



A Report by the
Prisons and
Probation
Ombudsman
Nigel Newcomen CBE

**Investigation into the death of a man at
HMP Woodhill in December 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 December 2013. He was 25 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 prison cooperated fully with the investigation.

The man was released on licence from prison in May 2011. On 4 October 2013, he was remanded to HMP Woodhill facing charges of burglary and theft. Prison reception staff at Woodhill received information that he had a history of attempted suicide and self-harm in prison but he said that he did not have any such thoughts and the staff did not consider he was a current risk. A health screen the next day did not identify any concerns.

For the next two months the man appeared to settle at the prison. However, one evening in December, he was found hanging in his cell. Attempts at resuscitation were unsuccessful and he was pronounced dead shortly after paramedics arrived. Evidence discovered after his death suggested that he had been very worried about his forthcoming trial and upset he had not been able to transfer to a prison nearer to his children.

I am concerned that Woodhill did not identify the man as at risk of suicide and self-harm when he first arrived there. He was remanded charged with further offences, but had also been recalled to prison after his licence from a previous sentence was revoked. He suffered from depression and had previously made two suicide attempts in prison. All of these are factors that increase risk, especially in the early weeks of custody. I am also concerned that no one assessed his risk again after he appeared at court by a videolink later in October. As in previous cases at Woodhill, the investigation found that emergency procedures were deficient after he was found hanging. There was also an unnecessary delay in informing his next of kin about his death.

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 remanded to HMP Woodhill on Friday 4 October 2013, charged with offences of burglary, theft and receiving stolen goods. This was not his first time in prison. He was on licence from a previous sentence and his licence was revoked. He told a nurse in the prison reception that he had a history of self-harm and had attempted suicide in prison twice before. However, he said that he had not harmed himself for four years and had no current thoughts of suicide or self-harm. He reported no mental or physical health problems. The nurse recorded that he engaged well and gave no cause for concern.
2. After he had been at the prison a few days, the man asked for a transfer to a prison nearer to London to make it easier for his children to visit him. This was refused as he still had to appear at a local court. He appeared by videolink to the court on 11 October, but no one assessed him afterwards to see if he was at increased risk of suicide or self-harm.
3. For the next two months, the man appeared to settle at the prison and gave little cause for concern. At his own request, he saw a nurse from the mental health team on 4 December and told her that he was worried about his children's welfare and was having problems sleeping. The nurse recorded that he engaged well and had no current thoughts of self-harm. The next day he was prescribed medication for 14 days to help him sleep.
4. In a letter written to his ex-girlfriend on 11 December (which was found in his cell after his death), the man said he was frustrated that he had not heard from his solicitors, although his court hearing was scheduled for 23 December. He described himself as being in a bad mood.
5. One evening, at 7.05pm, two prison officers were accompanying two nurses on the evening medication round when they found the man hanging from a torn bed sheet attached to his cell window. One of the nurses sounded the general alarm bell to alert staff but no one used the emergency medical code to alert staff to the nature of the emergency and to ensure an ambulance was called immediately. The staff cut the sheet and began cardiopulmonary resuscitation immediately. Other prison officers quickly arrived to assist and an officer requested an ambulance. The resuscitation attempt was unsuccessful and paramedics pronounced him dead at 7.55pm. His next of kin was not informed of his death for over five hours, although she lived relatively near the prison.
6. We have found no evidence to suggest that the man was obviously at risk of suicide or self-harm in the days leading to his death so that staff should have begun suicide and self-harm prevention procedures. However, we consider that suicide and self-harm prevention procedures should have begun when he first arrived at the prison as he had a number of known factors which would have increased his risk. We are concerned that his risk was not assessed again after he had a court appearance by video link. We consider that a mental health assessment on 4 December should have included a discussion

about his history of attempted suicide. We are also concerned that we have to repeat a recommendation about the use of emergency radio codes at Woodhill. We also make recommendations about first aid training and the need to contact families quickly after a death at the prison.

THE INVESTIGATION PROCESS

7. The investigator issued notices informing staff and prisoners at HMP Woodhill of the investigation and asking anyone with relevant information to contact him. No one responded.
8. On 17 December 2013, the investigator visited Woodhill and spoke to the man's friend who occupied the cell next door and obtained copies of the man's relevant prison and medical records. He interviewed members of staff at the prison in January and March 2014.
9. NHS England appointed a clinical reviewer to review of the man's clinical care in prison.
10. The investigator informed HM Coroner for Buckinghamshire of the investigation. We have sent the Coroner a copy of this report.
11. One of the Ombudsman's family liaison officers contacted the man's ex-girlfriend, his nominated next of kin, to explain the purpose of the investigation. At the time of writing the report, she had identified no specific concerns for the investigation to cover.

HMP WOODHILL

12. 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.
13. Central and North West London NHS Foundation Trust provides health services at HMP Woodhill.

Her Majesty's Inspectorate of Prisons

14. The most recent inspection of HMP Woodhill was completed in January 2014. Inspectors found that the incidence 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 in custody and inspectors recommended that all Prisons and Probation Ombudsman recommendations should be implemented in full. Prisoners had access to a well-trained Listener team.
15. Inspectors also 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 waited for two to four weeks.

Independent Monitoring Board

16. 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

17. Since 2012, there have been six deaths at Woodhill, four of which were self-inflicted deaths by hanging and two from natural causes. Following the death of a prisoner in November 2013, we made a recommendation to the prison about the need to comply with national instructions about the use of emergency medical codes. We repeat this recommendation in this investigation.

Assessment, Care in Custody and Teamwork (ACCT)

18. Assessment, Care in Custody and Teamwork (ACCT) is the Prison Service process for supporting and monitoring prisoners at risk of harming themselves. The purpose of 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 irregular to prevent the prisoner anticipating when they will occur. Part of the ACCT process involves drawing up a care map 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 of the actions on the care map have been completed.

KEY EVENTS

19. In May 2011, the man was released from HMP The Mount on licence until 2 November 2013. During his time in prison, he had attempted to hang himself in 2007 and had taken an overdose in 2010. On 2 October 2013, he was arrested and charged with offences of robbery and burglary.
20. The man attended court on 4 October. His Person Escort Record (PER) for the journey from the police station to Magistrates' Court noted that he might self-harm, had previously attempted suicide and suffered from depression.
21. At court, the man was remanded to HMP Woodhill and arrived at 6.42pm that day. In the prison's reception unit, an officer recorded that he was on remand and had last been in prison in May 2011. His next of kin was identified as his ex-girlfriend. "Alerts – self harm" was noted on the cell sharing risk assessment (CSRA - which is used to assess the risk of violence towards another person). He told staff he had no thoughts of wanting to harm himself.
22. The man was initially considered as medium risk on the CSRA. Anyone not assessed as a low risk is interviewed by the reception senior officer (SO). The SO saw him and concluded that he was a standard risk and could safely share a cell with another prisoner. He noted that the man had no thoughts of self-harm and did not identify any other concerns.
23. A nurse completed a routine health assessment in the First Night Centre at 10.09pm. The nurse recorded that although the man had no current thoughts of self-harm or suicide, he had harmed himself four years previously. Although the PER had indicated that he suffered from depression, the nurse noted that he had no history of mental health issues. The nurse recorded in the medical record that he made good eye contact throughout the assessment and did not identify any immediate health concerns.
24. An officer then interviewed the man, which he recorded on a First Night Interview sheet. He identified that the man had last self-harmed four years previously and said he did not have any current thoughts of suicide or self-harm. The man said he was okay and was polite throughout their conversation. The officer had no concerns about him. He explained the role of peer supporters and the rules of the prison to him and told him what he could expect in his induction over the next 24 hours.
25. The officer completed most of the First Night Interview sheet. However, he told the investigator that he did not write the summary at the end of the document. The investigator has been unable to discover who wrote it. The entry read:

"The man was very polite. Has a long history of self-harm and suicide attempts but the last time was 4 yrs ago and he is fine now...Canteen issued. Phone call taken".

26. The man was then taken to a cell on the First Night Centre. On 5 October, he saw a member of the chaplaincy team and raised no concerns. A nurse conducted a secondary health screening in the afternoon. There were no concerns about his physical health. He said he had no thoughts of suicide or self-harm. The nurse had no concerns about him during the assessment.
27. An officer completed the man's day two induction interview at around 5.47pm. He made good eye contact and the officer said his body language was positive throughout their conversation. He said he had no issues or concerns and would speak to staff if this changed.
28. Over the next few days, the man completed his prison induction. He applied for prison work and to attend education classes. Prison staff had no concerns about his wellbeing.
29. On 7 October, the man applied to be transferred to HMP The Mount. He was told (on 15 and 18 October) that while he was on remand and had outstanding court appearances, he would not be moved. In the event of a subsequent transfer he was likely to go to HMP Stocken or HMP Ranby and not in or near the London area. He was unhappy with this and said that he wanted a move to make it easier for his children to visit him.
30. At the time of his arrest, the man was still on licence from his earlier sentence. The National Offender Management Service revoked his licence and sent recall documents to Woodhill on 7 October. The documents noted that he had a history of self-harm and suicide attempts and would need to be monitored. The prison's safer custody team passed this information to the First Night Centre staff on 7 October. The investigator was unable to find any evidence that any further action was taken as a result and there is no record that his risk of suicide and self-harm was re-assessed as a result.
31. On 9 October, an officer explained the details of his recall to prison to the man. The officer noted on the record that he did not intend to make any written representations against the recall decision and had signed the recall documentation to confirm this.
32. On 11 October, the man appeared at court by video link from the prison. He pleaded not guilty to three of the charges against him and guilty to the remaining two. There is no record that his wellbeing was assessed after this court appearance.
33. On 15 October, the man moved to house unit 4 where he shared a cell with another prisoner. On 23 October, an officer recommended that his Incentive and Earned Privilege scheme (IEP) level should be reviewed because of his negative behaviour. (The IEP has three levels with varying degrees of privileges designed to encourage good behaviour.) He was placed on the basic IEP regime on 24 October.
34. On the same day, 24 October, staff searched their cell after security information was received and a bladed weapon was found. The man was

charged with a disciplinary offence. Shortly afterwards, he was also charged with using threatening and abusive language towards two prison officers and was locked in his cell.

35. The manager, who chaired the man's disciplinary hearing on 25 October, told the investigator that the man pleaded guilty to the charge of using abusive language, was very sorry about his behaviour and apologised to the officers. He lost privileges such as television, canteen and attendance at the gym for 14 days and also lost three days association. He pleaded not guilty to the charge of possession of a weapon and, after a number of adjudication hearings, the charge was dismissed.
36. The man moved to house unit 2B on 26 October. As he was on the basic IEP regime, his behaviour was monitored each day and recorded on an assessment sheet. An officer spoke to him when he first arrived on the wing. He was polite and raised no issues. The officer then reviewed his behaviour each day and recorded that staff had no issues or concerns. As a result of his sustained positive behaviour, his IEP level was returned to standard on 6 November.
37. On 15 November, the man was moved to a single cell (landing three, cell two) on house unit 2A. An officer told the investigator that he had no concerns about the man's welfare. He said that the man appeared to get along with other prisoners and raised no concerns.
38. The man started attending a PICTA (Prisoner Information and Computer Technology Academy) workshop on 23 November. However, he walked out of the PICTA workshop on the morning of 27 November and told the PICTA teacher that he no longer wanted to attend the class because the pace of the course was too slow for him. After some persuasion, he rejoined the class and agreed to participate.
39. The man received two e-mails from his ex-girlfriend on 4 December through the prison's "E-mail a prisoner" scheme. The emails did not contain any information to suggest that he had previously told her that he was not coping in prison or that he intended to harm himself.
40. That day, 4 December, the man saw a member of the mental health team, at his request. She noted that his appearance was neat, he was polite and that his mood was stable. However, he told her that he felt anxious and was not eating or sleeping well because he was worried about his children's welfare. He said that he had a history of depression and had previously taken antidepressants, but that this was not currently an issue for him. She noted that he had no thoughts of suicide or self-harm but wanted medication to help him sleep. She did not record whether she was aware of his history of self-harm. She said she would speak to the consultant psychiatrist and recommend that he should be prescribed zopiclone (used to treat insomnia) for 14 days. She explained to him that zopiclone was not prescribed on a long-term basis. She noted that he would be discharged from the mental healthcare caseload after

she had spoken to the consultant psychiatrist. She gave him some activity packs to complete in his cell to help relieve his anxiety.

41. On 5 December, the mental health nurse discussed the man at the healthcare multidisciplinary team meeting. It was agreed that he could be prescribed zopiclone for 14 days and he received his first dose that evening.
42. On 7 and 8 December, the man spoke to his ex-girlfriend by telephone. The investigator listened to recordings of these calls in which he gave no indication that he had any thoughts of suicide or self-harm.
43. The man completed an application form to become a Listener. (Prisoners trained by the Samaritans to support other prisoners in distress.) The application form was signed and dated 7 December and was found in his cell after his death. His PICTA teacher said that he had expressed an interest in becoming a Listener after seeing an advertisement on an information board asking for volunteers. She had helped him to complete the application form and felt that he was taking a positive step.
44. The man continued to attend the PICTA classes regularly and his teacher was pleased with his progress. On 9 December, she recorded in his prison record that he was polite, studied well and had helped other prisoners in the class who found the work difficult.
45. Prisoner A lived in the cell next door to the man. The prisoner thought that on 10 December (he was unsure of the exact date) the man had become anxious about his upcoming court case, which was scheduled for 23 December. He had wanted to speak to his solicitor and told the prisoner that he had asked an officer to unlock him from his cell so he could use the telephone. However, the prisoner said that the man had not been unlocked until about 5.00pm, by which time his solicitor had left his office. The prisoner said that he noticed that his mood had changed from around this time as he felt that staff were not helping him.
46. Prisoner A said that the day after this, he looked into the man's cell through the door observation panel at lunchtime. It was dark inside and he was sitting with his head in his hands. The prisoner thought that this was unusual behaviour for him but the man told him that he just wanted to sit in the dark.

Events leading up to the incident

47. During a PICTA workshop the teacher noted that the man was unusually quiet. Not long before 10.15am, he said he was bored and wanted to go back to his houseblock. She refused his request and he said that he was giving up the course. She tried to talk to him about what was wrong and how he was feeling, but he would not talk to her. She told the investigator that she did not think that he showed any signs of wanting to harm himself. She allowed him to go back to his houseblock during free-flow movements shortly after 10.15am, when prisoners were supervised as they moved between activities.

48. Prisoner A said he spoke to the man later that afternoon and described his mood as low. He told the prisoner that he intended to set fire to his cell to instigate a move to a different prison.
49. Prisoners who were due to attend activities such as the gym, education and visits were unlocked from their cells between 1.45pm and 2.00pm. All other prisoners remained in their cells. A wing officer said that no concerns about the man were raised at the afternoon staff briefing meeting.
50. The evening meal was served shortly before 4.30pm. Prisoner A and the man both collected their meals from the servery. The man offered his meal to the prisoner and said that he did not want it. He and the prisoner went back to their respective cells and the prisoner asked him if he was all right. He said he was and that he just wanted to "get out of this jail, watch me". All prisoners were then locked in their cells.
51. Although he was uncertain of the exact time, Officer A told the investigator that around 4.40pm he unlocked the man so that he could use the telephone. He did not say who he wanted to call and raised no concerns. He came back soon afterwards and told the officer that he had been unable to get through. (The investigator checked his PIN record and he made no telephone calls that day. The officer told the investigator that the PIN phone system shuts down across the prison around the time he wanted to make his telephone call. It is possible that this was why he was unable to get through on the phone.) The officer told him he could try again the next day. He then locked him back into his cell and continued to lock up the other cells. The officer said that he did not raise any concerns or look distressed at any time.
52. Around 5.30pm, Officers A and B unlocked prisoners who were attending the gym and the servery cleaners who would be working on the wing. Officer B unlocked Prisoner A so he could go to the gym. The prisoner looked through the man's observation panel and spoke to him. He told the investigator that the man said he was okay and no longer intended to set fire to his cell. The prisoner said he was pleased about that and they joked together before he left. He said he would see him again when he got back from the gym.
53. Officer B responded to the man's cell bell about 5.50pm. The man asked him to check whether any visits had been booked for him. The officer told him he would check the computer system later that evening when he got the chance. He said the man raised no other issues and thanked him.
54. Prisoner A returned from the gym at around 6.50pm. As he passed the man's cell, he looked through the cell observation flap. It was dark inside and he could not see him. He was then locked back into his cell.
55. That evening, shortly before 7.00pm, two nurses were issuing medication on the wing assisted by Officers A and B. When they arrived at the man's cell, Officer A looked through the observation panel. It was dark inside and at first he said he could not see him. He turned on the cell night light and, saw a shadow at the back of the cell. He unlocked the door and went in and found

him hanging from a ligature made from a torn piece of bed sheet tied around his neck and attached to the window handle.

56. Officer A shouted to Officer B and the nurses for assistance and quickly used his anti-ligature knife to cut the sheet and laid the man on the cell floor. The nurse who was not carrying a radio pressed the general emergency button outside of the cell to summon help. This was recorded on the prison incident log as occurring at 7.05pm. She then went to bring a medical emergency bag from the second landing and was back at the cell within a minute. Officer B had started to move some of the furniture in the cell to make some space.
57. A SO and an officer responded to the emergency alarm and arrived at the cell within seconds. The officer radioed the Control Room to request an ambulance. This was recorded on the incident log as happening at 7.06pm. Officer B left the cell to wait for the paramedics to arrive at the prison front gate so he could direct them to the cell quickly.
58. A nurse, Officer A and the SO assessed the man. The officers were both first aid trained, although their certificates had expired. The man's face was purple and although his body was warm, he showed no signs of life. Officer A began cardiopulmonary resuscitation (CPR). The nurse set up an oxygen mask from the emergency bag and attached a defibrillator which found no shockable heart rhythm.
59. Two managers and another nurse arrived at the cell after hearing the general alarm and assisted with the resuscitation attempts. The nurse said she had been unaware of the type of incident she was attending.
60. CPR continued until paramedics arrived at the cell at 7.20pm. The prison doctor arrived at the cell at 7.21pm and also assisted with CPR. The resuscitation attempts were unsuccessful and, at 7.55pm, the man was declared dead.

Events after the man's death

61. After the man's death three letters, written in diary format and dated 9 December, 10 December and 11 December, were found in his cell addressed to his ex-girlfriend. He did not indicate in any of them that he intended to harm himself. In his letter of 11 December, he said that he had woken up in a bad mood and had "feelings of loathing the [PICTA] course", but he intended to continue with it. He wrote about trying to contact his solicitor and was frustrated that he did not know what was happening with his case. A letter dated 12 December to his solicitor was found in the prison postal system waiting to be sent. In it, he expressed his dissatisfaction with the level of service his solicitor had provided.
62. A prison application form completed by the man and dated 13 December was also found in his cell. He wrote that he intended to refuse food until he was transferred to another prison which was closer to his children, who he only saw once a month.

63. Around 9.00pm, a manager held a debrief and offered support to the staff who had been involved in the emergency. The staff care team visited the wing and offered further support.
64. Two officers were appointed as the prison family liaison officers. The man had listed his ex-girlfriend as his next of kin. The officers went to her home at about 1.15am on 13 December to break the news. They explained what had happened to him and offered support and information. She gave them copies of three letters that he had recently sent her, dated 2 December, 6 December and 8 December. None of them indicated that he had any intention to harm himself.
65. Prisoners were informed of the man's death by notices which also outlined the support that was available to them. Prisoner A was offered support individually and access to a Listener. All prisoners subject to suicide and self-harm prevention procedures were reviewed in case they had been adversely affected by the death. Over the next week, prisoners on the wing raised money for flowers for the funeral.
66. The prison offered financial assistance towards funeral costs in line with Prison Service guidance. The funeral was held on 17 January 2014.

Post-mortem report

67. The post-mortem examination concluded that suspension was the cause of the man's death.

ISSUES

68. The clinical reviewer considers that the standard of healthcare the man received at Woodhill was equivalent to that he could have expected to receive in the community.

Management of risk of suicide and self-harm

69. Staff judgement is fundamental to the ACCT system. ACCT relies on staff using their experience and skills, as well as local and national assessment tools, to determine risk. They must balance this against the prisoner's known risk factors and their presentation. Prison Service Instruction (PSI) 64/2011 lists risk factors for suicide and self-harm and also states that "all staff who have contact with prisoners must be aware of the triggers that may increase the risk of suicide, self-harm or violence and take appropriate action". A list of risk factors for suicide includes previous deliberate self-harm, mental illness, early days in custody. Licence recall is listed as a trigger.
70. When the man arrived at Woodhill on 4 October 2013, a number of these factors applied to him. He was in the early days of custody, he had made two previous suicide attempts in prison and had previously been diagnosed with depression. He was open about these factors at reception but was not assessed as being at risk of suicide or self-harm. In addition he had been recalled to prison from a previous sentence (although information about this was not immediately available).
71. The man was assessed several times during his first days in custody at Woodhill. He had a reception health screen interview with a nurse, an induction interview with an officer and then a second health screen with a nurse. Despite having a documented history of self-harm, prison and healthcare staff believed that his level of engagement was good and assessed that he was not at risk of suicide or self-harm. Although staff noted his previous self-harm, his diagnosed depression appears to have been overlooked.
72. A prisoner's presentation is obviously important and reveals something about their level of risk. However, it is only a reflection of their state of mind at the time they are seen by the member of staff 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 consider that more weight should have been given to all the known risk factors in comparison to the man's presentation.
73. As the man presented with a range of risk factors when he arrived at Woodhill, we consider it would have been prudent for staff to have supported him using ACCT and to have continued to manage him under ACCT procedures until they were satisfied his risk to himself had reduced appropriately. We have previously made a recommendation to Woodhill about this issue which we repeat here:

The Governor should ensure that reception and first night staff consider and record all available risk factors of a newly-arrived prisoner when determining their risk of suicide or self-harm, particularly those identified in suicide and self-harm warning forms and PERs.

The man's risk assessment following his court appearance

74. The man appeared at court by video link from the prison on 11 October. He pleaded not guilty to three of the charges against him and guilty to the remaining two.
75. Prison Service Order 3050 (PSO) Continuity of Healthcare indicates that events such as attending court, sentencing at court and being questioned by the police are factors that might increase an individual's risk of suicide and self-harm. It says that for prisoners passing through reception prisons must have protocols to screen them for any potential healthcare, suicide or self-harm issues. PSO 74/2011 (Early days in Custody), section 2.18, states that assessments must also be made of prisoners who by-pass some reception processes and those whose status and demeanour might change after a court appearance via video link.
76. We recognise that an assessment after the man's court appearance by video link would not necessarily have led to additional support under ACCT procedures. However this was a missed opportunity to identify any underlying issues that might have been causing him to be stressed. This was all the more important because of his previous suicide attempts in prison. It would also have allowed the additional factor of his recall to prison to have been considered.
77. We make the following recommendation:

The Governor and Head of Healthcare should ensure that all prisoners should be assessed for potential health or suicide and self-harm issues after events which could involve a change in status, including court appearances by video-link.

The man's contact with the mental health team on 4 December

78. A mental health nurse saw the man on 4 December because he complained of not sleeping or eating well. In her assessment she recorded that he was anxious but his mood was stable and he had no current thoughts of self-harm. She noted that he suffered from depression and had previously taken anti-depressants.
79. The nurse did not ask about or record any details about the man's history of self-harm, information that was available in his medical record. The clinical reviewer commented that the treatment and management plan agreed for him by the healthcare team was appropriate, but it would have been helpful to have explored his history of self-harm further during this consultation. We make the following recommendation:

The Head of Healthcare should ensure that healthcare staff ask prisoners about their history of self-harm when conducting mental health assessments.

Emergency response

80. Some staff were already at the man's cell when he was found hanging and were able to respond immediately. However a nurse pressed the general alarm as she did not have a prison radio. Although the other staff present all had radios, none of them called an emergency response code blue, as they should have done according to Woodhill's local policy. The officer, who arrived at the cell within a minute, asked for an ambulance to be called, but again did not use an emergency code when he contacted the Control Room. This meant that other staff who responded did not know the nature of the emergency.
81. PSI 03/2013 *Medical Emergency Response Codes*, issued in February 2013, contains a mandatory instruction that prisons should have a local protocol which gives guidance on efficiently communicating the nature of a medical emergency, ensuring that staff take the correct 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 the protocol and their responsibilities during medical emergencies.
82. We have raised similar issues in previous investigations at Woodhill. In response to one of our recommendations, Governor's Order (64/13) was issued on 30 May 2013, which sets out a protocol for staff to follow when responding to a medical emergency. However, following an investigation into a death at Woodhill in November 2013, we made a further recommendation. In response, Woodhill told us that, in January 2014, they had issued a further instruction (SIN 003/14) that the control room should call an ambulance immediately when a code blue or red was called.
83. In this instance, an emergency code was not used as it should have been. As it appears that staff are still not aware of their responsibilities, we repeat this 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's Medical Emergency Response code protocol complies with PSI 03/2013 and:

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

84. We also note that, although the officers who were at the scene had been first aid trained, their certification had expired. It is important that first aid skills are kept up to date, not least as the guidance is frequently updated. We make the following recommendation:

The Governor should ensure that staff trained in first aid receive refresher training at appropriate intervals.

Family liaison

85. The man was declared dead at 7.55pm. However, his next of kin, his ex-girlfriend, was not informed for over five hours. PSI 64/2011, the Prison Service Instruction which covers informing next of kin of a death in prisons, notes that time is of the essence, not least to ensure that next of kin are not informed by other means. The prison family liaison log begins at 11.00pm on 12 December, when the family liaison officer recorded that he had been appointed. We have been unable to establish why it took so long to appoint a family liaison officer and for them to then visit the next of kin's home, just an hour's drive away. We believe that the visit should have occurred much more quickly and we make the following recommendation:

The Governor should ensure that family liaison officers are appointed promptly and that next of kin are informed as soon as possible after a death in custody.

RECOMMENDATIONS

1. The Governor should ensure that reception and first night staff consider and record all available risk factors of a newly-arrived prisoner when determining their risk of suicide or self-harm, particularly those identified in suicide and self-harm warning forms and PERs.
2. The Governor and Head of Healthcare should ensure that all prisoners should be assessed for potential health or suicide and self-harm issues after events which could involve a change in status, including court appearances by video-link.
3. The Head of Healthcare should ensure that healthcare staff ask prisoners about their history of self-harm when conducting mental health assessments.
4. 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's Medical Emergency Response code protocol complies with PSI 03/2013 and:
 - Provides guidance to staff on efficiently communicating the nature of a medical emergency;
 - Ensures staff called to the scene attend as quickly as possible and bring the relevant equipment; and
 - Ensures there are no delays in calling, directing or discharging ambulance
5. The Governor should ensure that staff trained in first aid receive refresher training at appropriate intervals.
6. The Governor should ensure that family liaison officers are appointed promptly and that next of kin are informed as soon as possible after a death in custody.