Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Daniel Dunkley a prisoner at HMP Woodhill on 2 August 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.

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 Daniel Dunkley hanged himself in his cell at HMP Woodhill on 29 July 2016, and died in hospital on 2 August. He was 34 years old. I offer my condolences to Mr Dunkley's family and friends.

Staff at Woodhill appropriately identified that Mr Dunkley was at risk of suicide and self-harm, but there were serious deficiencies in the way they operated suicide and self-harm prevention procedures. Case reviews were poorly managed, observations levels did not reflect Mr Dunkley's changing risk and caremaps were ineffective. The unit where Mr Dunkley lived was short staffed on the day Mr Dunkley hanged himself.

Mr Dunkley was the twelfth of fourteen prisoners to take his life at Woodhill since 2014. Once again, our investigation identified significant deficiencies in Woodhill's operation of suicide and self-harm prevention procedures. We draw these deficiencies to the attention of the Deputy Director for Custody for the High Security Estate in light of his assurances on progress to improve safety at Woodhill.

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

Richard Pickering
Deputy Prisons and Probation Ombudsman **April 2017**

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Summary

Events

1. On 21 July, Mr Daniel Dunkley was sentenced to four months in prison at HMP Woodhill. It was not his first time at Woodhill and staff knew him well. He had previously been monitored under ACCT suicide and self-harm procedures.

2. At an initial health screen, a nurse identified that Mr Dunkley needed drug and alcohol detoxification but noted no concerns about his physical or mental health. On 25 July, staff began ACCT monitoring after Mr Dunkley said he had tried to hang himself. Mr Dunkley was preoccupied about not being able to contact his girlfriend, who was in hospital. Over the next few days, Mr Dunkley did not participate fully in ACCT case reviews, and presented as under the influence of illicit substances.

3. Mr Dunkley remained concerned that he could not contact his girlfriend. Staff agreed at a case review on 29 July to reduce his ACCT observations. His behaviour deteriorated that day; the frequency of Mr Dunkley's set ACCT observations remained at two an hour.

4. During the day Mr Dunkley told staff he would kill himself. That afternoon, there was a staff shortage on the unit and no officer was given responsibility for monitoring those under ACCT procedures. At 2.38pm, an officer found Mr Dunkley hanged in his cell. Staff and paramedics resuscitated him. He was taken to hospital, where he died on 2 August.

Findings

5. Mr Dunkley was subject to ACCT suicide and self-harm monitoring at the time of his death. We identified significant failures in the management of Mr Dunkley's risk under those procedures, particularly in the initial assessment, the case reviews and the caremap.

6. Mr Dunkley had a history of substance misuse. No post mortem or toxicology tests took place after Mr Dunkley died in hospital. We do not know whether Mr Dunkley took illicit drugs before his death, but officers reported that he appeared under the influence of drugs in the days leading to his death.

Recommendations

- **The Governor should ensure that staff manage prisoners at risk of suicide or self-harm in line with national guidelines. In particular:**
    - **A trained ACCT assessor should complete an assessment within 24 hours of an ACCT being opened and use all relevant information to complete an assessment when a prisoner does not take part.**
    - **The frequency of observations should reflect the prisoner's risk and staff should adjust them when that risk changes. Staff should check on prisoners subject to ACCT procedures at**

unpredictable intervals and record their observations.

- **A multi-disciplinary case review should be held within 24 hours of an ACCT plan being opened and when there is evidence of significant change in risk.**

- **ACCT case reviews should assess and record the level of risk, taking into account all risk factors.**

- **Case managers should complete caremaps at the first ACCT case review, set specific and meaningful caremap actions, identify who is responsible for them and review progress at each review.**

- **The Governor should ensure that there are procedures in place to check the quality of ACCT procedures, identify bad practice, learn lessons, and where appropriate, provide staff refresher training on suicide and self-harm prevention procedures.**

- **The Governor should ensure that when staffing on a unit is reduced, arrangements are in place to ensure that prisoners subject to ACCT procedures are appropriately and formally monitored.**

- **The chair of the task force must satisfy himself that the governor of Woodhill has the resources and capabilities to deliver a safe and respectful environment for prisoners and that outstanding actions identified by the safer custody task force are implemented as soon as possible.**
- **The Governor should ensure there is an effective and well implemented substance misuse strategy to help reduce the availability and demand for illicit substances.**

The Investigation Process

7. 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 responded.

8. The investigator visited Woodhill on 8 August 2016. He obtained copies of relevant extracts from Mr Dunkley's prison and medical records.

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

10. The investigator interviewed 17 members of staff, some jointly with the clinical reviewer.

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

12. One of the Ombudsman's family liaison officers contacted Mr Dunkley's family to explain the investigation. They did not have any specific questions.

Background Information

HMP Woodhill

13. HMP Woodhill is both a local prison and a high security prison and can hold more than 800 men. House Unit 2A houses the substance misuse stabilisation unit. It is managed by the Westminster Drug Project, an independent healthcare provider which provides a range of staff including mental health nurses, GPs, pharmacy staff, a consultant psychiatrist and healthcare assistants to work with prison staff to support and monitor prisoners at Woodhill with substance misuse needs. The Westminster Drug Project also treats prisoners with a dual diagnosis of mental health and substance misuse issues.

HM Inspectorate of Prisons

14. The most recent inspection of Woodhill was in September 2015. Although staffing levels were better than they often found in other prisons, inspectors noted that the prison relied heavily on new recruits and officers drafted in from other prisons. Inspectors were very concerned about the high number of self-inflicted deaths at Woodhill and considered there was an insufficient whole-prison approach to understanding and addressing the issue.

15. Inspectors reported that our recommendations about suicide and self-harm monitoring had not been fully implemented. They noted weaknesses in the way staff had completed suicide and self-harm monitoring documentation. They said caremaps were poor and rarely updated. They found failings in the way case reviews were managed, and said they were not focused on the issues that had triggered the crisis. They said staff checked prisoners at predictable times.

Independent Monitoring Board

16. 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 latest annual report for the year to May 2016, the IMB reported that staff shortages had led to restricted regimes. They noted that cross deploying staff and using those on detached duty led to inconsistency in delivering services. They said the number of inexperienced staff had put a strain on those with more experience. The IMB was concerned about the quality of suicide and self-harm monitoring, particularly careplans.

Previous deaths at HMP Woodhill

17. Mr Dunkley was the twelfth prisoner to take his life at Woodhill since the start of 2014. Since Mr Dunkley's death, two more prisoners have apparently taken their lives. The National Offender Management Service and the Coroner remain concerned about the number of deaths at Woodhill.

18. Woodhill accepted the recommendation of HM Inspectorate of Prisons to implement a prison-wide strategy and action plan to reduce the number of self-inflicted deaths and incidents of self-harm, including implementing all our previous recommendations and improving the quality of ACCT monitoring. The Deputy Director of Custody for the High Security Estate set up a task force,

which started work in January 2016, to assess the increased number of deaths, review and improve safety at Woodhill. The prison published a local strategy to review existing procedures and identify and implement improvements in safer custody, and the task force is monitoring this strategy.

19. In November 2016, the High Court gave the families of prisoners who took their lives at Woodhill permission to pursue a claim against the prison Governor and the Secretary of State for failing to reduce the suicide rate in the prison. (Mr Dunkley's brother is a claimant in that case.)

20. Of our completed investigations of self-inflicted deaths at Woodhill since 2013, seven highlighted serious concerns about how staff managed suicide and self-harm procedures. In an investigation report we published in September 2016, we asked the Deputy Director of Custody to assure himself that the prison had effectively implemented all the recommendations made by the Prisons and Probation Ombudsman in the last five years. In January 2017, the Deputy Director of Custody responded. He told us that eight of our 44 recommendations had been fully implemented. 29 had been implemented and were generally effective with minor non-compliance. Six had been partially implemented (and were yet to achieve a satisfactory outcome). One recommendation had not yet been implemented.

Assessment, Care in Custody and Teamwork

21. 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.

22. 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.

23. 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

Background

24. Mr Daniel Dunkley had been to prison many times and had received over 100 convictions for minor offences, mostly related to drug use. He regularly used illicit drugs in the community, including new psychoactive substances (NPS).

25. In the 1990s, Mr Dunkley sustained a serious head injury and in 2010, a psychiatrist diagnosed him as having a personality disorder, compounded by drug and alcohol misuse. Mr Dunkley's medical records show a history of trying to manipulate staff to obtain medication. From 2010, prison staff monitored Mr Dunkley's risk of suicide and self-harm 16 times. He told staff he was estranged from his family, including his two children, but said he was in a relationship with a woman who had been hospitalised due to mental illness. (Mr Dunkley's family later told us that this was not the case.)

HMP Woodhill

26. On 21 July 2016, Mr Dunkley was sentenced to four months in prison for theft and assault, and sent to HMP Woodhill, where many staff knew him.

27. Supervising Officer (SO) A interviewed Mr Dunkley and noted that he was demanding. Mr Dunkley told the SO that he had no thoughts of self-harm. Mr Dunkley was moved to the prison's substance misuse unit, House Unit 2A.

28. At an initial health screen, the prison GP, and Nurse A, a reception nurse, assessed Mr Dunkley. They noted his history of alcohol and opiate substance misuse and referred him to the substance misuse team. The GP prescribed Mr Dunkley with chlordiazepoxide to help with symptoms of alcohol withdrawal. The nurse noted that Mr Dunkley displayed no signs of irritability or anxiety. She noted that he was receiving medication for epilepsy.

29. On 22 July, Nurse B recorded that Mr Dunkley had raised no concerns overnight. Nurse C, a substance misuse and mental health nurse, who knew Mr Dunkley from previous sentences, assessed him and prescribed methadone, an opiate substitute, as part of his drug detoxification programme. Nurse C said Mr Dunkley's behaviour was different from previous sentences, but not unusual. The prison doctor prescribed medication for Mr Dunkley's epilepsy.

30. That afternoon, Nurse D, a mental health nurse, assessed Mr Dunkley. She noted that he was clean, tidy and behaved appropriately, but noted his slightly slurred speech, which she said was normal for him. Mr Dunkley told the nurse he was trying to contact his girlfriend. The nurse suggested he speak to the prison chaplain about this. The nurse concluded that Mr Dunkley displayed no evidence of disordered thoughts or delusional ideation and did not need to see the mental health team.

31. On the afternoon of 24 July, officers found Mr Dunkley lying on the floor, apparently having a seizure, and asked Nurse E to assess Mr Dunkley. The nurse reassured Mr Dunkley that he was safe. After 20 minutes, Mr Dunkley got

up and asked about his medication. (Medical records suggest Mr Dunkley had a known history of feigning illness to obtain medication.)

Monitoring Mr Dunkley's risk of suicide and self-harm

32. On 25 July, Mr Dunkley told the prison chaplain and the chaplaincy safer custody champion, that he had tried to hang himself two days earlier and wanted to cut his wrists as he could not go on. Mr Dunkley told the chaplain that he was worried because he did not know how to contact his girlfriend, who was in hospital, and he was not around for his children. The chaplain noted that Mr Dunkley was almost incoherent and falling asleep. He started ACCT procedures that morning.

33. At 4.30pm, Officer A tried to assess Mr Dunkley under ACCT procedures, but noted he was not fit enough to take part and had asked for time to "get his head together." The officer did not assess Mr Dunkley, as he should have done. SO B later noted that Mr Dunkley was unsteady on his feet, could not hold a conversation with staff but had eaten his meal. The SO asked for a nurse to assess Mr Dunkley. (We have seen no evidence to verify if a nurse saw him.)

34. On the morning of 26 July, Mr Dunkley chose to spend most of the day in his cell and raised no concerns with staff. At 10.30am the chaplain confirmed that Mr Dunkley's partner was no longer at St Mary's Hospital, Kettering. He said he told SO C about this knowing that Mr Dunkley had his first ACCT review that day. (The SO said he could not recall speaking to the chaplain and so did not tell the custodial manager at Mr Dunkley's next review.)

35. At 2.20pm, the custodial manager, held Mr Dunkley's first ACCT review with SO C and Nurse F from the substance misuse team. They did not complete the review as Mr Dunkley could not stay awake. The nurse noted that Mr Dunkley could not speak or concentrate, and was disorientated. She noted that he should not receive his methadone medication until a doctor had reviewed him. No one formally considered Mr Dunkley's risk and he remained under hourly observations. A further review was scheduled for 27 July.

36. At 2.40pm, Nurse G, an emergency care technician, assessed Mr Dunkley. He denied taking any illicit substances but was sluggish and disorientated. Mr Dunkley told her that nurses were taking his girlfriend away. The nurse noted that Mr Dunkley should be checked every fifteen minutes.

37. At 4.00pm, Nurse C noted that Mr Dunkley was more stable, was aware of his surroundings, but remained upset about his girlfriend whom he could not contact. The nurse had no concerns about Mr Dunkley's mental health, but did not give him methadone. At 7.00pm, Nurse H noted that Mr Dunkley was sleeping on the cell floor, but appeared okay. Mr Dunkley's fifteen minute healthcare observations stopped at 7.00pm, but staff checked on him throughout the night.

38. On the morning of 27 July, at 11.00am, Nurse I, a substance misuse nurse, noted that Mr Dunkley's medical observations were normal, but he remained unsteady on his feet and appeared confused. The nurse noted that Mr Dunkley would not be given his methadone until he had been reviewed by the detoxification clinical team. At 2.43pm, Nurse C, a substance misuse and mental

health nurse, noted that although Mr Dunkley said he felt fine, he was told his methadone dosage would be reduced, because of his poor concentration, memory and unsteadiness. Mr Dunkley was not happy with this decision.

39. At 3.50pm, Nurse I noted that Mr Dunkley's presentation had worsened since the morning, but his observations were normal. As the nurse discussed with a colleague whether to withhold his methadone, Mr Dunkley laid on the floor, stiffened his body and made groaning noises. The nurse concluded that he was feigning a seizure. She said he then pretended to be asleep. Mr Dunkley did not receive his methadone because of his presentation.

40. Custodial manager, B, tried for a second time to assess Mr Dunkley under ACCT procedures. He discontinued his assessment as Mr Dunkley appeared 'spaced out' and did not participate. Mr Dunkley remained unsettled for the rest of the day. He was abusive to staff and repeatedly banged his cell door. Yet, he collected his evening meal and mixed with other prisoners. Later that evening, SO D removed a noose from Mr Dunkley.

41. The night manager, reviewed Mr Dunkley's ACCT record with Officer B, Officer C, a substance misuse support worker, and Nurse I. They noted that Mr Dunkley was worried about his girlfriend, but that his actions might have been in response to his methadone being withheld. Contrary to the nurse's account in Mr Dunkley's medical record, the night manager said that Mr Dunkley had not said that he had wanted to take his life. The nurse referred Mr Dunkley to the prison's mental health team. They considered Mr Dunkley's risk of suicide and self-harm to be raised, and increased his observations to two an hour. They scheduled a review for the next day. The night manager later rang the hospital but was told that Mr Dunkley's girlfriend was not there. She arranged for Mr Dunkley to be told this news.

42. On 28 July, Officer D assessed Mr Dunkley under ACCT procedures. She noted that he was angry about not having contact details for his girlfriend and became aggressive and threatening. The officer noted the issue of his girlfriend's location triggered his aggression. The officer told the investigator that Mr Dunkley was more withdrawn and aggressive than during previous sentences.

43. Later that morning, SO E, who was not familiar with House Unit 2A, where Mr Dunkley lived, chaired Mr Dunkley's third case review with Nurse C. The SO noted that Mr Dunkley was tearful and low in mood, but had now been given a contact address for his girlfriend. The SO did not complete Mr Dunkley's caremap. The supervising officer noted that Mr Dunkley's risk remained raised, and his observations remained at two an hour. They scheduled a review for the next day.

44. At around 12.30pm, the chaplain visited Mr Dunkley and told him that his girlfriend was no longer at the hospital. He noted that Mr Dunkley may have misunderstood, and thought his girlfriend had died. He noted in the ACCT record that Mr Dunkley had shouted out, cried and banged his head against the cell door. Officer D, who was nearby, said Mr Dunkley slid down the door shouting, "No, no, no." Later, Officer E spoke to Mr Dunkley, and told him not to be paranoid and to stop thinking the worst. The officer noted that Mr Dunkley thanked him. The chaplain said he did not discuss with Officer D whether an

ACCT review should be held as he felt that the officer was aware of the situation. He said he believed he had spoken to custodial manager A about Mr Dunkley but could not recall exactly when. He said the custodial manager told him that Mr Dunkley was taking illicit drugs and staff were managing the situation. (He gave no further information.)

45. At 3.37pm, Nurse C noted that Mr Dunkley appeared confused with poor co-ordination and remained concerned about not having an address for his girlfriend despite having been given her last known hospital address. The nurse concluded that Mr Dunkley appeared to have taken illicit drugs and referred him to the prison's mental health team. That afternoon, officers noted that Mr Dunkley collected his medication and spent time with other prisoners.

46. At 5.21pm, the chaplain emailed SO A, custodial manager, C and the head of healthcare, copying in the safer custody team. He said he was concerned that information about contact with Mr Dunkley's girlfriend, which he had given SO C, had not been noted in Mr Dunkley's ACCT record. The chaplain wrote about his visit to Mr Dunkley earlier that afternoon. He said that he and Officer D felt that discussing Mr Dunkley's girlfriend had triggered Mr Dunkley's sudden, violent behaviour and aggression. He noted his fear that Mr Dunkley might become the next prisoner to take his life at Woodhill. (Custodial manager C was on leave at the time and custodial manager A did not read the email until after Mr Dunkley's death.)

29 July

47. On 29 July, Officer F charged Mr Dunkley for breaking prison rules for trying to conceal his medication and being abusive earlier. The pharmacy technician with the substance misuse team, said Mr Dunkley was very angry that he had been accused of concealing his medication.

48. At 9.05am, SO C held Mr Dunkley's fourth case review with SO F and the pharmacy technician. He noted that Mr Dunkley did not fully participate, but had denied thoughts of self-harm. The pharmacy technician said Mr Dunkley told them that what he said did not matter and that his only concern was having an address for his girlfriend so she would receive a letter he had written to her. Mr Dunkley's observations were reduced to one an hour.

49. After the review, Mr Dunkley became tearful and concerned about whether his girlfriend would receive his letter. He asked the pharmacy technician to confirm her address. The pharmacy technician telephoned the hospital who confirmed that Mr Dunkley's girlfriend had been transferred. They could not say where she had gone. Mr Dunkley broke down in tears when he heard this. He told the pharmacy technician that he would hang himself as his girlfriend was not at the hospital anymore. The pharmacy technician talked to Mr Dunkley at length to reassure him. She agreed with him that they should send the letter, with the hope that the hospital would forward it to his girlfriend. She asked officers to check on Mr Dunkley and told SO C that Mr Dunkley's observations should remain at two an hour.

50. SO C updated the ACCT document and referred Mr Dunkley to the mental health team, noting that they should be invited to the next review. He noted that

although they had earlier agreed to reduce Mr Dunkley's observations, his observations would now remain at two an hour because of the new threats he had made to kill himself. The SO completed the caremap and scheduled a review for the next day.

51. At around 11.00am, Mr Dunkley again became tearful, and said he would harm himself that evening. The pharmacy technician and Officer F tried to reassure him that the hospital would forward his letter to his girlfriend and they persuaded him to collect his lunch. A little later, the pharmacy technician asked Mr Dunkley why he was wandering around the wing. He told her he was trying to trade his chocolate biscuit for tobacco. Shortly before midday, Officer G locked Mr Dunkley in his cell, and noted that he seemed agitated.

52. Officer G, who was covering the lunchtime period on House Unit 2, checked Mr Dunkley at 11.50am, and again at 12.11pm. He noted that Mr Dunkley was sitting on the floor of his cell. The officer said he encouraged Mr Dunkley to get up and eat his lunch. The officer said Mr Dunkley did not want to talk. At 12.20pm, the officer noted that Mr Dunkley was kicking his cupboard door against the cell door and did not respond to him. The officer checked Mr Dunkley at 12.45am, but did not record his observations in the ACCT record.

53. At 1.00pm, Officer I arrived on House Unit 2A. She had been deployed from another area and had not previously worked on the unit. SO C told the officer that she would be the cleaning officer, that the wing was on lock down due to staff shortages and as a result, the regime was restricted. Officer J arrived on the unit at the same time. He said he could not recall if there was a staff briefing, but said he was given responsibility for moving prisoners. Officer K arrived on the unit at 1.15pm, and was told to help the nurses dispense medication.

54. At 1.25pm, a general alarm sounded when another prisoner threatened to jump from the unit's top landing. The incident was resolved at 1.50pm. The officers who had responded to the incident left the unit.

55. At 1.55pm, Officer L gave Mr Dunkley a letter, advising him of a disciplinary hearing for trying to conceal his medication. Noting that Mr Dunkley appeared agitated, the officer sat on Mr Dunkley's bed and talked to him. The officer said Mr Dunkley told him that he had "lost his Mrs". At first, the officer thought that Mr Dunkley had meant she had died, but Mr Dunkley explained that his girlfriend was in a psychiatric hospital and staff had tried to help him contact her. The officer said he tried to reassure Mr Dunkley that everything would be okay, but Mr Dunkley said he was going to kill himself that night.

56. Officer L asked Officer K to keep an eye on Mr Dunkley because Mr Dunkley had said he would do 'something silly' that night. Officer L agreed and said that Mr Dunkley would soon be unlocked. Officer K said Officer L had told her that Mr Dunkley was upset.

57. Officer L said he did not believe that Mr Dunkley needed an ACCT review as he thought he was being monitored five times an hour. (This was not the case.) He said he asked Officer I to write in Mr Dunkley's ACCT record that he was tearful and had said he would do "something silly" that night. He said Officer I had

confirmed she would. Officer I said Officer L told her that Mr Dunkley had said he would hang himself that night and that it might be worth checking on him.

58. Officer I said that she had been under pressure that afternoon. She had mistakenly made an entry at 2.00pm in the ACCT record for the prisoner who had earlier threatened to jump from the landings rather than in Mr Dunkley's ACCT record (as she intended) to say that he wanted to hang himself.

Emergency response

59. At 2.38pm, Officer J went to unlock Mr Dunkley. Looking through the cell door observation panel, he saw Mr Dunkley hanging by a ligature, made from a bed sheet, from the cell window. The officer raised the alarm by shouting out a code blue. A code blue indicates a life-threatening situation such as when a prisoner is unconscious or not breathing. He asked Officer M, who was nearby, to press the general alarm. Officer J immediately went into the cell and cut the ligature from around Mr Dunkley's neck. Officer K, who was nearby, followed Officer J and helped him lay Mr Dunkley on the floor. Officer K checked for signs of life, but found none. She started cardiopulmonary resuscitation until healthcare staff took over.

60. At 2.38pm, Nurse J responded to the general alarm to go to House Unit 2A, which was followed by an emergency code blue. The nurse said that when she arrived, officers were trying to resuscitate Mr Dunkley. She said she gave Mr Dunkley oxygen and that other healthcare staff, including Nurse K, helped her. Mr Dunkley was later moved from his cell so there was more room to treat him.

61. At 2.45pm, paramedics arrived. They administered emergency treatment, re-established Mr Dunkley's pulse and took him to hospital at 3.14pm.

62. On 2 August, Mr Dunkley died in hospital, with his family present. After his death, undated notes, to and from his girlfriend, were found in his cell. Mr Dunkley talked of his love for her and how he could not handle the thought of her being with another person.

Contact with Mr Dunkley's family

63. Initially, there was some difficulty in making contact with Mr Dunkley's father, his next of kin. However the head of safer custody, was able to tell Mr Dunkley's sister at 9.00pm that her brother had been taken to hospital. During the night arrangements were made by the prison for Mr Dunkley's father to be taken, by taxi, to see his son in hospital. He later informed Mr Dunkley's mother, who also visited her son in hospital. The prison offered to contribute to the cost of Mr Dunkley's funeral in line with national policy.

Support for prisoners and staff

64. Managers debriefed the staff involved in the emergency response and offered support. Staff notified prisoners of Mr Dunkley's death, and offered them support. Officers reviewed prisoners assessed as at risk of suicide and self-harm in case the news of Mr Dunkley's death had affected them.

Cause of death

65. A post mortem examination of Mr Dunkley's body did not take place and no toxicology tests were carried out. However, the consultant neurosurgeon, gave a statement to the coroner in which he concluded that Mr Dunkley died from a hypoxic brain injury as a consequence of hanging.

Findings

Management of risk of suicide and self-harm

ACCT assessment and reviews

66. PSI 64/2011 says that a case manager should hold a multi-disciplinary first ACCT case review within 24 hours of the start of ACCT monitoring, ideally immediately after the assessment, and that if a prisoner refuses to participate, the assessor must complete the assessment based on all available information. This did not happen. When Mr Dunkley did not take part in the process, staff abandoned their assessment, and did not complete one until 28 July, three days after ACCT procedures started. They did not adequately consider and record an action plan nor identify the triggers for Mr Dunkley's risk.

67. There was no consistency with case review managers, and some staff that chaired or attended had little or no personal knowledge of Mr Dunkley. Critically, many case review records failed to address Mr Dunkley's needs and level of risk effectively. There is no evidence that anyone discussed Mr Dunkley's contact with his girlfriend and its potential impact on his risk. For example, no one discussed the chaplain's concerns, which he raised with SO C at the first review. Had staff done so, it might have informed subsequent reviews and the action staff took to support Mr Dunkley appropriately.

Observations

68. Even when staff assessed Mr Dunkley's risk as raised, the frequency of his observations was relatively low and did not reflect this risk. When an officer found him with a noose, his observations were increased to only two an hour. Similarly, the frequency of observations on the day he hanged himself did not reflect his changing level of risk. Despite deterioration in his behaviour including telling staff that he would take his life, staff did not to increase the frequency of formal monitoring. Many of the checks on Mr Dunkley were carried out at predictable intervals, contrary to PSI 64/2011 which says that ACCT observations must be conducted at unpredictable intervals.

Caremaps

69. PSI 64/2011 requires caremaps to reflect the prisoner's needs, level of risk and the triggers of their distress. They should aim to address issues identified in the ACCT assessment interview. They must be tailored to meet prisoners' individual needs and reduce risk. They must be time bound and say who is responsible for completing the action. No one considered Mr Dunkley's caremap until 29 July, the morning he was found hanging in his cell. Some of the caremap objectives such as a referral to the mental health team were useful but did not reduce Mr Dunkley's risk or ensure that identified issues were addressed. Staff failed to recognise how important it was to Mr Dunkley that he could contact his girlfriend, and that this affected his behaviour and thinking. While there is evidence that some staff had a caring approach, such as trying to establish where his girlfriend was, they failed to set and record clear and effective actions in Mr Dunkley's caremap, which might have reduced his risk. This meant that staff did not know

what was being done to support Mr Dunkley and no one discussed their actions in ACCT case reviews. This led to staff duplicating actions.

General conclusions about ACCT procedures

70. Staff judgement is fundamental in operating ACCT procedures. The system relies on staff using their experience and skills, as well as local and national assessment tools to determine risk. We are concerned that staff may have relied too heavily on their previous knowledge of Mr Dunkley, because they were familiar with him. While a prisoner's presentation is important and reveals something of their level of risk, it is only a reflection of their state of mind at the time and should be considered as a single piece of evidence when judging risk. Staff should consider all risk factors to ensure that a prisoner's level of risk is judged holistically. Staff did not interact effectively to identify Mr Dunkley's risk, needs and issues in the days leading to his death. While we cannot know whether this might have changed the outcome for Mr Dunkley, Woodhill did not manage his risk effectively. Once again, we must make recommendations to address the quality of ACCT procedures at HMP Woodhill:

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

- **A trained ACCT assessor should complete an assessment within 24 hours of an ACCT being opened and use all relevant information to complete an assessment when a prisoner does not engage in the process.**
- **The frequency of observations should reflect the prisoner's risk and be adjusted when that risk changes. Staff should check on prisoners subject to ACCT procedures at unpredictable intervals and record their observations.**
- **A multi-disciplinary case review should be held within 24 hours of an ACCT plan being opened and when there is evidence of significant change in risk.**
- **ACCT case reviews should assess and record the level of risk, taking into account all risk factors.**
- **Case managers should complete caremaps at the first ACCT case review, set specific and meaningful caremap actions, identify who is responsible for them and review progress at each review.**
- **The Governor should ensure that there are procedures in place to check the quality of ACCT procedures, identify bad practice, learn lessons, and where appropriate, provide staff refresher training on suicide and self-harm prevention procedures.**

Staffing levels and safer custody

71. There should have been five officers on duty in the substance misuse unit, where Mr Dunkley lived. On the afternoon he was found hanging, only three,

inexperienced officers, who were unfamiliar with the unit, were on duty. This meant that prisoners were subject to a restricted regime and were locked in their cells for much of the time. Another incident on the wing that afternoon increased pressure on staff. One officer said prisoners were not sufficiently supported because of staff shortages. Wing managers said that although staffing levels had recently improved, staff shortages remained a problem and prevented them from delivering the full regime and support to prisoners who required it.

72. On 29 July, around ten prisoners in the unit were being monitored under ACCT procedures. The supervising officer said all officers on duty were collectively responsible for ACCT procedures. At the start of the afternoon shift on 29 July, no one was therefore allocated specific responsibility for ensuring that prisoners subject to ACCT procedures were monitored appropriately. It was presented to us that with staffing below the expected level, staff were unable to fulfil all the duties expected of them. In those circumstances the supervising officer and prison management should have taken steps to ensure effective ACCT monitoring was in place. We make the following recommendation:

The Governor should ensure that when staffing on a unit is reduced, arrangements are in place to ensure that prisoners subject to ACCT procedures are appropriately and formally monitored.

Safer custody task force

73. Since 2013, we have made recommendations about ACCT procedures in seven of our investigation reports about self-inflicted deaths at Woodhill. Within the last two years, there have been fourteen self-inflicted deaths at Woodhill. The Deputy Director of Custody for the High Security Estate told us that Woodhill was in the process of implementing our recommendations to address the deficiencies in the operation of ACCT procedures and that they were now generally effective, with minor inconsistencies. Against that background we are bound to repeat our findings about the shortcomings of those procedures, to repeat our recommendations to address those findings and highlight the concerns raised by staff over their ability to meet the requirements of ACCT monitoring when resourcing is constrained. We make the following recommendation:

The chair of the task force must satisfy himself that the governor of Woodhill has the resources and capabilities to deliver a safe and respectful environment for prisoners and that outstanding actions identified by the safer custody task force are implemented as soon as possible.

Clinical care

Substance misuse

74. The clinical reviewer assessed Mr Dunkley's clinical care at Woodhill. Mr Dunkley had a history of illicit substance misuse. When he arrived, he undertook a methadone detoxification programme. She was satisfied that Mr Dunkley was appropriately housed in the substance misuse unit, where he was well known to staff. She concluded that he was seen daily for drug administration and his methadone was appropriately reviewed, withheld or reduced depending on his presentation.

75. No post mortem or toxicology tests took place after Mr Dunkley died in hospital. While we cannot therefore know whether Mr Dunkley took illicit drugs before his death, officers reported that he appeared under the influence of drugs in the days leading to his death. In our recent report into the death of a man at the prison in June 2016, we recommended to the Governor that there should be an effective strategy in place to reduce the availability and demand for new psychoactive substances. We make a similar recommendation here:

The Governor should ensure there is an effective and well implemented substance misuse strategy to help reduce the availability and demand for illicit substances.

Mental health

76. Staff raised concerns about Mr Dunkley's mental health two days before he was found hanged, and referred him to the mental health team, who never saw Mr Dunkley before he died. The clinical reviewer concluded that the substance misuse team did everything they could, based on how Mr Dunkley presented. However, she was concerned about the mental health referral process, which the Head of Healthcare at Woodhill will need to address. Despite this, she concluded that the general standard of healthcare Mr Dunkley received was equivalent to that he would have received in the community.

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