

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr David Rayner a prisoner at HMP Woodhill on 25 August 2016

**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 community supervision. One of the most important ways in which we work towards that aim is by carrying out **independent** investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

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

Mr David Rayner was found hanged in his cell at HMP Woodhill on 25 August 2016. He was 41 years old. I offer my condolences to Mr Rayner's family and friends.

Mr Rayner was identified as at risk of suicide when he arrived at Woodhill on 23 August and was put on a suicide and self-harm support plan. A review meeting the next day decided his risk had reduced and lowered his level of staff observations. Mr Rayner was found hanged the following afternoon.

I have raised concerns in the past with Woodhill about the quality of their assessments of prisoners' risk of suicide and self-harm. In particular, I have repeatedly flagged that staff place too much reliance on how someone appears at the time of a review and not on known risk factors, thus missing an opportunity to offer appropriate support and monitoring. We express similar concerns this case.

Woodhill has rightly made considerable efforts to halt the unacceptable numbers of self-inflicted deaths that have occurred in the prison in recent years. However, it is worrying that one such innovation, the recently introduced Early Days In Custody booklet, was poorly completed in Mr Rayner's case. Clearly, there is a need to review the implementation of such initiatives and learn appropriate lessons.

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

August 2017

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Summary

Events

1. On 23 August 2016, Mr David Rayner was remanded to HMP Woodhill. It was his first time in prison and he arrived with a suicide and self-harm warning form, indicating that he had been subject to constant supervision in police custody after banging his head on a cell wall.
2. At an initial health screen, Mr Rayner was identified as requiring alcohol detoxification and he was referred for a mental health assessment. The supervising officer in reception started monitoring under suicide self-harm prevention procedures (ACCT). That night, Mr Rayner told his cellmate he was depressed and wanted to end his life. The next day his cellmate told a drug worker, who in turn shared this information with officers on the unit and made an entry in his ACCT booklet. Mr Rayner told staff he felt threatened by his cellmate and so they arranged a move into another shared cell.
3. On 24 August, Mr Rayner met drug recovery staff and began an alcohol detoxification course. At an ACCT review later that day, it was decided that his observations could be reduced because he appeared positive and more settled at the review.
4. The next day, Mr Rayner's father was due to visit but he could not find the prison, so Mr Rayner was sent back to his houseblock without seeing him. He was locked in his cell at 3.35pm. At 5.02pm, Mr Rayner's cellmate found him hanged in their cell when he returned from work. Staff and paramedics were unsuccessful in their attempts to resuscitate him.

Findings

5. We found some weakness in the management of suicide and self-harm (ACCT) procedures at Woodhill. In particular, we do not think the first case review took into account all of the known risk factors about Mr Rayner and placed too much emphasis on how he appeared at the time of the review. Important information from Mr Rayner's time in police custody was not seen by anyone at the prison and reception staff did not consider all available information about his risk factors.
6. We are concerned about the implementation of an Early Days In Custody booklet, introduced a few months before Mr Rayner's death in response to the high number of deaths at the prison. Mr Rayner's booklet was not completed as it should have been.

Recommendations

- 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, including medical staff, should:
 - 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 police medical records.

- ACCT case reviews should assess the level of risk taking into account all risk factors, not just a person's presentation at that time.
 - Triggers and warning signs should be worded appropriately and not just list statements of fact.
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- The DDC for the High Security Estate and the Woodhill Taskforce should conduct a post-implementation review to ensure that the Early Days In Custody Booklet and Entry to Custody Risk Assessment are necessary, effective, supported by adequate training and being used by staff as intended. We expect a report within one month of receiving this initial report.

The Investigation Process

7. The investigator issued notices to staff and prisoners at HMP Woodhill informing them of the investigation and asking anyone with relevant information to contact her. No one came forward.
8. NHS England commissioned a clinical reviewer to review Mr Rayner's clinical care at the prison.
9. The investigator visited Woodhill on 30 August 2016. She obtained copies of relevant extracts from Mr Rayner's prison and medical records.
10. The investigator interviewed 13 members of staff and two prisoners at Woodhill in September and October 2016, and another member of staff provided written answers to questions.
11. We informed HM Coroner for Milton Keynes of the investigation, who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
12. One of the Ombudsman's family liaison officers contacted Mr Rayner's father to explain the investigation. Mr Rayner's father said it was his son's first time in prison and he was very worried about it. He wanted to understand why his son was in such a high security prison. Mr Rayner's father said that in police custody he was on constant supervision and took benzodiazepine (medication to help with alcohol withdrawal and anxiety), but did not think his son had been prescribed anything in prison.
13. Mr Rayner's family received a copy of the initial report. They had no further comments or questions about the report.

Background Information

HMP Woodhill

14. HMP Woodhill has a dual role as a local prison and high security prison and can hold more than 800 men. House Unit 2A is the substance misuse stabilisation unit. It is managed by the Westminster Drug Project who also provides support and monitoring to the prisoners. Prisoners with dual diagnosis of mental health and substance misuse issues are treated jointly by the Westminster Drug Project team and the prison's mental health team.

HM Inspectorate of Prisons

15. The most recent inspection of HMP Woodhill was in September 2015. Although staffing levels were better than they often found in other prisons, inspectors noted that the prison was heavily reliant on new recruits and officers from other prisons, temporarily working at Woodhill. Inspectors were very concerned about the high number of self-inflicted deaths at the prison and considered there was an insufficient whole-prison approach to understanding and addressing the contributory and preventative factors in prisoners' overall experience.
16. The Inspectorate recommended that Woodhill raise a prison-wide strategy and action plan to reduce the number of self-inflicted deaths and incidents of self-harm, which should include implementation of our office's previous recommendations and improvements in the quality and management of suicide and self-harm monitoring. Woodhill accepted the recommendation. A Safer Custody Task Force was commissioned by the Deputy Director of Custody for the High Security Estate and started work in January 2016.

Independent Monitoring Board

17. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its annual report for the year ending May 2016, the IMB commented that they were deeply saddened by the unprecedented number of deaths during the year. The level of assaults, violence and use of force had also continued to rise. The number of new staff was very high and the IMB commented that the number of inexperienced staff was regularly between 40 and 60% per unit. There were very poor retention rates. Overall, the IMB felt the impoverished regime and reduction in staff time to engage with prisoners were major contributing factors in the rising number of deaths and increase in violence.

Previous deaths at HMP Woodhill

18. Mr Rayner's death was the seventeenth self-inflicted death at Woodhill since 2010. We have identified the same issues in a number of our investigations, including concerns about the deaths of prisoners who were in the early days of custody. In particular, we have repeatedly made recommendations about staff considering all known risk factors or potential triggers for suicide and self-harm and sharing of information across departments in the prison. Since Mr Rayner's

death, one more prisoner has taken his own life, also shortly after arriving in prison.

19. The Deputy Director of Custody wrote to us in January 2017 setting out progress against recommendations this office have made in the past five years following self-inflicted deaths at Woodhill. He told us that eight of our 44 recommendations had been fully implemented. 29 had been implemented and were generally effective with minor non-compliance. Six had been partially implemented (and were yet to achieve a satisfactory outcome). One recommendation had yet to be implemented.

Assessment, Care in Custody and Teamwork

20. 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.
21. 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.
22. 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

23. Mr David Rayner was arrested and held in police custody from 20 to 22 August 2016, charged with possession of a bladed article. The police detention record said Mr Rayner had self-harm scars on his arms and chest but did not say when he had done these. Mr Rayner was initially observed every 30 minutes while in a police cell. Following a medical assessment on 22 August, police made him subject to constant supervision because he was banging his head on the cell wall.
24. A police officer noted on Mr Rayner's Person Escort Record (PER – which accompanies prisoners when they move between police custody, court and prison) that he had threatened suicide and self-harm on 22 August, had visible scars and stabbed himself in the arm and neck in police custody. The PER also noted that Mr Rayner was going through alcohol withdrawal, had depression and was getting help with his mental health.
25. Mr Rayner was remanded into custody on 23 August. Escort staff completed a suicide and self-harm warning form and noted Mr Rayner said he was depressed and fearful about prison. He was constantly observed until he arrived at Woodhill at 5.45pm. Mr Rayner had not been in prison before.
26. Prison staff told us that Mr Rayner's police medical record arrived in a sealed envelope and was sent to the healthcare department. Nobody working in Woodhill's reception remembered seeing the police medical record.
27. Woodhill introduced a booklet called Early Days In Custody a few months before Mr Rayner was in prison. Staff prioritise the assessment of prisoners who arrive with self-harm or suicide warnings, drug or alcohol issues, as a vulnerable adult, with mental health issues or those who are in prison for the first time because they may be at increased risk. A Supervising Officer (SO) completed Mr Rayner's Early Days In Custody booklet, but with some mistakes and gaps:
 - He did not tick the box for alcohol or substance misuse issues.
 - Although he ticked the box for a self-harm or suicide warning, the SO did not tick a subsequent table to indicate Mr Rayner arrived with a suicide and self-harm warning form.
 - The SO did not complete a required welfare check. Instead, he recorded in a separate paper record, which is not part of the Early Days In Custody booklet, that Mr Rayner had not been in custody before, had recently self-harmed by banging his head against the cell wall and said he wanted to die.
 - The safer custody risk factors section lists possible background, clinical, psychological and contextual factors that might increase someone's risk. The SO did not complete Mr Rayner's list, he said because it was a new form and he was not sure what he should complete.
28. The SO assessed Mr Rayner as at risk of suicide or self-harm, so started ACCT procedures at 6.40pm. He remembered seeing red marks on Mr Rayner's head from where he had hit the wall. Mr Rayner went to the first night centre, houseblock 1B for further assessment.

29. An officer did a first night in custody interview, noting this was Mr Rayner's first time in prison. Mr Rayner told him he had no thoughts of suicide or self-harm. She explained the regime and Mr Rayner tried to call his father but the answer machine picked up the call. A SO completed the ACCT immediate action plan and told officers to check him hourly until he could be properly assessed the next day.
30. Mr Rayner then saw a prison GP, who wrote in Mr Rayner's medical record that Mr Rayner had a history of depression and had attempted suicide in his teens, but had not recently self-harmed or attempted suicide. There is no evidence that he read the PER, the suicide and self-harm warning form, police medical record and the doctor did not record that Mr Rayner was on an ACCT. The GP prescribed sertraline (an antidepressant) and referred Mr Rayner for alcohol detoxification.
31. A nurse carried out a medical screen using a template on SystemOne. Mr Rayner told her about his depression and anxiety and said he had attempted suicide when he was 16 years old. Her entry did not refer to the open ACCT, nor that she had read the PER or suicide and self-harm warning form. She signed the front sheet of the Early Days In Custody booklet, but made no entries in it.
32. Mr Rayner was taken to a shared cell on Houseblock 2A, a unit specifically for those withdrawing from drugs or alcohol, at 10.30pm. Mr Rayner was checked at regular intervals by an officer and appeared asleep until some time after 2.15am. At 3.12am, Mr Rayner's ACCT noted that he was talking to his cellmate before being back in bed at 4.08am.
33. His cellmate said Mr Rayner sat on the floor drinking tea that night, smoking. He said he was going to kill himself. He told Mr Rayner he did not want to wake up and find him dead.
34. A SO spoke to Mr Rayner for about 25 minutes at 9.30am the next day and explained the detoxification and induction process. He thought Mr Rayner seemed a bit low. Mr Rayner told him he had been unable to speak to his father the day before, so he telephoned Mr Rayner's father. Mr Rayner's father said he had booked a visit for the next day. He asked an officer to tell Mr Rayner about his father's visit, as Mr Rayner had already left the wing for a healthcare appointment.
35. A nurse prescriber for the Westminster Drug Project (WDP) assessed Mr Rayner's substance misuse and prescribed him medication for alcohol withdrawal. He could not remember Mr Rayner specifically, but recorded in his ACCT that he was "low in mood, has expressed suicidal thoughts, no clear intent. To commence alcohol detox". Mr Rayner told a nurse he wanted to die and other prisoners were being aggressive towards him, particularly his cellmate.
36. Another nurse prescriber assessed Mr Rayner's withdrawal symptoms and recorded that he was shaking, feeling sick and had stomach cramps. His urine tested positive for benzodiazepines, likely to be due to the diazepam he was prescribed in police custody.

37. The cellmate told a drug recovery worker from the Westminster Drug Project that Mr Rayner sat on the floor all night, saying he was going to kill himself. He said he did not want to share a cell with Mr Rayner. She told officers on the unit, wrote in the wing observation book, his ACCT record and submitted an intelligence report. She then spoke to Mr Rayner and he told her he felt vulnerable sharing with his cellmate and would prefer to be in a single cell. She told him he had to share a cell while he was subject to ACCT monitoring and Mr Rayner said he understood this. He agreed that a new cellmate would help him feel more settled.
38. An officer assessed Mr Rayner at 3.30pm, as part of ACCT procedures. He said he had access to Mr Rayner's prison case notes and read his ACCT record before they met. Mr Rayner told him that he was coming to terms with being in prison and did not have suicidal thoughts. He described him as "upbeat". He wrote under 'reasons for living and coping resources' that Mr Rayner had a good relationship with his father, who was coming to visit the next day. He assessed that Mr Rayner was at low risk of suicide or self-harm.
39. At 4.20pm on 24 August, Mr Rayner moved cells to share with another cellmate, as a result of his earlier conversation with the drug recovery worker.
40. At 4.35pm, a SO chaired the first ACCT case review with Mr Rayner, a prison manager and a nurse. The suicide and self-harm warning form was at the front of the ACCT and the concern and keep safe form referred to Mr Rayner hitting his head on a wall. Mr Rayner told the review he had felt suicidal when he arrived, but wanted to use his time positively by withdrawing from alcohol and getting a job in the prison. The SO said Mr Rayner had good eye contact during the case review and seemed upbeat. Mr Rayner said that he felt better now that he had moved cells, was getting to know some prisoners on the wing and was looking forward to his father's visit. The SO said Mr Rayner seemed in a much better place than when he came into prison. The review agreed that Mr Rayner was at low risk of suicide or self-harm and reduced the level of staff observations from one per hour to one conversation am, pm, evening (and five observations overnight). The caremap targets were: complete induction, engage with WDP during his detoxification, gain employment and engage with the mental health team.
41. That evening, the cellmate said Mr Rayner smoked a lot, was stressed, said he had serious drinking issues and was worried about his accommodation and how long he might have to spend in prison. He was looking forward to his father's visit. The next morning, he said the two of them went outside for some fresh air and Mr Rayner seemed okay. Mr Rayner did not say anything to him about suicide.
42. The drug recovery worker saw Mr Rayner waiting at the medication hatch that morning. She thought he seemed brighter and he told her he was more settled with his new cellmate. Mr Rayner told her that he had "been in better places", but she thought he was in good spirits. Mr Rayner was looking forward to his father's visit that afternoon.
43. At a mental health triage assessment, Mr Rayner told a nurse that he suffered from severe depression, paranoia, high anxiety and was "scared of everything".

He said he was due to have an assessment with a community mental health service in Bishop's Stortford. She referred Mr Rayner for a mental health assessment, which was scheduled for 31 August.

44. A nursing Sister then did a routine secondary reception screen. Mr Rayner said he had no thoughts of self-harm or suicide and his main concern was that he had run out of tobacco.
45. A nurse reviewed Mr Rayner's alcohol withdrawal symptoms. Mr Rayner said he felt sick and had trouble sleeping, but he felt a bit better than he had done.
46. Mr Rayner was locked in his cell with his cellmate over lunchtime and he fell asleep. At about 1.45pm, their cell was unlocked and his cellmate went to work. Mr Rayner went to the visits area. An officer said Mr Rayner arrived about 2.05pm and waited at a table in the visits hall until 2.30pm, when no more visitors were allowed into the visits room. His father had not arrived. Mr Rayner left the visits area at around 3.15pm.
47. CCTV shows Mr Rayner returning to houseblock 2A at 3.33pm and being locked in his cell two minutes later by an officer. The officer said Mr Rayner asked where his items were. (The officer had taken tea bags and sugar off him as he was not allowed to take these to his visit.) He showed Mr Rayner that he had put them on his desk and he replied, "Thanks gov". He told the officer that he was fine. The officer did not know that Mr Rayner's father had not visited. He left the cell and locked the door.
48. No one else went to the cell that afternoon. The cellmate got back to the wing at about 5.00pm. CCTV shows him looking through the cell observation panel at 5.02pm. He saw Mr Rayner hanged from the bed (using some bed sheet as a ligature) and shouted to get staff's attention. An officer was nearby and ran to the cell, arriving in just a few seconds. He pressed the general alarm button and another officer was at the cell within seconds followed by two more staff. The first officer unlocked the cell and they went in (less than 40 seconds after the cellmate first looked inside). A custodial manager arrived 20 seconds later and radioed a code blue medical emergency (which indicates circumstances such as when a prisoner is unconscious or not breathing).
49. The officer cut the ligature from around Mr Rayner's neck while the other officer held Mr Rayner and they carried him onto the landing. The officer described Mr Rayner as very grey. He and the custodial manager began doing chest compressions. Healthcare staff arrived two minutes later with emergency bags and a defibrillator, which found no shockable heart rhythm. Staff tried to resuscitate Mr Rayner, giving breaths and chest compressions until the paramedics arrived and took over.
50. The control room recorded the general alarm at 5.02pm, the code blue and calling an ambulance at 5.03pm. South Central Ambulance Service Trust despatched an emergency ambulance one minute later. An air ambulance was also despatched.
51. The ambulance arrived at Woodhill at 5.14pm and a rapid response vehicle three minutes later. Woodhill said once the ambulance was inside the main gates, they had staff alongside each internal vehicle gate. This allowed the gates to be

opened together, so the ambulance got to the houseblock quickly. The paramedics reached Mr Rayner's cell at 5.19pm. The paramedics took over resuscitation, but a doctor pronounced Mr Rayner dead at 5.27pm.

Contact with Mr Rayner's family

52. A SO and an officer support grade visited Mr Rayner's father house at 8.00pm, but no one was in. The prison family liaison officers eventually broke the news of his son's death at around 9.30pm, when he returned home. They offered condolences and support. Mr Rayner's father said he had been unable to find the prison when he went to visit that afternoon.
53. The SO kept in contact with Mr Rayner's father and Woodhill offered help with the funeral arrangements and contributed to the costs, in line with national instructions.

Support for prisoners and staff

54. After Mr Rayner's death, an operational manager debriefed the staff involved in the emergency response. He offered his support and that of the staff care team.
55. The prison posted notices informing other prisoners of Mr Rayner's death, and offering support. Staff reviewed all prisoners assessed as at risk of suicide and self-harm, in case they had been adversely affected by Mr Rayner's death.

Post-mortem report

56. The preliminary findings of the post-mortem examination were that Mr Rayner died from hanging. There was some bruising on his forehead consistent with having banged his head against the cell wall while in police custody. There is no final post-mortem report at the time of issuing this report.
57. Toxicology tests showed the presence of Mr Rayner's prescribed medication. In addition, the blood sample tested positive for the chemicals produced by the body after cannabis use. Toxicology was not able to determine when Mr Rayner took cannabis.

Findings

Assessing and managing the risk of suicide and self-harm

58. This was Mr Rayner's first time in prison, he had self-harmed and attempted suicide in police custody, and his escort record (PER and suicide and self-harm warning form) indicated that he was at risk. It was the right decision of a SO to begin ACCT procedures after his assessment of Mr Rayner in reception.
59. We are concerned that the information contained in the person escort record, court suicide and self-harm warning form and police custody medical records do not appear to have been seen by healthcare staff and are not reflected in Mr Rayner's medical record. Mr Rayner's police medical record contained information about his self-harm in police custody. It was sent directly to the healthcare department in a sealed envelope, which meant that no one at the prison fully assessed Mr Rayner's risk of suicide and self-harm with all available information. All information received by the prison about a prisoner's risk of suicide and self-harm should be actively and urgently considered by those responsible for his care.
60. PSI 64/2011 says the first case review must agree the level of risk posed by the prisoner to themselves, taking into consideration all available sources of information. It must also agree how the prisoner will be supported and the frequency of observations and conversations. Mr Rayner's first case review took place less than 24 hours after he arrived at Woodhill. The actions identified on the caremap designed to reduce Mr Rayner's risk were appropriate, but none reduced his risk in the short-term. Despite this, staff at the case review agreed that Mr Rayner's risk had reduced because they were reassured by his presentation during the review, so they agreed to reduce the frequency of his observations to three conversations a day. The case review must also agree what events or signs will be watched out for and which would trigger further action or a review. The trigger and warning signs section of Mr Rayner's ACCT said "first time in custody". This is a statement of fact, not a trigger for review or further assessment and is not what the prison service instruction intended to be written in this section.
61. Staff judgement is fundamental in the operation of ACCT procedures. At its core, the system relies on staff using their experience and skills, as well as local and national assessment tools to determine risk. It is not an exact science, but we are concerned that staff may have relied too heavily on Mr Rayner's presentation at the case review. A prisoner's presentation is obviously important and reveals something of their level of risk. However, it is a reflection of his state of mind at the time and should have been considered only as a single piece of evidence when making a judgement of risk. All risk factors must be collated and considered to ensure that a prisoner's level of risk is judged holistically.
62. In a PPO thematic report, published in April 2014, about risk factors in self-inflicted deaths, we found that too often assessments of risk place insufficient weight on known risk factors and too much on staff perceptions of the prisoner's behaviour and demeanour. Mr Rayner was a vulnerable man in the early days of custody, who had expressed suicidal thoughts to several people, including a

nurse practitioner that morning. Mr Rayner might well have been feeling positive at the time of the review, but he had only been in prison for one day and we consider that his documented risk factors outweighed his positive presentation.

63. We note the importance which Mr Rayner placed on the visit which his father had arranged. We cannot know the impact of that failed visit. A more accurate assessment of Mr Rayner's risk would have resulted in an increased frequency of observation and staff contact, which could have given him the opportunity to discuss his distress with staff.
64. We do not consider that Woodhill managed Mr Rayner's risk effectively, in line with Prison Service national policy and procedures. We make the following recommendation:

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, including medical staff, should:

- **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 police medical records.**
- **ACCT case reviews should assess the level of risk taking into account all risk factors, not just a person's presentation at that time.**
- **Triggers and warning signs should be worded appropriately and not just list statements of fact.**

Early Days in Custody Booklet

65. In the past 12 months (since December 2015) there have been eight self-inflicted deaths at Woodhill and one more death since Mr Rayner's, also in the prisoners early days in custody.
66. The Task Force review in January 2016 resulted in an action plan to address some identified failings at the prison and to ensure the prison implement our recommendations, as well as those of the Inspectorate. One of the measures introduced a few months before Mr Rayner's death was an Entry to Custody Risk Assessment. The prison designed the process to reinforce the requirements already set out in PSI 64/2011 to ensure that risk factors are considered during the reception and first night screening process. It was also designed to improve the sharing of information between organisations and departments within Woodhill.
67. Staff record the assessment in the Early Days In Custody booklet completed for each prisoner. The booklet is started in reception with all documents listed such as the Person Escort Record, suicide and self-harm warning form, police medical record and police detention record. Each staff member conducting interviews, including healthcare staff, should confirm that they have seen and considered all documents received. All new prisoners are seen the next day by a member of the mental health team to complete an assessment.

68. The Deputy Director of Custody for the High Security Estate told this office that the Head of Residence and Head of Early Days in Custody carry out regular management checks of the booklets. Where deficiencies are found, they feed back directly to the individuals concerned. We were told in January 2017, in a letter responding to a recommendation we made that the Deputy Director of Custody review all recommendations made into deaths at Woodhill in the past five years, that management checks identified some elements were not being completed as expected and further guidance was provided. This led to the quality of assessments improving and the Early Days in Custody booklet is now rated as “implemented” (but still subject to ongoing assessment of its effectiveness and compliance).
69. Mr Rayner’s Early Days in Custody booklet was not completed as it should have been. There were many blank pages and key information about his risk was not shared between those looking after him. A nursing Sister said staff were not using the booklet properly and the system needed time to bed in. A nurse said she had not had any training about completing the booklet or what was expected from the mental health team. A SO was uncertain about whose responsibility it was to complete the risk factors page.
70. We are concerned that a process designed to reinforce existing prison service instruction was not properly implemented at the time of Mr Rayner’s death. It was another missed opportunity to consider his risk factors in the round. Some months have now passed since Mr Rayner’s death and the Deputy Director of Custody for the High Security Estate has confirmed that improvements have been made and the early days risk assessment process is now satisfactorily implemented. We recommend:

The DDC for the High Security Estate and the Woodhill Taskforce should conduct a post-implementation review to ensure that the Early Days In Custody Booklet and Entry to Custody Risk Assessment are necessary, effective, supported by adequate training and being used by staff as intended. We expect a report within one month of receiving this initial report.

Clinical care

71. The clinical reviewer judged the healthcare Mr Rayner received to be comparable to the care expected in the community. Mr Rayner’s treatment for alcohol withdrawal was appropriate and in line with recognised clinical practice.

Emergency Response

72. We note the very swift and efficient response from the point of a cellmate finding Mr Rayner to the well-managed arrival of the paramedics. Notwithstanding the tragic circumstances, this is a much faster transfer time for getting the ambulance crew to the patient than in some previous deaths and we are reassured by the improvements Woodhill have made in this area in response to our previous recommendations.

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