Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Robert Fenlon, a prisoner at HMP Woodhill, on 5 March 2016

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.

If my office is to best assist His Majesty's Prison and Probation Service (HMPPS) in ensuring the standard of care received by those within service remit is appropriate, our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.

Mr Robert Fenlon was found hanged in his cell at 10.45am on 5 March 2016 at HMP Woodhill. He died later that day at Milton Keynes General Hospital. He was 35 years old. I offer my condolences to Mr Fenlon's family and friends and my sincere apology for the very long time it has taken to produce this report. My investigation was initially delayed successively at the request of the police, then awaiting the CPS decision and the subsequent appeal. There was then a significant delay in resuming our investigation.

Our investigation has found that suicide and self-harm prevention processes (known as ACCT) at Woodhill were, at the time of Mr Fenlon's death, poorly managed.

There were missed opportunities by both officers and nursing staff to refer Mr Fenlon to mental health services despite a clear decline in his mental health.

An inspection by His Majesty's Chief Inspector of Prisons in August 2023, and subsequent issuing of an Urgent Notification to the Secretary of State, has served to highlight that there are clearly ongoing issues at Woodhill in a number of areas including safety.

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

Adrian Usher
Prisons and Probation Ombudsman **January 2024**

Contents

Summary

Events

1. Mr Robert Fenlon was remanded to HMP Woodhill on 15 October 2015, charged with burglary. Mr Fenlon had been to prison before and had a history of drug and alcohol use and mental health issues. Mr Fenlon had no recorded incidents of self-harm or thoughts of suicide during previous periods in prison and had not been monitored under Prison Service suicide and self-harm prevention procedures (ACCT).

2. On 21 October, a member of staff referred Mr Fenlon to the mental health team after Mr Fenlon said that he had a history of mental health problems, multiple personality disorders and experiencing bizarre thoughts about others hurting him. The referral was triaged the following day and the nurse concluded that Mr Fenlon would not be accepted onto the caseload at that time, as he was not considered to be displaying behaviours which required further assessment by the mental health team.

3. At 5.55pm on 26 February, Mr Fenlon pushed a note under his cell door which said that he was having thoughts of self-harm due to struggling on the wing. Staff started ACCT procedures. On 27 February, a case review assessed his needs and recorded that he said he was waiting for an appointment with the mental health team, that he felt unsettled on the wing, and was paranoid regards others hurting him. It was recorded that he should continue to engage with staff. He was checked once an hour.

4. On 2 March, prison staff reviewed Mr Fenlon's ACCT. No one from the healthcare team attended. During the review, Mr Fenlon said that he felt unsafe on the wing and was concerned about attending court the following day, as he thought he would be assaulted. Mr Fenlon also told staff that he was concerned that other prisoners thought he was in custody for sexual offences. The ACCT document remained open and observation levels remained unchanged. The caremap was not updated.

5. On 3 March, staff found Mr Fenlon with a ligature around his neck. A nurse reviewed him, and it was recorded that he had 'deep welts' around his neck. Staff increased Mr Fenlon's observations to two per hour but did not conduct a formal case review as they should have done.

6. At 9.30am on 4 March, Mr Fenlon told an officer that he was feeling suicidal, the officer said that they would try and contact someone from the mental health team, but no further actions were taken. At 12.25pm, Mr Fenlon pressed his cell bell and when staff answered, Mr Fenlon was extremely distressed. He told staff that he was going to kill himself but had 'wimped out'. When staff checked on him again at 12.40pm, Mr Fenlon had made a ligature and tied it to the window. Staff entered the cell and removed the ligature. The wing Supervising Officer (SO) spoke to Mr Fenlon at around 2.00pm. The SO incorrectly recorded the conversation as an ACCT review. The SO did not increase the frequency of checks, consider that Mr Fenlon was at an increased risk of suicide or conduct a formal case review.

7. At approximately 10.45am on 5 March, an officer went to check on Mr Fenlon and found that his observation panel was covered. The officer sought help from her colleagues, and they entered the cell and found Mr Fenlon suspended with a ligature around his neck, attached to the window. Staff called a medical emergency code, cut the ligature and started cardiopulmonary resuscitation (CPR). Nursing staff attended and took over CPR until paramedics arrived at approximately 11.00am. Mr Fenlon was transferred by emergency ambulance to hospital at 11.55am. He died at 8.14pm.

Findings

Management of ACCT /Assessment of risk

8. ACCT case reviews were not multidisciplinary. The majority of reviews involved only the wing Supervising Officer (SO). Healthcare staff did not attend any of the reviews and no attempts were made to seek engagement from the mental health team, despite the documented concerns about Mr Fenlon's mental well-being. There were no reviews following a deterioration in Mr Fenlon's mental well-being and increased risk and without these case reviews there could be no way to have adequately determined the most appropriate level of observations to safeguard Mr Fenlon.

9. Although the caremap was completed and indicated that Mr Fenlon was awaiting an appointment with the mental health team, there was no evidence that anyone followed this up or sought confirmation that an appointment had been scheduled and had this been the case, staff would have identified that no appointment was pending. There were no other caremap actions recorded to offer support to Mr Fenlon during his period of crisis.

10. Based on the documentary evidence and the statements shared by Thames Valley police, the investigation concluded that at that time, HMP Woodhill failed to appropriately act on the increased risk Mr Fenlon posed to himself. We conclude that ACCT procedures in place at that time were not followed and were poorly managed.

Healthcare

11. The clinical review concluded that the physical and mental health care Mr Fenlon received at Woodhill was not equivalent to what he could have expected to receive in the community. There were two missed opportunities for the primary care team to refer Mr Fenlon to the mental health team, on 28 February 2016 and 3 March 2016. The clinical reviewer also noted that healthcare staff did not attend any of Mr Fenlon's ACCT reviews as they should have done.

The Investigation Process

12. On 8 March 2016, HMPPS notified us of Mr Fenlon's death.

13. The investigator issued notices to staff and prisoners at HMP Woodhill informing them of the investigation and asking anyone with relevant information to contact him. He received two letters from prisoners that knew Mr Fenlon and shared their knowledge of him.

14. The investigator visited HMP Woodhill on 16 March 2016. He obtained copies of relevant extracts from Mr Fenlon's prison and medical records.

15. NHS England commissioned a clinical reviewer to review Mr Fenlon's clinical care at the prison. The review was subsequently re-assigned and completed by another investigator.

16. The case was suspended while we waited for the outcome of the police investigation into individual staff actions and possible charges of misconduct in a public office. A file was submitted to the Crown Prosecution Service (CPS) and the investigation remained suspended while this was reviewed. In April 2019, we were informed that the CPS had concluded that the threshold for criminal charges had not been met and therefore no charges against staff at Woodhill would be brought. The PPO investigation remained suspended as Mr Fenlon's family sought a Victims Right of Review and issued judicial review proceedings in the High Court. In December 2021 we were notified that the judicial review into the decision made by the CPS had found in favour of the CPS and our investigation could resume.

17. The investigator and a colleague met with the Governor at HMP Woodhill again on 16 May 2023. Thames Valley police provided us with the statements taken from all those involved with Mr Fenlon's care in 2016 to assist with completing this report.

18. We informed HM Coroner for Milton Keynes of the investigation. The Coroner informed us that no post-mortem was completed for Mr Fenlon.

19. At the outset of the investigation, the Ombudsman's family liaison officer contacted Mr Fenlon's family to explain the investigation and to ask if they had any matters, they wanted us to consider. Contact with the family was then taken over by the police during their investigation. The Ombudsman's family liaison officer has since had contact with the legal team representing Mr Fenlon's family.

20. An inquest held on 15 – 26 April 2024 into the circumstances of Mr Fenlon's death, gave a verdict of 'unlawful killing contributed to by neglect.'

Background Information

HMP Woodhill

21. HMP Woodhill is in Milton Keynes. In addition to its role as a category B training prison, it holds several category A prisoners on remand and operates several specialist units, making it a complex and high-risk institution for just over 600 male prisoners. Central and North-West London NHS Foundation Trust provides health services at the prison.

22. Until 2019, the main function of Woodhill was as a core local prison holding adult male prisoners on remand, those sentenced to less than 12 months from the southeast Midlands, some young offenders, and some category A prisoners. It also received category B and C prisoners for their last period of custody for resettlement purposes before release to their local area. It also held restricted status young prisoners (under 21), and provisional category A prisoners from across the Midlands. From late summer 2019, the prison was re-rolled to a training prison holding long-term category B prisoners serving sentences of four or more years. The prison also holds a small number of category A prisoners on remand and attending trial.

HM Inspectorate of Prisons

23. Following an unannounced inspection at HMP Woodhill in September 2015, inspectors commented that previous inspections of HMP Woodhill had repeatedly raised concerns about the prison and, in particular, weaknesses in the support of prisoners at risk of suicide or self-harm and the poor provision of purposeful activity. This inspection found real improvements had been made. Staffing levels were better than often found elsewhere, although heavily reliant on detached duty and new recruits, and the prison's leadership was effectively tackling some deep-rooted problems. Nevertheless, there was more that still needed to be done to reduce the likelihood of further self-inflicted deaths.

24. Following an unannounced inspection in February 2018, the Chief Inspector said that the previous inspection had expressed some optimism about the direction the prison was taking but was critical of the prison's approach to the issues of suicide and self-harm prevention, identifying several areas where improvement was required. This inspection showed that overall outcomes for those detained were decidedly mixed. There was no doubt that some very good work was being undertaken at Woodhill, but the inspection recorded quite significant deterioration in the areas of safety and activity, and judged outcomes for prisoners to be poor in both.

25. There was another unannounced inspection of HMP Woodhill in September 2021. Inspectors reported that the findings of the inspection were disappointing. As in 2018, outcomes in safety and purposeful activity were poor, while outcomes in respect and rehabilitation and release planning had deteriorated and were now not sufficiently good. Against nearly all the main measures, the prison was not safe enough. Violence was higher than comparable prisons; use of force, though mostly

legitimate, was also high; use of segregation was considerable; and there had been seven self-inflicted deaths since the last inspection. Self-harm was also high.

26. A progress visit by inspectors in June 2022, found that HMPPS had taken important steps to support local leaders and it was clear that recruitment and retention was now a fundamental strategic priority. A whole series of support measures had been introduced or were in development, but external forces and the relative affluence of the local area were having a serious impact on leaders' ability to recruit and retain staff. Indeed, the staffing position was no better than it had been at the time of the inspection, with as many staff leaving the prison as joining.

27. Following a further inspection between 14-25 August 2023, the Chief Inspector of Prisons issued an Urgent Notification to the Secretary of State, highlighting serious concerns. The urgent notification noted that:

- 71% of prisoners felt unsafe and 26 were found to be self-isolating for fear of their safety.
- Rates of self-harm were the highest in the adult estate.
- Illicit drug use was a serious problem.
- Lack of access to basic amenities was not being addressed.
- Cell bells were left unanswered for long periods.
- Relatively inexperienced staff lacked confidence and were not properly supported to challenge poor behaviour.
- Bullying and intimidation by prisoners was widespread.

The Chief Inspector noted that the chronic staff shortages remained at the heart of the prison's problems.

Independent Monitoring Board

28. 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 their report for the year to May 2016, the board commented that the number of ACCTs opened over the reporting period was 796 compared with 444 the previous year, a very significant increase. At one stage during April 2016, there were 71 ACCTs open, representing nearly 10% of the prison's population. This added considerably to the workload of wing staff. Most of the ACCTs were opened in Reception and House Unit 1B, the First Night and Induction Unit. The Board believed the rise was linked to an understandable response to the increase in the numbers of deaths in prison.

29. Throughout the year, additional training was held in an effort to improve the quality of the input into ACCT documents and for staff to identify prisoners at risk at the earliest possible stage. This training was ongoing and involved all levels of wing, support and management staff. Despite these measures, the Board continually raised concerns about inconsistencies in the quality of entries and poorly managed

care plans. In September 2015, the Safer Custody meeting was still reporting poor quality ACCT documents with the closure process not being well documented. A new 48/72-hour quality assurance check was introduced to address these shortcomings.

30. In its latest annual report, for the year to May 2022, the IMB reported that staffing levels and staffing confidence were a significant concern to them because of their impact on the delivery of the regime. Projections showed that Woodhill would continue to lose staff faster than could be recruited for the foreseeable future. Evidence from rota visits indicated that ACCT documents were by and large up to date, although the quality of the comments and interactions with the men varied widely, with some comments showing a clear understanding and concern for the prisoners in care whilst others could best be described as 'satisfying' the requirements to fill in the paperwork.

Previous deaths at HMP Woodhill

31. Mr Fenlon was the sixteenth prisoner to die at Woodhill since May 2013, twelve of the previous deaths were self-inflicted. Since then, a further twenty-eight deaths have occurred, fourteen of these were self-inflicted.

32. From 2013, we identified issues with ACCT procedures in eight investigations and made recommendations accordingly prior to Mr Fenlon's death. Since March 2016 we have made recommendations about ACCT procedures and management in a further seven investigations up to 2020. Since January 2021, we have identified no issues with ACCT in a further four investigations.

Assessment, Care in Custody and Teamwork

33. ACCT is the Prison Service care-planning system used to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk, how to reduce the risk and how best to monitor and supervise the prisoner.

34. After an initial assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. Checks should be irregular to prevent the prisoner anticipating when they will occur. There should be regular multi-disciplinary review meetings involving the prisoner. As part of the process, a caremap (plan of care, support, and intervention) is put in place. The ACCT plan should not be closed until all the actions of the caremap have been completed.

35. All decisions made as part of the ACCT process and any relevant observations about the prisoner should be written in the ACCT booklet, which accompanies the prisoner as they move around the prison. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

Key Events

36. On 15 October 2015, Mr Robert Fenlon was remanded to HMP Woodhill, charged with burglary. Mr Fenlon had spent time in prison on several occasions and had a history of drug and alcohol use. During previous periods of prison custody, he had received treatment for his addictions. He had also engaged with prison mental health teams and, on his release from HMP Ranby in June 2013, was referred to the community mental health team. Mr Fenlon was last released from Woodhill in October 2014. Mr Fenlon had an entry from July 2012 made at Ranby, which indicated that he had used a ligature in 2004, but he had no recorded incidents of self-harm or thoughts of suicide during previous periods in prison and had not been monitored under ACCT procedures.

37. On his arrival at Woodhill, a nurse completed Mr Fenlon's initial health screen. She recorded that Mr Fenlon was currently in receipt of 30mg of methadone daily and was dependent on opiates and alcohol. The screening recorded that Mr Fenlon had spent time in a psychiatric hospital in Northampton in 2002. Mr Fenlon told her that he had no thoughts of harming himself, but had a diagnosis of depression, and was struggling due to the death of his mother a few months earlier. She referred Mr Fenlon to the GP and prison drug services.

38. During his first night interview, Mr Fenlon told staff that he had been at Woodhill several times before, knew what to expect and had no issues. A GP at the prison also saw Mr Fenlon that evening and recorded his drug history, and that Mr Fenlon had a diagnosis of anti-social behavioural disorder. The GP recorded that Mr Fenlon had no other mental health issues and was not on any regular medication, other than methadone. He recorded that Mr Fenlon looked well and had no other issues; he also referred Mr Fenlon to drug services.

39. On 16 October, a nurse practitioner completed a drug treatment assessment with Mr Fenlon. Nursing staff also completed a second day interview and a secondary health screen and recorded no issues. Mr Fenlon denied any thoughts of suicide or self-harm.

40. On 19 October, a GP at the prison saw Mr Fenlon to discuss his drug treatment. Mr Fenlon told her that he had been chewing Fentanyl patches on a daily basis for the past six weeks and had been on and off heroin. Mr Fenlon said that he had been hospitalised a week prior to custody after an overdose but had left the hospital against medical advice. She recorded that Mr Fenlon would be stabilised on 40mg methadone and reviewed on 3 November.

41. On 21 October, a resettlement co-ordinator referred Mr Fenlon to the prison's mental health team. Mr Fenlon told her that he had been admitted to a psychiatric ward in 2001 and was suffering with multiple personality disorders. Mr Fenlon said that he often had 'bizarre' thoughts about other people, often about them hurting him. She recorded that Mr Fenlon was currently detoxing and that he had told her that he had used drugs and alcohol to cope and manage these thoughts.

42. The referral was triaged on 22 October, by a community mental health nurse. She recorded that Mr Fenlon was not presenting as requiring further assessment at that time and would therefore not be added to the MH caseload. However, she recorded

that a referral would be accepted if there were any further changes in his presentation.

43. Between October 2015 and February 2016, prison GPs continued to see Mr Fenlon and reviewed his progress on the detoxification programme. One GP also prescribed citalopram (antidepressant) and propranolol (used to treat anxiety) following a review in November 2015. During the review, Mr Fenlon denied any suicidal thoughts but told the GP that he had previously suffered panic attacks and periods of anxiety.

44. On 6 January, Mr Fenlon gained employment as wing painter.

45. On 20 February, an officer submitted an intelligence report (the investigation has been unable to identify the author) that Mr Fenlon reported that he was under threat from other prisoners on the wing, whom he named, and he believed that other prisoners thought he was in prison for sexual offences, and he was in debt.

46. On 21 February, an officer spoke to Mr Fenlon and told him that his work on the wing had fallen below the standard expected of him. He also challenged Mr Fenlon about passing items for other prisoners from cell to cell when he was unlocked. The following day, the officer challenged Mr Fenlon again when he observed him going to other prisoners' doors and instructed him to return to his own cell. He recorded that Mr Fenlon became argumentative and aggressive when given this instruction. Later that afternoon, Mr Fenlon spoke to another officer and asked her to remove his television from his cell, so he did not smash it. She removed the television and during the afternoon offered to return it to Mr Fenlon, but he declined. She recorded that Mr Fenlon was 'having a bit of a sulk'.

47. At 5.55pm on 26 February, Mr Fenlon pushed a note under his cell door, which was found by an officer. In the note, Mr Fenlon said that he was having thoughts of self-harm due to struggling on the wing. The officer started ACCT procedures. Supervising Officer (SO) 1 carried out an assessment with Mr Fenlon on 27 February. Mr Fenlon told the SO that he was struggling with paranoid thoughts but had written the letter at a 'low point' and had no current thoughts of self-harm. The SO asked Mr Fenlon about his current location and Mr Fenlon said that he had spoken to a wing manager about a possible move for his own protection, but he no longer wanted this as he was fearful of being identified as a vulnerable prisoner. The SO said that although Mr Fenlon denied any current thoughts of self-harm, he felt that the ACCT was needed to provide Mr Fenlon with additional support and fed this back to SO 2, who was to complete the ACCT review.

48. SO 2 chaired the ACCT review, which was also attended by SO 1 and Mr Fenlon. No other staff were present. The SO recorded that Mr Fenlon presented as paranoid and worried about his court appearance. Mr Fenlon said that while he had no current thoughts of self-harm, this often changed. She spoke to Mr Fenlon about moving to a different wing, but he declined. Mr Fenlon told her that he had seen the GP and was awaiting an appointment with the mental health team. She updated Mr Fenlon's ACCT caremap to indicate that he was awaiting an appointment with the mental health team, that he felt unsettled on the wing and that he should engage with staff. The ACCT remained open with hourly observations. There is no evidence that she contacted anyone from the mental health or primary care teams to confirm that Mr Fenlon was on the waiting list.

49. That day, Mr Fenlon was suspended from his painting job after a paintbrush was reported missing on the wing. The paintbrush was later found being used on a different wing, but Mr Fenlon was not reinstated due to recent issues with his work and not adhering to the rules.

50. On 28 February, Mr Fenlon requested to move to a different wing due to believing he was under threat from other prisoners. A SO told Mr Fenlon that unless he was able to give specific details of the prisoners involved and the threats being made, then a move would not be possible. Mr Fenlon also asked a Healthcare Assistant (HCA) if he could speak with her while she was on the wing the same day. In her police statement, she said that she had known Mr Fenlon for around four years when he had come into Woodhill and would see him daily when she was dispensing medication. She said that when Mr Fenlon spoke to her, he said that there was a conspiracy going on at the prison and that prisoners and staff were involved. He believed prisoners were being killed. She told Mr Fenlon that she would refer him to the GP who would be able to refer him to the mental health team if deemed appropriate. She said that she spoke to SO 1 following her conversation with Mr Fenlon, who told her that he was aware of Mr Fenlon's paranoia. She said that as this did not seem to be anything new, she did not record her conversation with Mr Fenlon and the SO in Mr Fenlon's ACCT document.

51. On 2 March, a SO chaired the second ACCT case review. The review was attended by an officer and Mr Fenlon. Neither healthcare nor mental healthcare staff attended the review. The SO said that before the review, he had read Mr Fenlon's ACCT document and previous case review and he was aware that one of his issues was around his court appearance. He also said that he spoke to a nurse, although he could not recall their name, and the nurse had told him that she had no concerns about Mr Fenlon. During the review, Mr Fenlon said that he felt unsafe, and thought he would be assaulted and that he believed other prisoners thought he was a sex offender. The SO said that, at the end of the review, Mr Fenlon had no current thoughts of self-harm but decided that ACCT monitoring would continue, and observation levels would remain unchanged. The caremap was not updated and no discussion was recorded about the appointment with the mental health team.

52. At around 8.10am on 3 March, an officer was unlocking prisoners from their cells. When he reached Mr Fenlon's cell, the observation panel was blocked from the inside. He called out to Mr Fenlon to remove the obstruction and heard what he described as 'croaking' noises coming from inside. He did not go into the cell, instead he went to the staff office and asked for assistance. A SO was in the office, and in a statement provided to the police said that he heard the officer's call for assistance and ran to the cell which was approximately three yards from the office. When the staff entered the cell, they found Mr Fenlon by the window with a ligature made from torn bedding around his neck. Mr Fenlon was standing up and the officer cut the ligature from around his neck and sat him on the bed.

53. The HCA was on the wing dispensing medication when she was asked to go to Mr Fenlon's cell as he had been found with a ligature around his neck. She said that she had not been aware of any emergency call but took the medical 'grab' bag and went to the cell. When she arrived, Mr Fenlon was sitting on a chair, and she sat on the bed and spoke to him. The HCA said that while sitting on the bed she noted that there was a razor that Mr Fenlon had removed the blades from, and she asked an officer to remove it from the cell. Mr Fenlon told her that the only reason he did not

succeed in killing himself was because the knot came undone. She said that she could see a clear indentation around Mr Fenlon's neck and was satisfied that it had been a serious suicide attempt. When she asked him if he would do it again, Mr Fenlon said that he could not say that he would not. She also said that while in the cell, she had picked up what appeared to be a suicide note written to another prisoner. When she asked Mr Fenlon about this, he said that it was just a joke. While staff were in the cell an officer said that he had seen writing on the cell wall, which he said was written in blood and read 'Sprigmores a grass'. However, there is no evidence that anyone challenged Mr Fenlon about this or recorded it at the time, we are therefore unable to say with any certainty that this was written by Mr Fenlon.

54. The HCA went to the staff office after leaving Mr Fenlon's cell, where she completed an 'injury to inmate report' and while doing so spoke to a SO. She told the SO that she felt Mr Fenlon's observations needed to be increased to two per hour. She said that this was a general conversation, and she did not consider this to be an ACCT review.

55. The SO contacted the Custodial Manager (CM), who was duty manager. The CM said that the SO contacted him and told him what Mr Fenlon had done but said he was not sure whether it was a serious attempt or a 'cry for help'. The SO did not have previous knowledge of Mr Fenlon and did not read the entries in his ACCT. He told the CM that Mr Fenlon had ligatured at a time when he knew staff were on the landing and therefore, they did not treat it as a serious attempt. The CM said that he was not told that a suicide note had been recovered or that razors had been removed. He said that he did not go and speak with Mr Fenlon or review his ACCT document, although he was aware that observations had been increased. Neither the SO or CM considered whether more frequent observations or constant supervision was appropriate, and they did not complete a formal ACCT review.

56. The SO recorded that he had completed an ACCT review and that both the HCA and a trainee nurse had attended. The HCA said that she had not attended a review and neither had the trainee nurse. After attending to Mr Fenlon, the trainee nurse had returned to the treatment room and after completing the necessary documentation and speaking briefly to the SO, the HCA had returned to the treatment room herself. The SO recorded that Mr Fenlon had been found hanging from the window bars at unlock, cut down and immediately seen by healthcare staff. He noted that Mr Fenlon was 'unharmed' but was paranoid and insecure. He noted that Mr Fenlon was waiting to see someone from the mental health team. There is no evidence that he contacted them to seek an update or update them on what had taken place. Later that evening Mr Fenlon spoke with a wing manager and again mentioned feeling low and that he felt he was at risk from other prisoners. Mr Fenlon also spoke with a listener (a prisoner trained by the Samaritans to offer confidential support) at around 7.00pm for approximately 20 minutes.

57. An officer recorded on the ACCT document that she had a long chat with Mr Fenlon at 10.00am on 4 March. Mr Fenlon told her that he felt his mental state was declining and was feeling suicidal. She advised him to speak with staff from the mental health team, and that she would also try and speak to them. She said that after speaking with Mr Fenlon she spoke to the SO on the wing and other staff about referring him to the mental health team, and attempted to call them herself, but no one answered. She said that she did not pursue this as she believed Mr

Fenlon was due to be seen the following Monday, although it is not clear what she had based this belief on.

58. At 12.25pm, an officer answered Mr Fenlon's cell bell. When he attended the cell, Mr Fenlon was extremely distressed. Mr Fenlon told him that he was going to kill himself but had 'wimped out. The officer said that he went into Mr Fenlon's cell, reassured him and told him that he would get someone to sit with him after lunch. He said that when Mr Fenlon was calm, he left the cell, went to the office and made an entry in the ACCT document. He returned to check on Mr Fenlon at 12.40pm and saw that Mr Fenlon had made a ligature and tied it to the window, he entered the cell and removed the ligature. He then spoke to a SO.

59. The SO said that he had gone for his lunch at around 12.00pm and while in the control room he had heard the officer asking for permission to enter a cell. He said that he then telephoned the wing to find out what was happening and spoke to the officer, who told him that Mr Fenlon had been found with a ligature, but Mr Fenlon had said that he did not want to kill himself. The SO went and spoke to Mr Fenlon when he returned to the wing at around 1.00pm. He told Mr Fenlon that he had some jobs to complete, but he would then come back and speak with him.

60. At around 2.00pm, the SO went back to Mr Fenlon and took him to an office to talk. He recorded the conversation as an ACCT review. Only he and Mr Fenlon were present. He recorded that Mr Fenlon was paranoid and felt that other prisoners were out to get him, and that he was unsure whether he would self-harm again as his 'head was all over the place. He recorded that he reassured Mr Fenlon that staff would keep an eye on him. He recorded that the level of observations should remain the same at two an hour, and that there was no increase in Mr Fenlon's level of risk.

61. The SO said that he had not intended his entry to be an ACCT review and therefore had not read Mr Fenlon's ACCT document before speaking with him. However, he said that he noted that the next review was set for 8 March, and he considered that two observations an hour was too onerous on staff so brought the review date forwards to 5 March and recorded this on the front of the ACCT document.

62. Officer A was on night duty on 4 March. He conducted an ACCT check on Mr Fenlon at 8.35pm and talked to him at his cell door. He recorded that the conversation was a little 'bizarre' and that Mr Fenlon spoke about being in hospital years before, and having a camera implanted in his eye. He told Mr Fenlon that if he needed to talk, to just press his cell bell. Mr Fenlon pressed his cell bell at 10.45pm, and when he answered, Mr Fenlon asked him about having his television back. He told Mr Fenlon that he would speak with the duty manager when he visited the wing. Mr Fenlon also told him that he was feeling paranoid and thought that staff were going to rush into his cell and grab him. He reassured Mr Fenlon that he was safe.

63. Officer A answered cell calls from Mr Fenlon a further four times between 11.10pm and 7.10am. On each occasion, Mr Fenlon talked about having a camera in his head and appeared paranoid. The officer said that despite this, Mr Fenlon listened to him when he reassured him and calmed down. He made entries in Mr Fenlon's ACCT document accordingly.

Events of 5 March

64. At around 7.00am on 5 March, Officer B arrived on the wing to start his day shift. Officer A told him that Mr Fenlon had been unsettled and awake for most of the night. Officer B completed a check on Mr Fenlon and said that when he went to the cell there was rubbish lying around, the bed was unmade, and Mr Fenlon was stood at his door. Officer B said that he returned to the cell a short time later as Mr Fenlon had pressed his cell bell. He said that Mr Fenlon seemed 'jumpy' and 'paranoid', which he said he found out of character. Mr Fenlon said that he thought someone was going to go into his cell and attack him and asked to speak to a listener. (A listener is a prisoner who has been trained by the Samaritans to provide support to prisoners experiencing periods of crisis.) Officer B reassured Mr Fenlon and said that he would arrange for him to speak to a listener. He updated the ACCT document and highlighted his entry to make other staff aware.

65. Mr Fenlon was unlocked from his cell to collect his medication just before 8.20am. Officer C spoke to him as he went to the gate and asked him how he was. Mr Fenlon said that he was fine, and he smiled at her.

66. Just after 8.20am, Officer B returned to Mr Fenlon cell and took him to a listeners' cell. The listener said in a statement to police that when Mr Fenlon was brought to his cell, he appeared paranoid and delusional, and spoke about having a microchip in his tooth. The listener said that during their conversation, Mr Fenlon did not mention any thoughts of suicide. The listener explained that conversations he had in his role as a listener were confidential and the only time he would breach that confidentiality was if a prisoner mentioned that they intended to attempt suicide.

67. Mr Fenlon spent around 30 minutes with the listener before Officer B collected him and returned him to his own cell. The officer said that Mr Fenlon appeared better. When they reached his cell, he gave Mr Fenlon his food items and tobacco that he had ordered from the weekly canteen and said that he noticed that he had ordered more than he normally would, which he thought was a good sign as he was planning ahead.

68. Officer D responded to Mr Fenlon's cell bell at 10.25am, Mr Fenlon asked him the time, which he told him and asked Mr Fenlon if he was ok. Mr Fenlon told him that he was 'doing ok'.

69. Officer C was passing Mr Fenlon's cell at 10.30am when she heard him knock and call 'Gov'. She opened his observation panel and Mr Fenlon asked her if he could be unlocked so he could find a cigarette. She told him that it would not be possible and asked him what he had done with the tobacco he had been given earlier. Mr Fenlon told her that he had to give it all away as he was in debt on the wing, but that he did not wish to discuss the matter. She asked him if he was all right apart from wanting a cigarette, and he said that he was. She went back to the office and updated the ACCT document.

70. Mr Fenlon had been given his canteen and had not had an opportunity to give anything away by the time he had spoken to Officer C.

71. Officer C was walking back past Mr Fenlon's cell at approximately 10.45am, and looked in through the observation panel, to see how he was. When she opened the

observation panel, she found it covered. She knocked on the door and called out to Mr Fenlon, but there was no response. She went across to the office on the other side of the landing and told staff that the observation panel was blocked. Officers B, C and D went into the cell and found Mr Fenlon with a ligature around his neck attached to the window.

72. Officer C radioed a medical emergency code blue (indicating a prisoner is unconscious or is having breathing difficulties). Staff cut the ligature and placed Mr Fenlon on the floor and began CPR. Nursing staff attended and took over resuscitation attempts until paramedics arrived at approximately 11.00am. Paramedics then took over resuscitation, providing advanced life support. Efforts to resuscitate Mr Fenlon continued and he was noted to have electrical activity but no pulse. He was transferred to hospital by emergency ambulance.

73. In hospital, Mr Fenlon was moved to the Intensive Care Unit. At 8.14pm, it was confirmed that Mr Fenlon had died. His family were at his bedside.

Contact with Mr Fenlon's family.

74. At 11.57am, the prison contacted Mr Fenlon's nominated next of kin by telephone and told them Mr Fenlon was in hospital. Mr Fenlon's family attended the hospital and met prison and nursing staff who updated them about Mr Fenlon's condition. The prison had initial contact with the family and explained the process that would follow.

75. Mr Fenlon's daughter asked the appointed prison family liaison officer (FLO) whether her father had left any notes in his cell and was told that he had not. Following the death of a prisoner it is normal practice that the cell will be sealed, and police will attend to view the cell and remove anything they feel relevant, which would include notes left by the deceased. A prison FLO would be aware of the process and should have asked the police whether such items had been seized. There is no evidence that this happened. Sometime after Mr Fenlon's death the police confirmed with his family that he had in fact left a note for his daughter. It is again not clear why the police did not make the family aware of this sooner. Had they been made aware sooner or the FLO had checked with the police, it would have avoided unnecessary stress and upset.

76. The prison offered a contribution towards the cost of Mr Fenlon's funeral, in line with national policy.

Support for prisoners and staff

77. After Mr Fenlon's death, the Head of Healthcare 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 to those involved.

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

Cause of death

79. The Coroner accepted the cause of death provided by a hospital doctor and no post-mortem examination was carried out. The doctor gave Mr Fenlon's cause of death as hypoxic brain injury caused by hanging. Toxicology was completed and indicated no illicit substances in Mr Fenlon's system at the time of his death.

Findings

Management of ACCT /Assessment of risk

80. The purpose of ACCT is to try to determine the level of risk, how to reduce the risk and how best to monitor and supervise the prisoner who is considered to be at risk and to avoid incidents of self-harm and deaths in custody.

81. Mr Fenlon had no history of suicidal thoughts or attempts, or self-harm while in custody. He had experienced previous mental health issues along with substance misuse issues. Initially on his return to Woodhill, he denied any thoughts of self-harm and staff had no particular concerns about him. However, over the week before he died, he presented as increasingly delusional and paranoid, believing that he was at risk from other prisoners and staff. He attempted suicide on 3 March, and on 4 March, told staff that he had planned to kill himself. He had also made a ligature that had to be removed from his cell. We have considered whether staff at Woodhill identified and assessed his risk appropriately, and managed ACCT procedures effectively.

82. In 2021, HMPPS introduced version 6 of the ACCT document. At the time of Mr Fenlon's death, staff were using ACCT version 5, but other than the layout of the document, the requirements for its completion have not changed.

83. In 2016, the ACCT process required staff to identify the prisoner's main concerns, and set appropriate levels of checks and interactions, according to the perceived risk. Regular multi-disciplinary review meetings involving the prisoner were required (with a member of healthcare staff required at the first review). Additional and ad-hoc case reviews would be convened if the level of perceived risk increased, there were further acts of self-harm or triggers for self-harm were reached. A caremap (plan of care, support, and intervention) would be put in place, and actions to support the individual on the caremap would be reviewed at each case review.

84. We found that all those involved in the ACCT process had received the appropriate training. Some aspects of Mr Fenlon's ACCT were managed well, with staff beginning ACCT monitoring as soon as concerns were raised, and observations being completed at prescribed frequency with good interactions recorded.

85. However, the case reviews were not multidisciplinary, with the majority involving only the wing SO. Healthcare staff did not attend any of the reviews and apparently no attempts were made to seek engagement from the mental health team, despite the documented concerns about Mr Fenlon's mental well-being. Although the caremap was completed and indicated that Mr Fenlon was awaiting an appointment with the mental health team, there was no evidence that anyone followed this up or sought confirmation that an appointment had been scheduled. Had staff taken the time to seek an update to the caremap actions, they would have been made aware that there was no pending appointment for Mr Fenlon.

86. Further actions recorded on the caremap were about Mr Fenlon doing things, such as engaging with staff, rather than what staff would do to support him during his period of crisis.

87. On 3 March, Mr Fenlon was found with a ligature tied around his neck suspended from the window in his cell. He was cut down and seen by nursing staff. His observations were increased to two per hour, but no formal review was completed. The following day, he was again found to have made a ligature and tied this to the window, although he had not made an attempt to use it. The ligature was removed.

88. Given the serious nature of Mr Fenlon's suicide attempt on 3 March, there should have been a full multidisciplinary review and consideration should have been given to whether he required more frequent checks or to be placed under constant supervision. The further incident on 4 March serves to highlight the increased risk that Mr Fenlon posed to himself and again a multidisciplinary review and discussion about levels of observation should have taken place. Without case reviews there could be no way to have adequately determined the most appropriate level of observations to safeguard Mr Fenlon.

89. We consider it inexplicable that staff did not identify that Mr Fenlon's mental health was deteriorating and that his suicide attempts indicated he was in crisis.

Police Investigation

90. The police investigated the individual actions of some staff and their management of the ACCT process. They submitted their findings to the Crown Prosecution Service (CPS), which found that the threshold for corporate manslaughter and gross negligence manslaughter had not been met for any member of staff or the Ministry of Justice (MOJ,) and therefore no criminal charges were brought against staff at Woodhill**.**

Urgent Notification.

91. An urgent notification is the process that HM Chief Inspector of Prisons follows if he identifies significant concerns about the treatment and conditions of those detained in prison, young offender institution or secure training centre after an inspection. The notification is directed to the Secretary of State, highlighting the concerns and summarising the judgements of the inspection and areas requiring improvement.

92. HMIP inspections since 2015 have noted concerns about prisoner safety at HMP Woodhill. Following an inspection at Woodhill in August 2023, the Chief Inspector issued an urgent notification (UN) to the Secretary of State. Amongst the concerns raised, inspectors found that 71% of prisoners felt unsafe and 26 were found to be self-isolating for fear of their safety, and that rates of self-harm were the highest in the adult estate.

93. It is clear from the most recent findings of HMIP, that there is still significant work to be done to improve prisoner safety at Woodhill. Ongoing staff shortages have been identified as a major risk factor at the prison.

94. In light of the UN, HMPPS headquarters is providing Woodhill with additional support. The Governor provided us with the initial plans which seek to address issues around safety both in the short and long term, and include:

    - an identified lead working together with the National Safety Team and Directorate of Security and the substance misuse team, to identify and address safety issues,

- increasing the staffing of the local safety team for a period of two years, and
- the national safety team completing a piece of work to understand the drivers of self-harm and violence at Woodhill to enable immediate action to be taken.

These plans will form part of a wider action plan in response to the UN. In light of developments since 2016, we make no recommendations about the management of ACCT processes.

Healthcare

95. The clinical reviewer found that Mr Fenlon's initial and secondary health screens identified his relevant issues, however, on both occasions, the screening nurse did not refer Mr Fenlon to the Mental Health Team even though his mental health history and ongoing issues had been highlighted.

96. Mr Fenlon was referred to the Mental Health Team on 22 October 2015, but he was considered not to require further assessment as he was not presenting in a way that indicated a need.

97. The clinical reviewer highlighted concerns that no one referred Mr Fenlon to the mental health team after his suicide attempts on 3 and 4 March, despite his clearly worsening paranoia and delusional thinking.

98. The clinical reviewer concluded that the mental health and clinical care extended to Mr Fenlon was not of the required standard and therefore not equivalent to what he could have expected to receive in the community. The clinical reviewer made some recommendations which we do not repeat in this report, but which the Head of Healthcare will wish to address.

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