Prisons & Probation Ombudsman
Independent Investigations

# Independent investigation into the death of Mr Darren Williams a prisoner at HMP Woodhill on 4 January 2019

## A report by the Prisons and Probation Ombudsman

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## Our Vision

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

## Our Values

**We are:**

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

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

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

Mr Darren Williams was found hanged in his cell at HMP Woodhill on 4 January 2019. He was 39 years old. I offer my condolences to Mr Williams' family and friends.

Staff monitored Mr Williams under suicide and self-harm procedures (known as ACCT) four times at Woodhill and stopped monitoring on 19 December 2018. The investigation found failings in the management of ACCT procedures at Woodhill, most notably that case reviews were not always multidisciplinary and caremaps were not always completed.

Mr Williams was a regular user of psychoactive substances (PS) and was often in debt to other prisoners because of this. He had complained of feeling under threat from other prisoners and had asked to be segregated for his own safety. The investigation found that Woodhill did not manage Mr Williams in accordance with its own Violence Reduction Strategy.

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

**Sue McAllister CB**
**Prisons and Probation Ombudsman** **October 2019**

## Contents

# Summary

## Events

1. Mr Darren Williams arrived at HMP Woodhill on 2 May 2018. He had a history of substance misuse, self-harm, anxiety and depression, but he declined support from the substance misuse and mental health services.

2. Mr Williams was a regular user of psychoactive substances (PS) and other illicit drugs. He was suspected of being under the influence of PS on two occasions and he failed three mandatory drug tests. He told staff and other prisoners that his use of illicit drugs was getting him into debt with other prisoners.

3. Staff monitored Mr Williams under suicide and self-harm procedures (known as ACCT) on four occasions at Woodhill, between July and December 2018. On all four occasions, staff started ACCT monitoring because Mr Williams had self-harmed, saying he was anxious about his debts and threats from other prisoners. He asked to be segregated for his own safety but, instead, staff moved him to different places around the prison.

4. The last period of ACCT monitoring ended on 19 December. Mr Williams said he wanted to move to the Vulnerable Prisoners' Unit but staff moved him to another house unit where it was thought he would feel safer.

5. At around 3.45pm on 4 January, an officer was unlocking prisoners for dinner and found Mr Williams hanging in his cell. The officer called a medical emergency code and went to the cell with another officer who took the ligature from Mr Williams' neck and started cardiopulmonary resuscitation (CPR). Healthcare staff arrived shortly afterwards and continued CPR until ambulance paramedics arrived at approximately 4.05pm. The paramedics briefly resuscitated Mr Williams but he died at 4.42pm before he could be transferred to hospital.

## Findings

6. We found some deficiencies in the way ACCT procedures were managed at Woodhill. Most ACCT case reviews were not multidisciplinary as they should have been and healthcare staff were not always at the first case reviews. For two periods of ACCT monitoring, staff did not create a caremap. Post-closure interviews were also completed late.

7. Mr Williams' medical record shows that he self-harmed on 31 August, three days after staff had stopped a period of ACCT monitoring. Wing staff failed to record this incident and failed to restart ACCT monitoring as they should have done.

8. Woodhill did not manage Mr Williams in line with its own Violence Reduction Strategy. Mr Williams provided staff with the names of those who were allegedly threatening him, but we found no evidence that his allegations were fully investigated. We also found no evidence that Mr Williams' request to be segregated for his own safety was fully considered.

9. Mr Williams' key risk factor throughout his time at Woodhill was that he was at risk of bullying because of his drug debts. He was moved to different house units to avoid the prisoners who were bullying him, but these were short-term solutions. Staff should have considered a long-term solution that addressed Mr Williams' individual situation. (We recognise that this would not have been straightforward as Mr Williams chose not to engage with drug or mental health services.)

10. We found that when Mr Williams was suspected of being under the influence of illicit drugs, staff acted in accordance with their own substance misuse policy by informing healthcare and submitting intelligence reports. Overall, we found that staff made regular attempts to engage Mr Williams in support for his substance misuse and mental health issues, but he refused help.

## Recommendations

- The Governor and Head of Healthcare should ensure that prison staff manage prisoners at risk of suicide or self-harm in line with national guidelines, including that staff:
    - hold multidisciplinary ACCT reviews, with healthcare staff in attendance at first case reviews;
    - set effective caremap actions that are specific and meaningful, update them at each case review, and do not close the ACCT until all caremap actions have been completed; and
    - complete the ACCT post-closure interview within seven days of the ACCT being closed.
- The Governor should ensure that staff start ACCT monitoring whenever a prisoner self-harms and record all incidents of self-harm.
- The Governor should ensure that all incidents of violence are investigated in accordance with PSI 64/2011 and Woodhill's own Violence Reduction Strategy, including providing feedback on the investigation to the victim and ensuring that details of the investigation are appropriately documented.
- The Governor should ensure that apparent victims of bullying are effectively supported and protected with meaningful long-term solutions which address their individual situation.

## 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 her. No one responded.

12. The investigator obtained copies of relevant extracts from Mr Williams' prison and medical records.

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

14. The investigator interviewed seven members of staff and one prisoner at Woodhill. The investigator also interviewed one prisoner and one member of staff by telephone. The interviews took place between January and June 2019.

15. We informed HM Coroner for Milton Keynes of the investigation. The coroner gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

16. We contacted Mr Williams' mother to explain the investigation and to ask if she had any matters she wanted the investigation to consider. Mr Williams' mother wanted to know about her son's mental health care in prison and whether he was being bullied or threatened at Woodhill. We have addressed those questions in this report.

17. We shared our initial report with the solicitor representing Mr Williams' family. The solicitor pointed out a factual inaccuracy which has been amended in this report. The family raised other issues which did not affect the factual accuracy of this report, so these issues have been addressed in separate correspondence with the family's solicitor.

18. We shared our initial report with the Prison Service. The Prison Service pointed out some factual inaccuracies and this report has been amended accordingly.

# Background Information

## HMP Woodhill

19. HMP Woodhill in Milton Keynes is a complex institution known as a 'core local' prison. As such it combines a local prison function for just over 600 men with a high security responsibility, holding a small number of category A prisoners, most of whom are going through the court process or have been recently convicted. In addition, the prison operates a close supervision centre (CSC), a specialist facility for some of the country's most disruptive prisoners.

20. Central and North-West London NHS Foundation Trust provides health services at the prison. There is an inpatient unit with 12 beds, which provides mental and physical healthcare, including end of life and palliative care.

21. As part of HM Prison and Probation Service's estate transformation, HMP Woodhill was due to become a category B training prison in 2018. At the time of writing (October 2019) this has not yet happened.

## HM Inspectorate of Prisons

22. The most recent inspection of HMP Woodhill was in February 2018. Inspectors reported that the number of recorded self-harm incidents had increased and was much higher than at similar prisons. The number of prisoners being managed under ACCT procedures was very high, so staff struggled to give them the attention they needed.

23. There had been some good actions to improve suicide and self-harm prevention systems but, overall, the prison had failed to sustain this work. Some aspects of the ACCT process had improved and were generally better than seen elsewhere. There was better multidisciplinary attendance at review meetings and assessments were now completed by the dedicated safer custody group. Care maps, overall, had sensible, achievable actions.

24. However, there were still some important frailties, especially in relation to understanding triggers. Documents were often chaotic, which meant that risk information was not readily available. The prison did not maintain an up-to-date action plan which measured their progress against recommendations from the PPO. Complex case meetings, to discuss prisoners in crisis, were not effective. All incidents of self-harm were followed up, capturing potentially useful learning. However, data analysis was much too weak and did not examine patterns across time.

25. Inspectors found that the mental health team was well-integrated with the rest of the prison and regularly involved in ACCT reviews and prison-wide meetings to support prisoners with complex needs.

26. Inspectors reported that levels of violence, particularly assaults against staff, had increased and were high. The response to violence required improvement: while most incidents were investigated, the challenge and monitoring of perpetrators on residential units was poor. Support for victims of bullying and violence was also underdeveloped.

## Independent Monitoring Board

27. 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 31 May 2018, the IMB reported that the proportion of prisoners being managed under ACCT remained high. While some innovative work had been done in developing safer custody strategies, the management of ACCTs was too inconsistent. Levels of violence were high. The use of psychoactive substances (PS) had been controlled with front end and targeted searching but remained a disruptive force when accessed by prisoners. Healthcare services had performed well against challenging staffing problems.

## Previous deaths at HMP Woodhill

28. In 2015 and 2016, a total of 12 prisoners took their lives at Woodhill, a much higher figure than at comparable prisons. There were no self-inflicted deaths at all in 2017 and only one in 2018. Since Mr Williams' death in January 2019, there have been three further self-inflicted deaths.

29. Previous PPO investigations identified deficiencies in ACCT management, notably the absence of healthcare staff from case reviews and inadequate caremaps. We also found that victims of bullying were not being properly supported in line with Woodhill's Violence Reduction Strategy.

## Assessment, Care in Custody and Teamwork (ACCT)

30. 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.

31. 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 (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.

32. 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, Safer Custody.

## Psychoactive substances (PS)

33. PS (formerly known as 'new psychoactive substances' or 'legal highs') are a serious problem across the prison estate. They are difficult to detect and can affect people in a number of ways including increasing heart rate, raising blood pressure, reducing blood supply to the heart and vomiting. Prisoners under the influence of PS can present with marked levels of disinhibition, heightened energy levels, a high tolerance of pain and a potential for violence. Besides

emerging evidence of such dangers to physical health, there is potential for precipitating or exacerbating the deterioration of mental health with links to suicide or self-harm.

34. In July 2015, we published a Learning Lessons Bulletin about the use of PS (still at that time NPS) and its dangers, including its close association with debt, bullying and violence. The bulletin identified the need for better awareness among staff and prisoners of the dangers of PS, the need for more effective drug supply reduction strategies, better monitoring by drug treatment services and effective violence reduction strategies.

35. HMPPS now has in place provisions that enable prisoners to be tested for specified non-controlled PS as part of established mandatory drugs testing arrangements.

# Key Events

36. Mr Darren Williams was remanded in prison custody on 10 April 2018, charged with burglary offences, and sent to HMP Bullingdon. On 2 May, he was moved to HMP Woodhill.

37. When Mr Williams arrived at Woodhill, he had a reception healthcare screening with a nurse. He told the nurse that he had a history of substance misuse, depression and anxiety and he had a heart condition for which he was on medication. The nurse made referrals to the substance misuse service and the mental health team. She also referred Mr Williams to the GP to prescribe his medication. She noted no concerns about suicide or self-harm.

38. A prison GP prescribed medication for Mr Williams' heart condition. He also prescribed medication to help with the effects of substance misuse withdrawal. He noted that Mr Williams was not on any mental health medication. He noted that he appeared stable in mood, showed no signs of withdrawal, engaged well with him and he had no concerns about suicide or self-harm. Mr Williams later said that he did not need substance misuse detoxification and he did not want to engage with the service.

39. On 3 May, a nurse from the mental health team, saw Mr Williams. He told the nurse that he had previously been prescribed mirtazapine for anxiety and depression and he wanted to discuss using this medication again. The nurse referred him to the GP.

40. On 4 May, Mr Williams was sentenced to 30 months imprisonment for theft and burglary.

41. On 10 May, Mr Williams was moved from the induction unit to House Unit 3A.

42. On 24 May, a prison GP prescribed Mr Williams mirtazapine, as requested. Mr Williams had previously missed two appointments with the GP to discuss his mental health medication.

43. On 13 July, staff submitted an intelligence report after they suspected Mr Williams had been assaulted by a group of prisoners on House Unit 3A. Mr Williams said he had not been assaulted and refused to cooperate with staff. No further action was taken.

44. On 20 July, Mr Williams' sentence was increased on appeal from 30 months to 44 months.

45. On 28 July, staff started suicide and self-harm procedures (known as ACCT) after Mr Williams made cuts to his neck and refused to be treated by healthcare. His cellmate told staff that he had found Mr Williams trying to hang himself the night before and had managed to stop him. Staff found suicide notes that he had written to his family. Mr Williams told staff that he was scared to come out of his cell due to drug debts but he did not say who was threatening him. He said he wanted to move to a different prison. Staff submitted an intelligence report on the allegations that Mr Williams was under threat.

46. A Custodial Manager (CM) chaired the first ACCT review on 29 July. A nurse was also present. By then, Mr Williams had been moved from House Unit 3A to House Unit 4A. He said that he felt safer but he still preferred to stay in his cell. The CM assessed Mr Williams' risk of harm as high and set observations at five an hour. The CM set caremap actions of a mental health review, a referral to the substance misuse service and an interview with the violence reduction team.

47. A Supervising Officer (SO) chaired the second ACCT review on 30 July. The CM and an officer were also present. Staff agreed that Mr Williams' risk remained high and they would give priority to relocating him and reviewing his medication.

48. On the same day, a doctor prescribed sleeping tablets to Mr Williams. Mr Williams also spoke to a mental health support worker, about his medication and mental health needs. She noted that he was only interested in getting his medication and did not want to engage with her about other options of support that she tried to offer him. She noted that Mr Williams walked off while she was speaking to him.

49. A SO chaired the third ACCT review on 2 August. A nurse was also present. Mr Williams said he was still anxious about threats from other prisoners but said he had no thoughts of suicide or self-harm. Staff assessed his risk as low and reduced his observations to hourly.

50. The SO chaired the fourth ACCT review on 9 August. A nurse also attended. They stopped ACCT monitoring after Mr Williams said he felt safer and his medication issues had been resolved. A post-closure interview was due to take place on 16 August but it did not happen (it did not take place until 20 August, by which time ACCT monitoring had restarted).

51. On 18 August, staff restarted ACCT monitoring after Mr Williams said that he had taken an overdose of around 50 tablets. He provided staff with empty blister packs of the medication. He did not have his medication in-possession so staff were unable to establish exactly how he came to have the empty packs or if he had indeed taken an overdose. Blood tests were taken and no abnormalities or physical health concerns were identified.

52. A CM chaired the first ACCT review on 19 August. An officer also attended. Mr Williams said that he had taken an overdose because he was in debt and was being bullied. He said the debt had followed him from House Unit 3A to House Unit 4A and he wanted to move to House Unit 4B, the Vulnerable Prisoners' Unit. The officer and the CM assessed Mr Williams' risk as raised and set hourly observations. They did not complete a caremap.

53. Staff also submitted an intelligence report including the names of those who Mr Williams said were threatening him. It is not clear what action, if any, was taken to investigate the allegations further or challenge the perpetrators.

54. A SO chaired the second ACCT review on 21 August. A nurse also attended. The SO noted that the review took place in Mr Williams' cell as he did not want to come out while other prisoners were unlocked. Mr Williams repeated that he wanted to move to House Unit 4B. The SO and nurse agreed that Mr Williams' risk was low as he presented well and said he had no thoughts of suicide or self-

harm. The SO completed a caremap with one action which was for a Rule 45 application to be submitted (an application to be segregated for a prisoner's own safety).

55. On 22 August, the SO noted on the caremap that Mr Williams was not suitable for Rule 45. The prison has been unable to provide a copy of the application so it is not clear who made the decision or how the decision was reached.

56. The SO chaired Mr Williams' third ACCT review on 28 August. No one else attended, although the ACCT record notes that input was sought from an officer on House Unit 4A. Mr Williams said that he no longer wanted to be monitored under ACCT as his Rule 45 application had been refused. He said he was coping on House Unit 4A. The SO assessed Mr Williams' risk as low. He stopped ACCT monitoring and scheduled a post-closure interview for 3 September.

57. On 31 August, a pharmacy technician recorded in Mr Williams' medical record that she attended his cell after he had made cuts to his arms. She noted that he refused to be treated and that she asked an officer to complete the form for her to sign to say she had attended to a prisoner with an injury. (We found no evidence that the form was completed.) Apart from her note in Mr Williams' medical record, there was no other record that Mr Williams had made cuts to his arms.

58. A SO carried out Mr Williams' ACCT post-closure interview on 5 September. The SO noted that Mr Williams' issues had not been resolved as he was continuing to use illicit drugs and was still in debt as a result. She wrote that he was choosing to self-isolate and he was not engaging in any purposeful activity. The SO did not ask Mr Williams about his self-harming on 31 August because it was not recorded.

59. On 28 September, Mr Williams was suspected of being under the influence of an illicit drug. Healthcare staff assessed him and he denied using an illicit substance, saying that he had fallen out of bed and bumped his head. Staff submitted an intelligence report.

60. On the morning of 5 October, staff suspected that Mr Williams had been assaulted by his cellmate after he was found with bruising to his face that was not there the night before. Mr Williams said that he had slipped over and had not been assaulted. Healthcare attended to see him, but he refused treatment. A SO submitted an intelligence report and requested an investigation into the suspected assault. Mr Williams moved to a different cell on House Unit 4A.

61. A SO from the violence reduction team spoke to Mr Williams on 7 October. Mr Williams maintained that he had slipped and had not been assaulted. The SO recorded that Mr Williams declined post-incident support. No further action was taken.

62. On 13 October, the results of Mr Williams' mandatory drug test on 3 October showed that he had tested positive for PS. Staff submitted an intelligence report.

63. On 13 November, Mr Williams met with his offender supervisor (OS). The OS recorded in Mr Williams' prison record that he interacted well with her for the first

time, but she thought he looked drawn, with dark circles under his eyes. She suspected he was continuing to use illicit drugs. Mr Williams had been convicted of a further offence for which he was awaiting sentence. He told the OS that he wanted to stay at Woodhill.

64. On 15 November, Mr Williams met his keyworker. The keyworker recorded that Mr Williams interacted well with him. Mr Williams said he was not using drugs and he wanted help to find work.

65. On 16 November, Mr Williams was due to attend court for sentencing for a further burglary offence. He refused to attend and was sentenced to 12 months imprisonment in his absence.

66. On 24 November, staff started ACCT monitoring after Mr Williams attempted to hang himself. He said he was stressed about being in debt and he was feeling low as he had not had any contact with his family. Mr Williams said he wanted to move from House Unit 4A so staff moved him to House Unit 2A. Mr Williams gave the names of the prisoners who were allegedly threatening him and staff submitted an intelligence report.

67. A SO chaired the first ACCT review on 25 November. An officer also attended. Mr Williams said he was happier since moving to House Unit 2A and said he just wanted to get on with his sentence and find some work. Staff assessed his risk as raised and set observations at two an hour.

68. On 26 November, a mental health support worker spoke to Mr Williams through his cell door as part of an ACCT check. He told her that he did not need any help from the mental health team. She recorded that she told Mr Williams he could self-refer if he needed any help in the future.

69. A SO chaired the second ACCT review on 29 November. An officer also attended. Mr Williams did not want to engage with the review but said he had no thoughts of suicide or self-harm. Staff assessed his risk as low and reduced his observations to hourly.

70. A SO chaired the third ACCT review on 30 November. A substance misuse nurse, also attended.

71. A SO chaired the fourth ACCT review on 3 December. An officer also attended. Mr Williams engaged fully in the review and maintained that he was happier on House Unit 2A. He was keen to get work on the wing and the officer agreed to arrange this for him. Staff closed the ACCT as they assessed that Mr Williams' risk had reduced and all caremap actions had been completed. Staff scheduled the post-closure interview for 10 December.

72. On 3 December, a mental health support worker, spoke to Mr Williams to see if he needed any support from the mental health team. She recorded that he was polite towards her but said he did not need any help.

73. On 12 December, the result of a mandatory drug test taken on 26 November came back positive. Mr Williams had been on House Unit 4A at the time the sample was taken. A SO decided that, given the progress Mr Williams was making on House Unit 2A, he would not impose a sanction for the positive result.

74. A SO carried out Mr Williams' ACCT post-closure interview on 13 December. He recorded that all Mr Williams' issues had been resolved, that he had support from peers and wing staff, and that he was working on the wing. Although reference to a caremap was made throughout the ACCT process, we found no evidence that a caremap was completed for the period of ACCT monitoring between 24 November and 3 December.

75. On 14 December, Mr Williams stuck a plastic fork in his left eye. A healthcare assistant treated Mr Williams and called for an ambulance to take him to hospital. Mr Williams said he was trying to remove a splinter from his eye when the fork slipped. Mr Williams was taken to hospital where he had the fork removed. He was returned to the prison later that evening.

76. On the morning of 15 December, the healthcare assistant attended to Mr Williams again when he stuck a plastic fork in his right eye. He told the investigator that he considered Mr Williams was self-harming. He called an ambulance and Mr Williams was taken to hospital again, returning later the same day. Staff started ACCT monitoring. Mr Williams told staff that he wanted to move to a different prison because of his debts. Staff moved him to House Unit 1A and observed him hourly.

77. A SO chaired the first ACCT case review on 15 December. An officer also attended. Mr Williams refused to engage. Staff assessed his risk of harm as raised and continued with hourly observations. No caremap was completed.

78. Further ACCT reviews were held on 17 and 19 December, with healthcare staff in attendance, but Mr Williams continued to refuse to engage in the process. He told staff he no longer wanted to be monitored under ACCT procedures. A SO closed the ACCT on 19 December and a second SO conducted the post-closure interview with Mr Williams on 26 December. The second SO recorded that all Mr Williams' issues had been resolved. We found no evidence that a caremap was completed for the period of ACCT monitoring between 15 and 19 December.

79. On 18 December, a mental health support worker, again offered Mr Williams support for his mental health issues. He declined support and refused to engage with her. She wrote in his medical notes that, as he had now twice refused to engage with the mental health team, she would discuss his case at a multidisciplinary team meeting. Mr Williams' medical notes show that he subsequently failed to engage with the community psychiatric nurse on 20 and 24 December. He also failed to attend mental health assessment appointments on 28 December, 31 December, 2 January and 3 January.

80. On 28 December, Mr Williams was placed on a disciplinary charge (for breaking prison rules) after the results of a mandatory drug test taken on 6 December showed that he had tested positive for heroin or morphine.

### Events of 4 January 2019

81. On 4 January 2019 at around 3.49pm, an officer was unlocking the prisoners for dinner when she found Mr Williams hanging from the end of the bunk bed. He had used a sheet as a ligature. The officer shouted to a second officer, who was nearby, and called a medical emergency code blue (used to indicate a prisoner is

unconscious or having breathing difficulties) over her radio. The second officer removed the ligature from Mr Williams' neck and began cardiopulmonary resuscitation (CPR) with assistance from the first officer.

82. A nurse arrived at approximately 3.51pm, followed by other healthcare staff with emergency equipment, and took over CPR from the prison staff. A GP arrived and administered adrenaline to Mr Williams. Paramedics arrived and took over Mr Williams' care at approximately 4.05pm. Paramedics obtained some signs of life, an air ambulance arrived, and Mr Williams was taken to the ambulance. However, paramedics pronounced that Mr Williams had died at 4.42pm before the ambulance could transfer him to the hospital.

### Contact with Mr Williams' family

83. The prison's family liaison officers (FLO) visited Mr Williams' mother at home at around 6.00pm on 4 January to tell her of her son's death. The prison contributed to the cost of Mr Williams' funeral in line with national guidance.

### Support for prisoners and staff

84. After Mr Williams' death, a prison manager debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

85. The prison posted notices informing other prisoners of Mr Williams' 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 Williams' death.

### Post-mortem report

86. The post-mortem report concluded that Mr Williams' death was due to hanging. PS was found in his blood but it was not possible to establish what impact that may have had on his decision to take his life.

# Findings

### Management of Mr Williams' risk of suicide and self-harm

87. Prison Service Instruction (PSI) 64/2011, *Management of prisoners at risk of harm to self, to others and from others (Safer Custody)*, says that ACCT case reviews should be multidisciplinary where possible, and that healthcare staff should always attend the first case review. The PSI also says that a caremap should be completed at the first case review. The caremap should give detailed and time-bound actions aimed at reducing the risk posed by the prisoner. The PSI includes a mandatory action for a post-closure review to be held within seven days of an ACCT being closed. The post-closure interview must review the caremap and the progress made by the prisoner since the ACCT was closed.

88. Mr Williams was managed under ACCT procedures four times at HMP Woodhill, from 28 July to 9 August; from 18 to 28 August; from 24 November to 3 December; and from 15 to 19 December. We have some concerns about the management of the ACCT procedures.

89. We found that healthcare staff did not always attend the first ACCT case review and subsequent case reviews were often not multidisciplinary. Of the four occasions when Mr Williams had a first ACCT case review, healthcare staff attended only one (on 29 July). There were ten subsequent case reviews and healthcare staff attended only six of them. We also found that ACCT post-closure interviews were held late on three occasions and that post-closure forms were not completed properly.

90. We found no evidence that caremaps were produced for two period of ACCT monitoring. Two SO's told the investigator that for the period 24 November to 3 December, they would not have completed ACCT reviews or stopped ACCT monitoring without sight of the caremap, but we found no evidence of a caremap. Furthermore, a quality check of the ACCT process, carried out on 14 December by the safer custody team, found that the caremap was missing. We also found no caremap for the period of ACCT monitoring between 15 and 19 December. While it is clear from the ACCT documentation that Mr Williams refused to engage in the process, we would still have expected to see caremap actions aimed at supporting him and reducing his risk.

91. 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 guidelines, including that staff:**

- **hold multidisciplinary ACCT reviews, with healthcare staff in attendance at first case reviews;**
- **set effective caremap actions that are specific and meaningful, and update them at each case review; and**
- **complete the ACCT post-closure interview within seven days of the ACCT being closed.**

92. On 31 August, a pharmacy technician, noted in Mr Williams' medical record that she had gone to his cell to attend to him after he had made cuts to his arms. He refused to be treated. This incident was not recorded anywhere else. She told the investigator that she could not clearly recall the incident, but she was sure that she would not have put the entry in Mr Williams' medical record if the incident had not happened. She was also sure she would not have mistakenly put the entry into the wrong prisoner's record.

93. She told the investigator that she asked an officer on the wing to complete the form to say that she had seen Mr Williams who had an injury. We found no evidence that this form was completed. The officer concerned no longer works at Woodhill so we have been unable to speak to him.

94. It would appear, based on Mr Williams' medical record, that he made cuts to his arms on 31 August. Mr Williams had been subject to ACCT monitoring up to 28 August and was in the post-closure phase. We are concerned that staff did not restart ACCT monitoring following this incident of self-harm. We are also concerned that wing staff made no record of this incident. We make the following recommendation:

**The Governor should ensure that staff start ACCT procedures whenever a prisoner self-harms and record all incidents of self-harm.**

### Violence reduction

95. Woodhill's Violence Reduction Strategy says that all incidents of assault, including fights, must be entered onto the incident reporting system. All staff, including healthcare, involved with prisoners should record key contacts with them, particularly information on risk of harm to/from others, on the prison record case notes system.

96. There were two occasions where staff suspected Mr Williams had been assaulted and tried to offer him support. He denied that he had been assaulted and said he did not need any support so the investigation could not proceed. Staff correctly submitted intelligence reports on both occasions. However, on a separate occasion when Mr Williams applied to be segregated for his own safety (a Rule 45 application), he gave staff the names of prisoners who were threatening him and this is recorded in intelligence reports. We found no evidence that any action was taken to challenge the perpetrators. The prison has also been unable to provide us with Mr Williams' Rule 45 application or the reasons why it was refused.

97. The PPO has published a range of publications identifying the links between bullying and suicide. Mr Williams was being threatened because of drug debts. An SO told the investigator that she believed Mr Williams' was self-harming so that he could get moved to the Vulnerable Prisoners' Unit. She said she was surprised when she found out that he had taken his life. We consider that staff may not have fully recognised the impact that Mr Williams' debts and the associated threats were having on him and how this may have increased his risk of suicide and self-harm.

98. We also think that moving Mr Williams to different house units was a short-term solution to a continuing problem and that staff should have considered a long-term solution that addressed Mr Williams' individual situation. (We recognise that this would not have been straightforward as Mr Williams chose not to engage with drug or mental health services.)

99. We make the following recommendations:

**The Governor should ensure that all incidents of violence are investigated in accordance with PSI 64/2011 and Woodhill's own Violence Reduction Strategy, including providing feedback on the investigation to the victim and ensuring that details of the investigation are appropriately documented.**

**The Governor should ensure that apparent victims of bullying are effectively supported and protected with meaningful long-term solutions which address their individual situation.**

### Substance misuse and mental health

100. The clinical reviewer concluded that Mr Williams received a good standard of healthcare, equivalent to that which he could have expected to receive in the community. We found that staff offered Mr Williams many opportunities to engage with support services to address his substance misuse and mental health issues. Where Mr Williams was suspected of being under the influence of illicit drugs, we found that staff acted in accordance with their own substance misuse policy by informing healthcare staff and submitting intelligence reports.

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