

**Investigation into the circumstances surrounding the
death of a man at HMP Woodhill
in April 2009**

**Report by the Prisons and Probation Ombudsman
for England and Wales**

November 2009

This is the report of the investigation into the apparently self-inflicted death of a man at HMP Woodhill in April 2009. He was found hanging from the bunk beds in his cell at 12.00pm during a routine check. He was 50 years old.

I offer my sincere condolences to his friends and family, and all those touched by his loss.

The investigation was carried out by one of the Ombudsman's investigators. The local Primary Care Trust (PCT) commissioned a clinical reviewer to undertake a review of the clinical care the man received at Woodhill. I am grateful for her thorough and timely review. I would also like to thank the then Governor of Woodhill and his staff for their co-operation. Particular thanks go to the senior officer who was the establishment's investigation liaison officer and offered excellent assistance.

The man was apparently not someone who shared his thoughts and feelings readily, and he tended to keep his own company. He had been in prison before (including at Woodhill) and on this occasion had been on remand for three months. He was charged with a number of offences and knew he might face a lengthy sentence. That said, he gave staff no cause for concern and consequently was not being monitored under the prison's suicide and self harm procedures.

I judge that there was little that staff at Woodhill could have done to prevent the man's death. An unfortunate combination of circumstances including a lock down search of the prison (meaning all prisoners remained locked in their cells for the majority of the day) and the transfer of his cellmate first thing that morning may have made his actions easier. Generally, I am pleased to note the professionalism of staff at the prison, although I make five recommendations, four concerning healthcare and one the prison's emergency response procedures.

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

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November 2009

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SUMMARY

The man arrived at HMP Woodhill in December 2008, having been remanded from court charged with a number of robberies. He had a history of injecting drugs but chose not to tell healthcare staff about this on his arrival. He said he had been in prison (including at Woodhill) before and had no concerns, other than that he needed reading glasses. The nurse assessing him concluded that the man had no physical or mental health problems and referred him to the optician.

Shortly after his arrival, the man made an undated written application for a doctor's appointment. He wrote that he had brought drugs into the prison with him, had used them all and had left himself "in trouble". An appointment was made for 9 January. The man apparently made no other mention of having used drugs at Woodhill, or needing any medical intervention as a result. The doctor, who had not seen the application form, recorded that the man had no health concerns and no further action was taken.

After his induction, the man moved to a double cell on House Unit 3A, sharing with another prisoner whom he knew from the community. He was allocated two personal officers, and told one that he had no history or current thoughts of suicide or self harm. Staff apparently had no concerns about the man, although they noted that he spent a lot of time in his cell.

The man referred himself to the prison substance use support service and had an appointment with a member of the team on 16 January. He explained his history of drug use and agreed to work with the service during his time in prison. He also asked for support on release. The man gave the drugs worker no other cause to be concerned for his welfare.

Between January and March 2009, the role of House Unit 3A was changing and, as a result, the man's cellmate was to be moved to another unit. In late January, the cellmate told a member of staff that he was worried about the man. It has not been possible to discover the exact nature of his concerns, but the man reassured staff that he was fine.

The man began working full time in the prison kitchens in early February. Staff described him as quiet but hard working and he became one of 12 prisoners trusted with greater responsibility. In March, the man spoke to another prisoner working in the kitchen and said he might like to talk to him in his capacity as a Listener (a prisoner trained to offer confidential support to other prisoners). As it was not convenient to talk while they were working, the prisoner advised the man to find him, or another trained Listener, when back on the unit. The man did not go on to speak to a Listener during his time at Woodhill.

On 3 March, the man began sharing a cell with another prisoner whom he also knew from the community. The man said he knew he might be facing a long sentence and that the thought was "doing his head in". He told his cellmate that he had previously tried to harm himself in the community, but gave no indication that he had any current thought of doing so. The cellmate said that the man used Subutex (a heroin

substitute) regularly while at Woodhill. He did not think the man was in debt to or being bullied by any other prisoners.

The man resigned from his kitchen job on 31 March. Kitchen staff asked an officer on House Unit 3A to find out why, and the man told him that he would be “leaving soon”. His demeanour gave staff no reason to worry.

One day early in April, the prison underwent a lock down search, following information that prisoners were planning an escape. As a result, all prisoners were to remain locked in their cells until the entire prison had been searched. Staff said that prisoners received notice of the search the previous evening, but those on House Unit 3A said they did not receive any notification.

First thing that morning, the man’s cellmate was told that he was being transferred to another prison. A senior officer collected him from the cell at 9.15am and described the man as seeming fine. The cellmate thought that, in hindsight, the man had been upset by his departure. Neither the man’s cellmate nor the officer who saw him that morning had any concerns.

At about 12.00 noon, staff arrived at the man’s cell to deliver his lunch. They found him hanging from the top of the bunk beds, suspended by a thickly twisted bedsheet. The officers removed the ligature and tried to resuscitate him, quickly joined by a number of healthcare staff. He was taken to hospital by ambulance, but efforts to resuscitate him were unsuccessful and hospital staff pronounced that he had died.

After his death, another prisoner said that the man had talked of harming himself about three days before his death. It appears that the prisoner did not tell staff of his concerns.

I make five recommendations as a result of this investigation. Four concern healthcare policies and procedures and one concerns the emergency radio protocol. I am satisfied, however, that the man’s death was neither foreseeable nor, for that reason, preventable.

THE INVESTIGATION PROCESS

1. The Ombudsman's office was informed of the death of the man in April 2009. The investigation was allocated to an investigator later that day. One of the Ombudsman's investigators visited HMP Woodhill on 7 April to open the investigation and met some staff who knew the man and a member of the Independent Monitoring Board (IMB).
2. The investigator issued notices inviting staff and prisoners to contact her with any information they felt might be relevant to the investigation. There was no response to the notices. The investigator carried out interviews with staff and prisoners at Woodhill between May and June 2009. A prisoner who had shared a cell with the man at Woodhill but had since been transferred to HMP Wellingborough was also interviewed. Additionally, the investigator made telephone contact with the man's criminal defence solicitor.
3. Milton Keynes PCT appointed a clinical reviewer to undertake a review of the clinical care the man received at Woodhill. The clinical reviewer and the investigator conducted a number of joint interviews with members of healthcare staff.
4. The investigator was provided with relevant documentation covering the man's time at Woodhill, including a copy of his prison records, his medical record and the staff incident reports written after his death.
5. HM Coroner for Buckinghamshire was informed of the nature and scope of the investigation, and provided the investigator with copies of statements gathered by the police. A copy of this report will be sent to him to assist with his inquiries.
6. One of the Ombudsman's family liaison officers contacted members of the man's family to invite them to be involved in the investigation process. They did not raise any particular concerns or questions about the care the man received at Woodhill. However, I hope this report will provide them with a picture of his time there and of the events in April.

HMP WOODHILL

7. HMP Woodhill is a local prison which can hold 819 adult male prisoners, on remand, convicted or sentenced. The prison serves a number of functions. In the late 1990's, Woodhill joined the High Security Estate and now also holds category A prisoners.
8. Each prison in England and Wales is subject to performance monitoring by the National Offender Management Service (NOMS). NOMS produces quarterly performance ratings, compiled using an agreed framework. Woodhill's performance has been rated as "good" (the second best rating available) for the past three quarters.
9. The prison last underwent a full announced inspection in September 2007. The Chief Inspector praised the new management team, and new Director of High Security, for focusing appropriately on:

"... the prison's principal role, as a local prison, holding short-sentenced and low risk adults and young men – without losing sight of the security and control needed to safely contain its high risk population."

10. Improvements were noted in all four key areas inspected: safety, respect, purposeful activity and resettlement. However, "serious deficits" were also highlighted. The lack of available activity places for the population meant that only 30 percent of the population were engaged in work or education. The provision of healthcare was also of "considerable concern", with mental healthcare "limited and ineffective".
11. The inspection noted that safety had improved, and that both violence reduction and safer custody work were "much more effective" than at the time of the last inspection.
12. Prisons in England and Wales are also subject to monitoring by an Independent Monitoring Board (IMB), made up of volunteers from the local community. Members of the IMB have access to every part of the prison and each prisoner there. They produce an annual report, the latest available for Woodhill covering the period June 2007 to May 2008.
13. The IMB noted the challenges of balancing the security demands of the prison's high security role with the needs of the majority of the prison's non-category A population. They also noted the pressures of overcrowding, staff shortages and recruitment difficulties. However, better links with local community agencies and with the Primary Care Trust were noted. The Board also recognised improvements in the daily regime and purposeful activities on offer.

KEY EVENTS

14. In December 2008, the man appeared at Northampton Magistrates' Court, charged with a number of robberies. His case was to be heard at the Crown Court and, in the meantime, he was remanded into the custody of Woodhill. He arrived at the prison at 4.00pm. The Prisoner Escort Record (PER) that accompanied him from court to the prison noted that the man had substance use problems. (One function of the PER is to highlight the risks the individual might pose to themselves or others.)
15. Once the man was processed through reception, he moved to the First Night Centre, where most prisoners spend their first night at the prison. The man underwent the first reception healthscreen with a nurse there. (The healthscreen is designed to identify any immediate physical or mental health problems requiring referral to the doctor or other specialist service.) The nurse had not read any other health related information about the man before conducting the assessment. The man told the nurse he had not seen a doctor recently, was not prescribed any medication and had no recent physical injuries. He said he had no concerns about his physical health, but needed glasses. The nurse noted that the man had been at Woodhill before.
16. The nurse, who has worked at Woodhill for 15 years, was interviewed as part of this investigation. He could not specifically remember assessing the man in reception. He explained that it is quite common to assess prisoners on their arrival without having seen any other health information about them. However, he said he would always see the PER as he had to complete one section of it. The nurse said that the man did not have his glasses with him, and so he would have referred to him to the optician. This referral is not recorded on the healthscreen, but he explained that he would have completed a referral form which would have been processed by an administrator. (The clinical reviewer confirmed that the man saw the optician on 16 March and received prescription reading glasses on 26 March.)
17. The man said that he had no history of mental health problems and had never tried to harm himself. The nurse asked whether he had any concerns about being in prison, and he replied that he did not. In interview, the nurse explained that the healthscreen was essentially a checklist. If the prisoner highlighted any areas of concern, the nurse would probe for further information. The nurse said he was quite experienced at assessing body language and identifying prisoners who were hesitant in their answers, and would take the time to draw them into conversation. The man told the nurse that he did not drink alcohol, and had not used drugs in the past month, although his PER recorded that he had substance use issues. The nurse told my investigator that where the PER and the prisoner provided conflicting information, he would normally ask the prisoner about the information on the PER. He said, however, that ultimately he would take the word of the prisoner. The nurse did not record on the healthscreen whether he and the man discussed the conflicting information on the PER. He said that prisoners are not routinely drug tested on arrival, unless they said they used drugs.

18. After completing the first reception healthscreen, the nurse carried out the secondary healthscreen. (This is designed to gather more detailed information about the prisoner's medical history. It must be completed within seven days of the prisoner's arrival, but not usually on the same day as the first reception healthscreen.) He recorded that the man had no outstanding hospital appointments, hereditary health conditions or concerns. The man told the nurse that he was a smoker, but did not want to stop. He and the nurse signed both healthscreens. The nurse decided that the man did not need to be referred to the doctor or to any of the other specialist services available.
19. The nurse also completed the healthcare section of the Cell Sharing Risk Assessment, which assesses whether the prisoner is suitable for sharing a cell. The assessment also provides another opportunity to consider whether there is evidence the prisoner may be a risk to himself. The nurse recorded that there was no indication that the man might harm himself. He noted that there were "no problems" and assessed the man as a low risk to other prisoners, and therefore suitable for sharing a cell. An officer completed the remainder of the form. She noted that she had seen both the PER and the warrant accompanying the man into prison. The man told the officer that he had no substance misuse problems, did not get angry easily and had been at Woodhill before. The officer also judged the man to be a low risk to other prisoners and suitable for sharing a cell.
20. A second officer met the man that evening, and completed the first night "passport". The second officer was interviewed as part of the investigation. He explained that the passport provides an opportunity to assess the prisoner and to consider "what we need to be thinking about for this person, what actions we need to put in to keep the person perhaps safe from themselves or from other people". He noted that the man had been given information about what to expect from his first days in custody and offered a telephone call. The officer wrote that the man did not know the telephone numbers of any friends or family and so had not made any calls. He confirmed that he gave the man information about Listeners and the Samaritans, and that use of his cell bell was explained. (Listeners are prisoners trained and supported by the Samaritans to offer a 24 hours a day, confidential listening service to other prisoners. The cell bell, one of which is installed in every cell, can be used to alert staff attention, and is intended for emergency use.) The officer also completed the housing needs assessment and recorded that the man had no fixed accommodation prior to coming to prison. The man said he would be living with his father on his release. Following their meeting, the officer made an entry in the man's wing history sheet, writing that he "doesn't have any thoughts of self harm or more".
21. In interview, the second officer said that, had he had any concerns about the man, he would have placed him on an Assessment, Care in Custody and Teamwork (ACCT) document. (The ACCT system is in place across all prisons in England and Wales and is designed to support and monitor those judged to be at risk of suicide or self harm.) He also confirmed that had he concerns of any nature about the man, he would have recorded them in his file.
22. It appears that within days of his arrival at Woodhill, the man applied for an appointment with the prison doctor. The referral form is undated (and in fact, no

space is provided to record the date) but the man wrote that he wanted to see a doctor because he “came into prison Tuesday with gear (hidden somewhere) and things, now done what I came with, now I’ve left myself bang in trouble”. (Gear is a common street name for heroin.) The healthcare department could not confirm whether an appointment was booked as a result. The man did, in fact, see the prison doctor on 9 January. The doctor made an entry in the man’s medical record, noting he was “no longer constipated. Has no complaints at the moment.” The doctor was interviewed during the investigation and said that he could not remember examining the man on 9 January, and had not seen him again. He was shown the referral form the man had completed and said he had not seen it before. He was unable to confirm whether his examination of the man was a result of the referral form. There is no evidence to suggest that any substance use issues were reconsidered in the light of his application.

23. On 14 January, the man moved to House Unit 3A after his induction period was completed. This unit holds 82 prisoners in a mix of single and double cells. When the man arrived it was the substance support wing, holding prisoners with histories of substance use. However, its role was in the process of changing to accommodate prisoners with jobs in the prison. Staff working there described it as a generally calm unit with a good atmosphere and few problems. Both staff and prisoners described relationships between them as positive, and most staff thought that prisoners would approach them if they had any problems. The man was placed in a double cell with another prisoner whom he already knew. (Some staff described the two men as cousins whilst others thought the prisoner was the man’s father-in-law.)
24. The man was assigned two personal officers. (The personal officer scheme is intended to provide prisoners with a named point of contact who they can approach with any questions or concerns. At Woodhill, personal officers should make entries in their prisoners’ files at least every two weeks.) One of the man’s personal officers made an entry in the man’s file on his arrival, noting that the man had completed an application for a job in the prison. The personal officer also filled in the Personal Officer Interview Sheet, recording that the man had never tried to harm himself in the past. The man said he had no issues or concerns and did not need to complete any courses while in prison. He signed the Voluntary Drugs Testing Compact, agreeing to remain drug free while on the unit and undergo drugs tests whenever he was required to do so.
25. Two days later, on 16 January 2009 a CARATs worker saw the man after he referred himself to the service. (The Counselling, Assessment, Referral, Advice and Throughcare service is established in all prisons in England and Wales. It offers non-clinical interventions to prisoners with substance use issues, including group and one to one sessions. CARATs can also refer prisoners to community agencies on their release.) The referral form the man completed is not dated, but he wrote that wanted to see CARATs for “personal [reasons] to do with drug problems”.
26. The CARATs worker recorded that the man had been an intravenous amphetamine user before coming into prison. He told her he had started using drugs four years ago and, prior to coming to prison, was using them every day.

The man said his former partner had been a heroin user, and that he had committed offences so she could buy drugs. He said that his partner had left him since he had been remanded into custody. The man said he had never sought treatment for his drug use in the past, but now wanted to work with CARATs and have support in the community on his release. The CARATs worker recorded that she sent a copy of the man's assessment to his community Drug Intervention Programme and that she had begun to devise a care plan for him.

27. The investigator spoke to the CARATs worker as part of this investigation. She said that she met the man once during his time at Woodhill, spending about half an hour with him. He caused her no concern during their meeting. Although he mentioned that his partner had ended the relationship, he did not seem upset but said he felt "used" by her. The CARATs worker said that, had she had any concerns about him, she would have opened an ACCT, as she had been trained to do. The man did not tell her that he had brought drugs into the prison with him.

28. The man's second personal officer recorded that he talked to the man on 29 January about the amount of time he spent in his cell. He wrote that the man said he did not know anyone on the unit, and "just wants to get on with his sentence". The man told the officer that he wrote to his family. The second personal officer concluded that the man "seems ok". Three days later, the first personal officer made an entry in the man's file following a conversation with his cellmate. The entry is not easy to understand but appears to outline the cellmate's concerns about the man. The first personal officer wrote:

"Informed by his cellmate he shows concern on when he transfers he would not be able to cope. Having spoken to the cellmate he states all is well. Shall monitor this issue, staff are aware. When I asked the man how he is feeling on the wing and if there was anything I could help him with, he stated is "ok". Have asked him to put in some app[lications] for ed[ucation]/work to keep himself busy. Shall chat with him again next week."

29. The investigator attempted to interview both the first personal officer and the cellmate but was unable to. The first personal officer has been on sick leave since the investigation began and efforts to contact him were unsuccessful. The cellmate was asked if he would be willing to speak to the investigator, but did not wish to do so.

30. Staff told the investigator that the role of the unit was due to change in March. The cellmate was to transfer to another wing as he was not in employment, but the man was to stay on House Unit 3A, as he had applied for full time work. It is possible that the cellmate thought the man would not be able to cope if they were not sharing a cell.

31. The first personal officer received confirmation on 2 February that the man had been given a job in the prison kitchen and he began working there the following day. The first personal officer wrote that, as a result of his job, the man had gained confidence. The officer noted that the man was receiving support from his cellmate.

32. On 17 February, the man made an application to see a probation officer in the prison, due to “personal circumstances”. The man was told that, as an unsentenced prisoner, he was not allocated a prison probation officer. He was given the name of a member of staff who dealt with prisoners seeking bail. He was also invited to provide more information about the nature of his application, so that staff could decide what action to take. The man did not do so, and made no further applications.
33. A solicitor from the firm of solicitors representing the man in his criminal matters visited Woodhill on 2 March. The investigator spoke to the solicitor by telephone. He said that, as a former police officer in the Northampton area, he had known the man for a number of years and thought they enjoyed a good relationship. He had been unable to advise the man of the sentence he might receive if found guilty of his offences, but told him it was likely to be lengthy. The solicitor visited the man several times at Woodhill, and said that on one occasion, the man said he wanted to “sort everything out because he had had enough”. The solicitor took this to mean that the man wanted to change aspects of his life and stop using drugs, and did not want to return to prison again. He told the investigator he never had any concerns that the man might be thinking of harming himself. He explained that, had he any concerns, he would have informed prison staff immediately. The solicitor said he had been very shocked to learn that the man had died.
34. Two further officers became the man’s personal officers when he moved to cell 1:20 on the ground floor of House Unit 3A on 4 March. The man was now sharing a cell with another cellmate whom he had known for some time outside prison. The second cellmate was transferred to HMP Wellingborough on 1 April, and was interviewed there by the investigator. He said that he and the man were both amphetamine users, who had met through mutual friends. He described the man as quiet and generally “keeping himself to himself”. He said the man would not normally share his thoughts or feelings with other people. The second cellmate told the investigator that the man and his girlfriend had split up since he came to prison and he had seemed upset about this. He said the man had been in prison before, but was “hating it” this time. As he had been charged with a number of serious offences, the man thought he might be facing an Indeterminate Public Protection (IPP) sentence. (IPP sentences apply to those who are convicted of certain serious violent or sexual offences and are deemed to pose a “significant risk of serious harm in the future”. The sentencing court must set a minimum period of imprisonment required, but the individual will only be released after that point if they can show the Parole Board that they have reduced the risk to the public.) He told the second cellmate that he would not be able to handle a long sentence.
35. The man appeared at Northampton Crown Court in March. He was convicted of two offences and was to face trial for nine more. He was remanded into custody to appear at the Crown Court once the trial date had been fixed. The third personal officer made an entry in the man’s wing file on 27 March, recording that no concerns or issues had been raised.

36. On 31 March, the man resigned from his kitchen job. The investigator spoke to one of the chefs responsible for managing prisoners working in the kitchen. She said that the man had worked well and was helpful, always doing what was asked of him and “keeping his head down”. The chef said the man became a “Super 12” prisoner, the term given to the 12 most trusted prisoners working in the kitchen. She had no reason to be concerned about him, and had never noticed any changes in his mood. She described him as quiet, and said he did not talk to others in the kitchen very much. None of the other kitchen workers had reported any worries about him.
37. The chef showed the investigator the kitchen observation book (where staff record information every day) and the entry made on 31 March. The entry records that kitchen staff telephoned House Unit 3A that morning to ask why the man had not come to work. An officer on the unit went to speak to the man and, having done so, said that he had resigned because he would be “leaving soon”. When the member of kitchen staff asked what this meant, they were told the man might be referring to an upcoming court appearance. The investigator also spoke to the officer who, unfortunately, could not remember the conversation he had with the man. He said, however, that had the man caused him any concern, he would have talked to other staff, and made a note in the file and the unit observation book. The chef said that all those working in the kitchen were very shocked to learn that the man had died. She confirmed that, since his death, no one had mentioned having any concerns about him.
38. The investigator spoke to a Listener who worked with the man in the kitchen. The Listener said he did not know the man well as they only worked together for a short time. He said that one day (he could not remember exactly when, but it would have been some time in March) whilst working together, the man had said he might like to talk to him in his capacity as a Listener. The Listener said that, as they were working in the kitchen, it was not appropriate to talk in detail then, but he had told the man to find him when they were back on unit 3A (where the Listener also lived). The man gave no indication of why he might want to speak to a Listener. He did not come to see him, and shortly after, the Listener was transferred to another unit. He explained that prisoners are generally not able to ask to see a particular Listener, but if the man had asked, he would have been able to speak to any Listener available in the prison. In March 2009, there were several Listeners living on House Unit 3A, and the Listener explained that they all wore green t-shirts so that they could be easily identified. He was fairly confident that prisoners at Woodhill were aware of, and knew how to access, Listeners.

The day the man died

39. A lock down search of Woodhill was planned for a day in April, following information that prisoners might be planning an escape attempt. This meant that over the course of the day every cell in each unit would be searched in detail. Prisoners remained locked in their cells until the entire prison had been searched. Staff told the investigator that all prisoners received a notice of the search under their cell doors first thing that day. However, several prisoners living on unit 3A on that day were interviewed and said that they had not received any information

about the search. Staff were deployed across the prison so that no one searched the unit where they were normally based.

40. A senior officer (SO), one of the unit 3A managers, was tasked with patrolling the unit while staff searched other units. (Generally, when prisoners are locked in their cells, fewer staff are on duty. This is often known as a 'patrol state'.) At about 8.20am, he went to cell 1:20 to tell the man's cellmate, who was being transferred to HMP Wellingborough that day, that he would return in an hour to take him to reception. The SO said prisoners being transferred would normally be informed the night before, to give them an opportunity to telephone family and friends and pack their belongings. The cellmate told the investigator that he had received no warning before his transfer.
41. The SO returned to the cell at 9.15am. He said that the two prisoners wished each other well as the cellmate left. He noticed nothing of concern in the man's demeanour, and thought that, had the cellmate had any concerns, he would have discussed them on his way to reception.
42. The cellmate told the investigator that as he was about to leave the cell, the man said "don't go". At the time, he had not thought anything of this, and had not been concerned. However, he said the man had been feeling low, and had been sleeping a lot. He described the man as "not his usual self" but thought this was because he was worried about the sentence he might receive. The man had told the cellmate that the thought of a long sentence was "doing his head in". He said he had tried to harm himself before in the community, but never mentioned thinking of or wanting to harm himself while in prison. The cellmate said that the man was taking Subutex (a heroin substitute) about twice a week at Woodhill, (although he had not been a heroin user in the community) and using tobacco to trade with other prisoners. As far as he knew, the man was not in debt to any other prisoners, and was not being bullied or pressured.
43. At 11.40am, staff began to serve lunch on unit 3A. Because the prisoners were still locked in their cells, they were served cold food at their cell doors, with staff unlocking each cell in turn. About 20 members of staff were on the unit, helping to serve lunch. A prison officer was one of those serving lunch to the cells on the ground floor. He was interviewed and explained that staff had begun with cell 1:01, working round to end with the man's cell 1:20, which is located in the far corner of the unit.
44. The prison officer reached the man's cell at about 12.00 noon, while other staff were serving lunch to the prisoners in cells 1:18 and 1:19. A card is displayed outside each cell, detailing the names of the prisoners in the cell. The officer saw that cell 1:20 contained two prisoners (the cellmate's name had not yet been removed from the card). Before unlocking the cell, he looked through the observation panel in the cell door. He saw the man hanging from the frame of the top bunk bed, suspended by a bed sheet, facing the cell door. The officer opened the cell, calling for staff to help as he did so. He went in and tried to support the weight of the man's body, putting his arms around his waist. No other staff had arrived and so the officer called out again.

45. A second officer heard his colleague's call, went into the man's cell and helped to support the weight of his body. He told the investigator that the ligature around the man's neck was made from a thickly twisted bedsheet. All frontline staff at Woodhill carry a ligature knife, which is specially designed to cut ligatures safely. The second officer tried to cut the ligature using his knife but was unable to because the material was so thick. Both officers recalled a number of other staff arriving in the cell very quickly. A third officer also tried to cut the ligature but could not. An SO who had arrived at the cell took the third officer's ligature knife and managed to cut through the material. The staff laid the man's body on the cell floor and the SO checked for a pulse and signs that he was breathing and found neither. The SO described the man as looking "in a bad way". Because the cell was small and cramped, staff carried the man to the association area, a large, spacious area directly outside the cell.
46. A fourth officer also responded to the call for staff. When she arrived at the cell, she found four members of staff already there. She used her radio to call for medical staff to attend a "medical emergency". The officer told the control room the nature and location of the emergency.
47. Staff began to attempt to resuscitate the man. The third officer told the investigator that he always carries a resuscitation pack, containing a one way valve for giving mouth to mouth resuscitation, alcohol wipes and latex gloves. He said he had received first aid training when he joined the prison service five years ago, but had done none since. However, he said he felt comfortable beginning mouth to mouth resuscitation.
48. Two Healthcare Officers (HCO) were dispensing medications across the whole prison that day, because of the lock down search. At 12.00 noon, they were helping colleagues dispense medication on House Units 3A and B. One HCO was carrying a radio, and both members of staff heard the emergency call for staff to go to unit 3A. The other HCO was interviewed during the investigation and said he responded to the call, quickly running to the unit. He had not heard the exact wording of the radio call and so did not know what kind of emergency it was. On entering the unit, he saw a number of staff gathered outside cell 1:20, and made his way to them. He saw the man lying on the floor with staff about to commence mouth to mouth resuscitation. The HCO confirmed that the man was not breathing and began chest compressions.
49. Emergency medical equipment is kept in the central area separating unit 3A and 3B. The equipment includes a defibrillator (a machine which delivers electric shocks and can help to restart the heart in some circumstances) and oxygen. A nurse and the HCO who was carrying the radio collected the equipment and then assisted the resuscitation efforts. The HCO who was first to arrive at the scene told the investigator that they attached the defibrillator and followed the automatic instructions. The defibrillator advised that no shock should be delivered and so staff continued to administer cardio-pulmonary resuscitation (CPR). By this time, several members of healthcare staff had arrived, and staff took turns to deliver breaths and compressions.

50. A prison doctor was completing paperwork in the healthcare centre when he heard the medical emergency call over the radio. He collected his medical bag and went quickly to House Unit 3A. The doctor was interviewed during the investigation and explained that, on checking, the man had no blood pressure reading, and his pupils were fixed and dilated. He could not find a pulse and advised staff to continue with CPR. Every two minutes he re-checked the man for a pulse. The doctor said that staff gave the man oxygen; he tried to administer medication intravenously, but could not find a vein.
51. An ambulance arrived at the prison at 12.10pm and at unit 3A three minutes later. The paramedics assessed the man and asked staff to continue CPR while they treated him. They decided that the man should be taken to Milton Keynes Hospital and he was placed in the ambulance. When a prisoner has to leave the prison, a risk assessment should be carried out which assesses whether they need to be restrained (in handcuffs) and how many officers need to go with them. Because of the nature of the emergency, the man was not restrained. Two officers were directed to escort the man to hospital in the ambulance. The paramedics asked the nurse who had carried out the man's first reception healthscreen, and who had arrived to help with resuscitation efforts, to accompany them in the ambulance, which left the prison at 12.40pm. During the journey to hospital, one of the accompanying officers and the nurse continued to administer CPR under instruction from one of the paramedics.
52. On arrival at the hospital, the man was assessed by doctors who pronounced at 12.51pm that he had died. The man was moved to a quiet room, and a member of prison staff came to collect one of the officers and the nurse. The other officer who had accompanied the man in the ambulance remained at the hospital with the man until the coroner's officer arrived.
53. After the man had been taken to hospital, staff found a length of plaited bedsheet approximately eight feet long in his cell bin.
54. Later that day, another officer told the man's former cellmate that he had died. The prisoner said he had told unit staff that he had concerns about the man and that he posed a risk to himself. The prisoner told the officer that he had found the man with a ligature on one occasion, which he had thrown in the unit bin. He said he had shown an officer the ligature before disposing of it. The prisoner could not remember the names of any members of staff he had spoken to. Because the prisoner did not wish to take part in the investigation, it has not been possible to investigate this matter further.
55. Several days after the man's death, a second Listener approached a principle officer (PO), the unit 3A manager. The Listener told the PO that another prisoner had talked to the man about three days before his death. This prisoner said the man had told him he would kill himself. Unfortunately, the prisoner could not be interviewed as he had already been released from the prison and had no forwarding address. It would seem that he did not tell any staff what the man had said.

Contact with the man's family

56. The duty governor asked two Family Liaison Officers to visit the man's family to inform them of his death. At 1.45pm, they and a governor went to the man's father's home. The prison Family Liaison Officers remained in contact with the man's family over the following weeks. They attended the funeral and arranged for members of the man's family to visit the prison and House Unit 3A.

Support for other prisoners

57. On hearing the nature of the emergency radio call at 12.00 noon on the day the man died, the senior officer in the prison control room instructed that staff carry out a check on all prisoners on an ACCT document. The lock down search continued in the afternoon.

58. Following the man's death, the then Governor issued a notice informing prisoners, which was placed under all cell doors. The second cellmate, who had been transferred to HMP Wellingborough earlier that day, was also told that the man had died. He said he was very upset when he heard and was placed on an ACCT for five days so that he could be offered the necessary support. He told the investigator that, in the days that followed, he received support from the prison chaplain, the mental health team and staff on the wing where he was located.

Support for staff

59. At 2.00pm, the Deputy Governor held a 'hot debrief'. (This is a requirement of Prison Service Order (PSO) 2710 Follow up to a death in custody. The PSO directs all staff involved be invited to attend a meeting held immediately after the death. The purpose of the hot debrief is to provide reassurance and information.) As the man had been taken to hospital, staff did not know for certain at the time that he had died. The Deputy Governor confirmed his death during the hot debrief.

60. All staff interviewed as part of this investigation said they felt very well supported by senior managers. Those who attended the hot debrief described it as helpful. A member of the IMB also attended and said he had been impressed with how sensitively the Deputy Governor handled the meeting.

61. Staff involved had all had contact with a member of the prison's Care Team (of whom they all spoke very highly) and were provided with ongoing support in the days and weeks following the man's death. Some staff said they were offered the opportunity to leave work early on the day the man died.

ISSUES IDENTIFIED DURING THE INVESTIGATION

Clinical care

62. The clinical reviewer concludes in her clinical review that the man's mental and physical health was appropriately assessed on his arrival at Woodhill and that he gave no indications that he intended to harm himself. She notes, however, that the secondary healthscreen was conducted on the same day as the first reception healthscreen. A senior nurse at the prison told the clinical reviewer that this should not happen. Prison Service Order (PSO) 0500, Reception, directs that the secondary healthscreen must take place within seven days of the prisoner's arrival. The clinical reviewer suggests that staff receive clarification on the ideal timing of the secondary healthscreen. The secondary healthscreen provides healthcare staff with another opportunity to assess the general wellbeing of newly arrived prisoners. I believe that for this reason, while the PSO is vague about the most appropriate timing of the secondary healthscreen, it should not be conducted on the day the prisoner arrives.

The Head of Healthcare should ensure that first and secondary healthscreens are not conducted on the same day.

63. The man completed an application form to see the doctor, apparently within a few days of his arrival. He said he had brought drugs into the prison, which he had now taken and had "left himself in trouble". The clinical reviewer was concerned to find that the application form was undated, and in fact provides no space for recording the date. She was not able to track what action was taken by healthcare on receipt of the application. The man was examined by a prison doctor on 9 January, but there is no record of the reason for the appointment, or whether it was as a result of his application (although the clinical reviewer concludes that this is the most likely reason.) Since January, a new system has been introduced whereby prisoners wishing to make an appointment with the doctor or other health service now do so by telephone. The clinical reviewer makes the following recommendation:

The Head of Healthcare should ensure that the doctors' appointment system enables staff to accurately track each patient's contact and treatment.

64. The clinical reviewer highlights a general problem with healthcare record keeping at Woodhill. She notes that it was not always possible to identify which members of staff made entries in the medical record or what actions were taken. She concludes that redesigning or updating some healthcare forms might help to improve general record keeping, and I endorse her recommendation in that respect. A number of other prisons now use an electronic healthcare system, which has largely improved the standard of record keeping. The Head of Healthcare might wish to pursue this option with the PCT; in the meantime the standard of record keeping in healthcare should be improved.

The Head of Healthcare should ensure that all entries in medical records meet the requirements of the Nursing and Midwifery Council guidance.

Indications of the man's vulnerability

65. On his arrival at Woodhill, the man was asked several times whether he had ever harmed himself in the past, or whether he now had any thoughts of self harm or suicide. The man told staff that he had no concerns and no thoughts of harming himself.
66. During the course of the investigation, the investigator spoke to a number of people who had contact with the man during his three months at the prison. No one had any concerns about him. The second cellmate, who shared a cell with the man in the weeks before his death and knew him from outside prison, said the man told him he had harmed himself in the past. On the second cellmate's departure from Woodhill, the man said "don't go". At the time, he thought nothing of this, but said that, in retrospect, perhaps he should have been concerned. The solicitor, from the firm of solicitors representing the man in his criminal matters, also knew him well. The man gave him no cause to worry.
67. After the man's death his first cellmate and another prisoner said that the man had talked of harming himself. The first cellmate said that he had found the man with a ligature and had shown it to staff before disposing of it. Unfortunately, neither the first cellmate nor the other prisoner could be interviewed. I am satisfied that, had such indications of risk come to light, staff on unit 3A would have taken the appropriate action. Staff were clear about their obligations under the ACCT process and the unit managers were confident that any concerns would have been recorded in his wing file and the unit observation book. I have found no reason to doubt this.

The response to finding the man hanging

68. Staff interviews and incident reports written shortly after the man's death indicate that the staff responded quickly to finding him hanging. The officer who found the man hanging entered the cell and supported the weight of the man's body until other staff arrived and helped to cut the ligature. Staff moved the man to the association area outside his cell, which gave them space to assess his condition and begin CPR. Although not all of the discipline staff present had up to date first aid training, those who administered CPR said they felt comfortable and confident to do so. I have made previous recommendations about first aid training for staff at Woodhill and have been assured that a sufficient number of discipline staff across the prison have received up to date training. The Governor will wish to assure himself that this is still the case.
69. Healthcare staff who happened to be working on unit 3 were alerted to the medical emergency and arrived at the man's cell very quickly. One of the HCOs, one of the first to arrive, described the staff response as "organised ... and under control". Healthcare staff began to assist with CPR, while others fetched the emergency medical equipment which was stored in the central area between units 3A and B. The clinical reviewer found that within minutes of the medical emergency radio call, 11 members of healthcare staff had arrived on unit 3A. I

am pleased to echo her conclusion that the resuscitation attempts were made effectively and efficiently.

70. The clinical reviewer highlights, however, that two members of healthcare staff had not received Basic Life Support training within the last year, in line with the NHS Milton Keynes local policy. She advises that this be addressed as a matter of urgency. The Ombudsman made a similar recommendation in a recent report and so I do not repeat it here. The Head of Healthcare will now wish to assure themselves that the appropriate action has been taken. One member of discipline staff interviewed thought that discipline staff should receive training in the use of the defibrillator because they are often the first to arrive at an incident. Again, a similar recommendation was made in the recently issued report. The Prison Service responded that all nursing staff had been trained to use a defibrillator and can respond quickly to a medical emergency. However, as the defibrillators are stored in the central area of each unit, the Governor and Head of Healthcare might wish to re-consider training a spread of discipline staff too.

71. Each set of emergency medical equipment in the prison should be checked weekly and a log book is provided to record the dates of such checks. The investigator and clinical reviewer examined the log books on two units (including unit 3) and found that weekly checks were not being carried out. On unit 3, the equipment had usually been checked on a monthly basis and, at the time of the investigator's visit, had not been checked since the day after the man died (some six weeks before). Although there is no suggestion that the emergency equipment did not work on the day the man died, it is essential that it be checked on a regular basis and in line with local policy.

The Head of Healthcare may wish to review the protocol for checking emergency equipment and ensure it is implemented.

72. Interviews with discipline and healthcare staff highlighted some confusion about the correct procedures for alerting staff to a medical emergency. The investigator was told that the policy had recently changed. Healthcare staff interviewed were following a policy dated April 2006, which used the term 'Code Red'. In fact, the correct procedure is to announce an 'Urgent Message'. While I am satisfied that this confusion had no impact on the response to finding the man, the Governor will wish to address it nonetheless.

The Governor may wish to remind staff of the correct emergency radio procedure.

73. The man was not pronounced dead until he arrived at Milton Keynes Hospital. After he died, one of the officers who had accompanied him in the ambulance remained with him until the coroner's officer arrived. He told the investigator that he had not wanted the man to be alone. I commend the officer for the sensitivity and care he showed to the man at that time. I ask the Governor to formally pass on my commendation to the officer.

CONCLUSION

74. The man had been in prison a number of times before, and had been at Woodhill previously. He had been charged with a number of serious offences and knew he might be facing a lengthy sentence, which he told his cellmate he would struggle to cope with. He was 50 years old and isolated from his family. He had a history of drug use and there was suggestion that he had been taking drugs while at Woodhill. Two other prisoners said that the man talked about harming himself, but did not make staff aware of this. In fact, staff had no concerns about him and so he was not being monitored under the suicide and self harm procedures. While I make five recommendations, I judge that his death was not foreseeable or preventable.

RECOMMENDATIONS

For the Head of Healthcare:

1. The Head of Healthcare should ensure that first and secondary healthscreens are not conducted on the same day.

The Prison Service has accepted this recommendation. Secondary healthscreens are now carried out on the prisoner's second day in the prison as part of the New Prisoner process.

2. The Head of Healthcare should ensure that the doctors' appointment system enables staff to accurately track each patient's contact and treatment.

This recommendation has been accepted. The telephone appointment system is logged and auditable.

3. The Head of Healthcare should ensure that all entries in medical records meet the requirements of the Nursing and Midwifery Council guidance.

This recommendation has been accepted. All nurses will be given the Nursing and Midwifery Council guidelines and education regarding documentation standards is ongoing.

4. The Head of Healthcare may wish to review the protocol for checking emergency equipment and ensure it is implemented.

This recommendation has been accepted. A new Emergency Equipment Checking Protocol has been implemented and emergency equipment has been reviewed.

For the prison Governor:

5. The Governor may wish to remind staff of the correct emergency radio procedure.

The Prison Service has accepted this recommendation. New instructions have been issued to staff.