

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Philip Green, a prisoner at HMP Woodhill, on 30 April 2019

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.

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 Philip Green died on 30 April 2019 at HMP Woodhill as a result of severe blood loss caused by cutting his neck and his arm. Mr Green was 53 years old. I offer my condolences to Mr Green's family and friends.

Mr Green was briefly subject to suicide and self-harm prevention procedures when he first went to prison in 2016, but staff subsequently had no further concerns.

I am, however, concerned that there were some potential issues that were not properly addressed. I cannot say that the outcome would necessarily have been different for Mr Green if these issues had been addressed, but it might have been.

Mr Green did not receive a formal mental health assessment by a qualified member of staff when he was referred to the mental health team in November 2018.

Suicidal thoughts which Mr Green expressed in course work in January 2019 were not shared with prison staff.

In the two weeks before he died, Mr Green repeatedly told staff that he was being bullied by another prisoner. I consider that more should have been done to support Mr Green and to monitor the alleged perpetrator. I am also concerned that staff did not consider the impact of this alleged bullying on Mr Green's risk of suicide and self-harm.

I am also concerned that two prisoners who knew Mr Green well and who found him in his cell, said that they had not felt adequately supported after Mr Green's 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

January 2020

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Summary

Events

1. Mr Philip Green was remanded into custody in February 2016, charged with the attempted murder of his partner. He was taken to HMP Woodhill. Staff began Prison Service suicide and self-harm prevention procedures (known as ACCT). A week later, Mr Green's ACCT was closed and he was no longer considered a risk to himself during the remainder of his time at Woodhill.
2. Mr Green was a quiet prisoner who avoided confrontation. He associated with a small number of other prisoners. He settled well at Woodhill, was employed in the workshops and was working towards progressing to another prison. Mr Green had difficulty coming to terms with the offence he had committed.
3. In November 2018, Mr Green's offender supervisor referred him to the mental health team because she was concerned about his mental health. Mr Green was never properly assessed by the team but saw a support worker on a single occasion at his cell door. The support worker added Mr Green to the waiting list for a group which was not being run in the prison at the time.
4. In January 2019, in a workbook he was completing for a victim empathy course, Mr Green wrote that he sometimes had suicidal feelings. The course tutor offered him the support of the prison chaplain but Mr Green declined. The tutor did not have any concerns that he was a risk to himself at that point and did not share this information with prison staff.
5. During the last two weeks of April, Mr Green alleged that he was being bullied by another prisoner. Staff spoke to Mr Green several times and submitted intelligence reports. The other prisoner remained on the wing as there was no corroborating evidence that he was bullying Mr Green. Staff and prisoners said, however, that Mr Green's demeanour changed and he became more withdrawn, nervous and distracted.
6. On 30 April, Mr Green's cellmate found him slumped in his cell. Mr Green had cut his neck and an arm with the lid of a tin and had lost a lot of blood. The prisoner alerted staff who called an emergency code and attempted to resuscitate Mr Green. The prison GP responded and pronounced Mr Green dead at 4.45pm.

Findings

7. Mr Green was assessed as being a risk to himself during the first week he was in prison, in February 2016. After this, staff thought he had settled well. He was progressing in his sentence and considering a move to another prison.
8. There were, however, some concerns: in November 2018, Mr Green's offender supervisor referred him to the mental health team; in January 2019, Mr Green expressed suicidal thoughts in course work; and in the last two weeks of his life Mr Green complained that he was being bullied.

9. We are concerned that these concerns were not properly addressed. We cannot say that the outcome would necessarily have been different for Mr Green if these issues had been addressed, but it might have been.

Allegations of bullying

10. Over the two weeks before his death, Mr Green told several staff that he was being bullied. Staff submitted intelligence reports appropriately and tried to reassure Mr Green.
11. We are concerned, however, that neither Mr Green nor the alleged perpetrator were monitored as they should have been and that Mr Green was not adequately supported. We are also concerned that staff did not consider the effect of this potential bullying on Mr Green's risk to himself.

Course work

12. We are concerned that the suicidal thoughts Mr Green expressed in his course work were not shared with prison staff.

Clinical care

13. Mr Green's physical healthcare was appropriate but his mental healthcare was of a mixed standard. We are concerned that he was not formally assessed by a qualified member of staff when he was referred to the mental health team.

Prisoner support

14. We are concerned that some other prisoners did not feel adequately supported after Mr Green's death.

Recommendations

- The Governor should ensure that:
 - those suspected of involvement in bullying or violence are appropriately monitored;
 - staff consider whether apparent victims of bullying are at increased risk of suicide or self-harm; and
 - apparent victims are effectively supported and protected with meaningful, long-term solutions which address their individual situation.
- The Governor should work with the Prison Fellowship and the Chaplaincy to establish procedures for formal information-sharing when there are concerns that a prisoner may be a risk to himself or others.
- The Head of Healthcare should ensure that:
 - all prisoners referred to the mental health team receive an assessment in a private room with a qualified member of staff; and
 - unqualified members of staff are supervised and monitored to ensure that their interventions are appropriate.

- The Governor should ensure that prisoners are offered appropriate support following a death in custody or other traumatic event.

The Investigation Process

15. 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.
16. The investigator obtained copies of relevant extracts from Mr Green's prison and medical records.
17. The investigator interviewed six members of staff and two prisoners at Woodhill in June 2019. One prisoner refused to be interviewed.
18. NHS England commissioned a clinical reviewer to review Mr Green's clinical care at the prison. The investigator and clinical reviewer jointly interviewed healthcare staff.
19. We informed HM Coroner for Milton Keynes of the investigation. The coroner provided us with a copy of the post-mortem report in October 2019. We have sent the coroner a copy of this report.
20. One of the Ombudsman's family liaison officers contacted Mr Green's sister, to explain the investigation and to ask whether she had any matters the family wanted the investigation to consider.
21. Mr Green's sister provided the investigator with copies of Mr Green's victim empathy coursework which had been returned to her with his belongings. In this, Mr Green had written that his suicidal thoughts had contributed to his offending behaviour. He also wrote that if a restorative justice approach was adopted for his crime it would help him stop being "depressed, stressed, anxious and sometimes feeling suicidal". Mr Green's sister asked what was done with this information.
22. Mr Green's sister received a copy of the initial report. They did not make any comments.
23. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

Background Information

HMP Woodhill

24. 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.
25. 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.
26. 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

27. The most recent inspection of HMP Woodhill was carried out 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.
28. 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 to and monitoring of perpetrators on residential units was poor. Support for victims of bullying and violence was also underdeveloped.

Independent Monitoring Board

29. 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. Healthcare services had performed well against challenging staffing problems.

Previous deaths at HMP Woodhill

30. In 2015 and 2016, 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 one in 2018. Mr Green's death was the third self-inflicted death in 2019. There was a further self-inflicted death a week after that of Mr Green.
31. Previous PPO investigations 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)

32. ACCT is the care planning system the Prison Service uses to support prisoners at risk of suicide or self-harm. The purpose of the ACCT is to try to determine the level of risk posed, the steps that staff might take to reduce this and the extent to which staff need to monitor and supervise the prisoner. Checks should be made at irregular intervals to prevent the prisoner anticipating when they will occur.
33. Part of the ACCT process involves assessing immediate needs and drawing up a caremap to identify the prisoner's most urgent issues and how they will be met. Staff should hold regular multidisciplinary reviews and should not close the ACCT plan until all the actions of the caremap are completed.
34. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011, *Management of prisoners at risk of harm to self, to others and from others (Safer Custody)*.

Key Events

35. On 9 February 2016, Mr Philip Green was remanded into custody, charged with the attempted murder of his partner by cutting her throat. He was taken to HMP Woodhill. It was his first time in prison. Mr Green was very quiet, low in mood and withdrawing from alcohol. Staff started Prison Service suicide and self-harm prevention procedures, known as ACCT. A GP assessed Mr Green and prescribed him medication to alleviate his withdrawal symptoms from alcohol. During an ACCT assessment held on 10 February, Mr Green told staff that he was going to hang himself after he was arrested but that police officers had prevented him.
36. Mr Green was kept under observation over the next few days as he completed his alcohol detoxification. He told healthcare staff that he had no thoughts of suicide or self-harm and did not want antidepressant medication. Staff closed his ACCT on 15 February. A nurse recorded that she did not agree with this decision as Mr Green was tearful during the ACCT review. The nurse referred him to the mental health team.
37. On 17 February, Mr Green was distressed. He told staff that he could not remember the offence due to the amount of alcohol he had consumed and said that his partner meant everything to him. Mr Green said that before he committed the offence he had been intending to take his own life but his partner had stopped him. He said that his mood had improved since he first arrived in prison and he had no current thoughts of suicide or self-harm. On 19 February, the Deputy Head of Healthcare, met Mr Green. She assessed that he did not need mental health support.
38. Mr Green settled well at the prison, made friends, started work in the workshops and said that prison was not as bad as he thought it would be. In April, he spent time in hospital for a collapsed lung. He had surgery and returned to the prison in June and, after spending time in the healthcare unit, started employment in the workshops again.
39. An officer was appointed as Mr Green's offender supervisor. He told her that he intended to plead guilty to his offence. In September 2016, Mr Green was convicted and sentenced to 14 years imprisonment. She met him a few days later. He told her that he was relieved at the length of his sentence as he had been expecting longer. She referred Mr Green for psychosocial support for his previous alcohol misuse. She told the investigator that Mr Green was quite a quiet, withdrawn prisoner.
40. Mr Green's offender supervisor saw Mr Green regularly over the following months. She told the investigator that initially her sessions with Mr Green were focused on trying to alleviate some of his anxiety about moving prisons in order to complete an offending behaviour programme. They tried to identify prisons where it was more convenient for his sister to visit him. She said that she had difficulty getting Mr Green accepted for courses as the risk assessment tools they used meant that he did not qualify for the domestic abuse programme which he needed to complete. She said this was an ongoing issue that was never

resolved. She said that Mr Green wanted to stay at Woodhill but also appreciated the need for him to move to make progress in his sentence.

41. In September 2017, another prisoner stole Mr Green's tobacco. Mr Green said he did not want any further support but staff placed him on a victim support plan for 14 days. Mr Green continued to be employed in the workshops, received regular visits from his sister and largely kept to himself on the unit. Records indicate that he was a hardworking and polite prisoner.
42. In January 2018, an officer who was Mr Green's personal officer, noted that he continued to be polite and caused no concerns. (Personal officers are a prisoner's first point of contact for resolving any issues.)
43. In May, Mr Green's personal officer, told Mr Green's offender supervisor he felt under less stress than he had when he had arrived in prison and she suggested that he completed an emotional management programme.
44. On 8 November, Mr Green spoke to his offender manager along with his offender supervisor. He said he felt stressed due to the amount of illicit psychoactive substances (PS) available on the wing. Despite this, he said he wanted to stay at Woodhill as he "feared the unknown". She tried to encourage him to consider the positives of transferring to another prison. He agreed to talk to the mental health team about his coping skills.
45. She referred him to the mental health team later that day. Her email to the mental health team noted that Mr Green felt "low", "stressed" and was anxious about his cellmate and his use of drugs. She also noted that Mr Green was reluctant to do any groupwork. In response, the Mental Health Manager emailed a support worker to tell her that she had added Mr Green to a support worker, wing clinic.
46. On 12 November, the support worker, recorded that she spoke to Mr Green at his cell door (because staff were unable to unlock him at the time). He told her he did not engage with other prisoners, was unhappy and that there were thieves on the unit. Mr Green said that he isolated himself in his cell, apart from when he attended work. He said he felt anxious about his possessions when he left his cell. The support worker noted that Mr Green engaged well and appeared calm. She added Mr Green to the waiting list for 'the rolling programme' and told Mr Green that he could return to the wing clinic if he wanted to. (The rolling programme is a groupwork programme run on a weekly basis covering different mental health issues such as depression, anxiety and managing emotions.)
47. On 19 November, Mr Green moved to the rehabilitative culture unit (RCU). This is a small unit for enhanced prisoners. The offender supervisor said that Mr Green was noticeably more relaxed once he moved to the RCU. Mr Green moved into a cell with Prisoner X and they continued to share a cell until 20 February 2019. Prisoner X told the investigator that Mr Green was quiet, likeable and unfrontational. He said Mr Green had his own routine, whereby he would go to work in the morning, and play pool with other prisoners in the afternoon.
48. On 20 November, an officer had her first keyworker session with Mr Green. (Keyworkers have replaced personal officers as a prisoner's first point of

- contact.) Mr Green said that he had settled well since moving to the RCU and preferred the calmer atmosphere. The officer said that they would meet weekly and complete a progression plan together.
49. The officer met with Mr Green weekly over the following months. Mr Green did not disclose any difficulties. He continued to tell staff that he felt settled at the prison and did not want to transfer. The officer told the investigator that she never had any concerns that Mr Green was a risk to himself.
 50. In January and February 2019, Mr Green completed a six-week victim awareness course. The course tutor told the investigator that Mr Green was a noticeably quieter participant and appeared to be “a bit of a loner”. She said that during one of the sessions, the course facilitator told her that he was concerned about Mr Green. She spoke to Mr Green who said that he was “okay”. She said she asked Mr Green on more than one occasion if he would like to meet the chaplain for support, but he declined.
 51. The offender supervisor said that Mr Green found the course difficult due to his feelings of remorse and guilt about the offence he had committed. However, she also said that completing the course represented progress for Mr Green in terms of being in a group and working with other people. She said that he never disclosed any suicidal thoughts to her. Nor did she ever assess that he was a risk to himself. She said that Mr Green’s mood fluctuated over the time she knew him, from being “quite low” to being more engaged.
 52. The offender supervisor continued to try to get Mr Green accepted onto an offending behaviour course at HMP Dovegate but when this was not possible, she referred him to HMP Swaleside. She said that although Mr Green wanted to stay at Woodhill, he found the uncertainty unsettling. She tried to reassure him that any move between prisons would be properly planned.
 53. An officer first met Mr Green when he moved to the RCU. She said that he was a quiet prisoner who kept to himself but was always polite and never confrontational. The officer said that Mr Green was friends with a small number of prisoners with whom he would sometimes socialise, and at other times he would choose to remain in his cell. She said she never had any concerns that Mr Green was a risk to himself.
 54. Prisoner W began sharing Mr Green’s cell on 8 March. He said that Mr Green seemed “alright”, he kept to himself and they got on well. He said that he snored and Mr Green complained that he was not getting enough sleep. On 12 March, he moved to the cell next door because of this issue and another prisoner began sharing Mr Green’s cell. He said he continued to speak to Mr Green every day until he moved off the unit on 31 March.
 55. On 14 March, an officer noted that Mr Green was keen to complete a course on alcohol misuse and continued to make progress in prison. On 17 March, Mr Green told an officer that his new cellmate had threatened to assault him. His cellmate was moved to another wing. When Officer Wilson saw Mr Green on 19 March, he seemed happy that the situation had been resolved. The officer continued to meet Mr Green weekly. On 27 March, Mr Green said that he had

begun to feel slightly anxious because he had had several new cellmates over recent weeks.

56. Prisoner X said that from around the end of March, Mr Green started staying in his cell more and that he was always the last one to leave for work. He saw him in his capacity as a Listener (prisoners who are trained by the Samaritans to provide support to other prisoners) but was unable to disclose the conversations he had with Mr Green in this capacity to staff, as they were confidential.
57. On 15 April, Prisoner Y moved to the RCU and began sharing Mr Green's cell. He refused to be interviewed by the investigator. Prisoner X said that Mr Green seemed more withdrawn when he shared a cell with Prisoner Y.
58. On 18 April, Mr Green asked an officer to lock his cell door during evening association. As this behaviour was unusual, the officer asked Mr Green how he was. Mr Green responded that he was not in any immediate danger but did not feel safe and did not want to name the prisoner involved. Mr Green later told two SO's that his Prisoner Y was bullying him. Staff passed the information onto a Custodial Manager (CM) and submitted an intelligence report. Staff noted in the observation book that staff should be vigilant of the cellmate around Mr Green and moved him to another cell in the RCU.
59. On 19 April, Mr Green told staff that he was worried he had offended a group of Muslim prisoners, of which Prisoner Y was one, due to a joke he had made which had been misinterpreted. He said he felt safe in the RCU but was worried every time he left it. Mr Green said that Prisoner Y had threatened to plant either drugs or a weapon in his cell. Staff submitted an intelligence report. Mr Green said that he did not have any thoughts of self-harm. The SO said that Mr Green "did not want anything further to come of it".
60. Prisoner Z began sharing Mr Green's cell on 20 April. He said that they got on well and knew each other from the workshop. Mr Green told him that Prisoner Y had threatened his family and accused him of being racist. Prisoner Z said that Mr Green was a quiet prisoner who did not seek trouble and was trying to "keep his head down". He told police that Mr Green seemed happy and relaxed and told his new cellmate that he liked sharing a cell with him.
61. On 24 April, Mr Green told workshop staff that he felt under threat and asked staff to "keep an eye" on him. Staff noted that he looked nervous and scared. They submitted an intelligence report and telephoned unit staff.
62. Prisoner X told the investigator that he never thought that Mr Green was a risk to himself, he thought he was "just very low". He said once Mr Green started sharing a cell with Prisoner Z, he started coming out of his cell more and playing pool. Prisoner Z was aware of allegations that Prisoner Y was bullying Mr Green. Prisoner W worked in the kitchen with Prisoner Y. Prisoner W said that Prisoner Y often talked about Mr Green, was very vocal in his dislike for him and spoke about getting people to go to Mr Green's house.
63. On 25 April, Mr Green told an officer that he was feeling "particularly down" due to issues with Prisoner Y, who he said was bullying and threatening him due to a misunderstanding. Mr Green also said that Prisoner Y had found out why he was

in prison and had made comments about this, as well as threatening to find out where his sister lived and hurt her. Mr Green said that he had spoken to unit staff about the situation but was becoming increasingly agitated and worried. Mr Green told the officer he did not want to be moved to another unit as he did not think this would solve the problem and preferred the quiet environment of the RCU.

64. The officer spoke to Mr Green about the support available to him and Mr Green told him he had spoken to a Listener. The officer offered to contact the chaplaincy, but Mr Green declined. Mr Green said that the officer should not have any immediate concerns for his safety. Staff were adding his sister's telephone number to his pinphone account so that he could ring her. The officer said that Mr Green seemed worried and frightened. When asked, he told the officer he had no thoughts of suicide or self-harm.
65. The officer spoke to unit staff who said they were trying to get Prisoner Y moved to another unit as his general behaviour was not of the expected standard for the RCU. The officer reflected that this would help Mr Green who was a naturally shy prisoner who had been progressing well until then. The officer said she would see Mr Green within the next few days. She submitted an intelligence report.
66. On 26 April, following an email from the security department to safer custody that Mr Green was allegedly being bullied, two officers spoke to Mr Green about these allegations. Mr Green confirmed that Prisoner Y had threatened him and had spread details of his conviction which had made Mr Green feel paranoid. Prisoner Y had told Mr Green that he only had to give "the nod" and something would happen to him. Mr Green had continued to attend work but said that other prisoners had started treating him differently and no longer came to his cell to socialise with him.
67. An officer noted that Mr Green seemed nervous throughout the interview and appeared deep in thought, often forgetting what he was about to say. Mr Green said that he did not think anything would happen to him in the RCU as Prisoner Y did not want to jeopardise his place there, but he thought that he might be in danger elsewhere in the prison. Mr Green suspected that Prisoner Y had a mobile telephone. An officer told the investigator that Mr Green had the demeanour of a prisoner being bullied but he had no concerns that he was a risk to himself.
68. An officer spoke to a SO and passed on all the information from Mr Green. He suggested that she consider moving Prisoner Y to a different unit. He also made an entry in the unit observation book. The officer noted that staff needed to consider whether to talk to Prisoner Y about the allegations. He submitted an intelligence report to security staff, seeking security's view about whether it was appropriate to speak to Prisoner Y directly.
69. The SO told the investigator she spoke to the Head of Reoffending, about getting Prisoner Y moved from the RCU. She said that without any corroborative evidence it was just one prisoner's word against another's and this was insufficient for Prisoner Y to be moved from the unit. She spoke to security staff and listened to Prisoner Y's telephone calls to see whether he had referred to

threatening Mr Green or his family. Prisoner Y had not. Staff told Prisoner Y that if there were any further reports of poor behaviour he would be moved from the RCU.

Events of 30 April

70. On 30 April, Prisoner X said that Mr Green seemed “fine” that morning. Mr Green then went to work. Prisoner W told police that Prisoner Y had threatened him that morning. Prisoner W told Mr Green this, while they were at work. He said that Mr Green seemed concerned as he did not want Prisoner Z to be moved from the cell they shared. Workshop staff telephoned the RCU and spoke to an officer. They told her that Prisoner Z felt threatened by Prisoner Y. The officer noted this information in the unit observation book.
71. Around 11.00am, an officer went to see Mr Green in the workshop. Mr Green said that other prisoners were continuing to make comments about him, although not Prisoner Y himself. He said he sometimes found the comments threatening but at other times was able to ignore them. The officer encouraged Mr Green to continue to talk to unit staff so that they could monitor Prisoner Y’s behaviour. Mr Green did not want to move units as he felt settled and liked the quieter environment of the RCU. Mr Green said he had not yet had his sister’s number added to his prison telephone account. He said staff had looked busy when he was going to talk to them that morning. The officer encouraged him to talk to staff and to speak to a Listener if he felt the need. She also offered him the Samaritan’s telephone (a telephone which can only be used to call the Samaritans) or to talk to chaplaincy staff but he declined.
72. The officer asked Mr Green if she could assist him in any other way. Mr Green declined and said he was “okay”. He said that he was feeling better than the week before and things had settled somewhat. However, the officer recorded that he still looked worried. She encouraged him to speak to herself or to unit staff if he had any concerns. She noted that he left the session looking a little more positive and told the investigator that he seemed a little less anxious than when she had seen him the week before.
73. Prisoner Z and Mr Green returned to their cell after work. He said that Mr Green watched television, while he slept. Prisoner Z returned to work in the afternoon, around 1.45pm.
74. During the early afternoon, Mr Green went to the unit office and asked an officer for his solicitor’s details. She checked his electronic record but could not find the information, so she went to his cell to tell him this. She said she would ask other staff to try to find the information. Mr Green thanked her and told her this was “fine”. She had no concerns about Mr Green who, she said, seemed his usual self. She said he spent most of that afternoon’s association time in his cell, which was not unusual as most prisoners were at work.
75. Between 3.00pm and 3.15pm, Mr Green can be seen on CCTV, standing in the doorway of his cell, watching others play pool, and talking to Prisoner W. Prisoner W had returned to the RCU that afternoon and was allocated a cell with Prisoner Y. Prisoner W said that Mr Green looked “stressed” and as if he had lost weight. Mr Green told Prisoner W that he was a “bit down” as Prisoner Y

had been bullying him, threatening his family and saying that he would harm his sister. Prisoner W had not yet met Prisoner Y but said that he would talk to officers if Prisoner Y said anything about Mr Green to him.

76. After talking to Prisoner W, Mr Green went into his cell and closed the door. At around 3.40pm, an officer offered Mr Green the opportunity to exercise which he declined. She locked his cell door. When a second officer returned from the exercise yard with other prisoners at 4.00pm, the first officer unlocked Mr Green's door. She shouted to Mr Green, asking whether he was alright, and she said that at the time she thought he confirmed that he was. However, in retrospect she was not completely sure whether he had replied. She assumed that Mr Green was in the bathroom.

Around 4.20pm, other prisoners returned from work, including Prisoner Z. At 4.26pm, Prisoner Z went into his cell, assuming that Mr Green was not in there. Prisoner Z went to the unit office briefly to talk to staff and then returned to his cell at 4.30pm. He found Mr Green slumped on the toilet with a large amount of congealed blood around his feet. (He had not noticed Mr Green earlier as a privacy curtain separated the bathroom from the rest of the cell.) Prisoner Z ran to the unit office to alert staff. The second officer told police that he looked panicked and she immediately thought something was wrong.

77. Meanwhile, Prisoner X said that he looked in through Mr Green's observation panel and could see blood on the floor. He assumed that Mr Green had had a nosebleed. Prisoner X went into the cell, tried to get a response from Mr Green and shook his shoulders.
78. The second officer reached the cell a few seconds after Prisoner Z had left it. She told police that she immediately thought that Mr Green was dead. She ran back to the unit office as she did not have a radio.
79. The first officer finished her call and was locking the office when the second officer ran towards her and asked her to assist her as there was a lot of blood. The first officer radioed a code red emergency immediately, at 4.30pm. Control room staff immediately telephoned an ambulance. Both staff returned to Mr Green's cell. Mr Green had a large cut to his throat and one of his arms. Prisoners were standing inside and around Mr Green's cell. The officers told them to return to their cells. These prisoners included Prisoner X, who had been inside Mr Green's cell. This was around 45 seconds after Prisoner Z had first found Mr Green.
80. Officers tried to get a response from Mr Green. The first officer told the investigator that she thought Mr Green was dead and did not think she would be able to assist him with her limited medical knowledge. She and the second officer therefore started locking the other prisoners into their cells. At 4.31pm, an officer, a SO, and two nurses arrived and went into Mr Green's cell. The first officer took Prisoner Z into a common room and spoke to him as he was visibly distressed.
81. Staff laid Mr Green on the floor, assessed him for any signs of life and began chest compressions. They administered oxygen and attached the defibrillator (a machine used to give the heart an electric shock to re-establish a normal heart

rhythm). Staff noted that there was a tin can lid lying between Mr Green's legs which they assumed he had used to cut himself. More nurses arrived, inserted an airway, administered adrenaline and applied the defibrillator. A prison GP also responded. He examined Mr Green and advised staff to stop attempting resuscitation. He pronounced Mr Green dead at 4.45pm.

82. Prisoner W told the investigator that after Mr Green had been found, an officer locked him and his cellmate, Prisoner Y, back into their cell. He said that Prisoner Y immediately used the phone in their cell and told the person he had phoned that someone had died. He said that from the way Prisoner Y said it, he thought that the other person already knew who he was talking about without Prisoner Y naming him. Prisoner W said that Prisoner Y repeatedly told him to be quiet so he could hear what staff were saying outside their cell. Prisoner Y told Prisoner W that staff kept looking at their cell door and reading out Prisoner Y's name on the door. Prisoner W told the investigator that Prisoner Y seemed paranoid about something.
83. The investigator asked for access to Prisoner Y's telephone calls for this period but, despite several requests, the prison did not make these available. The investigator was later told that these calls had been wiped from the system after 90 days.
84. Prisoner Z told police that when he had returned to Mr Green's cell after fetching help from the second officer, Prisoner Y was looking through the observation panel and said, "It's nothing to do with me." Prisoner Z thought that Mr Green had killed himself because of Prisoner Y's bullying. Prisoner Z was very shocked by what he had seen. He said he had had no concerns about Mr Green's mental health or that he was a risk to himself.
85. Other prisoners also blamed Prisoner Y for Mr Green's death and he was therefore moved to a different unit for his own safety.

Contact with Mr Green's family

86. A CM was appointed as the family liaison officer (FLO). On 30 April, at 8.10pm, she went to Mr Green's sister's house along with another member of staff. The FLO broke the news of Mr Green's death and offered her condolences. She stayed in contact with Mr Green's sister over the following days and offered a contribution to the funeral expenses in line with Prison Service policy. Several members of staff attended Mr Green's funeral.

Support for prisoners and staff

87. After Mr Green's death, the Governor of Woodhill 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. Staff said that they had felt well supported after Mr Green's death.
88. The prison posted notices informing other prisoners of Mr Green's death and offering support. They held a memorial ceremony for Mr Green on 15 May. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Green's death.

89. Both prisoners we spoke to – Prisoners W and X - said they had not felt adequately supported after Mr Green’s death. They were both clearly traumatised by what they had seen and were having difficulty sleeping. Prisoner W was told that he had to move from the RCU and felt blamed by staff for Mr Green’s death. Prisoner X said he was receiving weekly support from the mental health team but did not think this was sufficient.

Post-mortem report

90. The post-mortem report examination found that Mr Green died of blood loss caused by deep cuts to his neck and cuts to his chest and arm, which appeared to be self-inflicted. Toxicology tests detected no drugs or alcohol in Mr Green’s system.

Findings

Assessment of risk

91. Staff and prisoners said that Mr Green was a quiet and compliant prisoner who wanted to avoid conflict and confrontation. It was his first time in prison, and he was deeply remorseful for the offence he had committed.
92. He settled well in prison, completed an alcohol detoxification programme and appeared to be willing to consider his progression to another prison. He had a prison job throughout his time at Woodhill and associated with a small group of prisoners.
93. Staff assessed Mr Green as presenting a risk to himself when he first entered prison in February 2016 and he was therefore subject to ACCT support for his first week in prison. After that he was not assessed as a risk to himself.
94. We are, however, concerned that staff may not have fully recognised the impact that the alleged bullying was having on Mr Green and how this may have increased his risk of suicide and self-harm. This is addressed further below.

Allegations of bullying

95. Mr Green did not leave a suicide note and we cannot know why he decided to take his life.
96. In the last two weeks of his life Mr Green told several staff and prisoners that Prisoner Y was bullying him. We are not able to say whether this was the case or not. However, there is evidence that Mr Green's demeanour changed, and that he was nervous and distracted, and some staff and prisoners said he became increasingly withdrawn. Prisoners also said that Prisoner Y was vocal in his dislike of Mr Green.
97. Woodhill's Violence Reduction Strategy states that victim support procedures will be activated when a prisoner is identified as the victim of any antisocial behaviour or where a prisoner states that he is under threat from another prisoner or group. Woodhill's violence reduction manager, said that at the time Mr Green was at Woodhill, anyone who was a potential victim or perpetrator of violence or bullying should have been monitored for 28 days. The violence reduction department confirmed that neither Mr Green nor Prisoner Y had been subject to monitoring (apart from in 2017 after Mr Green had his tobacco stolen).
98. Staff did take some action. They spoke to Mr Green on several occasions about his allegations. They checked how he was feeling and submitted intelligence reports in line with procedure.
99. Staff also moved Prisoner Y to another cell. They told us that they had considered moving Prisoner Y from the RCU the weekend before Mr Green died. However, they decided that they could not justify moving Prisoner Y without corroborative evidence that he was bullying Mr Green. Staff did not speak to Prisoner Y directly about the bullying allegations but submitted intelligence reports and were waiting for the advice of security staff. A SO said that speaking to prisoners directly can be disruptive on a small unit like the RCU and

the potential repercussions have to be carefully considered both for the alleged victim and perpetrator.

100. Although we appreciate that this was a sensitive situation, we are concerned that staff did not take sufficient action to establish whether there was any foundation to Mr Green's allegations or to support Mr Green. The victim support procedures were not activated and there was no plan for managing the situation. We are also concerned that prison staff do not seem to have considered whether the alleged bullying and threats might have increased Mr Green's risk of suicide and self-harm.
101. The violence reduction manager told the investigator that a new Prison Service initiative to tackle violence and bullying - the challenge support intervention plan (CSIP) - was introduced at Woodhill on 1 May 2019 (that is, just after Mr Green's death). This is aimed at supporting both victims and perpetrators of violence with bespoke management plans. The prison has also introduced weekly safety intervention meetings. We welcome this initiative but we are concerned that he told the investigator that he was not convinced Woodhill had sufficient staff to implement CSIPs successfully.
102. Previous PPO investigations into some self-inflicted deaths at Woodhill found that victims of bullying were not being properly supported. We are disappointed to be raising these concerns at Woodhill again and hope that the new CSIP arrangements are adequately resourced to properly support victims and challenge perpetrators. We make the following recommendation:

The Governor should ensure that:

- **those suspected of involvement in bullying or violence are appropriately monitored;**
- **staff consider whether apparent victims of bullying are at increased risk of suicide or self-harm; and**
- **apparent victims are effectively supported and protected with meaningful, long term solutions which address their individual situation.**

Victim Empathy Coursework

103. In January 2019, Mr Green wrote in his victim empathy coursework book that he sometimes had suicidal feelings. Mr Green's sister asked whether any action had been taken as a result.
104. This course is run by volunteers from the Prison Fellowship, a Christian charity that supports prisoners. The course tutor told the investigator that the content of the workbooks remains confidential and is not disclosed to Prison Service staff unless there is a concern that the individual is at risk of harm to himself or to others. In that case, tutors would inform the prison chaplain of their concerns. The course tutor said that group facilitators read the workbooks at the start of each session and she herself sees them at the mid-way point, and once prisoners have finished the course.

105. The course tutor who is a trained Samaritan, could not specifically remember reading about Mr Green's thoughts of suicide but said that she must have done. She said she had no concerns that Mr Green was a risk of suicide. She could not remember whether she asked Mr Green directly whether he had thoughts of suicide but said that she would have done had she felt it necessary. She said she offered Mr Green the support of the prison chaplain if he wanted to discuss his feelings or concerns but he declined this on more than one occasion.
106. The course facilitator could not recall whether he had read what Mr Green had written after session five. He said that there was not always enough time to read all the prisoners' workbooks.
107. Although we are satisfied that Prison Fellowship staff acted with good intentions, we are concerned that the information that Mr Green was having suicidal thoughts was not shared with prison staff. Although the course tutor did not consider that Mr Green was a suicide risk, she would not have been aware of all Mr Green's risk factors, including his experiences in prison. We recognise that there are issues about confidentiality but the duty of care for Mr Green rested with the prison and not with the Prison Fellowship, and the prison can only discharge its duty effectively if it is aware of all the information that might affect a prisoner's safety. We recommend:

The Governor should work with the Prison Fellowship and the Chaplaincy to establish procedures for formal information-sharing when there are concerns that a prisoner may be a risk to himself or others.

Clinical care

108. The clinical reviewer concluded that the physical healthcare Mr Green received was adequate but that his mental healthcare was of a mixed standard and was not wholly equivalent to the level of care he could have expected to receive in the community.
109. On 8 November 2018, Mr Green's offender supervisor referred him to the mental health team. He was seen by a support worker and added to the waiting list for the rolling programme. The Mental Health Manager told the clinical reviewer that this programme was not running at the time due to staffing issues. In addition, it was a groupwork programme which Mr Green had indicated he would be reluctant to participate in. A support worker told the clinical reviewer that she did not know that Mr Green had said he did not want to attend a group programme. She said that she would have also offered him one-to-one work in her wing clinic if she had known this.
110. The Mental Health Manager told the clinical reviewer that even after the programme had started, Mr Green did not participate or have any contact with mental health services. She said that unqualified support workers were expected to bring their initial assessment of a prisoner to the team meeting for discussion, but there is no evidence that this had happened. The support worker said that her role was to provide emotional support and low-level interventions, not to conduct mental health assessments. She did not provide feedback to the team meeting as there were no significant issues to discuss. The support worker

acknowledged that, although there had been no waiting list for the programme, Mr Green had not been offered a place before he died.

111. The clinical reviewer concluded that this was a missed opportunity to engage with Mr Green. He was concerned that Mr Green did not have a full mental health assessment by a qualified member of staff, only a discussion through a locked cell door with a support worker. The outcome of this assessment does not appear to have been discussed with a qualified member of staff. Neither did staff follow up with Mr Green once the rolling programme restarted. We make the following recommendation:

The Head of Healthcare should ensure that:

- **all prisoners referred to the mental health team receive an assessment in a private room with a qualified member of staff; and**
- **unqualified members of staff are supervised and monitored to ensure that their interventions are appropriate.**

Prisoner support

112. Prisoner W and X said that they had not felt adequately supported following Mr Green's death. They were the first to find Mr Green, who had lost a significant amount of blood. It was an extremely traumatic and distressing experience for prisoners and staff alike. We make the following recommendation:

The Governor should ensure that prisoners are offered appropriate support following a death in custody or other traumatic event.

**Prisons &
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