Prisons & Probation
Ombudsman
Independent Investigations

Independent investigation into the death of Mr Michael Cameron a prisoner at HMP Woodhill on 28 April 2016

A report by the Prisons and Probation Ombudsman
Nigel Newcomen CBE

PO Box 70769
London, SE1P 4XY
Email: mail@ppo.gsi.gov.uk
Web: www.ppo.gov.uk
T | 020 7633 4100
F | 020 7633 4141

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*

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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.

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

Mr Michael Cameron was found hanged in his cell at HMP Woodhill on 26 April 2016. He was 45 years old. I offer my condolences to Mr Cameron's family and friends.

Staff at Woodhill appropriately identified that Mr Cameron was at risk of suicide and self-harm when he arrived on 19 April, and began monitoring his risk. I recognise that there was little to indicate that Mr Cameron was at imminent and high risk of suicide immediately before his death.

Mr Cameron had used drugs in the community and appears to have used Spice, a new psychoactive substance, during his time in prison. I would have expected Woodhill to prioritise a mental health assessment to support any needs Mr Cameron might have had. Woodhill failed to alert Mr Cameron's family immediately after he was taken to hospital in a critical condition.

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 **February 2017**

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Summary

Events

1. On 19 April 2016, Mr Michael Cameron was remanded to HMP Woodhill, charged with a serious violent offence against his partner. It was not his first time in prison. He had harmed himself and tried to take his life in police custody. Mr Cameron arrived at Woodhill with a suicide and self-harm warning from court. Reception staff began suicide and self-harm prevention procedures, and placed him under hourly observations.

2. Mr Cameron had alcohol withdrawal symptoms and spent his first night on the prison's detoxification wing. The next morning, Mr Cameron began an alcohol detoxification programme. A nurse referred Mr Cameron to the mental health team after he described having visual and auditory hallucinations. He felt his mental health had been affected by what he had done to his partner.

3. On 21 April, Mr Cameron went to the treatment room hatch on the wing to collect his morning medication. The nurse noticed that he was unsteady on his feet and his speech was slurred. She examined Mr Cameron and suspected he had smoked a new psychoactive substance (a synthetic cannabinoid). Staff placed him on 15 minute observations and withheld his alcohol detoxification medication that morning. There is no record to explain why his medication was withheld.

4. On 23 April, Mr Cameron told staff that he felt unsafe and was moved to the vulnerable prisoner wing. At the ACCT review immediately afterwards, Mr Cameron was tearful and said he felt guilty about his offence, but relieved about moving to a different unit. He said he had taken a new psychoactive substance. Mr Cameron remained on hourly observations. The next day, Mr Cameron did not receive his detoxification medication. There is no record to explain why not.

5. On 25 April, Mr Cameron's cellmate gave an officer a broken razor blade that he had taken from Mr Cameron. He said Mr Cameron had intended to harm himself. Mr Cameron was upset and said he had not spoken to his family. He said that he had current thoughts of suicide but would not hurt himself. An immediate ACCT review noted that Mr Cameron's risk of suicide and self-harm was high and his observation level was increased to half hourly.

6. On the afternoon of 26 April, the wing manager and nurse saw Mr Cameron for an ACCT review. Mr Cameron engaged well but was tearful and showed remorse for his alleged offence. He said he had thoughts of suicide but had made no plans. By the end of the review, Mr Cameron appeared more positive. The nurse referred him to the mental health team for psychological support and Mr Cameron was allowed to telephone his mother. His frequency of observations remained half hourly and his risk level was lowered to raised, to be reviewed the next day.

7. Around 4.30pm that day, Mr Cameron's cellmate was moved to a different wing, leaving him alone in his cell. At 6.16pm, an officer went to Mr Cameron's cell to check him and found that he had hanged himself. He alerted officers who radioed an emergency code. Prison officers and nurses tried to resuscitate Mr Cameron, until paramedics arrived and took him to hospital. Mr Cameron died on 28 April.

8. As a consequence of Mr Cameron dying in hospital, no toxicology test was undertaken. Therefore, although it is very likely, that he had taken Spice, we cannot conclude whether this contributed to his death.

Findings

9. Mr Cameron appropriately began an alcohol detoxification programme when he arrived at Woodhill. We are concerned however that there were two days when he did not receive his detoxification medication. On one of these days, no one recorded a reason for this; it was not clear if this was related to Mr Cameron taking a new psychoactive substance the previous day and whether that was an appropriate response.

10. Although Mr Cameron was appropriately identified as at risk of suicide and self-harm when he arrived at Woodhill and was referred to the mental health team on four occasions, we are concerned that the mental health team never fully assessed him.

11. After Mr Cameron was found hanged in his cell, paramedics took him to hospital. Staff took an hour and 45 minutes before they contacted Mr Cameron's next of kin.

Recommendations

- The Head of Healthcare should ensure that when a prisoner is being treated for any drug or alcohol misuse, all healthcare staff identify and clearly record the diagnosis, the medication required and the duration of treatment, and ensure that there are no unnecessary breaks in treatment.
- The Governor and Head of Healthcare should ensure that there is a clear pathway for mental health services, which ensures that prisoners identified as at risk of suicide and self-harm have an urgent mental health assessment within three days.
- The Governor should ensure, in line with Prison Rule 22, that the next of kin of seriously ill prisoners are informed as soon as possible.

The Investigation Process

12. 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. No one came forward.

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

14. The investigator visited Woodhill on 6 May 2016. He obtained copies of relevant extracts from Mr Cameron's prison and medical records. He interviewed 13 members of staff at Woodhill.

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

16. One of the Ombudsman's family liaison officers contacted Mr Cameron's mother to explain the investigation. She asked us to consider the following matters.

- She was concerned that Mr Cameron was only checked every 30 minutes despite the prison knowing Mr Cameron was depressed. She felt that staff had not properly assessed his risk.
- She was not told that her son had died until 10.00pm, several hours after he was found hanged at approximately 6.30pm.

17. Mr Cameron's family received a copy of the initial report. The solicitor representing them wrote to us pointing out some factual inaccuracies. The report has been amended accordingly. They also raised a number of questions that do not impact on the factual accuracy of this report. We have provided clarification by way of separate correspondence to the solicitor.

Background Information

HMP Woodhill

18. HMP Woodhill is both a local and a high security prison, which can hold more than 800 men. Central and North West London NHS Foundation Trust provide all health services at the prison. Westminster Drug Project provides drug and alcohol support services.

HM Inspectorate of Prisons

19. The most recent inspection of HMP Woodhill was in September 2015. While the prison was reliant on detached duty officers and new recruits, inspectors found that staffing levels were better than at other prisons they had inspected. Mental health services had been hit by staff shortages and waits to see the mental health team were too long. Inspectors were concerned about the high number of self-inflicted deaths (nine since 2012). They felt there was not a sufficiently whole-prison approach to understanding and addressing the contributory and preventative factors in prisoners' overall experience. Inspectors found the quality of ACCT documentation was inconsistent, and often failed to address underlying causes. Caremaps were not always updated and did not include all steps to address underlying issues.

Independent Monitoring Board

20. 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 and severe staff shortages remained a concern. They felt 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 ACCT monitoring procedures. The IMB commented that the prison had abandoned the personal officer scheme (except on house unit six). They felt this meant the loss of an early opportunity to identify prisoners who might be at risk of suicide or self-harm.

Previous deaths at HMP Woodhill

21. Mr Cameron was the tenth self-inflicted death at Woodhill since the start of 2014. In this report and in three of the previous reports, we identified deficiencies in the delivery of the mental health services. Since Mr Cameron's death, two more prisoners have apparently taken their lives.

Assessment, Care in Custody and Teamwork

22. 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.

23. 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 multi-disciplinary 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.

New Psychoactive Substances

24. New psychoactive substances are an increasing problem across the prison estate. They are difficult to detect, as they are not identified in current drug screening tests. Many new psychoactive substances contain synthetic cannabinoids, which can produce experiences similar to cannabis. New psychoactive substances are usually made up of dried, shredded plant material with chemical additives and are smoked. They can affect the body in a number of ways including increasing heart rate, raising blood pressure, reducing blood supply to the heart and vomiting.

25. In July 2015, we published a Learning Lesson Bulletin about the link between the use of new psychoactive substances and an increased risk of death, damage to physical and mental health, bullying, debt and possibly suicide and self-harm. The bulletin identified the need for better awareness among prison staff and prisoners of the dangers of new psychoactive substances; the need for more effective drug supply reduction strategies; better monitoring by drug treatment services; and effective violence reduction strategies.

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Key Events

18-19 April 2016

26. On 19 April, Mr Michael Cameron was remanded to HMP Woodhill, charged with attempted murder and raping his partner, possessing a firearm, common assault and criminal damage. It was not his first time in prison but he had not been in prison for nine years. Mr Cameron arrived with a suicide and self-harm warning form from court and his person escort record (a document which accompanies prisoners on all journeys between police stations, courts and prisons), which also noted his suicide and self-harm risk. He had harmed himself in police custody and had been placed under constant observation.

27. An officer assessed Mr Cameron in reception. She noted his offences, his risk of suicide and self-harm, that he had a history of alcohol and drug misuse but did not appear to have any mental health concerns. Based on this information, another officer started ACCT suicide and self-harm prevention procedures. Mr Cameron named his mother as his next of kin. The officer recorded that potential triggers for Mr Cameron's self-harm were his "offence against his partner" and his alcohol and substance misuse.

28. A Supervising Officer (SO) recorded that Mr Cameron was to start a detoxification programme. Because his charge involved domestic violence, Mr Cameron was not allowed to telephone anyone until his telephone numbers had been checked. Mr Cameron arrived with no money.

29. A nurse saw Mr Cameron for an initial health screen. She recorded in his medical record that he had hurt his head and hands and had a history of substance misuse, including using methadone, cocaine and heroin. Mr Cameron said he had no problems with alcohol and it was noted that he was a moderate drinker. While she noted a previous serious attempt on his life, Mr Cameron said he had no current thoughts of suicide or self-harm but felt hopeless. His relationship with his partner had recently broken down. She noted Mr Cameron was being supported by ACCT procedures and that he was not allowed to keep medication in his possession.

30. An officer noted Mr Cameron was tearful during his first night interview. She arranged for him to speak to his mother. He asked his mother to send him some money and she told him she had spoken to a solicitor.

31. A SO set Mr Cameron's ACCT observations for hourly until his ACCT assessment. Mr Cameron was assessed as fit to share a cell with another prisoner. Due to his offence, staff offered to locate Mr Cameron on the vulnerable prisoner wing but he declined.

32. A prison GP recorded in Mr Cameron's medical record that he did not see him during the reception screening process. This was because the nurse did not indicate that Mr Cameron was taking regular medication, misusing drugs or alcohol. The GP noted that he would review Mr Cameron's physical health through the normal GP clinics.

33. However, shortly afterwards, the detoxification nurse telephoned the prison GP. She said Mr Cameron had alcohol withdrawal symptoms. This information was not consistent with another nurse's earlier entry on SystmOne, that Mr Cameron was only a moderate drinker. As there was no member of the Westminster Drugs Project team (a substance misuse service) on duty, the GP prescribed librium detoxification medication until Mr Cameron could be reviewed the next morning. This consisted of chlordiazepoxide in a reducing dose along with paracetamol, ibuprofen and an antacid (used to control acid levels in the stomach). Mr Cameron was moved to another unit for detoxification, where he shared a cell with another prisoner. He received his first dose of detoxification medication that evening.

20 April 2016

34. That morning, Mr Cameron received his second day prison induction, and was visited by a chaplain. Mr Cameron told staff that he was concerned about his flat (where his young daughter was).

35. A prescriber nurse and another nurse saw Mr Cameron to complete his screening for the Westminster Drugs Project. Mr Cameron told the prescriber nurse that he had used cocaine, 'Power' (a drug which he described as more powerful than crack cocaine) and alcohol at least five days earlier. He said that he could not recall his offence, but remembered that in police custody, he had delirium tremens (a severe form of alcohol withdrawal, with symptoms of confusion and an altered mental state and physical symptoms, which can result in seizures and cardiovascular collapse). He said he had visual and auditory hallucinations and had had a seizure. He said that before his arrest, he drank more than 15 pints of alcohol per day. She recorded that Mr Cameron's mood was low and he was tearful at times when discussing his offence. She noted his history of self-harm. Mr Cameron said he had fleeting thoughts of self-harm but would not act on these now. He said he planned to speak to prison staff about having a single cell because of his history of violence.

36. The prescriber nurse diagnosed Mr Cameron with depression and referred him to the mental health team. She discussed with Mr Cameron safe alcohol withdrawal and lifestyle advice, specifically about the risks of taking Spice, a new psychoactive substance. She noted that Mr Cameron would be reviewed in a week's time. She prescribed an anti-epileptic medication and thiamine, vitamin B and rectal diazepam (as needed in the event of prolonged seizure activity).

37. A SO assessed Mr Cameron under ACCT procedures. Mr Cameron said that he could not remember being arrested and had self-harmed in police custody. He talked about his history of drug and alcohol misuse and that he had overdosed on methadone three years ago. He was worried about his mental health. He had nightmares, hallucinations and heard voices. He was concerned about sharing a cell as his behaviour could affect his cellmate. The SO noted that Mr Cameron said he had some current thoughts of suicide and self-harm. He said he had good family support from his mother and wanted a legal visit from a solicitor.

38. The SO explained the ACCT process to Mr Cameron. He summarised Mr Cameron's main issues and noted that his eye contact was poor during their conversation. He reminded Mr Cameron that he could be moved to the vulnerable prisoner wing at a later date, if he wished and he should keep himself occupied to help reduce his risk. The SO said that a senior manager would review Mr Cameron's cell sharing risk later that day.

39. A nurse saw Mr Cameron for his secondary health screening. Mr Cameron engaged well and said he hoped to get a job in prison soon. The nurse recorded Mr Cameron's physical and mental health history and noted he was being monitored under ACCT procedures. Mr Cameron said that although he had had earlier thoughts of self-harm, he had no thoughts now.

40. A SO held Mr Cameron's first ACCT case review with another SO and a nurse from the Westminster Drug Project. Mr Cameron said he was worried about sharing a cell because of the difficulties he had at night. Mr Cameron said he would to talk to staff if he felt that he was not coping. He admitted that he had a problem with drugs, wanted help and was happy to engage with the services offered by the Westminster Drug Project. The SO told Mr Cameron that he had contacted Mr Cameron's mother and had told her how to contact him. Mr Cameron was pleased and thanked him.

41. The review panel agreed that, while Mr Cameron was being supported by ACCT procedures, having a cellmate provided him with additional support. They assessed his risk of suicide and self-harm as raised and decided that staff should continue to observe him hourly until he felt settled.

42. A SO noted four issues in Mr Cameron's ACCT caremap. Another SO had already completed the first issue by contacting Mr Cameron's mother and asking her to send Mr Cameron money; the second issue was to review and discuss Mr Cameron's cell sharing risk; the third was for staff to get the contact details for Mr Cameron's solicitor; and the fourth was to refer Mr Cameron to the mental health team. The SO emailed a referral to the mental health team after the review. He scheduled the next case review for 22 April and noted that representatives from the mental health team, the Westminster Drug Project team and wing staff should attend. He explained to Mr Cameron that because of his offences, he might want to live on the vulnerable prisoner wing. Mr Cameron declined.

43. On the same day, an officer completed Mr Cameron's second day induction interview.

44. That evening, the duty governor and a SO saw Mr Cameron to discuss his cell sharing risk. The duty governor noted that he had a long conversation with Mr Cameron about being subject to ACCT procedures and his state of mind. Mr Cameron explained that his offence had caused him stress and although he had no current thoughts of suicide and self-harm, he said he wanted to be on his own in a cell to clear his head. He was aware that he had woken up in the night shouting but said he would not harm his cellmate. He said he got on with well with his cellmate. The duty governor noted that he was happy for Mr Cameron to remain in a double cell.

21 April 2016

45. Mr Cameron went to the treatment room hatch on the wing to collect his morning medication. He told the Westminster Drug Project pharmacy technician that he felt unwell. She noted that Mr Cameron was unsteady on his feet. She noted his heart rate was normal but his blood pressure was slightly low. She withheld his medication and staff agreed to observe him at 15 minute intervals. She arranged to review Mr Cameron at lunchtime. She said that staff had suspicions that day about a number of prisoners taking new psychoactive substances.

46. A mental health nurse was on the wing and saw Mr Cameron that afternoon. She noted that he appeared under the influence of an illicit substance, was having difficulties standing and speech was slurred. However, Mr Cameron answered most of her questions. He said he had taken an overdose three years ago but had no current thoughts of suicide or self-harm. He had nightmares and difficulties sleeping at night. She noted that wing staff had informed her that Mr Cameron had been screaming in his cell the previous night. She referred Mr Cameron to the mental health in-reach team.

22 April 2016

47. Due to Mr Cameron's behaviour the previous day, staff suspected that he was under the influence of a new psychoactive substance and he was placed under observation at 15 minute intervals and placed on report.

48. The pharmacy technician examined Mr Cameron at 9.25am and noted his suspected illicit drug use. He was unsteady on his feet, his pupils were dilated and unresponsive to light, his speech was slow and he had difficulties keeping his eyes open. His pulse was high. When Mr Cameron was checked at 10.50am, she noted that his pupils and pulse rate had returned to normal. Mr Cameron was still a little drowsy. Mr Cameron did not attend a scheduled doctor's appointment that morning.

49. That afternoon, a worker from the Offender Management Unit sent a note to Mr Cameron in response to questions he had asked, confirming his daughter was safe but she had no information about where she was. She asked for the address of his flat so she could look into his concerns.

50. That afternoon, a SO noted that he had postponed Mr Cameron's second ACCT case review because the healthcare team had confirmed that Mr Cameron was under the influence of a new psychoactive substance, and had spent much of the day asleep in his cell. He rescheduled the case review for the next day. Mr Cameron's ACCT observations and risk level remained the same.

23 April 2016

51. In the morning, Mr Cameron collected his medication. In the afternoon, he told the SO that he did not feel safe and wanted to move to the vulnerable prisoners' wing. He did not say why he felt unsafe. The SO arranged for him to move.

52. Shortly after 4.00pm, Mr Cameron moved to another unit because there was no space on the vulnerable prisoners' wing. The unit where he was sent was still able to accommodate vulnerable prisoners as it offered a split regime (two activity schedules for prisoners on the same wing). Mr Cameron shared a cell with Prisoner A.

53. A SO chaired Mr Cameron's third ACCT review with a mental health nurse. He noted Mr Cameron was tearful and said he felt guilty about his offence, relieved at moving unit and had taken Spice. The panel decided that Mr Cameron would remain on hourly observations and scheduled his next ACCT review for 26 April. A member of the mental health team was to attend this review. He reviewed the ACCT caremap and noted that Mr Cameron had no credit on his PIN phone account to make calls. He noted that another SO should look into this.

24 April 2016

54. There were no entries in Mr Cameron's medical record to indicate whether he had received his medication.

25 April 2016

55. Mr Cameron attended a disciplinary hearing in the segregation unit. The adjudicator found him guilty of being under the influence of a new psychoactive substance and reduced his Incentive and Earned Privileges (IEP) level to basic. (Under normal circumstances, this would mean a reduction of privileges or some financial penalty, but there was no immediate detrimental effect to Mr Cameron's IEP level as he was new to Woodhill and did not work or attend education.)

56. Mr Cameron told a member of the chaplaincy team that "he was not in a good place" and had previously taken a new psychoactive substance which had affected him. He said he had not received his alcohol detoxification medication the previous day. A wing officer escorted Mr Cameron to the medication hatch where he was given his medication.

57. At 4.20pm, Prisoner A (Mr Cameron's cellmate) gave an officer a broken razor blade that he had taken from Mr Cameron. He said Mr Cameron had intended to harm himself. The officer had a lengthy conversation with Mr Cameron, who was upset. The officer reported the incident to a SO, as the unit manager, and scheduled an interim ACCT review with a member of the healthcare team to discuss the incident.

58. The SO held the interim ACCT case review at 6.30pm with a mental health nurse. He noted that Mr Cameron was upset about his situation and the charges against him. Mr Cameron told the review panel he had not had any contact with his family. He said that he had thoughts of suicide but would not hurt himself. He said he loved his children, who were his main motivation and wanted to fight the charges against him. He said that his mood was low and he had no "drive". Mr Cameron accepted that he needed help. The SO told Mr Cameron that he would arrange a telephone call to his mother and contact his solicitor. He reminded Mr Cameron of the support available, including

from his cellmate. The nurse noted that Mr Cameron still had not seen a member of the mental health team. By the end of the review, the SO judged that Mr Cameron's mood had improved. The panel however increased his observations to half hourly and noted his risk level was high. He scheduled the next ACCT review for the next day.

26 April 2016

59. At 10.40am, the case manager for Thames Valley Community Rehabilitation interviewed Mr Cameron in the resettlement unit to complete his immediate needs screening. Mr Cameron engaged well during the interview although intermittently became upset when talking about his young daughter. Mr Cameron said he that he had lived with his partner and young daughter. He had other family members – his mother lived in London and he had four other children. He wanted his two older sons to collect his belongings from the property and asked her to contact the police to arrange this. She told Mr Cameron that she would refer him for the domestic violence and counselling courses to address his offending behaviour. Mr Cameron agreed and said that he was on a detoxification programme. She said she would contact the mental health team as she noticed that they had not yet assessed him.

60. A SO began his duty at 1.15pm. The previous SO completed a handover to him and updated him about the previous evening's events with Mr Cameron. He told him that an ACCT case review was due that afternoon.

61. The SO held the ACCT review at 2.10pm with a nurse. He noted that Mr Cameron engaged well during the review although was tearful at times. Mr Cameron said he felt isolated because his offence was against his partner and he was not allowed to contact her or his children. He was remorseful about the incident. He said he had no legal representative. The SO gave Mr Cameron details of a solicitor he could use. Mr Cameron said he had thoughts of suicide but had made no plans. He rated his mood as two out of ten (with one being the lowest). He said he would feel better if he was able to talk to his mother and a solicitor. The nurse reminded Mr Cameron of the services of the Samaritans and Listeners. She referred him to the mental health team and said staff would arrange for Mr Cameron to speak to his mother. The SO and nurse agreed that the frequency of Mr Cameron's observations would remain at half hourly intervals. His risk level was lowered to raised and his next ACCT case review was scheduled for the next day.

62. Immediately afterwards, at 2.27pm, Mr Cameron telephoned his mother. He told her that he was not okay and got caught trying to cut his wrists. He said staff were monitoring him every half an hour. His mother told him not to be stupid. Mr Cameron said he had not heard from a solicitor. He confirmed that he had received the money his mother had sent him but was unable to spend it yet. His mother said she was trying to arrange to visit him and would send him more money. Mr Cameron said he liked his cellmate and promised his mother that he would not harm himself.

63. Around 4.30pm, staff moved Mr Griffiths to a different unit for security reasons. Aware that Mr Cameron would be alone in his cell, the SO tried to find a suitable cellmate for him. Staff identified that a new vulnerable prisoner had

arrived that afternoon and could share a cell with Mr Cameron. Staff expected the prisoner to complete his first night reception interview at about 6.30pm after which they planned to escort him to Mr Cameron's unit.

64. Mr Cameron collected his evening meal just after 4.30pm and returned to his cell. By 5.00pm, staff had locked all the cells on the unit for the night.

65. Officer A started duty on Mr Cameron's unit at 5.30pm. The SO updated him about all the prisoners subject to ACCT procedures. The officer's first task was to check these prisoners and he started with Mr Cameron. He noted that Mr Cameron had had his evening meal and was tidying his cell.

66. Prisoner B was working on the wing, checking and ensuring the correct nameplates where displayed outside cell doors. When he checked Mr Cameron's nameplate, he opened the observation flap and saw what appeared to be him watching television.

67. At 6.16pm, Officer A returned to complete an ACCT check for Mr Cameron. He looked through the door observation panel and saw Mr Cameron sitting between the top and bottom bunk bed, facing the window. Mr Cameron did not respond to him when he called his name. He saw something around Mr Cameron's neck and immediately pressed the general alarm button outside the cell while trying to open the door.

68. Officer B responded quickly to the general alarm (logged at 6.16pm) and entered the cell with Officer A. Officer A cut the ligature (twisted green bed sheet) while Officer B supported Mr Cameron's weight and they lowered him to the floor. The SO arrived at the cell within a minute and helped the two officers lower Mr Cameron to the bed. He radioed a medical emergency code blue (logged at 6.18pm). The control room called an ambulance immediately.

69. Officer B assessed Mr Cameron and found no signs of life. He started cardiopulmonary resuscitation on Mr Cameron. A nurse arrived. She told the officers to move Mr Cameron to the wing landing for ease of access. She checked Mr Cameron for signs of life but found none.

70. Officer A continued with cardiopulmonary resuscitation, and alternated with Officer B and the SO while the nurse set up the medical emergency equipment. The nurse attached a defibrillator, which found no shockable heart rhythm. Staff continued cardiopulmonary resuscitation and Mr Cameron was given oxygen through a facial mask. A prison GP arrived at the cell at 6.25pm. He helped with the resuscitation efforts and administered adrenalin to Mr Cameron. The paramedics arrived at the cell at 6.31pm followed by a second ambulance paramedic two minutes later. Shortly afterwards, paramedics detected a pulse.

71. At 7.14pm, they took Mr Cameron to hospital. On 28 April, Mr Cameron died in hospital. Mr Cameron had left two notes in his cell for his partner and son.

Support for staff and prisoners

72. The Head of Reducing Re-offending debriefed the staff involved in the emergency response and offered his support and that of the staff care team.

Staff reviewed prisoners assessed as at risk of suicide and self-harm in case they had been affected by Mr Cameron's actions. There was a further debrief on 28 April when Mr Cameron died.

Family liaison

73. An officer was appointed as the prison's family liaison officer around 8.45pm on 26 April. He was at home and came into Woodhill. At 9.00pm, he telephoned Mr Cameron's mother, his next of kin, to tell her what had happened and that Mr Cameron was in hospital. When he arrived at the prison, he telephoned Mr Cameron's mother, explained what had happened and arranged to meet her at the hospital. Mr Cameron's mother and other family members arrived at 11.44pm and he stayed with Mr Cameron's family until around 3.30am, and offered support. In line with Prison Service policy, the prison contributed to the costs of Mr Cameron's funeral.

Cause of death

74. A hospital consultant who specialised in critical care confirmed Mr Cameron's cause of death as brain damage caused by a lack of oxygen resulting from hanging. The coroner was satisfied that there was no need for a post-mortem examination. As Mr Cameron had been in hospital for two days before his death, no toxicology tests were undertaken.

Findings

ACCT procedures and assessing risk

75. Prison Service Instruction (PSI) 64/2011 on safer custody and PSI 07/2015 on early days in custody list a number of risk factors and potential triggers for suicide and self-harm. Mr Cameron had a number of these risks when he arrived at Woodhill:

- He had been charged with violent offences against his partner
- He had a history of self-harm and attempted suicide.
- He had current thoughts of suicide and self-harm.
- He was withdrawing from alcohol and had a history of drug and alcohol misuse.

76. In the short period Mr Cameron was at Woodhill, staff operated ACCT procedures effectively to address his risk of suicide and self-harm, and support him. Mr Cameron arrived with a suicide and self-harm warning form, and staff appropriately considered his risks and began ACCT monitoring. PSI 64/2011 requires case reviews to be multi-disciplinary, and a member of healthcare attended each case review. Staff at Mr Cameron's first case review assessed his risk of suicide and self-harm as raised and appropriately required staff to monitor Mr Cameron hourly. Staff appropriately increased Mr Cameron's risk and level of observations to half hourly after his cellmate removed a razor blade from him.

77. Staff ensured Mr Cameron shared a cell to reduce his risk of self-harm and suicide. In the immediate period before he hanged himself, Mr Cameron gave little indication that he was at very high and imminent risk of suicide and it would have been difficult for staff to anticipate his actions. It was reasonable therefore that staff left Mr Cameron alone in his cell for a short period on the afternoon of 26 April while they found another cellmate for him.

Emergency response

78. When Officer A found Mr Cameron hanged, he shouted for help and pressed the general alarm button, but did not radio a medical emergency code blue. However, the SO radioed a code blue when he arrived at the cell, very shortly afterwards. The officer told the investigator that he knew he should have radioed a code blue, but his priority was to go into the cell and help Mr Cameron. As there was only a very slight delay in calling the emergency code, this did not affect the outcome for Mr Cameron.

Family liaison

79. Mr Cameron was taken to hospital by emergency ambulance at 7.14pm. However, no one from the prison informed Mr Cameron's family of his admission to hospital until 9.00pm, an hour and 45 minutes after his admission.

80. Prison Rule 22 requires that when a prisoner is seriously ill, the governor should tell the prisoner's spouse or next of kin "at once". Woodhill should have contacted his next of kin immediately he was taken to hospital. We make the following recommendation:

The Governor should ensure, in line with Prison Rule 22, that the next of kin of seriously ill prisoners are informed as soon as possible.

New psychoactive substances

81. As in many prisons, the use of "Spice", a synthetic cannabinoid and one of a range of new psychoactive substances, is a problem at Woodhill. In July 2015, we issued a Learning Lessons Bulletin about the use of new psychoactive substances, including the dangers to both physical and mental health and the possible links to suicide and self-harm. In response, Woodhill created a protocol to address how to manage prisoners found under the influence of new psychoactive substances, and displayed posters in the prison, warning prisoners of the detrimental effects of new psychoactive substances.

82. Mr Cameron arrived at Woodhill with a known history of alcohol and drug misuse. Despite healthcare staff at Woodhill identifying early on that Mr Cameron should be prescribed alcohol detoxification medication, they did not assess the extent of his substance misuse as part of his reception screening.

83. Mr Cameron was subject to Woodhill's protocol on new psychoactive substances two days after he arrived at Woodhill because staff alleged that he had taken Spice. In the days before Mr Cameron was found hanged in his cell, staff recorded no further incidents about his behaviour to indicate that Mr Cameron had used Spice again. As a consequence, and with no toxicology test undertaken (because Mr Cameron died in hospital a few days after he had hanged himself), we cannot conclude whether or not the use of new psychoactive substances contributed to his death.

Alcohol detoxification

84. The clinical reviewer noted that healthcare staff should have assessed whether some of Mr Cameron's symptoms after taking a new psychoactive substance might have resulted from his withdrawal from alcohol. While this would have ensured that staff administered the right balance of medication to cope with a potential overdose or withdrawal symptoms, this did not happen and staff only recorded physical observations. Staff failed to record why Mr Cameron did not receive his detoxification medication on 24 April. While we recognise that Mr Cameron had recently taken a new psychoactive substance and this might have explained why his medication was withheld, staff should have explained the change in medication clearly in Mr Cameron's medical record. We make the following recommendation:

The Head of Healthcare should ensure that when a prisoner is being treated for any drug or alcohol misuse, all health practitioners clearly identify and record the diagnosis, medication required and duration of

treatment or programme, ensuring that there are no unnecessary breaks in treatment.

Mental health referral

85. Healthcare staff identified and referred Mr Cameron for mental health support four times. Yet, the mental health never assessed Mr Cameron and the only mental health reviews which took place were part of the ACCT case reviews. We are concerned that the mental health team never urgently saw Mr Cameron after he told his cellmate he intended to harm himself with a razor blade on 25 April. Mr Cameron had been identified as at risk of suicide and self-harm, with a history of self-harm, low and emotional mood and had nightmares, hallucinations and heard voices. Mr Cameron had also recently committed a serious violent domestic offence, which appeared to have disturbed him deeply. In this context, it is unacceptable that the mental health team did not prioritise his care.

86. A nurse said it was her job to assess prisoners, but she had a large caseload. She said that unless a prisoner's mental health needs were identified as urgent, there was no agreed timescale to assess them. Her experience reflects the findings of the most recent inspection by HM Inspectorate of Prisons, which found staff shortages in the mental health team and long waits for prisoners to see the mental health team. We make the following recommendations:

    The Governor and Head of Healthcare should ensure that there is a clear pathway for mental health services, which ensures that prisoners identified as at risk of suicide and self-harm have an urgent mental health assessment within three days.

Clinical care

87. The clinical reviewer concluded that the general standard of care that Mr Cameron received was equivalent to the care he would have received in the community.

Prisons & Probation
Ombudsman
Independent Investigations

PO Box 70769
London, SE1P 4XY

Email: mail@ppo.gsi.gov.uk
Web: www.ppo.gov.uk

T | 020 7633 4100
F | 020 7633 4141