager held a hot debrief later that morning and all the staff involved were offered the support of the care team.

**Family liaison**

47. Two staff were appointed the prison's family liaison officers. The man's family lived in Birmingham, and Woodhill asked that a member of staff from HMP Birmingham should visit his family and notify them of his death, although Woodhill is only 70 miles away. This was done but there is no note of what time the visit took place or who attended.

48. Later that day at 3.35pm, after the man's family had been told the news, a FLO spoke to the man's mother and arranged to visit on 29 May. At this visit, both FLOs explained their role, offered the opportunity for the family to visit the man's cell (which they accepted) and spoke about funeral costs.

49. The prison offered to pay towards funeral costs, in line with national guidance. Three members of prison staff attended the funeral on 12 June.

**Post-mortem report**

50. A post-mortem examination indicated that the man had died from hanging. The pathologist found external and internal injuries which were entirely consistent with fatal ligature compression of the neck.

51. The man also had a number of cuts on his neck legs and wrists, which the pathologist concluded were common sites for self-injury. A toxicology report was not available as an insufficient amount of blood was taken for analysis.

## ISSUES

### Clinical care

52. The clinical reviewer found that the clinical care the man received while he was at HMP Woodhill was equivalent to the care he could have expected to receive in the community.

### Assessment of risk

53. At his initial health screen with the nurse, the man said he had no thoughts of harming himself. However, the nurse said that the only historical information he had to work from was the PER and reception notes in front of him. These did not contain any information that he had been recalled to prison from a previous sentence and was facing further serious charges for an alleged violent offence, although he told the nurse that he had been in prison before. The nurse said that because of the number of prisoners who need to be assessed in reception, and the time constraints, he did not have time to look at his past records.

54. None of the staff who saw the man during reception or during his induction period expressed any concerns about him or his risk of suicide and self-harm. No one noted that the fact that he was had been recalled to prison and was charged with a further serious violent offence increased his risk.

55. Prison Service Instruction (PSI) 64/2011 – Safer Custody, outlines different risk factors associated with suicide and self-harm. The man should have been identified as at possible heightened risk of suicide and self-harm because he was in the early stage of custody, had been recalled to prison for breach of licence and was charged with a serious violent offence. There is no evidence that these risk factors were considered in assessing his risk of suicide or if they were, what weight was given to them. The records merely reflect that he said he had no thoughts of suicide or self-harm and that his presentation caused no concerns.

56. We cannot conclude that suicide and self-monitoring should definitely have begun had these factors been considered, but it is a concern that they do not seem to have been taken into account. A prisoner's presentation is obviously important and reveals something of their level of risk. However, it is only a reflection of their state of mind at the time and should be considered as a single piece of evidence used to make a judgement of risk. All risk factors must be collated and considered to ensure that a prisoner's level of risk is holistically judged. We make the following recommendation:

**The Governor should ensure that all the known risk factors of a newly-arrived prisoner are fully considered when determining their risk of self-harm or suicide.**

## Emergency response

57. Officer A did not go into the man's cell immediately the alarm was raised because he was working alone and did not feel it was safe to do so.

58. The prison's instructions for night patrol routines and duties says:

> "A sealed pouch containing a cell key is issued to enable staff to respond quickly to open a cell door if it is thought that a prisoner's life is in danger. The sealed pouch must be held on a key chain and securely attached to the person. Night staff must be careful when opening a cell door on their own and must always consider the possibility that the incident is not genuine."

59. Officer A waited for assistance before going into the cell, although it was apparent at that stage that the man was unresponsive and the officer understood that the situation was potentially life-threatening. He said that he would have gone into the cell if the man been in a single cell, or if he had been accompanied by another colleague. However, he considered that there was too great a security risk if the incident was not genuine. Staff have a responsibility to place the preservation of life above security concerns where this would not put themselves or others in unnecessary danger. We accept that the officer made a reasoned assessment not to open the cell but we are concerned that when an officer is alone at night in the first night centre, a high risk area, such an assessment is likely to be repeated. It was four minutes before other staff arrived which would be crucial in some incidents where an immediate response is necessary. We are concerned that the first night centre did not have two staff on duty as detailed and that this could impact on prisoner safety. We make the following recommendation.

    **The Governor should ensure that there are sufficient numbers of staff on duty at night in the first night centre to enable effective responses to emergencies.**

60. Officer A did not use an emergency response code when the man was found unresponsive but radioed for urgent assistance from other staff. This meant that they were not alerted to the nature of the emergency. Two supervising officers and a custodial manager arrived after four minutes but an ambulance was not called until six minutes later - 10 minutes after the man was found. This was an unacceptable delay and a matter we have raised with Woodhill previously. Ambulance Service records indicate that there were then further delays of several minutes getting into the prison.

61. PSI 03/2013 was issued at the beginning of February 2013 and governors were required to have a medical emergency response code protocol based on the instruction by 28 February 2013. This should instruct staff how to communicate the nature of a medical emergency using agreed emergency codes and ensure that the control room calls an ambulance automatically as soon as an emergency code is called.

62. It is a serious concern that Woodhill had not complied with the mandatory requirement of PSI 03/2013 to ensure that all staff had clear guidance about what to do in a medical emergency. Neither did the staff involved follow previous guidance issued by the Chief Executive of the National Offender Management Service in February 2011, which we have previously drawn to Woodhill's attention, which was to ensure that an ambulance was called quickly whenever there were serious concerns about the immediate health of a prisoner.

63. Belatedly, after the man's death a Governor's Order (64/13) was issued on 30 May 2013, setting out a protocol for staff to follow when responding to a medical emergency. We are not satisfied that the protocol is compliant with PSI 03/2013 as it requires the first person on the scene to call an emergency code and state that an ambulance is required rather than one being called automatically as soon as the emergency code is called. We make the following recommendation:

**The Governor should ensure that all prison staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies and that Woodhill has a Medical Emergency Response Code protocol which:**

- **Provides guidance to staff on efficiently communicating the nature of a medical emergency;**
- **Ensures staff called to the scene bring the relevant equipment; and**
- **Ensures there are no delays in calling, directing or discharging ambulances**

## RECOMMENDATIONS

1. The Governor should ensure that all the known risk factors of a newly-arrived prisoner are fully considered when determining their risk of self-harm or suicide.

2. The Governor should ensure that there are sufficient numbers of staff on duty at night in the first night centre to enable effective responses to emergencies.

3. The Governor should ensure that all prison staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies and that Woodhill has a Medical Emergency Response Code protocol which:

    - Provides guidance to staff on efficiently communicating the nature of a medical emergency;
    - Ensures staff called to the scene bring the relevant equipment; and
    - Ensures there are no delays in calling, directing or discharging ambulances

**ACTION PLAN: The Man - HMP Woodhill – May 2013**

| No | Recommendation | Accepted/Not accepted | Response | Target date for completion and function responsible | Progress (to be updated after 6 months) |
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| 1 | The Governor should ensure that all the known risk factors of a newly-arrived prisoner are fully considered when determining their risk of self-harm or suicide. | Accepted | All prisoners are screened when they enter the establishment. Information is sourced from the PER, 2050 if available (the man was a licence recall and his record was at HMP Sudbury), C-Nomis and any other information received from the Police via the escort contractor.<br>In addition, any prisoner who has had their licence revoked will have their C-Nomis history live available when they are admitted into reception. This will now form part of our initial screening. The process includes a series of interviews in both Reception and the First Night Centre with both discipline and healthcare staff. At each stage, prisoners are asked if they feel suicidal or have any thoughts of self harm. Decisions on whether to place a man onto an ACCT are determined by the responses of the individual, supported by how the man presents at that time. Staff will use the ACCT process as appropriate. | 31 Dec 13<br><br>The Governor, FNC Induction unit<br><br>The Governor, Head of Reception | |
| 2 | The Governor should ensure that there are sufficient numbers of staff on duty at night in the first night centre to enable effective responses to emergencies. | Accepted | Discipline staffing is dictated by Specification and Benchmarking with levels determined by comparator prisons. Healthcare staffing is also determined by the local Health commission. These staffing levels are reviewed regularly and further resources committed through benchmarking will make available six officers available to respond to incidents throughout the night state. | May 2014<br><br>Governor, In Vision team. | |

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| 3 | The Governor should ensure that all prison staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies and that Woodhill has a Medical Emergency Response Code protocol which:<br><br>a) Provides guidance to staff on efficiently communicating the nature of a medical emergency;<br><br>b) Ensures staff called to the scene bring the relevant equipment; and<br><br>c) Ensures there are no delays in calling, directing or discharging ambulances | Accepted | A Staff information Notice has already been produced, but this will be further updated with amendment as recommended in discussions with Prison and Probation Ombudsman and Safer Custody Department, this will then be republished.<br><br>Due to safer custody conducting a further investigation of staff information notices upon receipt of draft copy of PPO report on the 07-02-2014, it has been confirmed that staff a information notice 044/2013 was published on the 20-02-2013 in response to a copy of PSI 03/2013 which was issued on the 1st February with an effective date of the 28th February. 2013. Which clearly implemented a code RED and Code Blue system from its date of issue which contained guidance for all staff dealing with a medical emergency. | Completed<br><br>SIN 044/13 was published on 20th February 2013 informing all staff of the requirements contained within PSI03/2013 which had an effective date of 28/02/2013.<br><br>SIN 360/13 was published on the 29.11.13 and a reviewed notice sent for publishing on the 23-12-13.<br><br>After further discussions with PPO and listening to various recommendations of interpretations, a further review was conducted and a final draft notice was published on the 09-01-2014.<br><br>Responsible group Safer Custody Department. | |