Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Ireneusz Polubinski a prisoner at HMP Woodhill on 31 January 2016

A report by the Prisons and Probation Ombudsman
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Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

Our Values

We are:

Impartial: *we do not take sides*
Respectful: *we are considerate and courteous*
Inclusive: *we value diversity*
Dedicated: *we are determined and focused*
Fair: *we are honest and act with integrity*

The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out **independent** investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

My office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Ireneusz Polubinski was found hanged in his cell at HMP Woodhill on 31 January 2016. He was 58 years old. I offer my condolences to his family and friends.

Although Mr Polubinski was correctly identified as at risk of suicide and self-harm when he arrived at the prison on 5 January, staff decided too quickly that his risk had reduced and then ended suicide prevention measures without resolving the main issue he said was concerning him. Mr Polubinski's isolation was compounded by his lack of English and there is little evidence of any meaningful interaction with staff once monitoring ended. He should also have been referred for a mental health assessment when he first got to the prison.

Mr Polubinski's sad case was the eighth of eleven apparently self-inflicted deaths at Woodhill since 2014 and, yet again, I raise concerns about the assessment and management of prisoners' risk of suicide and self-harm at the prison. The Deputy Director of Custody for the High Security Estate has, rightly, set up a task force to review and improve safety at the prison, clearly urgent action is required.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman **September 2016**

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Summary

Events

1. On 5 January 2016, Mr Ireneusz Polubinski was remanded to HMP Woodhill charged with a sexual offence. It was Mr Polubinski's first time in prison. He was Polish and spoke and understood little English. Mr Polubinski had recently attempted suicide and arrived with a warning form highlighting his risk. Staff immediately began Prison Service suicide and self-harm prevention procedures, known as ACCT. No one referred Mr Polubinski for a mental health assessment.

2. Using a member of staff to interpret, staff assessed that Mr Polubinski was at high risk to himself and constantly supervised him. Mr Polubinski was very anxious about some lost identity documents. The next day, staff reduced the frequency of observations to twice an hour and just six days later, on 12 January, staff stopped ACCT monitoring, after Mr Polubinski moved to the prison's vulnerable prisoner unit (VPU). Mr Polubinski had still not received his lost documents. There is no record that officers in the VPU spoke to Mr Polubinski or checked how he was after the ACCT monitoring stopped.

3. On 15 January, Mr Polubinski told a resettlement worker that he was still very worried about his lost identity documents. He said he was isolated and was thinking about suicide. The resettlement worker reported this to officers who took Mr Polubinski back to the vulnerable prisoner unit and briefed the unit manager. The unit manager did not speak to Mr Polubinski, start ACCT procedures or take any other action.

4. Shortly before midday on 31 January, an officer found Mr Polubinski hanged in his cell. He raised the alarm and tried to resuscitate Mr Polubinski until nurses arrived and took over. Paramedics arrived quickly, but at 12.23pm, a doctor recorded that Mr Polubinski had died.

Findings

5. Staff appropriately began ACCT suicide and self-harm procedures when Mr Polubinski arrived at Woodhill but we are concerned that ACCT case reviews did not fully examine the reasons behind Mr Polubinski's distress or set effective caremap actions to address his concerns and help reduce his risk. Staff considered his risk had reduced and ended monitoring without resolving the problem of his lost documents; the only issue staff had identified was concerning him.

6. Despite Mr Polubinski's recent suicide attempt, no one referred him for a mental health assessment. No one from the mental health team saw him before he died.

7. There was little evidence of supportive interactions with Mr Polubinski after he moved to the vulnerable prisoner unit. We are very concerned that no one spoke to him or began ACCT procedures after he reported suicidal thoughts on 15 January.

Recommendations

- The Governor should ensure that staff manage prisoners at risk of suicide or self-harm in line with national guidelines. In particular:
    - ACCT case reviews should assess the level of risk taking into account all risk factors.
    - ACCT case reviews should set caremap actions which are specific and meaningful, aimed at reducing a prisoner's risk and identify who is responsible for them.
    - Case managers should review progress against caremaps at each review and continue ACCT monitoring until the risk posed by the prisoner has reduced and all caremap actions have been completed.
    - Staff should review a prisoner's risk when they express thoughts of suicide and begin ACCT monitoring when indicated.
    - ACCT post-closure reviews should be held as scheduled.

- As part of a planned reintroduction of an effective personal officer scheme, the Governor should introduce an adapted scheme so that prisoners in the early days of custody and other vulnerable periods of their time in prison have an assigned officer who gets to know and support them.
- The Governor and Head of Healthcare should ensure that the prisoners identified as being at risk of suicide are referred urgently for a mental health assessment.

The Investigation Process

8. The investigator issued notices to staff and prisoners at HMP Woodhill informing them of the investigation and asking anyone with relevant information to contact him. Two prisoners wrote to him.

9. NHS England commissioned a clinical reviewer to review Mr Polubinski's clinical care at the prison.

10. The investigator visited Woodhill on 4 February 2016. He obtained copies of relevant extracts from Mr Polubinski's prison and medical records. He subsequently interviewed four prisoners and 12 members of staff at Woodhill. At the initial report stage, the National Offender Management Service (NOMS) responded to the recommendations.

11. We informed HM Coroner for Milton Keynes of the investigation and have sent him a copy of this report.

Background Information

HMP Woodhill

12. HMP Woodhill has a dual role of a local prison and a high security prison and can hold more than 700 men. Central and North West London NHS Foundation Trust provides health services at the prison. Westminster Drug Project provides drug and alcohol support services.

HM Inspectorate of Prisons

13. The most recent inspection of HMP Woodhill was in September 2015. Although staffing levels were better than they often found in other prisons, inspectors noted that the prison was heavily reliant on new recruits and officers from other prisons, temporarily working at Woodhill. Inspectors were very concerned about the high number of self-inflicted deaths at the prison and considered there was an insufficiently whole-prison approach to understanding and addressing the contributory and preventative factors in prisoners' overall experience. Inspectors commented that the prison had not done enough to implement recommendations from the Ombudsman.

14. Inspectors found the quality of support for prisoners at risk of suicide or self-harm was inconsistent, and often failed to address underlying causes. Caremaps were not always updated.

15. Inspectors found that work with foreign national prisoners focused on immigration concerns but there was no forum to discuss their wider issues. They found that some prisoners who struggled with English received little assistance. In their survey of prisoners, a high proportion of foreign national prisoners compared to British prisoners said they felt unsafe.

16. In their survey, more prisoners than in comparator prisons said most staff treated them with respect, but prisoners told inspectors that the number of temporary staff from other prisoners had affected the quality of relationships. There was no personal officer scheme but 67% of prisoners surveyed said that they had a member of staff they could turn to for help, which was similar to comparator prisons. Officers' entries in prisoners' records mostly focused on institutional behaviour and showed little knowledge of prisoners' wider circumstances.

Independent Monitoring Board

17. Each prison 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 annual report for the year ending May 2015, the IMB commented that the stability of the prison was fragile. Severe staff shortages remained a concern and the IMB was worried that the loss of experienced staff would impact on the mentoring and support of new staff joining the prison. The IMB said that more staff training was needed to improve the management of suicide prevention monitoring procedures. The IMB commented that the personal officer scheme had all but been abandoned and considered this was a lost opportunity to help identify prisoners who might be at risk of suicide or self-harm.

Previous deaths at HMP Woodhill

18. Mr Polubinski's was the eighth self-inflicted death at Woodhill since the start of 2014. In this report and in five of the previous reports, we identified deficiencies in the quality of ACCT procedures. Since Mr Polubinski's death, three more prisoners have apparently taken their own lives.

19. In our most recent investigation report, we recommended that the Deputy Director of Custody for High Security Prisons assures himself that Woodhill has effectively implemented all PPO recommendations made following self-inflicted deaths at the prison in the last five years.

Assessment, Care in Custody and Teamwork

20. ACCT is the Prison Service care-planning system used to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk, how to reduce the risk and how best to monitor and supervise the prisoner.

21. After an initial assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. Checks should be irregular to prevent the prisoner anticipating when they will occur. There should be regular multidisciplinary review meetings involving the prisoner. As part of the process, a caremap (plan of care, support and intervention) is put in place. The ACCT plan should not be closed until all the actions of the caremap have been completed.

22. All decisions made as part of the ACCT process and any relevant observations about the prisoner should be written in the ACCT booklet, which accompanies the prisoner as they move around the prison. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

Key Events

23. On 5 January 2016, Mr Polubinski was remanded to HMP Woodhill, charged with a sexual offence. Mr Polubinski was Polish and spoke and understood little English. He had not been in prison before. An assessment while he was in police custody had concluded that he did not have a mental illness. Police noted on Mr Polubinski's Person Escort Record (PER – which accompanies prisoners when they move between police custody, court and prison), that he had cut himself in his police cell and had tried to hang himself two weeks before his arrest and had drunk poison. A court custody officer completed a suicide and self-harm warning form with the information about Mr Polubinski's suicide attempts. Mr Polubinski had told the court custody officer that he had felt down because two partners had died in the previous five years.

24. A Supervising Officer (SO), who was managing the prison's reception that day, signed to say he had received Mr Polubinski's suicide and self-harm warning form. The SO started ACCT suicide and self-harm prevention procedures and noted the information on the court suicide and self-harm warning form. A healthcare assistant acted as an interpreter. The SO suggested that Mr Polubinski should share a cell for support and decided that staff should check him at least hourly until his risk could be properly assessed.

25. The healthcare assistant also interpreted at Mr Polubinski's initial health screen, when a nurse noted that Mr Polubinski had tried to kill himself and that he was confused. The nurse told us that she had seen the suicide and self-harm warning form, but she could not remember seeing his police medical records. Mr Polubinski said that he had taken an overdose two weeks earlier and had taken poison two months before that. She noted that he was a very heavy drinker and referred him to speak to a doctor about alcohol withdrawal. She said she thought Mr Polubinski would be seen by someone from the mental health team the next day as part of the ACCT process, so she did not refer him for a mental health assessment.

26. A prison GP recorded that Mr Polubinski was an alcoholic and had no other health concerns. The GP prescribed Mr Polubinski chlordiazepoxide to manage symptoms of alcohol withdrawal. The doctor said he knew that Mr Polubinski had been assessed as at risk of suicide or self-harm, but he did not discuss it with him. Again, the healthcare assistant interpreted.

27. An officer in the first night centre interviewed Mr Polubinski later that evening, using Language Line (a telephone interpreting service). Mr Polubinski talked about his three previous suicide attempts and told the officer that his fourth attempt would be more successful. Afterwards, the officer spoke to the SO in reception, the prison GP, the SO who was managing the first night centre and the night manager. They agreed that Mr Polubinski was at high risk of suicide and should be constantly supervised. He was taken to a constant supervision cell in the detoxification unit.

28. The next morning, Mr Polubinski told a substance misuse nurse that he drank ten cans of beer and a bottle of vodka daily and had recently tried to kill himself with an overdose of morphine and alcohol. She noted that he had been prescribed

chlordiazepoxide for symptoms of alcohol withdrawal. She wrote that he was subject to ACCT monitoring, might be depressed and an interpreter would be needed to assess his mental state and risk of suicide or self-harm further. She used an online translation tool to communicate with Mr Polubinski.

29. That afternoon, an officer assessed Mr Polubinski as part of ACCT procedures. Another officer interpreted. Mr Polubinski said that he was worried about his passport and some other identification documents that he had lost before he went to prison. He said he had no family in the United Kingdom or in Poland. Mr Polubinski said he had no reason for living but seemed reassured when the officer told him that staff would try to help him find his missing documents.

30. Afterwards, a substance misuse nurse, who also used the officer as an interpreter, drew up Mr Polubinski's care plan. She recorded that he told her that he had tried to kill himself by taking an overdose of alcohol and morphine four years before, after the death of his partner; he had taken poison two years before after a second partner died; and he had recently tried to hang himself after losing his job, accommodation and identification documents. She noted that Mr Polubinski was constantly supervised because of his risk of suicide and had been prescribed chlordiazepoxide to manage alcohol withdrawal symptoms. She planned to review him again in 12 weeks.

31. Later on 6 January, the manager of the offender management unit (OMU) chaired Mr Polubinski's first ACCT case review with several staff. She described Mr Polubinski as chatty and recorded that he said he had no thoughts of suicide or self-harm. She recorded that Mr Polubinski said he would get replacement identification when he was released so that he could find a new job.

32. The staff at the case review considered that Mr Polubinski was at low risk of suicide or self-harm. They decided that he should no longer be constantly supervised, but staff should check him at least twice an hour. The only issue a SO recorded on Mr Polubinski's caremap (designed to address main concerns and should include actions to reduce risk) was Mr Polubinski's lost identification documents. The SO wrote that Mr Polubinski should write to friends for help to replace the documents and the manager of OMU agreed to contact an immigration officer, who dealt with foreign national prisoners at Woodhill. The caremap was never updated after that.

33. After the case review, the manager of OMU emailed her team in the offender management unit and asked for an immigration officer to speak to Mr Polubinski about his lost documents when one was next in the prison, on 7 January.

34. That afternoon, Mr Polubinski moved into a double cell with another Polish prisoner. A SO wrote on the front page of the ACCT document that, as Mr Polubinski could not speak English, he agreed that thumbs up meant that he was fine and thumbs down meant that staff needed to find an interpreter to speak to him.

35. On 7 January, an immigration officer interviewed Mr Polubinski, using an officer to interpret. Mr Polubinski told her he had left his passport at a previous address and had misplaced his identity card after he was arrested. She told the investigator she had advised Mr Polubinski to contact the Polish Embassy to

replace his identification documents. She updated Mr Polubinski's ACCT record with details of their conversation and recorded that he said he felt better and understood everything they had discussed. She recorded in Mr Polubinski's prison record (NOMIS) that he had no current thoughts of suicide or self-harm. She did not meet Mr Polubinski again.

36. On 8 January, a SO postponed Mr Polubinski's ACCT case review until the next day when a Polish speaking member of staff was on duty. He noted that Mr Polubinski's level of risk had not changed.

37. On 9 January, the SO held the ACCT case review with a nurse and the healthcare assistant acting as an interpreter. The SO assessed that Mr Polubinski's level of risk of suicide or self-harm was low and kept his level of observations at twice an hour. He scheduled the next case review for 16 January. The SO did not update the caremap, but he emailed the manager of OMU to ask for someone to help Mr Polubinski replace his lost identity documents.

38. During the evening of 11 January, Mr Polubinski moved to a single cell in the vulnerable prisoner unit. There is no recorded reason for his move, but it is likely that staff regarded him as at risk from other prisoners because of the nature of the charge he was facing. There is no record that anyone considered whether moving Mr Polubinski to a single cell increased his risk of suicide or self-harm.

39. The next day, 12 January, the manager of the vulnerable prisoner unit (VPU) chaired an ACCT case review with a SO, and a healthcare assistant. They used Language Line to communicate with Mr Polubinski. He noted that the police were trying to find Mr Polubinski's lost documents, but he did not update the caremap. He told the investigator that he did not know what documents Mr Polubinski had lost. He said he told Mr Polubinski that he would check if the documents had been found or replaced in a fortnight and would follow it up if not. The staff at the case review agreed that Mr Polubinski was no longer at risk of suicide or self-harm, so they closed the ACCT. Mr Polubinski had been living in the vulnerable prisoner unit for less than a day at the time.

40. A post-closure interview was due to take place on 19 January but this did not happen. The healthcare assistant noted in Mr Polubinski's medical record that the manager of the VPU asked for a Polish speaking member of the healthcare team to check Mr Polubinski's wellbeing regularly, but there is no record that this happened. The ACCT case review was the last recorded contact that Mr Polubinski had with any officer in the vulnerable prisoner unit before he died more than two and half weeks later.

41. Other prisoners in the vulnerable prisoner unit said Mr Polubinski would either put his thumb up and nod his head or put his thumb down and shake his head when they asked if he was okay. They said there were no other Polish-speaking prisoners in the unit and Mr Polubinski did not communicate to prisoners or staff, except a Polish-speaking nurse. There is no record of these conversations in Mr Polubinski's prison or medical record. The prisoners said that Mr Polubinski played chess and watched other prisoners playing chess.

42. On 12 January, the manager of OMU replied to the SO's email sent on 9 January, in which he had asked someone to help Mr Polubinski replace his lost identity documents. She asked whether Mr Polubinski needed to see an immigration officer again. No one replied to her email, contacted the vulnerable prisoner unit, or spoke to an immigration officer about this.

43. On 15 January, a resettlement officer recorded that Mr Polubinski was upset about losing his passport and other identity documents. Mr Polubinski told her he felt isolated, as he had no one to talk to, and that he was thinking about suicide. She completed a security information report and told two other resettlement officers about what Mr Polubinski had said. She did not speak to anyone in the vulnerable prisoner unit or start ACCT monitoring and neither did the other officers.

44. Two officers escorted Mr Polubinski back to the vulnerable prisoner unit and told the manager of the unit that Mr Polubinski had told the resettlement officer he was isolated and had thoughts of suicide. The manager remembered an officer telling him that he thought there was a strong possibility that Mr Polubinski would hurt himself because of his lost documents. He said that he knew Mr Polubinski was anxious about his lost documents and he would talk to him about it. He told the investigator he did not speak to Mr Polubinski that day, as he had spoken to him at the case review on 12 January. He took no further action. He told the investigator that he intended to review the situation after the two weeks had passed, but Mr Polubinski died before he could follow it up.

45. Woodhill's police intelligence officer said a member of the IMB asked him to look into Mr Polubinski's lost identity documents in the middle of January. He said he checked the police national computer and the Thames Valley police systems, but could not find records of his arrest. He asked the IMB to find out more details of Mr Polubinski's arrest to help him track the documents, but he heard nothing more. (The IMB could not find any record of their contact with Mr Polubinski or the police intelligence officer.)

46. On 20 January, Mr Polubinski completed his alcohol detoxification programme. The drug and alcohol support team discharged him from their caseload, as he had not attended two appointments with the team. There is no evidence that Mr Polubinski knew he had the appointments or that anyone spoke to Mr Polubinski about why he did not attend these appointments. (The service manager for the drug and alcohol support team has identified this as a point of learning for her team.)

Sunday 31 January 2016

47. At 7.22am on Sunday 31 January, CCTV footage showed an officer checked Mr Polubinski's cell. He told the investigator that, when he looked through the observation hatch in the cell door, Mr Polubinski was asleep.

48. At 9.00am, Officer A unlocked the prisoner who was in the cell next to Mr Polubinski, and asked him to help distribute clean bedding and clothing to other prisoners in the unit. Although the officer thought he had unlocked Mr Polubinski's cell at the same time, CCTV footage showed he was distracted by

someone calling him to another part of the wing and did not unlock Mr Polubinski's cell or any other nearby cells at the time.

49. The CCTV shows that no one checked Mr Polubinski or opened his cell, or any of the cells around them, after the 7.22am check. Officer A and Officer B, who also worked in the unit, said that this was an oversight. Because of shortages of staff at Woodhill, both officers were working at Woodhill temporarily.

50. At around 11.40am, Officer B unlocked prisoners' cells so that they could collect their lunch. At 11.43am, he unlocked Mr Polubinski's cell and found him hanged by a ligature made from a sheet tied to a wall bracket. He shouted, 'code blue' and went into the cell. Officer C radioed a code blue (a medical emergency code used in circumstances such as when a prisoner is unconscious or not breathing). The control room rang for an ambulance at 11.44am. Officer B supported Mr Polubinski's weight and cut the ligature and Officer C helped him place Mr Polubinski on the floor. They were joined by the healthcare assistant and another officer, who started cardiopulmonary resuscitation. Officers B and C left the cell. A nurse arrived and attached a defibrillator but this found no shockable heart rhythm, so they continued resuscitation.

51. At 11.56am, paramedics arrived at Mr Polubinski's cell and took over emergency treatment. A prison doctor joined them. Advanced life support was unsucceful and, at 12.23pm, the doctor recorded that Mr Polubinski had died.

52. When he arrived at Woodhill, Mr Polubinski told staff he had no contact details for a next of kin. After his death, the prison and the coroner liaised with the Polish Embassy who arranged for Mr Polubinski's body to be repatriated to his home town in Poland. The prison contributed to the costs, in line with national instructions.

Support for prisoners and staff

53. At 1.30pm on 31 January, an operational manager debriefed the staff involved in the emergency response. She offered her support and that of the care team.

54. The prison posted notices informing other prisoners of Mr Polubinski's death. Staff reviewed all prisoners assessed as at risk of suicide and self-harm, in case they had been adversely affected by Mr Polubinski's death.

Post-mortem report

55. The post-mortem examination found that the cause of death was ligature around the neck (hanging). A toxicology report found traces of the medication Mr Polubinski had taken for alcohol withdrawal in his blood, but there was no evidence that he had taken any other substances.

Findings

Assessment and management of risk of suicide and self-harm

56. When Mr Polubinski arrived at Woodhill he had recently tried to kill himself, had a history of attempted suicide and it was his first time in prison. He spoke little English and was charged with a sexual offence. All of these factors increased his risk of suicide. Court staff had completed a suicide and self-harm warning form and prison reception staff appropriately began ACCT procedures. However, we have some concerns about how effectively the procedures operated to protect him.

57. On Mr Polubinski's first night in prison, he was appropriately assessed as at high risk of suicide and constantly supervised. The next day, although nothing had been done to reduce his level of risk, a case review assessed him as at low risk of suicide and reduced his level of observations to twice an hour. We do not consider that the assessment that he was low risk accurately reflected his risk at the time. Mr Polubinski had recently attempted suicide, he had cut himself in police custody and had voiced further suicidal thoughts the night before at his first night interview. This was his first time in prison and he was in the very early days – he had not yet spent a full day at the prison. It is therefore difficult to understand how staff assessed his risk as low.

58. Prison Service Instruction (PSI) 64/2011, which covers safer custody, says that ACCT caremaps should reflect the prisoner's needs, level of risk and the triggers for distress. There should be detailed time-bound actions aimed at reducing the risk posed by the prisoner and cover the issues identified in the ACCT assessment interview. They should say who is responsible for completing the action within a specified timeframe. Caremaps should be reviewed and updated at each case review with new actions added, if necessary. ACCT plans should not be closed until caremap actions are completed.

59. The main concern that staff identified was that Mr Polubinski had lost his identity documents. This was the only recorded issue on his caremap. No one spoke to him about bereavement, which he said had prompted his previous suicide attempts or about his hopelessness after losing his job and accommodation. His alcohol dependency and detoxification were not identified as risk factors.

60. After seven days, staff decided that Mr Polubinski was no longer at risk of suicide or self-harm and ended ACCT monitoring. At the time, Mr Polubinski was still very anxious about his lost documents and the one action on his ACCT care plan had not been completed. No individual member of staff had been identified to help resolve Mr Polubinski's concern about his lost documents. No one appeared to consider his other risk factors as an isolated newly arrived prisoner with a history of suicide attempts, withdrawing from alcohol, who was unable to communicate with those around him. We consider that ending ACCT monitoring at this stage was inadvisable and premature. Staff did not hold the required post-closure review on 19 January, so did not identify that Mr Polubinski was still very worried about his lost documents, or whether he had any other concerns.

61. On 15 January, Mr Polubinski told an officer that he had suicidal thoughts and was feeling isolated, as he had no one to talk to. He was also still concerned

about replacing his lost identity documents. She did not start ACCT monitoring, but passed this information on to other officers to tell the staff in the vulnerable prisoner unit, where Mr Polubinski lived. The manager of the vulnerable prisoner unit, did not speak to Mr Polubinski or take any other action. Prison Service Instruction (PSI) 64/2011 Safer Custody requires that "any member of staff who receives information … which may indicate a risk of suicide or self-harm must open an ACCT". We consider that staff should have begun ACCT procedures on 15 January. 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. In particular:

- **ACCT case reviews should assess the level of risk taking into account all risk factors.**
- **ACCT case reviews should set caremap actions which are specific and meaningful, aimed at reducing a prisoner's risk and identify who is responsible for them.**
- **Case managers should review progress against caremaps at each review and continue ACCT monitoring until the risk posed by the prisoner has reduced and all caremap actions have been completed.**
- **Staff should review a prisoner's risk when they express thoughts of suicide and begin ACCT monitoring when indicated.**
- **ACCT post-closure reviews should be held as scheduled.**

Clinical care

62. The clinical reviewer reviewed the clinical care Mr Polubinski received at Woodhill. He found that Mr Polubinski received the appropriate medication to deal with symptoms of alcohol withdrawal. In his clinical review, he has made recommendations about areas for improvement in the delivery of healthcare services, which the Head of Healthcare and manager of the drug and alcohol support team will need to address.

63. Mr Polubinski had tried to kill himself shortly before he went to prison and had cut himself when he was in police custody. He told a member of reception staff that his next suicide attempt would be successful. Staff began ACCT procedures as soon as he arrived yet no one referred him for a mental health assessment, either as an ACCT caremap action or following healthcare appointments. The reception nurse wrongly assumed that someone would assess Mr Polubinski's mental health as part of the ACCT process, so did not refer him herself. We make the following recommendation:

The Governor and Head of Healthcare should ensure that the prisoners identified as being at risk of suicide and self-harm are referred urgently for a mental health assessment.

Contact with staff

64. While it might have been difficult to have foreseen Mr Polubinski's actions, some of the information about his state of mind could have been more effectively co-ordinated and might have identified concerns. The National Offender

Management Service's guidance to prisons about managing foreign national prisoners states:

> 'Language barriers … can exacerbate all other problems. As professional staff, we have a responsibility to ensure that prisoners understand what is being said to them and what is expected of them. Staff should not assume that prisoners with 'some' command of the English language, fully understand what is being said or the implications. Staff need to understand and be equipped to respond to requests … Foreign national prisoners may be vulnerable to self-harm as they are more likely to experience feelings of isolation, difficulties in communication and may be in custody for the first time…For some, cultural norms may mean a reluctance to complain or seek help and staff need to be alert to this.'

65. Mr Polubinski spoke and understood little English. He did not seek out staff and appeared to raise concerns with staff only at formal reviews and meetings, when an interpreter was provided. Staff appropriately used colleagues who spoke Polish and Language Line at these reviews and meetings to communicate with Mr Polubinski. However, there were no entries from officers in Mr Polubinski's records to indicate that anyone had checked on his wellbeing while he was in the vulnerable prisoner unit and staff knew little about him. There is no evidence that staff used interpreting services after he moved to the vulnerable prisoner unit and Mr Polubinski did not have an assigned personal officer.

66. The Ombudsman supports the concept of personal officer schemes to ensure all prisoners have a named member of staff tasked to get to know their allocated prisoners, identify their risks and need, and offer support. We therefore agree with the IMB's view that the loss of the personal officer scheme at Woodhill is a missed opportunity for staff to identify prisoners who might be at risk of suicide or self-harm.

67. We are concerned about the lack of staff interaction with Mr Polubinski at Woodhill, especially after he moved to the vulnerable prisoner unit. In a recently published review of all self-inflicted deaths in prison in 2013/14, we noted that there had been an increase in deaths of prisoners at an early stage in a new prison. Most of the prisoners who died had spent less than three months in their final prison. The very early days in prison are often recognised as a high-risk time, but there is also a need to ensure that staff are vigilant for signs of vulnerability in the weeks that follow. This requires appropriate interaction with prisoners and this is particularly the case with foreign national prisoners like Mr Polubinski, who may be particularly isolated because of language barriers.

68. In another recent investigation into a death in the vulnerable prisoner unit at Woodhill on 29 December 2015, we recognised that, currently, staffing levels and vacancies at Woodhill made it difficult to run a comprehensive personal officer scheme but a modified scheme for prisoners at known periods of high risk, such as the early period in custody should be achievable. Not only was Mr Polubinski in the early period of custody, his vulnerability was heightened by his isolation. We repeat our previous recommendation:

As part of a planned reintroduction of an effective personal officer scheme, the Governor should introduce an adapted scheme so that prisoners in the early days of custody and other vulnerable periods of their time in prison have an assigned officer who gets to know and support them.

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Independent Investigations

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