Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Michael Woodman, a prisoner at HMP Long Lartin, on 29 November 2018

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 Woodman was found hanged in his cell at HMP Long Lartin on 29 November 2018. He was 56 years old. I offer my condolences to Mr Woodman's family and friends.

Mr Woodman was a life sentence prisoner who had been in prison custody since September 2005. He had been managed under Prison Service suicide and self-harm prevention procedures (known as ACCT) in the past, but the last occasion was in 2014, and he had not given staff or other prisoners cause since then to consider that he might be at risk of suicide.

At the time of his death, Mr Woodman appeared to be working well towards progressing through his sentence and I am satisfied that staff at Long Lartin staff could not reasonably have been expected to have predicted or prevented his death.

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 **June 2019**

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Summary

Events

1. On 13 September 2005, Mr Michael Woodman was remanded to prison custody after being charged with the murder of his partner. On 5 December 2006, he was sentenced to life imprisonment with a minimum term of 13 years. On 28 January 2010, Mr Woodman was transferred to HMP Long Lartin.

2. Throughout his time in prison, Mr Woodman maintained his innocence and as a result, he refused to engage in offender behaviour work. This prevented him from progressing through his sentence and from being considered for release on parole.

3. Prior to moving to Long Lartin, Mr Woodman's custodial behaviour had been poor. However, he settled at Long Lartin and, for the most part, his prison record was positive. Mr Woodman engaged in offending behaviour work and staff said that he was helpful and friendly.

4. Mr Woodman had used heroin and other drugs in the community and received support and treatment from drug support services in prison, including detoxification. He continued to use drugs but in January 2018, Mr Woodman told staff that he was completely drug free.

5. Mr Woodman was monitored under the Prison Service suicide and self-harm prevention procedures (ACCT) on 14 occasions from 2005, the last period being in 2014, when he had threatened to use a ligature, over an issue with his medication. There were no concerns after 2014 that Mr Woodman might be at risk of suicide or self-harm.

6. On the morning of 29 November, Mr Woodman was unlocked to collect his medication. Another prisoner told an officer that Mr Woodman had not attended for treatment. The prisoner was asked to knock on Mr Woodman's cell door to check that he was awake.

7. The prisoner checked and told the officer that Mr Woodman was hanging. The officer went straight to Mr Woodman's door and saw that he was hanging. The officer was not carrying a radio, so ran back to another officer, who was at the end of the landing and asked him to call an emergency code blue on his radio. The officers then ran to the cell, closely followed by other prison and healthcare staff. The ligature was removed and staff began cardiopulmonary resuscitation (CPR.)

8. A nurse assessed Mr Woodman and concluded that rigor mortis was present and that staff should therefore stop CPR. At 7.58am, the nurse pronounced Mr Woodman dead.

9. Paramedics arrived at the prison at 8.00am and confirmed that Mr Woodman had died.

Findings

Management of risk of suicide and self-harm

10. Mr Woodman had not been subject to suicide prevention measures at Long Lartin since 2014.

11. Staff and other prisoners were shocked that he took his life. We are satisfied that Mr Woodman gave little indication that he was at increased risk of suicide or self-harm in the period leading up to his death and that prison staff could not reasonably have foreseen Mr Woodman's actions on 29 November 2018.

Emergency Response

12. There was a slight delay in staff accessing the appropriate emergency equipment from another wing.

Clinical care

13. Mr Woodman had developed several long-term conditions, some of which were a result of his previous substance misuse. He was also concerned about his memory loss. The clinical reviewer considered that Mr Woodman was well supported by the healthcare services.

14. There had not been any recent concerns about Mr Woodman's mental health, and staff had not been aware of any issues prior to his death which would have indicated any concerns that should have been raised.

15. The clinical reviewer concluded that the care Mr Woodman received at Long Lartin was equivalent to that which he could have expected to receive in the community.

Recommendation

- The Head of Healthcare should review the location of emergency equipment and ensure that all staff on the wings have easy access to the medical equipment in the event of a medical emergency.

The Investigation Process

16. The investigator issued notices to staff and prisoners at HMP Long Lartin informing them of the investigation and asking anyone with relevant information to contact him. No one responded.

17. The investigator obtained copies of relevant extracts from Mr Woodman's prison and medical records.

18. The investigator interviewed six members of staff and two prisoners at Long Lartin on 6 and 7 February 2019.

19. NHS England commissioned a clinical reviewer to review Mr Woodman's clinical care at the prison. The clinical reviewer attended interviews with the investigator on 7 February.

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

21. We wrote to Mr Woodman's family to explain the investigation and to ask if they had any matters they wanted the investigation to consider. The family did not raise any concerns.

Background Information

HMP Long Lartin

22. HMP Long Lartin is a high security prison in the Vale of Evesham, Worcestershire. It holds up to 609 men across five main wings and two support wings. All prisoners are accommodated in single cells. Healthcare is provided by Care UK, with mental healthcare subcontracted to South Staffordshire and Shropshire NHS Foundation Trust Mental Health Team.

HM Inspectorate of Prisons

23. The most recent inspection of HMP Long Lartin was in January 2018. Inspectors reported that strategic management of suicide and self-harm prevention was good and ACCT case management for prisoners at risk of suicide and self-harm was implemented well.

Independent Monitoring Board

24. 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 January 2018, the IMB reported that during the reporting year the work of the Offender Management Unit had been hindered by the diversion of staff to other areas of work.

Previous deaths at HMP Long Lartin

25. Mr Woodman's was the fifth self-inflicted death at Long Lartin since December 2016. There has been one other self-inflicted death at the prison since Mr Woodman's death. There are no similarities with those cases.

Key Events

26. On 13 September 2005, Mr Michael Woodman was remanded into prison custody charged with the murder of his partner. Mr Woodman pleaded not guilty, but on 5 December 2006, he was found guilty and sentenced to life imprisonment, with a minimum term of 13 years. Throughout his time in custody, Mr Woodman maintained his innocence and as a result, he refused to engage in offender behaviour work. This prevented him from progressing through his sentence and being considered for parole.

27. When Mr Woodman entered custody in 2005, he had a long history of substance misuse. He told staff that he had been a heroin user for 30 years and had also misused synthetic cannabis (spice,) tramadol, fluoxetine and subutex. Mr Woodman received support and treatment from support services, including detoxification, but he continued to use drugs, despite warnings of the potential harm to himself. In January 2018, Mr Woodman told staff that he was completely drug free. Staff recorded that Mr Woodman was positive about his progress and said that he no longer felt the need for input from the drug treatment services.

28. Mr Woodman had no history of self-harm or suicide in the community, but in prison he was placed on ACCT monitoring on 14 separate occasions between September 2005 and July 2014. The last ACCT was opened in May 2014. Mr Woodman threatened to cause problems if he was not prescribed certain medications and he placed a ligature made from torn bedding around his neck and cut both his arms. Mr Woodman was moved to an anti-ligature cell (a cell designed with no obvious points to secure a ligature) for a brief period as a precautionary measure. An ACCT was opened and remained open until July 2014. After the ACCT was closed, there were no further incidents and no further concerns that Mr Woodman might be at risk of suicide or self-harm.

29. Mr Woodman was diagnosed with anxiety and depression and had been supported by the prison mental health team. He had also recently begun to complain of short-term memory loss, an issue that was causing him some concern. Mr Woodman was prescribed 11 different medications a day to treat his ongoing conditions.

30. In June 2018, Mr Woodman asked to speak with someone from Inclusion (which provides integrated drug treatment and mental health interventions at Long Lartin). On 14 June, he was seen for a one-to-one nursing assessment. Mr Woodman said that he had been feeling low in mood, and said that he regretted not keeping in touch with his family, although he said that he had recently had a visit from his daughter and made contact with his ex-wife. Mr Woodman said that he was frustrated at not being able to help his daughter and grandchildren. At the end of the assessment, Mr Woodman was recorded as saying that he felt much better for having had the opportunity to talk and when asked, he denied any thoughts or intentions of suicide and self-harm.

31. Mr Woodman was described as a ‘model’ prisoner, always conforming to the regime and polite and respectful to all those he had contact with. However, on 31 July, Mr Woodman assaulted another prisoner, by throwing a bucket containing urine and excrement over him. It was recorded that as he threw the

liquid, Mr Woodman called the other prisoner 'a rapist.' Mr Woodman immediately apologised to staff for his actions. He gave no reason for what he had done, although his prison record indicates that he had had previous issues with prisoners he considered to be sex offenders.

32. Mr Woodman was placed on a violence reduction (VR) compact, which meant that his movements and interactions would be monitored and recorded by staff, and he was downgraded to the basic regime.

33. A supervising officer (SO) reviewed Mr Woodman's VR compact on 7 and 22 August. The SO told the investigator that during the review, Mr Woodman had said that he had had a disagreement with the other prisoner. The SO said that the victim had been moved from the wing and there were no further issues. Mr Woodman remained on the VR compact for 28 days and the basic regime and the VR ran simultaneously. On 22 August, Mr Woodman was taken off the VR compact restrictions, and he was returned to standard regime on 28 August.

34. On 11 October, a prison GP reviewed Mr Woodman. He recorded that Mr Woodman interacted well and he noted nothing of concern. He reviewed Mr Woodman's medication and advised him to speak with the mental health team, if needed. Mr Woodman did not contact the mental health team.

35. Mr Woodman's friend who lived in the cell next door, told the investigator that the assault on the other prisoner at the end of July was out of character for Mr Woodman and although he was a large man, he did not go around forcing his will on people, and he mostly kept to himself. He said that in all the time that he had known Mr Woodman, he had never mentioned having thoughts of harming himself and he had not seen him using illicit drugs.

36. He said that he was aware that Mr Woodman had recently been back in touch with his daughter and he appeared happy about this. He said that Mr Woodman had not mentioned any concerns about his daughter to him, but he said that on the whole, Mr Woodman was quite private about these matters.

37. On the evening of 28 November, Mr Woodman was said to have been socialising with his friends on the wing, and appeared his usual self. Mr Woodman's friend said that he was laughing and joking as he usually did, and gave no indication that anything was wrong or bothering him. He told the investigator that as Mr Woodman's best friend, he thought he would have spoken to him if he had any problems. He said that if Mr Woodman had ever mentioned harming himself, he would have tried to talk him out of it or spoken to staff.

Morning of 29 November

38. An Operational Support Grade (OSG) said that Mr Woodman and was asleep in bed when he completed a roll check at around 5.30am on 29 November.

39. The cells on A wing, as with some other wings at Long Lartin, have no in-cell sanitation. This means that the prison has a Sanitation and Control System (SACS). The system controls the cell doors when prisoners are locked in. If a prisoner needs to use the toilet they can call the control room and ask to use the toilet via an intercom and their cell door will be electronically released. While cell doors can be locked and unlocked electronically during association periods,

prisoners can lock their own doors by using a privy key to prevent others from entering their cells. However, prison staff also have keys which can be used to override the privy key system.

40. An officer told the investigator that she went to A wing to help with issuing medications that morning. When the required minimum of three staff had arrived, they telephoned the control room and told them which cell needed to be opened and control room staff unlocked the doors remotely. The officer said that she was standing by the main door to the wing, monitoring those prisoners who were going off the wing to collect their treatments. Another officer was on the landing above locking in those prisoners returning from treatments, and the officer remained on the ground floor with another officer.

Emergency response

41. Mr Woodman's friend had been unlocked for treatments along with another friend of Mr Woodman's. When the two prisoners returned to the wing, Mr Woodman's friend told an officer that Mr Woodman had not attended for treatment. An officer then asked him if he would go and 'give him a knock' just to make sure that he was awake. An officer told the investigator that it was not unusual for prisoners not to hear the call for medication or their doors clicking open.

42. An officer said that she went to lock another prisoner in who had returned, and as she returned along the landing, Mr Woodman's friend looked at her and said, 'he's hanging.' The officer said that Mr Woodman's friend said it very calmly, and at first, she did not believe him, but he then said, 'he is, he is.'

43. The officer went straight to Mr Woodman's door, and said that as she pushed it open, she could very clearly see that Mr Woodman was hanging. The officer was not carrying a radio, so ran back to another officer, who was at the end of the landing and asked him to radio a code blue emergency and both officers ran back to Mr Woodman's cell. The code blue was recorded at 7.48am. An ambulance was called immediately and at 7.53am, the emergency team were on route to the prison.

44. An officer said that he and other staff ran to the cell, where Mr Woodman was lying on the floor with a ligature around his neck and an officer was in the process of cutting the ligature.

45. An officer said that once the ligature was removed, he checked for a pulse and there was none present, and he and the other staff began cardiopulmonary resuscitation (CPR). An officer said that although Mr Woodman's face was very purple, he was not aware of any obvious signs of rigor mortis, so continued CPR. Nursing staff arrived at Mr Woodman's cell at 7.55am.

46. A nurse arrived, but then left to collect the emergency bag and defibrillator (from either A wing or the healthcare unit). When she returned, she immediately assessed Mr Woodman and concluded that rigor mortis was present, and therefore out of decency instructed the officers to stop CPR. The nurse pronounced Mr Woodman dead at 7.58am. Paramedics arrived at the prison at 8.00am, and after being updated by nursing staff, went to the cell at 8.13am and confirmed that Mr Woodman had died.

Contact with Mr Woodman's family

47. Following Mr Woodman's death, the prison appointed a SO as the family liaison officer.

48. Due to the distance to the next of kin's home address, the prison contacted HMP Dartmoor to assist with informing them of Mr Woodman's death. At 6.35pm, on 29 November, a member of staff from Dartmoor informed Mr Woodman's sister of his death. The SO then contacted the family and told them about the process that would follow and gave advice and support.

49. The prison contributed towards the cost of the funeral, in line with national guidance. In addition, prisoners at Long Lartin had a collection and the prison arranged for flowers to be bought on their behalf.

Support for prisoners and staff

50. After the incident on 29 November, the duty 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.

51. The prison posted notices informing other prisoners of Mr Woodman'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 the death. In addition, Mr Woodman's two closest friends, were both placed on ACCT monitoring to ensure that they had additional support.

Post-mortem report

52. The post-mortem concluded that the cause of Mr Woodman's death was ligature suspension (hanging).

53. Toxicology tests found no illicit substances in his system.

Findings

Management of risk of suicide and self-harm

54. Mr Woodman had not been subject to suicide prevention measures at Long Lartin since 2014 and had not given staff or his friends any reason to think that he was at risk of suicide or self-harm in the period before his death.

55. He had recently re-established contact with his daughter, after a prolonged period, and his friends said that he appeared to be happy about this. However, they also said that he kept things to himself.

56. In June, five months before his death, he asked to see a mental health support worker and said that he was low in mood and that he regretted not maintaining contact with his family. He said that he had recent contact with his daughter and ex-wife, and was pleased about this, but felt frustrated at not being able to help his daughter and grandchildren more. Afterwards, he said he felt better for having had the opportunity to talk about things, and denied feeling suicidal or having any thoughts of self-harm. We do not consider that this warranted the opening of an ACCT at the time.

57. We are satisfied that staff at Long Lartin managed Mr Woodman appropriately while he was in their care and we do not consider that they could have predicted or prevented his death.

Emergency response

58. When the emergency was called, a nurse initially went to Mr Woodman's cell but then left to collect the emergency bag and defibrillator (from either A wing or the healthcare unit). The clinical reviewer is satisfied that Prison Service Instruction (PSI) 03/2013, *Emergency response protocol*, was followed and that healthcare staff were on the scene within minutes. However, there was no emergency bag and defibrillator on the wing.

59. The Deputy Head of Healthcare and a prison resuscitation lead told the investigator that that call signs Hotel 3 and Hotel 11 are the designated healthcare responders on any day and usually Hotel 3 attends to assess the situation and Hotel 11 collects the emergency equipment. The emergency bags and defibrillators are located on the healthcare unit and B wing, along with oxygen cylinders. There is also a large oxygen cylinder located on every wing. There is no emergency equipment on A wing (Mr Woodman's wing) as it is the closest wing to the healthcare unit.

60. We are concerned that there was a slight delay in staff accessing the appropriate emergency equipment. This did not affect the outcome for Mr Woodman as he was dead when he was found, but it could be critical in other cases. A nurse told the investigation that the healthcare team planned to review the availability of emergency equipment throughout the prison. We recommend:

    The Head of Healthcare should review the location of emergency equipment and ensure that all staff on the wings have easy access to the medical equipment in the event of a medical emergency.

61. The nurse's assessment was that Mr Woodman was not breathing, his face and neck were blue/purple in colour and swollen, there was blood pooling and mottling of the skin, his arms were stiff and unmoveable and he had been incontinent of urine. Based on her assessment, the nurse considered that rigor mortis had set in, and instructed the officers to stop resuscitation.

62. *National Offender Management Service: Guidance to support the decision-making process of when not to perform Cardiopulmonary Resuscitation in prisons and immigration removal centres* provides advice to staff who are not able to recognise rigor mortis, that they should start resuscitation until advised otherwise by a competent member of staff. In Mr Woodman's case, the nurse recognised that rigor mortis had set in and resuscitation attempts by the officers were stopped on her instruction. We are satisfied that this was appropriate.

Clinical care

63. The clinical reviewer found that Mr Woodman had described himself as 'happy and did not want to be released'. Mr Woodman had developed a number of long-term health conditions, some of which, the clinical reviewer says were a result of his previous substance misuse, and he had also recently been concerned about his memory loss. However, there had not been any issues that raised concerns that he might be at risk of suicide or self-harm.

64. We are satisfied that Mr Woodman had been well supported by the healthcare services and that the care he received at Long Lartin was equivalent to that which he could have expected to receive in the community.

65. We make no recommendation.

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