

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# Independent investigation into the death of a prisoner at HMP Woodhill in February 2015

**A report by the Prisons and Probation Ombudsman  
Nigel Newcomen CBE**

## Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

## Our Values

**We are:**

**Impartial:** *we do not take sides*

**Respectful:** *we are considerate and courteous*

**Inclusive:** *we value diversity*

**Dedicated:** *we are determined and focused*

**Fair:** *we are honest and act with integrity*



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The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and offender supervision. One of the most important ways in which we work towards that aim is by carrying out independent investigations such as this into deaths, due to any cause, including any apparent suicides and natural causes, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

My office carries out investigations to understand what happened, correct any injustice and identify how the organisations whose actions we oversee can improve their work in the future.

This man was found hanging in his cell at HMP Woodhill in February 2015, and died in hospital the next day. He was 28 years old. I offer my condolences to the man's family and friends.

While the man was identified as at risk of suicide and self-harm the day after he arrived at the prison, I am very concerned that his risk was not identified when he first arrived. The investigation found that there was no systematic consideration of the man's risk factors, poor communication and poor handling of information, which led to staff underestimating his level of risk. I have raised most of these matters with Woodhill before. I am also concerned that no one referred him for a mental health assessment. After the man was found hanging, it took too long for paramedics to reach his cell from the prison gate and too long for the prison to tell his family that he had been taken to hospital in a critical condition. This version of my report, published on my website, has been amended to remove the names of staff and prisoners involved in my investigation.

**Nigel Newcomen CBE**  
**Prisons and Probation Ombudsman**

**November 2015**

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# Summary

## Events

1. On 20 February 2015, the man was remanded to HMP Woodhill, charged with a serious offence associated with an increased risk of suicide or self-harm. The police had assessed him as at risk of suicide and self-harm, and court staff completed a suicide and self-harm warning form. Reception staff at Woodhill signed the suicide and self-harm warning form but, when he arrived at the prison, no one considered he was at risk so did not begin Prison Service suicide and self-harm prevention procedures, known as ACCT.
2. The next day, the man told a healthcare assistant that he had an outstanding mental health appointment in the community because he was anxious, depressed and had suicidal thoughts. She was concerned about him and began ACCT procedures. She did not refer him for a mental health assessment but asked him to refer himself. He did not complete the form.
3. On 22 February, an ACCT case review assessed the man as at low risk of suicide and self-harm. It was agreed that staff should have a conversation with him once every shift (morning, afternoon and evening) and check him three times during the night.
4. Just before 1.00pm on 25 February, an officer found the man hanging by a bed sheet tied to the window bars. She radioed for emergency help and the control room called an ambulance immediately. Officers and healthcare staff attempted to resuscitate him. An ambulance arrived at the prison at 1.09pm, but paramedics did not get to his cell until 1.24pm. After emergency treatment, the paramedics took him to outside hospital. At 3.50pm, the prison informed the man's family that he was critically ill in hospital. He died the next day.

## Findings

5. The investigation found serious shortcomings in how staff at Woodhill identify, and assess prisoners at risk of suicide and self-harm and how they manage that risk. Information about the man's risk from several sources was repeatedly overlooked by staff when he arrived. He should have been referred for an urgent mental health assessment but this did not happen. After he was found hanging, there was a quick emergency response from prison staff but it took too long to get paramedics to his cell from the prison gate. The man's family should have been informed immediately, when he was taken to hospital in a critical condition.

## Recommendations

- The Governor should ensure that there are effective operating procedures in reception and that all staff understand the procedures for identifying prisoners at risk of suicide and self-harm and for managing and supporting them. In particular, staff should:
  - Have a clear understanding of their responsibilities and the need to record relevant information about risk;

- Consider and record all the known risk factors of newly arrived prisoners when determining their risk of suicide or self-harm, including information from suicide and self-harm warning forms, PERs and medical records;
  - Open an ACCT whenever a prisoner has recently self-harmed, expressed suicidal intent or has other significant risk factors, irrespective of their stated intentions;
  - Review all information about a prisoner's risk to inform the management of his risk of suicide and self-harm;
  - Set effective ACCT caremap objectives which are specific and meaningful, aimed at reducing a prisoner's risk, include issues of family contact where relevant and which identify who is responsible for them.
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- The Governor and Head of Healthcare should ensure that staff request all relevant community health records and that prisoners identified as at risk of suicide and self-harm are referred urgently for a mental health assessment.
  - The Governor should ensure that there is no unnecessary delay in paramedics reaching a prisoner in a medical emergency.
  - The Governor should ensure, in line with Prison Rule 22, that the next of kin of seriously ill prisoners are informed as soon as possible so that they are able to visit them in hospital without unnecessary delay.

## The Investigation Process

6. The investigator issued notices to staff and prisoners at HMP Woodhill informing them of the investigation and asking anyone with relevant information to contact him. No one responded.
7. The investigator visited Woodhill on 5 March 2015. He obtained copies of relevant extracts from the man's prison and medical records.
8. We interviewed 12 members of staff at Woodhill between June and August.
9. NHS England commissioned a clinical reviewer to review the man's clinical care at the prison. In his review, the clinical reviewer made some recommendations about clinical matters, not covered in this report, which the Head of Healthcare will need to address.
10. We informed HM Coroner for Milton Keynes of the investigation. We have sent the coroner a copy of this report.
11. One of the Ombudsman's family liaison officers contacted the man's mother to explain the investigation. His mother asked about the circumstances of her son's arrest and if he was able to telephone his family when he arrived in prison. She asked if the prison had considered her son's history of self-harm and how officers monitored his risk. His mother also asked if the prison knew he had been in contact with a crisis team in the community and what mental health treatment he received in prison.
12. The man's family received a copy of the initial report. The solicitor representing the family wrote to us raising 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.

## **Background Information**

### **HMP Woodhill**

13. HMP Woodhill has a dual role of a local prison and a high security prison and can hold more than 800 men. Central and North West London NHS Foundation Trust provides health services at the prison.

### **Her Majesty's Inspectorate of Prisons**

14. HM Inspectorate of Prisons last inspected Woodhill in January 2014. The number of self-harm incidents was very high and almost double what the Inspectorate found in other local prisons. The quality of ACCT suicide and self-harm prevention procedures was generally poor, although prisoners supported by ACCT were positive about their care. The Inspectorate noted that five prisoners had killed themselves in the two years since the previous inspection and that the Prisons and Probation Ombudsman had identified some common themes. Inspectors considered that action plans in response needed further development to ensure safer practice. Health services were generally good but mental health provision was insufficient to meet demand.

### **Independent Monitoring Board**

15. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help ensure that prisoners are treated fairly and decently. In its most recent published report for the year to May 2014, the IMB noted that health services continued to improve. The IMB considered that greater emphasis on the quality of ACCT procedures was needed.

### **Previous deaths at HMP Woodhill**

16. This man's was the seventh self-inflicted death at Woodhill since 2013, and there have been two since. We are concerned that many of the same issues have been repeated in a number of our investigations, including this one. In six cases investigated in 2013 and 2014, we found that staff had failed to identify or properly assess the risk of suicide and self-harm in newly arrived prisoners. We also made recommendations about the quality of ACCT procedures in two cases.

### **Assessment, Care in Custody and Teamwork (ACCT)**

17. ACCT is the Prison Service care-planning system used to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk, how to reduce the risk and how best to monitor and supervise the prisoner.
18. After an initial assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. Checks should be irregular to prevent the prisoner anticipating when they will occur. There should be regular multi-disciplinary review meetings involving the prisoner. As part of the process, a caremap (plan of care, support and intervention) is put in

place. The ACCT plan should not be closed until all the actions of the caremap have been completed.

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

## Key Events

20. On 18 February 2015, the man was arrested and charged with a serious offence associated with an increased risk of suicide or self-harm. While he was in police custody, he said that he had gone to the roof of a car park two days earlier and had thought about jumping off. A police nurse recorded that he would need more healthcare support if he remained in the community, and that the prison should be warned about his level of risk if he was remanded. She concluded that his risk of self-harm was raised. Staff at the police station checked him every thirty minutes.
21. On 19 February, a local hospital faxed the police a report from 4 February, when the man had gone to hospital reporting suicidal thoughts. In the report, a nurse noted that the man had previously had depression, had a history of self-harm and had been referred to a community mental health team. He told the nurse that he had recently split up with his partner and had lost his home, his job and had no hope of improving his circumstances. The nurse concluded that he had no thought disorder and was at low risk of suicide. He was prescribed mirtazapine (an antidepressant) and the nurse contacted the man's GP to follow up.
22. Also on 19 February, a police officer completed the man's Person Escort Record, (PER - a document which accompanies all prisoners when they move between police stations, courts and prisons) indicating that he had self-harmed in June 2004, and had thoughts about jumping off buildings. The police officer noted that the man's father had died by suicide. He noted that the man had been convicted of a serious offence in the past and was charged with the another serious offence. The officer recorded that the man took medication for depression.
23. The next day, 20 February, the man appeared at court. A court officer completed a suicide and self-harm warning form. The officer noted that the man said he was fine, but he had completed the form as a precautionary measure, in light of the information on the PER.
24. The man was remanded to HMP Woodhill. A supervising officer (SO) signed to confirm receipt of the suicide and self-harm warning form but took no action on it. He said he would not start ACCT monitoring if he was worried about a prisoner, but would pass his concerns to the officer conducting the reception interview, who would assess the risk of suicide or self-harm and also complete the cell sharing risk assessment. The supervising officer did not pass on any concerns about the man.
25. An officer completed the reception interview. This included the cell sharing risk assessment to identify the risk of a prisoner seriously assaulting or killing a cellmate in a locked cell. He noted a number of risk factors on the form: the nature of the man's offence, that court staff had opened a suicide and self-harm warning form, that the man had previously been monitored through the ACCT process, had a history of self-harm and had been identified as a bully (which meant he would have had at least three violent offences on his prison record). He said he could see from the man's previous prison record that he had been considered high risk at Woodhill on a previous sentence. The officer therefore concluded that he was a high risk for sharing a cell with another prisoner. He

said that the man would not have shared a cell on the first night centre anyway because he was a vulnerable prisoner, and he expected the cell sharing risk assessment to be reviewed by induction officers.

26. The officer also considered the man's risk of suicide and self-harm. Although he could not remember him specifically, the officer told the investigator that he asks prisoners how they feel and judges their risk by the way they react. He did not refer to assessing prisoners on their risk factors for suicide and self-harm. The officer wrote that the man had no thoughts of suicide or self-harm and, despite his evident risk factors and the suicide and self-harm warning form, did not begin ACCT procedures.
27. At an initial health screen, a nurse noted that the man had no history of significant self-harm or serious suicide attempts. She did not record whether he had tried to harm himself outside prison, but noted that he had last harmed himself in prison three years previously. She recorded that he did not have a psychiatrist or mental health worker in the community. He told her that he had been prescribed mirtazapine for depression, but he had stopped taking it because it was not working. She wrote that he appeared well and said he had no thoughts of suicide or self-harm.
28. The nurse did not sign the suicide and self-harm warning form and told the investigator that she was certain that she had not seen it. She could not remember whether she had seen the detained person's medical record from the police, or his Person Escort Record. She did not think she had seen the hospital report from 4 February. In the absence of any other sources of information, she said she relied on her interaction with the prisoner and her experience to assess suicide risks and medical needs. She did not open an ACCT because she did not think he was at risk of suicide or self-harm. She said she had referred him to the GP because he said that he had been prescribed antidepressants, which he had not found helpful.
29. Later that evening, a doctor assessed the man in the prison's first night centre and prescribed him mirtazapine (one 30mg tablet a day) for depression and salbutamol for asthma. He recorded that the man made good eye contact and seemed fine, although noted he had a history of not taking his medication. The man told the GP that he had no thoughts of suicide or self-harm. The GP had no concerns about him.
30. An officer interviewed the man in the first night centre. He recorded that the man had been at Woodhill four years previously and that he posed a high risk if sharing a cell because of his mental health. He noted that the man had a suicide and self-harm warning form and a history of suicide and self-harm, but no one had opened an ACCT. He did not think that he was at risk of suicide or self-harm and did not open an ACCT either.
31. That evening, the man applied to be separated from the main prison under Prison Rule 45, for his own protection. He told staff that he felt at risk because of the nature of his alleged offence and that he had lived in the vulnerable prisoner unit (VPU) before. He had been assessed as high risk for cell sharing so could not share a cell. There were no free single cells in the VPU, so he stayed in the

first night centre. Neither the wing manager nor the governor had dealt with the man's application to be kept separate under Prison Rule 45, before he died.

32. On Saturday 21 February, a supervising officer completed the man's basic custody screening, an assessment developed at Woodhill, which is completed by supervising officers to establish what support each prisoner needs. He noted that the man had already seen the prison GP to discuss his mental health needs and medication. The man told him that he had been to hospital because of his mental health, and the supervising officer recorded that the hospital crisis team might have further information. He told the investigator that healthcare staff do not see this document and officers would not have followed it up. The Head of Safer Custody said that she expected staff to share such information with relevant departments.
33. That morning, a healthcare assistant carried out a secondary health screen. She said the only information she had access to was from SystemOne (the electronic medical record). She did not see the suicide and self-harm warning form, the police medical records or the hospital report. The man told the healthcare assistant that he had been due to have a mental health review at his GP surgery on 24 February. The healthcare assistant wrote that he refused to answer questions about his physical health, and said he had no thoughts of suicide or self-harm. When she asked him what the mental health review was for, he explained that it was for anxiety, depression and suicidal thoughts. He refused to complete a mental health questionnaire. The healthcare assistant was concerned about him and, after the health screen, agreed with her supervisor that she should open an ACCT, because she was concerned that he did not engage with the health screen and seemed withdrawn.
34. When she went back to the wing to tell officers she was opening an ACCT, the healthcare assistant went to the man's cell and asked him to complete a mental health referral form. She told the investigator that she thought he would be more open if he completed the form and referred himself. As she was leaving his cell, she noticed that he had marks on the right side of his neck, which she had not seen previously, because of the way he was sitting. She said the marks were red and bright. She could not tell whether they were recent or whether they were caused by self-harm. She said that she could not ask him about the marks because other prisoners were nearby and she did not want to compromise his safety by identifying his vulnerability in front of others.
35. At 4.30pm, a supervising officer completed an ACCT immediate action plan. He decided that officers should check the man every hour until he had an ACCT assessment, and that he did not need immediate medical intervention. The supervising officer explained that he could speak to a Listener if he needed extra support. (Listeners are prisoners trained by the Samaritans to offer confidential support to other prisoners.)
36. The healthcare assistant went back to the wing later that afternoon, and checked whether the man had completed the mental health referral form. He had not and said he would fill it in after he had eaten his meal. The healthcare assistant said that she felt reassured that his mental health needs would be addressed as part of the ACCT process and staff would monitor him. The man told her that he was

feeling down, and after she discussed him with a doctor, the doctor prescribed a sleeping tablet.

37. At 2.00pm on 22 February, an officer assessed the man as part of the ACCT process. The man said that he was feeling down, but felt better and could not understand why staff had opened an ACCT. The officer said that he did not have time to look at the man's records before his assessment, and had only read the concern and keep safe form that the healthcare assistant completed. The officer said that he had to rely on what the man told him to assess his risk. The man said he had no issues in or out of prison. He said that he had punched through a window and had tried to kill himself four years previously, when he was in prison. He said that he was hoping he would only receive a short prison sentence. The officer also noted the marks on the man's neck, which he thought looked like a rash. The man said that his jumper had rubbed his neck, causing the marks. The officer accepted this explanation.
38. The man told the officer that he thought he needed mental health support and would like to speak to his mother. The officer noted that officers would have to check his mother's telephone number to make sure this did not breach his public protection arrangements. He did not record this on the man's prison record, caremap or case review notes, and there is no evidence that anyone checked the man's telephone numbers. He did not make any phone calls before his death.
39. A supervising officer chaired an ACCT case review at 3.30pm that day, attended by a nurse, an officer and the man. The man again said that the marks on his neck were from his jumper rubbing. The supervising officer recorded that the man would remain in the first night centre until a single cell became free in the VPU. He explained that to protect vulnerable prisoners in the first night centre they were unlocked at different times from other prisoners to attend induction sessions, use the telephones and showers and collect meals.
40. The caremap reflected that the man was waiting for a mental health assessment, and that he would move to the VPU when there was a space. The supervising officer told the investigator that he intended to ask the man to complete a self-referral and the nurse was also going to refer him for a mental health assessment. There is no evidence that either was done. The review agreed that the man was at low risk of suicide or self-harm and scheduled the next case review for 27 February. They agreed that officers should have at least one conversation with the man each shift (morning, afternoon and evening) and check him three times during the night.
41. At 10.30am on 25 February, the man told an officer that he had not slept well and had been having dreams. The officer noted this in the ACCT record.
42. At about 11.25am, an officer unlocked the man's cell so that he could collect his lunch. She said that the man had been confused about being unlocked before other prisoners, and she had explained that he would have to collect his lunch first because he was being kept separate from the other prisoners as a vulnerable prisoner. She thought he seemed fine at the time. The man collected his lunch and went back to his cell.

43. At 12.57pm, an officer went to check all prisoners subject to ACCT monitoring. When she looked through the door observation panel into the man's cell, she saw that he had a sheet around his neck attached to the window bars. She radioed a code blue at 12.58pm. (Code blue is a medical emergency code used to summon help in circumstances such as when a prisoner is unconscious or not breathing.) An officer was nearby and joined her as she went into the cell. One officer supported the man while the other cut the sheet. Two officers then moved him out of his cell and found no signs of life, so started chest compressions and rescue breaths.
44. The emergency response nurse and other nurses responded quickly to the code blue. When they got to the cell, they took over resuscitation, continued chest compressions and administered oxygen. One of the nurses attached a defibrillator to the man, which advised that cardiopulmonary resuscitation should continue. It did not advise a shock.
45. As soon as they received the code blue, the control room called an ambulance, which arrived at the prison gate at 1.09pm. However, paramedics did not get to the houseblock until 1.24pm. The paramedics took over the emergency treatment and stabilised the man ready to leave for hospital.
46. At 1.45pm, the ambulance left the prison and took the man to the hospital emergency department. At 3.20pm, he was moved to the hospital's intensive treatment unit. After he was taken to hospital, officers found a note in his cell, saying that he could not bear it any more and that he was sorry.
47. At 3.50pm, a prison manager contacted the man's mother to tell her that her son was in hospital in a critical condition. She arranged for the prison's family liaison officer to take the man's mother to the hospital. The family liaison officer went to collect the man's mother and her partner to drive them to the hospital and arrived at about 7.00pm.
48. The next day, 27 February, a doctor told an escort officer that the man was unlikely to survive. Hospital staff pronounced him dead at 12.55pm that afternoon. His family were with him at the time.

### **Contact with the man's family**

49. The prison's family liaison officer stayed for some time with the man's family at the hospital on 26 February. He met them again at the hospital the next day and stayed to support them until the man died. On 4 March, the family liaison officer visited the man's family at their home and discussed funeral arrangements. In line with national Prison Service policy, the prison contributed to the costs.

### **Support for prisoners and staff**

50. After the man was taken to hospital, a prison manager debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and for managers to offer support. The staff care team also offered support.

51. The prison posted notices informing other prisoners of the man's death, and offering support. Staff reviewed all prisoners subject to suicide and self-harm prevention procedures, in case they had been adversely affected by the man's death.

**Post-mortem report**

52. A post-mortem examination found that the man died from hanging.

# Findings

## Assessing and managing risk of suicide and self-harm

### *Assessment of risk of suicide and self-harm in reception*

53. On 18 February, the man told a police nurse that he had thought about jumping off a building, and that his antidepressants were not working. A hospital report received on 19 December, said that he went to hospital on 4 February because he was suicidal and felt he had nothing to live for. This information was summarised on the man's PER, which also noted that his father had committed suicide. The court custody officer recorded on the man's suicide and self-harm warning form that, although the man had said he was not thinking about self-harm or suicide, he had completed the form as a precautionary measure in light of the information on the PER. No one in reception remembered seeing the detained person's medical record or the hospital report. No one considered that the man was at risk of suicide or self-harm, or started ACCT monitoring.
54. A supervising officer signed the suicide and self-harm warning form to confirm its receipt, but said that he did not consider it his responsibility to assess the man's risk but would pass on any concerns to the other staff who would be assessing him. An officer who assessed the man in reception, did not consider any risk factors for suicide and self-harm and said he relied solely on how prisoners presented when he assessed their risk. He did not open an ACCT. A nurse said she had not seen the suicide and self-harm warning form, but assessed the man's risk based on his presentation during their conversation and the information from his previous sentences on SystemOne. She did not think he was at risk of suicide or self-harm and did not open an ACCT. We are concerned that the nurse did not have all the information available to make an assessment.
55. Prison Service Instruction (PSI) 7/2015, about early days in custody, sets out mandatory reception procedures and says 'The PER and any other available documentation including Suicide & Self Harm Warning Forms, ACCT documents and CSRAs, must be examined, and the prisoner interviewed in Reception, to assess the risk of self-harm or harm to others by the prisoner, or harm from others. All available, relevant information must be considered...' As reception, staff did not properly consider the information on the escort record and suicide and self-harm warning form highlighting the man's risks, we do not think that the prison complied with this instruction.
56. PSI 64/2011 (Safer Custody) lists a number of risk factors and potential triggers for suicide and self-harm. The man had a number of these risks. He was in the early days of custody, had recently thought about killing himself, he had had recent contact with mental health services, an outstanding appointment with the community mental health crisis team, had a close family member who had killed himself and had been charged with a serious offence. PSI 7/2015 requires staff to interview new prisoners in reception to assess the risk of suicide and self-harm and expects all staff to be alert to the increased risk and to act appropriately to address any concerns. This includes opening an ACCT.

57. Despite his recent suicidal thoughts, the charge he was facing, and his contact with community mental health services, an officer, a supervising officer and a nurse all relied almost entirely on his presentation and his assertion that he did not intend to harm himself. There is no evidence that they balanced this against the information he arrived with at the prison or his known risk factors.
58. Staff judgment is fundamental to the ACCT system. It relies on staff to use their experience and skills, as well as local and national assessment tools, to determine risk. This must include the prisoner's known risk factors and their presentation. PSI 64/2011 states that 'all staff who have contact with prisoners must be aware of the triggers that may increase the risk of suicide, self-harm or violence and take appropriate action'. The need to take full account of risk factors on reception is a matter we have raised with the prison before.

*Managing risk of suicide and self-harm*

59. The day after he arrived at the prison, a healthcare assistant appropriately assessed the man as at risk of suicide and self-harm. She based her concerns on the man's presentation but said that she had not seen his detained person's medical records or his hospital report.
60. PSI 64/2011 expects the ACCT assessor to undertake the assessment based on all available information such as pre-sentence reports, OASys, health care information, NOMIS case notes and previous ACCT documents, as well as from interviewing the prisoner. The officer who interviewed the man for an ACCT assessment told the investigator that he had not had time to review any of the man's records before he saw him. He had to base his judgement on what the man said during the assessment and the concern and keep safe form that the healthcare assistant had completed. When he chaired the ACCT case review, the supervising officer had no other information about the man, except what he had gathered during the basic custody screen.
61. Even had the healthcare assistant, the officer or the supervising officer had the opportunity to review the man's records more extensively, it is unlikely that they would have reviewed his detained person's medical records or the hospital report. These documents arrived in the prison with the man, but were not reviewed in reception or scanned into his medical record. It is not clear where they were filed, and no one we spoke to remembered seeing them. The Head of Healthcare said that such records would normally be passed to the healthcare team who scan them and attach them to a prisoner's medical records the next working day, which in this case would have been Monday 23 February. The records were not attached to the man's medical record and were not reviewed by any member of staff.
62. PSI 64/2011 requires that an ACCT assessment is based on all available information about a prisoner's risk. The staff at the ACCT case review decided that the man was at low risk of suicide and self-harm. We are concerned that the man's assessed level of risk did not reflect his actual level of risk, because no one took into account all of the information about his risk. Each person who is responsible for assessing a prisoner's risk of suicide and self-harm needs to see and consider all relevant information.

63. PSI 64/2011 requires caremaps to reflect the prisoner's needs, level of risk and the triggers of their distress. Caremaps should aim to address issues identified in the ACCT assessment interview and consider a range of factors including health interventions, peer support, location, provision of diversionary activities, including occupations in cell and access to gym and other activities. Each action on the caremap must be tailored to meet the individual needs of the prisoner, be aimed at reducing risk to themselves and be time bound.
64. The two entries on the man's caremap noted that a mental health referral had been made (although it had not), and that he would move to the vulnerable prisoners unit when there was space. Neither entry triggered staff to take any action to reduce the man's risk. It is concerning that staff did not identify issues such as family contact, which, if addressed, might have helped to reduce his risk,
65. We are concerned about the assessment and management of risk at Woodhill. We make the following recommendation:

**The Governor should ensure that there are effective operating procedures in reception and that all staff understand the procedures for identifying prisoners at risk of suicide and self-harm and for managing and supporting them. In particular, staff should:**

- **Have a clear understanding of their responsibilities and the need to record relevant information about risk;**
- **Consider and record all the known risk factors of newly arrived prisoners when determining their risk of suicide or self-harm, including information from suicide and self-harm warning forms, PERs and medical records;**
- **Open an ACCT whenever a prisoner has recently self-harmed, expressed suicidal intent or has other significant risk factors, irrespective of their stated intentions;**
- **Review all information about a prisoner's risk to inform the management of his risk of suicide and self-harm;**
- **Set effective ACCT caremap objectives which are specific and meaningful, aimed at reducing a prisoner's risk, include issues of family contact where relevant and which identify who is responsible for them.**

## **Mental health**

66. During his basic custody screening, the man told a supervising officer that he had seen a hospital crisis team because of his mental health. The supervising officer recorded that the hospital crisis team might have more information about the man's mental health. He told the investigator that he did not expect officers to follow this up and he knew that healthcare staff would not see the form. As the supervising officer expected, no one contacted the hospital crisis team for information. We agree with Woodhill's Head of Safer Custody that this information should have been shared with healthcare staff who could have requested the relevant information.

67. The healthcare assistant asked the man to complete a self-referral form for a mental health assessment. As it was the weekend, she could not contact the mental health team directly, but said that she could have sent an electronic prompt to the mental health team that would have been picked up on Monday morning. She chose to use the self-referral form because she thought it would give the mental health team a fuller picture, and give the man the opportunity to disclose more information if he was not comfortable sharing with her. The man did not complete the self-referral form.
68. At the ACCT case review, the supervising officer recalled that the nurse agreed to refer the man to the mental health team. The supervising officer said that he would ask the man to complete a self-referral. There is no evidence that the man was ever referred to the mental health team, either by a member of staff or himself.
69. The healthcare assistant, the nurse and the supervising officer all considered that the man needed a mental health assessment, yet none of them referred him to the mental health team. We consider that, as he had been identified as at risk of suicide and self-harm, staff should have referred him for a mental health assessment as a matter of priority and not expected him to refer himself. However, even if prioritised, we accept that it was unlikely that he would have had a mental health assessment before he died. We make the following recommendation:

**The Governor and Head of Healthcare should ensure that staff request all relevant community health records and that prisoners identified as at risk of suicide and self-harm are referred urgently for a mental health assessment.**

### **Emergency response**

70. According to the incident log from 26 February, the ambulance arrived at the prison gate at 1.09pm, but paramedics did not reach the man's cell until 1.24pm, 15 minutes later. There were four gates between the prison entrance and the man's wing. The prison could not explain why it took so long to get paramedics to his cell and we were unable to obtain this information from the ambulance service.
71. Prison Service Instruction (PSI) 3/2013 sets out how a prison should respond to a medical emergency. It requires that every prison should develop a protocol with the local ambulance service, which ensures, among other things, that there is no unnecessary delay in escorting ambulances and paramedics to the patient and discharging them from the prison.
72. We consider that 15 minutes is too long to get paramedics from the prison gate to a cell in a medical emergency. Such a delay can be critical. We make the following recommendation:

**The Governor should ensure that there is no unnecessary delay in paramedics reaching a prisoner in a medical emergency.**

## Notifying the family

73. The man was taken to hospital in a critical condition at 1.45pm but the prison did not inform his family until 3.50pm, more than two hours later. Prison Rule 22 requires that when a prisoner becomes seriously ill, the Governor should “**at once** inform the prisoner’s spouse or next of kin, and also any person who the prisoner may reasonably have asked should be informed”.
74. When the man was taken to hospital, his condition was critical and we consider the prison should have informed his family straight away. Any delay in informing families when a prisoner is seriously ill or has suffered sudden life-threatening harm can mean that families miss the opportunity to see them before they die. We make the following recommendation:

**The Governor should ensure, in line with Prison Rule 22, that the next of kin of seriously ill prisoners are informed as soon as possible so that they are able to visit them in hospital without unnecessary delay.**