



A Report by the
Prisons and
Probation
Ombudsman
Nigel Newcomen CBE

**Investigation into the death of a man at HMP Woodhill
in May 2013**

Our Vision

*'To be a leading, independent investigatory body,
a model to others, that makes a significant contribution to
safer, fairer custody and offender supervision'*

This is the report of an investigation into the death of a man, who was found hanging in his cell at HMP Woodhill in May 2013. He was 30 years old. I offer my condolences to his family and friends.

A clinical review of the medical care the man received at Woodhill was undertaken. The prison cooperated fully with the investigation

The man arrived at Woodhill on 14 January 2013. He had a history of self-harm, alcohol and drug misuse, mental health problems and physical complications related to a previous fracture of his leg. He had been charged and subsequently convicted of a serious violent offence and due to court restrictions was unable to have contact with his family, which distressed him. He had not been sentenced but was likely to receive an indeterminate sentence about which he was anxious. He was sometimes abusive towards staff who found it difficult to manage his challenging and self-harming behaviour. He repeatedly self-harmed and was managed under the suicide and self-harm monitoring provisions for most of his time at Woodhill but his range of risk factors do not appear to have been fully recognised and considered.

In May an officer discovered the man hanging in his cell, while subject to self-harm and suicide monitoring. Prison and healthcare staff attempted to resuscitate him, but sadly without success.

The man was a vulnerable man with complex needs. Although prison and healthcare staff individually offered a lot of support and held frequent reviews of his risk, I am concerned that they did not assess him with sufficient rigour. Greater consideration should have been given to his numerous known risk factors and the root causes of his behaviour. Similarly, sanctions to address his difficult behaviour were not coordinated or consistent and took little account of his vulnerability. A few days before his death, he was placed on the basic regime leaving him to deal with enforced isolation for most of the day and few sources of distraction. A more holistic approach to managing him might have been more effective and provided greater support.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman

February 2014

CONTENTS

Summary

The investigation process

HMP Woodhill

Key events

Issues

Recommendations

Prison Service action plan

SUMMARY

1. The man was remanded to Woodhill on 14 January 2013 charged with armed robbery, for which he was later convicted. He had not been sentenced at the time of his death. He had a full health assessment which identified drug and alcohol misuse, mental health disorders, deep vein thrombosis and an injury to his leg. He had a long history of self-harm both in prison during previous sentences and in the community. Subsequent health reviews indicated a number of other risk factors for suicide and self-harm, such as the suicide of his father and that he was not permitted contact with his partner, stepfather or his mother (who had been diagnosed with multiple sclerosis during his imprisonment).
2. The man was referred to the mental health team and placed on a drug reduction programme. Throughout his time at Woodhill, he was under the care of the mental health team and a psychiatrist, with weekly and sometimes daily reviews of his mental health.
3. The man's first incident of self-harm at Woodhill was on 5 February. Thereafter, he repeatedly self-harmed by cutting his arms as well as burning himself. On one occasion, he took an overdose of paracetamol at a toxic level and prison staff disregarded the instructions of the local hospital and the prison doctor to send him to hospital as an emergency. For much of his time at Woodhill, he was subject to suicide and self-harm monitoring. Case reviews were not always held after episodes of self-harm.
4. From 30 March to 9 May, the man lived in the healthcare centre. He then moved to a double cell in the drug and alcohol detoxification unit, which he occupied alone. He continued to self-harm.
5. The man's behaviour became increasingly challenging and he was given a number of warnings for negative behaviour. On 18 May, his status under the prison's incentives and earned privileges scheme was reduced to basic, which involved the removal of his television and restrictions on his association with other prisoners. This decision was not discussed at a case review to monitor his risk of suicide and self-harm. He continued to harm himself frequently and often refused treatment from healthcare staff.
6. At a case review on 21 May, the man reported thoughts of hanging himself and an appointment was made for him to see the psychiatrist the next day.
7. At about 8.30am the man was unlocked from his cell for a period of association with other prisoners. He was abusive towards prison staff and was formally warned about his behaviour and taken back to his cell. He then persistently pressed his emergency cell bell and told the officer who responded each time that he was just doing this to annoy the staff.

8. At about 11.00am, the man had an appointment with a substance misuse nurse to discuss and review his drug reduction programme. He then collected his lunch and was locked in his cell over the lunchtime period. At 12.30pm, a senior officer informed him that he was moving to another unit that afternoon and asked him to pack his belongings. He spoke briefly about his move to two neighbouring prisoners, who said he told them he was going to wreck his cell before he moved.
9. Between 1.50pm and 1.55, an officer unlocking cells looked through the observation panel of the man's cell and saw him with a bed sheet around his neck tied to the top bunk bed frame. He and other officers called for assistance, but did not use an emergency code. Several other officers and healthcare staff responded and attempted to resuscitate him. They were subsequently assisted by the prison doctor, who administered adrenalin. Paramedics arrived shortly afterwards. However, he continued to be unresponsive and was pronounced dead at 2.26pm.
10. Staff were offered support and a debrief was held. A prison family liaison officer and a manager visited his family in person to break the news.
11. The investigation found that, although the man was managed under the Prison Service's suicide and self-harm prevention measures for much of the time he was at Woodhill, the approach to managing his complex needs, repeated self-harm and negative behaviour was not consistent or coordinated between the various staff and specialists involved in his care. Key risks were insufficiently considered during his case reviews. When he was found hanging, staff did not follow the emergency procedures set out in Prison Service guidance.

THE INVESTIGATION PROCESS

12. Notices were issued to staff and prisoners at HMP Woodhill, informing them of the investigation and inviting anyone who had relevant information to contact the investigator. Two prisoners came forward.
13. The investigator visited HMP Woodhill on 28 May and obtained copies of the man's prison and medical records. She visited house unit 5 and interviewed two prisoners. On 4 July 2013, she interviewed staff and briefed the Governor about her initial findings.
14. NHS England commissioned a clinical reviewer to review the man's clinical care at the prison.
15. HM Coroner for Milton Keynes was informed of the investigation and provided the results of the post-mortem examination. This report has been sent to the Coroner.
16. One of the Ombudsman's family liaison officers contacted the man's mother to explain the investigation process. She asked for the following issues to be considered:
 - Why her son was in a cell with a bunk bed on his own and whether he was on suicide and self-harm monitoring at the time of his death?
 - When her son was last seen and assessed by the mental health team?
17. The man's family received a copy of the draft report. The solicitor representing his mother identified some factual inaccuracies and the report has been amended accordingly. They also raised a number of questions that do not impact on the factual accuracy of this report. We have provided clarification by way of separate correspondence to the solicitor.

HMP WOODHILL

18. HMP Woodhill has the dual role of a local prison and a high security prison and can hold more than 800 prisoners. It takes adult male prisoners and young offenders from the Magistrates' and Crown courts in the Milton Keynes area and also holds category A prisoners (prisoners regarded as a high risk to the public should they escape). It has a close supervision centre housing prisoners whose behaviour is especially complex or challenging. There is also a unit for protected witnesses.
19. Central and North West London NHS Foundation Trust commissions health services at HMP Woodhill.

Her Majesty's Inspectorate of Prisons

20. The most recent inspection of HMP Woodhill was an unannounced inspection in January 2012. The Inspectorate found that the number of self-harm incidents had risen considerably over the previous 12 months and a number of procedures aimed at supporting those in crisis were just adequate.
21. The Inspectorate reported that all new prisoners went to the dedicated first night centre and their vulnerability was assessed. Inspectors noted that there were some examples where care under the suicide and self-harm prevention measures was poor.

Independent Monitoring Board

22. Each prison in England and Wales has an Independent Monitoring Board (IMB) made up of unpaid volunteers from the local community who help ensure that prisoners are treated fairly and decently.
23. In its 2012 annual report, the IMB noted that the Safer Custody team at the prison produced in-depth documentation and statistics which were reviewed monthly at combined Safer Custody/Violence Reduction meetings. Trends were investigated and potential solutions put in place.

Previous deaths at HMP Woodhill

24. Since 2012, there have been six deaths at Woodhill, four were self-inflicted deaths by hanging. The other two prisoners died from natural causes. We have previously made recommendations about assessing a prisoner's risk of self-harm and delays in calling an emergency ambulance. Similar concerns are identified in this report.

Assessment, Care in Custody and Teamwork

25. Assessment, Care in Custody and Teamwork (ACCT) is the Prison Service process for supporting and monitoring prisoners at risk of harming themselves. The purpose of ACCT is to try to determine the level of risk posed, the steps that might be taken to reduce this and the extent to which staff need to monitor and supervise the prisoner. Checks should be irregular to prevent the prisoner anticipating when they will occur. Part of the ACCT process involves drawing up a caremap to identify the prisoner's most urgent issues and how they will be met. Regular multi-disciplinary reviews should be held. The ACCT plan should not be closed until all of the actions on the caremap have been completed.

KEY EVENTS

26. The man was charged with armed robbery and remanded to HMP Woodhill by Magistrates' Court on 14 January 2013. (He was later convicted but had not been sentenced at the time of his death.) The court had imposed restrictions on contact with his family and he was prohibited from contacting his mother, stepfather and partner.
27. At an initial reception health screen at Woodhill, the man disclosed to a nurse that he misused drugs (cocaine and heroin), was a heavy drinker and had been diagnosed with bipolar disorder, depression and other mental health conditions. He had a history of self-harm both during previous prison sentences and in the community but said he had no current thoughts of self-harm or suicide. She referred him to the mental health in-reach team. He had fractured his right leg about two months before and had deep vein thrombosis (DVT), for which he had received injections.
28. Shortly after the health screen, a doctor prescribed methadone and referred him to the drug treatment service. He prescribed other medication, including fluoxetine (an antidepressant), gabapentin (for anxiety), quetiapine (an antipsychotic) and zopiclone (a sleeping tablet). He was then taken to a cell in house unit 5, the drug and alcohol detoxification wing.
29. The man had a further health assessment on 15 January, when a nurse recorded that he had no suicidal thoughts and there were no concerns about self-harm and suicidal intent. A cell sharing risk assessment concluded that he was a high risk of violence to a cell mate, but they noted that he would be able to share with a specific named prisoner if a mental health team assessment on 21 January was positive.
30. On 18 January, the man reported pains in his leg and an inability to move around with one crutch. A doctor noted that he was waiting for a scan on his right leg, for possible DVT. He asked for tramadol (a strong opiate based painkiller) but the doctor told him that he would not be given additional opiates while he was taking methadone. Instead, he increased the dosage of gabapentin and zopiclone.
31. On 21 January, at an appointment with a mental health nurse, the man asked to share a cell. He told her that he had been under the care of the mental health team at HMP Stafford from where he had been released from a previous sentence in April 2012. He said he did not like being in a cell on his own and felt his mental health would deteriorate if he remained in a single cell. The nurse spoke to officers on his unit, who said they would arrange for him to share a cell with someone he knew.

32. Over the next few days, the man continued to experience pains in his leg and was prescribed paracetamol. On 28 January, he told a doctor that he felt the problem with his leg was affecting his mental state and, although he had been reviewed by the mental health team, he did not think anything had been done to help him. The doctor asked the mental health team to assess him again.
33. The man's first incident of self-harm at Woodhill was at lunchtime on 5 February, when he cut his arms. He told a nurse, who went to his cell to treat him, that he had cut himself to relieve the pressure as he was due to appear at court the next day. He refused to have stitches, so the nurse cleaned and covered the wound.
34. Unit staff started monitoring the man hourly under Assessment Care in Custody and Teamwork (ACCT) procedures, the Prison Service process for supporting and monitoring prisoners at risk of harming themselves. In addition to the prospective court appearance, he said that had not been able to contact his partner owing to public protection restrictions. He described cutting himself as a stress reliever and said he had no intention of killing himself. He had been subject to self-harm monitoring during previous prison sentences and it was noted that he was quite forthcoming about his feelings. His risk of self-harm was considered to be low but he was said to be impulsive in dealing with stress. None of his other risk factors appear to have been considered.
35. The next day, 6 February, staff stopped the ACCT monitoring as the man was reported to be upbeat, had a good rapport with staff and his cellmate and his court hearing did not take place. A post-closure review was set for 13 February. However, on 7 February, the ACCT plan was re-opened as his solicitor had told him that he could expect a sentence of more than 15 years. He was tearful and told an officer that he had no support and he would not be able to complete the sentence as he "hasn't got it in him". The ACCT was closed again on 13 February, but re-opened on 19 February after he made superficial cuts on his wrist, which he said was to relieve stress. He felt low in mood because of the continuing restrictions on contact with his family and said he did not understand why they were in place.
36. On the morning of 21 February, a mental health nurse assessed the man. They discussed his long history of mental illness (including schizophrenia), his self-harm since the age of 15 and an attempted suicide by overdose two years before. His father had suffered from mental health problems and had committed suicide several years previously. He said that he was expecting to receive a prison sentence of at least twelve years and that he had suicidal thoughts.
37. At 4.00pm that afternoon, the man's case manager held a case review and completed a new caremap, listing issues to be address. These included arranging for him to receive money and clothes (which had been difficult because of the restrictions on contact with his family), clarification of his charges and the restrictions on his family contact and a referral to the mental health team. The

summary of the review stated that he was likely to continue harming himself as a means of relieving stress, that he was concerned about his forthcoming court case in March and had had brief thoughts of killing himself, but the review team again assessed him as a low risk of self-harm. It was agreed that staff would have one conversation with him each session during the day and that he should be observed five times at night. The next case review was scheduled for 4 March.

38. Around an hour after the case review, the man said that he had taken an overdose of 100 paracetamol and 30 naproxen (both painkillers). (There is no evidence to indicate that there was any investigation to examine how he obtained such a large quantity of medication.) He said that he had taken the tablets to get to hospital for an X-ray. He was taken to hospital and then discharged himself as he did not wish to wait. Just after 9.00pm, a nurse took blood samples and sent them to the hospital for testing. At 1.30am on 22 February, a nurse telephoned the hospital for the outcome and interpretation of the test results. These indicated that his paracetamol level was 143, a toxic level. The nurse was informed that, as his paracetamol level was over 100mg/L, he should be sent to the accident and emergency department for further management. She discussed this with the on-call doctor, who said he should be taken straight to hospital.
39. The officer in charge of the prison that night told the on-call doctor, who had said that he needed to be taken to hospital urgently, that there were insufficient staff on duty to escort the man to hospital. He added that officers had observed him hourly, no health concerns had been raised and he had said he was fine. At 2.45am, the officer in charge informed a nurse that as he was a potential category A (the highest security category) prisoner, he would have to wait until the morning.
40. At 6.30am, the nurse informed the on-call doctor that although he had stressed that the man should be taken to hospital urgently (after he had discussed his case with the biochemist), prison staff had not followed his instruction. The doctor recorded his concern in the medical records and reiterated that he must go to hospital urgently. He did not arrive at the accident and emergency department until just after 11.00am but again returned to the prison when he said that he did not wish to wait. A healthcare assistant took further blood samples, by which time his paracetamol level had fallen considerably.
41. A case review was held at 15.55 that afternoon. Despite the overdose, the man's risk was again assessed as low. The summary stated that his level of observations were reduced to one each session and five observations at night. (This does not accord with the front of the ACCT document, which indicated that the observations should be hourly.) The next case review was set for 28 February. However, it was brief as he was due to be sentenced the next day. It was agreed that a full review would be held after he returned from court and knew the length of his sentence.

42. The review did not take place on 1 March, as planned. Instead, a review was conducted on 2 March (although signed and dated as 8 March). A further court appearance had been set for 22 March and the man said he had no current thoughts of self-harm. His risk was assessed as low and the ACCT was closed, with a post-closure review scheduled for 9 March.
43. On 7 March, the man made cuts to his arm. He told an officer that it was because he had not received his property but he was feeling much better. His appointment with the mental health team that day had been cancelled but arrangements were made for a mental health nurse to speak to him later in the day. During a cell check, an officer found two razor blades under his pillow. A nurse examined him and dressed the wound. An ACCT was not opened.
44. In the afternoon of 7 March, a support worker from the mental health team recorded that the man had cut himself after thinking about it for four days. She described him as tearful and paranoid. He said that he still had the urge to cut himself, but “did not have the bottle” to kill himself. The case manager and other officers spoke to him throughout the afternoon, including discussions about the ongoing restrictions on contact with his family and a disciplinary hearing the next day. He asked to share a cell with his co-defendant, a friend (initially thought by staff to be his cousin) who had recently arrived in the unit. After consulting other staff, the case manager decided not to re-open the ACCT. It was agreed that they would wait to see if he settled better with the support of his co-defendant. (The front sheet of the ACCT plan notes “9/3/13 post closure but there is no note of such a meeting and no other evidence that it took place.)
45. The support worker saw the man again on 8 March. He said he felt supported by his friend, but probation staff had just told him by video link that they would be recommending an indeterminate sentence. He told her he was unsure how he would cope and stated ‘I’d do myself in if I got that, my head couldn’t take it.’ The case manager noted that they would try to keep him with his friend and that his money and property issues were being resolved.
46. On 12 March, the man cut himself and was also found to have made cuts in the preceding days. He admitted buying illicit medication and said that he ‘would love to kill himself’. The support worker then opened an ACCT. He was given a formal written warning under the prison’s incentives and earned privileges (IEP) scheme, (a system to encourage and reward responsible behaviour) for concealing his medication.
47. An officer interviewed the man for an ACCT assessment on 13 March. He noted that he had said that he “wants to go” and had worked out that if he cut his arms he would slowly bleed to death. (It had been difficult to stem the flow of blood previously as he was on warfarin – a medication to thin his blood.) At a case review that day, he said he was concerned about the prospect of a long sentence

and the continuing delay with his property being sent in. His risk was assessed as high and appointments were made with the mental health team and the doctor, to review his medication. The level of observations was set at hourly and the next review was scheduled for 15 March.

48. At a mental health review follow-up the next day, a nurse described him as paranoid with poor eye contact. He said that he had nothing to carry on for, as he was not allowed to contact his family and was due back in court on 27 March. A care plan was created, including weekly mental health appointments and stating that if he or any staff member had any concerns about his mental state they should contact the mental health team immediately for an emergency assessment.
49. A psychiatrist reviewed the man on 14 March. They discussed his background and history. He believed his mental health problems began after his father's suicide. He described getting a 'release' and a 'buzz' from his self-harm. He still felt angry and agitated and had fleeting suicidal thoughts. He did not have a job and could not go to the gym due to his leg fracture but he was trying to get a wing job. The psychiatrist prescribed further medication, advised that he remain on ACCT monitoring and planned a review on 25 March. He did not attend that appointment. No reasons were recorded by prison healthcare staff but the psychiatrist offered another appointment on 8 April.
50. The next ACCT case review took place on 16 March, a day later than planned. It was noted in the summary that the man had had a settled couple of days and that the mental health team and psychiatrist had seen him. He remained anxious about his forthcoming court appearances and the restrictions on his contact with his family, but was aware that efforts were being made to resolve this. The ACCT plan was closed, with a post-closure review set for 23 March. Again, no post-closure meeting was recorded.
51. During the man's time at Woodhill, staff recorded several episodes of negative behaviour, often towards staff, as well as abuse of medication and illicit substances. On 20 March, the case manager recorded in his records that his behaviour continued to be erratic with verbal outbursts and childish behaviour. He told him that his recurrent poor behaviour was at an unacceptable level, that it was not good enough to apologise after the event and that further outbursts would result in a period on the basic regime, the lowest level of the IEP scheme. He apologised again and asked to speak to the mental health team. Later that day, he received two further warnings for being abusive to staff and attempting to conceal his medication and was reduced to the basic regime.
52. On 23 March, the man's personal officer, noted that he had completed the induction process but had been disruptive throughout and displayed a poor attitude.

53. After prisoners were locked in their cells on the evening of 29 March, the man put a note under his cell door in which he had written that he was anxious and wanted to harm himself. He said that 10 – 15 other prisoners on the wing had approached him and accused him of being a “grass” and it was making him anxious. He pleaded for someone to do something to help him. An officer opened an ACCT plan later that night and he was placed on hourly observations. (This ACCT plan continued until his death but some of the case review documents are either out of sequence or incorrectly numbered.)
54. At an assessment interview the following afternoon, the man explained that he had not spoken to his girlfriend or mother (who he later said had been diagnosed with a terminal illness) and had not had a telephone call since the beginning of January. He was concerned that his girlfriend would think he had “dropped her” and his mother would be worried about him. He also mentioned that he had been “spooked” by being accused of being a grass. He did not feel safe and was in debt. He added that the only reason he did not harm himself more was that his cellmate talked to him and kept him from doing it. He described himself as suicidal and wanting to die, getting angry at people for no reason and had had enough. He said he did not eat and his cellmate was annoyed with him as he did not sleep and “I think about cutting 10 times a day ... all the time the thought is there...”
55. At the first case review after the assessment, at 3.00pm on 30 March, the man was assessed as a raised risk of self-harm and likelihood of future risk behaviours. The fact that he was on the basic level of the IEP scheme with a very restricted regime was not discussed. The level of monitoring was reduced to two conversations each session and five observations at night. This was not marked on the front of the ACCT document as required. It appears that observations continued as hourly. A further review was planned for 5 April. The next day, he made multiple cuts to his right arm. He refused healthcare intervention or to allow a nurse to dress the wounds. The nurse gave him dressings and he said he was happy to do it himself. A prison manager then agreed that he should move to the prison’s healthcare centre for 24 hours and a case review took place.
56. The key actions identified on the caremap completed on 31 March, were support and advice, (which was noted as completed the same day); a review of his medication, completed on 3 April; continue to attempt contact with his family – noted as completed on 3 April, but annotated to indicate ongoing issues with public protection restrictions; and to get an application approved by the duty governor to make purchases from the prison shop, noted as ongoing.
57. In the healthcare centre, the man initially remained on hourly observations, which were then reduced to two conversations each session and five observations at night. Although he was supposed to return to a residential unit after 24 hours, staff at the case review on 1 April considered that he would benefit from a few

more days of respite in the healthcare centre. In the event, he remained there until 9 May. The mental health team worked with him to manage his paranoia and assist with the recognition of triggers, in an attempt to reduce his need to self-harm. The action plan specified daily case reviews by the psychiatric nurses and a weekly review by the psychiatrist. The psychiatrist assessed him on 9 April and altered the dosage of his medications.

58. Throughout his time in the healthcare centre, the man continued to have intermittent thoughts of self-harm. On 12 April, he asked for a razor to shave and used it to cut himself. As a result, he was given an IEP warning for negative behaviour. He reported cutting himself again 13 April, but dressed the wounds himself. An ACCT review took place on 15 April when it was made clear that the restrictions on family contact would not be resolved until his court case concluded.
59. On 16 April, a manager spoke to the man about the condition of his cell. He became angry and, at lunchtime, he was found with a ligature around his neck. He said that he was 'fed up with everything'. He did not require any medical intervention, but his observations were increased to four an hour and an ACCT case review was then held. At the review, his risk was considered to be 'raised' and observations were now set at hourly. He agreed to speak to a Listener (a prisoner trained by the Samaritans to support fellow prisoners) in the evening, if he needed to.
60. On 18 April, the man refused to attend court as he said he did not know which of his cases it related to, he had no documentation and he had not prepared. He was also still concerned and anxious about the pains in his leg. Later that day, the psychiatrist noted cigarette burns on his hands and cheek. He told him he had burned himself as he did not have access to a razor. He continued to have fleeting suicidal thoughts. An ACCT case review was not held but an ad hoc review was conducted on 21 April, after he tried to climb over railings on account of continued frustration about restrictions on family contact. He declined the offer of a prison visitor.
61. The man attended court on 26 April and, after an altercation with his co-defendant, with whom he had previously shared a cell, he was arrested for assault. The judge sent him back to the prison. On his return to Woodhill, healthcare staff examined him as he was unable to put any weight on his leg. He was treated for cuts to his face and forearms. He remained on ACCT monitoring, with hourly observations during the night. He also received an increasing number of IEP warnings for negative behaviour.
62. The man had an ACCT review six days later, on 2 May. His observations were reduced to three per session, remaining at five during the night and his risk was assessed as low. This was the first time that a member of the mental health team had attended an ACCT case review. Mental health representatives then

attended reviews on 7 and 9 May and all but one of the subsequent review meetings. It was decided, at the latter review, that his need for a bed in the healthcare unit had diminished and he would return to a residential wing that day. He was reluctant to leave the healthcare centre and expressed concern about returning to a wing.

63. The same day, the man said that he wished to undergo a rapid detoxification from methadone. A doctor advised him to remain on his existing dose until his mental health stabilised but he insisted, so the doctor agreed to a reduction. He moved to a double cell on the ground floor of HU5. ACCT monitoring continued with two conversations each session and five night-time checks. He was in the cell on his own. An officer told the investigator that she thought wing staff were trying to find a suitable cellmate for him but there was no evidence that cell sharing was discussed after his move.
64. At an ACCT review on 10 May, the case manager noted that the man had received a warning under the IEP scheme since he had moved back to the unit and that, due to the number of warnings he had accumulated, he should have been placed on the basic regime. However, this was deferred because of the ACCT review but he was warned of the consequences of continued negative behaviour.
65. On 11 May, the man told his support worker he was unhappy in HU5. He said he would cut himself and had enough blades to do so. He added that he had a book of the body to know where to do it. When asked how imminent his risk was, he replied that he would be surprised if he lasted 24 hours. She advised him to use his coping strategies, such as reading, watching television and staying in his cell. She recorded the details of their discussion in both the ACCT ongoing record and the medical record. That day, he was also heard to threaten to cut someone's throat. The next day, 12 May, he explained to a nurse that he was keen to move to another prison because of his disagreement with his co-defendant. She reminded him that he needed to work on his challenging behaviour, self-harm and detoxification first. He cut himself during the night on 13 May but did not tell staff. An ACCT review took place the next afternoon.
66. On 14 May, the man attended hospital, where he was diagnosed with DVT and prescribed warfarin. It was noted that consideration was to be given to him remaining at Woodhill while he received treatment and that he would remain living in HU5 for eight weeks while he was undergoing an opiate reduction programme. His ACCT observations and level of risk remained the same. Later that evening, he disclosed he had cut his arms but refused any healthcare intervention and was given dressings. He cut his arm again the next day.
67. The man's behaviour continued to deteriorate and staff found it difficult to manage him. He received a number of behaviour warnings over a nine-day period and was placed on the basic regime on 18 May. As a result, his television

was removed and he was only allowed one hour of association with other prisoners each day. Prison staff placed a sign on his cell door advising other prisoners not to engage with him, as this would impact on their status. It is noted in his prison record that officers had asked the safer custody team if he could be issued with a radio while he remained on the basic level of privilege and ACCT monitoring. There is no evidence that this was provided. On 19 May, it was noted that he refused to go to the segregation unit for a disciplinary hearing. The next day, he was placed on report for spitting at an officer.

68. An ACCT review on 21 May was attended by a principal officer, a senior officer, a nurse, the nurse manager and the man. In the summary of the case review, the case manager noted that he had not considered self-harming for a period of time. He was concerned about his cell location and they would consider relocation to help him 'return to normality'. However, the notes written by the nurse in his medical record state that he disclosed he had been experiencing thoughts of self-harm and had considered hanging himself two hours before the review. There is no evidence that the case review considered the impact that being on the basic regime might have on him.
69. The man told the nurse that he had felt safer living in the healthcare unit and did not like the noisy environment of HU5. The location of his cell, close to the medication hatch, meant that it was always busy and this made him low and anxious. He thought he might have been rushing his methadone reduction. A move to another house unit was discussed and he appeared happy with this decision. His rapid drug reduction programme was discussed and he was advised to consider a slower detoxification until his mood stabilised. Prison staff involved in the review were satisfied that he had no suicidal ideation as he talked positively about a move. However, they decided the ACCT should remain open with two observations each session during the day and five at night.
70. Later that day, the man went to the medication hatch and requested a tissue to wipe some blood from his left hand. A nurse asked if she could examine the wound but he refused. There is no evidence that consideration was given to holding an ACCT review after this discovery.
71. On 22 May, an officer unlocked the man's cell (1-01) at about 8.00am. While he was out of his cell during the association period, he was described as agitated, rude and abusive towards staff. At 9.00am, he was instructed to return to his cell and given a warning. He then frequently pressed his cell bell and received a further warning. The officer said that she had responded to the cell bell about thirty to forty times that morning and each time he indicated that he did not need anything and that he had just wanted to annoy staff.
72. At 11.15am on HU5, a substance misuse nurse reviewed the man's methadone regime and drug reduction programme. She described him as calm with good rapport and eye contact. She said he had been told he would be moving to

another unit and was happy about this. She noticed some fresh cuts on his arm. She asked if he would allow a nurse to dress them and he agreed. She thought that he then went to the treatment room. After the meeting, he collected his lunch and medication and returned to his cell about thirty minutes later. Again, there is no indication that thought was given to a further ACCT review because of the apparent act of self-harm.

73. A senior officer was informed over the lunchtime period that the man would be moved to HU2, a standard residential unit, that afternoon. He went to his cell, told him of the move and asked him to pack his property in the bags provided. He did not appear upset by this news. He then spoke to two prisoners in the next cell through an open window and said he was being moved. Both prisoners told the investigator that he seemed all right but had stated he was going to 'smash up' his cell before he left. The conversation ended and one prisoner said he heard a loud noise which he had assumed was him damaging the cell.
74. At about 1.50/1.55pm, two officers began to unlock the cells. The man was not going to be unlocked, but Officer A looked through the small observation hole. She told Officer B that she could not see him and moved on to the next cell. Officer B then opened the observation hatch and saw him at the back of his cell with a strip of bed sheet tied around his neck. He called out to Officer A, who unlocked the cell and they both shouted for other staff to assist. Neither officer radioed an emergency medical code for assistance. Officer B cut through the bed sheet, which was attached to the top bunk bed frame and laid him on the floor. He looked for a pulse but was unable to find one and said he was not breathing.
75. Officer C was unlocking cells on the landing above, when he heard a shout for help. In a statement, he said that he went to the man's cell and saw him lying at the end of the cell with a ligature around his neck. He radioed the control room, told them there was a medical emergency and asked for a doctor to attend. A minute or two later, he called the control room again and said that the man "had tried to hang himself and a defibrillator was required". (A defibrillator is a life-saving machine that can restart the heart in the event of cardiac arrest provided a shockable rhythm can be detected.) Another officer also attended in response to Officer A's shout for assistance. He said that the man's belongings had been packed and were obstructing the door so he moved them to allow the door to fully open. None of the officers administered emergency first aid.
76. Officer A left the cell and went to the medication hatch to get help from healthcare staff and a nurse and a healthcare assistant went with her back to the cell. When they got there, the nurse asked the officers to call more nurses to attend and asked for an ambulance to be called. He directed the healthcare assistant to collect the emergency bag from the other end of the landing and the oxygen and blood pressure machine from the treatment room. Another nurse arrived at the cell just after 2.00pm. The nurse who had started cardiopulmonary

resuscitation asked him to attach the defibrillator. This advised not to shock and to continue with chest compressions. Other healthcare staff then arrived and assisted with the resuscitation attempts.

77. A senior officer arrived and then went to the unit office to telephone the control room to request a doctor. The doctor arrived at 2.10pm and assisted nurses with the resuscitation attempts and administered adrenalin. The South Central Ambulance Service recorded receiving a call from the prison and arrived at the man's cell at 2.15pm. Despite repeated attempts by healthcare staff and paramedics, they were unable to revive him. The doctor pronounced him dead at 2.26pm.
78. Prison managers debriefed the staff involved in the emergency later that day and offered support. Staff informed the other prisoners of the man's death and offered them support if they had been affected.
79. The prison's family liaison officer visited the man's family at their home at 4.00pm that day and informed them of his death. Financial assistance was offered towards his funeral expenses.

ISSUES

Clinical care

Reception

80. When the man arrived at Woodhill on 14 January 2013, he had an initial health screen, including a consultation with a prison doctor, followed by a full medical assessment the next day. He disclosed a history of alcohol and drug misuse and that he had an ongoing physical injury to his right leg. He also had a long history of deliberate self-harm and several mental health conditions. He was immediately referred for drug treatment and began a methadone maintenance programme which continued throughout his time at Woodhill.

Physical and mental health

81. Healthcare staff agreed a care plan to develop the man's coping strategies to help him avoid self-harming behaviour and to manage his paranoia. Healthcare staff reviewed him weekly (and during some periods daily) and had escalation plans to see him more frequently should his level of risk increase. A psychiatrist reviewed him frequently and adjusted his medication as necessary.
82. The clinical reviewer is satisfied that input from healthcare staff and referrals for mental health and drug treatment services were appropriate and that his level of care was comparable to that expected for patients treated in the community. However, he identifies some concerns and makes recommendations, which the head of healthcare will need to consider, about prompt access to a GP, arranging a timely ultrasound scan and sending the man to hospital after an overdose of paracetamol. (The latter event is discussed below.)

Management of the man's risk of self-harm

Assessment of risk and ACCT case reviews

82. Prison Service Instruction (PSI) 64/2011, Management of prisoners at risk of harm to self, to others and from others (Safer Custody), lists a number of risk factors and triggers for suicide and self-harm. Of those listed, the man had or was subject to the following, irrational behaviour; deliberate self-harm; mental illness such as depression or bipolar disorder; family history of suicide; family member diagnosed with terminal illness; substance misuse or detoxification; physical illness, especially those associated with pain; recent contact with psychiatric services; family and relationship problems; violent offences against family members; recent contact with psychiatric services; fear of violence or intimidation; court appearances, especially sentencing and the prospect of a long indeterminate sentence.

83. With the range of risk factors, we would have expected the man to have been identified as a risk when he first arrived at the prison in January but there seems to have been a reliance on him saying that he had no current thoughts of suicide and self-harm. Staff judgement is fundamental to the ACCT system. At its core, the system relies on staff using their experience and skills, as well as local and national assessment tools, to determine risk. It is not an exact science. However, we are concerned that staff relied on his personal presentation, when he had a number of known risk factors when he arrived at Woodhill. A prisoner's presentation is obviously important and reveals something of their level of risk. However, it is only a reflection of their state of mind at the time they are seen by the member of staff and should be considered as a single piece of evidence used to make a judgement of risk. All risk factors must be collated and considered to ensure that a prisoner's level of risk is holistically judged. We consider that more weight should have been given to the known risk factors. We make the following recommendation:

The Governor should ensure that all the known risk factors of a newly-arrived prisoner are fully considered when determining his risk of suicide or self-harm.

84. The man was subsequently identified as a risk of suicide after an act of self-harm but in spite of the considerable number of risks and potential triggers, he was generally not considered high risk even after an ACCT was opened. ACCT assessments and reviews consistently concluded he was low risk, even on those occasions when he had self-harmed or reported suicidal thoughts just a short time before. Few of his risk factors were discussed or addressed at case reviews. We cannot therefore be satisfied that his risk of suicide was appropriately identified and assessed.

84. The man started harming himself as a teenager, mainly but not only by cutting. Throughout his time in prison, he continued to self-harm. An ACCT plan was opened on 5 February, after the first time he cut himself at Woodhill. It was closed on 13 February, re-opened on 19 February and finally closed on 2 March. He cut himself again on 7 March (within the post-closure review period) but the case manager decided not to resume ACCT monitoring. Instead, he decided to wait and see if having a cellmate settled him. A member of the mental health team opened a further ACCT plan on 12 March, after he cut himself again and told her that he wanted to kill himself. This was closed on 16 March, with a post-closure review set for 23 March.

85. The man's most recent ACCT monitoring started on 31 March and remained in place until his death. This was reviewed frequently, particularly as he continued to cut himself often and his level of observations were adjusted depending on his perceived level of risk.

86. The last case review was carried out on 21 May at 2.30pm, during which we know from his medical record that the man disclosed he had had thoughts of hanging himself that morning. However, this information was not recorded on the ACCT document. The report of the review recorded that he had no thoughts of self-harm, was a low risk and a move to another unit was to be considered. His observation levels were maintained at two each session during the day and five during the night. This information conflicts with the account of the review recorded by a nurse in his medical records. Her entry notes that he had experienced thoughts of self-harm two hours before the meeting and described the method (hanging) he had considered. Nevertheless, she felt that his suicidal ideation had been considered during the ACCT review.
87. PSI 64/2011 contains a considerable number of requirements about actions, timescales and people to be involved in ACCT procedures. In the man's case, there was a consistent case manager for the first two periods of ACCT monitoring, but case reviews were not multidisciplinary, as expected in Prison Service instructions. As he had well documented mental health problems, it is a concern that there was no involvement of mental health staff at these first two ACCT case reviews.
88. Another requirement is that a case review is held when self-harming behaviour changes or escalates, to consider whether to carry out another assessment or whether a prisoner's caremap needs updating. ACCT case reviews were held following many of the man's acts or threats of self-harm but there were some occasions when a review did not take place. For example, he self-harmed by cutting on 12 and 13 April but, in spite of this, a case review was not held until the next scheduled review on 15 April. After what was to be his last ACCT review on 21 May, he cut himself and repeated this the next day, but no further ACCT reviews took place. Although several reviews were held during each period of ACCT monitoring, it is important that any episode of self-harm should prompt a case review to enable the continual monitoring and assessing of risk.
89. We are also concerned that in later reviews there was no longer a consistent case manager and each review was chaired by a different person; ACCT documents were sometimes completed inaccurately or important information omitted; and although notes were made during the post-closure period, there is no evidence that the required post-closure reviews took place. When a person is on an ACCT plan for a long time, there may be a danger of the processes and checks becoming routine. We note that after the man harmed himself on 7 March, a decision was taken not to resume ACCT monitoring and that he was to be supervised informally. PSI 64/2011 states:

“An ACCT plan can be re-opened at any point following closure if the risk posed by the prisoner is deemed to have been increased. The Case Manager must determine whether or not the circumstances for re-opening are different from that of the original plan and whether or not a new

assessment needs to be undertaken.”

90. The rationale for not re-opening the ACCT was that staff would monitor whether sharing a cell with his co-defendant, who had recently arrived at the prison, would give him more stability. While we do not wish to second guess the decisions made at the time, we consider that this could have been monitored within the ACCT process and if the man settled, the ACCT plan could then have been closed. At the least, staff should have considered conducting a formal assessment to determine whether to resume ACCT monitoring. We make the following recommendation:

The Governor should ensure that prison staff manage prisoners at risk of suicide or self-harm in line with national guidelines, including:

- **Holding multidisciplinary case reviews which include all relevant people involved in a prisoner’s care;**
- **Completing ACCT documents fully and accurately;**
- **Conducting an ACCT review after any act of self-harm;**
- **Considering all known risk factors when determining the level of risk of self-harm; and**
- **Conducting a post-closure review and recording the outcome.**

Handling of the man’s overdose on 21/22 February 2013

91. The man took an overdose of paracetamol on 21 February. He discharged himself from hospital without being seen but prison healthcare staff later took blood samples and sent them for testing the results of which showed that his paracetamol level was 143mg/L. In the early hours of 22 February, a nurse telephoned the hospital to ask for the results to be interpreted and was told that the patient should be sent to hospital as an emergency if the level was above 100. The nurse consulted the on-call prison doctor who endorsed the need for him to be taken to hospital urgently. The officer in charge told her that there were insufficient staff to escort him so he would have to go later in the morning. At 6.30am, the prison doctor expressed his concern that his instruction for him to be taken to hospital had not been followed and reiterated that he should be taken urgently. However, he was not taken to hospital till 11.00am.
92. PSI 5/2013, which gives guidance on the management of potential and provisional category A prisoners, requires prisons to have local security strategies. Although the officer in charge believed the man was a potential category A prisoner, during the investigation the prison confirmed that he would, in fact, have been treated as a category B prisoner for escort purposes. Nevertheless, the PSI provides for prisoners to be taken to hospital as an emergency, without the need for pre-approval by the central Prison Service category A team. Woodhill was unable to provide a local protocol as mandated

by the PSI.

93. The clinical reviewer states that this delay could have had serious consequences and could have been detrimental in him making a full recovery. We agree. Prisoners are entitled to receive urgent health interventions irrespective of their security category. Although the man recovered, such a delay could jeopardise the life of a prisoner in future. The clinical reviewer recommends that the prison conduct a review of this incident as a serious untoward incident and we make the following recommendation:

The Governor should ensure that staff call an emergency ambulance promptly when advised to do so by a doctor or a prison clinician and that local escort procedures reflect this whatever the security category of the prisoner.

The man's location

94. After a period of respite in the healthcare centre, the man moved to a ground floor double cell, close to the medication hatch, which he occupied on his own. His cell sharing risk assessment indicated he was a high risk, due to an altercation he had had with his co-defendant, as well as concerns about possible homophobia and racism. However, he had previously told a nurse he preferred to share a cell, as this was a positive influence on his mental health. He said that his mental health would get worse if he remained on his own. During her interview, Officer A said she thought that attempts were being made to find a suitable cellmate, but there is no evidence that this was actually reconsidered, discussed at ACCT reviews or acted on.
95. House Unit 5 is a drug and alcohol detoxification wing which has three safer cells. They are for single occupation and furniture is adapted to provide a safer environment for prisoners at risk. Officers interviewed were unaware of whose responsibility it was to place a prisoner in a safer cell. Although the man was subject to self-harm monitoring, a prolific self-harmer and displayed increasingly challenging behaviour, it appears that no active consideration was given to allocating him to a safer cell, in the interim, until a cellmate was found. As noted earlier, there also seems to have been a general under-estimation of his level of risk.
96. PSI 64/2011 instructs prison staff to "consider and agree whether any items which the prisoner might use to self-harm should be removed from them. Removal of items should be kept to a minimum and must never be automatic". Razor blades were often removed from the man or his cell, apparently appropriately to protect him from self-harm. He then used other means such as burning but also continued to cut himself frequently. There is no record in his ACCT documents of any considered discussions or decisions during case

reviews about locating him in a safer cell or removing sharp objects. We therefore make the following recommendation:

The Governor should ensure that staff consider, agree and record at ACCT reviews whether a prisoner's risk needs to be managed by use of a safer cell and what items should be removed from prisoners at risk of suicide and self-harm.

Handling of the man's challenging behaviour under IEP

97. The man's behaviour became increasingly difficult to manage and staff found him challenging and erratic. This was addressed with repeated warnings and a reduction in his privilege status to the basic level. His television was removed and his association time was reduced to one hour per day. (Shortly before this he had been advised by a member of the mental health team to watch television as a coping strategy.) Staff placed a note on his cell door, to deter other prisoners from engaging with him while he was in his cell. However, these measures had no impact and his behaviour continued to deteriorate. Staff did not seem to recognise that his behaviour might have masked his vulnerability.
98. Despite his acknowledged risk, the man was not given any activities to help keep him occupied and seems to have had little in his cell to distract him. Although an officer enquired whether he could be given a radio, there is no evidence that this was considered or acted on. It appears no consideration was given to implementing a plan to manage his challenging behaviour. On 12 April, when he cut himself with a razor that he had requested in order to shave, he was given a warning for negative behaviour. Punishing an act of self-harm is inappropriate.
99. PSI 11/2011 *Incentives and Earned Privileges* requires prisons to ensure that they implement local IEP scheme which consider the needs of prisoners, such as the man, who are at risk of suicide or self-harm and also have complex behaviour issues. The decision to withdraw privileges should be considered on a case by case basis alongside the ACCT process. There is no evidence that this happened and, although Woodhill's local policy at the time of his death mentioned giving consideration to the status of those at risk or vulnerable, it contained no explicit reference or guidance in relation to managing challenging behaviour in conjunction with the ACCT process. The PSI also states that all prisoners considered at risk of self-harm may be considered for in-cell TV, irrespective of privilege level. Again, there is no evidence that staff thought about or discussed this during case reviews or that the implications of him being on the basic regime level were considered. We make the following recommendation:

The Governor should ensure that staff adhere to the principles for IEP schemes laid down in PSI 11/2011. Decisions to place prisoners at risk of suicide and self-harm should be decided individually and alongside the ACCT process and documented in the ACCT plan.

Enhanced case management for prisoners with complex needs

100. Under Prison Service procedures to manage prisoners regarded as at risk of suicide and self-harm, prisons have the discretion to manage the most severely disruptive, volatile and difficult to manage prisoners under an enhanced case review process. These reviews are designed to allow staff to respond more effectively to the prisoner's individual needs to provide a flexible but consistent approach to changing the prisoner's behaviour and managing their risk.
101. The man might have benefitted from the enhanced ACCT case management process, which brings with it a higher level of coordination between the different teams involved in the prisoner's care. It necessitates daily case reviews by a prison manager. He was not an automatic candidate for this intense level of supervision, but we consider his complex needs would have benefited from this more coordinated approach with some senior management involvement. An enhanced case management process might have led to more effective and holistic consideration of his risks, a more coordinated approach to dealing with his self-harming behaviour and better consideration of the impact of managing him as a discipline problem rather than a vulnerable person. While this might not have prevented him taking his own life, it might have provided a crucial level of support. The National Offender Management Service has recently issued a 'Quick Time Learning Bulletin' to remind prisons to consider using enhanced procedures in appropriate cases and that anti-social behaviour during periods of distress is often a sign of increased vulnerability. We make the following recommendation:

The Governor should ensure that staff are aware of and understand the enhanced ACCT case management approach and that it is used appropriately for suicidal prisoners with complex needs and those difficult to manage, to help identify and address the root cause of their behaviour and distress.

Emergency response

102. PSI 03/2013 *Medical Emergency Response Codes*, issued in February 2013, contains mandatory instructions for governors to have a protocol to provide guidance on efficiently communicating the nature of a medical emergency, ensuring staff take the relevant equipment to the incident and that there are no delays in calling an ambulance. It explicitly states that all prison staff must be made aware of and understand this instruction and their responsibilities during medical emergencies.
103. Officers A and B did not use an emergency response code when they found the man unresponsive at around 1.55pm but called out to other staff for assistance. This meant that the other staff who responded were not immediately alerted to

the nature of the emergency. Neither Officer C, nor the senior officer used a code when they called the control room. Ambulance Service records indicate that an ambulance was not requested until 2.05pm, ten or fifteen minutes after officers discovered him.

104. It is a serious concern that, by the time of the man's death, Woodhill had not complied with the mandatory requirement of PSI 03/2013 to ensure that all staff had clear guidance about what to do in a medical emergency. Neither did the staff involved follow previous guidance issued by the Chief Executive of the National Offender Management Service in February 2011, which we have previously drawn to Woodhill's attention.
105. Belatedly, eight days after the man's death, a Governor's Order (64/13) was issued on 30 May 2013, setting out a protocol for staff to follow when responding to a medical emergency. We are not satisfied that the protocol is compliant with PSI 03/2013, as it requires the first person on the scene to call an emergency code and state that an ambulance is required rather than one being called automatically as soon as the emergency code is called. We make the following recommendation:

The Governor should ensure that all prison staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies and that Woodhill has a Medical Emergency Response Code protocol which:

- **Provides guidance to staff on efficiently communicating the nature of a medical emergency;**
- **Ensures staff called to the scene bring the relevant equipment; and**
- **Ensures there are no delays in calling, directing or discharging ambulances.**

RECOMMENDATIONS

1. The Governor should ensure that all the known risk factors of a newly-arrived prisoner are fully considered when determining his risk of suicide or self-harm.
2. The Governor should ensure that prison staff manage prisoners at risk of suicide or self-harm in line with national guidelines, including:
 - Holding multidisciplinary case reviews which include all relevant people involved in a prisoner's care;
 - Completing ACCT documents fully and accurately;
 - Conducting an ACCT review after any act of self-harm;
 - Considering all known risk factors when determining the level of risk of self-harm; and
 - Conducting a post-closure review and recording the outcome.
3. The Governor should ensure that staff call an emergency ambulance promptly when advised to do so by a doctor or a prison clinician and that local escort procedures reflect this whatever the security category of the prisoner.
4. The Governor should ensure that staff consider, agree and record at ACCT reviews whether a prisoner's risk needs to be managed by use of a safer cell and what items should be removed from prisoners at risk of suicide and self-harm.
5. The Governor should ensure that staff adhere to the principles for IEP schemes laid down in PSI 11/2011. Decisions to place prisoners at risk of suicide and self-harm should be decided individually and alongside the ACCT process and documented in the ACCT plan.
6. The Governor should ensure that staff are aware of and understand the enhanced ACCT case management approach and that it is used appropriately for suicidal prisoners with complex needs and those difficult to manage, to help identify and address the root cause of their behaviour and distress.
7. The Governor should ensure that all prison staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies and that Woodhill has a Medical Emergency Response Code protocol which:
 - Provides guidance to staff on efficiently communicating the nature of a medical emergency;
 - Ensures staff called to the scene bring the relevant equipment; and
 - Ensures there are no delays in calling, directing or discharging ambulances.

ACTION PLAN: The man - HMP Woodhill - 22 May 2013

No	Recommendation	Accepted/Not accepted	Response	Target date for completion	Progress (to be updated after 6 months)
1	The Governor should ensure that all the known risk factors of a newly-arrived prisoner are fully considered when determining his risk of suicide or self-harm.	Accepted	All prisoners are screened when they enter the establishment. Information is sourced from the PER, 2050 if available, C-Nomis and any other information received from the Police via the escort contractor. Any prisoner who has had their licence revoked will have their C-Nomis history live and available when they are admitted into reception. This will now form part of our initial screening. The process includes a series of interviews in both Reception and the First Night Centre with both discipline and healthcare staff. At each stage, prisoners are asked if they feel suicidal or have any thoughts of self harm. Decisions on whether to place a man onto an ACCT are determined by the responses of the individual, supported by how the man presents at that time and any previous known history which will form part of the overall decision making. Staff will use the ACCT process as appropriate.	31 Dec 13	
2	The Governor should ensure that prison staff manage prisoners at risk of suicide or self-harm in line with national guidelines, including:	Accepted	A full review of the ACCT Case Review process has been initiated and will be discussed at the next Safer Custody meeting (11.12.13), with the aim of	31 Dec 13	

	<p>a) Holding multidisciplinary case reviews which include all relevant people involved in a prisoner's care;</p> <p>b) Completing ACCT documents fully and accurately;</p> <p>c) Conducting an ACCT review after any act of self-harm;</p> <p>d) Considering all known risk factors when determining the level of risk of self-harm; and</p> <p>e) Conducting a post-closure review and recording the outcome.</p>		<p>implementation soon after. This process will address the issues of a & b.</p> <p>Local policy to be reviewed to ensure that it has included that reviews are to be conducted after incidents of self harm, as per section c.</p> <p>SIN to be produced to ensure that staff are aware of reviews following an act of self-harm and to determine risk factors of prisoners.</p> <p>Weekly management checks are conducted, with failures highlighted to unit managers. In addition, these are discussed at monthly Safer Custody meetings. Safer Custody coordinator conducting weekly checks and is sitting on reviews to support the process.</p>	<p>SIN has been completed and published. 29.11.13</p> <p>Completed</p>	
3	<p>The Governor should ensure that staff call an emergency ambulance promptly when advised to do so by a doctor or a prison clinician and that local escort procedures reflect whatever the security category of the prisoner.</p>	Accepted	<p>A Staff information Notice has already been produced and has been published in relation to calling an ambulance.</p> <p>A review of local escort procedures for cuffing restrictions is to be conducted.</p>	<p>Completed</p> <p>End Feb 2014</p>	
4	<p>The Governor should ensure that staff consider, agree and record at ACCT reviews whether a prisoner's risk needs to be managed by use of a safer cell and what items should be</p>	Accepted	<p>This is to be incorporated into the case review process with the outcome documented in the ACCT document.</p>	31 Dec 13	

	removed from prisoners at risk of suicide and self-harm.				
5	The Governor should ensure that staff adhere to the principles for IEP schemes laid down in PSI 11/2011. Decisions to place prisoners at risk of suicide and self-harm should be decided individually and alongside the ACCT process and documented in the ACCT plan.	Accepted	New IEP Scheme implemented in line with national policy PSI 30-2013 which allows Governors to make decisions for prisoners on ACCT documents on a case by case basis. Guidance published in SIN 325/13 and 326/13	Completed	
6	The Governor should ensure that staff are aware of and understand the enhanced ACCT case management approach and that it is used appropriately for suicidal prisoners with complex needs and those difficult to manage, to help identify and address the root cause of their behaviour and distress.	Accepted	Enhanced case management guidance was published to all staff in Staff information notice 264/13 on the 30-September 2013 with a full explanation of the process. This aspect of ACCT management is also discussed as part of the ACCT case managers training delivered as part of local training strategy. SIN issued with reference to QuickTime bulletin 14 Enhanced case review management.	Ongoing	
7	The Governor should ensure that all prison staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies and that Woodhill has a	Accepted	PSI 03/2013 Medical emergency response codes was published on 01-02-2013 with an effective date of the 28-02-2013. HMP Woodhill published a staff information	Completed Completed	

<p>Medical Emergency Response Code protocol which:</p> <p>a) Provides guidance to staff on efficiently communicating the nature of a medical emergency;</p> <p>b) Ensures staff called to the scene bring the relevant equipment; and</p> <p>c) Ensures there are no delays in calling, directing or discharging ambulances</p>		<p>notice 044/ 2013 to all staff highlighting this policy on the 20-02-2013.</p> <p>SIN 360/13 reissued on 29-11-2013</p> <p>Staff where provided with a detailed flow chart of actions for them to take when dealing with a medical emergency this formed part of staff information notice 044/13.</p> <p>H/care staff responding to either a code Red or a code blue carry to the scene a emergency response bag fully equipped to deal incident</p> <p>Control room upon hearing an urgent message medical emergency, will always immediately confirm with call sign involved if ambulance required, if so they will immediately alert the emergency services with details of the incident in order that an appropriate response vehicle is despatched.</p> <p>Contingency plans are available and are immediately implemented as part of this requirement which will ensure emergency vehicles are directed to the scene without delay. A review of the current risk assessment and protocols is to take place to improve discharge in an emergency.</p>	<p>Completed</p> <p>Completed and SIN 360/13 reissued 29-11-13</p> <p>Current practise and ongoing.</p> <p>Current practise</p> <p>31 Jan 2014</p>	
---	--	--	--	--