



A Report by the
Prisons and
Probation
Ombudsman
Nigel Newcomen CBE

**Investigation into the death of a man in April 2014
at HMP Woodhill**

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, who was found hanged in his cell in the segregation unit at HMP Woodhill in April 2014. He was 32 years old. I offer my condolences to his family and friends.

A clinical review of the care the man received at Woodhill was undertaken.

The man was released on licence from a prison sentence on 14 August 2013, but did not report to the Probation Service as he was required to do. He was recalled to prison two days later and taken to HMP Woodhill. At Woodhill, he received methadone treatment for opiate dependency and was under the care of the prison's mental health team and a psychiatrist. He had a history of self-harm but frequently told prison staff that he did not want to harm himself. In January 2014, his mother reported that he had mentioned having suicidal thoughts in a telephone conversation and staff monitored him informally. Staff later supported him under Prison Service suicide and self-harm prevention procedures for two short periods. He continued to maintain that he had no intention of harming himself.

On 29 March 2014, the man was taken to the segregation unit after he became violent and abusive to staff. Three days later, staff in the unit became concerned about his state of mind after he appeared to exhibit paranoid behaviour. A mental health nurse and psychiatrist conducted emergency assessments and on 2 April, concluded that he was fit to remain in the segregation unit. The psychiatrist prescribed antipsychotic medication and planned to review him a week later and continue the medication if beneficial and, if not, to consider referring him to a secure psychiatric hospital. One morning a few days later, a segregation unit officer found him hanged in his cell. Although there was a slight delay in calling an ambulance, this did not delay the emergency response and prison staff quickly began to attempt resuscitation. Paramedics also arrived quickly, but despite all efforts, he could not be revived.

I agree with the findings of the clinical reviewer that the man received a good standard of physical and mental healthcare at the prison. The investigation found that the operation of some aspects of the Prison Service suicide and self-harm prevention procedures, could have been better, including beginning support procedures as soon as his mother reported concern and more effective involvement of healthcare staff in case reviews for prisoners at risk. However, despite his apparent deterioration in mental health in the days before his death, a psychiatrist did not consider he was at risk of suicide and I consider it would have been difficult for prison staff to have predicted or prevented his actions. While it does not appear that it would have affected the outcome for him, I am concerned that an ambulance was not requested immediately an emergency was called as national instructions require. In other emergencies, a delay of even a few minutes 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

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SUMMARY

1. The man was released from prison on licence on 14 August 2013. His licence was revoked almost immediately as he failed to report to his offender manager after his release. He was recalled to prison two days later. When he arrived at Woodhill, he was angry about being recalled to prison but said he had no thoughts of suicide or self-harm. During the next few months, he was under the care of the substance misuse and mental health teams. A visiting psychiatrist reviewed him periodically.
2. On 28 January 2014, the man's mother notified the prison that he had told her that he wanted to hang himself. A supervising officer discussed this with him at length, but did not begin Prison Service suicide and self-harm prevention procedures, known as ACCT; instead, he asked staff to monitor him informally. Two days later, wing staff found him crying, with a razor blade in front of him and then opened an ACCT. He was worried about his father's health and other family problems, but said he would not harm himself and staff ended the ACCT monitoring on 4 February. Staff opened an ACCT again on 26 February, after he made an apparently superficial cut to the side of his neck. The ACCT was closed at a review the next day without any healthcare presence. He said that he had cut himself because he had not been allowed to use the telephone and had no thoughts of suicide or further self-harm.
3. At 8.30am on 29 March, the man threatened staff and was taken to the segregation unit. On 1 April, segregation staff reported that he was behaving strangely. A mental health nurse conducted an emergency health assessment and thought he might have had a psychotic episode, but his risk to himself was low. The next day, the nurse and a psychiatrist assessed him together. The psychiatrist prescribed antipsychotic medication, to be reviewed a week later and was satisfied that he was fit to remain in the segregation unit. He did not consider he was at risk of suicide.
4. One morning a few days later, an officer found the man hanging from a ligature attached to the window. He called an emergency code blue. The control room did not call an ambulance immediately but one arrived very quickly at 3.46am, after a manager requested one at 3.39am. Resuscitation attempts were unsuccessful and the prison doctor pronounced him dead at 4.18am.
5. The clinical review found that the man's physical and mental healthcare was equivalent to that he could have expected in the community. We consider that some aspects of ACCT procedures could have been more effective; staff should have opened an ACCT when his mother reported her concerns and mental health staff were not appropriately represented at ACCT case reviews. An ambulance should have been called immediately the emergency code was received. We make recommendations about these issues, but consider it would have been difficult for prison staff to have predicted or prevented his death.

THE INVESTIGATION PROCESS

6. On 7 April 2014, the investigator issued notices to staff and prisoners at HMP Woodhill, informing them of the investigation and inviting anyone with relevant information to contact him. No one responded.
7. The investigator went to Woodhill on 7 April and obtained copies of the man's prison and healthcare records. He visited the segregation unit and saw the cell he had occupied and spoke to staff there.
8. NHS England appointed a clinical reviewer to review the man's clinical care.
9. The investigator and clinical reviewer interviewed six members of staff at Woodhill on 27 February. After the interviews, the investigator gave the Governor written feedback about the initial findings of the investigation.
10. We informed HM Coroner for Buckinghamshire of the investigation and we have sent him a copy of the investigation report.
11. One of our family liaison officers wrote to the man's family on 8 May, to explain the role of the Ombudsman and the investigation process. Solicitors representing the family responded on 10 May, but identified no specific issues that they wanted the investigation to consider.
12. The man's family were sent a copy of the draft report. A response was received from the legal representatives for the family on 19 November 2014 asking additional questions, but no factual inaccuracies were raised. The questions raised have not altered the findings of the original report and have been dealt with in separate correspondence.
13. The Prison Service responded on 15 December 2014, and indicated that all recommendations made in this report have been accepted. A copy of the Prison Service Action Plan for addressing these has been attached.

HMP WOODHILL

14. HMP Woodhill has the dual role of a local prison and a high security prison and can hold more than 800 men. It takes prisoners 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.
15. Central and North West London NHS Foundation Trust provides health services at HMP Woodhill.

Her Majesty's Inspectorate of Prisons

16. The most recent inspection of HMP Woodhill was in January 2014. Inspectors found that the incidents of self-harm (double the average for a local prison) and the number of prisoners supported under suicide and self-harm prevention measures were high and the quality of documentation was poor, although prisoners reported feeling well cared for. There had been a large number of self-inflicted deaths at the prison and inspectors recommended that all Prisons and Probation Ombudsman recommendations should be implemented in full. Prisoners had access to a well-trained Listener team.
17. Inspectors reported that the mental health service had moved to an integrated primary and secondary mental health and learning disability service. Staffing shortages had had a serious impact on service delivery but there had been a consistent team of three mental health nurses, led by an experienced clinical manager. Waiting times for appointments had improved, although non-urgent referrals still took two to four weeks.

Independent Monitoring Board

18. Each prison in England and Wales has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its 2012-13 annual report, the IMB noted that incidents of self-harm were monitored and factors such as age and ethnicity examined.

Previous deaths at HMP Woodhill

19. The man's death was the sixth of seven deaths at Woodhill since 2013. In previous investigations at Woodhill we have been critical of the emergency procedures and we repeat a recommendation about calling ambulances immediately in response to emergency codes.

Assessment, Care in Custody and Teamwork (ACCT)

20. ACCT is the Prison Service process for supporting and monitoring prisoners at risk of harming themselves. The purpose of the ACCT is to try to determine the level of risk posed, the steps that might be taken to reduce this and the extent to which staff need to monitor and supervise the prisoner. Checks should be at irregular intervals to prevent the prisoner anticipating when they will occur. Part of the ACCT process involves assessing immediate needs and drawing up a caremap to identify the prisoner's most urgent issues and how they will be met. Regular multi-disciplinary reviews should be held. The ACCT plan should not be closed until all the actions of the caremap have been completed. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

KEY EVENTS

21. The man was convicted of burglary and sentenced to three years imprisonment in November 2010. In March 2012, after assaulting two prison officers, he was convicted of actual bodily harm and sentenced to a further two years nine months, to run concurrently with his earlier sentence. He was released on conditional licence from HMP Liverpool on 14 August 2013.
22. One of the man's licence conditions was to report directly to his supervising probation officer after his release. He failed to do so and his licence was immediately revoked as a result. The police arrested him and he was recalled to HMP Woodhill on 16 August 2013. His escort record noted a number of risk alerts including, cutting and swallowing as a means of self-harm in 2010/2011; violence; heroin use in 2005; and setting fire to his cell in 2009.
23. Over the next two days, the man had a number of health assessments, including detailed alcohol and mental health screens and a GP review. He had a history of heroin and cocaine misuse and the reception nurse referred him to the substance misuse team. He told all the prison and healthcare staff involved in the reception and induction procedures that he had no thoughts of suicide or self-harm.
24. At his first night interview, the man said that he had only been out of prison for one day and was annoyed about the reasons for his recall. He was allocated a cell in the prison's specialist substance misuse unit, where he was assessed and monitored for signs of withdrawal. He was dependent on opiates and the prison continued an existing prescription for methadone as part of a methadone maintenance programme.
25. On 19 August, the man met his prison offender supervisor. He repeated that he was upset about being recalled and felt it was unwarranted as he had only been late for an appointment and had not behaved badly. He asked his offender supervisor to contact his offender manager in the community for further information about his recall.
26. The substance misuse team reviewed the man frequently as he complained that he did not feel he was being prescribed a high enough dose of methadone. He often requested additional pain relief medication, such as tramadol, but was advised that due to potential adverse reactions, this could not be prescribed while he was taking methadone.
27. The man's general behaviour in prison was regarded as poor and he received several warnings for inappropriate and threatening behaviour, as well as trying to conceal and divert controlled medication instead of taking it in sight of staff.
28. A visiting psychiatrist assessed the man on 24 October. He told the psychiatrist that before he went to prison he had been under the care of the community mental health team and had been diagnosed as having a multiple personality disorder, as

well as paranoid schizophrenia with psychotic tendencies. He said that he had experienced thoughts of suicide and self-harm in the past but no such current thoughts or intentions. His concern was about having violent thoughts about harming others.

29. On 5 November, the Parole Board notified the man that he would not be released from the recall and would have to continue to serve his sentence, which was due to end on 29 December 2014. His offender supervisor discussed offending behaviour programmes with him and told him that the Parole Board would review his case again in February 2014.
30. On 13 November, staff began monitoring the man under anti-bullying procedures as they had received information that he was bullying other prisoners for their medication.
31. On 28 November, the man asked a doctor from the substance misuse team, to increase his methadone as he had pain from a scald to his groin. The doctor advised him that it would not be appropriate and referred him to the primary care GP for advice on pain management.

2014

32. On 16 January 2014, the man told the psychiatrist that his concentration was better and he had felt more motivated since starting new medication for attention deficit hyperactivity disorder (ADHD). He added that he had some paranoia about other prisoners attacking him, and thought this might be a side effect. He asked the psychiatrist about medication to help him sleep. The psychiatrist advised that he could not prescribe long term sedative medication, but agreed to a two-week prescription for zopiclone (a medication to aid sleep) and planned to review him in three months.
33. On 28 January, the man's mother notified the prison that her son had telephoned her and had threatened to 'string himself up'. The information was passed to wing staff and a Supervising Officer (SO) spoke to him about what he had said. He said that he felt stressed as his father was in hospital. They discussed the ACCT process and the support available, but he said he did not feel that this was required. The SO did not begin ACCT suicide and self-harm prevention procedures, but he allowed him out of his cell to telephone his mother and take a shower and asked wing staff to monitor him informally for the next few days.
34. Two days later, on the evening of 30 January, wing staff found the man sitting at his cell table crying. He had a razor blade on the table in front of him and said he felt low. The officers removed the razor blade and began ACCT procedures. The next morning, a community mental health nurse assessed him. He told the nurse that he was 'not in a good place at the moment'. He was worried about his father who had suffered complications after major heart surgery and he found it difficult to contact his partner as she worked long hours. He was also angry that his Parole Board review had been postponed until the end of March. He said that he did not

feel that he was on the correct medication as he felt uptight and aggressive all the time and that he had not received medication the previous evening to help him sleep. The nurse told him that the prescription had expired as it had only been prescribed for two weeks. She said that in view of recent events, she would bring forward his next scheduled appointment with the psychiatrist. This was subsequently arranged for 4 February.

35. That afternoon, an officer completed an ACCT assessment. The man mentioned a number of problems, including complications after his father's heart surgery, his inability to contact him in hospital and his worry that his father would die. He said he had had an argument with his partner and had difficulties with other family members. He told the officer about his previous suicide attempts and self-harm in prison, including when his brother had died. He said he was helpless and stressed, unable to sleep and felt that the Ritalin he had been prescribed for ADHD had not had a good effect on him. He said he had no current suicidal thoughts and did not know whether he wanted to die. He did not want to be in prison but very much wanted a job while he was there. He asked for a pen to write letters.
36. After the assessment, a SO held his first ACCT case review which an officer also attended. There was no member of the healthcare team present which is a mandatory requirement. The SO recorded that the man's main concern was his father's health and that he would ask the chaplaincy team to contact his family on his behalf. The actions listed on the caremap were for him to address his anger issues and emotional thinking skills by completing the RESOLVE offending behaviour course starting on 27 January; apply for work; and increase his contact with his family, particularly in writing which would also be a form of therapy. His level of risk of self-harm was assessed as low. The next ACCT review was scheduled for 4 February.
37. On 3 February, the man told his offender supervisor that he was upset as his partner had told him that she was pregnant and the baby was not his. He said that he was also concerned about whether this might affect him using her address for his release. His offender supervisor advised him that he had done the right thing by telling him and he would pass the information to his community probation officer. He recorded that the man left the meeting in a good mood and was looking forward to a visit from his partner later that week.
38. The next day, a different supervising officer chaired the second ACCT case review. A drug worker from the Westminster Drugs Programme (who provide substance misuse support at Woodhill) and a nurse attended. They noted that he was very open and honest during the review and repeated some of his problems. He said he felt better and that he did not want to harm himself or die. He spoke about his future and the review team told him he had shown resilience in dealing with the issue about his partner. He said that he would never take his own life as his twin brother had recently been shot in the head and killed while serving in the forces and he would never put his family through that again. The review panel

closed the ACCT document and updated the caremap. (A post closure review was held on 9 February.)

39. The nurse noted in the man's medical record that he had begun his offending behaviour course, but had said that because of this he was unable to work or earn any money. The SO had offered try to find some wing-based work for him when he was not attending the course.
40. Later that afternoon, the man told the psychiatrist about his concerns about his partner and father and that he was now attending an anger management course as part of his pre-release plan. He said that he was scared of being released from prison and reported some anxiety about leaving his cell as well as poor sleep. The psychiatrist recorded he had been tearful at times, which had not happened before and had made numerous requests to be prescribed benzodiazepines (used to treat anxiety). The psychiatrist noted that he was already receiving clonazepam for epilepsy, ritalin for ADHD, pregabalin for pain relief and methadone. He therefore explained to him that some of his feelings were a normal reaction to receiving bad news as well as confronting his anger issues and previous offending and that taking medication to stop these feelings would be unhelpful. However, he agreed to prescribe another short course of medication to help him sleep.
41. After the psychiatrist declined to prescribe benzodiazepines, the man said that he could buy drugs in the prison, (which the psychiatrist cautioned him against) and that he had urges to throw himself over the railings. The psychiatrist noted that these comments were in response to his refusal to prescribe the additional medication.
42. The substance misuse team frequently reviewed the man's treatment. In mid February, he agreed to start reducing his methadone dose by 2ml each week.
43. At a review on 20 February, the man told the psychiatrist that he was struggling with the anger management course as it explored early life experiences. He hoped that after he completed the course, the next month, probation staff would support his release. The psychiatrist noted that he appeared irritable and angry towards prison staff. He felt that he had been unfairly treated as he had been placed on the basic level of the privileges scheme and was subject to closed visits (where the prisoner and his visitors are separated by a glass screen with no physical contact). He said that he was generally happy with his medication. His methadone had been reduced, but he again requested a long term prescription of sleeping tablets. The psychiatrist agreed to a further 28 day course while he was completing his offending behaviour work and planned a review in six weeks.
44. Prison records show that during the evening of 26 February, the man pressed his cell bell repeatedly and asked to use the telephone. An officer told him that as they were in patrol state (when all prisoners are locked in their cells and there are fewer staff on duty) he would not be allowed to leave his cell to use the telephone. The officer consulted the supervising officer, who reiterated this. He was then

recorded to have become threatening and abusive and said that he had previously assaulted staff who had refused to let him use the telephone.

45. At 7.25pm, the man pressed his cell bell again. The officer went to his cell and noticed that he had made a small superficial cut to the side of his neck. He said, 'Now you will have to open my door'. The officer did not open the cell, but opened an ACCT document and monitored him hourly.
46. At lunchtime the next day, 27 February, a nurse examined the man's wound. The same day, an officer completed an ACCT assessment. He had initially refused to speak to him and said he did not need ACCT support as he was able to deal with his problems. However, the officer Phillips and a SO eventually had a one hour discussion with him, who told them he had been frustrated the previous night as his partner had miscarried earlier in the day. He said he had cut his neck as he felt he had to carry through his earlier threats but he now felt far better and was slightly embarrassed by his actions. He reiterated that he could cope with his own problems and assured them he would speak to staff if needed to. He said he had no suicidal intentions and that he could not put his partner and mother through that. His reasons for living were recorded as his family and his parole review, which he would have after completing his course.
47. After the assessment, the SO held a first ACCT case review, attended by the officer and the drug worker who had taken part in the previous case review. Again there was no member of healthcare staff present. The SO recorded that the man had engaged positively. He had explained that he had been wound up the previous evening as staff had not allowed him to use the telephone. He repeated that he had no intentions to harm himself; he was positive about his future and working towards parole. The ACCT case review decided to end ACCT procedures.
48. On 26 March, the man successfully completed the RESOLVE anger management course. He had a further appointment with the psychiatrist the next day, who recorded that there was no evidence of psychosis. He had found the man unusually talkative and he gave an account of his recent self-harm, stating that he had cut open his neck, put his fingers into the wound and planned to pull out his jugular vein. He claimed he had then stuck the wound back together using sugar and wood glue. His explanation for his actions was hearing the bad news about his partner and not being able to contact her. The psychiatrist recorded that he had a superficial scar on his neck which was not in keeping with the amount of trauma he had described.
49. At around 8.30am on 29 March, the man was reported to be abusive and violent when talking to officers in a wing office. He refused to return to his cell and became volatile. Four officers restrained him. As he continued to fight they took him to the segregation unit.
50. A nurse completed the safety algorithm (a safety screen required to assess whether a prisoner is fit to be held in the segregation unit) and a medical report.

She recorded that she had observed the man kicking out and shouting abusive words to officers. The officers had encouraged him to calm down but he had remained adamant that he was going to hurt them. After searching him, officers found a sharpened plastic knife and other sharp objects in his pocket. He was found guilty of disciplinary charges in relation to the incident and punished by 7 days cellular confinement in the segregation unit.

51. Over the next few days, the man made no complaint about his physical or emotional well-being to the doctor, chaplaincy representative or prison manager who visited daily. However, the segregation unit staff became concerned about his state of mind when he accused them of calling him names and said that people were shouting abuse to him from the upper floor of the unit. The upper floors were empty as the cells were being refurbished and the officers took him upstairs so that he could see this for himself.
52. On 31 March, the nurse manager reviewed the man's mental health care plan and no changes were made.
53. On 1 April, segregation unit staff were particularly concerned about the man's presentation, as he appeared to be arguing with imaginary people and acting 'bizarrely'. They requested an emergency mental health assessment. The mental health lead at Woodhill assessed him. She concluded that there were no signs of a formal thought disorder and that his risk to himself was low, but his risk to others was high. She found it difficult to determine whether he had experienced a psychotic episode as most of his account had been plausible, so she decided to speak to the psychiatrist the next day, who knew him better. She considered that he was fit to remain in the unit. He continued to tell staff that people were calling out to him and shouting abuse and they tried to reassure him.
54. On 2 April, the psychiatrist and the mental health lead jointly carried out a full assessment of the man. The psychiatrist recorded that he had been talking to himself at night and was adamant that people had been whispering and calling him a sex offender. He also believed that he was at risk of attack by a number of other prisoners with weapons and said that, as a result, he had engineered a move off the wing by disclosing weapons to officers. He had been very reluctant to accept that he might need medication to improve his mental health.
55. The psychiatrist wrote that he had previously seen no evidence of psychosis but on the man's current presentation, he considered that he might well be psychotic. He agreed to take quetiapine (antipsychotic medication) daily for one week. The psychiatrist planned to continue the medication if it was beneficial but, if not, he would consider referring him to a secure psychiatric hospital. He felt there were no reasons to preclude him from remaining in the segregation unit and noted he said he had no thoughts of self-harm.
56. Segregation unit staff checked the man hourly, day and night. They recorded that his behaviour remained strange and that he continued to shout and argue with

imaginary people. He did not seem to pose any risk to himself and any violent behaviour was directed either to the staff or other prisoners in the unit.

Events leading up to the incident

57. Officer A was on night duty in the segregation unit. He told the investigator that he had known the man for a number of years, both in prison and in the community, and he had been cordial. Earlier that day, officers had moved Prisoner A to a cell next door to him as they got on well and staff thought that he might help to settle and reassure him. However, the man began shouting at the prisoner shortly after 9.00pm. The officer recorded that he believed that the prisoner had used the Google search facility on a telephone to get his family's address and he had spent at least two hours trying to dig through the cell wall into the prisoner's cell. The officer was not sure what he was using as it was wrapped in a pillow case, but it sounded metallic. The prisoner had tried to ignore him by playing music but this had provoked him further. The officer contacted the SO, the assistant night manager and explained the situation.
58. The SO told the investigator that at some point during the evening (he could not recall the exact time) Officer A had telephoned him to say that the man had become aggressive towards Prisoner A and had threatened to take staff hostage to get to him. The officer had suggested he might calm down if the prisoner was moved to the other end of the landing. The SO agreed and he went the segregation unit with a colleague to facilitate the move.
59. After the prisoner moved cells, the man continued to shout abuse and the officer tried to reassure him during the hourly, routine checks. The investigator reviewed the CCTV footage of the checks. At 2.55am, the officer noted that he seemed to have settled down and he appeared to be asleep, lying on his front.
60. When he next checked, at 3.36am, the officer saw the man slumped in an unusual position at the back of the cell, with a ligature of torn bedding around his neck attached to the window. He immediately radioed a code blue (signifying a medical emergency where a person is unresponsive, unconscious or not breathing). He said that due to his earlier behaviour and threats to staff and prisoners, he had waited for other staff to reach the gate of the unit before unlocking and entering the cell.
61. In response to the emergency call, the SO and a custodial manager ran to the segregation unit. They had both been in the operations room around 130 metres away and estimated it took them about two minutes to arrive. An officer joined them. The custodial manager said that the man's arms were stretched out, his eyes were open and his skin was grey. Officer A used his cut-down tool to release the ligature from the window. The custodial manager then cut the material from around his neck. At 3.39am, he radioed the control room to confirm that an ambulance was required. Records indicate that the control room called an

ambulance at 3.39am.

62. As the cell was cramped, the staff moved the man to the landing outside and began cardiopulmonary resuscitation. The custodial manager gave breaths while the SO administered chest compressions.
63. A nurse heard the emergency call and went immediately to the segregation unit. She then ran upstairs to collect a defibrillator (a life-saving device that gives the heart an electric shock in some cases of cardiac arrest) and to alert her colleague. Both nurses went to the cell with the defibrillator and the emergency medical bag containing oxygen and emergency drugs and took over emergency care.
64. The defibrillator detected no cardiac output and the staff continued resuscitation until paramedics arrived at 3.46am. The nurse telephoned the on-call doctor at around 3.55am. When the doctor arrived, at around 4.16am, the paramedics explained that cardiopulmonary resuscitation had been in progress for at least 25 minutes, with no response. The doctor agreed with the paramedics and nurses that they should stop the resuscitation attempts and, at 4.18pm, he pronounced the man dead.

Events after the man's death

65. Prison staff notified the duty manager of the man's death and she arrived at Woodhill at 4.33am. The prison's family liaison officers also went to the prison. At 7.30am, the duty manager debriefed all the staff involved in the emergency response and offered support. She arranged for the prisoners in the segregation unit and other areas of the prison to be told of the death and offered support.
66. The family liaison officers and one of the prison chaplains left the prison at 9.00am to break the news of the man's death to his parents. When they arrived at their home at 11.00am, they were informed that his parents were attending a hospital outpatient appointment. They went to the hospital but had missed them, as his father had already been seen. They therefore went back to their home and informed them of his death. They offered support and financial assistance with funeral costs.
67. Three staff attended the funeral on 24 April.

ISSUES

Clinical care

68. The clinical reviewer found that the man's physical, mental health and drug problems were appropriately identified and managed. Healthcare staff, the mental health team and a psychiatrist reviewed him frequently. He was satisfied that there had been no delays in referral, assessment or treatment and that healthcare staff had been responsive to the man's changing needs. When concerns about his mental wellbeing were raised they were dealt with appropriately. He was also satisfied that the resuscitation attempts were conducted in accordance with good medical practice. He concluded that the healthcare team's initial assessments, as well as ongoing interventions and contact with him, were comparable to that expected in the community.

Management of the suicide and self-harm prevention procedures

Assessment of risk of suicide and self-harm

69. When he was recalled to Woodhill, the man's escort record indicated that he had a history of self-harm in prison. At health screens and subsequent medical consultations, he reported previous thoughts of suicide and self-harm but insisted that he no longer had such thoughts.
70. On 28 January 2014, the man's mother notified the prison that he had telephoned her to say that he was going to "string himself up". When questioned about this, he told a SO that he felt stressed as his father was in hospital. They discussed ACCT procedures but he said they were not necessary. The SO asked wing staff to keep an eye on him for the next few days. Two days later, he was found in distress with a razor blade and ACCT procedures began then.
71. Prison Service Instruction (PSI) 64/2011 covers the suicide and self-harm prevention procedures and safer custody. It is a mandatory requirement that if staff receive information from a concerned family member that indicates an increase in a prisoner's risk, they should begin ACCT procedures. The PSI also lists a number of risk factors and triggers for self-harm. Of those listed, the man had a history of self-harm, family problems, drug detoxification, mental health issues, recent contact with psychiatric services and irrational behaviour.
72. The SO's rationale for not opening the ACCT procedures is unclear as it is not fully documented. He spoke to the man at length, but accepted his view that ACCT monitoring was unnecessary. The SO would not necessarily have been aware of all the man's risk factors, particularly those related to his medical care, but he knew that he had threatened to harm himself and he was sufficiently concerned about him to ask other staff to monitor him informally. We consider that the SO should have given more weight to the information from the man's mother and his known risk factors. In line with mandatory national instructions, he should have at

least completed the initial stages of the ACCT procedures to determine what, if any, support was needed.

The ACCT procedures

73. Staff at Woodhill managed the man under the ACCT procedures for two short periods. They started ACCT monitoring on 30 January, after they found him crying, with a razor blade on a table. He told staff about a number of problems, including worrying about his father's serious medical condition, difficulties contacting his partner, concerns about his medication, sleeplessness and anger that his parole review had been rescheduled. Staff completed a caremap, which was reviewed before the ACCT was closed after the second of two case reviews, on 4 February. A mental health nurse attended the second review only. On 26 February, a further ACCT plan was opened when he cut his neck after staff refused to let him out of his cell to use the telephone. It was closed the next day after the first case review, although there had been no mental health input or any other healthcare representation.
74. On both occasions, we are satisfied that the staff completed a full assessment, held prompt case reviews and carried out post-closure reviews. A drug worker attended two of the three case reviews and a mental health nurse was present at one of them. However, PSI 64/2011 indicates that case review teams should be multidisciplinary and include staff involved in a prisoner's care where possible. In view of the man's continuing care under the mental health team and a psychiatrist, we consider that there should have been more mental health involvement in the ACCT process.
75. There was no healthcare representation at either of the first ACCT case reviews which is a mandatory requirement of the PSI. This meant that the ACCT review of 27 February ended monitoring without any healthcare input at all. This should not happen. He had harmed himself the night before and we consider that it was premature to close the ACCT at that stage. There was too much reliance on him saying he did not need ACCT support rather than an effective examination of what could be done to support him at the time. While there is no indication that the issues we have identified would have prevented his later actions, it is important that ACCT procedures are followed to help ensure that prisoners at risk receive the most effective support. We make the following recommendation:

The Governor should ensure that staff manage prisoners at risk of suicide or self-harm in line with national guidelines including ensuring that:

- **Staff open an ACCT by completing a Concern and Keep Safe form when they receive information from family members which might indicate a risk of suicide or self-harm.**
- **A member of healthcare staff attends all ACCT first case reviews and that ACCTs are not closed where there has been no healthcare input into the process.**

- **Case reviews include all relevant people involved in a prisoner's care, including mental health staff when appropriate.**

76. We agree with the clinical reviewer that, although the man's behaviour had been challenging, with threats of violence and hostility towards others, other than his ongoing risk factors, there was little to indicate that he was at imminent risk of suicide or self-harm in the period leading up to 4 April 2014.

Segregation

77. On 29 March, staff moved the man to the segregation unit after he became violent and threatening to staff. When he arrived in the segregation unit, a nurse carried out a segregation safety algorithm and a doctor assessed him to ensure that he had no injuries and was fit to be held in the unit.

78. When the man's erratic behaviour increased on 1 April, staff appropriately requested an emergency mental health assessment, which took place the same day. Afterwards, the mental health nurse consulted his psychiatrist. The psychiatrist and the mental health nurse conducted a joint assessment the next day. The psychiatrist concluded that he might be psychotic, but his mental condition did not preclude him from being held on the unit and he did not pose a threat to himself. He planned to review him a week later, to decide whether to continue with newly-prescribed medication or refer him to a secure psychiatric hospital. Staff continued to observe him hourly, as is usual in the segregation unit.

79. We are satisfied that the man was appropriately managed in the segregation unit and that staff acted promptly when his mental health deteriorated.

Emergency response

80. The incident log shows the sequence of events after the officer found the man. The officer raised the alarm promptly and correctly, by calling a code blue at 3.36am. The next entry says that a manager called the control room to request an ambulance three minutes later at 3.39am. The third entry, on the line below, records that control room staff then called an ambulance at 3.39am. The manager explained that he was aware that an ambulance should have been called automatically in line with the prison's contingency plans, but as he had the authority to stand the ambulance down, he had contacted the control room to confirm that it was required. It is not entirely clear why he thought this was necessary, but the documentary evidence is that the ambulance was called three minutes after the code blue and not until after the manager's call. The ambulance log indicates that the ambulance was despatched at 3.40am and paramedics arrived at the cell quickly, at 3.46am.

81. PSI 03/2013 *Medical Emergency Response Codes*, issued in February 2013, contains mandatory instructions for governors to have a protocol to provide guidance on efficiently communicating the nature of a medical emergency, ensuring staff take the relevant equipment to the incident and that there are no

delays in calling an ambulance. It explicitly states that all prison staff must be made aware of and understand this instruction and their responsibilities during medical emergencies. It gives a clear instruction that an ambulance should be called immediately an emergency code is called and that it should not be a requirement for a manager to attend the scene first. While a delay of three minutes might not appear significant, and we accept it was unlikely to have affected the outcome for the man, it could be vital in other cases. We have made several previous recommendations about the emergency procedures at Woodhill and we make the following recommendation:

The Governor should ensure that the control room call an ambulance immediately when a medical emergency code is received.

RECOMMENDATIONS

1. The Governor should ensure that staff manage prisoners at risk of suicide or self-harm in line with national guidelines including ensuring that:
 - Staff open an ACCT by completing a Concern and Keep Safe form when they receive information from family members which might indicate a risk of suicide or self-harm.
 - A member of healthcare staff attends all ACCT first case reviews and that ACCTs are not closed where there has been no healthcare input into the process.
 - Case reviews include all relevant people involved in a prisoner's care, including mental health staff when appropriate.
2. The Governor should ensure that the control room call an ambulance immediately when a medical emergency code is received.

ACTION PLAN

No	Recommendation	Accepted/Not accepted	Response	Target date for completion	Progress (to be updated after 6 months)
1	<p>The Governor should ensure that staff manage prisoners at risk of suicide or self-harm in line with national guidelines including ensuring that:</p> <ul style="list-style-type: none"> • Staff open an ACCT by completing a Concern and Keep Safe form when they receive information from family members which might indicate a risk of suicide or self-harm. • A member of healthcare staff attends all ACCT first case reviews 	Accepted	<p>A staff information notice was published in October 2014 (a copy of which is now located in the Operations room) to remind staff that they should open an ACCT if they receive risk related information from family members or external agencies, or observe behaviour which may indicate a risk of suicide and/or self-harm.</p> <p>Each wing is assigned a member of healthcare staff on a daily basis who will be available to attend ACCT case reviews at the request of wing staff. In exceptional circumstances when a member of healthcare staff cannot attend, a written or telephone contribution will be submitted for review by the ACCT case review team. The ACCTs plan will not be closed until there has been healthcare input (either in person, or</p>	<p>Complete</p> <p>Head of Safer Custody.</p> <p>Complete</p> <p>Head of Healthcare and Case Managers</p>	

	<p>and that ACCTs are not closed where there has been no healthcare input into the process.</p> <ul style="list-style-type: none"> • Case reviews include all relevant people involved in a prisoner's care, including mental health staff when appropriate. 		<p>written or telephone contribution) into the process.</p> <p>All relevant staff involved in a prisoner's care, including mental health staff when appropriate, will attend all enhanced ACCT reviews as requested. In normal cases attendance by the Mental Health team will be identified in each case review. In exceptional circumstances, where a member of staff cannot attend the ACCT case review, a written contribution will be submitted. This has been communicated to all staff through a revised Staff Information Notice issued in October 2014.</p>	<p>Complete</p> <p>Head of Healthcare and Case Managers</p>	
2	<p>The Governor should ensure that the control room call an ambulance immediately when a medical emergency code is received.</p>	<p>Accepted</p>	<p>Staff briefing has taken place and a staff information notice was re-issued in July 2014 to remind control room staff that they are required to call an ambulance immediately when a medical emergency code is received.</p>	<p>Complete</p> <p>Head of Operations</p>	

			A laminated copy of the instruction has been placed on the control room desk so all staff are aware.		
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