Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Sheldon Woodford, a prisoner at HMP Winchester, on 12 March 2015

A report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

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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*

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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.

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 Woodford died in hospital on 12 March 2015, after he had hanged himself in his cell at HMP Winchester on 9 March. I offer my condolences to Mr Woodford's family and friends.

It is commendable that staff at Winchester managed to save Mr Woodford, after he had tried to hang himself on 24 February. This makes it all the more tragic that they were not able to prevent him taking his life two weeks later. Despite the earlier staff efforts, the investigation found a number of failings in the assessment of Mr Woodford's risk of suicide and self-harm in reception and in managing his risk, once the extent of his vulnerability had been recognised. I am also concerned that the emergency response was delayed and that it took too long to notify Mr Woodford's partner that he had been taken to hospital in a critical condition.

It is troubling that similar issues have arisen in previous investigations into deaths at Winchester. The Governor needs to take urgent action to ensure that lessons are learned and changes implemented and sustained.

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.

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

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Prisons & Probation Ombudsman
Independent Investigations

Summary

Events

1. On 16 January 2015, Mr Woodford arrived at Winchester, sentenced to 28 days. At court, he had said he would kill himself in prison and court staff completed a suicide and self-harm warning form. Reception staff did not consider the warning form and they did not begin ACCT suicide and self-harm prevention procedures.

2. Mr Woodford had been prescribed an antipsychotic in the community but a psychiatrist noted he had not collected it for some time. The psychiatrist decided he should have a trial period without it.

3. On 23 January, Mr Woodford appeared in court by video link and pleaded guilty to robbery. No one reviewed his risk. On 26 January, Mr Woodford cut his arm and staff began ACCT procedures. The next day a mental health nurse decided he would benefit from some mental health support.

4. On 13 February, Mr Woodford was sentenced to four and a half years for robbery, which was longer than he had expected. No one reviewed his risk of suicide and self-harm. Three days later, staff ended the ACCT monitoring. On 20 February, Mr Woodford said he had taken an overdose of ibuprofen and was observed overnight. Staff began ACCT procedures again. Mr Woodford said he was stressed because his partner had not received some money he had sent to her. That day, Mr Woodford's partner asked the prison to prevent him contacting her but no one did anything about this.

5. On 23 February, after three days, staff ended the ACCT monitoring. On 24 February, Mr Woodford repeatedly rang his partner and left threatening messages. Later that evening, an officer found Mr Woodford hanging in his cell. Staff were able to rescue him and he was admitted to hospital, until 1 March. Staff opened an ACCT again.

6. When Mr Woodford returned to the prison, officers checked him twice an hour. A psychiatrist reviewed him on 4 March and concluded that he did not need any antidepressant or antipsychotic medication. On 8 March, a Supervising Officer, who did not know Mr Woodford reduced his ACCT observations to once an hour, without an ACCT review.

7. On 9 March, an officer found Mr Woodford hanging in his cell. There were delays with the prison's emergency response and in informing his partner. Mr Woodford died in hospital on 12 March.

Findings

8. We have serious concerns about the assessment of risk and the operation of ACCT suicide and self-harm procedures at Winchester, which were not in line with national policy. The emergency response was poor; it took too long for healthcare staff to respond and there was a delay calling an ambulance. It also took too long to inform Mr Woodford's family that he had been taken to hospital in a critical condition, both on 24 February and 9 March.

Recommendations

- The Governor should produce clear local guidance about procedures for identifying newly arrived prisoners at risk of suicide and self-harm. In particular, this should ensure that reception and first night staff:
  - i. Have a clear understanding of responsibilities and the need to share all relevant information about risk.
  - ii. Consider and record all the known risk factors of a newly arrived prisoner when determining their risk of suicide or self-harm, including information from suicide and self-harm warning forms and PERs.
  - iii. Open an ACCT whenever a prisoner has recently self-harmed or expressed suicidal intent.
- The Governor and Head of Healthcare should ensure that prisoners are assessed for potential health or suicide and self-harm issues after events which could involve a change in status, including court appearances by video-link
- The Governor and Head of Healthcare should ensure that prison staff manage prisoners at risk of suicide or self-harm in line with national guidance, including in particular:
  - i. A multi-disciplinary approach for all case reviews with continuity of case management.
  - ii. Healthcare staff attending all first case reviews.

iii. Setting caremap actions, which are specific and meaningful, aimed at reducing prisoners' risks and reviewed and updated as necessary.
iv. Setting levels of observations, which reflect the prisoner's actual risk rather than the resources required.
v. Reviewing risk whenever an event occurs which indicates an increase in risk and holding a case review if required.
vi. All staff, including healthcare staff, recording relevant information about risk, observations and interactions with prisoners in ACCT documents and any action taken.

- The Governor should ensure that all prison staff understand their responsibilities during medical emergencies and in particular that staff efficiently communicate the nature of a medical emergency and that control room staff call an ambulance immediately a medical emergency code is broadcast.

- 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 so that they are able to visit them in hospital without unnecessary delay..

The Investigation Process

9. The investigator issued notices to staff and prisoners at HMP Winchester informing them of the investigation and asking anyone with relevant information to contact her. Mr Woodford's former cellmate wrote to the investigator.

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

11. The investigator visited Winchester on 17 March 2015 and obtained copies of relevant extracts from Mr Woodford's prison and medical records. The investigator interviewed 21 members of staff and one prisoner at Winchester in May and July, some jointly with the clinical reviewer. In his clinical review, the clinical reviewer made some recommendations, which the Head of Healthcare will need to address. We do not repeat them in this report, as they were not directly related to the circumstances of Mr Woodford's death.

12. We informed HM Coroner for Winchester of the investigation who gave us the preliminary cause of death and a post-mortem toxicology analysis. We have sent the coroner a copy of this report.

13. One of the Ombudsman's family liaison officers contacted Mr Woodford's partner to explain the investigation and to ask if she had any matters she wanted the investigation to consider. His partner was concerned that Mr Woodford had been diagnosed with schizophrenia but had not received antipsychotic medication in prison. She said that Mr Woodford had been bullied by another prisoner and had sent someone money to stop the bullying. We have covered these issues in this report.

14. Mr Woodford's partner received a copy of the initial report. The solicitor representing Mr Woodford's partner wrote to us raising 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 Winchester

15. HMP Winchester is a local prison, serving the courts in Hampshire. It holds around 700 adult remanded and sentenced men. It includes a separate lower security unit for up to 129 sentenced men nearing the end of their sentences, known as West Hill. Central and North West London NHS Foundation Trust provides health services at the prison. The prison's healthcare centre has 24-hour nursing cover and doctors from a local practice run surgeries from Monday to Friday.

Her Majesty's Inspectorate of Prisons

16. The most recent inspection of HMP Winchester was in February 2014. Inspectors found that risk assessment processes in reception were generally good, but first night centre support was lacking. People at risk of suicide or self-harm were reasonably well cared for. Weaknesses in responses to emergencies were identified. The level of violence was high and overall management of violence reduction was poor.

17. Nurses saw all new prisoners promptly and made appropriate referrals to relevant services. Good community liaison ensured continuity of care.

Previous deaths at HMP Winchester

18. Mr Woodford's death was the third self-inflicted death at Winchester since July 2012. In two of these cases, we made recommendations about emergency response and in one about reception practices. There have been four deaths at HMP Winchester since Mr Woodford's death, three of which were apparently self-inflicted. Our preliminary investigations into two of those deaths have also identified concerns about ACCT procedures.

Assessment, Care in Custody and Teamwork (ACCT)

19. ACCT is the care planning system the Prison Service uses to support prisoners at risk of suicide or self-harm. Once a prisoner has been identified as at risk, the purpose of the ACCT process is to try to determine the level of risk, the steps that might be taken to reduce this and the extent to which staff need to monitor and supervise the prisoner. Part of the ACCT process involves assessing immediate needs and drawing up a caremap to identify the prisoner's most urgent issues and how they will be met. Staff should hold regular

multidisciplinary reviews and should not close the ACCT plan until all the actions of the caremap are completed. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

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Key Events

20. On 15 January 2015, Mr Sheldon Woodford was arrested for theft. The police referred him to the Criminal Justice Liaison and Diversion Service, which assesses offenders with possible mental health problems to determine what support they need through the criminal justice process.

21. Nurse A assessed Mr Woodford and noted that he had attention deficit hyperactivity disorder (ADHD), but that he would not need additional support through the criminal justice system. She considered that he was at high risk of suicide or self-harm because he had harmed himself in custody before. Mr Woodford started punching the walls because he was upset that he would be spending the night in police custody.

22. A police officer completed Mr Woodford's Person Escort Record (PER – a document which accompanies all prisoners when they move between police stations, courts and prisons) indicating that he was at risk of self-harm because he had banged his head against the wall and slashed his arms with broken glass. There is no record of when he did this. The police officer recorded that use of drugs was one of Mr Woodford's risk factors.

23. On Friday 16 January 2015, Mr Woodford was sentenced to 28 days imprisonment for theft. He was also remanded on a charge of robbery, which had received some press coverage because of the age of the victim. It was not his first time in prison. At court, Mr Woodford had become upset when talking to his solicitor so court custody staff checked him six times an hour. Mr Woodford told a court custody officer that he would kill himself in prison and, at 1.10pm, another officer completed a suicide and self-harm warning form and recorded that he had said he would kill himself in prison, had head butted walls since his arrest, and had tried to hang himself and cut himself during his last period in prison.

24. When Mr Woodford arrived at HMP Winchester, Supervising Officer (SO) A read his escort record and spoke to him. The SO said that he did not remember Mr Woodford or seeing the suicide and self-harm warning form, which he did not sign. The SO said he assesses whether a prisoner is at risk of suicide and self-harm based on the information he has received and the prisoner's body language. He did not begin ACCT procedures for Mr Woodford.

25. During his initial health screen, Mr Woodford told Nurse B that he had ADHD, obsessive compulsive disorder (OCD) and depression. He said he was

prescribed quetiapine (an antipsychotic), concerta (for ADHD) and omeprazole (for stomach acid reflux). Mr Woodford said that he had harmed himself by cutting his arm seven years previously, but he had no current thoughts of suicide or self-harm. The nurse signed the suicide and self-harm warning form to say she had seen it. She said that she did not start ACCT monitoring because SO A had already interviewed Mr Woodford and concluded that he was not at risk of suicide or self-harm. She said she saw no need to challenge his judgement. She referred Mr Woodford to the mental health team.

26. Officer A then interviewed Mr Woodford on A Wing, the prison's first night centre. He told her he had learning difficulties and mental health problems. Officer A did not see the escort record or the suicide and self-harm warning form and recorded that Mr Woodford was not at risk of suicide or self-harm. Mr Woodford declined the offer of a phone call.

27. On 17 January, Dr A, a prison GP, saw Mr Woodford, who repeated that he was taking concerta and quetiapine for OCD and ADHD. The doctor wrote in his clinical record that there was a letter from the Criminal Justice Liaison Service about Mr Woodford's medication, but no doses were recorded so he could not continue his prescription. He explained this to Mr Woodford. Healthcare administrative staff requested Mr Woodford's medical records from his community GP to check his medication and other medical history.

28. On 21 January, Dr B, a psychiatrist, saw Mr Woodward and reviewed his medication. Dr B read Mr Woodford's community GP records and recorded that he had not been collecting his antipsychotic medication in the community. It is not clear how long that had been the case. He decided that Mr Woodford should have a trial period without it. He noted that Mr Woodford had ADHD, but had no diagnosis of OCD. The doctor prescribed concerta from 23 January (to allow the pharmacy time to obtain it) and referred Mr Woodford for a mental health assessment. On 22 January, Mr Woodford was upset after an argument with Nurse C when he told him he could not get concerta before 23 January.

29. On 23 January, Mr Woodford attended a court hearing by video link. He pleaded guilty to robbery and was remanded for a pre-sentence report. There is no record that anyone spoke to Mr Woodford after his court appearance or assessed his risk.

30. At about 9.30pm on 26 January, Mr Woodford's cellmate pressed the cell bell to alert staff that Mr Woodford had cut his left arm with a razor blade. Officer B began ACCT procedures and recorded that Mr Woodford was crying and

vulnerable. Mr Woodford told the officer that he had had an altercation on C Wing earlier in the day and had been moved to A Wing in response. In fact, Mr Woodford had been living on A Wing since he had arrived at the prison. There is no record of any incident with another prisoner that day.

31. On 27 January, Nurse D, the manager of the primary care mental health team, reviewed Mr Woodford, who said he harmed himself because he was upset that the psychiatrist had stopped his antipsychotic medication. He said he was also worried because his partner and his five-month old daughter were unwell. Nurse D recorded that Mr Woodford was unshaven and unkempt but maintained good eye contact and engaged appropriately. Mr Woodford said he did not have suicidal thoughts but still thought about self-harm. Nurse D did not write anything in Mr Woodford's ACCT record.

32. Later that morning, Officer C assessed Mr Woodford as part of the ACCT process. Mr Woodford said he was having problems registering his telephone numbers on the prison phone system and had not spoken to his family since he had arrived at Winchester. He said his family had disowned him and the only support he received was from his partner, but he did not want to die. He told the officer that he had self-harmed for 11 years and that he had tried to kill himself three times in the past; by hanging when he was in a young offender institution and by taking two overdoses in the community. He said this had been in response to his brother killing himself. (His brother had died of an overdose in 2009.)

33. After the assessment, Officer C completed the triggers section of the ACCT document and noted that Mr Woodford was upset because he was not in touch with his partner and daughter, had medication issues and he wanted staff to listen to him more. He noted that Mr Woodford was due to be sentenced on 13 February and was expecting a three-year sentence.

34. SO B held an ACCT case review after the assessment, which Officer C attended, but there was no member of healthcare staff present. Mr Woodford was very tearful and low in mood. He said he harmed himself because he felt no one was listening to him. The review assessed Mr Woodford as at raised risk of suicide or self-harm and noted that he had been referred to the mental health team. Officers were required to check Mr Woodford at least once an hour. SO B scheduled the next ACCT case review for 2 February and recorded that someone from the mental health team should be invited.

35. On 27 January, Officer C wrote in the ACCT record that he had had a long conversation with Mr Woodford, who had been tearful and concerned about his partner. The officer said that he phoned Mr Woodford's partner and left a message to let her know that Mr Woodford had not been able to contact her because the prison had not yet set up his telephone account.

36. On 28 January, Officer D completed Mr Woodford's caremap (which should have been completed at the first ACCT case review). The officer noted that Mr Woodford needed mental health treatment and that the psychiatrist or mental health team should resolve his medication issues.

37. On 2 February, SO C and Officer E held another ACCT review. Again, there was no member of healthcare staff present, although Mr Woodford's mental health and medication had been identified as problems and SO B had indicated, at the last review, that mental health staff should be invited to this review. SO C and Officer E decided that Mr Woodford's level of risk had reduced to 'low,' as problems he had had with access to his spending account had been resolved and he was feeling more stable. They reduced the level of observations to every two hours.

38. On 3 February, Mr Woodford applied for £75.00 to be sent out of his cash account to the address of another prisoner's partner, although he wrote his partner's name as the recipient. On 6 February, Mr Woodford asked for £100.00 to be sent to his partner at his partner's address. Mr Woodford's partner did not receive this money. Custodial manager A investigated this after Mr Woodford's death. The first payment was apparently to settle a debt of £75.00 Mr Woodford owed to a former cellmate, but incurred before he arrived at Winchester. When his cellmate was released, Mr Woodford had still not settled the debt and his cellmate asked another prisoner to arrange for the money to be paid to an address he gave. Mr Woodford had named his partner as the recipient to avoid suspicion. The prison's finance department sent the second sum of £100 to the same address as the first in error. The prison apologised for the error and compensated Mr Woodford's partner for the missing money.

39. On 9 February, SO C and Officer F held another ACCT case review, with no other staff present. Mr Woodford said he felt more settled and almost ready for the ACCT to be closed. The staff agreed that his risk of suicide and self-harm was still low and that the frequency of staff observations should be reduced to one conversation a day and three checks at irregular intervals during the night. That evening, Mr Woodford cut his arm. Nurse E dressed the wound and booked

a mental health appointment for the next day. There was no ACCT review or reconsideration of his risk after this further act of self-harm.

40. The next morning, Mr Woodford told Nurse D that he felt low, was not sleeping and had thoughts of self-harm, but not suicide. Mr Woodford was worried he might receive a three-year sentence on 13 February. The nurse advised him to keep busy by continuing to attend education classes each afternoon and to seek support from the Samaritans, Listeners or members of the chaplaincy. (Listeners are prisoners trained by the Samaritans to offer confidential support to other prisoners.) He wrote in Mr Woodford's medical record that the primary care mental health team would review him in two weeks. The nurse did not record his conversation in the ACCT document so that other staff would be aware.

41. At 6.33pm, Officer G responded to Mr Woodford's cell bell. Mr Woodford was crying and said that the head of security had let him down. He said that the head of security had promised to see him but had not done so. (There is no record of why Mr Woodford wanted to speak to the head of security.) Mr Woodford told Officer G that he was going to be sentenced soon. The officer spoke to a nurse and custodial manager C, the most senior member of staff on duty, and described Mr Woodford as needy. Nurse F went to see Mr Woodford in his cell and wrote in his medical record that there were superficial scratches on his right arm. Again, no one reviewed his level of risk.

42. On 11 February, a community psychiatric nurse (CPN), from the prisons' community mental health team (CMHT - which cares for patients with severe and enduring mental illness) and Nurse D from the primary care mental health team discussed the level of mental health support Mr Woodford needed. Nurse D said that he had reviewed Mr Woodford on 27 January and 10 February and did not think he needed secondary mental health care. He had already arranged a primary mental health review in two weeks. The CPN agreed with other members of the prison's community mental health team that Mr Woodford should stay on the primary mental health team caseload and did not need more intensive support.

43. On 12 February, Dr C, a prison GP, saw Mr Woodford, who was very angry that he had not received any antipsychotic medication since arriving at Winchester. He said decisions had been made about his medication without him being there. The doctor said that Mr Woodford was manipulative about his mental health and recorded that he lacked empathy. The doctor did not record the outcome of the appointment.

44. On 13 February, Mr Woodford was sentenced to four and a half years in prison for robbery, 18 months longer than he was expecting. There is no record that anyone assessed his risk in reception when he got back from court. He told two officers on A Wing that he was okay and they recorded this in the ACCT record.

45. On Saturday 14 February, Mr Woodford's cellmate told Officer H he was concerned about Mr Woodford. Mr Woodford had said that he was worried that he had not received some post that he had been expecting and that he had sent some money to his partner three weeks previously, but it had still not arrived. (Mr Woodford had asked his partner to buy him some items with some of the money.) Officer H said he would check whether there was any mail from him still in the prison. Mr Woodford mentioned it again to SO B, who suggested he should speak to officers on Monday, who could check with the finance team. Officer E telephoned a member of the finance staff who said that the money had been sent to Mr Woodford's partner.

46. On 16 February, custodial manager B held an ACCT case review, which a community psychiatric nurse, also attended. Mr Woodford said he did not have any thoughts of suicide or self-harm, he had accepted his sentence, was to going to education classes and was in touch with his family. Custodial manager B and the community psychiatric nurse agreed that Mr Woodford's risk of suicide or self-harm was low and closed the ACCT. Custodial manager B scheduled a post-closure review for 23 February.

47. On 17 February, Officer I assessed Mr Woodford as suitable to move to a lower security prison. She suggested he should go to either HMP Guys Marsh or HMP Erlestoke.

48. On 19 February, Mr Woodford punched his cell wall. A healthcare support worker saw him at 8.15pm and wrote in his medical record that his hand was swollen and very painful. She referred him to see a GP the next day. Officers did not record this as an act of self-harm and there is no evidence that anyone considered re-opening Mr Woodford's ACCT.

49. The next day, 20 February, Dr A examined Mr Woodford and referred him to hospital for an X-ray of his hand, which was swollen and tender. That day, Mr Woodford's partner telephoned the Public Protection Unit (PPU) at Winchester and asked the prison to block all letters and telephone calls from Mr Woodford to her. Mr Woodford's record was updated with this information and the Public Protection Unit emailed the finance department to remove his partner's number

from his list of approved numbers. There is no record that anyone spoke to Mr Woodford about this.

50. At 11.10pm on 20 February, Nurse G went to see Mr Woodford, who had reported that he had taken 24 ibuprofen tablets. His face was grey and he was vomiting. The nurse admitted him to the prison's healthcare centre for observation overnight. When he arrived, he cried because wanted a cigarette and smoking is not allowed in the healthcare centre. The next morning, Mr Woodford refused to see the doctor and wanted to go back to his wing. Nurse D spoke to the National Poisons Unit, who advised that Mr Woodford did not need to go to hospital.

51. Later that morning, custodial manager A, started ACCT monitoring again, and asked officers to check Mr Woodford at least twice an hour. Nurse D decided that Mr Woodford should not keep any medication in his cell as he was at risk of suicide or self-harm.

52. Officer J assessed Mr Woodford as part of the ACCT process. Mr Woodford said he thought he was being singled out by officers on A Wing but did not explain why. He was still worried that his partner had not received the money he had sent her. He said he did not want to kill or harm himself but he felt angry and frustrated. The officer described him as very angry.

53. SO D chaired the ACCT case review, which Officer J attended. There was no healthcare representative. Mr Woodford was angry during the review and was mainly concerned that his partner had not received the money he had sent. His risk of suicide or self-harm was assessed as low. His caremap contained one action, for money to be sent to Mr Woodford's partner from the prison.

54. On 22 February, Mr Woodford spoke to a nurse on the wing because he wanted to be assessed as fit to transfer to Erlestoke, nearer his family. He did not yet have an appointment for the X-ray and the nurse advised him to wait until this had been done.

55. On 23 February, SO C held another ACCT review, attended by SO D. No other staff were present. Mr Woodford said he would be happy to transfer to Erlestoke, as he would be nearer his family and able to see his daughter. During the review, SO C checked with the prison department responsible for transfers and confirmed that Mr Woodford was going to be transferred to Erlestoke in due course. SO C and SO D agreed that Mr Woodford's risk of suicide or self-harm was low and closed the ACCT. They arranged a post-closure review for 2 March.

24 February

56. Between 5.00pm and 7.00pm on 24 February, Mr Woodford telephoned his partner seven times. (The prison had still not put in place the public protection measures that Mr Woodford's partner had asked for four days earlier.) Some of his messages were abusive and threatening.

57. When Officer E arrived on A Wing that evening, he heard banging, shouting and a cell bell ringing. (The cell bell records show that Mr Woodford's bell had been ringing for just over five minutes.) The bell was from Mr Woodford's cell and the officer responded immediately. At 8.40pm, he looked through the door observation panel and saw Mr Woodford hanging from the window frame with a sheet around his neck. The officer shouted for help and Officer K, Officer L and Officer M joined him. Officer K blew his whistle to alert other staff and, at 8.42pm, custodial manager C radioed a code blue medical emergency. At 8.44pm, a communications room operator called an ambulance, which arrived at the prison at 8.48pm.

58. Officer E went into the cell immediately, saw Mr Woodford hanging and cut the sheet. Officer L started chest compressions and Officer K gave rescue breaths. Mr Woodford's cellmate told the officers that he had been asleep and when he woke he saw what Mr Woodford had done. He had tried to support his body, but after a while he was too heavy to support any longer. He had pressed the emergency cell bell and shouted to get the officers attention. In a statement made afterwards, Nurse H said he had heard the code blue call and ran to Mr Woodford's cell. He said that when he arrived, Mr Woodford was in the recovery position, but having difficulty breathing, so he gave him oxygen. A fast response paramedic crew took Mr Woodford to hospital and then transferred him to the intensive care unit at another hospital. His condition was critical and he was in an induced coma.

59. Officers found a three-page note in Mr Woodford's cell, addressed to his partner and daughter. Officer E opened an ACCT again and custodial manager A concluded that when Mr Woodford was well enough to return to the prison, he should be constantly supervised.

60. Mr Woodford had nominated his partner as his next of kin. No one telephoned her immediately to let her know what had happened. The next day, the prison's family liaison officer and chaplain went to inform Mr Woodford's partner at her home.

Mr Woodford's return to Winchester

61. On 26 February, doctors brought Mr Woodford out of his coma and discharged him on 1 March, when he returned to Winchester. At 6.25pm, custodial manager D and SO A held an ACCT review. No member of healthcare staff attended. Custodial manager D told the investigator that he had wanted Mr Woodford to be admitted to the healthcare centre and to be observed either constantly or at least four times an hour. However, Mr Woodford wanted to go back to A Wing. The review agreed that his level of risk had not changed. (Although it is not clear what his assessed risk was.) Although custodial manager A had indicated that Mr Woodford should be constantly supervised when he returned to prison, and custodial manager D said that he had wanted him to be observed at least four times an hour, custodial manager D recorded that Mr Woodford should be checked twice an hour and reviewed the next morning. Custodial manager D told the investigator that, although he had regarded Mr Woodford as high risk, he had told the night patrol operational support grade that he should regard the observation level of twice an hour as a minimum and should check him as often as possible. Custodial manager D said that while he had been considering what arrangements he could put in place for Mr Woodford, another high risk prisoner tried to kill himself and he needed to balance the resources available with the risk each prisoner presented.

62. On 2 March, custodial manager B chaired an ACCT case review, which Nurse I attended. Mr Woodford said he could not remember trying to take his life or why he did it. He wanted staff to close the ACCT because he did not want to hold up a transfer to Erlestoke. Custodial manager B did not record Mr Woodford's assessed level of risk. She updated the caremap, identifying that Mr Woodford needed a mental health assessment; custodial manager A was to check Mr Woodford's phone account to ensure he was able to keep in touch with his family; and that Mr Woodford and officers should work towards a transfer to Erlestoke. (Mr Woodford's partner had let the prison know that she was happy for him to contact her again.)

63. On 4 March, SO D chaired an ACCT case review, with Dr B and custodial manager B. Mr Woodford said he did not have thoughts of suicide or self-harm and had applied to move to Erlestoke. Dr B did not have concerns about Mr Woodford's mental health at that time. The review agreed that Mr Woodford's level of risk was low, and that officers should check him at least once an hour and have two conversations a day with him. SO D scheduled his next ACCT review for 11 March.

64. After the ACCT case review, Dr B saw Mr Woodford for a psychiatric review. He recorded that, in 2011, Mr Woodford had been prescribed a low dose of an antipsychotic medication (25mg) to help him sleep but had later persuaded a GP to increase the dose to 300mg. There was no date or reason noted in Mr Woodford's community medical records for this increase. Dr B wrote that there had never been any suggestion that Mr Woodford was psychotic, although two close family members had been diagnosed with paranoid schizophrenia. The doctor concluded that Mr Woodford did not need antidepressant or antipsychotic medication, and he did not need to be under the care of the prison's community mental health team.

65. Mr Woodford told Dr B that he had tried to hang himself on 24 February after he had argued with his partner, who had told him not to transfer to Erlestoke because their relationship was over. The doctor recorded that Mr Woodford was making plans for the future and said he had no thoughts of suicide or self-harm at the time.

66. At 9.35am on 6 March, Officer N wrote in the ACCT record that Mr Woodford had told him that he had nearly hanged himself the previous evening. He said that he was glad that he had not gone through with it, as he wanted to be a father to his daughter. Five minutes later, Officer O commented how immaculate his cell was, but Mr Woodford said that he did not think it was clean enough. The officer wrote in Mr Woodford's ACCT record that he was worried about Mr Woodford's sudden cleanliness. (Mr Woodford's, his previous cellmate, said that Mr Woodford was always obsessively clean and tidy.) No one held a review but Mr Woodford's ACCT observations were increased to every half an hour. There is no record of who decided to increase the observations.)

67. At 7.50pm on 6 March, SO C gave Mr Woodford back a letter he had written to tell him that he was not allowed to contact his partner. The SO did not know that contact had been permitted since 2 March. Mr Woodford was upset and shouted that officers had better watch out that night. At 8.25pm, Mr Woodford seemed agitated, but assured officers that he would not do anything stupid.

68. At 9.30am on 8 March, SO E wrote in Mr Woodford's ACCT document that he had spoken to Mr Woodford and agreed with him that his checks should be reduced to hourly again. The SO told the investigator that he normally worked on C Wing but had been asked to work on A Wing for the day. He noticed that there were about eight open ACCT documents and he thought that the frequency of observation on Mr Woodford could return to hourly. He believed that this would help the staff, who were finding it difficult to complete the number of observations

they had to make. He accepted that he had never met Mr Woodford before, did not know his history and did not recall reading previous entries in his ACCT record. Despite this, he reduced Mr Woodford's frequency of observations to hourly.

9 March

69. An officer observed Mr Woodford hourly through the night until 7.45am on 9 March. Officers on the wing that morning had no concerns about him. He collected his medication and officers noted he was talking to other prisoners on the wing. At 11.00am, Mr Woodford asked Nurse D for ibuprofen for neck pain. The nurse said that Mr Woodford made good eye contact during their conversation. He said that he saw Mr Woodford a few times during the day and he was chatting with other prisoners and gave him no cause for concern.

70. At 6.00pm, Mr Woodford told Officer P that his neck hurt. At 6.55pm, Officer G checked him and Mr Woodford was lying on his bed in the dark. Mr Woodford told Officer G that he was waiting for a nurse to see him. At 7.20pm, he pressed his cell bell and asked Officer G if he could see a nurse. The officer left a message on the healthcare centre's answer phone.

71. At 8.13pm, Officer Q looked into Mr Woodford's cell and saw him hanging by a sheet attached to the door. He shouted to Officer K who was passing by, and then blew his whistle. Custodial manager C heard the whistle and informed the communications room that help was needed on A4 landing. Officer K radioed an emergency code blue (which indicates a life-threatening emergency, such as when a prisoner is unconscious or not breathing.)

72. Officer Q cut the sheet from around Mr Woodford's neck and laid him on the floor. Custodial manager A, custodial manager C, and Officer R responded to the code blue. Officer K and Officer M began cardiopulmonary resuscitation. At 8.20pm, officers checked Mr Woodford and found no signs of life so continued cardiopulmonary resuscitation. Custodial manager C radioed again for healthcare staff and oxygen.

73. Officer S who was working in the prison's control room radioed the code blue again. At 8.22pm, Nurse J arrived at Mr Woodford's cell. He said he had not heard the first code blue. When he arrived, officers were giving rescue breaths and chest compressions. The nurse gave Mr Woodford oxygen and attached a defibrillator, which found no shockable heart rhythm and advised that they should continue resuscitation.

74. At 8.22pm, Officer S called an ambulance. She told the investigator she did not realise that she should call an ambulance automatically as soon a code blue is received. The ambulance arrived at the prison at 8.26pm. Paramedics stabilised Mr Woodford and, at 9.00pm, took him to hospital. The hospital admitted him to the Intensive Treatment Unit, where he was ventilated and sedated. A CT scan showed significant brain damage. There is no record that anyone contacted Mr Woodford's partner that evening to let her know of his serious condition in hospital.

75. The next day, Officer J, the prison's family liaison officer, contacted Mr Woodford's partner and arranged to meet her at the hospital that morning. On 11 March, on the advice of hospital doctors, Mr Woodford's partner agreed that they should withdraw treatment, as there was little chance of recovery. His partner and other family members stayed with him in hospital until he died at 2.11pm on 12 March, without regaining consciousness. Officer J was with Mr Woodford's family when he died.

76. In line with Prison Service policy, the prison contributed to the costs of the funeral.

Support for prisoners and staff

77. Several of the staff who were involved in the successful attempt to resuscitate Mr Woodford on 24 February, were also involved in the emergency response on 9 March, which was very distressing for them. A senior manager debriefed the staff involved to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

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

Post-mortem examination

79. The results of the post-mortem examination were not available at the time of issuing this initial report, but the coroner gave the preliminary cause of death as hanging. Toxicology tests showed that Mr Woodford had no illicit substances in his bloodstream at the time he died.

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Findings

Assessing risk of suicide and self-harm

80. Mr Woodford had told court staff that he would try to kill himself in prison. This was recorded on his suicide and self-harm warning form, along with his self-harm in police custody and the fact that he had tried to hang himself during his last time in prison. The police had written on Mr Woodford's escort record (PER) that he was at risk of suicide and self-harm because he had banged his head against the wall and slashed his arms with broken glass.

81. SO A did not sign the suicide and self-harm warning form to confirm its receipt, and could not remember seeing it. He said that he read all of the paperwork given to him by escort staff, including the PER, yet he did not open an ACCT. He said that it was not clear from the PER when Mr Woodford had self-harmed and he usually relied on how a prisoner presented to assess his risk. Nurse B said that from her conversation with Mr Woodford, she did not consider that he was at risk. She said she had taken into account that the SO had judged that Mr Woodford was not at risk of suicide or self-harm. The nurse signed the suicide and self-harm warning form, but saw no reason to start suicide prevention procedures.

82. Prison Service Instruction (PSI) 7/2015, about early days in custody, sets out mandatory reception procedures and says 'The PER and any other available documentation including Suicide & Self Harm Warning Forms, ACCT documents and CSRAs, must be examined, and the prisoner interviewed in Reception, to assess the risk of self-harm or harm to others by the prisoner, or harm from others. All available, relevant information must be considered…' As reception, staff did not properly consider the information on the escort record and suicide and self-harm warning form highlighting Mr Woodford's risks, we do not think that the prison complied with this instruction.

83. PSI 64/2011 (Safer Custody) lists risk factors and potential triggers for suicide and self-harm. Mr Woodford had a number of these risks. He was in the early days of custody, had recently threatened to kill himself, had recently self-harmed and was prescribed medication for his mental health. PSI 7/2015 requires staff to interview new prisoners in reception to assess the risk of suicide and self-harm and expects all staff to be alert to the increased risk and to act appropriately to address any concerns. This includes opening an ACCT.

84. Despite his recent suicidal thoughts, self-harm and his mental health treatment, SO A and Nurse B relied almost entirely on Mr Woodford's presentation and his assertion that he did not intend to harm himself. There is no evidence that they balanced this against the information that arrived with him at the prison, or his other risk factors.

85. Staff judgement is fundamental to the ACCT system. It relies on staff to use their experience and skills, as well as local and national assessment tools, to determine risk. This must include the prisoner's known risk factors as well as their presentation. PSI 64/2011 states that 'all staff who have contact with prisoners must be aware of the triggers that may increase the risk of suicide, self-harm or violence and take appropriate action'. The need to take full account of risk factors on reception is a matter we have raised with the prison before in an investigation report into a death at the prison in 2014. The prison accepted our recommendation and said that they had taken action to ensure that staff were aware of all risk factors that reception staff took into account all information from external sources when assessing a newly arrived prisoner's risk. We are not satisfied that this happened when Mr Woodford arrived and make a further recommendation:

The Governor should produce clear local guidance about procedures for identifying newly arrived prisoners at risk of suicide and self-harm. In particular, this should ensure that reception and first night staff:

- **Have a clear understanding of responsibilities and the need to share all relevant information about risk.**
- **Consider and record all the known risk factors of a newly-arrived prisoner when determining their risk of suicide or self-harm, including information from suicide and self-harm warning forms and PERs.**
- **Open an ACCT whenever a prisoner has recently self-harmed or expressed suicidal intent.**

Assessment of risk after a court appearance

86. On 23 January, Mr Woodford appeared in court by video link, when he pleaded guilty to a high profile offence of robbery. He received a longer sentence than he expected. There is no evidence that an officer or a member of the healthcare team reviewed Mr Woodford after his appearance.

87. On 13 February, Mr Woodford received a four and a half year sentence for robbery. The sentence was longer than he expected, and he had told officers that he was worried about his court appearance. Even though, the court appearance was recorded as a trigger to prompt immediate review, in his ACCT document, there is no record that he was formally reviewed by officers or healthcare staff when he got back from court. Officers said he had assured them he was okay afterwards, but there was no formal assessment of his risk.

88. Prison Service Order 3050 (PSO) about Continuity of Healthcare indicates that events such as attending court, sentencing at court and being questioned by the police are factors that might increase someone's risk of suicide and self-harm. Prisons are required to have protocols to screen prisoners passing through reception for any potential healthcare or suicide/self-harm issues. The PSO specifies a court appearance by video-link as a significant event that can affect the health of a prisoner and that prisoners might need to be assessed for risk of suicide and self-harm afterwards. We are concerned that Winchester did not follow the mandatory procedures of PSO 3050. We make the following recommendation:

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

Management of risk of suicide and self-harm

89. Mr Woodford was identified at risk of suicide and managed under ACCT procedures three separate times in the seven weeks he was at Winchester. We are concerned that ACCT procedures were not well managed. In particular, we found that:

- There was no member of healthcare staff present at any of his first case reviews, which is contrary to a mandatory instruction in Prison Service Instruction 64/2011.
- There was inconsistent case management with seven different chairs for ten reviews.
- ACCT case reviews were rarely multidisciplinary and mental health staff attended only three reviews, although Mr Woodford's risks were largely associated with his mental health and medication.
- Interactions with healthcare staff were not recorded in the ACCT document to inform other staff.

- Caremaps were not used effectively to identify and manage Mr Woodford's immediate concerns.
- There was no review of his risk after apparent incidents of self-harm, including on 19 February when he badly injured his hand, and no evidence that staff considered re-opening the ACCT that had been closed just three days before.
- The level of observations did not always reflect the risk of suicide and self-harm. In particular, we are concerned that officers were required to check Mr Woodford only twice an hour when he had returned to the prison on 1 March, after a serious suicide attempt.
- A supervising officer who did not know Mr Woodford reduced the frequency of his observations on 8 March without holding a case review.

90. ACCT procedures were not operated in line with national guidance and communication, recording of information and the assessment of Mr Woodford's risk were poor. We make the following recommendation:

The Governor and Head of Healthcare should ensure that prison staff manage prisoners at risk of suicide or self-harm in line with national guidance, including in particular:

- **A multi-disciplinary approach for all case reviews with continuity of case management.**
- **Healthcare staff attending all first case reviews.**
- **Setting caremap actions, which are specific and meaningful, aimed at reducing prisoners' risks and reviewed and updated as necessary.**
- **Setting levels of observations, which reflect the prisoner's actual risk rather than the resources required.**
- **Reviewing risk whenever an event occurs which indicates an increase in risk and holding a case review if required.**
- **All staff, including healthcare staff, recording relevant information about risk, observations and interactions with prisoners in ACCT documents and any action taken.**

Possible bullying

91. The prison had no intelligence before Mr Woodford died to suggest that other prisoners were bullying him and he did not report being bullied. After his death, Mr Woodford's partner told the prison that she was concerned that other prisoners at Winchester had bullied him.

92. Mr Woodford sent another prisoner's partner £75.00. He addressed the money to his partner to avoid suspicion. Custodial manager A investigated the allegations and spoke to the prisoner concerned. The other prisoner said that he was collecting a debt on behalf of a friend, and the prison took no further action.

93. We are satisfied from correspondence between Mr Woodford and his partner that the other money he sent out was legitimately intended for her. While the prison should have spotted the discrepancy in address for the first payment and made further enquiries at the time, there is no evidence that Mr Woodford was being bullied during his time at Winchester.

Emergency response

94. On 24 February, when an officer found Mr Woodford hanging, it took two minutes to radio a code blue, and two more minutes to call an ambulance. After Officer Q found Mr Woodford hanging on 9 March, he did not radio a code blue, but Officer K appears to have called one quickly afterwards.

95. Officer S, who was working in the control room on 9 March, recorded a code blue at 8.16pm. Healthcare staff told our investigator that they did not hear the first code blue call and the officer repeated it at 8.22pm, after which, healthcare staff responded. This meant that there was a six-minute delay in the initial healthcare response to a medical emergency.

96. Officer S did not call an ambulance until 8.25pm, nine minutes after the code blue. She told the investigator that she did not know that an ambulance should be called automatically when a code blue is received. She waited for an instruction from a member of the healthcare team or custodial manager C until she did so. She believed custodial manager C had asked her to call an ambulance but she was not certain.

97. Prison Service Instruction (PSI) 3/2013 sets out how a prison should respond to a medical emergency. It requires that every prison should develop a protocol to ensure that officers use emergency radio codes immediately and an ambulance should be called automatically when a medical emergency code is used. We have made three recommendations to Winchester in the last two years about emergency procedures but it is apparent that staff still do not understand what is

expected of them. It is particularly important that all staff working in the control room know to call an ambulance immediately in an emergency. The delays in this case could have been critical. We make the following recommendation:

The Governor should ensure that all prison staff understand their responsibilities during medical emergencies and in particular that staff efficiently communicate the nature of a medical emergency and that control room staff call an ambulance immediately a medical emergency code is broadcast.

Family liaison

98. Mr Woodford was taken to hospital in a critical condition at 9.00pm on 9 March yet the prison did not inform his family until the next morning. There had been a similar delay when Mr Woodford was taken to the hospital on 24 February.

99. Prison Rule 22 requires that when a prisoner becomes seriously ill, the Governor should "***at once*** inform the prisoner's spouse or next of kin, and also any person who the prisoner may reasonably have asked should be informed".

100. When Mr Woodford was taken to hospital, his condition was critical and the prison should have informed his family straight away. Any delay in informing families when a prisoner is seriously ill or has suffered sudden life-threatening harm can mean that families miss the opportunity to see them before they die. 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 so that they are able to visit them in hospital without unnecessary delay.

Clinical care

101. Mr Woodford's partner was concerned that a prison doctor had stopped his antipsychotic medication. The prison obtained Mr Woodford's community medical records and, after reviewing the records, Dr B decided to stop Mr Woodford's antipsychotic medication. On 4 March, the doctor revisited this decision and was satisfied that Mr Woodford did not need to be prescribed an antipsychotic. There was no clear clinical evidence to support the prescribing and Mr Woodford had never been diagnosed with schizophrenia. It appeared that Mr Woodford had not been collecting his prescriptions in the community for some time and we consider that the doctor, as a qualified psychiatrist in

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possession of Mr Woodford's community records, made a reasonable clinical decision.

102. Mr Woodford received support from the primary care mental health team after his first act self-harm in custody on 26 January and throughout his time in the prison. Dr B completed a psychiatric review, and concluded that he had no severe and enduring mental illness and did not need secondary mental health support.