

A Report by the
Prisons and
Probation
Ombudsman
Nigel Newcomen CBE

**Investigation into the death of a man in October 2014,
while a prisoner at HMP Woodhill**

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 investigation report into the death of a man, who was found hanging in his cell at HMP Woodhill in October 2014. Despite resuscitation attempts, he was pronounced dead at hospital. He was 37 years old. I offer my condolences to his family and friends.

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

The man had a history of offending to fund his substance misuse and he had been in prison, including at Woodhill, before. He had a history of anxiety and depression, and in the past, it had been suggested that he might have a personality disorder and be suffering drug induced psychosis. He had tried to kill himself before and had a history of self-harm by various methods.

The man was remanded to Woodhill on 12 February 2014. At court that day, he banged his head against walls and said that he would kill himself in prison and this information was passed to reception staff at the prison. They did not properly assess his risk of suicide and self-harm. The same thing happened when he returned from court in April. On other occasions, when he told staff that he had harmed himself, including banging his head against walls, they took no action. In April, he said that he had overdosed on paracetamol. This time, he was monitored under Prison Service suicide and self-harm prevention procedures for a day, but staff did not properly follow mandatory instructions.

The man disclosed that he was using illicit drugs at Woodhill. Although his friends said that he was not in debt to other prisoners or subject to any bullying, twice he claimed that he had been assaulted. It appears that Woodhill did little to further investigate either the alleged assaults or his illicit drug use.

One evening in October, the man told a friend that he had not been able to buy any drugs that day; however, his friend thought that he seemed fine. The next morning, an officer found him hanging from the light fitting in his cell. Despite his history of self-harm, he was never considered to be at risk of suicide and his death came as a shock. I consider that it would have been difficult for staff to have predicted his actions or prevented his death.

This investigation shows that the Governor of Woodhill still has much work to do to educate his staff about identifying and assessing risk. I am disappointed that some of the recommendations made in this investigation were made in earlier investigations.

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

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SUMMARY

1. On 12 February 2014, the man was appeared in court, charged with attempted burglary. He had a long history of drug misuse and mental health problems and had been in prison, including at Woodhill, before. He had tried to kill himself before and had a history of self-harm by various means. At court, he banged his head against walls and told staff in the court cells that he would kill himself in prison. When he was remanded to Woodhill, this information was recorded and passed to prison reception staff. However, his risk of suicide and self-harm was not properly assessed and Prison Service suicide and self-harm prevention procedures (known as ACCT) were not begun.
2. A week later, the man stabbed himself in the ear with a pen because he said he was hearing voices. His behaviour was not treated as self-harm and ACCT procedures were not considered. He saw a psychiatrist and said that he was hearing voices. He was diagnosed with depression but said that he had no thoughts of suicide or self-harm.
3. On 11 March, the man said that he had been assaulted in the shower. Although the incident was not investigated, he was moved to the drug detoxification and recovery wing.
4. On 3 April, the man said that he had overdosed on paracetamol. The amount of the medication in his blood was not sufficient to require hospitalisation. He also said that he often banged his head against walls or hit himself around the head. Staff began ACCT procedures but they were ended the next day when he said that he had only overdosed because he wanted to see a specific external psychiatrist. He gave a bizarre account of why he had overdosed and so the duty doctor referred him for an urgent mental health review, which did not take place.
5. The man was often reprimanded for breaking prison rules and several times during his time at Woodhill had privileges, such as time out of cell and an in-cell television, removed.
6. On 28 April, the man appeared at court again and banged his head against walls. Again, the information was passed to reception staff at Woodhill who did not properly assess his risk of suicide and self-harm and did not begin ACCT procedures.
7. The man disclosed that he was using illicit drugs at Woodhill and was placed on and completed a detoxification programme. However, he linked his use of illicit substances with his anxiety and substance misuse specialists concluded that until he could manage his anxiety, he would continue to use illicit substances. On that basis, he was judged unsuitable for further detoxification programmes and was advised to engage with the mental health team. However, he did not attend a number of appointments with a mental health nurse and the psychiatrist.

8. On 27 August, the man moved to a normal residential wing. Four days later, on 31 August, he said he had been assaulted. Again, the incident was not investigated. His friends at Woodhill said that he could afford to buy the drugs he needed and was not in debt. They did not think that he was subject to any bullying.
9. The man continued to disclose that he often hit himself around the head, and sometime presented to healthcare staff worried about brain injuries. This behaviour was not treated as self-harm and no one considered beginning ACCT procedures. No one had any concerns that he might be at risk of suicide.
10. On 13 October, prisoners on the man's house unit spent most of the day in their cells. During time out of his cell in the evening, he told a friend that he had not been able to buy any drugs that day as they were in short supply on the unit. His friend thought that he seemed fine.
11. At about 5.30am, the night patrol officer saw the man asleep in bed. Another officer checked prisoners again and at 7.20am, found him hanging from the light fitting in his cell with a sheet tied around his neck. The officer raised the alarm and waited for other officers to arrive before going into the cell. The officers and then nurses tried to resuscitate him. The paramedics arrived shortly after and took him to hospital, where he was pronounced dead.
12. Although we conclude that the man's actions came without apparent warning and could not easily have been predicted by staff, the investigation raised a number of concerns. This investigation has highlighted serious shortcomings in how staff at Woodhill identify, assess and respond to risk of suicide and self-harm. It is also worrying that the prison, which is part of the high secure estate, did not investigate allegations of assault and illicit drug use. We have also raised some concerns about the emergency response when he was found hanging. We make five recommendations.

THE INVESTIGATION PROCESS

13. The investigator issued notices to staff and prisoners at HMP Woodhill informing them of the investigation and inviting anyone with relevant information to contact her. No-one responded.
14. On 24 October 2014, the investigator visited Woodhill and obtained copies of the man's prison and healthcare records. She later interviewed 15 staff and three prisoners
15. NHS England appointed a clinical reviewer to review the man's clinical care at HMP Woodhill.
16. The investigator informed the Coroner for Milton Keynes of the investigation, who provided a post-mortem report. We have sent him a copy of this report.
17. One of the Ombudsman's family liaison officers contacted the man's mother to explain the purpose of the investigation and invite her to raise matters she wanted the investigation to consider. She did not identify any particular issues that she wanted us to investigate.
18. The man's family received a copy of the draft report but made no further comment. The prison received a copy of the draft report and has submitted an action plan detailing how they will address the issues we raised in the report. It is included at the end of the report.

HMP WOODHILL

19. 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. Westminster Drug Project provides the substance misuse services.

HM Inspectorate of Prisons

20. HM Inspectorate of Prisons inspected Woodhill in January 2014. Inspectors found that health services were generally good but mental health provision was insufficient to meet demand. Illicit drug availability had increased since the last inspection in 2012, but was similar to other local prisons. The number of self-harm incidents was very high and almost double what the Inspectorate found in other local prisons and the quality of suicide and self-harm prevention procedures were generally poor, although prisoners subject to those processes felt well cared for. The Inspectorate commented that five prisoners had taken their lives since the previous inspection and the prison's response required immediate improvement.

Independent Monitoring Board

21. 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 recommended that greater emphasis be placed on the quality of suicide and self-harm prevention procedures.

Previous deaths

22. The man's was the sixth self-inflicted death at Woodhill since 2013, and there has been one since. It is very disappointing to find so many of the same issues repeated in a number of our investigations, including this one. In five cases investigated in 2013 and 2014, we raised concerns about staff failing to identify or properly assess the risk of suicide and self-harm in newly arrived prisoners. We also made a recommendation about the quality of suicide and self-harm prevention procedures in one case. In three cases, we raised concerns about the emergency response, including not using the correct emergency radio code and not going into the cell quickly enough.

Assessment, care in custody and teamwork (ACCT)

23. ACCT - assessment, care in custody and teamwork - is the care planning system the Prison Service uses to support prisoners at risk of suicide or self-harm. Once a prisoner has been identified as at risk, the purpose of the ACCT process is to try to determine the level of risk, the steps that might be taken to reduce this and the extent to which staff need to monitor and supervise the prisoner. Part of the ACCT process involves assessing immediate needs and 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. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

KEY EVENTS

24. The man was first convicted of an offence aged 15 and had served numerous prison sentences for burglaries and theft which he had committed to fund his use of amphetamines, heroin and subutex (a heroin substitute). In prison, he was often prescribed methadone. He said that he had a long history of depression and, in 2012, said that he was hearing voices. He had attempted suicide by hanging in 1998 and took a paracetamol overdose in 2010. Over the years, he reported a range of self-harm behaviours, including cutting himself, trying to strangle himself, hitting himself in the eye and repeatedly hitting his head on his cell wall. Between April 2009 and July 2013, he was supported by Prison Service suicide and self-harm prevention procedures (ACCT) on ten separate occasions. He was last released from prison on 27 September 2013.
25. On 10 February 2014, the man was arrested and taken to a police station, where he was later charged with attempted burglary. While in police custody, he disclosed that he suffered from depression and anxiety with possible psychotic features, for which he was prescribed diazepam. He said that he was an amphetamine user. A doctor examined him at the police station and prescribed a low dose of diazepam (5mg) every eight hours until he appeared in court.
26. The escort contractors, Geo Amey, collected the man from the police station at 8.25am on 12 February. The police completed the front page of the Person Escort Record (PER – which details any of the detained person's known risks and is a record of events while the individual is escorted between police custody, court and prisons). They noted that he had been 'possibly suicidal' in 2012, had anxiety and depression and might be suffering a psychotic mental illness.
27. At 8.35am, a Prisoner Custody Officer (PCO) wrote in the PER that the man was headbutting the cubicle of the cellular escort van. He began a suicide and self-harm warning form. Later that day, he updated the warning form noting that the man was upset, depressed and had continued to bang his head against walls. On three occasions, staff decided to constantly observe him in the court cells because they were worried he might hurt himself. He told one of the officers that he would kill himself in prison and this was also recorded on the warning form. Details of the day's events were recorded in the PER. He was remanded into Woodhill's custody awaiting trial.
28. The man arrived at Woodhill at 3.20pm. A Supervising Officer (SO) signed his suicide and self-harm warning form and the PER to indicate he understood their contents. The warning form instructed reception staff to keep the prisoner safe according to local protocols until a member of healthcare staff had assessed the prisoner and had seen the form. The SO did not open an ACCT plan, record that he had assessed the man's risk of suicide or self-harm or make any note of how staff should keep him safe.

29. A nurse assessed the man in reception and recorded that he had been banging his head for the last two days while he was in police custody, because he was frustrated. He said that he had a history of amphetamine misuse and suffered from anxiety and depression, which were controlled by his prescribed diazepam. The nurse asked him about his history of self-harm and he said that he had harmed himself years ago but that it was no longer a problem. She wrote in his clinical record that he appeared well and had denied any thoughts of suicide or self-harm (despite his recent head banging), and made no mention of the suicide and self-harm warning form in his clinical record. She did not complete the healthcare section on the form which records the actions taken in response to the warning form, nor begin ACCT procedures.
30. Based on information gathered during the man's previous prison sentences, an officer assessed him as currently unsuitable for sharing a cell. When asked, he told the officer that he had no concerns about returning to prison.
31. The man went to the First Night Centre for newly received prisoners where an officer interviewed him to assess his immediate needs. Discussing the suicide and self-harm warning form, he said he had banged his head out of frustration at returning to prison. He said that he did not have any more thoughts of self-harm and no thoughts of suicide. He said that he had spoken to a Listener (a prisoner trained by the Samaritans to offer support to other prisoners) in reception. The officer explained to him the support available to him. He told the investigator that if he had thought that the information on the warning form had warranted opening an ACCT, he would have done so. He said if he had had any concerns about his safety, he would not have hesitated to open an ACCT to keep him safe.
32. A prison doctor examined the man later that evening in the First Night Centre. He said that his community doctor had referred him to the community mental health team because of his possible diagnosis of amphetamine related psychosis. He said that he was prescribed diazepam but was happy to reduce his dosage with a view to stopping. The doctor noted that he displayed good eye contact and did not have any obvious withdrawal symptoms. He prescribed 5mg diazepam for seven days to be taken at night. He was happy with this. He gave a urine sample, which tested positive for amphetamine, subutex (which he was not prescribed) and benzodiazepine. The doctor wrote in his clinical record that he would refer him to the mental health team and that he needed to undergo a tailored diazepam reduction programme.
33. On 13 February, an officer interviewed the man in the First Night Centre to check that he felt supported. He said he felt better than the day before and did not have any thoughts of self-harm or suicide. A nurse carried out a second health screen that day and recorded that she had no concerns about him.
34. An administrator in the Offender Management Unit filled out a Prisoner Alert Log after examining the suicide and self-harm warning form which was in the

man's custodial documents file. She informed an officer in the First Night Centre and a member of the Safer Custody Team by email that the man had told a PCO he would kill himself in prison. The officer checked with a colleague that he had interviewed the man in the First Night Centre and that he had not expressed thoughts of self-harm or suicide and wrote a note in his record. She also updated his record, emailed his wing managers and notified the healthcare department. (This follow-up check was the procedure at the time but was discontinued in August 2014.)

35. On 16 February, a healthcare assistant visited the man in his cell after he complained of paranoia and feeling stressed. She noticed a small amount of blood in his right ear and he said that he had stabbed his ear with a pen. He asked whether he could have his diazepam tablet in the late afternoon rather than in the evening. She reassured him that a nurse would visit him before the end of the day. She did not open an ACCT or record that she had discussed his actions with unit staff. No further entries were made in his clinical record that day.
36. On 18 February, a nurse saw the man for a mental health assessment. He told her that he had a history of anxiety and depression and that he had perforated his ear drum in response to hearing voices since last Christmas. (It is not clear if this referred to him having stabbed his ear with a pen two days earlier or a previous act.) He said he had tried to kill himself in 1998 and in 2007. When the voices in his head got worse, he would smack himself to stop them.
37. The nurse conducted the Patient Health Questionnaire 9 (PHQ-9), a basic tool which screens for depression and the man scored 23 out of 27. He answered that he felt down, depressed or hopeless every day, felt bad about himself nearly every day and had had thoughts that he would be better off dead or of hurting himself several days in the last fortnight. However, she wrote that he had no thoughts of suicide. She did not record whether she had considered opening an ACCT. She referred him to a visiting psychiatrist to have his medication reviewed.
38. Later that afternoon, the psychiatrist assessed the man, who said he was feeling low and anxious. He complained of hearing voices which put him down and said he had stabbed himself in the ear with a pen to stop them. He said he was a heavy amphetamine user and committed offences to fund his substance misuse. He said that he did not have thoughts of suicide. The psychiatrist wrote that he might be suffering from amphetamine-induced psychosis. He declined antipsychotic medication but was keen to start venlafaxine, an antidepressant, which he said had been helpful in his previous prison sentence.
39. On 9 March, a custodial manager reviewed the man's cell sharing risk. She concluded that he should remain high risk but that he could share a cell with his brother, who was also at Woodhill until 18 June, when he transferred to HMP Ranby.

40. On 11 March, the man told a SO that, while he had been drying himself in a shower on House Unit 3B, someone had slashed him across the back of his right arm. A nurse examined him and noted two superficial sharp weapon wounds across the back of his right upper arm and the back of his shoulder with no fresh bleeding. The injuries were reported and staff in the security department noted suspicions that he might have staged an incident to claim compensation. There is no evidence that the incident was subject to any further investigation but, on 12 March, he and his brother were moved to House Unit 5, the drug detoxification and recovery unit. They were moved to House Unit 5 for operational reasons, rather than for substance misuse support or treatment. At some point, he and his brother were given single cells. He got a job in the unit kitchen.
41. The man did not turn up for an appointment with the psychiatrist on 13 March, but he saw a nurse later that day. She recorded that he had probably missed his earlier appointment because he had moved residential units the day before. She wrote that he had been refusing his antidepressant (venlafaxine) for two weeks, but did not record why. She advised him to see a doctor to discuss his medication. Two days later, on 15 March, he asked a healthcare assistant to continue his diazepam prescription because he was feeling anxious. The healthcare assistant placed him on the mental health team's waiting list.
42. On 27 March, the psychiatrist saw the man and noted that he seemed flat in mood and complained of depression. However, he did not express any thoughts of suicide or self-harm. He said he did not find venlafaxine helpful (despite previously having asked to be prescribed it) and asked for a benzodiazepine-based medication. He complained that he could not sleep and heard voices at night. The psychiatrist diagnosed him with a depressive disorder and drug seeking behaviour. He prescribed trazodone as an alternative to venlafaxine and agreed that his diazepam prescription could continue on the same low dose as before.
43. On 2 April, the man asked to be referred to a recovery practitioner from the Westminster Drug Project who ran House Unit 5, where he was now living. He was referred and given an appointment on 10 April (which he did not attend). He saw her on 22 April, when he said that he did not need to complete any work with her.
44. Also on 2 April, an officer gave the man a behaviour warning after finding 'numerous [unspecified] unauthorised articles' in his cell during a routine cell check. The next day, the officer warned him that he was not pulling his weight in the kitchen.
45. On the evening of 3 April, the man told a healthcare assistant that he had obtained paracetamol from other prisoners on the unit and had taken 30 tablets three days earlier and 32 tablets that evening. He said that he had taken the overdose so he could see a psychiatrist in hospital who would tell him that he was not psychotic or schizophrenic. He said that he wanted to use the internet to research lie detectors. She recorded that he mentioned

hearing a female neighbour's voice, that there were 'megabytes in the airways linking to his guitar' and that he had been set up by a female police officer, who he said was controlling his penis and messing with his head. She alerted the doctor on duty, who arranged an urgent blood test for him.

46. At 7.20pm, a SO opened an ACCT. She completed the Immediate Action Plan, noting that he should remain in a single cell and be checked once an hour. She told him that they would wait for the blood test results before deciding whether he needed to go to hospital.
47. A nurse examined the man at 8.53pm and wrote in the ACCT and his clinical record that he appeared coherent, alert and his speech was not slurred. She noted that he needed to be reviewed by the mental health team the next day. At 9.38pm, healthcare staff received the blood test results which indicated that the level of paracetamol in his blood was not enough to require hospitalisation. A nurse gave him the blood test results and told him that healthcare staff would monitor him overnight and the blood test would be repeated the next morning. He was not happy and swore at the nurse; however, he slept for most of the night.
48. At 10.25am on 4 April, a doctor asked the man about his reasons for taking an overdose. He said he wanted to see an external psychiatrist so that he could explain how lie detector and MRI technology was being used by a female police officer to frame him. He said that he heard her voice and believed she was using the technology to send signals to his brain to make him fantasize about her. He said that he had no thoughts of suicide or self-harm, or of harming anyone else. The doctor's clinical notes described him as delusional and queried whether he had drug induced psychosis. The doctor noted that he needed an urgent mental health review. There is nothing in his clinical record to indicate that anyone from the mental health team tried to assess him in the days immediately following the overdose. (He missed several mental health appointments in May and June and did not see anyone from the mental health team until 18 July.)
49. At 2.20pm that afternoon, a SO carried out the man's ACCT assessment. He told her that he could not be bothered, had had enough and wanted to see a specific external psychiatrist. He said this psychiatrist was the only one who knew what was going on in his life. He said that if he could not see him he would probably take more paracetamol.
50. The man said that he had no thoughts or plans to kill himself and felt all right at the moment, but he said he had been feeling frustrated and punching the side of his head for nine days. He said he had no support from family or friends but that he would be fine. (His relationship with his brother was not explored in the assessment.) He said that he should have been taken to hospital after the paracetamol overdose as his liver could have been damaged. He said he had no mental health problems and did not want medication but just wanted to return to his cell and 'forget it all'. He said that he did not understand why staff had opened an ACCT.

51. After the assessment, staff and the man attended a case review. He repeated that he had only overdosed because he wanted to see an external psychiatrist and that he had no thoughts of suicide or self-harm. He asked for the results of that morning's blood tests and a nurse said she would find out and let him know, which she did. (Again, the blood tests revealed no cause for concern.) The SO wrote that a doctor had referred him to the mental health team. The case review record contains no mention of him having been punching his head or of his threat to overdose again if he did not see a specific psychiatrist.
52. The SO who chaired the review made two entries in the man's ACCT caremap (a plan of care, support and intervention). The first was that he had overdosed on paracetamol and was receiving ongoing medical treatment. The second entry recorded that he had been referred to the mental health team. He had not yet had a mental health assessment.
53. The SO did not complete the section assessing the man's risk of harm to self or the likelihood of further risk behaviours. However, the case review panel agreed to close the ACCT. The nurse told the investigator that he had maintained good eye contact and had sounded credible. She was not sure whether she knew he had a history of previous self-harm attempts but said that she was comfortable with closing the ACCT as it could be re-opened if necessary. The SO told the investigator that he was surprised the man had taken an overdose as 'it was not like him'. He said that he had come to know him well as he had been in Woodhill several times. The SO knew that he had a history of self-harm but said that he had been quite clear that he did not intend to harm himself this time.
54. On 5 April, an officer gave the man a final work warning for lack of personal cleanliness. No further action was taken at the time.
55. In the six days that followed the closure of his ACCT Plan, daily post-closure staff summaries showed that the man was interacting well with others. However, the post-closure interview, which was due on 11 April, did not take place. The SO told the investigator that he was on leave and he did not know why it had not been arranged.
56. On 16 April, a pharmacy technician wrote in the man's clinical record that 30 paracetamol tablets had been removed from his cell during a cell search. However, there is no further information about this in his prison record or security intelligence. At about 3.05pm, he asked her whether he could have more tablets to replace the ones taken. She wrote that he had previously claimed to have overdosed on paracetamol but she did not record whether she had discussed with him his reasons for keeping the medication in his cell, or wanting more, or whether she had considered opening an ACCT.
57. On 28 April, the man appeared at Crown Court. At about 1.27pm, while in a court cell, he told a PCO that he had a headache and asked for paracetamol. When she returned to his cell four minutes later, he said that he did not have a headache but had been hitting his head and nobody had done anything about it and he wanted valium.

58. Court cell staff saw the man banging his head against the cell wall and one of them asked him how he was. He said he was fine and that he was not hitting his head, but the staff noticed a red mark on his forehead. A PCO initiated a suicide and self-harm warning form. She ticked the box titled 'bizarre behaviour or other signs of mental disorder' to describe the nature of her concern and noted that his ACCT had been closed on 4 April. She wrote that another PCO had also seen him banging his head but when he had asked him to stop he had said it was not hurting him. He was observed intermittently while in the court cells. His case was adjourned for trial and he was remanded back to Woodhill.
59. While the man was at court, a SO reviewed his recent behaviour record. Earlier that day, his cell had been searched and a five litre container of water found. He had also been given a behaviour warning on 16 April for keeping homemade weights in his cell. The SO decided to downgrade him to the basic level of the Incentives and Earned Privileges scheme (which aims to encourage and reward responsible behaviour) with reduced privileges.
60. The man arrived at Woodhill at 4.00pm and saw a SO in reception, who asked him how he was feeling. He said he was fine and just needed his medication. The SO signed the warning form but did not open an ACCT. A nurse also saw him in reception. She wrote in his clinical record that she had given him his prescribed medication and some paracetamol for a headache. She did not record that she had asked him about his actions at court or assessed his risk of suicide or self-harm. She did not open an ACCT and signed the warning form to this effect at 4.30pm.
61. On 29 April, an administrator in the Offender Management Unit completed another Prisoner Alert Log in response to the previous day's suicide and self-harm warning form. She contacted House Unit 5 and informed a SO and emailed the warning form to a member of the safer custody team. The member of the safer custody team emailed the House Unit 5 managers, the healthcare centre and the mental health team but there is no record that anyone spoke to the man about the warning form and no one opened an ACCT.
62. On the same morning, the man told a nurse that he had been using illicit subutex (buprenorphine) but had not taken any for three days and was getting withdrawal symptoms. The nurse took a urine sample which tested positive for buprenorphine and arranged for him to see a doctor later that day. Another nurse told the investigator that subutex was not prescribed at Woodhill. As it had to be smuggled into the prison illegally, it was expensive to buy on the units.
63. The man saw a doctor that afternoon. He told her he had hurt his head by hitting himself with his knuckles out of frustration. The doctor arranged for him to start a lofexidine detoxification and advised him to stop taking illegal substances. He began his detoxification on 30 April and a doctor examined

him on 1 May and found him well. He told the doctor he was very keen not to take drugs.

64. The man finished his lofexidine detoxification on 12 May. He told a nurse that he felt better but was still struggling to sleep and so she prescribed promethazine for eight days.
65. On 13 May, an officer reviewed the man's behaviour under the Incentives and Earned Privileges scheme. He said he accepted responsibility for his past actions and understood where he went wrong. He was upgraded from basic to standard. However, four days later he ignored an officer's instruction. Five days later, on 18 May, officers searched his cell and found drug paraphernalia, a tablet which was not prescribed to him and a sharpened plastic knife. On 19 May, he received two more warnings from officers for breaching prison rules and on 23 May, he was downgraded to basic again. He returned to standard level on 29 May. There is nothing in his security file to suggest that staff reported or investigated the items found during the cell search.
66. The man did not turn up for an appointment with a community mental health nurse on 27 May. On 24 June, he missed another appointment with her, and she telephoned House Unit 5 to find out why. An officer told her that he had refused to go. On the same day, he also refused to see the psychiatrist. The psychiatrist said he would rebook him if he or a member of staff requested it.
67. On 1 July, a nurse wrote in the man's clinical record that he had been refusing his antidepressants for the previous two weeks and had only taken diazepam. She wrote that she had arranged for a doctor to review his medications, although there is no evidence that such a review took place.
68. On 18 July, the man met the community mental health nurse. She wrote that he appeared settled, calm and interacted with her appropriately. His body language was relaxed and he made good eye contact. He denied having suicidal thoughts but said he had been hitting his head with his hands. He thought he had lost weight and said he felt worse on medication and needed something to lift his mood. He asked to see the psychiatrist for a medication review but did not turn up for an appointment on 29 July. The psychiatrist rebooked the appointment.
69. On 8 August, the man saw a nurse and told her that he was taking large amounts of subutex. She arranged for him to see another nurse on 11 August for a detoxification appointment. At that appointment, he said that he could not complete another lofexidine detoxification and asked for a short methadone detoxification instead. However, she decided that a lofexidine detoxification was most suitable.
70. On 11 August, the man returned to the basic regime for 14 days after receiving several warnings about his behaviour.

71. The man missed a third appointment with the psychiatrist on 12 August and no further appointment was made for him. On 27 August, he saw a doctor. He told the doctor he was not doing well and wanted to be prescribed diazepam again (having finished his last prescription in May) as it helped him to cope with his situation and with his depression. He told the doctor he had been using heroin and other drugs on the unit and said that antidepressants did not help him at all. The doctor asked him to describe his symptoms but he would only say that he had banged his head against a wall 1,200 times since arriving at Woodhill in April.
72. The doctor did not see any recent bruising or trauma to the man's head. He noted that he had not displayed any psychotic or depressive features or expressed any thoughts of suicide or self-harm during the consultation. He wrote that he thought the man had requested the appointment only to get a further prescription of benzodiazepines. He told him that he would not prescribe benzodiazepines but could prescribe an antidepressant. He was unhappy with the doctor's suggestion and left the clinic. The doctor noted that he did not currently need any further psychiatric input but that he would inform a nurse of his discussions with him. The doctor wrote that, in his view, the man had mental and behavioural disorders due to his substance misuse.
73. On 27 August, the man moved to a single cell on House Unit 2B, a normal residential unit. The reason for the move is not recorded.
74. On 31 August, the man saw a nurse, complaining of a head injury. He said that he had been assaulted in the shower the day before and showed her a large bruise at the front of his head. She checked him and found him to be physically well but she recorded that he was very anxious. She reassured him and told him to speak to healthcare staff if he continued to feel unwell. There are no other documents or entries concerning this assault in his record.
75. On 3 September, the man saw a pharmacy technician in the healthcare treatment room saying that he had repeatedly punched his temple for about six months due to frustration. He was worried that he might have injured his brain and suggested he should go to hospital. When she offered to refer him to mental health team, he became more agitated and said he was of sound mind. She took his pulse, blood pressure and temperature and all were within the normal range. She did not apparently discuss his self-harm with him or any other healthcare or unit staff and she did not open an ACCT.
76. The next day, 4 September, the man told a doctor that he had scalded himself five days earlier when he had knocked over his kettle while bending over. He was worried he had a brain injury. He repeated that he had been feeling anxious and frustrated over the past few months and had been punching the left side of his head. The doctor examined him and found he had mild scalding and an old bruise to his left temple. The doctor wrote that he expressed no thoughts of suicide or self-harm and did not seem agitated or aggressive. He prescribed a short course of buspirone tablets to help manage the symptoms of his anxiety.

77. On 22 September, the man met the recovery practitioner. He had not completed any of the work exercises she had previously set him and she encouraged him to at least read them.
78. On 25 September, the man saw a nurse and told her that he had been getting subutex from other prisoners on the unit and taking 3-6mg a day to help him with his anxiety. She told the investigator that this was not a large daily dose and the clinical reviewer confirmed that the maximum prescribed daily dose is 16mg. She had no particular concerns about him during the appointment. She asked a substance misuse specialist to assess his suitability for a detoxification programme. He told the specialist that he wanted to start a lofexidine detoxification but only if he was also prescribed valium to help with his anxiety. The specialist told the investigator he was concerned that he was asking for more drugs on top of those he was already taking and felt that his anxieties needed to be managed first. He told the nurse that the man was not suitable for detoxification at that time as he was not ready to stop taking drugs.
79. On 2 October, the man attended the dual diagnosis clinic for prisoners with both mental health and substance misuse problems and saw two nurses. He said he had reduced taking subutex but was now controlling his withdrawal by using diazepam, which he was buying on the house unit. He requested a Librium detoxification so he could leave prison clean. One nurse told the investigator that she always asked prisoners about thoughts of suicide and self-harm and did not know why she had not recorded any information about this during his appointment. The other nurse told the investigator that she had no concerns about his risk of suicide or self-harm or mental health during the consultation.
80. A nurse said that she had worked more closely with the man's brother while he was at Woodhill. She remembered him telling her that the man was in debt to other prisoners because of his drug use. The investigator interviewed three prisoners who knew the man. Prisoner A said that the man sometimes spent more than he could afford but only ever got into manageable debt. He said that the man was not subject to any bullying or intimidation.
81. Prisoner B lived next door to the man on House Unit 2B. He said that the man had enough money to buy the drugs he needed and was not in any debt. Neither he nor Prisoner A had ever thought that he was contemplating suicide.
82. The substance misuse specialist saw the man again on 2 October and concluded that as he used illicit substances to manage his anxiety, he could not undergo a detoxification until his anxiety was being properly managed. The doctor referred him for further psychosocial and psychiatric input. This was the last contact he had with healthcare staff before his death.
83. There are no security intelligence reports relating to the man's disclosed use of illicit drugs in his file. A nurse told the investigator she was aware that staff had submitted intelligence reports about general drug misuse on the house

units but did not see a visible response from officers or the security department.

84. On 8 October, the man's solicitor contacted Woodhill's bail officer to apply for suitable accommodation with the Bail Accommodation Support Service if he was successful in getting bail. She interviewed him on 10 October. She told the investigator that he said he was innocent of the charges. She said that she had read his file and knew he had banged his head while in the court cells. When she asked him about this, he said he had been frustrated at the time. She said that she had no concerns about him following their meeting. She sent his application to BASS, who approved it on 15 October.
85. A prisoner told the investigator that prisoners were locked in their cells for most of the day on 13 October due to staff training. He said that he saw the man during evening association between 6.00 and 7.00pm. He said that the man told him he had not been able to buy any drugs that day as they were in scarce supply. He said that the man felt down if he could not take drugs every day, but seemed fine that evening.
86. The night patrol officer on House Unit 2, in his initial internal incident statement, said that he saw the man in bed at 8.57pm. At 5.48am, he carried out a roll check and said that, again, he was in bed. A prisoner said that he was awake for the early morning roll check and that, as far as he knew, the man was okay at the time.
87. An officer arrived on House Unit 2 at about 6.50am. He let the night patrol officer off the unit and began to count the prisoners on both A and B spurs. He looked into the man's cell at about 7.20am, and saw that he appeared to be standing in the middle of the cell. He then noticed a sheet coming down from the light fitting and around his neck. At 7.20am, he radioed an urgent message for assistance, saying he had found a prisoner with a ligature and giving the location. He did not use the term 'code blue', which is the standard procedure at Woodhill if a prisoner is not breathing. Staff in the control room confirmed with him that it was a code blue at 7.21am and called an ambulance immediately.
88. The officer told the investigator that he waited for staff to arrive on the unit before going into the cell as he was the only officer present and he understood that officers should never enter a cell alone. Staff arrived on House Unit 2B within a minute or two. They saw him standing outside cell 3-18 with a ligature-cutting tool in his hand. He unlocked the cell and an officer supported the man while he cut the ligature from his neck. The officer placed him on the floor and another officer felt for a pulse but could not detect one.
89. An officer began cardiopulmonary resuscitation and two nurses arrived at the cell very quickly after. One nurse told the investigator that she asked an officer to collect the emergency medical bag from the unit office. She said that the man was warm to the touch, but he was not breathing and his pupils were fixed and dilated. The nurses used a defibrillator (which can help to restart the heart in some instances of cardiac arrest) but it instructed them to

continue cardiopulmonary resuscitation. The ambulance arrived at 7.28am, and paramedics continued the resuscitation attempts and decided to take him to hospital. He left Woodhill in the ambulance at 8.37am, accompanied by two custodial managers. He was pronounced dead at hospital at 8.55am.

90. A custodial manager found a note in the man's cell and passed it to Thames Valley Police. In a somewhat confusing style, he wrote that he had killed himself because named individuals were torturing him by using a wireless brain fingerprinting device which had caused him to bang his head up to 4,000 times. Thames Valley Police discussed the contents of the note with Northamptonshire Police, who decided not to investigate it further.

Contact with the man's family

91. On the morning of 14 October, a family liaison officer and a chaplain drove to Kettering to tell the man's mother of his death. She was not at home and after waiting several hours for her to return, they obtained the contact details for one of his brothers and told him of his brother's death. He said he would tell his mother when she returned home. They returned the next day to meet with the man's mother and brothers. His brother at HMP Ranby was supported by staff there. Woodhill offered financial assistance towards funeral expenses in line with national guidance.

Support for staff and prisoners

92. Notices to prisoners and staff were issued to let them know of the man's death and sources of support for anyone affected by it. Prisoners assessed as at risk of suicide or self-harm were reviewed in case they had been adversely affected by his death.
93. Two members of the staff care team spoke to and supported staff involved in the emergency response. The duty governor held a debriefing session on 14 October for all staff involved so they could talk through the experience.

Post-mortem and toxicology reports

94. The post mortem report gave the man's cause of death as hanging. A toxicology report indicated the presence of dihydrocodeine, lansoprazole and naproxen in therapeutic doses and not an overdose. He was prescribed lansoprazole and naproxen but not dihydrocodeine, an opiate-related medication.

ISSUES

Identification and management of risk of suicide and self-harm

95. On 12 February 2014, when the man first arrived at Woodhill, he was accompanied by a suicide and self-harm warning form opened by court staff after he had repeatedly banged his head against walls. Although it contained the information that he seemed very depressed, had head butted a cell wall, had extreme mood swings all day and had told a prisoner custody officer that he was going to kill himself when in prison, the reception supervising officer signed the warning form to confirm its receipt but did not assess his risk of suicide and self-harm or open an ACCT. Despite the information on the form, a nurse took his word that he had only been banging his head out of frustration at court. She did not initiate the ACCT process either.
96. On 28 April, the man returned to Woodhill from court and was again accompanied by a suicide and self-harm warning form because he had been banging his head on walls. Again, the SO and nurse did not record that they had properly assessed his risk of suicide or self-harm in light of the information on the form and did not begin ACCT procedures.
97. Prison Service Instruction (PSI) 74/2011, 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 CSRA assessments, 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'. As there is no evidence that reception officers acted on the suicide and self-harm warning form highlighting his risks, we do not consider that the prison complied with this instruction.
98. Prison Service Instruction (PSI) 64/2011 (Safer Custody) and PSI 74/2011, both list 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 previously (and recently) self-harmed, had diagnosed mental health problems and a history of substance misuse. PSI 74/2011 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.
99. Staff judgement 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'. Despite the man's numerous risk factors, twice neither the reception officer nor the reception nurse opened an ACCT. The deficiencies in assessing his risk suggest a need for improved procedures, which all staff understand and follow. It is a shame that the Offender Management Unit administrator's check, which

offered a helpful safeguard against staff missing or failing to act on risk information during the reception process, was ended in August 2014.

100. We are concerned that, more generally, staff at Woodhill had a narrow view of what constituted self-harm. On 16 February, the man disclosed that he had stabbed himself in the ear with a pen, because he was hearing voices. His risk was not assessed and staff did not begin ACCT procedures. On countless occasions, he told healthcare staff that he had been banging his head. This was rarely recorded as self-harm and no one considered or commenced ACCT procedures as a result.
101. On 3 April, the man disclosed that he had overdosed on paracetamol and an ACCT was opened. On this occasion, the levels of paracetamol in his blood were not sufficient to require hospitalisation. However, he had overdosed on medication before.
102. A SO chaired the first ACCT case review on 4 April. We have several concerns about the operation of the ACCT process on this occasion:
 - The SO did not record the panel's assessment of the man's risk of suicide or self-harm;
 - The first case review notes contained no reference to his disclosure during the ACCT assessment that he had been punching his head;
 - The caremap contained two entries which did not meet the requirements of PSI 64/2011 which states that the panel must set 'detailed and time-bound actions aimed at reducing the risk posed by the prisoner'.
103. The review panel decided that the ACCT could be closed when the man assured them that he had only taken the overdose because he wanted to see a specific external psychiatrist. We consider that the ACCT was closed too quickly and without a proper consideration of his risk, although we recognise that he did not kill himself until six months later. An ACCT post-closure interview, which should have been conducted a week after the ACCT was closed, did not take place. We make the following recommendation about the identification and management of the risk of suicide and self-harm at Woodhill:

The Governor should ensure 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.**
- **Complete ACCTs fully and accurately.**
- **Consider all known risk factors when determining the level of risk of suicide and self-harm or closing an ACCT plan.**
- **Set meaningful caremap actions aimed at reducing risk.**
- **Carry out post-closure reviews promptly on the due date.**

104. We acknowledge, however, that in the days leading to the man's death, he apparently gave no indication that he was struggling to cope or contemplating suicide. For that reason, we do not think that staff could reasonably have predicted or prevented his death.

Clinical care

105. The clinical reviewer reviewed the medical care provided to the man while he was at Woodhill. He noted that the man had complex and long-standing issues around the use of illicit and prescribed medication which pre-dated his arrival at Woodhill. He also suffered from anxiety, low mood, depression and features of an emotional unstable personality disorder. He had also been diagnosed with possible drug induced psychosis several times, both in the community and in prison.

106. The clinical reviewer commented that at times the man's presentation was complex and challenging but concluded that healthcare staff used a consistent approach and offered appropriate assessments, reviews and treatments. He was satisfied that healthcare provided to him was appropriate and was equivalent to that provided to NHS patients in the community. He made two recommendations, not specifically linked to his death, which the Head of Healthcare will need to address.

107. We are surprised that the man's mental health was not urgently reviewed after he overdosed on 3 April. His stated reasons for overdosing were bizarre and healthcare staff queried whether he was suffering some kind of psychosis. A doctor apparently referred him for an urgent mental health assessment but it did not take place. We make the following recommendation:

The Head of Healthcare should ensure that all urgent mental health referrals are followed up in a timely manner, to ensure prisoners receive effective care.

Recording and responding to security related information

108. In March, the man told staff that he had been the victim of an assault. A nurse submitted information to the security department who were suspicious that he had staged the incident. However, he was moved to a different wing very shortly after he made the allegation. In August, on a different house unit, he reported that he had been attacked again. This time, it appears his claim

was not reported to the security department. There is no evidence that either allegation was investigated thoroughly.

109. The man disclosed several times that he was using illicit drugs at Woodhill. Buying and trading in illicit substances in prison can lead prisoners into debt, which can leave them vulnerable to intimidation and violence. In fact, his friends said that they did not believe he had accumulated significant, if any, debts and they did not think that he was subject to any bullying or intimidation. However, we are concerned that the allegations of assault were not properly explored. We make the following recommendation:

The Governor should ensure that all allegations of assault are investigated promptly and thoroughly.

110. The man's security file contained almost no recent information and none related to his misuse of illicit substances at Woodhill. A nurse said that healthcare staff had submitted general information about illicit substance misuse on the house units to the security department but apparently none of the healthcare staff reported him specifically. We make the following recommendation:

The Governor should ensure that there is an effective response to security information about illicit drug use in the prison and, together with the Head of Healthcare, ensure that healthcare staff understand the circumstances in which they can contribute security information about illicit substance use without compromising individual patient confidentiality.

Emergency response

111. An officer found the man hanging from the light fitting in his cell. He radioed an urgent message, giving details of the incident and his location. However, he did not use the term code blue. PSI 03/2013 Medical Emergency Response Codes, issued in February 2013, sets out the actions staff should take in a medical emergency. It contains mandatory instructions for governors to provide guidance on efficiently communicating the nature of a medical emergency. Woodhill has an emergency protocol in line with the PSI which was issued in July 2014. The protocol states that help can be summoned by 'transmitting an urgent message via the radio stating medical assistance required code red or blue, whichever is appropriate ...'.
112. Although the officer could see that the man was suspended from the light fitting with a sheet around his neck, he did not go into the cell until other staff had arrived. He said that he did not believe there were any circumstances in which an officer should go into a cell without other staff present. A SO agreed that officers should wait for a sufficient number of staff to be present before unlocking a cell.
113. Woodhill's emergency protocol directs that staff should enter a cell as soon as possible and may enter a single cell alone in order to preserve life. On this

occasion, other officers arrived at the cell within about a minute of the emergency radio call, but any delay is regrettable and could have serious consequences. We have made recommendations about the emergency response at Woodhill in five previous investigations and it is disappointing to be repeating such a recommendation again:

The Governor should ensure that all staff are made aware of and understand the local protocol and their responsibilities during medical emergencies and that:

- **Staff efficiently communicate the nature of a medical emergency;**
- **Staff understand that, subject to a personal risk assessment, they should enter a cell when there are serious concerns about the health of a prisoner.**

RECOMMENDATIONS

1. The Governor should ensure 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.
 - Complete ACCTs fully and accurately.
 - Consider all known risk factors when determining the level of risk of suicide and self-harm or closing an ACCT plan.
 - Set meaningful caremap actions aimed at reducing risk.
 - Carry out post-closure reviews promptly on the due date.
2. The Head of Healthcare should ensure that all urgent mental health referrals are followed up in a timely manner, to ensure prisoners receive effective care.
3. The Governor should ensure that all allegations of assault are investigated promptly and thoroughly.
4. The Governor should ensure that there is an effective response to security information about illicit drug use in the prison and, together with the Head of Healthcare, ensure that healthcare staff understand the circumstances in which they can contribute security information about illicit substance use without compromising individual patient confidentiality.
5. The Governor should ensure that all staff are made aware of and understand the local protocol and their responsibilities during medical emergencies and that:
 - Staff efficiently communicate the nature of a medical emergency;
 - Staff understand that, subject to a personal risk assessment, they should enter a cell when there are serious concerns about the health of a prisoner.

Action Plan

| No | Recommendation | Accepted/Not Accepted | Response | Target date for completion and function responsible | Progress (to be updated after 6 months) |
|----|--|-----------------------|---|---|---|
| 1 | <p>The Governor should ensure 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:</p> <ul style="list-style-type: none"> ▪ 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 | Accepted | <p>The reception and first night centre staff will fully consider and record all available risks factors for newly arrived prisoners when determining their risk of suicide or self harm, particularly those identified in suicide and self harming warning forms and PER form.</p> <p>Decisions on whether to open an ACCT will be based upon national guidelines, and take into consideration, the documented information contained within the core records and the sharing of information with healthcare clinicians.</p> <p>All prisoners are screened, including court returns, as part of the reception screening. Known risk factors information is sourced from the warrant, PER, the 2050 if available, P-NOMIS, SystemOne and any other information received from the Police via the escort contractor.</p> <p>The reception and first night centre screening processes include reception interviews/screening by HMPS, Registered General Nurse (Healthcare provider screening), Basic Custody Screening Tool (BSCT) and second day induction interview by First Night Centre and Healthcare Provider .</p> <p>The Training Needs Analysis undertaken and the training</p> | | |

| Action Plan | | | | | |
|-------------|--|-----------------------|---|--|---|
| No | Recommendation | Accepted/Not Accepted | Response | Target date for completion and function responsible | Progress (to be updated after 6 months) |
| | <p>prisoner has recently self-harmed, expressed suicidal intent or has other significant risk factors, irrespective of their stated intentions.</p> <ul style="list-style-type: none"> ▪ Complete ACCTs fully and accurately. ▪ Consider all known risk factors when determining the level of risk of suicide and self-harm or closing an ACCT plan. ▪ Set meaningful caremap actions aimed at reducing risk. ▪ Carry out post-closure reviews promptly on the due date. | | <p>plan includes the delivery and allocation of staff to attend Introduction to Safer Custody training, which incorporates the completion of ACCT documents. A revised management check and audit procedure has been implemented to monitor compliance.</p> <p>Reception and First Night Centre staff will be prioritised for Safer Custody training and guidance issued around the identification of risk factors</p> <p>A Staff Information Notice will be issued reminding staff of the procedures for identifying prisoners at risk of suicide and self-harm and for managing and supporting them</p> <p>To ensure that ACCT's are completed fully & accurately, the Safer Prisons team will complete a 10% quality assurance checks on open ACCT's and a 100% of closed ACCT documents. Guidance will be issued to staff and managers.</p> | <p>30/03/16 People Hub</p> <p>30/05/15 Head of Residence & Safety</p> <p>31/07/15 Head of Residence & Safety</p> | |
| 2 | The Head of Healthcare should ensure that all urgent mental | Accepted | A review of the process as to how referrals are made to the mental health team will be undertaken to ensure that prisoners receive timely and effective care. | 31/07/15 Healthcare | |

| Action Plan | | | | | |
|-------------|--|-----------------------|--|---|---|
| No | Recommendation | Accepted/Not Accepted | Response | Target date for completion and function responsible | Progress (to be updated after 6 months) |
| | health referrals are followed up in a timely manner, to ensure prisoners receive effective care. | | <p>All referrals received by the mental health team are triaged in the Multi-Disciplinary Team (MDT) meeting and outcomes documented. Appointments are then allocated on a needs basis at the MDT meeting.</p> <p>A referral log is kept and monitored.</p> <p>All staff to be issued advice on the process for urgent and non-urgent referrals to the mental health team.</p> | | |
| 3 | The Governor should ensure that all allegations of assault are investigated promptly and thoroughly. | Accepted | <p>All reported/known incidents of violence and/or anti-social behaviour and/or unexplained injuries will be subject to local fact finding investigations initiated by the Safer Prisons team.</p> <p>The Violence Reduction Coordinator will conduct a weekly check of observation book entries and submitted Security Reports</p> | 31/07/15 Head of Residence and Safety | |
| 4 | The Governor should ensure that that there is an effective response to security information about illicit drug use in the prison and, together with the Head of Healthcare, ensure that healthcare | Accepted | The Safer Medications Policy which contains information on the reporting of illicit drug use to be re issued to remind all staff of the procedure. | 30/06/15 Head of Security | |

| Action Plan | | | | | |
|-------------|---|-----------------------|---|---|---|
| No | Recommendation | Accepted/Not Accepted | Response | Target date for completion and function responsible | Progress (to be updated after 6 months) |
| | staff understand the circumstances in which they can contribute security information about illicit substance use without compromising individual patient confidentiality. | | | | |
| 5 | <p>The Governor should ensure that all staff are made aware of and understand the local protocol and their responsibilities during medical emergencies and that:</p> <ul style="list-style-type: none"> ▪ Staff efficiently communicate the nature of a medical emergency; ▪ Staff understand that, subject to a personal risk assessment, they should enter a cell when there are serious concerns about the health of a prisoner. | Accepted | <p>As per PSI 03/2013, Medical Emergency response codes are in place. A notice to staff will be published once a quarter to remind staff of this procedure. Notices to staff are sent out via global email and the matter discussed in staff briefings.</p> <p>All staff will be reminded via a notice to staff that subject to a personal risk assessment staff should enter a cell at night when there is potentially a risk to life. The notice to staff will clarify that it is down to the individual on duty at the time to undertake a dynamic personal risk assessment on whether it is safe to enter the cell.</p> | 30/06/15 Head of Residence and Safety | |

