The Death in Custody of a man at HMP Woodhill on 20 July 2005

Report by the Prisons and Probation Ombudsman

for England and Wales

January 2006

This is the report of an investigation into the death of a man at HMP Woodhill on 20 July 2005. He was found hanging in his cell on House Unit 5, the Induction Unit at Woodhill. He had arrived at Woodhill the previous afternoon and was 22 years of age.

A letter, addressed to his sister, which was found in his cell after his death would appear to indicate that he intended to take his own life.

I took over responsibility for investigating deaths in prison custody in April 2004 and this was the third apparently self-inflicted death that I have investigated at Woodhill. The purpose of the investigation was to establish the circumstances and events surrounding the man's death, including the quality of care provided by the Prison Service. One of my Family Liaison Officers, made contact with the man's sister and mother to explain how my investigation would proceed. I offer my profound condolences on their loss to his sister, parents and other members of the family.

The investigation was conducted by a member of my office. I commissioned a clinical review from Milton Keynes Primary Care Trust and I am most grateful to the Supervising Consultant Psychiatrist for conducting the review. I thank the Governor of Woodhill and his staff for the cooperation my investigator received at all stages of the investigation. I am especially grateful to the senior Woodhill Governor and to the manager on House Unit 5 for responding so cheerfully and professionally to all the demands on their time during the investigation. I acknowledge also the significant assistance I received from Thames Valley Police and Hertfordshire Constabulary.

I do not think the man's death could have been prevented because he gave prison staff at Woodhill no indication of the distress he must have been feeling. At several points during his short time in the prison, and after his death, there were examples of staff sensibly using their initiative and I was pleased to see that one of my previous recommendations had already been implemented. There remain a number of areas in which Woodhill could refine and improve its procedures. I draw attention to these in my recommendations. I am pleased to report that seven of my eight recommendations have been accepted and the remaining recommendation has been partially accepted.

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

STEPHEN SHAW CBE
Prisons and Probation Ombudsman **January 2006**

CONTENTS

	Page
Summary	3
Conduct of the investigation	4
The man	5
HMP Woodhill	7
Events between 6 and 19 July	8
The morning of 20 July	16
Follow-up action after the man's death	20
Significant issues and conclusions	22
Recommendations	29

SUMMARY

1. The man was born in 1982 and was just 22 years old at the time of his death on 20 July 2005.

2. He had been continuously in prison custody from November 2001 until he was released from HMP The Mount in Hertfordshire on 6 July 2005. On release, he reported as instructed to his probation officer and then made his way to hostel in South London.

3. On the evening of Sunday 17 July, he was missing from the hostel at the curfew time of 11:00pm. In due course, the hostel authorities discovered that the reason he did not appear was that he had been arrested by Hertfordshire police earlier in the evening. As a result of information supplied by a prisoner at The Mount, he was caught outside the prison in possession of heroin. He was subsequently charged with possession and attempted supply of heroin to a named prisoner in the jail.

4. He was held in police cells at Hemel Hempstead until the morning of Tuesday 19 July. On that date, he appeared at Hemel Hempstead Magistrates' Court and was sent for trial at St Albans Crown Court. The warrant instructed that he be conveyed to Woodhill prison and held there until 26 July when he was to make an appearance at St Albans Crown Court by video link.

5. He had contact with a number of people during his first day at Woodhill. His First Reception Healthscreen was conducted by an experienced Healthcare Officer who had no concerns about him. Shortly before tea time, he was transferred to House Unit 5, the Induction Unit at Woodhill, where his Induction Interview was conducted by an officer who has 15 years' experience as a prison officer. She was aware that he was to be allocated a single cell because he had threatened violence against his cellmate if he was required to share. She established a very good rapport with him, so much so that she was thinking of arranging a cleaning job which would maximise his time out of cell. The No. 1 prisoner cleaner on the wing saw him and could tell by his calm demeanour that he had been in prison before. He did not seem at all depressed to the cleaner.

6. At approximately 8:15am on the morning of 20 July, he was found hanging from the window of his cell. He had made the ligature from a torn up white sheet. Strenuous and skilled efforts were made to save him, but to no avail, and the prison doctor pronounced death at 9:20am.

7. The news of his death was broken to his family in East London by the Chaplain from HMP Belmarsh. A letter to his sister was found in his cell. The letter indicated that he could not endure another prison sentence so soon after finishing his previous one.

8. I do not believe that his death could have been predicted, but I make eight recommendations designed to improve a number of processes at Woodhill.

CONDUCT OF THE INVESTIGATION

9. The investigation was opened on 27 July 2005 when my colleague visited Woodhill. He met with the Deputy Governor, the Chair of the Independent Monitoring Board (IMB), the Chairman of the local branch of the Prison Officers' Association, and the senior Woodhill Governor who was appointed as Investigation Liaison Officer. They were all briefed on the nature and scope of the investigation. Notices were issued to staff and prisoners announcing the terms of reference and inviting anyone who wished to contribute to the investigation to make themselves known to my investigator.

10. The man's death occurred on House Unit 5, the Induction Unit at Woodhill. My investigator visited the cell where he died and based himself on that House Unit when he returned to Woodhill for three days in August to interview a number of staff and one prisoner. Members of staff who had had significant contact with the man during his short time at Woodhill were interviewed on tape. My investigator also interviewed the No. 1 cleaner on House Unit 5, as he is out of his cell all day and had a brief conversation with the man shortly after his arrival.

11. One of my Family Liaison Officers (FLOs) made contact with the man's sister and mother to explain the role of the Ombudsman and to ask whether they had any questions or concerns. They asked to be kept informed of the progress of the investigation, but they did not request a home visit from my investigator and FLO.

12. The man's father wrote to my investigator and set out his views as to why his son had died. My investigator telephoned him in response to the issues he had raised in his letter.

13. I obtained information from Hertfordshire Constabulary about the time that the man spent in their custody between 17 and 19 July. I also obtained information from both the police and The Mount about the circumstances of his arrest outside the prison on the evening of 17 July. My investigator spoke with a Project Worker for the Hertfordshire Drug Arrest Referral Service who saw him in police cells at Hemel Hempstead on 18 July.

14. My investigator contacted the Chaplain from HMP Belmarsh who broke the news of the man's death to his family. He also visited the hostel in South London, where the man went following his release from The Mount on 6 July. At the hostel, he spoke with the man's friend and with a member of staff who took a close interest in the man during the 11 days he spent there.

15. An Independent Clinical Review of the management of the man's health needs while he was in custody was undertaken by a Supervising Consultant Psychiatrist on behalf of the Milton Keynes Primary Care Trust.

16. Her Majesty's Chief Inspector of Prisons (HMCIP) made an unannounced inspection at Woodhill in August 2005. My investigator has maintained contact with the leader of the inspection team to discuss issues of common concern.

THE MAN

17. His previous prison record contains a number of Pre-Sentence Reports which supply information about his life prior to July 2005. He was a young black man, born in Hackney, East London, on 19 November 1982. A report written in March 2002 referred to an address in East London where he had lived with his sister and mother since 1994. He was described at that time as having occasional contact with his father who had separated from his mother when he was aged four. He obtained three GCSEs at school and then attended Barking College where he studied an NVQ in Engineering. He did not complete this course and left after approximately eight months. A report for court written in February 2000 described his main hobby at the time as body building, an interest he shared with his father.

18. After leaving college, he was employed in a pharmacy where he had previously worked on a part-time basis. He then had other short-term jobs and also studied a National Diploma in Information Technology. After release from his first custodial sentence, he managed to find employment with a women's clothing store in the West End. He was dismissed from that position because of poor punctuality. He insisted to the probation officer who wrote the report that he had never used any illegal drugs.

19. A further Pre-Sentence Report was completed when he appeared at the Central Criminal Court (Old Bailey) in London in September 2002. That report also referred to his parents' separation and stated that he had experienced an unsettled period with frequent changes of address. He had responded to this by running away on several occasions in an attempt to find his father. The report said that his relationship with his father had improved as he got older. The probation officer who wrote the report understood from him that, after his first offence, subsequent offending *"was committed impulsively with peers and was motivated by the desire to purchase luxury items".* After his first release from custody, he told the probation officer that he intended to leave his offending past behind him and concentrate on working: *"However he told me that his resolve weakened in the face of the apparent ease with which friends obtained considerably more money than he earned. He, accordingly, succumbed to temptation and once more resorted to criminal activity."*

20. The letter written by the man to his sister, which was found in his cell after his death, refers to the amount of time he had already spent in prison, and his fear that he would receive a long sentence, given that he had been denied bail. I therefore set out in some detail his contact with the prison system before July 2005.

21. He committed an offence of robbery on 1 September 2000 and was then held on remand in HMP Chelmsford until being sentenced to 15 months detention in a Young Offender Institution (YOI) at Snaresbrook Crown Court on 1 March 2001. As he had already spent a lengthy period on remand, he was released on licence from HMYOI Hollesley Bay on 17 April 2001.

22. He was then continuously in custody from 19 November 2001, his 19th birthday, until his release from The Mount on 6 July 2005. From 20 November 2001, he was held at HMP Chelmsford accused of a number of serious sexual offences. He was transferred to HMYOI Feltham in West London on 27 November 2001. On 3 April

2002, he was sentenced at Snaresbrook Crown Court to two and a half years detention in a YOI for a robbery committed in October 2001. On 13 September 2002, he was sentenced to five years detention at the Old Bailey for a number of offences against young girls committed when he had been in the company of other young men. Four days after sentence at the Old Bailey, he was transferred from Feltham to HMYOI Aylesbury where he remained for almost two years. In July 2004, he was transferred to HMP The Mount, an adult prison. Prior to his arrival there on 14 July, he spent nine days at Woodhill.

23. A panel of the Parole Board considered him for early release on 30 July 2004. One of the documents considered by the panel was a report written by his probation officer in East London, in June 2004. The probation officer wrote that the man did not want to return to his home area when he was released from custody. She said that this consequently affected his housing options, as he appeared to have no-one else he could live with outside East London. She added that in recent months he had been considering a placement at a Probation Hostel. He maintained strong ties with his family who remained supportive of him: *"He is only unable to return to live with them due to the location of their addresses and the fact that he does not want to return to his home."*

24. The Parole Board panel rejected his application for early release. In the last paragraph of their reasons for refusing parole, the panel set out their view that a stable release address away from his past associates would be important in managing his risk of reoffending.

25. My investigator telephoned the Senior Officer (SO) on Brister wing where the man was held at HMP The Mount. The SO knew him well and remembered him as a happy-go-lucky young man who always had a smile on his face. The SO recalled that he was *"always bouncing around".*

26. His father wrote to my investigator from a prison in East Anglia. He said that a woman, whom he named in his letter, was responsible for his prison sentence because she had sent armed police to his residence. He said that, if he had not been in custody himself, he would have been able to obtain a job for his son and he could also have shared his accommodation.

27. The man's father added in his letter that his son loved life and was not the suicidal type. He thought that he would be expecting another lengthy sentence after being arrested outside HMP The Mount *"so that's why he did what he did".* His son was smart and intelligent but *"wanted things in life quickly".*

HMP WOODHILL

28. In her 2002 report HM Chief Inspector of Prisons wrote that Woodhill is an extremely complex prison: *"As a core local, it holds all categories of prisoner from high risk category A prisoners awaiting trial or sentence, to remanded young prisoners and fine defaulters. In addition, it is one of only two prisons with Close Supervision Centres designed to hold the most dangerous prisoners in the prison system."*

29. Woodhill was opened in 1992 and was the last prison to be built with public money. There is spacious residential accommodation, broken down into five house units. There are large grassed areas between each house unit and other buildings used for healthcare, administration, and the like. The prison is located on the outskirts of Milton Keynes. It serves four Crown Courts and magistrates' courts within the Milton Keynes, Buckinghamshire and Bedfordshire areas.

30. The operational capacity of the prison is 762 and on three successive mornings when this investigation was proceeding the unlocked figures were 759, 760 and 757. The operational capacity on House Unit 5, the Induction Unit, is 86 and the unit is nearly always full to capacity.

31. I investigated two apparently self-inflicted deaths at Woodhill in 2004. In April 2004, a prisoner took an overdose of medication which had been prescribed to him to alleviate back pain. In June 2004, a prisoner who had been charged with two counts of murder tied a ligature around his neck and made very deep cuts to his neck with razor blades. He was found in his cell in the Segregation Unit by the prison chaplain but could not be revived.

32. Soon after the man's death, a further apparently self-inflicted death occurred in the prison's Healthcare Centre. That death is presently being investigated by two colleagues from my office.

EVENTS BETWEEN 6 AND 19 JULY

33. The man was released from HMP The Mount on Wednesday 6 July. His licence informed him that his supervision began on 6 July and was to expire on 19 December 2005. The licence instructed him on his release from prison to report to a probation officer in East London, without delay. He did so. He then made his way to a hostel in South London. A place at the hostel had been reserved for him in May. My investigator visited the hostel where he was given a very helpful briefing by a member of staff there who had had a good working relationship with the man. My investigator obtained a copy of the Contact Log which outlines significant contacts between the man and hostel staff.

34. A probation hostel (Approved Premises) is a much more relaxed environment than a prison cell, but one major formal requirement was that the man and other residents had to be back in the hostel for curfew by 11:00pm each evening. The Contact Log indicates that he was fully inducted on his arrival at the hostel at 6 July. He was described as pleasant throughout the induction process. On the evening of 8 July, he rang to say he would be late for curfew and he did not arrive until just after midnight. When staff asked him the next day about his late appearance, he said that he had been at his mother's and had lost track of time. The Contact Log for Saturday 16 July states that he was pleasant when seen, then the following day's entry notes that he was absent at curfew time. His community supervision had been transferred immediately from the probation officer he saw on the day of his release from prison to another probation officer located much nearer the hostel. He was instructed to report to the new probation officer on Wednesday 13 July and did so. She recalled that he was very keen for everything to go well, he wanted to make a fresh start and he was the only person who had ever said to her that he liked the hostel.

35. When my investigator discussed the man's time at the hostel with a member of staff, she told him that he had been upbeat and jovial. He was speaking about the future and about the education and work he intended to obtain. He was friendly towards the staff and would give them sweets when he returned to the hostel. She was not his keyworker at the hostel but both had a good, friendly relationship with each other, based in part on their shared interest in PlayStations. He loaned her one of his PlayStation magazines. She said there was absolutely no indication that he was taking drugs during his time at the hostel.

36. My investigator also had a long discussion with the man's friend who had first met him when they were prisoners together at Aylesbury. They remained together at Aylesbury for two years. He remembered the man as a hyperactive man, who spent as much time in the gym as he could. At Aylesbury he described him as "*fine and cool*". The two men had not seen each other since Aylesbury but, about a week after the man's arrival at the hostel, they met up again there. The man's friend thought he seemed a bit quiet but he attributed that to the readjustment he was making after a lengthy period of custody. The man told him that he was looking for a job and his friend took him to the gym where he was a member. He said that he was happy to be at the gym and afterwards they went to Pizza Hut with his friend's girlfriend. The man then disappeared at the weekend without telling his friend where he was going. The

last important contact that the member of staff remembers having with the man was on the afternoon of Saturday 16 July. She remembers him discussing with her a list he had drawn up of things he felt he must do. The list included keeping the hostel rules, keeping his probation appointments (another one had been scheduled for 20 July), and getting a job.

37. The reason for his curfew failure at the hostel on the evening of Sunday 17 July was that he had been arrested that evening outside HMP The Mount.

38. He was arrested by officers from Hertfordshire Constabulary at 8:30pm and arrived at Hemel Hempstead police station just after 9:00pm. The two offences with which he was subsequently charged were:

    i. on Sunday 17 July 2005 at Hemel Hempstead had in your possession 3.54 grammes of heroin with intent to supply it to Mr Z and/or other unknown persons or prisoners within HMP The Mount;

    ii. on or between 1 July 2005 and Sunday 17 July 2005 at Hemel Hempstead conspired together with Mr Z to supply 3.56 grammes of heroin to occupants of HMP The Mount.

39. In the letter to his sister found in his cell at Woodhill on 20 July, he described his arrest thus: *"I went back to the jail to throw some drugs over and my man was gonna send me a few bills but somehow the police got wind and were waiting for me. I tried to tell them that the drugs were for me and that I'm a user but they knew the truth and had phone conversations taped."*

40. My investigator discussed the arrest with the Head of Operations at HMP The Mount, who confirmed that a registered (prisoner) source in the prison had provided the intelligence which led to a prison/police operation and the man's arrest.

41. He remained at Hemel Hempstead police station from the evening of 17 July until the morning of Tuesday 19 July. Hertfordshire Constabulary have made available to me their custody records relating to this period of time. The Initial Assessment Record notes that he was asked if he needed to see a doctor. He replied that he was suffering from withdrawal from heroin. He also said that he had never tried to harm himself. The first entry in the Initial Detention Log was made at 9:01pm and states that *"the detained person (DP) requests a doctor due to heroin withdrawal. No other medical issues."*

42. He was seen by a police doctor just before midnight on 17 July. The doctor's notes state that he had been a drug addict for six to seven months and that he smoked heroin but had never used it intravenously. He bought two or three bags per day at a cost of £30. The doctor prescribed dihydrocodeine and zopiclone. On a sheet headed Doctor's Instructions, the doctor recorded that he was suffering from opiate withdrawal.

43. Just before 10:00am on Monday 18 August, the man was examined by another police doctor. The police requested this examination because he said he was suffering from

drug addiction and backache. The doctor decided he should be given no further medication for his addiction but prescribed neurofen for the backache.

44. At 1:40pm, a police interview with him had to be suspended because he was feeling unwell. He said he was feeling sick and was having stomach cramps. The police sent for the same doctor who had examined him the previous evening and medication was prescribed.

45. At 3:35pm, he vomited whilst talking to his solicitor. The doctor was contacted again and advised regular checks. He stated that the vomiting could be due to painkillers.

46. The Detention Log indicates that he spoke to "Drug Awareness" at 6:51pm and was then placed back in his cell. I have obtained a good deal of information about this interview with the project worker for CRI, a company contributing to the Hertfordshire Drug Arrest Referral Service. She completed a detailed Drug Interventions Record and also wrote to the CARATs Manager at Woodhill on 22 July about her dealings with the man. (CARATs stands for Counselling, Assessment, Referral, Advice and Throughcare Services. The CARATs team in each prison provides a drug misuse intervention service to any prisoner who requests it.)

47. In her letter of 22 July, the project worker confirmed that she met him at the police station on the evening of 18 July and then again for a few minutes at Hemel Hempstead Magistrates' Court on the morning of Tuesday 19 July. During both conversations he appeared polite and calm and quite willing to discuss his situation. The letter continued as follows: *"He expressed a willingness to deal with his drug use and was keen to access all treatment services available to him. He seemed positive about the future and we talked about possible activities for him to involve himself with both at prison and upon release … He explained that he had no history or intentions of harming himself and showed no traits of mental illness. He did however admit to feeling anxious and was slightly distressed due to the difficulties in contacting his family."*

48. She recorded a great deal of information about him in the Drug Interventions Record, a 17 page document. He told her that he had started using heroin six/seven months previously and that he was introduced to the drug when he was in prison. He told her that he wanted to get clean from heroin. He agreed to accept further intervention and also agreed that the information recorded on the form could be shared with Prison Healthcare and CARATs in any prison establishment supporting his continuity of care. This 17 page document did not reach Woodhill until 22 July, two days after his death.

49. On the morning of Tuesday 19 July, he appeared at Hemel Hempstead Magistrates' Court accused of the two drugs offences. The magistrates sent him for trial at St Albans Crown Court and remanded him in custody to Woodhill. He was to appear by video link for a preliminary hearing at the Crown Court on 26 July, a week later. Global Solutions Limited (GSL) were responsible for transferring him from the court to prison. They recorded on his Prisoner Escort Record that he arrived at Woodhill at 12:24pm. The risk categories on the front part of the form identified no known medical or suicide/self-harm risks. The drugs/alcohol issues box was ticked but there was no information at all as to the nature of these drugs/alcohol issues. The first

page of his core prison record was completed by a Prisoner Custody Officer (PCO), a GSL employee. There is apparently an arrangement between GSL and Woodhill for this to happen so that new prisoners can be speeded through the Reception process as rapidly as possible. The first page of the record contains a good deal of information about the prisoner and his appearance. It also has a section for the name and address of his next of kin and he named his sister. The PCO did not spell her address in East London correctly. The man also named a friend who could be notified in an emergency.

50. The first night procedures for a new prisoner at Woodhill are set out at page 9 of the prison's policy document on Suicide and Self-harm Prevention, which was published in May 2004. The document states that House Unit 5 will operate as the establishment's First Night/Induction Unit. When new prisoners are received into Woodhill they will progress through the normal Reception procedures. They will be searched and interviewed, and will then see a member of the Healthcare staff who will carry out a First Reception Healthscreen. Following the healthscreen, and if they are allocated to normal location, a member of staff will locate the prisoner on House Unit 5. They will be provided with a Reception phone call, a shower, a canteen pack, first night interview and allocated a cell. Each cell will be equipped with a television and reading materials will be available. A First Night Officer will interview the prisoner and explain what will happen during their first night in custody. The emphasis will be on keeping the prisoner safe during the first 24 hours.

51. The last part of the Reception process at Woodhill before the healthscreen interview is that a new prisoner has his photograph taken for an ID card and a Cell Sharing Risk Assessment is conducted. An officer undertook these two parts of the Reception process with the man. In a memorandum written on 27 July, the officer wrote that he recalled very little of his conversation with him, *"other than he stated he had been released from prison two weeks ago, and he was not happy about being back in prison so soon after release and would likely assault his cellmate because he was back in prison so soon. He also stated that after being in a single cell for most of his last sentence he did not want to share one now. His attitude was one of annoyance at his return to prison so soon."*

52. The cell sharing risk assessment (CSRA) is a four section document designed to measure the level of risk if a new prisoner shares a cell. The document also asks the prisoner some questions about possible self-harm. After recording his statement that he would probably assault his cellmate, the officer ticked the high-risk box at Section 2 of the form. His judgment was that there was a *"clear indication of high level of risk that prisoner might assault cellmate".* Section 3 of the document is completed by a member of the Healthcare team. The Healthcare Officer (HCO) was also of the view that the man posed a high level of risk to a potential cellmate. Section 4 of the document requires a senior member of staff to make a judgment if previous sections have identified a high risk. Shortly before 4:00pm on the afternoon of 19 July, the Duty Governor went to Reception and decided that the man should be allocated a single cell. He was polite and his manner caused the governor no concern while he was being questioned, but he claimed he might assault another prisoner if he was required to share a cell.

53. In interview, the HCO explained that he started work as a prison officer at Woodhill in 1992, soon after the prison opened. He became an HCO five years ago. Although the man arrived at Woodhill just before 12:30pm, it was not until approximately 3:00pm that the HCO led him out of the holding cell to the interview room where healthscreens take place.

54. In a memorandum to the Governor on 20 July, the HCO explained that he had to stay behind on the Healthcare Centre after lunch to "*facilitate the regime*". He left the Healthcare Centre at approximately 2:30pm to begin his duty in Reception. When he arrived at Reception he was instructed by the senior officer in charge there to interview a juvenile prisoner who was to be located in the Segregation Unit. It was only then that he was able to turn his attention to the man. When the interview started, he apologised for keeping him waiting and his apology was accepted.

55. The purpose of a healthscreen interview is to gain a brief confidential medical and psychiatric history of a new prisoner. On the second page of the document, the HCO indicated that he had received no health information from outside sources. At the beginning of the Physical Health Section, the man was asked if he had seen a doctor in the last few months. He replied that a police doctor had given him a check-up. He gave a negative response to all the other questions in this section of the document.

56. The next section of the document deals with Substance Use but, when he was asked if he had used drugs in the past month, he replied that he had not. This information was of course directly at variance with what he had said to the doctor and Drugs Project Worker who saw him in the police cells at Hemel Hempstead. In the Mental Health Section of the form, he was asked if he had ever tried to harm himself or whether he might consider harming himself because coming into prison was so difficult. He answered no to both questions. If he had answered yes the HCO would have been obliged to refer him to the prison's Mental Health Inreach team and to consider opening an ACCT document. (Woodhill was a pilot prison, along with four others, for new Assessment, Care in Custody and Teamwork (ACCT) procedures which were piloted from January 2004 and are now being rolled out throughout the Prison Service. Prison Service instructions state that a member of staff should open an ACCT plan in the event of any incident of self-harm or whenever he/she has cause for concern that a prisoner may be at risk.)

57. He told the HCO that he had trouble sleeping but he did not think there was any reason why he might need to see a doctor. The eighth page of the healthscreen document requires the screening nurse to indicate any planned action. The HCO indicated that no immediate action was required and signed the form at 3:15pm.

58. In interview, the HCO was asked why he was not able to see the man more quickly. He replied that he helped to supervise exercise for the prisoners in the Healthcare Centre which had not happened in the morning due to lack of staff: *"It was very much a last minute thing [supervising exercise] that I had foisted upon me."* He told my investigator that he had no concerns whatsoever prompted by the man's physical appearance. When asked how he looked he replied that he was *"very fit, very confident, a fit young man".*

59. The HCO also explained that when he asks prisoners questions about self-harm or potential self-harm, he gives them lots of eye contact and ample opportunity *"to give anything away"*. When he asked the man the questions about self-harm, he appeared happy and confident and gave him no concerns whatsoever. Towards the end of the interview the HCO spoke of his overall assessment of him. He was in no hurry to process him quickly, because he was one of the first receptions of the day, and he came across as *"being the model inmate. It was an easy interview and, doing the job that I do, you would wish that all inmates would behave the way he behaved. He was just a very relaxed, easy to get on with guy."* At the very end of the interview with my investigator, the HCO reiterated that the man was a pleasure to interview. He was bright and articulate and gave him no problems whatsoever, despite the entry on the CSRA that he was unhappy about being back in prison again so quickly.

60. The next person to have extended contact with him was an officer on House Unit 5. She has been a prison officer for 15 years and has spent the last five years of her career on House Unit 5 at Woodhill. At approximately 4pm, he arrived on House Unit 5 from Reception and the officer conducted the First Night Interview with him. She estimated that she took 10 to 15 minutes to complete the interview process. The two page First Night Interview document requires the officer to ask 21 questions, many of which are routine. For this investigation, the most important questions are No. 2 which asks if the prisoner is on an open ACCT and No. 19 which asks whether the prisoner has any urgent needs that should be addressed prior to him commencing the induction process. She recorded that he answered no to both these questions.

61. The officer told my investigator in interview that she is an experienced member of staff who has interviewed many prisoners on their first day at Woodhill. She explained that, after reading his CSRA and noting that he was not happy about being brought back into prison after just two weeks in the community, she went into the interview room, *"expecting him to be an inmate with a bit of an attitude. But it was totally different. He was smiling, very nice character, very polite. I started asking the questions and built up a very good rapport in the few minutes that we were there."*

62. Her relationship with him was so good that she told him of the possibility that she would arrange a voluntary cleaning job which would enable him to spend much more time out of his cell. She was asked if he gave any indication of the possibility that he would self-harm and replied *"no indication at all, not at all".*

63. She located him in Cell 1/10 on the Unit because it was the only available cell at that time. She knew that the television reception in the cell was not very good and promised him that staff would endeavour to move him later in the evening to another cell where the television reception would be better. She explained that, had he been a prisoner who was shouting abuse, she would not have gone to that effort. There was just time for him to have a shower before he and the cleaners on the unit were locked in their cells at approximately 4:45pm.

64. An important witness for my investigation is the No. 1 cleaner on House Unit 5. He had vivid recall of the brief contacts he had with the man during the late afternoon of 19 July. In interview, he explained that he had been No. 1 cleaner on the Unit for

about three months and that all the cleaners spend an average of 12 hours outside their cells each day. He was therefore in a position to know what was happening on House Unit 5. He first saw the man at about 4:15 or 4:30pm when he came back from gym. The cleaner immediately paid attention to him because he was black. He said, *"I am the foreign national representative and so it is my duty to pick-up on certain things."* He came over to me and asked if the barber was on the Unit. He was not sure if he really needed a barber and wondered if he asked the question in order to make conversation. The cleaner explained that he, his cellmate and the man were the only black prisoners on the bottom landing (the 1's) of House Unit 5.

65. The cleaner had further contact with him at the time of the evening meal. As No. 1 cleaner, he helped staff to serve food to the other prisoners. He was serving desserts and the man was the only prisoner who chose an apple in preference to the apple crumble and custard selected by all the others. When the man took the apple from him, *"there wasn't a sign of depression in his eyes. There was nothing like 'this is it – my time has come,' you know. There was nothing like that."*

66. Later in the evening, at approximately 6:30pm, the cleaner saw him come out of his cell to make a telephone call. All new prisoners on House Unit 5 are entitled to make a three minute Reception phone call on the day of their arrival. The cleaner did not speak to him at this time because he described himself as a man who just gets his jobs done and does what he has to do.

67. My investigator asked the cleaner if the man gave any signals that concerned him. He replied, *"He didn't look depressed in any way. It wasn't as if he was looking jovial because nobody looks jovial, but sometimes you see people come into prison and you know that they are a bit shaken by the whole experience. He looked like somebody who had transferred from another prison to Woodhill."*

68. The cleaner was sure that the man had taken his own life and at the close of the interview he said: *"As I said before, if there is a certain criteria in deciding who is going to take his life, he did not fall into the category in any way."*

69. A memorandum from an officer confirms that he enabled the man to make his three minute Reception phone call just before 6:30pm. My investigator has listened to a tape recording of that call, which was made to his friend in East London. During the call, his friend told him that he did not think he would be successful in obtaining bail. The man asked his friend to go to the hostel to collect his belongings there. His friend did, indeed, go to the hostel the following evening, by which time the man had died.

70. The officer's memorandum explains that later the same evening he was present on the 1's landing when another officer organised for the man to move from Cell 1/10 to 1/7 in accordance with the commitment made earlier by the officer who had conducted the induction interview. The officer said the interaction between the officer and the prisoner was particularly jocular. He added that, *"nothing in his [the man's] behaviour would indicate, to me, his subsequent and consequently fatal actions".*

71. The officer on duty at the end of the evening wrote in his memorandum to me that he was working a late shift on House Unit 5 on the evening of 19 July. He did the final

roll count of the 1's landing where the man was in Cell 1/07. As far as he can remember, when he went to the man's cell he was watching his television and raised no concerns.

72. The officer on night shift on House Unit 5 from 19 July until the morning of Wednesday 20 July stated in her memorandum to the Governor that the night was very quiet. I have examined the document which identifies the organisational arrangements for night patrol routines and duties on House Unit 5. The only prisoners who must be checked during the night, according to the organisational arrangements, are Escape List and Category A prisoners. The frequency with which checks must be conducted is laid out in the document. The document adds that staff must follow the specific instructions given to them in regard to prisoners subject to ACCT and be familiar with their cell locations. The man was in none of those categories so he was not checked during the night. Indeed, the organisational arrangements stipulate that, *"patrolling staff will not attempt to wake prisoners during the night unless there are reasonable grounds for suspecting something is amiss".*

73. At approximately 5:50am on 20 July, the officer woke the prisoners who were going to court. She then proceeded to do her morning count and noticed the man standing at his window. She heard talking and assumed he was talking to the prisoner in the cell next door whom she had woken for court.

THE MORNING OF 20 JULY

74. An officer arriving for duty at House Unit 5 at 7:00am on 20 July asked the Night Patrol if she had anything to report from the night shift and was told it had been a very quiet night. She began checking the cells on the 1's landing and estimated she reached the man's cell at approximately 7:10 or 7:15am. The purpose of her check was to make sure that there was a prisoner in each cell unless the occupant had already gone to court. She saw him standing at his window and had no reason to be concerned about him. She knew that a prisoner had gone to court in the cell next door to him. She was not surprised to see him standing at his window because it is not unusual for prisoners to be woken up by men going to court. She said if it is light at that time in the morning they very often get up.

75. A member of the main group of staff came on duty on House Unit 5 at 7:30am. The day started off as normal with him helping his colleagues to unlock each cell on the Unit so that prisoners could receive their breakfast and any prescribed medication. He unlocked the man's cell then proceeded to unlock Cells 1/08 and 1/09. Then he turned back to Cell 1/07. He explained it is his normal practice to unlock a few cells at a time and then double back to ensure that prisoners do not sleep in and miss the opportunity to have their breakfast and medication.

76. In his statements on the day, the officer reckoned that he first unlocked the man's cell at approximately 8:10am. (A feature of the statements submitted by staff is that they do not agree about the time at which the man was found hanging. This strongly suggests that staff wrote their statements independently and did not consult each other about critical parts of the story, such as the time at which he was found. This is to their credit.) A reliable account of what happened and when it happened is contained in the log which a regular member of staff on House Unit 5 was instructed to keep very shortly after the man was first discovered. The first entry in the officer's log is that another officer opened Cell 1/09 (it was actually Cell 1/07) to find the man with a ligature around his neck.

77. In interview, the officer stated that when he went back to the cell he noticed that the man was standing in the same place where he had seen him before. He explained that he was standing by the window. It seemed as if he was looking down at the television and the officer said it was a little bit odd because the TV was not on. He noticed that the man had not moved since the time he first unlocked the cell door. As the officer stood in the doorway, the man was at the back of the cell with his body almost directly facing the door and his head down as if he was looking at the TV to his right. The officer's concern was aroused because the man was still standing in exactly the same position. He had to squint slightly because it was a bright mid-summer morning. He could see the man's outline but not all the particular details.

78. The officer took three or four steps into the cell before he noticed that the man's face was very swollen and his tongue was sticking out of his mouth very slightly. The officer was shocked and, as he walked towards him, he saw a ligature made from a white bed sheet tied around his neck. The ligature was tied to the cell window. The officer could not see the whole ligature because the man's head was down and to the

side, so his chin was covering most of the ligature. The officer could see enough of the ligature to realise what was wrong and he shouted for staff.

79. At this time breakfast was being served to prisoners at the servery on the ground floor of the Unit, so there were many prisoners and staff in close proximity to the man's cell. Another officer, the Senior Officer and the Unit Manager were at the servery and they came running to the officer's aid. He went back into the cell and lifted the man's weight off the floor. In interview, he explained that he grabbed hold of him between his waist and his hips and pulled upwards to lift him off the floor to release the pressure from around his neck. The officer lifted the man off his feet all by himself because he wanted to get him off the floor as quickly as possible. He was in front of the man, holding him up so another officer scrambled over the top of the bed and grabbed hold of the ligature which had been tied around the outside of the window. Staff at Woodhill do not carry a ligature knife but he was able to untie the ligature quickly and the man was then placed on his back on the cell floor. The officer realised at this point that he was very stiff.

80. The Senior Officer took immediate control of the attempt to resuscitate him. He said to one of the officers that they had to do cardiopulmonary resuscitation (CPR) together. The Senior Officer gave the officer a plastic face mask that he carried on his belt so that the officer could attempt to blow air into the man's lungs. In interview, the officer explained that the Senior Officer proceeded to start CPR on the man's chest while the officer got the face mask onto his face. The Senior Officer was leading, telling the officer when to breathe into the man's mouth. The officer said it was very difficult to get the tube into the man's mouth because his face had gone rigid. He described his face as being *"completely set like stone".* In his memorandum to the Governor on 20 July, the Senior Officer wrote that he gave compressions to the man's chest while the officer was giving mouth-to-mouth. They continued at a rate of one breath to five compressions. An agency nurse arrived in the cell very rapidly. She recounted in her memorandum that she was already on House Unit 5 at the time of the emergency. She was administering medication in the treatment room, which is also on the 1's landing of the Unit.

81. When the Staff Nurse arrived at the cell she found the two officers carrying out CPR and they continued to do so whilst she checked for vital signs. The man felt cold to touch and she could not find a pulse in his wrist or neck. There were no signs of breathing. His tongue was protruding, swollen and deep purple to black in colour. His jaw was rigid and his eyes were opened and fixed. His arms were outstretched above his body and were rigid. The staff continued with CPR whilst she went to the office and dialled for more medical assistance.

82. The nurse asked the officer to obtain oxygen and a defibrillator. Another officer told him where to locate the necessary equipment. Earlier this year, after a previous death at Woodhill, I recommended that oxygen and a defibrillator should be available on each unit. I am pleased to note that this equipment was duly in place on House Unit 5. The defibrillator is a small automated machine. The pads are attached to a patient's chest. The machine then analyses the information being fed to it and

instructs the user on the action to be taken. The machine can administer an electric shock which is intended to restore heart rhythm.

83. The Senior Officer helped the nurse to put the two pads on the man's chest. After doing its test, the machine told them that he should not be shocked and they should carry on with CPR.

84. The Senior Officer and nurse were just attaching the pads to the man's chest as the Senior Sister and HCO, who was in training, arrived in the cell. The Senior Sister is a vastly experienced nurse, who qualified in 1970 and joined the Prison Service six years ago. She had completed an intermediate life support course at Milton Keynes General Hospital and was most recently trained in the use of a defibrillator in November 2004. She is the nurse in charge of outpatient primary care for prisoners at Woodhill. On the morning of 20 July, she was carrying Hotel 1 Radio which informs the holder of any medical emergency. She would normally detail more junior staff to attend the emergency and remain in the Healthcare Centre to coordinate anything that needed to be done. The Senior Sister was well aware that the nurse on House Unit 5 was an agency nurse, perhaps not used to Woodhill's systems and procedures, and that the HCO was still under training and so, very commendably, she decided to attend the emergency in person.

85. When the Sister was first called on the radio by the Control Room, she was not told the precise nature of the emergency. She called back and was told that the emergency was an attempted hanging on House Unit 5. The first entry in the Control Room Log is timed at 8:17am. It records an urgent message from Call Sign Quebec 5 that a prisoner was hanging on HU5 (House Unit 5) and medical assistance was required. The Control Room Log confirms that Hotel 1 was informed. The log maintained by the officer on House Unit 5 states that the sister and HCO arrived from the Healthcare Centre at 8:22am. Once the sister had established the nature of the emergency, she instructed the HCO to bring two emergency bags, one green and one red. The green bag contains oxygen and the red bag contains packs made up for various medical emergencies. The sister and the HCO had to travel a distance she estimated as being several hundred yards, as House Unit 5 is the second from furthest House Unit in relation to the Healthcare Centre.

86. When she arrived at the cell, she found the man lying on the floor with his head towards the door and his feet towards the cell window. She established that CPR led by the Senior Officer had already begun and that the defibrillator gave the instruction to continue with CPR. The Senior Officer carried on with chest compressions whilst the sister and the HCO administered oxygen via the ambu-bag they had brought with them. The nurse held the mask on the man's face to ensure a good fit and the HCO squeezed the bag to get oxygen into him. The Control Room Log indicates that an ambulance was requested by an officer at 8:24am and the Control Room dialled 999 at 8:26am. An ambulance appeared very quickly, with the Control Room Log timing its arrival at the front entrance of the prison at 8:30am. Both the Control Room Log and the log kept at the scene on House Unit 5 agree that paramedics arrived at the man's cell at 8:35am.

87. The paramedics asked the Senior Officer to stop compressions so that they could assist the man. They placed leads from a heart monitor on his chest and carried out what the Senior Sister called a rhythm strip, taking a recording of his heart. Prison staff withdrew from the cell at this point so that the paramedics had the necessary space in which to work. The Senior Officer heard one of them say that he thought that the man was dead and the officer's log notes a statement from the ambulance crew at 8:40am that rigor mortis had set in. The paramedics also withdrew from the cell and the officer's log notes that the cell was secured by the sister and HCO at 8:42am. At 9:02am, the ambulance crew left House Unit 5 and the prison doctor arrived. The Chaplain said commendatory prayers (prayers made over the dying). The Coroner's Officer and two detectives arrived on House Unit 5 at 9:16am. They opened the door of the man's cell and entered. The prison doctor examined him and pronounced death at 9:20am.

FOLLOW-UP ACTION AFTER THE MAN'S DEATH

88. Prisoners on House Unit 5 were informed swiftly of what had happened. The officer's log records that at 9:35am all wing prisoners were informed cell by cell of the situation. The No. 1 cleaner on the Unit confirmed in interview that he learned of the man's death when, *"the PO came in and said that he was sorry to report an incident that a gentleman had killed himself."* The cleaner added that the PO and his staff went round all the cells trying to console people.

89. When the man began his previous period of imprisonment, at Chelmsford in November 2001, he named his father as next of kin and his sister as the person to be contacted in an emergency. In July 2005, he named his sister as next of kin and nominated a friend in East London for emergency contact. He had supplied a mobile phone number for his friend, but not for his sister. The Chaplaincy team at Woodhill immediately attempted to trace his sister, although their job was made more difficult by the transposition of two letters in the street name recorded on the first page of his prison record. The Chaplains showed good initiative by contacting HMP The Mount, where the man had been a prisoner until a fortnight previously, and they obtained the correct address for his sister from that source.

90. Prison Service Order 2710 sets out Prison Service policy on Follow-up to Deaths in Custody. The PSO states at Chapter 3, *"unless inappropriate for geographical reasons (i.e. distance from establishment and time taken to travel), it is recommended that notification (of a death) should be made in person by a visit to the next of kin by the Governor and Chaplain."*

91. Woodhill made contact with the Chaplain at HMP Belmarsh and asked him to break the news of the man's death to his sister. He was approached because Belmarsh is in South East London and the journey to the family home was therefore shorter than from Woodhill. The Chaplain was aware that the man's sister is a young woman and he did not want her to be intimidated by his unexpected arrival. He wanted to be accompanied to her home by a female police officer and there was some delay before this could be arranged. When the Belmarsh Chaplain arrived at the home of the man's sister, both she and her mother were out. The door was opened by his grandmother and the Chaplain gave the news of his death to her and her partner. About 45 minutes later, his mother returned home and the Chaplain informed her also of his death. He offered her the opportunity to ring Woodhill and she did so. She spoke for nearly half an hour to the Governor who has liaised both with the family and with my investigator. This provided a very early opportunity for the prison to express condolences to the family.

92. On 21 July, the day after his death, the liaison governor spoke for over an hour to his sister and subsequently made a visit to the family on 1 August. The prison has offered practical assistance to the family with funeral arrangements and the liaison governor also visited his father. She has personally maintained contact with family members on a very regular basis throughout the weeks since his death.

93. A hot debrief, chaired by the Duty Governor, was held on the morning of his death and a critical incident debrief was held in mid-August for the staff who had been most closely involved.

SIGNIFICANT ISSUES AND CONCLUSIONS

94. The Prisoner Escort Record (PER) form which flowed from Hertfordshire Constabulary to the escort contractor (GSL) to Woodhill contains very limited information about the 36 hours that the man spent in police custody. The medical section of the form at Part 4 has a tick against No Known Risk and there is also a tick against Drug/Alcohol Issues in another section of Part 4. There is, however, no information about what these drugs and alcohol issues might be and about whether they are current or long ago. The section of the form where further information can be supplied about risk is blank. I know from scrutiny of police custody records that he was seen by police doctors on several occasions and also vomited in police cells. I am of course conscious of the demands of medical confidentiality, but the PER is a most important document for the sharing of information between one criminal justice agency and another, and the circumstances of his death raise concerns about the effectiveness of information sharing.

I recommend that the Governor considers setting up a meeting between a senior colleague and a senior Hertfordshire Constabulary manager so that arrangements can be made to improve the quality and quantity of information on the PER form.

95. The available evidence from the prison strongly suggests that he intended to take his own life. On the day after his death, his sister told the Governor that he had written to her when he was released from The Mount, stating that if he ever went back to prison he would kill himself.

96. During the night of 19 to 20 July, he was the only occupant of a locked cell and there is absolutely no suggestion that his cell was entered by any other person, either prisoners or staff. He was a strong young man and I have no doubt that he would have resisted violently anyone who entered his cell with the intention of harming him.

97. A crucial indicator of his frame of mind at the time of his death is the letter dated 19 July which was addressed to his sister and found in his cell the following day. He begins the letter by observing that, *"after only two weeks, I've put myself in this situation again. After coming out and seeing how well everyone was doing, I wanted to make some dough too. I know I have let everybody down, every and anyone who cares about me."*

98. Later in the letter he suggests that he should have proved his love for his family by staying out of prison and adds: "*I feel and am such a failure after doing three years eight months, I only lasted one week four days! I don't think I can do time again, knowing how hard it was last time and the chance I have just had was my last to fix my life up."*

99. He went on to predict that he would be looking at a sentence of between four and six years. He wrote that if he did half of that time he would be 25-26 years old when released and that would be too late for him to get to where he wanted to be in life. On the second page of the letter, he said he had been told by his solicitor that bail was very unlikely because he was on licence. In a poignant sentence, he observed that

he was born to suffer from a young age but did not know that, *"the suffering would go on for this long. I just want it to end."*

100. His own assessment of his current situation and future was bleak in the extreme, but he gave no indication whatsoever of the way he was thinking to either staff or prisoners at Woodhill. All the members of staff with whom he came into contact were impressed by him. He gave negative answers to all the questions posed by the HCO on his First Reception Healthscreen. In particular, he denied having any mental health or drugs issues and gave the HCO no reason at all to suspect that he was contemplating self-harm. He ensured that he was allocated a single cell by warning staff of the risk of violence to his cellmate if he were placed in a joint cell. He was consistent when he said he had concerns about sharing a cell because he supplied similar information when received at HMP The Mount a year previously. There too he was allocated a single cell due to the assessment that he was a high risk to potential cellmates.

101. On three occasions during the interview with my investigator, the HCO, who is a very experienced officer, indicated that the man gave him no concerns whatsoever during the Reception Healthscreen.

102. Another similarly experienced officer had no concerns when she conducted the induction interview with him on House Unit 5. He seemed to her to be in good spirits and she built up a very good rapport with him as they spoke for approximately 15 minutes. She had anticipated that her interview with him might be difficult because he had returned to prison so quickly but he was totally different from her expectations. He smiled and struck her as such a nice character that she arranged for him to be moved to a cell with better TV reception, and was considering giving him a cleaning job so that he could spend maximum time out of his cell.

103. The fact that he had to wait two and a half hours in the Reception area before his healthscreen is disturbing. Such a delay is particularly unfortunate in the early part of the afternoon when the number of new receptions is still at a low level. Experienced Reception staff told my investigator that lengthy delays were not uncommon and were particularly liable to happen if prisoners had to see a doctor. This is particularly worrying because it is the prisoners who have the most obvious physical and mental health needs who are identified as having to see a doctor on the day of their reception. I note the HCO's comment that staffing shortages in the Healthcare Centre prevented him from attending to new receptions as speedily as he would have wished, although there is no evidence that the man's distress was increased by the lengthy amount of time he spent in the Reception holding room before seeing the HCO.

104. The report from HM Chief Inspector of Prisons following her inspection of Woodhill in February 2002 indicates that lengthy delays in the Reception area are not new. In her chapter devoted to arrival in custody, she wrote: *"Prisoners were often delayed getting to the Induction Unit location as they had to wait several hours in Reception before they were able to see a doctor who was only available for a short time in Reception in the evening. Our survey of prisoners indicated that nearly 40% of*

prisoners were in Reception for between two to three hours. 20% said that they were there for over three hours. We met some prisoners who had been waiting in Reception for five hours. ***The delay experienced by prisoners waiting to see a doctor in Reception should be avoided****.”* *{Emphasis in original.]*

105. A number of staff who spoke to my investigator advocated transferring as many Reception processes as possible to the First Night Centre/Induction Unit. The Senior Sister, for example, made this point persuasively. She said: *“What’s happening now is that the prisoner comes in and is received into Reception. He has all his prison things, his property, identification, etc. done. At the end of that process is healthcare. By the time the prisoner normally gets to be seen by a Healthcare professional in the evening, it’s very busy, very noisy, lots of people in Reception and the pressure is on for prisoners to be seen by Healthcare and located so that the staff can go off duty … However, if the prisoner was brought to House Unit 5 as a First Night Centre with the Healthcare worker on duty, the environment becomes more calm, people have more time to see them. The opportunity to pick up on little things that may be overlooked is greatly reduced and it can only benefit everyone in the long run.”*

106. The option of transferring more Reception business to House Unit 5 was put to my investigator by prison officers as well as Healthcare professionals. It is most undesirable for the stress of imprisonment to be compounded by long hours spent in a holding room in Reception.

I recommend that the Governor reviews Reception processes, especially the First Reception Healthscreen, with a view to minimising waiting times for new prisoners.

107. Two experienced officers interviewed the man and saw nothing in his speech and behaviour during his first afternoon at Woodhill to worry them. Another person who had significant, though brief, contact with him that day was the No. 1 cleaner. He impressed my investigator as a shrewd and observant judge of character. When he gave the man an apple at the tea time meal he observed no sign of depression in his eyes. At another point in the interview, he said that the man did not look depressed in any way. He thought that he had been in prison before because he was calm and did not behave like people who have never been in prison before who *“ask stupid questions and try to put up this macho stature”.*

108. I conclude that no action could have been taken by staff at Woodhill to prevent him from self-harming because they had absolutely no information that suggested such a possibility. He was the only source of information they had. In particular, the HCO was supplied with no information from the man’s time in police custody that would have alerted him to the possibility that he was using heroin.

109. There is conflicting evidence about whether he was indeed using heroin. He said so to both the drug worker and the doctors who saw him in police cells at Hemel Hempstead. However, he denied using drugs when interviewed by the HCO at Woodhill. Although he told the Arrest Referral Drugs Worker that he had started using heroin in prison six to seven months previously and that he had last used three to four days previously, there is also evidence that casts significant doubt on this

claim. Both his friend and the member of staff to whom my investigator spoke at the hostel in South London expressed surprise when told of the possibility that he was using heroin. A number of witnesses commented on how fit and well he looked. On a number of occasions during the last year of his previous prison sentence, he was tested for drug use and the results were always negative. During the short time that he spent at Woodhill in July 2004 he was tested on suspicion of using drugs. The result was negative. Soon after he went to HMP The Mount he had a voluntary drug test on 20 September and tested negative. As a result, he was moved to Brister wing, a drug free wing. He underwent further voluntary drug tests on 28 March and 13 June 2005 and on both occasions the results were negative. He was released from The Mount less than a month after the most recent negative test.

110. A toxicology report has been supplied to me by the coroner. The report's first conclusion is that: *"Dihydrocodeine was detected in his blood and vitreous humour indicating consumption of therapeutic amounts at some time."* Dihydrocodeine had been prescribed to him by police doctors in Hemel Hempstead immediately before his arrival at Woodhill.

111. A possible explanation for his claim that he was using heroin is contained in the letter of 19 July to his sister. He recounts how the police were waiting for him when he went to HMP The Mount on the evening of 17 July to throw heroin over the wall. He adds that he tried to tell them that the drugs were for his own use and that he was a user, *"but they knew the truth and had phone conversations taped."* The expression *"but they knew the truth"* suggests that he may have claimed to be a heroin user as a defence against the charge that he was supplying the drug to prisoners at HMP The Mount.

112. Whether he was using heroin or not, my investigation has revealed a serious weakness in the flow of information from one agency to another. Although he was interviewed by the project worker on the evening of 18 July, the Drug Interventions Record was not received at Woodhill until 22 July, two days after his death. The document was sent to the CARATs team by post. I am required to investigate the deaths of many prisoners who use drugs and die in their first hours and days at local prisons, such as Woodhill. I need hardly emphasise how critical it is for information about their drug use and treatment to flow smoothly and rapidly into the prison so that the duty of care can be discharged as effectively as possible at each stage of the process. My investigator discussed this issue with the CARATs Manager at Woodhill. He spoke of his desire for Drug Interventions Records to be faxed to Reception, although he was aware of the complication that Woodhill receives prisoners from so many different geographical areas. I know that work is already proceeding at Woodhill to draw up some appropriate protocols.

I recommend that, as a matter of urgency, the NOMS Safer Custody Group offers advice to prisons on the development of protocols so that Drug Interventions Records may, where the individual user has agreed, be transferred rapidly from community agencies to appropriate prison colleagues. Protocols should be drawn up with Drug Intervention Teams and equivalent Drug Action Team Managers.

113. The man's opportunities for contact with other people on House Unit 5 after tea were limited. He had arrived on the Unit at the end of the hour's association permitted to prisoners each afternoon. He did have the opportunity to make his Reception phone call to his friend shortly before 6:30pm and my investigator was unable to detect any obvious signs of distress during that three minute conversation.

114. I do not criticise staff on House Unit 5 for failing to realise more quickly that he was hanging from the window of his cell. When the two officers were doing their count on the 1's landing in the early morning, they had no reason to be concerned about him. One officer had heard talking and assumed, reasonably in the circumstances, that he had been conversing with the prisoner next door who was unlocked early so that he could go to court. When another officer first opened the man's cell, he had to squint because of the bright light and, as he quickly glanced in before moving on to the next cell, it seemed as if the man was watching the television. Even when he returned to the cell a second time, he did not immediately realise that something was amiss. He could see the ligature only when he had taken several steps inside the cell. The man was not subject to any detailed observations prompted by concerns about his safety. On his arrival at Woodhill, there had been no indication that an ACCT document should be opened.

115. In this case, a Clinical Review has been supplied by the Supervising Consultant Psychiatrist. I am very grateful to him for his review and to the Milton Keynes Primary Care Trust for commissioning it. In his review, the consultant observes that no mental health or physical health issues came to the fore as a result of the man's Reception Healthscreen. He comments that, if a prisoner is admitted because of possession of drugs with intent, it might be appropriate to pursue drugs issues a little more by informal questioning even when he says he has not taken drugs in the last month. The consultant does not identify the absence of further questions in the man's case as a failure in his care. His judgment is that the documentation and standards of record keeping were adequate and appropriate. In relation to suicide and self-harm, he reports that no key suicide or self-harm indicators were identified and, as a consequence, he was not on a support plan nor was he referred to the local Mental Health Services. His summary at the end of his review is that, *"There is nothing on the documentation given to me to suggest any shortcoming in the Reception, initial assessment and housing of this prisoner."*

116. The consultant presumes that he was already dead when he was found as his body was cold. My assessment is that the staff response once he had been found hanging was energetic, compassionate and professional. The Senior and another officer did their utmost to revive him, despite the rigidity of his body and the physical difficulty of inserting an airway. Another officer cut himself on the cell window in his haste to remove the ligature around the man's neck. The Senior Officer demonstrated notable devotion to duty by continuously maintaining the arduous task of maintaining chest compressions for approximately 20 minutes until paramedics arrived at 8:35am. The Senior Sister showed good leadership by proceeding to the cell herself, rather than leaving emergency care to much less experienced colleagues. She has been a nurse for 35 years and had recently completed an Intermediate Life Support Course at

Milton Keynes General Hospital. During that course she had been tested on the use of a defibrillator.

117. At the end of his interview the Senior Officer told my investigator that he thought everything that could have been done in the cell was done and everybody responded. He said *"We tried our best to save him but, unfortunately, we were unable to do so."*

I recommend that the Senior Officer, two further officers and the Senior Sister should be commended by the Prison Service for their efforts to save the man on the morning of 20 July.

118. The Senior Sister expressed some important views on ways in which the information flow to Hotel 1 could be improved when there is a medical emergency. She suggested that a code system should be introduced at Woodhill and added, *"The code would clearly define what the emergency is and, as healthcare professionals, we would know what we need to take with us and what we were going to".* I am pleased that senior management at Woodhill has already identified this weakness in contingency plans and I am aware of the intention to publish a Governor's Order so that all staff are aware of the nature of an incident.

I recommend the introduction of a coding system at Woodhill so that staff, and especially medical staff, can respond appropriately to a medical emergency.

119. The way in which the prison made and maintained contact with the man's family after his death is most commendable. The decision to have the news of his death broken to his family by the Chaplain at Belmarsh was an example of good practice. There were some practical difficulties because Woodhill did not have a telephone number for his sister, his nominated next of kin, and the address for her recorded on his prison record was slightly incorrect. Despite these problems, the Chaplain at Belmarsh made his way to the address as rapidly as possible. My investigator discussed the events of 20 July with him. He suggested that prison chaplains should be used as a matter of course to break such news when the family lives in another part of the country. He trained as a prison chaplain in 1990 and saw such a task as part of his core ministry. He assumed that prison chaplains are regularly used to break such tragic news in similar circumstances, although in many of my investigations I have found that it is still the local police who undertake such a role. He had been adequately briefed by Woodhill before going to the family home in East London. He was able to offer the man's mother the option of immediate telephone contact with the Liaison Governor, an authoritative source of information at the prison.

120. The existing Prison Service Order on Follow-up to Deaths in Custody recommends that notification should be made in person by a visit to the next of kin by the Governor and Chaplain or another religious leader. The existing Order is not explicit about what should be done when the family lives a considerable distance from the prison.

I recommend that the Prison Service issues an instruction that notification of a death should be undertaken by a chaplain or trained Family Liaison Officer from a prison near the family, if this is possible and if senior staff from the

prison where the death has occurred are unable to provide notification in person.

121. The prison made early, meaningful contact with the man's family and I am pleased to note the visits made by the Liaison Governor to both his sister and father.

122. Some training issues were identified during the course of my investigation. After a previous self-inflicted death at Woodhill in April 2004, I recommended that all staff trained in first aid should be additionally trained in the use of the defibrillator. In response, Woodhill produced an action plan which indicated that all Healthcare Centre nursing staff would be trained in intermediate life support, including the use of an advisory (automatic) defibrillator. I am very pleased to note that the Senior Sister had recently received this training at the local general hospital. The prison's action plan also includes the training of night managers in intermediate life support, with additional training for all Principal and Senior Officers in immediate life support to be considered, subject to budget and staff resource considerations. Woodhill informed my investigator that 36 staff are due to receive this training in sessions scheduled for July, September and October 2005.

123. In addition to intermediate life support training, this investigation has identified the importance of maintaining a pool of staff who are trained to apply First Aid. Staff who had intimate dealings with the man told my investigator that their first aid training had lapsed or that they were not confident they would be able to maintain the qualification.

I recommend that the Governor reviews his existing arrangements for ensuring that sufficient members of staff retain their First Aid training qualification.

124. My investigation after the death in April 2004 also recommended that all staff involved in carrying out the First Reception Healthscreen Interview receive additional suicide refresher training and are retrained on an annual basis.

125. I am aware of the Governor's response that suicide prevention training is being provided on a rolling programme to all staff and that ACCT Foundation module training is regularly arranged. The HCO told my investigator that he had received no suicide prevention training in the five years he has spent as a HCO.

I repeat the recommendation in my previous report that all staff involved in the carrying out of the First Reception Healthscreen Interview should receive appropriate suicide prevention training as a matter of urgency.

RECOMMENDATIONS

1. **I recommend that the Governor considers setting up a meeting between a senior colleague and a senior Hertfordshire Constabulary manager so that arrangements can be made to improve the quality and quantity of information on the PER form.**

2. **I recommend that the Governor reviews Reception processes, especially the First Reception Healthscreen, with a view to minimising waiting times for new prisoners.**

3. **I recommend that, as a matter of urgency, the NOMS Safer Custody Group offers advice to prisons on the development of protocols so that Drug Interventions Records may, where the individual user has agreed, be transferred rapidly from community agencies to appropriate prison colleagues. Protocols should be drawn up with Drug Intervention Teams and equivalent Drug Action Team Managers.**

4. **I recommend that the Senior Officer, two further officers and the Senior Sister should be commended by the Prison Service for their efforts to save the man on the morning of 20 July.**

5. **I recommend the introduction of a coding system at Woodhill so that staff, and especially medical staff, can respond appropriately to a medical emergency.**

6. **I recommend that the Prison Service issues an instruction that notification of a death should be undertaken by a chaplain or trained Family Liaison Officer from a prison near the family, if this is possible and if senior staff from the prison where the death has occurred are unable to provide notification in person.**

7. **I recommend that the Governor reviews his existing arrangements for ensuring that sufficient members of staff retain their First Aid training qualification.**

8. **I repeat the recommendation in my previous report that all staff involved in the carrying out of the First Reception Healthscreen Interview should receive appropriate suicide prevention training as a matter of urgency.**