

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Ryan Harvey a prisoner at HMP Woodhill on 8 May 2015

A report by the Prisons and Probation Ombudsman

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.

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

Mr Harvey was found hanged in his cell at HMP Woodhill on 3 May 2015, and died in hospital five days later. Mr Harvey was 23 years old. I offer my condolences to Mr Harvey's family and friends.

The investigation, which was suspended to allow police investigations and criminal proceedings to take place, found a number of deficiencies in the operation of suicide and self-harm prevention procedures, which the prison will need to address. I am most concerned that although Woodhill received community medical information stating that Mr Harvey was a vulnerable adult with mental health needs before he arrived at the prison, no mental health assessment took place and Mr Harvey never received support from the mental health team.

I am also concerned that the emergency procedures did not follow national instructions.

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

Elizabeth Moody
Acting Prisons and Probation Ombudsman

September 2018

Contents

| | |
|---------------------------------|----|
| Summary | 1 |
| The Investigation Process | 3 |
| Background Information | 4 |
| Key Events | 6 |
| Findings..... | 11 |

Summary

Events

1. On 22 April 2015, Mr Harvey was remanded into custody at Woodhill charged with arson and burglary. Mr Harvey was aged 23 and single. He had a learning disability and had been assessed as a vulnerable adult. He also had a history of drug and alcohol abuse. Mr Harvey had a conviction history dating back to 2002 and had served custodial sentences since 2011.
2. The mental health team at Woodhill were aware that Mr Harvey had a learning disability. Mr Harvey saw a doctor, who referred him for an assessment with the mental health team and the substance misuse team. The mental health team did not assess Mr Harvey and he did not receive any mental health support during his time at Woodhill.
3. On 2 May, staff started monitoring Mr Harvey under Prison Service suicide and self-harm prevention procedures (known as ACCT) after he was found with a ligature around his neck.
4. At 8.40pm on 3 May, an officer saw Mr Harvey attempting to tie a ligature to the light fitting in his cell. A custodial manager increased Mr Harvey's observations to every 30 minutes.
5. At 9.59pm, an officer found Mr Harvey hanged in his cell. Staff started resuscitation until paramedics arrived and took Mr Harvey to hospital, where he was placed on life support. Hospital doctors withdrew life support on 8 May, and Mr Harvey was pronounced dead at 5.10pm.

Findings

Clinical care

6. The investigation identified concerns with Mr Harvey's mental health care while in custody. The clinical review concluded that the mental health care provided to Mr Harvey was not equivalent to that which he could have expected to receive in the community.
7. Mr Harvey had no interventions to address his mental health needs. Woodhill did not act on the medical information it received in advance of his arrival on 22 April which disclosed that Mr Harvey was a vulnerable adult and had a learning disability. No mental health assessment was undertaken and Mr Harvey was not supported by the mental health team.

Management of risk of suicide and self-harm

8. We found that ACCT procedures at Woodhill were not correctly conducted in line with mandatory national instructions. At the case review the assessment of Mr Harvey's risk did not include all his risk factors, and reduced the frequency of checks without any evidence that Mr Harvey's risk of suicide and self-harm had reduced.

9. We also found that an immediate case review was not carried out, as required, when Mr Harvey was found tying a ligature to the light fitting at 8.40pm on 3 May, and the decisions taken were not documented.

Emergency response

10. We are concerned about the emergency response. Staff did not use the emergency code as required and after Mr Harvey had been found there was a five-minute delay in calling an ambulance. We do not know whether a quicker response would have affected the outcome for Mr Harvey, but it could be crucial in other circumstances.

Recommendations

- The Head of Healthcare should:
 - ensure that critical information about a prisoner is properly recorded and shared with other prison staff; and
 - review the referral process to the mental health team to ensure prisoners are assessed promptly and that management audits all referrals undertaken.
- The Governor should ensure that staff manage prisoners at risk of suicide or self-harm in line with national guidelines, including:
 - understanding their responsibilities and the need to share all relevant information about risk;
 - considering and recording all the known risk factors of a prisoner when determining their risk of suicide or self-harm;
 - assessing the level of risk and recording the reasons for decisions;
 - setting and recording appropriate levels of observations which are adjusted as the perceived level of risk changes;
 - setting caremap actions which are specific and meaningful and reviewing progress against the caremap at each review; and
 - conducting ACCT reviews as specified in the national instructions.
- The Governor should ensure that all prison staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies which:
 - ensures staff efficiently and effectively communicate the nature of a medical emergency; and
 - ensures staff call for an ambulance immediately after an emergency code message is radioed.

The Investigation Process

11. 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.
12. The investigator visited Woodhill on 14 May 2015. He obtained copies of relevant extracts from Mr Harvey's prison and medical records.
13. NHS England commissioned a clinical reviewer to review Mr Harvey's clinical care at the prison.
14. The investigator interviewed 12 members of staff and one prisoner at Woodhill in June and July 2015, nine jointly with the clinical reviewer.
15. We informed HM Coroner for Milton Keynes of the investigation. He gave us a copy of the cause of death statement from the hospital. We have sent the coroner a copy of this report.
16. Our investigation was suspended on 9 July 2015, pending the outcome of a police investigation and criminal proceedings against a Custodial Manager (CM) related to the circumstances of Mr Harvey's death. On 30 January 2018, the criminal proceedings were concluded, the CM was found not guilty and we re-opened our investigation.
17. One of the Ombudsman's family liaison officers contacted Mr Harvey's mother to explain the investigation and to ask whether she had any matters she wanted the investigation to consider. Mr Harvey's mother had concerns about:
 - what information was passed to the prison from court;
 - how frequently Mr Harvey was checked;
 - her communication with the prison; and
 - the role prison staff had at the hospital.

Mr Harvey's mother received a copy of the draft report. The solicitor representing Mr Harvey's mother wrote to us raising a number of questions. We have provided clarification by way of separate correspondence to the solicitor.

Background Information

HMP Woodhill

18. HMP Woodhill has a dual role as a local prison and a high security prison and can hold more than 800 men. Central and North-West London NHS Foundation Trust provides health services at the prison. Westminster Drug Project provides the substance misuse services.

HM Inspectorate of Prisons

19. The most recent inspection of HMP Woodhill was conducted in September 2015. In previous inspections inspectors had repeatedly raised concerns about weaknesses in the support of prisoners at risk of suicide and self-harm. Inspectors found the number of self-inflicted deaths had been unacceptably high, and that recommendations about suicide and self-harm procedures made by the Ombudsman following previous deaths had not been implemented. Inspectors also found that mental health services were inadequate to meet the needs of the prison population and the wait for prisoners to see the mental health team was too long.

Independent Monitoring Board

20. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its annual report, published in November 2017, the IMB were concerned that the mental health team was underfunded and understaffed. The IMB commented that continued serious staff shortages had directly affected the delivery of the regime and reduced the amount of time staff could engage with prisoners. This had resulted in increased incidents of self-harm and violence. The IMB were concerned about the high number of deaths in custody and the increased number of prisoner on suicide and self-harm prevention measures (known as ACCT).

Previous deaths at HMP Woodhill

21. Mr Harvey's was the eighth self-inflicted death at Woodhill between May 2013 and May 2015, and there have been twelve self-inflicted deaths since May 2015. It is very disappointing to find so many of the same issues repeated across a number of our investigations, including this one. We raised concerns about the assessment of risk of suicide and self-harm at Woodhill and made recommendations about the quality of suicide and self-harm prevention procedures. In three cases, we raised also concerns about the emergency procedures at the prison, which were not consistent with national instructions.
22. In February 2017, a former Prisons and Probation Ombudsman was commissioned by the Ministry of Justice to produce a report for the Secretary of State on the prevention of self-inflicted deaths and self-harm at HMP Woodhill. This report was published in May 2017.
23. In his report, the former Ombudsman highlighted weaknesses he had observed in the ACCT process. There was failure to consider all risk factors of suicide and

self-harm, failure to hold multi-disciplinary reviews and full and accurate completion of ACCT documentation. He concluded that, although there was a focus on prisoner safety at Woodhill, it had coincided with a culture of risk aversion which placed a great strain on the management of the ACCT process and the wider prison regime. He also identified a need to ensure staff fully understand and implement the national instructions when responding to a medical emergency.

Assessment, Care in Custody and Teamwork (ACCT)

24. 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. 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 carried out at irregular intervals to prevent the prisoner anticipating when they will occur. Regular multidisciplinary review meetings involving the prisoner should be held. As part of the process, a caremap (a 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. 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, *Management of prisons at risk of harm to self, to others and from others (Safer Custody)*.

Key Events

25. On 22 April 2015, Mr Harvey was remanded into custody at HMP Woodhill charged with arson and burglary at his mother's property. Mr Harvey had a conviction history dating back to 2002 and had served custodial sentences from 2011, including at Woodhill.
26. Prior to Mr Harvey's arrival at Woodhill, the mental health team received community medical information from a community mental health nurse. This recorded that Mr Harvey had a learning disability, was a vulnerable adult and lived in semi-supported accommodation. Mr Harvey also had a history of alcohol and drug abuse. The nurse added that Mr Harvey could be vague during interaction with others and it would be difficult to know whether he fully understood issues being discussed with him.
27. The mental health team leader summarised the information that had been received from the community mental health nurse in Mr Harvey's medical record, together with the fact that it had been received before Mr Harvey had arrived at Woodhill. He was to be seen by the mental health team and supported during his time at the prison. She recorded that all staff needed to be aware that Mr Harvey may not fully understand issues being discussed with him. Despite this entry, no referral or appointment was ever made for Mr Harvey to see a member of the mental health team. Neither was this information passed on to other prison staff.
28. A nurse saw Mr Harvey in reception to conduct the initial health screen. Mr Harvey said that he was just able to read and write and did not have any mental health issues. Mr Harvey said that he had no thoughts of self-harm or suicide. Mr Harvey refused to give his consent to allow prison healthcare to obtain his community records. She recorded that Mr Harvey had a history of drug abuse and did not have psychiatric nurse or care worker in the community. She noted that Mr Harvey continually fidgeted and his concentration was poor. She referred Mr Harvey to be seen by the doctor.
29. The nurse told the investigator she had been told by another nurse that Mr Harvey had learning difficulties, but that she did not know how to record this. However, she said she had no concerns about Mr Harvey's mental health and did not make a referral to the mental health team.
30. Later that evening, a prison doctor saw Mr Harvey following the referral made by the nurse. The doctor recorded that Mr Harvey had a learning disability and that the mental health team was already aware of his needs. Mr Harvey said that he drank heavily but did not use drugs. He said he had no thoughts of self-harm or suicide. The doctor prescribed one dose of chlordiazepoxide (for alcohol withdrawal) and referred Mr Harvey for review by the mental health team and the substance misuse team the next day.
31. An officer completed the first night induction interview with Mr Harvey. Mr Harvey said that he had been in Woodhill before, was tired and wanted to go to his cell. The officer recorded that no suicide and self-harm warning form had been received from court and that Mr Harvey had no previous history of self-harm while in custody. Mr Harvey said that he had no thoughts of suicide or self-

harm. A cell-sharing risk assessment was completed and Mr Harvey was assessed as being a high risk to others due to his offences. The officer asked Mr Harvey if he wanted to telephone someone but he declined. Prison records show that Mr Harvey made no phone calls or had any visits during his time at Woodhill.

32. On 23 April, Mr Harvey saw a substance misuse nurse for an initial detoxification screen. The nurse noted that Mr Harvey was a binge drinker and recorded his weight, height and blood pressure. Mr Harvey then saw a substance misuse doctor. Mr Harvey said that he had last had an alcoholic drink the previous day and would drink a pint of whisky mixed with beer or cider daily. He said he had never been admitted to hospital with alcohol-related problems. Mr Harvey said he had no thoughts of suicide or self-harm.
33. The substance misuse doctor prescribed alcohol detoxification medication (carbamazepine, chlordiazepoxide, thiamine and vitamin B) and set a review date for 27 April. He told the investigator that he had prescribed the standard detoxification medication, and the plan for Mr Harvey was to end the detoxification treatment in 11 days. The doctor said that nurses were required to supervise Mr Harvey taking his medication in the treatment room.
34. On 27 April, Mr Harvey did not attend the appointment arranged by the substance misuse doctor. This was re-scheduled for 30 April. Mr Harvey also failed to attend this appointment and the doctor re-scheduled it again for seven days later.
35. On 29 April, Mr Harvey had a case management hearing at Crown Court via video link and pleaded guilty to the charge of arson. A further court date was listed for 16 July.
36. On 2 May, at 7.10pm, a supervisory officer (SO) was conducting a roll check (a physical count of all prisoners). When the SO arrived at Mr Harvey's cell, he found Mr Harvey with a ligature around his neck although it was not attached to anything. He went into the cell and took the ligature from Mr Harvey. He recorded in Mr Harvey's prison computer record that Mr Harvey made bizarre statements. He advised Mr Harvey to calm down and watch the television.
37. The SO immediately opened an ACCT document and completed the concern and keep safe form and the immediate action plan. He assessed Mr Harvey's level of risk as raised and set the level of observations at every 30 minutes until the first case review.

Events of Sunday 3 May

38. On 3 May, at 2.00pm, an officer assessed Mr Harvey as part of the ACCT procedures. Mr Harvey said that he had thought about suicide since he arrived at Woodhill, and had actively wanted to die the previous evening. He said he was stressed because of being in prison, was on remand until July and did not have any tobacco. The officer recorded that Mr Harvey made poor eye contact and his speech was very erratic.
39. The officer told the investigator that he had spent over 30 minutes with Mr Harvey and it had been extremely difficult to get Mr Harvey to engage with him.

He said that based on his 13 years' experience, Mr Harvey should have been seen by the mental health team. However, there is no mental health team presence at Woodhill at weekends.

40. At 3.10pm, a SO chaired the first case review with an officer, nurse and Mr Harvey. Mr Harvey said that he was not happy at being in prison but had no thoughts of self-harm or suicide at that time. The review assessed that Mr Harvey was at low risk of self-harm and the level of observations was reduced to hourly. The SO completed the ACCT caremap with two actions: for Mr Harvey to complete his education induction and a referral to the substance misuse team.
41. At approximately 8.40pm, an officer went to Mr Harvey's cell to conduct an ACCT check. On looking through the observation panel, she saw Mr Harvey with a ligature around his neck and attempting to tie it to the light fitting. She used her radio to summon urgent assistance. She remained at Mr Harvey's cell door and persuaded Mr Harvey to take the ligature down. Mr Harvey put the ligature in his pocket and told her that if she came into the cell he would throw the television at her.
42. A Custodial Manager (CM), an officer, a SO and a nurse responded to the urgent radio message. The officer told the investigator that she told the CM she had found Mr Harvey with a ligature and that Mr Harvey had put this into his pocket and had threatened to throw the television at her. She said that he was on an ACCT.
43. The CM told the investigator that he was not aware that Mr Harvey had been found with a ligature. Because Mr Harvey had threatened to throw his television, the CM said he took the decision not to open the cell door. He spoke to Mr Harvey at the door to ask what the problem was. Mr Harvey said that he wanted to move wings and wanted some cigarettes. He told Mr Harvey that as it was night time it was not possible to move, and he was unable to provide him with any cigarettes. Mr Harvey sat on his bed and turned on the television.
44. The CM told the investigator that the officer had expressed her concern about Mr Harvey being on an ACCT and that he authorised the increase of observations from hourly to every 30 minutes. He said that if had he had known that Mr Harvey had a ligature he would have tried to get it from him.
45. The nurse told the investigator that she spoke to Mr Harvey at the cell door. She said that Mr Harvey asked if she smoked and when she said she did not he continued to lie on his bed and watch television. She told the investigator that she saw strips of torn bed sheet on the window ledge and told the CM this.
46. At 9.00pm, the officer recorded in the ACCT document that the CM had authorised an increase in the level of observations to every 30 minutes, and that the cell door had not been unlocked because Mr Harvey had threatened to throw his television.
47. At 9.30pm, the officer returned to Mr Harvey's cell to undertake an ACCT check. She recorded that she spoke to Mr Harvey, who was awake and sitting up on his bed. Mr Harvey asked her to turn off the cell night light.

48. At 9.59pm, the officer returned to conduct a further ACCT check. On opening the observation panel in the cell door, she saw Mr Harvey hanging from the light fitting by a ligature made from bedding. She used her radio and called for urgent assistance and described what she saw. The control room log shows the urgent message was called over the radio at 9.59pm.
49. The officer told the investigator that she was aware of the national instruction to use an emergency code when someone is found not breathing. She said she was shocked by what she saw when she found Mr Harvey hanging and just called for urgent assistance.
50. The CM and an officer responded and as soon as they arrived at the cell door, they entered immediately. The CM supported Mr Harvey's body while the officer cut the ligature with his anti-ligature knife. They placed Mr Harvey on the floor and started cardiopulmonary resuscitation (CPR) assisted by the first officer.
51. A nurse arrived shortly afterwards and requested an emergency ambulance. The staff continued resuscitation and used an automated external defibrillator. (This monitors the heart rhythm and administers electrical shocks to restore normal rhythm when necessary.) The defibrillator found no shockable rhythm. The control room staff called an ambulance at 10.04pm.
52. Paramedics arrived at 10.12pm and took over Mr Harvey's care. The paramedics took him to hospital, where he was admitted to the intensive care unit and placed on life support. In line with Prison Service instructions, two officers accompanied Mr Harvey in hospital but no restraints were used.
53. In the days that followed, healthcare staff at Woodhill kept in contact with the hospital. Staff informed them that Mr Harvey was in a critical condition and the prognosis for his recovery was very poor. On 8 May, after an assessment by a consultant, doctors withdrew life support and, at 5.10pm, pronounced Mr Harvey dead.

Contact with Mr Harvey's family

54. At approximately 12.45am on 4 May, the Head of Operations and the duty Governor contacted Mr Harvey's mother by phone. The Head of Operations told the investigator that he informed Mr Harvey's mother that there had been an incident in the prison and that her son had been taken to hospital. He said he had been told Mr Harvey would be in an induced coma for the next 72 hours. He told Mr Harvey's mother that a liaison officer would call her later.
55. Later that day, a prison family liaison officer was appointed. He contacted Mr Harvey's mother and met her at the hospital that evening. In the days that followed, he maintained contact with Mr Harvey's mother. Following Mr Harvey's death, the prison contributed to the costs of his funeral, in line with Prison Service guidance.

Support for prisoners and staff

56. The Head of Operations held a debrief for the staff involved in the emergency response, including the healthcare staff, to ensure they had the opportunity to

discuss any issues arising, and for managers to offer support. The staff care team also offered support.

57. The prison posted notices informing staff and prisoners of Mr Harvey's death, and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Harvey's death.

Post-mortem report

58. No post-mortem examination was undertaken. A consultant intensivist at the hospital gave the cause of Mr Harvey's death as hypoxic brain injury caused by hanging.

Findings

Clinical Care

59. Prior to Mr Harvey's arrival at Woodhill, healthcare staff had received community health information that he had a learning disability and was a vulnerable adult. This critical information was not shared with other prison staff. The mental health team leader recorded this in Mr Harvey's medical record. She also recorded that Mr Harvey was to be assessed and supported by the mental health team. She did not follow this up to ensure that Mr Harvey was seen. Mr Harvey was not assessed, nor did he receive any mental health support during his time at Woodhill.
60. The clinical reviewer noted that at Mr Harvey's first night assessment the nurse was aware that he was a vulnerable adult with learning difficulties. However, as Mr Harvey told the nurse that he did not have these issues, she didn't know how to record them and did not do so.
61. The clinical reviewer commented that the mental health team was aware of Mr Harvey's needs and that he should have been supported, but there was no robust system in place to identify missed referrals or appointments.
62. The clinical reviewer's assessment was that there were service and care delivery shortfalls at Woodhill. In his opinion, the standard of health care received by Mr Harvey was not equivalent to that which he could have expected to receive in the community. We agree with him and make the following recommendation:

The Head of Healthcare should:

- **ensure that critical information about a prisoner is properly recorded and shared with other prison staff; and**
- **review the referral process to the mental health team to ensure prisoners are assessed promptly, and that management audits all referrals undertaken.**

Management of risk of suicide and self-harm

63. Prison Service Instruction (PSI) 64/2011, *Management of prisoners at risk of harm to self, to others and from others (Safer Custody)*, which sets out the Prison Service's framework for delivering safer custody procedures, lists a number of risk factors and potential triggers for suicide and self-harm. These include first time in custody, recall to custody, early days in custody, previous self-harm, being charged with a violent offence, a history of alcohol or drug abuse and court appearances, especially at the start of a trial and sentencing. Staff should interview new prisoners in reception to assess their risk of suicide or self-harm. All staff should be alert to the increased risk of self-harm or suicide posed by prisoners with these risk factors and should act appropriately to address any concerns, including opening an ACCT if necessary.
64. Staff correctly opened an ACCT on 2 May after Mr Harvey was found with a ligature around his neck. A SO completed an immediate action plan and assessed Mr Harvey as being at raised risk of suicide and self-harm. He set the level of observations at every 30 minutes. We consider the initial level of

observations appears relatively low for someone considered at raised risk of suicide.

65. At the first case review, held on 3 May, a SO assessed Mr Harvey's risk of further self-harm as low, despite Mr Harvey's apparent intention to end his life the previous evening. In addition, he reduced the level of observation to hourly. We consider that this assessment and level of observation was inappropriate given Mr Harvey's level of risk.
66. The caremap objectives listed in the ACCT opened on 3 May amounted to no more than referrals to services. These actions were insufficient in themselves to ensure that Mr Harvey's risk of suicide and self-harm had reduced, that he received the support he needed or that the underlying issues that led to his suicidal intent had been successfully addressed.
67. PSI 64/2011, which sets out the Prison Service's framework for delivering safer custody procedures, states that caremap actions should aim to reduce the risk a prisoner poses to himself. While an essential first step, it is difficult to see how a caremap action simply referring someone for an assessment will reduce his risk.
68. The caremap for Mr Harvey should have had more specific actions clearly aimed at reducing Mr Harvey's risk, and the ACCT should not have been closed until the outcomes of the caremap actions were known and discussed fully at an ACCT case review.
69. In addition, PSI 64/2011 contains a mandatory instruction about when staff must conduct case reviews. The instruction states: "In addition to planned case reviews where an ACCT trigger is activated, i.e. the event actually occurs or there are other concerns such as increases in frequency or lethality, e.g. from cutting or using ligatures, a case review must be held". The CM did not follow this instruction when Mr Harvey was found with a ligature and attempting to tie it to the cell light fitting. Although he told the investigator that he did not know that Mr Harvey had a ligature, he did not record why he thought it necessary to increase the frequency of Mr Harvey's observations.
70. Thames Valley Police investigated the CM's actions and he was charged with criminal negligence manslaughter in relation to Mr Harvey's death. On 30 January 2018, following a criminal trial, he was found not guilty.
71. In a thematic report about risk factors in self-inflicted deaths published in April 2014, we identified that assessments of risk too often place insufficient weight on known risk factors and too much on staff perceptions of the prisoner's behaviour and demeanour. Mr Harvey had a number of factors known to increase the risk of suicide and self-harm which are identified in our thematic report and in Prison Service instructions. He had told staff that he actively wanted to die, he had mental health problems and he had made two ligatures indicating a suicidal intent. We make the following recommendation:

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

- understanding their responsibilities and the need to share all relevant information about risk;
- considering and recording all the known risk factors of a prisoner when determining their risk of suicide or self-harm;
- assessing the level of risk and recording the reasons for decisions;
- setting and recording appropriate levels of observations which are adjusted as the perceived level of risk changes;
- setting ACCT caremap actions which are specific and meaningful and which are aimed at reducing prisoners' risks to themselves; and
- conducting ACCT reviews as specified in the national instructions

Emergency response

72. PSI 03/2013 *Medical Emergency Response Codes*, issued in February 2013, contains mandatory instructions for efficiently communicating the nature of a medical emergency, ensuring staff take the relevant equipment to the incident and that there are no delays in calling an ambulance. It explicitly states that all prison staff must be made aware of and understand this instruction and their responsibilities during medical emergencies.
73. This national instruction requires prisons to have a two-level code system, which differentiates between a blood injury and all other injuries – usually code red and code blue. Woodhill's local protocol states the control room should call an ambulance automatically as soon as any emergency code is radioed. An officer did not use an emergency code and there was therefore a delay of five minutes before an ambulance was called. We do not know whether this delay, albeit short, would have affected the outcome for Mr Harvey. We make the following recommendation:

The Governor should ensure that all prison staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies which:

- ensures staff efficiently and effectively communicate the nature of a medical emergency; and
- ensures staff call for an ambulance immediately after an emergency code message is radioed.

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