

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Brett Oelrich a prisoner at HMP Woodhill on 11 May 2018

A report by the Prisons and Probation Ombudsman

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 Brett Oelrich was found hanged in his cell at HMP Woodhill on 11 May 2018. He was 44 years old. I offer my condolences to Mr Oelrich's family and friends.

Staff monitored Mr Oelrich under suicide and self-harm procedures (known as ACCT) twice at Woodhill and stopped monitoring on 9 May, two days before he died. In the early hours of 11 May, Mr Oelrich told staff he had been vomiting blood and had diarrhoea. A nurse saw him and assessed that he was not acutely unwell. He was checked again by a nurse during the night. Staff had no concerns overnight but he was found hanged in his cell at around 5.15am, during a roll check.

I am concerned that no one considered whether to restart ACCT monitoring in the light of Mr Oelrich's behaviour in the period after the ACCT was closed on the morning of 9 May. The investigation also identified deficiencies in the ACCT procedures at Woodhill, most notably the lack of engagement from healthcare staff in ACCT case reviews, and inadequate caremap actions.

Mr Oelrich had complained of feeling under threat from other prisoners. The investigation found that Woodhill did not manage him in accordance with its own Violence Reduction Strategy.

The investigation also found there was no joined-up approach in tackling Mr Oelrich's mental health and substance misuse problems.

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

Sue McAllister CB
Prisons and Probation Ombudsman

February 2019

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Summary

Events

1. Mr Brett Oelrich was recalled to prison custody on 26 December 2017 and sent to HMP Woodhill. He had a history of substance misuse, self-harm and mental health problems.
2. Mr Oelrich was assaulted by other prisoners on several occasions at Woodhill. He told staff that he had been the victim of a crime in the community and that the perpetrator, who was also at Woodhill, was asking other prisoners to attack him.
3. Staff monitored Mr Oelrich under suicide and self-harm procedures (known as ACCT) on two occasions at Woodhill, between 19 March and 5 April, and 5 and 9 May 2018. On both occasions, staff started ACCT monitoring because Mr Oelrich had tied a ligature around his neck after complaining that he was vomiting blood and that healthcare staff were not helping him. He also said he felt under threat from other prisoners.
4. ACCT monitoring ended on the morning of 9 May and Mr Oelrich was moved to another wing where it was thought he would feel safer. However, later that day he said that he did not feel safe and asked to be segregated for his own protection. When this was refused, he punched a member of staff and was placed on a disciplinary charge.
5. At around midnight on 10/11 May 2018, an officer went to Mr Oelrich's cell after hearing him vomiting loudly. Mr Oelrich said he had been vomiting blood and had diarrhoea. He asked to see a doctor and to be let out for a shower. The officer thought Mr Oelrich had been making himself sick and described his behaviour as 'very odd' and 'very erratic'. A nurse assessed him and concluded he was not acutely unwell. Staff told him that he could not have a shower as the prison was in night state.
6. The nurse checked Mr Oelrich again around 3.00am and had no concerns about his physical health. Prison staff told the investigator that they monitored him during the night.
7. At around 5.15am, while carrying out a roll check, an officer found Mr Oelrich hanging from the window bars of his cell. The officer called a medical emergency code and went into the cell. A nurse arrived and they cut Mr Oelrich down and started cardiopulmonary resuscitation (CPR). Other staff arrived and continued CPR until ambulance paramedics arrived at 5.26am. They decided to stop CPR and at 6.12am, a prison GP declared that Mr Oelrich had died.

Findings

8. Staff closed an ACCT on the morning of 9 May, two days before Mr Oelrich took his own life. We are concerned that prison staff did not consider whether to reopen the ACCT in the light of Mr Oelrich's behaviour on the afternoon of 9 May and/or on the night of 10/11 May.

9. The ACCT records did not travel with Mr Oelrich when he transferred to a new unit and as a result some staff were not aware that he was in the post-closure phase of an ACCT. They were also unaware that his behaviour on 10/11 May mirrored previous triggers for self-harm.
10. We found some deficiencies in the way ACCT procedures were managed at Woodhill. ACCT case reviews were not multidisciplinary as they should have been and, most notably, healthcare staff did not attend any of the case reviews for the second ACCT, apart from the last one. Caremap actions were also inadequate.
11. Woodhill did not manage Mr Oelrich in line with its own Violence Reduction Strategy. Intelligence reports were not always submitted after assaults on him or after he told staff he felt under threat and there was only one occasion when Mr Oelrich was managed under victim support arrangements.
12. Mr Oelrich had interactions with both the mental health and substance misuse teams. We found there was no joined-up approach to tackle his issues and a lack of information sharing between the two services.

Recommendations

- The Governor and Head of Healthcare should ensure that all staff, regardless of grade or discipline, understand that they have a responsibility to open (or reopen) an ACCT if they consider it necessary.
- The Governor and Head of Healthcare should ensure that prison staff manage prisoners at risk of suicide or self-harm in line with national guidelines, including that staff:
 - hold multidisciplinary ACCT reviews, with healthcare staff in attendance at the first case review;
 - set effective caremap actions that are specific and meaningful, aimed at reducing risk, and update them at each case review; and
 - keep the ACCT document with the prisoner until the post-closure review has been completed.
- The Governor should ensure that:
 - all information about bullying and intimidation is fully coordinated and investigated;
 - those suspected of involvement are appropriately challenged and monitored;
 - staff consider whether victims are at increased risk of suicide or self-harm; and
 - apparent victims are effectively supported and protected with meaningful, long term solutions, which address their individual situation.

- The Head of Healthcare should ensure that prisoners with a dual diagnosis receive appropriate integrated treatment.

The Investigation Process

13. 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 responded.
14. The investigator visited Woodhill on 23 May 2018. She obtained copies of relevant extracts from Mr Oelrich's prison and medical records.
15. NHS England commissioned a clinical reviewer to review Mr Oelrich's clinical care at the prison.
16. The investigator and clinical reviewer interviewed 12 members of staff and five prisoners at Woodhill on 3 and 17 July and 24 September. The investigator interviewed a further three members of staff by phone on 23 August and 19 September.
17. We informed HM Coroner for Milton Keynes of the investigation. The coroner gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
18. We contacted Mr Oelrich's mother to explain the investigation and to ask if she had any matters she wanted the investigation to consider. Mr Oelrich's mother wanted to know about her son's mental health care in prison and whether he was being bullied or threatened at Woodhill.
19. We shared a copy of our initial report with the Prison Service. They identified one factual inaccuracy and this report has been amended accordingly. The action plan has been annexed to this report.
20. We provided Mr Oelrich's family with a copy of the initial report. They did not raise any further issues, or comment on the factual accuracy of the report.

Background Information

HMP Woodhill

21. HMP Woodhill in Milton Keynes is both a local prison and a high security prison and can hold up to 637 men. Central and North-West London NHS Foundation Trust provides health services at the prison. There is an inpatient unit with 12 beds, which provides mental and physical healthcare, including end of life and palliative care. Woodhill also operates a Close Supervision Centre, a specialist facility for some of the country's most dangerous prisoners.

HM Inspectorate of Prisons

22. The most recent inspection of HMP Woodhill was in February 2018. Inspectors reported that the number of recorded self-harm incidents had increased and was much higher than at similar prisons. The number of prisoners being managed under ACCT procedures was very high, so staff struggled to give them the attention they needed.
23. Inspectors found that the mental health team was well-integrated with the rest of the prison and regularly involved in ACCT reviews and prison-wide meetings to support prisoners with complex needs.
24. Inspectors reported that levels of violence, particularly assaults against staff, had increased and were high. The response to violence required improvement: while most incidents were investigated, the challenge and monitoring of perpetrators on residential units was poor. Support for victims of bullying and violence was also underdeveloped.

Independent Monitoring Board

25. 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 latest annual report, for the year to 31 May 2018, the IMB reported that the proportion of prisoners being managed under ACCT remained high. While some innovative work had been done in developing Safer Custody strategies, the management of ACCTs was too inconsistent. Levels of violence were high. The use of psychoactive substances (PS) had been controlled with front end and targeted searching but remained a disruptive force when accessed by prisoners. Healthcare services had performed well against challenging staffing problems.

Previous deaths at HMP Woodhill

26. Mr Oelrich was the 21st prisoner to die at Woodhill since May 2015. Of the previous deaths, 11 were self-inflicted, eight were from natural causes and one was drug-related. There have been four deaths since, two from natural causes, one suspected homicide and one awaiting classification. Previous investigations have identified deficiencies in the assessment of risk and ACCT management, lack of mental health care and inadequate victim support measures.

Assessment, Care in Custody and Teamwork (ACCT)

27. 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.
28. 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 (a 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.
29. 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, Safer Custody.

Incentives and Earned Privileges Scheme (IEP)

30. Each prison has an incentives and earned privileges (IEP) scheme which aims to encourage and reward responsible behaviour, encourage sentenced prisoners to engage in activities designed to reduce the risk of reoffending, and to help create a disciplined and safer environment for prisoners and staff. Under the scheme, prisoners can earn additional privileges such as extra visits, more time out of cell, the ability to earn more money in prison jobs and wear their own clothes. There are four levels, entry, basic, standard and enhanced.

Key Events

HMP Hewell

31. On 17 July 2017, Mr Brett Oelrich was sentenced to 12 weeks in prison for theft and sent to HMP Hewell. It was not his first time in prison.
32. Mr Oelrich had a history of substance misuse, self-harm and mental health problems. He told staff that he had tried to hang himself when he was 19 years old. He also told staff he had been discharged from a mental health facility before coming into prison and that he had Asperger's syndrome and depression.
33. Between 5 and 11 September, staff monitored Mr Oelrich under suicide and self-harm procedures (known as ACCT) after he told staff he was going to hang himself. He said he was being bullied by prisoners trying to get money from him and felt scared for his safety. Intelligence suggested that Mr Oelrich was being bullied for his medication.
34. On 18 December, Mr Oelrich was released from HMP Hewell.

HMP Woodhill

35. On 26 December, Mr Oelrich was recalled to custody and sent to HMP Woodhill after being sentenced to five weeks in prison for assaulting a police officer. He was sentenced to a further 12 weeks on 21 March 2018, for theft, fraud and retaining wrongful credit.
36. A nurse assessed Mr Oelrich in reception. She noted that he had a history of substance misuse and mental health problems, including a suicide attempt aged 19. Mr Oelrich told the nurse that he had been taking pregabalin (used to treat epilepsy, anxiety or nerve pain), lansoprazole (used to treat acid reflux), quetiapine (antipsychotic medication), diazepam (for anxiety) and venlafaxine (an antidepressant), and that he felt well as long as he took his medication. The nurse noted that Mr Oelrich was dependent on opiates and that he was worried about withdrawing from drugs. She referred Mr Oelrich to the GP.
37. A GP assessed Mr Oelrich and noted that he engaged well and had no signs of psychosis or thought disorder. The GP recorded that healthcare staff should confirm what medication Mr Oelrich was prescribed in the community and referred him to the substance misuse team for detoxification.

Mental health and substance misuse

38. On 27 December 2017, a substance misuse nurse reviewed Mr Oelrich and noted that he had been diagnosed with borderline personality disorder and depression and tested positive for benzodiazepine (a sedative), cocaine and opiates. The nurse noted that Mr Oelrich would start taking 20ml of methadone (a synthetic opioid used to treat heroin addiction) a day and that he seemed motivated to go through detoxification. The nurse prescribed chloridiazepoxide (used to treat the symptoms of withdrawal from substances), diazepam (medication for anxiety) and methadone. Mr Oelrich was placed on the substance misuse wing and the nurse reviewed him regularly.

39. A pharmacist prescribed diazepam, folic acid (a vitamin), lansoprazole, quetiapine and venlafaxine for Mr Oelrich. He did not prescribe pregabalin and noted there was no evidence that Mr Oelrich had been prescribed pregabalin in the community. (Pregabalin is a prescription-only drug which can produce feelings of calmness and euphoria and can enhance the euphoric effects of other drugs such as opiates. For these reasons it can be abused and trafficked in prisons.)
40. On 28 December, a community psychiatric nurse assessed Mr Oelrich. She noted that he had been detained under the Mental Health Act two years before and had a history of poly-substance misuse and suicide attempts. Mr Oelrich told the nurse that he had been diagnosed with borderline personality disorder. The nurse noted that Mr Oelrich appeared calm and tidy and his behaviour was appropriate. She recorded there was no evidence of thought disorder or perceptual difficulties. The nurse told Mr Oelrich how to access mental health services if he needed them in the future.
41. On 3 January 2018, the Head of Mental Health reviewed Mr Oelrich. He told her that he had been prescribed pregabalin at a previous prison and was only out of custody for four days so wanted to know why his prescription had been stopped. He also said he had been diagnosed with Attention Deficit Hyperactivity Disorder (ADHD) at Hewell and had been prescribed Ritalin for it. (Ritalin is a prescription-only drug used to treat ADHD and which can be abused for its stimulant effects.) The Head of Mental Health said she would check this and speak to a psychiatrist about restarting his medication if necessary. Later that day, she noted in Mr Oelrich's medical records that he had not been diagnosed with ADHD or prescribed Ritalin. She noted that there was no further need for clinical input from the mental health team.
42. On 6 January, a healthcare assistant assessed Mr Oelrich as part of a second reception screening appointment. Mr Oelrich said he had a history of stomach ulcers, anxiety, depression, auditory hallucinations, was paranoid and had not been sleeping. He said he needed his mental health medication and that the mental health team had told him that he would be assessed for ADHD. The healthcare assistant noted that Mr Oelrich seemed angry and was 'animated and loud'. He told her that he was under threat on the wing and that officers were not listening to him. She spoke to a wing officer who told her that Mr Oelrich was offered a wing move but did not want to move. She did not submit an intelligence report.
43. On 15 February, wing staff asked a nurse to review Mr Oelrich. The nurse noted that Mr Oelrich appeared well and said that he was coping okay, and so he would reduce his methadone dose. On 5 March, the nurse noted that Mr Oelrich wanted to continue his methadone reduction but had high anxiety about this. He also noted that Mr Oelrich said he had issues with other prisoners. The nurse did not submit an intelligence report or note this in Mr Oelrich's prison record.
44. On 6 March, an associate mental health practitioner reviewed Mr Oelrich in the wing clinic. Mr Oelrich engaged well throughout the screening appointment but appeared anxious. He told the mental health practitioner that he had previously been diagnosed with ADHD, borderline personality disorder and depression. He

said he was not medicated for ADHD and anxiety and had previously been prescribed Ritalin and pregabalin.

45. On 8 March, the associate mental health practitioner reviewed Mr Oelrich for a mental health and wellbeing screening. Mr Oelrich said that he was experiencing issues with anxiety, sleep and ADHD symptoms and again mentioned that he had previously been prescribed Ritalin and pregabalin. The mental health practitioner reviewed Mr Oelrich's notes and saw that both a pharmacist and a GP had said there was no evidence that he had been prescribed Ritalin. She also reviewed Mr Oelrich's medical records and found no mention of this medication. She noted that she would send Mr Oelrich an activity pack (containing puzzles and colouring books) but there would be no further input from mental health at that time.
46. On 12 March, Mr Oelrich spoke to the mental health practitioner on the wing and asked for an update about his medication. She told him that there was no evidence that he needed Ritalin or pregabalin. She told him that he would need to provide evidence from his psychiatrist before he could be prescribed this medication.
47. On 18 April, a nurse from the substance misuse team noted that Mr Oelrich was very motivated and determined and wanted to stop methadone and start a lofexadine detoxification (medication to treat the symptoms of opiate withdrawal). The nurse explained this process and Mr Oelrich said that he was happy to start lofexadine the next day. The nurse prescribed lofexadine for Mr Oelrich.
48. On 1 May, an intelligence report noted that there was a tobacco smell coming from Mr Oelrich's cell. When staff opened the observation panel of Mr Oelrich's cell they saw him and his cellmate looking 'spaced out'. There is no evidence that Mr Oelrich was referred to the substance misuse team.

Bullying and threats

49. On 31 December 2017, an officer noted that Mr Oelrich and his cellmate were having a 'very heated discussion'. The officer spoke to both prisoners and noted that the issue could not be resolved and might 'end in blows'. He arranged for Mr Oelrich to be moved to a different cell.
50. On 23 January 2018, Mr Oelrich was involved in a fight. He said the other prisoner had hit him. A supervising officer (SO) put him onto the basic IEP level and noted that he would be monitored under violence reduction procedures for 28 days. At the subsequent disciplinary hearing, staff decided that the fight was not Mr Oelrich's fault. Staff put him back onto the standard IEP level and stopped monitoring him under violence reduction procedures. There is no evidence that staff considered starting victim support procedures.
51. On 31 January, a nurse was called to assess Mr Oelrich after another prisoner punched him in the face. She gave him some paracetamol and made him a GP appointment for the next day. Staff submitted an intelligence report.
52. On 1 February, Mr Oelrich applied to move to the segregation unit under Rule 45 (where a prisoner is segregated for their own protection) saying he had been beaten up because a prisoner who was serving a sentence for mugging him had

asked people to attack him. He did not attend his GP appointment because he said he did not want to see a doctor. Staff moved Mr Oelrich to a different house unit.

53. On 7 February, a prison manager refused Mr Oelrich's Rule 45 application because he said he did not meet the criteria. The prison manager noted that Mr Oelrich should be managed using victim support procedures or a wing move, rather than under Rule 45.
54. On 8 February, an officer spoke to Mr Oelrich about the assault on 1 February. He offered Mr Oelrich victim support and noted that he would be monitored for 14 days. The next day, another officer spoke to Mr Oelrich and noted that he had settled into the new house unit and felt more relaxed. Mr Oelrich said he would still have problems if he was moved to another house unit. Mr Oelrich provided some information that the officer noted he would submit in an intelligence report. There is no evidence that he did so.
55. On 20 February, Mr Oelrich asked an officer if he could make sure he did not run into the prisoner who wanted to assault him so he could go off the house unit. The officer emailed security to make sure this prisoner was kept separate from Mr Oelrich when he was moved around the prison.
56. On 22 February, Mr Oelrich refused to move to another house unit. An officer noted he had been on the induction unit too long and placed Mr Oelrich on a disciplinary charge.
57. On 27 February, an English tutor spoke to Mr Oelrich about why he had stopped going to education classes. Mr Oelrich said that he did not want to come 'due to safer custody concerns' but would not go into detail. The tutor checked Mr Oelrich's prison record and saw that it was noted that he was not to have any contact with a particular prisoner, who did not go to education. She went back to speak to Mr Oelrich and reassured him that the prisoner who wanted to assault him was not in education. Mr Oelrich said that he was also worried about getting to and from education on moves in case he ran into this prisoner or someone who might act on his behalf. Mr Oelrich said he did not want to go to education any more. The tutor submitted an intelligence report.
58. On 16 March, staff noted in an intelligence report that during serving of the meal, a prisoner passed an unknown item to Mr Oelrich who then walked over to a cell and passed something to another prisoner. The officer could not see what it was.
59. On 13 April, staff submitted an intelligence report noting that Mr Oelrich appeared to pass something to another prisoner. The prisoner's cell was searched and staff found a damaged vape capsule with something burned in it and two small squares of paper. The intelligence report noted that Mr Oelrich was causing problems on the house unit but there is no evidence that staff took any further action.
60. On 17 April, staff submitted an intelligence report noting that a prisoner was paid by two other prisoners to assault Mr Oelrich. The report stated that Mr Oelrich was assaulted because he had told one of the prisoners, who was involved in

selling psychoactive substances (PS), that another prisoner on the wing 'was good for tick' but the prisoner was moved off the wing without paying for his PS. There is no evidence that staff took any further action.

61. Prisoner A met Mr Oelrich when he was on House Unit 4A (sometime prior to 9 May when Mr Oelrich was moved from 4A to 2B). After Mr Oelrich's death, Prisoner A told the investigator that on his first night in prison a prisoner with a knife dragged him and Mr Oelrich into Prisoner A's cell. The prisoner stripped Prisoner A of his clothing and threatened to rape Mr Oelrich. Mr Oelrich told Prisoner A not to do anything about this. Prisoner A said that other prisoners took Mr Oelrich's property and tried to get him to transfer money into their bank accounts. Prisoner A said that Mr Oelrich was not coping well with being under threat and had thoughts of suicide. He said that Mr Oelrich took PS in prison and said he wanted to kill himself. Prisoner A said that other prisoners called Mr Oelrich a 'grass'.

ACCT procedures

First ACCT – 19 March to 5 April 2018

62. At around 12.20pm on 18 March 2018, a nurse assessed Mr Oelrich after he said he had been vomiting blood. Mr Oelrich thought it was his stomach ulcer. The nurse discussed Mr Oelrich with the nurse in charge and they agreed to observe him again in an hour.
63. At around 2.50pm, the nurse reviewed Mr Oelrich with another nurse. Mr Oelrich said he had vomited three times since he was last checked. The nurse took Mr Oelrich's vital signs and told him that everything was normal which meant there was no internal bleeding, but he had raised blood pressure. She offered Mr Oelrich pain medication but he declined. She referred Mr Oelrich to the GP for further assessment. At 5.14pm, she reviewed Mr Oelrich who said he had not vomited again.
64. At around 12.00am on 19 March, Mr Oelrich told a nurse that he had vomited blood several times and kept passing out. The nurse noted that Mr Oelrich looked well and was able to walk from his cell to the association area to have his observations taken. Mr Oelrich became angry and said that nurses kept monitoring him but were not helping him. The nurse contacted the GP to ask him to assess Mr Oelrich.
65. At 12.15am, a GP assessed Mr Oelrich and noted that he said he had been retching and vomiting but had no abdominal pain or diarrhoea. The GP prescribed mucogel (to treat indigestion) and metoclopramide (to treat reflux and to prevent nausea and vomiting).
66. At 5.07am, a custodial manager (CM) noted that Mr Oelrich had punched his cellmate in the face. Mr Oelrich said that his cellmate had threatened violence and tried to kick him in the head so he had acted in self-defence. Staff downgraded Mr Oelrich to the basic IEP level. The CM did not submit an intelligence report about the assault.
67. Shortly before 6.00am, Mr Oelrich pressed his cell bell. The CM noted he was in a distressed state because he said he had health issues and staff were not

listening to him. While he was speaking to staff, he put a ligature, made from shoelaces and attached to the top bunk, around his neck and dropped down. Staff called a medical emergency code blue (which indicates a prisoner is unconscious or having breathing difficulties), went into his cell and removed the ligature. A nurse noted that Mr Oelrich remained conscious and alert and was able to speak in full sentences but there was a ligature mark around his neck. Mr Oelrich said that he was frustrated because he had not been prescribed pregabalin. The CM noted that Mr Oelrich had soiled himself so staff took him to have a shower and gave him clean bedding.

68. At 6.00am, an officer started ACCT procedures for Mr Oelrich who said he could not take it anymore and that he wanted to kill himself. At 6.10am, the CM completed the immediate action plan and set observations at twice an hour. The CM noted that Mr Oelrich would be seen by the doctor but his medical record shows he did not attend his GP appointment the next day because staff had not unlocked him.
69. At 1.40pm, an officer held an ACCT assessment interview with Mr Oelrich, who told him that he had ligatured because he felt that he was not being listened to and it was a 'cry for help' rather than a suicide attempt. He said he felt better than at the time of the incident and now felt listened to but he would still like to speak to a GP. He said he felt under threat around the prison because he was a victim of crime in the community and the perpetrator was also at Woodhill. He said he had no current thoughts of suicide or self-harm.
70. At 2.00pm, two officers held an ACCT case review with Mr Oelrich, who said he had no thoughts of suicide or self-harm and had ligatured out of frustration. An officer rebooked Mr Oelrich's GP appointment. Mr Oelrich said that he was annoyed because he had no TV because he had been reduced to the basic IEP level after punching his cellmate. They assessed Mr Oelrich's risk of self-harm as low and reduced his observations to two conversations morning, afternoon and evening with five observations during the night. They noted two actions on his caremap: that security would speak to him about his safety concerns, and that he needed to see a GP.
71. At 4.52pm, an officer noted that a prisoner had asked to speak to Mr Oelrich on his way back from collecting his evening meal. The prisoner and Mr Oelrich chatted in his cell and then on the landing. They stopped speaking and Mr Oelrich was going back to his cell when the prisoner said, 'Hold on, wait one minute', and then attacked Mr Oelrich, who defended himself. Staff split them up and took them back to their cells. The officer did not submit an intelligence report.
72. At 5.15pm, a mental health practitioner reviewed Mr Oelrich by speaking to him through his observation panel. He told her that he felt 'emotionally exhausted', was finding it hard to concentrate and was hearing voices. He said that he had either bought or been prescribed pregabalin for the past four years. The mental health practitioner said that he would need to get evidence of his prescription if he wanted this medication but he said he had been homeless and did not have the evidence. She asked Mr Oelrich how he usually spent his time and he told her that he watched TV but this had been taken away after he punched his

cellmate. She encouraged Mr Oelrich to go on exercise or to the gym and arranged to send him an activity pack. She noted that Mr Oelrich seemed settled in mood, maintained eye contact and engaged well in conversation.

73. At 9.48am on 22 March, a SO and a nurse went to Mr Oelrich's cell to hold an ACCT case review. The SO noted that when they tried to speak to Mr Oelrich, he charged at his cell door, swore at them and threatened violence if they opened the door. They assessed Mr Oelrich's risk as raised and increased his observations to one an hour.
74. The next day, 23 March, a nurse attended an ACCT case review with another SO and Mr Oelrich. She noted that Mr Oelrich became tearful about his family issues and said it helped to be able to talk about things. Mr Oelrich said that he was feeling much better and had no thoughts of self-harm. He said that he wanted the substance misuse team or the GP to review his prescribed medication. Staff told Mr Oelrich to put an application in to see the GP and the substance misuse team. Staff assessed Mr Oelrich's risk of harm as low and reduced the frequency of his observations to two conversations morning, afternoon and evening and five observations at night.
75. On 30 March, a SO and an officer held an ACCT case review with Mr Oelrich and recorded that he was in good spirits. Mr Oelrich said no one from security had seen him, so the SO emailed the security unit with Mr Oelrich's concerns. Mr Oelrich said he wanted to see the doctor because his stomach medication had been reduced. Staff noted that Mr Oelrich had no thoughts of suicide or self-harm and the only reason the ACCT was still open was because the caremap actions had not been completed. Staff assessed Mr Oelrich's risk of harm as low and reduced his observations to one conversation morning, afternoon and evening and three observations at night.
76. On 31 March, staff submitted an intelligence report saying that a prisoner had paid people in 'Spice paper' (PS) to assault Mr Oelrich. There is no evidence any action was taken.
77. On 2 April, a SO put Mr Oelrich back on the standard IEP level.
78. On 5 April, a SO and a nurse held an ACCT case review with Mr Oelrich. They noted he was in good spirits and that he had not had any thoughts of suicide or self-harm for some time. They also noted that Mr Oelrich's concerns about being under threat had been submitted to the security unit, which he was happy with. He felt he no longer needed the support of an ACCT and so they agreed to close it.
79. It is unclear when Mr Oelrich's post-closure review was held as the form is undated. Mr Oelrich noted that his problems had been resolved but the process could have been improved by a better chain of communication.

Second ACCT – 5 to 9 May 2018

80. During the morning of 3 May, Mr Oelrich told the nurse at the medication hatch that he was feeling nauseous, had diarrhoea and had been spitting blood. The nurse reviewed him that afternoon and Mr Oelrich said he felt much better. That night, Mr Oelrich pressed his cell bell complaining of stomach pains and blood in

his vomit. A nurse assessed him and gave him metoclopramide (used to prevent nausea and vomiting).

81. At 6.45am on 5 May, an officer started ACCT procedures because Mr Oelrich had tied a ligature around his neck. He had been asking for a shower because he said he had soiled himself and had threatened to self-harm if he did not get one. Staff called a code blue but Mr Oelrich removed the ligature himself. A nurse responded and noted that Mr Oelrich was alert and breathing normally but had a slight red mark around his neck. Staff noted that there was no smell of diarrhoea and told him he would not be able to have a shower until later.
82. In the immediate action plan, the CM noted that the long length of the ligature, and the fact Mr Oelrich had told staff and had removed the ligature himself, indicated to him that it was not a genuine attempt to take his life. He noted that this situation was the same as a previous incident on 19 March and challenged Mr Oelrich about the danger he had put himself in. The CM told staff to get Mr Oelrich out at unlock for a shower but that he had a sink and toilet in his cell in the meantime. Mr Oelrich was complaining about healthcare provision but the CM noted that he had medication for his health complaint. He set observations at two an hour.
83. The same day, Mr Oelrich told a nurse that he was still having stomach problems and was unable to keep food down. The nurse told Mr Oelrich that he should see the GP to review his medication. That afternoon, Mr Oelrich asked the nurse for lansoprazole (medication used to treat reflux). The nurse arranged for a GP to prescribe it for him.
84. At 3.00pm on 5 May, an officer held an ACCT assessment interview with Mr Oelrich. Mr Oelrich said he regretted tying the ligature but his stomach illness had made him frustrated and he just wanted a shower.
85. At 3.50pm, a CM and an officer held an ACCT case review. The CM noted that healthcare staff were asked to attend but declined, and that he had 'also tried to discuss this with them to no avail'. Mr Oelrich said he regretted tying the ligature and had no thoughts of suicide or self-harm. The CM noted that the ACCT would remain open because healthcare staff had not attended and that a full review would be held on 7 May. Staff recorded one action on his caremap, 'stomach pains/issues', and noted that Mr Oelrich would see a nurse with a view to a GP referral. Staff assessed Mr Oelrich's risk of suicide and self-harm as low and kept his observations at twice an hour.
86. On 7 May, a CM and an officer held an ACCT case review with Mr Oelrich. The CM noted that Mr Oelrich was open throughout and made good eye contact and had positive body language. Mr Oelrich said that he felt this had been a 'wake-up call' and that he did not want to kill himself. He said that he had stopped taking drugs and wanted to go to court on 14 May and find out if he had a sentence and 'get on with it'. Mr Oelrich said that he had lost several family members recently and did not want to ruin any more of his life. He said that he would prefer to move to a quieter unit but would take that night to think about it. He said he had no thoughts of suicide or self-harm and that he would like to come off the ACCT. The CM scheduled another review for 8 May due to no nurse being present. Staff assessed Mr Oelrich's risk of self-harm as low and set

observations at one an hour with two conversations every morning, afternoon and evening.

87. On 8 May, a SO and an officer held an ACCT case review with Mr Oelrich. The SO noted that Mr Oelrich seemed in good spirits and was socialising with a prisoner when they arrived at his cell. The SO told him that another SO would be his ACCT case manager and he wanted to speak to him the next day so they would arrange another case review. Mr Oelrich said that he had no thoughts of suicide or self-harm. He said that he wanted to speak to the SO case manager about something but it could wait until the next day. Staff assessed Mr Oelrich's risk as low and kept his observations the same.
88. On 9 May, the SO case manager and a nurse held an ACCT case review with Mr Oelrich. Mr Oelrich said that the act of self-harm had scared him and that he had self-harmed because he was frustrated about not having his medical issues addressed. He said that the death of his parents was also having an effect on him (even though he previously said that he was in contact with his mother). Mr Oelrich said that he did not have any thoughts of suicide or self-harm and that the crisis was over.
89. The nurse noted Mr Oelrich said that he was having problems with other prisoners on House Unit 4A because of issues that started before he came to Woodhill. The SO agreed that Mr Oelrich could be relocated to House Unit 2B that afternoon and Mr Oelrich was happy with this. Staff noted that they would arrange for a Cell Sharing Risk Assessment (CSRA) to be completed so he could share a cell on the new wing. Mr Oelrich said that his reflux medication was not enough as he had heartburn every evening. The nurse put Mr Oelrich on the GP waiting list. Staff closed the ACCT. The SO noted that Mr Oelrich's post-closure review would be held on 16 May.
90. That evening, Mr Oelrich was moved from House Unit 4A to House Unit 2B. An officer noted that Mr Oelrich refused to lock up at roll check because of safety concerns. He said that Mr Oelrich told him that he had been approached by several prisoners who asked why he had been moved to the unit. He said he would rather be in the segregation unit. The officer noted that, although he assured Mr Oelrich that he would be moved to somewhere he felt safer the next day, he ignored instructions to go behind his door. Mr Oelrich assaulted the officer and another officer restrained him and moved him to the segregation unit. The officer noted that Mr Oelrich had been put on a disciplinary charge and would be reduced to the basic IEP level.
91. A CM took Mr Oelrich to the segregation unit but said he was there for only around an hour because the segregation unit was full. Mr Oelrich was then put in a dual-purpose cell (which has an additional Perspex door with bars so it can be used as a constant watch cell) on House Unit 2A (a substance misuse wing).
92. On 10 May, a prison manager and a SO downgraded Mr Oelrich to the basic IEP level. After Mr Oelrich's death, Prisoner B told the investigator that he visited Mr Oelrich in his cell between 4.30 and 5.00pm. He said that Mr Oelrich was not happy because he did not have a mattress and wanted to collect his dinner but had to eat it in his cell.

Events during the night of 10/11 May

93. Prisoner B and his cellmate were in the cell above Mr Oelrich's cell. Prisoner B told the investigator that at around 10.00pm on 10 May, he heard a choking sound coming from Mr Oelrich's cell. Prisoner B's cellmate said that he could hear someone being violently sick from around 11.30pm and it sounded like a coughing or choking sound. Prisoner B said that Mr Oelrich pressed his cell bell but staff did not come for a long time. The investigator asked the prison to provide cell bell records but was told that cell bells are not recorded at Woodhill.
94. Officer A was on night duty on Mr Oelrich's house unit that night. He said that he was aware that Mr Oelrich was awaiting an adjudication hearing for assaulting a member of staff and was on 'VR3 regime' (a segregation regime), and that he was in the ACCT post-closure period. At around 12.00am on 11 May, he was carrying out ACCT checks, when he heard Mr Oelrich vomiting loudly and went to see if he was okay. Mr Oelrich said that he had been vomiting blood and had diarrhoea. Officer A spoke to Nurse A, who was the dedicated nurse on the unit that night, and also called Nurse B, the nurse in charge, and the night orderly officer (a CM).
95. Officer A and Nurse A went to Mr Oelrich's cell and looked through the observation panel. Officer A noted that Mr Oelrich's fingers were wet, which he thought suggested he had been making himself sick. He could not see any blood on the floor, though Mr Oelrich said he had vomited in the toilet. Nurse A told Mr Oelrich he had a GP appointment on 16 May but Mr Oelrich said he wanted to see a doctor that night. He said he thought he was going to faint and then dropped to the floor. Nurse A told the investigator that he believed Mr Oelrich fell intentionally. Officer A put a night light on in Mr Oelrich's cell and they watched him as he got up and sat back on the bed. Officer A told the investigator that Mr Oelrich's behaviour was 'very odd', 'very erratic' and that he seemed 'agitated' and 'a little bit distressed'.
96. The night orderly officer, Nurse B and other officers arrived and unlocked Mr Oelrich's cell. Mr Oelrich told Nurse A that he had been vomiting blood all day. He again asked to see a doctor and to have a shower. Nurse A told the investigator there was vomit everywhere, including on the floor and in the toilet. He could see a tiny bit of blood but could not smell diarrhoea. Mr Oelrich's clinical observations were normal apart from high blood pressure. Nurse A told him there was nothing acutely wrong with him and that he would be okay. The night orderly officer told Mr Oelrich that he could not let him have a shower because the prison was in night state. Officer B gave Mr Oelrich some clean clothes.
97. Nurse A told the investigator that he looked at Mr Oelrich's records and noted that he had been on an ACCT up to the day before, and had previously tried to hang himself. He said this raised alarm bells so he recommended to the officers that they reopen his ACCT. He said that he was not concerned about Mr Oelrich's abdominal symptoms, but felt there could be something more to his behaviour. Nurse A made an entry on Mr Oelrich's medical record at 2.12am saying that he had raised this with the manager in charge (the night orderly

- officer) who said that Mr Oelrich would be observed hourly overnight, but the ACCT was not reopened.
98. At interview, the night orderly officer said that he asked if Mr Oelrich was on an ACCT and was told 'no'. He said he did not know that Mr Oelrich was in the post-closure phase of an ACCT because he had been transferred from another unit and the ACCT record book had not transferred with him. He said that if he had known, he would have looked through the record to see what Mr Oelrich's triggers were and considered whether to reopen the ACCT.
 99. He said that he did not recall Nurse A raising the issue of opening an ACCT with him and said that anyone could open an ACCT if they considered it appropriate.
 100. Officer A also told the investigator that he could not recall any discussion about opening an ACCT. He said that, as Mr Oelrich had recently assaulted a member of staff, they were concerned that his bizarre behaviour might be a ruse to get staff in the cell.
 101. The night orderly officer said that he asked Officer A to keep an eye on Mr Oelrich. Officer A said the night orderly officer asked him to do some random checks on Mr Oelrich. He said that he took turns with an operational support grade (OSG) to check on Mr Oelrich. Officer A said that he checked on Mr Oelrich around 3.00am by turning on his light and asking if he was okay. He said Mr Oelrich was awake and sitting at the back of the cell against the wall. Mr Oelrich said that he was fine and asked Officer A to turn off his light.
 102. At 3.21am, Nurse A checked on Mr Oelrich and noted that Mr Oelrich was sitting on his bed wide awake and calmly smoking. He said that Mr Oelrich's night light was on but he did not speak to him.
 103. Prisoner B told the investigator that up to around 3.00am, Mr Oelrich called out 'help' a few times. He said that the choking sounds from Mr Oelrich's cell continued until around 5.00am. The prisoner in the cell next to Mr Oelrich, Prisoner C, said that he could hear Mr Oelrich being sick until around 4.30am. He said that Mr Oelrich was being sick about every 20 minutes. He said that he could hear Mr Oelrich speaking to the officers around 5.00am, but he could not hear what they were saying.
 104. At around 5.15am, Officer A started the roll check. When he got to Mr Oelrich's cell, he looked through the observation panel and saw Mr Oelrich in a seated position with a ligature made of shoelaces around his neck, attached to the window bars. At 5.18am, he called a code blue and went into the cell. Nurse A and Nurse B arrived shortly after. Officer A cut the ligature and he and Nurse A moved Mr Oelrich to the floor and started cardiopulmonary resuscitation (CPR). At 5.19am, the control room called an ambulance. Other officers responded to the code blue and arrived at Mr Oelrich's cell.
 105. Officer A did chest compressions for two and a half minutes before Officer B took over. Nurse B did chest compressions and Nurse A managed Mr Oelrich's airways. Nurse A noted that Mr Oelrich was not responding or breathing and his pupils were fixed and dilated. Nurse A gave him oxygen and attached the

defibrillator machine which said to continue CPR and advised not to give Mr Oelrich any shocks.

106. At 5.26am, the paramedics arrived. They decided to stop the resuscitation attempt and the GP was called. At 6.12am, a GP recorded that Mr Oelrich had died.

Contact with Mr Oelrich's family

107. At 8.15am, the prison's family liaison officers left Woodhill to travel to Mr Oelrich's mother's address. They arrived there at 9.00am and told her of Mr Oelrich's death. The prison contributed to the cost of Mr Oelrich's funeral in line with national guidance.

Support for prisoners and staff

108. After Mr Oelrich's death, a prison manager debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.
109. The prison posted notices informing other prisoners of Mr Oelrich's death, and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Oelrich's death.

Post-mortem report

110. The post-mortem examination found that Mr Oelrich died from hanging. Toxicology tests showed that Mr Oelrich had low levels of venlafaxine and quetiapine (drugs he had been prescribed) in his system when he died, and also mirtazapine (an antidepressant) which he had not been prescribed. No illicit drugs or alcohol were found in his system. The post-mortem report noted that there were six self-harm slashes on his left forearm which were healing.

Findings

Management of Mr Oelrich's risk of suicide and self-harm

111. Prison Service Instruction (PSI) 64/2011 (Safer Custody) requires all staff in contact with prisoners to be aware of the risk factors and triggers that might increase prisoners' risk of suicide and self-harm and to take appropriate action. Any prisoner identified as at risk of suicide or self-harm must be managed under ACCT procedures, as set out in PSI 64/2011.
112. Mr Oelrich was managed under ACCT procedures twice at HMP Woodhill, from 19 March to 5 April, and again between 5 and 9 May, just before he died. We have some concerns about the management of the ACCT procedures in Mr Oelrich's case.
113. Caremaps should reflect the prisoner's needs, level of risk and the triggers of their distress. Instructions say they should aim to address issues identified in the ACCT assessment interview and later reviews, and consider a range of factors including health interventions, peer support, family contact and access to diversionary activities. Each action on the caremap should be tailored to the individual needs of the prisoner, be aimed at reducing risk and be time-bound.
114. We consider the caremap actions set for Mr Oelrich were insufficient. Mr Oelrich said that his issues were frustration about his healthcare and medication, and fears for his safety. Seeing a doctor and speaking to security were the only actions on his caremap.
115. Although he was seen by nurses, Mr Oelrich had not seen a GP for a review of his medication when the ACCT was closed. As far as his fears for his safety were concerned, Mr Oelrich had been saying he was under threat since arriving at Woodhill. He was assaulted by other prisoners twice in January 2018 and again in February and had applied, unsuccessfully, to be segregated for his own protection. There was intelligence in March that other prisoners had been paid to assault him, and on 19 March he had been involved in a fight with his cellmate (which he said was self-defence) and was subsequently assaulted by another prisoner. We would, therefore, have expected staff to have considered whether he should be supported under victim support procedures as one of the caremap actions, but this did not happen.
116. The second ACCT was opened on 5 May after Mr Oelrich used a ligature, again citing frustrations about his health and medication. He also continued to express fears for his safety.
117. We are concerned that healthcare staff did not attend Mr Oelrich's first ACCT case review on 5 May. Healthcare staff attendance at the first ACCT case review is a mandatory requirement as set out in PSI 64/2011. It was also particularly important in Mr Oelrich's case because his issues stemmed from his perception that his physical healthcare needs were not being met. The CM noted that healthcare staff were invited but declined to attend. Healthcare staff did not attend the next two case reviews on 7 and 8 May either, and it was noted in the 7 May case review that the ACCT had to be kept open because of the failure of a nurse to attend.

118. The ACCT was closed on 9 May when Mr Oelrich said he no longer had thoughts of suicide or self-harm, but, again, he had not seen a doctor for a review of his medication before the ACCT was closed.
119. In both cases we consider that the ACCT was closed prematurely before Mr Oelrich's issues had been properly resolved. In our view staff placed too much reliance on Mr Oelrich saying that he no longer had thoughts of suicide and self-harm and did not consider sufficiently whether action had been taken to reduce his risks.
120. We are also concerned that prison staff did not consider reopening Mr Oelrich's second ACCT when his behaviour deteriorated in the days immediately after it was closed.
121. One of Mr Oelrich's key concerns had been his personal safety. The ACCT was closed on the morning of 9 May, and in the afternoon he was moved to another house unit where it was thought he would be safer. However, Mr Oelrich later refused to lock up saying he felt under threat and he asked to be relocated to the segregation unit. When this was refused, he punched an officer and was taken to the segregation unit as a result (albeit briefly). Mr Oelrich was in the ACCT post-closure period and we are concerned that staff did not consider whether his behaviour was a continuation of the distressed behaviour which had led to the ACCT being opened just a few days earlier.
122. Mr Oelrich's behaviour continued to give cause for concern on the night of 10/11 May, again in the post-closure period. Nurse A said he was concerned about Mr Oelrich's behaviour that night and that he spoke to the night orderly officer about reopening the ACCT and he said that officers would do hourly checks. Nurse A recorded this at the time. He checked on Mr Oelrich himself at 3.21am.
123. The night orderly officer and Officer A told the investigator that said they did not remember Nurse A raising the possibility of reopening the ACCT. Officer A was aware that Mr Oelrich was in the post-closure period of an ACCT and he described Mr Oelrich's behaviour that night as 'very odd'. However, he said that they were more concerned about the risk he might pose to staff than his risk to himself.
124. Mr Oelrich's behaviour that night was very similar to the two previous occasions when he had placed a ligature round his neck after saying he was vomiting blood and asking for a shower. We are concerned that staff did not recognise this because Mr Oelrich's ACCT paperwork had not travelled with him when he moved units, as it should have done. PSI 64/2011 states that the closed ACCT book must remain on the wing until completion of the post-closure review. The night orderly officer said that Mr Oelrich's ACCT document was not on the unit the night before he died and he did not know he had recently been managed under the ACCT process - although we note that Officer A knew.
125. Although the ACCT was not reopened, Officer A said that the night orderly officer agreed that staff would carry out checks on Mr Oelrich at random times. He told the investigator that he checked Mr Oelrich at 3.00am. However, there is no evidence that any further checks were carried out by prison staff between 3.00am and the roll check at 5.15am when Mr Oelrich was found hanging.

126. We are satisfied that the record Nurse A made in the medical records shows that he did raise the issue of the ACCT with the night orderly officer. The night orderly officer said that if Nurse A had been concerned, he could have reopened the ACCT himself. It is the case that all staff, regardless of grade or discipline, have the responsibility to open an ACCT if they have concerns that a prisoner may be at risk, although we appreciate that it would have been difficult for Nurse A to do this in the circumstances and that he was satisfied that the night orderly officer had arranged for Mr Oelrich to be checked during the night.

127. We make the following recommendations:

The Governor and Head of Healthcare should ensure that all staff, regardless of grade or discipline, understand that they have a responsibility to open (or reopen) an ACCT if they consider it necessary.

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

- **hold multidisciplinary ACCT reviews, with healthcare staff in attendance at all first ACCT reviews;**
- **set effective caremap actions that are specific and meaningful, aimed at reducing risk, and update them at each case review; and**
- **keep the ACCT document with the prisoner until the post-closure review has been completed.**

Violence reduction

128. Woodhill's Violence Reduction Strategy says that all incidents of assault, including fights, must be entered onto the incident reporting system. All staff, including healthcare, involved with prisoners should record key contacts with them, particularly information on risk of harm to/from others, on the prison record case notes system. Staff must ensure that where there are clear indications that a prisoner has been, or is likely to be, involved in acts of violence that the risk of such occurrence is reported to a relevant manager in line with the local rules for doing so and must be shared with other staff in contact with the prisoner as soon as is practicable and at least at shift change.

129. There were several occasions where Mr Oelrich had been assaulted, told staff he was under threat or had information about other prisoners, but staff did not submit an intelligence report. For example, on 6 January and 8 February, Mr Oelrich told staff he was under threat but they did not submit intelligence reports. On 19 March, Mr Oelrich was assaulted in two separate incidents but there was no intelligence report submitted for either incident.

130. The Strategy provides that victim support procedures will be activated when a prisoner is identified as the victim of any antisocial behaviour or where a prisoner states that he is under threat from another prisoner or group. The Unit Supervising Officer or Custodial Manager must issue a Post-Incident Support

letter and inform the prisoner that they can be monitored for 14 days by the Safer Prisons team.

131. Mr Oelrich was monitored under victim support procedures for 14 days after he was assaulted on 1 February but there is no evidence that this was considered following other assaults at Woodhill.
132. The PPO has published a range of publications identifying the links between bullying and suicide, but we are concerned that prison staff do not seem to have recognised or considered that the assaults, bullying and intimidation Mr Oelrich experienced might have increased his risk of suicide and self-harm.
133. In a review of self-inflicted deaths, published in June 2011, we found evidence of bullying and intimidation in 20 per cent of the cases we reviewed. In a follow-up report published in October 2011, 'Violence reduction, bullying and safety', we identified the importance of implementing local violence reduction strategies, investigating all allegations of bullying and recognising that individuals who have been the victim of bullying are potentially at greater risk of suicide and self-harm.
134. We repeated similar messages in our review of all self-inflicted deaths in prisons in 2013-14 and identified the need for all reports or suspicions that a prisoner is being threatened or bullied to be recorded and thoroughly investigated and for the potential impact on the victim's risk of suicide to be considered. We make the following recommendation:

The Governor should ensure that:

- **all information about bullying and intimidation is fully coordinated and investigated;**
- **those suspected of involvement are appropriately challenged and monitored;**
- **staff consider whether victims are at increased risk of suicide or self-harm; and**
- **apparent victims are effectively supported and protected with meaningful, long term solutions which address their individual situation.**

Mental health, substance misuse and dual diagnosis

135. Woodhill's 'Policy for Dual Diagnosis' says that the term describes a broad spectrum of mental health and substance misuse problems that an individual might experience concurrently. The policy advises use of the Shared Care Model, a collaborative approach involving the delivery of parallel treatment with close collaboration and communication between teams and careful planning of interventions.
136. Mr Oelrich was referred to the substance misuse team when he arrived at Woodhill and managed appropriately. However, the nurse prescriber who saw him for regular reviews did not know that he had mental health problems or that he had been prescribed mental health medication. He also did not know that Mr

Oelrich had been displaying possible drug-seeking behaviour by asking for other medications, such as Ritalin and pregabalin. Mr Oelrich was also seen by the mental health team on several occasions and while he was not on the team's caseload, he had a personality disorder diagnosis and was prescribed mental health medication.

137. The clinical reviewer considered that Mr Oelrich met the criteria for dual diagnosis. She found that Mr Oelrich's care was not equivalent to that which he could have expected to receive in the community. She said that while there was evidence of each service interacting with Mr Oelrich and taking reasonable action individually, there was a general lack of integrated working and sharing of information. Better collaborative working might have led to an improved recognition of his raised levels of anxiety and potential risk of self-harm.
138. The PPO published a learning lessons bulletin on 'Prisoner Mental Health' in January 2016. In this bulletin we identified that difficulties in coping with mental health problems can be made worse when a prisoner also has to cope with the difficulties of battling substance dependence. We recommended that mental health and substance misuse services should work together to provide a coordinated approach to prisoner care which should involve the use of agreed dual diagnosis tools to assess prisoner needs and regular meetings to discuss and plan joint care. We make the following recommendation:

The Head of Healthcare should ensure that prisoners with a dual diagnosis receive appropriate integrated treatment.

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