Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Scott Rider, a prisoner at HMP Woodhill, on 13 June 2022

A report by the Prisons and Probation Ombudsman

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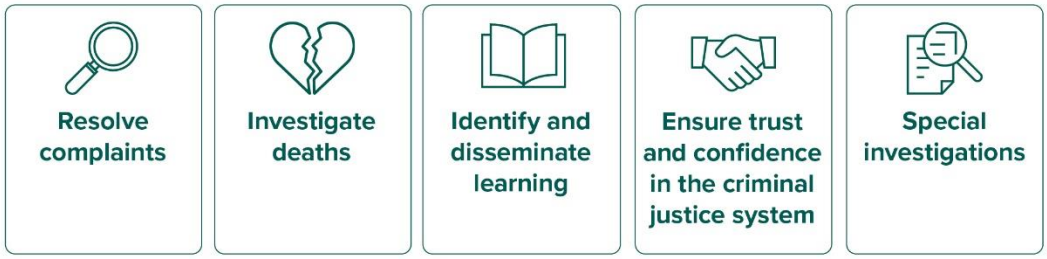
OUR VISION

To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.

WHAT WE DO



WHAT WE VALUE

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 Scott Rider was found hanged in his cell on 13 June 2022 at HMP Woodhill. He was 45 years old. I offer my condolences to Mr Rider's family and friends.

Mr Rider was serving an Imprisonment for Public Protection (IPP) sentence which had expired in 2008. He had been charged and sentenced for a further offence in 2018 and disengaged with the parole process because he felt hopeless about the prospect of release. Mr Rider's behaviour in prison was mixed. He was often verbally abusive to staff or did not engage with them, and he was fearful of other prisoners. He isolated himself for most of his time at Woodhill and withdrew completely from the regime.

Staff were generally very supportive of Mr Rider and made consistent efforts to engage him and encourage him to come out of his cell. They put a range of support systems in place to reduce the impact of isolation on Mr Rider's wellbeing but unfortunately, he did not engage with most of these. I found some gaps in the prison's implementation of its policy on isolating prisoners, including the failure to review Mr Rider's plan regularly. I found no evidence that opportunities to support Mr Rider were missed, but recommend that these issues are addressed to prevent issues arising in future.

I am extremely concerned about the staff shortages we found at Woodhill. This is putting significant limitations on the Governor's ability to run a meaningful, safe and decent regime. Mr Rider had very few key worker sessions due to staff shortages and missed out on a potential opportunity to build a trusting relationship. I seek assurances that HM Prison and Probation Service (HMPPS) is prioritising improvements in staffing resources at Woodhill.

I have also made recommendations that isolating prisoners are offered regular mental health reviews whether or not they engage, and that Woodhill takes action to address prisoners blocking their cell door observation panels to ensure that their safety can be monitored effectively.

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

Kimberley Bingham
Acting Prisons and Probation Ombudsman **December 2022**

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Summary

Events

1. On 30 June 2021, Mr Scott Rider was transferred to HMP Woodhill. He was not happy with the transfer and wanted to be located in Northern England. Mr Rider was concerned that other prisoners thought that he was racist and was fearful of the threat that they posed to him. He spent most of his time in his cell and additional monitoring was put in place for two weeks before he was moved to a different unit. After this time, Mr Rider consistently denied that he had any thoughts of suicide or self-harm. He was abusive to staff on several occasions and was pre-occupied with being moved to a different prison. He did not engage with the regime or his sentence progression, including his upcoming parole board at which he would be considered for release. Woodhill made several requests for a transfer to other prisons but these were not accepted because of Mr Rider's difficult behaviour and treatment of staff.

2. Mr Rider continued to withdraw and his behaviour was volatile. On some days, he would engage with staff and prisoners and on other occasions, he would be rude and abusive. It appears that Mr Rider was struggling with the amount of time that he had spent in prison and was losing hope about getting released. In May 2022, he said that he would not engage with the parole process and threw his parole dossier in the bin. Mr Rider was monitored and supported using a Challenge Support Intervention Plan and an Isolating Individuals Policy plan.

3. On 13 June, staff noticed that Mr Rider had refused his lunch and was having a difficult day. They had no immediate concerns because his behaviour was not unusual. At around 12.00pm, two officers checked on Mr Rider and said that he responded to them. At around 3.30pm, an officer went to Mr Rider's cell to give him some vape capsules but could not see through his cell door observation panel, so unlocked his cell and found him hanging. The officer shouted for help and went into the cell once they could hear other staff approaching. While officers were radioing a medical emergency code and seeking further assistance, a prisoner went into Mr Rider's cell to support the emergency response. Staff tried to resuscitate Mr Rider and paramedics continued when they arrived but pronounced his death at 4.31pm.

Findings

4. Mr Rider did not come out of his cell for most of his time at Woodhill. We saw evidence of staff making consistent efforts to build relationships with Mr Rider and encourage him to come out of his cell and engage with support systems. In addition to his formal care plans, they put in place measures to try to reduce the impact of isolation on his wellbeing.

5. Mr Rider said that he felt unsafe but staff had very limited evidence to suggest that there was an actual threat to his safety at Woodhill. We found no further evidence during the course of our investigation. An isolating individual's plan was put in place to monitor Mr Rider's wellbeing but daily updates and weekly reviews did not take place as they should have done.

6. Staff tried to deliver key work sessions on six occasions during the year that Mr Rider lived at Woodhill, which is significantly less than he should have received based on national guidelines. However, Woodhill was short of 45% of its officers at the time and an Exceptional Delivery Model (EDM) was in place nationally due to the COVID-19 pandemic. The EDM reduced key work activity to the most vulnerable prisoners only. The Governor explained that key work could not be prioritised with such low staffing levels and we recognise that this was outside of her control.

7. The clinical reviewer concluded that Mr Rider's physical healthcare was of a good standard and equivalent to that which he could have expected to receive in the community. However, his mental healthcare was only partially equivalent. Mental health staff did not continue to monitor Mr Rider during his isolation and did not refer him to a GP when they found that he needed a memory assessment.

8. When staff found Mr Rider hanging, part of his observation panel had been covered for several hours. Some officers said that they were able to see into the cell but they did not challenge Mr Rider. Officers told us that this was a widespread issue at Woodhill and that they found it difficult to enforce the rules.

Recommendations

- The Governor should ensure that plans for isolating prisoners contain detailed information about identified risks and agreed actions to reduce or end isolation, and that prison staff regularly review them and ensure that any changes are recorded and actioned.

- The Director General of Prisons and MoJ People Group should consider what additional support can be put in place to address the significant staff shortages at Woodhill and consider how it can reasonably deliver key work in these circumstances.

- The Head of Healthcare should ensure that the mental health team offers routine reviews of all isolating prisoners, even if they are not engaging, to ensure that their mental health is appropriately monitored.

- The Governor should ensure that all staff respond appropriately to blocked cell door observation panels to ensure prisoner security and safety, and that managers support staff to enforce this**.**

The Investigation Process

9. 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.

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

11. The investigator interviewed two members of staff and two prisoners at Woodhill on 5 August 2022. She also interviewed three members of staff by telephone.

12. NHS England commissioned a clinical reviewer to review Mr Rider's clinical care at the prison. The investigator and clinical reviewer jointly interviewed two healthcare staff by video conference.

13. 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.

14. The Ombudsman's family liaison officer contacted Mr Rider's sister to explain the investigation and to ask if she had any matters she wanted us to consider. She asked why the prison had disposed of Mr Rider's possessions before asking whether she wanted them. A Custodial Manager (CM) said that Mr Rider had named his father as his next of kin. When the CM had contacted him, he said that he did not want Mr Rider's property, and the prison therefore disposed of it. This was before Mr Rider's sister had contacted the prison.

15. Mr Rider's sister received a copy of the draft report. She did not make any comments.

16. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

Background Information

HMP Woodhill

17. HMP Woodhill is a high security prison in Milton Keynes, holding primarily Category B prisoners and a small number of Category A prisoners. It has capacity for around 556 men in total. Mr Rider was housed within the main part of the prison.

18. Central and North-West London NHS Foundation Trust provides health services.

HM Inspectorate of Prisons

19. The most recent inspection of HMP Woodhill was in September 2021. Inspectors reported that their findings were disappointing. They noted that the prison was not safe enough and that there had been seven self-inflicted deaths since their previous inspection. They found some useful work had been done to try to understand the causes of these problems, but this had not yet made a difference.

20. There was a high proportion of inexperienced officers at the time of the inspection. Inspectors found that staff were generally well intentioned but not sufficiently or consistently effective and poor behaviour was often not addressed. Inspectors noted that most of Woodhill's problems could be related to the inability to recruit and retain staff. They found that there were examples of good leadership but Woodhill needed more support to improve outcomes at the prison.

21. Inspectors found that the number of prisoners with a named key worker had increased from 38% to 66% since their last inspection. However, they noted that most prisoners were not receiving key work sessions, and the maximum compliance rate over the previous 12 months was 12%, with limited quality assurance checks.

22. Inspectors found that the multidisciplinary mental health team delivered an impressive range of support for prisoners but the team was stretched because of staff vacancies.

Independent Monitoring Board

23. 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 May 2021, the IMB reported that levels of violence were high at Woodhill and there was a high proportion of inexperienced staff which had led to some difficult situations being mishandled.

24. The IMB found that the number of prisoners isolating themselves had increased but the prison was actively managing the situation, with weekly safety meetings which aimed to understand better the needs of those who were doing so.

Previous deaths at HMP Woodhill

25. Mr Rider was the fourth prisoner to die at Woodhill since June 2020. Two of the previous deaths were self-inflicted and the cause of the third death has not been confirmed at the time of writing this report. Previous investigations found that there was a delay going into a cell during an emergency response and that staff needed to consider the risks that prisoners presented to themselves more carefully. There has been a further self-inflicted death since that of Mr Rider, which we are currently investigating.

Imprisonment for Public Protection (IPP)

26. IPP sentences are indeterminate, which means that when the minimum tariff has expired, individuals are required to demonstrate to the Parole Board that their risk has reduced enough to be managed in the community. IPP sentences were introduced in 2005 and abolished in 2012, but the abolition did not apply retrospectively to those who had already received the sentence.

Assessment, Care in Custody and Teamwork

27. 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.

28. Part of the ACCT process involves assessing immediate needs and drawing up a caremap to identify the prisoner's most urgent issues and how they will be met. Staff should hold regular multidisciplinary reviews and should not close the ACCT plan until all the actions of the caremap are completed. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011 on safer custody.

Key worker scheme

29. The key worker scheme aims to improve safer custody by engaging with prisoners, building better relationships between staff and prisoners and helping prisoners settle into life in prison. It provides that all adult male prisoners will be allocated a key worker who will spend an average of 45 minutes a week on key worker activities, including having meaningful conversation which each of their allocated prisoners.

30. The key worker scheme was suspended across the estate on 24 March 2020 due to the COVID-19 pandemic. To ensure that meaningful interaction continued for priority prisoners such as those who were at risk of suicide or self-harm, the Prison Service introduced the Exceptional Delivery Model for key work in May 2020. This provided for officers to have a weekly conversation with prisoners identified as vulnerable. The model was stood down in May 2022 and prisons are now expected to be delivering the full scheme again.

Key Events

Background

31. On 30 May 2005, Mr Rider committed an offence of grievous bodily harm. He was recalled to custody. On 9 September, Mr Rider received an Imprisonment for Public Protection (IPP) sentence, with a tariff to serve of 32 months.

32. Before his transfer to Woodhill, Mr Rider spent time in several prisons and substantial periods in segregation due to his abusive behaviour towards staff. This had a negative impact on Mr Rider's completion of offence-focused work and psychological interventions required by his sentence plan. In 2018, Mr Rider was convicted of the racially aggravated harassment of an officer and received a further six-month sentence. On 23 December 2020, the Parole Board wrote to Mr Rider to explain that he could not be moved to open conditions or released.

HMP Woodhill

33. On 30 June 2021, Mr Rider was transferred to HMP Woodhill. He told staff that he had no thoughts of suicide or self-harm or mental health issues. On 1 July, a nurse from the mental health team completed an initial assessment for Mr Rider. He said that he was distraught about the transfer, which had taken him far away from his family in Northern England, and said that he would not receive any visits as a result. The nurse noted no mental health needs that needed ongoing support.

34. On 10 July, Mr Rider said that he was under threat from other prisoners due to a debt related to psychoactive substances (PS). Staff referred him for a Challenge Support Intervention Plan (CSIP, used to challenge those who pose a risk of violence to others or support those who are at risk from others) to help manage the risks.

35. On 14 July, Mr Rider moved to House Unit 3B. On 21 July, a Prison Offender Manager (POM) introduced herself to Mr Rider. He was aggressive, did not want to engage and said that he wanted to transfer to Lowdham Grange. She explained that he needed to settle at Woodhill before he could be considered for a move. Mr Rider was upset about this.

36. During July and August, staff suspected that Mr Rider was under the influence of illicit drugs on several occasions. He did not engage when he was offered follow-up substance misuse support. Staff also noted that Mr Rider was isolating himself most of the time. He said that he was isolating because other prisoners thought that he was racist and he was under threat from Muslim prisoners as a result. Mr Rider was moved again, to House Unit 3A, but said that his problems followed him there.

37. On 17 August, prisoners squirted excrement through the side of Mr Rider's cell door. Mr Rider made superficial cuts to both his arms and said he did so because he was frustrated that staff were not protecting him. Staff started ACCT monitoring. An intelligence report indicated that Mr Rider might have been in debt to other prisoners and that was why the prisoner had squirted the excrement. The next day, during an ACCT assessment, Mr Rider said that he felt unsafe on the unit because other prisoners thought he was racist. Staff said that they would see if he could

move to a different unit within the prison but Mr Rider said that he wanted to be transferred to a different prison. On 19 August, Mr Rider moved to House Unit 2 and staff closed his CSIP. He was positive about the move and said that he had no thoughts of suicide or self-harm.

38. On 30 August, Mr Rider said that he wanted to move to a different wing again. During an ACCT review, he said he had no thoughts of suicide and self-harm and staff stopped ACCT monitoring. They referred him to the mental health team. (There was no further information in the referral to explain the reason for this.) On 21 September, a nurse from the mental health team tried to assess Mr Rider but he did not want to engage. On 30 September, staff recorded that the Prison Reform Trust had called the prison following contact from Mr Rider. He had told them that he had thoughts of suicide and had had urine thrown through his door the day before. Officers on Mr Rider's wing were told, and the safer custody team went to see Mr Rider but he did not want to engage. Mr Rider continued to isolate himself.

39. On 13 October, Mr Rider was moved to House Unit 4. He told staff that he would continue to isolate himself because he had issues with Muslim prisoners. He repeated that he wanted to be in a prison in Northern England. On 12 November, an administrator in the Observation Classification Allocation (OCA) team, responsible for prison transfers, contacted HMP Lowdham Grange to see if Mr Rider could be transferred there. They rejected the request because he had been disruptive when he had last spent time there.

40. On 25 November, Mr Rider had a key worker session with an officer, during which he repeated his request for a transfer to Lowdham Grange. Throughout December, Mr Rider often refused to engage with staff and was angry that he was not being moved to another prison. Staff reviewed his CSIP on a monthly basis due to his continued isolation. Mr Rider's engagement with the process was mixed. In January 2022, Mr Rider did not engage with a key worker session that was offered to him.

41. In February 2022, staff logged several security reports that stated that Mr Rider had been abusive to officers, particularly female officers, and threatened to kill prisoners. The reports noted that Mr Rider used his aggression to intimidate staff and for personal gain. An officer tried to hold key work sessions with Mr Rider but he did not engage. Mr Rider was told that he could not transfer to other prisons because he was at Woodhill to complete offending behaviour programmes, which were important for his parole hearing.

42. The administrator in the OCA team requested a transfer to HMP Doncaster, HMP Durham, HMP Liverpool or HMP Leeds. The OCA team rejected the application because none of the prisons were accepting long-term prisoners on permanent transfers. She shared the news with Mr Rider.

43. On 11 March, the administrator asked HMP Dovegate to consider Mr Rider for transfer at his request. Later in March, Mr Rider declined to engage with psychology and safer custody staff and did not attend his CSIP review.

44. On 29 March, Officer A noted that he had had regular conversations with Mr Rider and had not seen him leave his cell during the four months he had worked on the wing. Mr Rider told the officer that he wanted to transfer to another prison, and the

officer chased the latest request. The officer suggested that he should become Mr Rider's key worker because of the rapport they were building. On 30 March, the administrator contacted Dovegate to find out if they had looked at Mr Rider's transfer request. They said they would not accept him because he had not complied with the regime during a previous stay.

45. On 2 April, staff noted that Mr Rider was becoming increasingly hostile and could regularly be heard shouting abuse at staff and other prisoners. On 9 April, Mr Rider had a key work session with Officer A. The officer said that Mr Rider felt let down by the system because he had been in prison so long after his original tariff had expired. He encouraged Mr Rider to engage with his POM and other services and made it clear to him that without doing this, he would not be considered for a transfer.

46. We spoke to staff who were working on House Unit 4 during Mr Rider's time there. They all said that Mr Rider's mood was volatile. Sometimes, he had long conversations with officers but on other days, he did not engage or was rude or abusive. They said that Mr Rider engaged with some prisoners who would give him newspapers or vape capsules. He also spoke about his plans for release. Staff on the wing never witnessed Mr Rider being threatened by other prisoners and he told staff that he could "handle" himself and used to box. Staff had no concerns that Mr Rider was a risk to himself and did not notice any deterioration in his mood over the time he was isolating.

47. A Custodial Manager (CM) managed House Unit 4 during the period that Mr Rider was living there. He said that staff consistently tried to encourage Mr Rider to come out of his cell, but he did not want to. The CM spoke about his awareness of the potential effect of isolation on Mr Rider's mental health and what he did to try and address it. This included the offering of showers and exercise without other prisoners and encouraging the use of virtual visits with family and physical visits in a private room. Mr Rider did not take up these offers. The CM also made the decision not to remove Mr Rider's television when his behaviour was poor, given it was one of few activities he had available to him in his cell.

48. A prisoner who lived in the cell next to Mr Rider on House Unit 4 told the investigator that they spoke every day through the pipes in their cells. Mr Rider had told the prisoner that a member of staff had told other prisoners that he was racist when he first arrived in the prison and that was the reason for his isolation. The prisoner never witnessed any prisoners threatening Mr Rider. He said that sometimes, Mr Rider had "down days" but he had no concerns about his wellbeing.

49. On 19 April, prison staff referred Mr Rider to the mental health team under the local Isolating Individuals Policy because they were concerned about his continued withdrawal from the regime. A mental health nurse tried to assess Mr Rider in his cell but he declined to talk to them. They rebooked the assessment for 26 April. Mr Rider said he wanted to try and contact his father and an officer gave him details of the family tracing service.

50. On 20 April, the administrator in the OCA team contacted HMP Manchester to see if Mr Rider could transfer there. On 26 April, a nurse from the mental health team tried to assess Mr Rider again, but he refused to engage with them. During April,

May and June Mr Rider continued to isolate, but accepted his meals and engaged with prisoners and staff from his cell.

51. On 2 May, an officer from safer custody spoke to Mr Rider. She told him about the new Isolating Individuals Policy that the prison had introduced and asked if he wanted to be involved in the creation of his care plan. Mr Rider said he had no specific requests, other than to transfer to another prison. He said he had been let down several times at Woodhill which had caused him to isolate. Mr Rider also said that he wanted to focus on his parole board in June and thought that if he came out of his cell, he might jeopardise this.

52. Mr Rider said that he had received a letter asking for his thoughts about security recategorisation. Prisoners are categorised based on their assessed security risks and are accommodated in prisons that match their security category. They spoke about how this might be a quicker way of getting transferred and the officer encouraged him to contribute to the process but noted that Mr Rider did not seem keen. The officer said that she would see him again after the Safety Intervention Meeting (SIM), at which staff were due to discuss Mr Rider's circumstances. The SIM is a weekly multidisciplinary meeting which prison and healthcare staff attend to discuss prisoners of concern.

53. On 3 May, the administrator contacted Manchester for a decision about Mr Rider's transfer request. They did not accept the request because they were not sure if he really wanted a transfer there and were concerned about his risk to female staff. They told her to contact them again once Mr Rider's parole was complete. A nurse from the mental health team assessed Mr Rider. He expressed frustration with how long he had been in prison and said he did not feel safe on the wing and that was why he was self-isolating. He said he had no thoughts of suicide or self-harm. He also said that he was finding it hard to self-isolate because he had been doing it for nine months. It was affecting his mood, which he rated as a three out of ten.

54. On 4 May, an officer referred Mr Rider to the isolating individuals' scheme formally because staff felt this was more appropriate than Mr Rider being on a CSIP. In the issues log in the weekly multidisciplinary action plan, staff recorded some very brief notes, indicating that Mr Rider had previously used PS in prison, was racist, had trust issues and issues with the offender management unit. The rest of the plan was left blank and there was no detail to explain what action would be taken.

55. On 5 May, an officer noted that although Mr Rider continued to isolate, he had engaged well with staff and had spoken to them about his family, sentence and transfer from Woodhill. The officer praised Mr Rider's new engagement with mental health staff and the offender management unit and recorded that this was a "step in the right direction".

56. On 6 May, a CM chaired a complex case multidisciplinary team (MDT) meeting to discuss Mr Rider's issues, as requested by the SIM. A trainee forensic psychologist and the Mental Health Clinical Lead attended. Mr Rider did not attend. The CM noted that Mr Rider could not transfer from Woodhill because he was within his parole review period. Prison Service policy advises against transfers during this period, during which prisoners should be focused on preparing for their parole, and to ensure that there is no change in the staff contributing to parole assessments. He noted that Mr Rider had taken only two showers since isolating and opted to

wash at his sink but that his cell was clean. He also recorded that Mr Rider was currently on a two person unlock due to threats he had made to staff. Finally, he noted that Mr Rider had made racist comments out of his window. The trainee psychologist confirmed that Mr Rider had refused to engage with the psychology department in the past. The CM noted that he also refused to engage with risk reduction interventions required by his sentence plan, but he would ask education to see him again in case he had changed his mind. They noted that the next complex MDT would be arranged for the end of June.

57. The mental health team discussed Mr Rider later that day. They decided that Mr Rider needed no further input from them. They intended to refer Mr Rider to a GP for assessment because Mr Rider said that he had memory problems after he had had been attacked many years ago. Due to an administrative error, staff did not make the referral.

58. Staff continued to discuss Mr Rider at the weekly SIM and identified actions to be completed such as a referral to the therapy dog and completion of in-cell work. On 8 May, an officer noted that Mr Rider seemed to be in "high spirits" and was interacting well with staff.

59. On 13 May, Mr Rider telephoned his Community Probation Officer (COM). He said that he was going through "hell", felt anxious about his release, could not leave his cell because he did not feel safe and was under threat from Muslim prisoners. He said that his parole hearing would have to be a paper review because he could not go to an oral hearing. Mr Rider also said that his parole hearing should be deferred so that he could be transferred from Woodhill because he was not safe. He said that he was having a mental breakdown, was ready for a hunger strike and had harmed himself at Woodhill. She encouraged him to call her the following week.

60. On 17 May, Mr Rider telephoned his COM. He said that it was "disgusting" that he was still in prison, he had not deserved an indeterminate sentence and that the Governor would be getting "rid of him" but it was unfortunate that he was in his parole window. He said he had no money and no family ties. Mr Rider said that his best friend had hanged himself at HMP Leeds, his life was out of his control, his sentence had ruined his life and there was no hope. She tried to encourage Mr Rider, but he reiterated that he did not feel safe coming out of his cell for video link appointments and his mental health was suffering. He told her that he did not think she was listening to him, and he did not like "people like you".

61. On 19 May, a CM noted that Mr Rider had agreed to start seeing the prison's therapy dog and arranged for them to have contact. Mr Rider had told the CM that he could not work because he was isolating and therefore did not have much money. On 24 May, the CM found some work that Mr Rider could do in his cell, making leaflets. He told Mr Rider that if there was any further work that he could do in his cell, he would give it to him. Mr Rider told him that he no longer wanted to see the therapy dog.

62. On 25 May, the Mental Health Clinical Lead wrote a report about Mr Rider's behaviour since he had been at Woodhill. She noted that he had found it hard to settle and had remained isolated because he felt that it was the best way of keeping out of trouble and avoiding conflict with other prisoners. His relationship with wing staff was volatile but she noted that he had generally been polite in recent months

and seemed comfortable speaking with regular staff. Mr Rider had been referred for a psychological assessment but did not co-operate with them.

63. On 31 May, at 2.30pm, Mr Rider telephoned his COM. He repeated that he could not engage with the parole process. Mr Rider said that Woodhill was "despicable" and he was going "insane". He said that he had written to his solicitor, who he had asked to contact the Parole Board to ask for a deferral. He said that this would allow him to transfer from Woodhill first and improve his state of mind. Mr Rider said that he had given up and would never get released. He also said that he wanted to be transferred to a different probation office, swore at his COM and ended the call.

64. At around 3.00pm, Mr Rider rang the probation office and said that he wanted to make a complaint about his COM. The receptionist was unable to connect him to a manager. He said that he should be under the supervision of Bradford Probation Office and did not like people from North Yorkshire. The receptionist suggested that he should call back the next day, and he agreed to do so. At around 10.00pm, Mr Rider left an abusive and threatening voicemail for his COM and her colleagues at Scarborough Probation Office.

65. On 1 June, the COM wrote Mr Rider's parole report. (The parole board was still due to go ahead at this time.) She wrote that she believed that Mr Rider had unrealistic expectations of her role and thought that she could influence a prison transfer. She noted that Mr Rider was frustrated about his situation and struggled to accept the support he was offered. She concluded that Mr Rider felt he was in a cycle of constant transfers between prisons and would be forgotten. She also noted that Mr Rider was not working with other agencies in prison and had said that he would not work with her until he had been transferred and was safe. He said that he was unsafe due to his conviction for racially aggravated harassment and thought he was at risk of being killed if he left his cell.

66. The COM noted that there were issues with Mr Rider's engagement with his POM and he had been allocated a temporary POM as a result. She noted that Mr Rider was prepared to engage if he felt he would receive something in return. If his needs were not being met, he tended to become verbally abusive. She concluded that she could not recommend Mr Rider's release.

67. On 1 June, Mr Rider telephoned a number ending in 844 and left a voicemail which said, "You are a proper slag" and that a person whom he named (but could not be distinguished) would find out and that he had a picture of them naked too.

68. On 2 June Mr Rider telephoned the number again, on four occasions. The longest of the calls was just 17 seconds and after one of them, Mr Rider left a voicemail which said, "Dirty old slag". The number was registered to someone who was not linked to Mr Rider on prison systems, so we were unable to verify who he was contacting and what their relationship was.

69. A prisoner told the investigator that on around 10 June, Mr Rider had told him that his brother had agreed to send him some money but when he called him back, his brother's partner answered the telephone and told him not to call their number again. These calls are not documented in Mr Rider's prison PIN phone record. The prisoner said that he had no concerns that Mr Rider posed a risk to himself. He

said that since he had been given his parole papers, there had been a "downwards spiral" but then Mr Rider was "alright again".

70. On 10 June, Mr Rider gave Officer A an envelope which he said was full of legal documents and asked him to shred it. The officer put the documents in the confidential waste bin in the wing office.

Events of 13 June

71. At around 7.00am on 13 June, a prisoner said that Mr Rider spoke to him through the pipe connecting their cells, which they did most mornings. The prisoner told Mr Rider that he would speak to him when he returned from work. He had no concerns about Mr Rider, based on their conversation.

72. At around 8.00am, Officer B told the investigator that Mr Rider rang his cell bell. (Woodhill does not have electronic cell bell records so we are unable to verify this.) When she responded, Mr Rider told her that his washing was still outside the cell door of another prisoner who was responsible for doing the laundry. She said that Mr Rider was agitated and said that he was going to "start smashing heads". She spoke to the prisoner responsible for laundry, who confirmed that the washing was being done. She relayed the information to Mr Rider. She said that it was not unusual for Mr Rider to get agitated or make threats when he thought things had not been done according to his timescales.

73. At 9.58am, Mr Rider's key worker, Officer A, made a note of their key work session a couple of weeks earlier. The officer wrote that he had been on leave for eight weeks and Mr Rider had been pleased to see him back at work. Mr Rider had thanked him for helping him before his time off. The officer told the investigator that Mr Rider's priority was a transfer from Woodhill and not his parole. He offered to speak to Mr Rider's POM for an update about the request for a transfer.

74. At around 11.00am, Officer B and Officer C took Mr Rider's lunch to his cell. Officer C said that his cell door observation panel was covered which was not unusual. She said that she could not see through the panel but could see through the crack in his door. When the officers opened his door, Mr Rider pushed it back at them and told them to "fuck off". He said that he did not want his lunch. Officer B said that, again, this was not out of character for Mr Rider, and she had no concerns. She returned a short time later to ask Mr Rider about his meal choices for the next two days and he told her to "put whatever on".

75. At 12.00pm, Officers B and C completed a roll check on the wing. At 12.04pm, CCTV footage shows that Officer C looked into Mr Rider's cell. At interview, she could not recall what she saw. Officer B followed a couple of minutes later and found that part of Mr Rider's observation panel was covered with toilet paper, which she had no concerns about because it was not unusual for him. She said that she could see down one side of the toilet paper but could not recall where Mr Rider was in his cell or what he was doing. She said that he responded to her when she called his name.

76. Officer D started her shift on the wing at lunch time. During the shift handover, other officers said that Mr Rider had been a bit "grumpy" that morning. Mr Rider's cell was not due to be unlocked that afternoon because prisoners who wanted to

exercise had already done so that morning. Officer C did not think that Mr Rider had been offered exercise that day because he was in a bad mood, and it often aggravated his mood further if officers disturbed him. This meant that no one was expected to check on Mr Rider after lunch.

77. At around 3.30pm, a prisoner asked Officer D if she could give Mr Rider some vape capsules, which was not unusual. She thought that running out of capsules might have been the reason why Mr Rider was in a bad mood.

78. At 3.37pm, Officer D went to Mr Rider's cell door, knocked on it and looked through the observation panel which was still covered with toilet roll. She opened the cell door, intending to put the vape capsules in the sink, which was next to the door. She saw Mr Rider kneeling and facing the window, away from her. Initially, she thought that Mr Rider was praying, but then noticed that he had tied a ligature made of bedsheets to the light fitting and that his knees were not touching the floor. She knew that Officer C was nearby, so shouted for her and then thought that she radioed a medical emergency code blue (indicating that a prisoner is not breathing or is having difficulty breathing). However, the code blue was not broadcast on the radio.

79. Officer C heard Officer D's call for help and made her way to Mr Rider's cell. Officer D waited until she could hear Officer C running towards the cell before she went in, in case of any risks to her safety. This took approximately 15 seconds after she had first opened the door. Officer D got her anti-ligature knife out of her belt and tried to support Mr Rider while cutting it but could not do so and did not want to injure him further by not supporting him properly.

80. Officer C arrived at the cell and radioed a code blue. The code was broadcast, and the control room called for an ambulance. She shouted for further help from another officer, who was in the wing office at the time. Officer D asked someone to help her support Mr Rider. A prisoner saw what was happening and went into the cell.

81. The prisoner supported Mr Rider's weight while Officer D cut down the ligature. Mr Rider fell to the floor and the prisoner and other staff turned him onto his back. The prisoner said that Officer D was having difficulty cutting the ligature from Mr Rider's neck, so he took the anti-ligature knife from her and cut it off. Officer D gave a different account, that the ligature was still tight around Mr Rider's neck, and she had difficulty cutting it off, so the prisoner assisted her while she held the knife.

82. Officer E entered the cell soon afterwards and checked if Mr Rider had a pulse. The prisoner said that Mr Rider was dead. A Supervising Officer (SO) arrived at the cell and assessed Mr Rider for signs of life. Officer E began chest compressions. Officer C took the prisoner back to his cell.

83. A nursing associate and a nurse were working on another wing when they heard the code blue. The nursing associate fetched a small emergency response bag and went to Mr Rider's cell immediately when she heard the code blue. She arrived at the cell around a minute after Officer D had found Mr Rider and checked his airway, which was clear. She confirmed that there were no signs of life. The nurse arrived soon after and the nursing associate told him to get the bigger emergency response

bag, including a defibrillator. The defibrillator was collected quickly and attached to Mr Rider.

84. At 3.58pm, paramedics arrived and took over resuscitation efforts from prison staff. At 4.31pm, paramedics pronounced that Mr Rider had died.

85. Later that evening, staff submitted a security report which noted that in the morning, Mr Rider had told a prisoner that he wanted to take his own life, but the prisoner did not think that he was serious. The prisoner told the investigator that this conversation did not happen.

86. After Mr Rider's death, Officer A retrieved the envelope that he had placed in the confidential waste for Mr Rider on 10 June, in case it contained a note that Mr Rider had wanted someone to see after his death. The envelope contained Mr Rider's parole documents.

Contact with Mr Rider's family

87. Two CMs were allocated as family liaison officers and were responsible for notifying Mr Rider's next of kin of his death and providing ongoing contact after his death. At 6.15pm, they left Woodhill to travel to Mr Rider's father's address. They arrived at 9.00pm, but there was no answer. A neighbour told them that Mr Rider's father no longer lived there. They went to Mr Rider's brother's address but were told that he no longer lived there. They tried to contact Mr Rider's brother by telephone but were unable to do so and returned to Woodhill at 1.00am on 14 June. Later that day, they telephoned Mr Rider's brother and his sister, but there was no reply. One CM telephoned Mr Rider's probation office, but they had no next of kin details for Mr Rider. He then telephoned Mr Rider's solicitor and the police, who provided addresses for Mr Rider's father and brother. Another member of staff contacted HMP Durham, which was closer to Mr Rider's father's address, to arrange for them to let him know.

88. On 15 June, staff from HMP Durham went to Mr Rider's father's address. They told Mr Rider's father that his son had died and offered their condolences. Mr Rider's father did not want any further support. He said that he would contact Mr Rider's sister to let her know.

89. On 20 June, Mr Rider's sister called the prison and said she wanted to be involved in his funeral arrangements. A CM called her the following day and she said she was happy for the prison to arrange Mr Rider's funeral, which they did.

Support for prisoners and staff

90. After Mr Rider's death, a governor held a debrief for the staff involved in the emergency response. She gave them the opportunity to discuss any issues arising and offered support. The staff care team were also available.

91. Officer C shared concerns that staff involved in the emergency response were expected to work the day after Mr Rider's death. She did not think that this was a supportive approach. She said that she was offered a counselling session but her request for a change to the time had not been responded to at the time of our

interview. Officer C also asked to work on a different wing for a few days after Mr Rider's death, but this request was not actioned.

92. All other staff said that they had felt appropriately supported after Mr Rider's death.

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

Post-mortem report

94. The pathologist concluded that Mr Rider had died from hanging. No alcohol or illicit drugs were detected in Mr Rider's system.

Findings

Assessment and management of risk

95. Prison Service Instruction (PSI) 64/2011 on safer custody lists risk factors and potential triggers for suicide and self-harm. It requires that staff are aware of these risk factors and the increased risk of suicide and self-harm they pose, and that they manage any prisoner identified as at risk of suicide and self-harm under ACCT procedures. PSI 64/2011 states that any information that becomes available which may affect a prisoner's risk must be recorded and shared to inform proper decision-making.

96. Mr Rider had most recently been subject to ACCT support for around two weeks in August 2021. He did not share any information that suggested he was in crisis but isolated himself for most of his time at Woodhill. His behaviour demonstrated that he was finding things difficult. Staff noted their concerns and put steps in place to mitigate this. Mr Rider acknowledged the impact of his self-isolation on his mood when a mental nurse assessed him in May 2022. However, he also consistently said that he had no thoughts of suicide or self-harm.

97. Mr Rider was one of many IPP prisoners struggling to progress in his sentence and with limited hope for release. When we listened to Mr Rider's telephone conversations with his COM, he appeared to lack any interest or engagement in preparing for his upcoming parole board. He was preoccupied with being transferred to another prison in Northern England and prioritised this over his sentence plan. We now know that he asked for his parole dossier to be disposed of a few days before his death.

98. Mr Rider clearly struggled to engage with staff and other prisoners and was often abusive towards them, although he developed some relationships and engaged with some opportunities such as his key work sessions with Officer A, with whom he seemed to develop a trusting relationship.

99. A prisoner who lived in the cell next to Mr Rider told us that on around 10 June Mr Rider received a call from his brother's partner, asking for him to stop contacting his brother. We were unable to verify this because there was no record of the call on Mr Rider's phone.

Self-isolation

100. PSI 64/2011 requires that staff engage with prisoners who withdraw from the regime to encourage their participation and reduce their risk of social isolation.

101. Woodhill's local Isolating Individuals Policy was introduced in March 2022 following an increase in this behaviour at the prison. The policy highlights the importance of staff understanding why a prisoner is isolating and implementing an action plan in consultation with them to encourage an end to their isolation. For example, this may include offering the prisoner showers or exercise at times when other prisoners were not present, considering wing transfers and discussing actions at the weekly SIM. The policy requires that when a prisoner starts isolating, a supervising officer speaks to them, establishes the causes for isolation, refers them to the safer

custody department and completes a residential monitoring plan. Wing staff should update this plan daily. Supervising officers should check on isolating prisoners weekly and conduct a weekly multidisciplinary review. The policy also advises that staff should consider providing distraction materials, access to Listeners (prisoners trained by the Samaritans), in-cell education and referrals to the mental health team.

102. On 20 July 2021, staff put a CSIP in place for Mr Rider. The process involves the setting of individualised targets that prison staff review regularly. In April 2022, staff referred Mr Rider to the mental healthcare team under the Isolating Prisoners Policy when they had concerns about his withdrawal from the regime and lack of engagement with staff and prisoners. At the beginning of May, Mr Rider moved onto the Isolating Individuals Policy formally, when staff felt that this was more appropriate than a CSIP for managing his risks.

103. The root cause for Mr Rider's isolation appears to have been that he felt at risk of violence from other prisoners because he considered that they thought that he was racist. On 17 August excrement was squirted into Mr Rider's cell. He told the Prison Reform Trust that urine had been squired into his cell on 29 September. Staff monitored Mr Rider under ACCT procedures after this event and moved him to another unit, to manage the impact on his wellbeing. They also used a CSIP to manage the risk of Mr Rider being under threat.

104. Staff believed that Mr Rider was isolating himself to try and obtain a transfer to another prison. We agree that he seemed preoccupied with the chance of moving to another prison and note that transfers were requested for several prisons, but were not accepted because of his history of poor behaviour and later because he was within the parole window.

105. CSIPs and Isolating Prisoners Policy Plans have different purposes. The CSIP put in place between July 2021 and May 2022 monitored the risk of violence that Mr Rider reported from other prisoners which was the reason for his self-isolation. CSIPs are not designed to support prisoners who isolate and the impact on their wellbeing. However, other support systems were put in place to monitor this and encourage his engagement with staff and the regime before the Isolating Individuals Policy was introduced and Mr Rider was moved onto it. These included ACCT monitoring in August, a referral to the mental health team and attempted assessments, SIM and MDT meetings and other ad hoc support such as distraction packs, contact with a therapy dog and the offer of in-cell employment where possible. Staff also offered Mr Rider the opportunity to exercise and shower on his own.

106. Mr Rider's needs were complex and staff at Woodhill had to respond to the risk he posed to others and the risk he posed to himself. Mr Rider isolated himself for over nine months before he died. This was a significant period and would have impacted on his mental health. He could be abusive to staff but also had some positive interactions with individuals and engaged with the mental health assessment on 3 May. We recognise that for some individuals, isolation and abusive behaviour may be forms of self-harm or signs of crisis but this can be very difficult to determine. In Mr Rider's case, staff used the appropriate processes: ACCT, CSIP and an Isolating Individuals Plan to address the short-term and long-term risk factors. To some extent, the SIM and MDT meeting discussions held to discuss Mr Rider's care

ensured that overlapping issues were considered and that his care was considered more holistically. We were pleased to see that there was input by the psychology and mental health teams in these discussions. While Mr Rider's self-isolation and abusive behaviour towards staff were identified as concerning, these were relatively consistent patterns of behaviour. There was no obvious deterioration or change that signalled crisis or an imminent risk. We found that staff were taking action to support Mr Rider with a range of processes and resources to effect longer term change, because there was no single process that applied. We are also conscious that the reality of the prison workforce does not always allow for consistency in staffing on residential wings or for key work, which might have had an impact on his ability to build trust and open up to staff.

107. Overall, we consider that Mr Rider was generally well supported. However, we found that the Isolating Prisoners Plan put in place for Mr Rider lacked detail and forward planning in some areas. The initial plan contained very few details about the issues that had been identified and did not address how staff would encourage Mr Rider to end his self-isolation. There is no evidence that wing staff contributed to the plan on a daily basis or that a supervising officer reviewed it weekly. We found no evidence that these factors impacted on the outcome for Mr Rider, but they might impact on future outcomes. We make the following recommendation:

The Governor should ensure that plans for isolating prisoners contain detailed information about identified risks and agreed actions to reduce or end isolation, and that prison staff regularly review them and ensure that any changes are recorded and actioned.

Meaningful contact

108. Staff attempted six key work sessions with Mr Rider at Woodhill. The first three were with different officers. He refused to engage in one of them and for another, he did not answer the telephone. In March 2022, Officer A asked to become Mr Rider's key worker because of the relationship they had started to build. We were pleased to see this proactive approach to key work for an individual with complex needs and who had difficulty engaging with staff. Unfortunately, there was a break in Mr Rider's key work due to the officer taking unexpected leave between April and June, but he contacted Mr Rider as soon as he returned and assured him that he was taking his concerns seriously. Mr Rider was thankful for the officer's support, and we commend his proactive approach at a time when key work was not being delivered for the vast majority of prisoners due to the COVID-19 pandemic.

109. Despite the limited key worker sessions, staff had a positive and proactive attitude towards Mr Rider. They were consistent in trying to engage him throughout his time on House Unit 4 and were conscious of the impact of self-isolation on his wellbeing.

110. The Governor told the investigator that, on average, Woodhill was short-staffed by at least 45% at officer grade. The prison had been categorised as a "red plus site" for staff shortages which meant that officers were given some additional pay to attract them to the role. However, there was also a shortage of experienced staff at SO grade, for which there was no extra pay as an incentive.

111. HMPPS has recently agreed to close Woodhill's separation centre and move the witness protection unit to help address some of the staffing pressures. Woodhill

also uses a lot of staff on detached duty (officers temporarily working at Woodhill from another prison) to help tackle the problem in the shorter term.

112. The Governor told us that key work had been affected by staff shortages and was not happening for the vast majority of prisoners during Mr Rider's time at the prison. She had prioritised the 54 most vulnerable prisoners at the time, in line with the national Exceptional Delivery Model that was in place due to the pandemic. She said that HMPPS were aware of the issues and had sent a coaching team to Woodhill to develop and assist staff. She said that it was incredibly difficult operating the prison with such low staffing levels and with lots of very inexperienced staff. HMIP and IMB also found that these issues were central to Woodhill's difficulties.

113. We are very concerned about the low staffing levels at Woodhill, which impacted on Mr Rider's meaningful contact and continue to affect the prison. The Governor was unable to run a meaningful and decent regime, and in turn, the availability and lack of consistency of key workers affected Mr Rider's care. HMPPS rolled out the key worker scheme to improve safety in prisons and we are concerned that Woodhill cannot reasonably deliver it because of the lack of staff. We note the additional support that HMPPS has provided but consider that more should be done to support the prison. We make the following recommendation:

The Director General of Prisons and MoJ People Group should consider what additional support can be put in place to address the significant staff shortages at Woodhill and consider how it can reasonably be expected to deliver key work in these circumstances.

Clinical care

114. The clinical reviewer concluded that Mr Rider's physical healthcare was of a good standard and at least equivalent to that which he could have received in the community. Mr Rider's mental healthcare was partially equivalent to that which he could have expected to receive in the community.

115. Following a mental health meeting, Mr Rider was supposed to be referred to a GP for a memory assessment. The referral never took place due to an administrative error. A nurse said that she now undertakes a weekly audit to ensure that these referrals take place as they should. We note the clinical reviewer's recommendation about this process. The Head of Healthcare should ensure that such referrals are being processed consistently and appropriately in future.

116. The mental health team did not see Mr Rider between 6 May 2022 and 13 June 2022, during which he continued to self-isolate. A nurse said that the mental health team does not routinely monitor prisoners who are self-isolating, but a referral can be made to the mental health team if there are any mental health concerns. Despite this, the clinical reviewer concluded that this was a lapse of care of monitoring prisoners whose mental health might be at risk of deterioration. They noted that safer custody staff are not qualified mental health practitioners and may not be aware of the signs of relapse of mental ill health. They therefore concluded that this process should be reviewed. We make the following recommendation:

The Head of Healthcare should ensure that the mental health team offers routine reviews of all isolating prisoners, even if they are not engaging, to ensure that their mental health is appropriately monitored.

Covered observation panels

117. At 11.00am, officers saw that Mr Rider had blocked his cell door observation panel. However, Officer C said that she could still see through the crack in his door. At 12.00pm, Officer B said that Mr Rider's observation panel was blocked but she could see down the side of it. At 3.30pm, Officer D said that Mr Rider's observation panel was blocked, so she opened the cell and found Mr Rider hanging. Mr Rider was never challenged about his blocked observation panel.

118. Officer C said that she had challenged prisoners on some occasions, but that the rules were hard to enforce, and prisoners continued to cover them. She estimated between 10-15 out of 60 cells had blocked observation panels at any one time. However, she said that on other wings where she had worked, this number was much higher.

119. While we recognise the challenges in addressing this issue, we are concerned that this has become commonplace in some parts of Woodhill and may affect the prison's ability to monitor prisoners' safety and security. Staff must challenge prisoners who cover their panels and, if they are not responding, request emergency assistance. We make the following recommendation:

The Governor should ensure that all staff respond appropriately to blocked cell door observation panels to ensure prisoner security and safety, and that managers support staff to enforce this.

Emergency response

120. When Officer D found Mr Rider hanging, she shouted to an officer nearby and waited until she could hear them running towards her before she went in. She told us that this was following a 'dynamic risk assessment' which took into account the risk to her own safety. This was because she knew that Mr Rider had previously assaulted staff and had, at times, been rude and abusive towards her. She was concerned that the ligature might not have been genuine. This resulted in a delay of a few seconds, and, in the circumstances, we consider that her actions were appropriate.

121. Officer D thought that she had radioed a code blue before going into Mr Rider's cell. This was not transmitted, and we are unable to verify the reason for this. However, another officer transmitted the code blue within seconds after realising this and we are satisfied that there was no notable delay caused that impacted on the emergency response. We recognise that finding Mr Rider in these circumstances would have been traumatic for the officers involved who might have gone into shock.

122. We would also like to highlight the contribution that a prisoner made to the emergency response, which again must have been very difficult in the

circumstances. He provided support to officers with the intention of saving another prisoner's life.

Support for staff after Mr Rider's death

123. Officer C shared her concerns with us that staff involved in the emergency response were expected to work the day after Mr Rider's death and that although she was offered a counselling session, she had asked for a change to the time, but this had not been actioned at the time of our interview. She had also asked to work on a different wing for a few days after Mr Rider's death, but this request was not addressed. While we do not make a recommendation about this as all other staff said that they had felt appropriately supported and we are pleased that a debrief was held and support offered after Mr Rider's death, we draw these concerns to the Governor's attention.

Inquest

124. The inquest concluded the cause of Mr Rider's death was hanging.

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