INDEPENDENT PROFESSIONAL ADVICE ON THE PREVENTION OF SELF-INFLICTED DEATHS AND SELF-HARM AT HMP WOODHILL

REPORT BY STEPHEN SHAW

May 2017

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Acknowledgements

I am most grateful to officials in the Ministry of Justice and HM Prison and Probation Service for their support of my work.

I am particularly indebted to Ms Nicola Marfleet, Acting Governor of HMP Woodhill, and all her colleagues for facilitating my access to every part of the prison and to all the documentation I asked to review. Special thanks are due to [redacted]

In the MoJ and Prison Service Headquarters, I would like to thank [redacted]

Foreword

On the morning of 3 May 2017, I was carrying out observations of first night interviews on House Unit 1B. The alarm sounded and a Code Blue (indicating a prisoner with breathing difficulties) was called. A prisoner on an open ACCT form had barricaded his cell, placed a prison issue property bag over his head and used an item (variously described as a t-shirt or the cord from his dressing gown) as a ligature.

There was an initial delay as the cell door could not be removed because the joint had been painted over, but staff eventually entered the cell and cut the ligature using a fish-knife. The man concerned then threatened to jump from the landing and was handcuffed. He was carefully escorted down to the ground floor and subsequently placed on constant watch.

The situation was both well managed and successfully de-escalated.

I spent twenty minutes or so talking to the prisoner concerned later that morning. I do not know his intentions when barricading and tying the ligature. When we spoke, he discussed his plans to give up smoking.

Some younger members of staff were understandably shocked by what they had seen, and I was concerned that the Custodial Manager who had actually cut the ligature had little time for post-incident support and reflection before continuing his tasks. However, alongside the evident professionalism that had been demonstrated, I was struck by how everyday and matter-of-fact the whole incident was treated.

Every life lost in prison is a tragedy. Every life saved goes virtually unnoticed.

Executive summary

This is my report on the prevention of self-inflicted deaths and self-harm at HMP Woodhill. It was commissioned following the deaths of twenty prisoners at their own hand since 2011.

In carrying out this work, my methodology has included meetings with relevant stakeholders, a careful review of the key documentation, and my own observations of practices within Woodhill.

I explain that, given the announcement that Woodhill will transition to a category B training prison by the end of March 2018, I have not included formal recommendations in this report. My advice takes the form of findings and judgements throughout the text.

I set out my first impressions of Woodhill some ten years after my last visit to the prison. I say that I found much to admire in the culture of the gaol, but was immediately struck by the number of prisoners on open ACCT documents. It was also apparent that the prison was facing acute staffing difficulties – manifested in the number of vacancies, the reliance upon cross-deployment and detached duty, and the relative inexperience of those in post.

I then discuss the two principal policy documents in respect of keeping prisoners safe.

I report the views of Woodhill's Independent Monitoring Board, and those of the local branch of the Prison Officers' Association. I also report on discussions with other stakeholders, focussing in particular upon HM Coroner and the Prisons and Probation Ombudsman. I discuss the Coroner's regulation 28 reports and the responses they have received from officials, and list the main findings of Ombudsman investigations.

The next section of the report covers my own observations in Woodhill – in particular, in Reception and on the First Night Centre. I discuss the Early Days in Custody process, and provide accounts of those ACCT reviews I attended. I also set out my observations of night-time procedures.

I carried out an audit of a small number of closed ACCT documents and reproduce my contemporaneous notes. Four of the seven ACCTs had been open for just one day, and I suggest that this is an indication of the current degree of risk aversion on the part of staff.

After a brief discussion of the context of prison suicide and the phenomenon of 'clustering', I offer an assessment of the actions taken locally, nationally, and by the Secretary of State.

Locally, I say that no one visiting Woodhill at the present time could be in any doubt as to the absolute focus upon the prevention of self-harm and suicide. I suggest that the challenge is to maintain that focus while having the confidence

to reduce the use of formal ACCT processes to something like the norm for local prisons.

I provide specific comments on Woodhill's application of ACCT procedures, the use of constant watch, and staff familiarity with emergency codes.

Nationally, I draw upon the Witness Statement provided by the Deputy Director of Custody for the High Security Estate in respect of the recent Judicial Review. I argue that the actions taken represent a robust and focussed approach to the tragedies at Woodhill.

Notwithstanding my terms of reference, I am circumspect in my assessment of the actions of the Secretary of State. I offer observations on a range of topics.

I conclude that there is today a remarkable focus on prisoner safety in Woodhill. However, that has coincided with a culture of risk aversion that itself places a great strain on ACCT processes and the wider regime. I say that the continuing weaknesses in ACCT procedures that I observed are unlikely to be overcome until the number of open ACCTs is significantly reduced.

Overall, I suggest that while ACCT remains a world-class system it no longer operates as its authors intended. I also say that the staffing pressures at Woodhill have been allowed to persist for far too long.

Woodhill has understandably been defined by its failures – the deaths of 20 men since 2011. I express the hope that in the future it can be defined by its successes.

Introduction

1. I was commissioned on 15 February 2017 to provide independent professional advice on the prevention of self-inflicted deaths and self-harm at HMP Woodhill. The commissioning note set out that there had been no self-inflicted deaths in Woodhill in 2010, one each in 2011 and 2012, but then four in 2013, two in 2014, five in 2015 and seven in 2016. Acts of self-harm had also increased very substantially.

2. I have appended basic information provided to me by the Ministry of Justice about the twenty men who have died since 2011, the wings on which they died and their custodial history. My role was not to investigate those deaths – either individually or in total – so I simply note that from other information I know that ten had a history of mental health problems, seven had a drug history, seven had alcohol problems, and five were on detoxification medication at the time of their deaths (some of the categories overlap of course). Seven of the men did not have any of these characteristics according to the information provided to me.

3. I have reproduced my terms of reference at Annex 2. The commissioning note makes no mention of the Judicial Review brought on behalf of relatives of two Woodhill prisoners, Mr Ian Brown and Mr Daniel Dunkley, who died in Summer 2015 and Summer 2016 respectively, although it is not in doubt that the JR was the precipitating factor. However, I have taken the view that the legal proceedings are not directly my concern and I have done no more than read what is publicly available along with the Witness Statements of the Acting Governor, Ms Nicola Marfleet, and the Deputy Director of Custody (DDC) for the High Security Estate, Mr Richard Vince.

4. I need hardly say that I have also made no enquiries into those deaths that are the subject of continuing police investigation or where the Crown Prosecution Service has agreed that charges should be brought. But I would be remiss in not reporting that the involvement of the police and CPS has had a significant impact upon the mood (and, I believe, the actions) of Woodhill staff. The unfavourable media reputation of the prison has also put pressure on staff. What I found in Woodhill was that a culture of risk aversion had developed, and ACCT (Assessment, Care in Custody and Teamwork) forms were being opened at a rate unknown across the rest of the prison estate.

My approach

4. In carrying out this work, I have adopted a broad methodology that has included meetings with relevant stakeholders, a careful reading of reports both on individual deaths and the prison as a whole, and my own observations of practices inside Woodhill.

5. Within the prison, I had a number of meetings with the Acting Governor and the Head of Healthcare, [redacted], as well as speaking with many individual members of staff. I also benefited from discussions with the chair of the Independent Monitoring Board, and with the chairman and secretary of the local branch of the Prison Officers' Association. In addition, I attended one of the Governor's morning briefings, and a meeting of the Task Force chaired by Mr Vince.

6. I have, of course, also spoken to many prisoners.

7. Outside the prison I met with the following observers and stakeholders:

   Mr Peter Clarke, HM Chief Inspector of Prisons
   Mr Nigel Newcomen, Prisons and Probation Ombudsman for England and Wales (PPO)
   Ms Juliet Lyon, Chair of the Independent Advisory Committee on Deaths in Custody
   Mr Tom Osborne, Senior Coroner for Milton Keynes
   Mr Richard Vince, DDC for the High Security Estate
   Mr Rob Davis, Governor HMP Belmarsh on detachment from Woodhill.

8. I also enjoyed an informal conversation with Mr Michael Spurr, chief executive of HM Prison and Probation Service, and we have agreed to meet more formally following the submission of this report.

9. Two invitations to the organisation, Inquest, asking if they would like to meet with me went unanswered.

10. I have also offered to meet with one of the lawyers who represented the families at the Judicial Review and, if it is their wish, with family members themselves. Any such meeting(s) will now take place after this report is completed.

11. In terms of the documentation, I have read each of the PPO reports into recent deaths, as well as the reports to prevent future deaths issued by the Coroner, and the relevant responses and action plans.

12. I have also read and assessed a variety of other documents, as set out in my terms of reference. These included the *Joint review of the self-inflicted deaths in custody at HMP Woodhill* (31 March 2016)[1], the PPO Lessons Learned bulletin, *Self-inflicted deaths of prisoners 2013/14* (March 2015), the MoJ *Safety in Custody Statistics Bulletin* (January 2017), two Care Quality Commission reports on healthcare and detoxification provision at Woodhill (December 2017), the *National Offender Management Service Safer Custody Audit of Woodhill* (May 2015), the internal Safer Custody

[1] Commissioned by the Governor of Woodhill, the local NHS commissioners, and the healthcare provider.

Review conducted at Woodhill in January 2016[2], and the DDC's response to the recommendation made by the PPO that he should assure himself that Woodhill has effectively implemented all PPO recommendations made in the last five years (January 2017).

13. Statistical and other supporting information was kindly provided for me by the Ministry of Justice.

14. I have visited every Unit in HMP Woodhill, and carried out focussed observations in Reception and the First Night Centre. I observed a number of ACCT reviews, and read a sample of closed ACCT reports.

15. I spent a night on House Unit 1 to witness observations of those on open ACCT documents.

16. Each of these Unit and other visits offers no more than a snapshot on a particular day and at a particular time. The observations in Reception coincided with a particularly acute staff shortage, and the prison was 'locking out' from 6.00pm. In contrast, my night-time observations coincided with an unusually generous staffing level in each Unit.

17. I have also paid special attention to the three PSIs listed in my terms of reference.

HMP Woodhill

18. Given the likely audience for this report, I do not need to do more than set out some basic facts about Woodhill and my impressions of the gaol overall.

19. Woodhill opened as a local prison in 1992, subsequently taking on responsibilities for category A prisoners as one of three core local prisons in the high security estate.

20. The intrinsic challenges of running a multi-function gaol – in which security concerns are necessarily prioritised – has shaped Woodhill ever since the 1990s. The prison has also faced significant recruitment and retention difficulties, given the cost of housing, and the number of alternative jobs both in Milton Keynes itself and (30 minutes away by the fastest trains) in London.

21. As one House Unit is currently out of action, the prison can presently hold up to 727 prisoners. The roll has been around the 700 mark on the days I have visited.

[2] Commissioned by the DDC.

22. It has now been agreed that, as part of the Prison Estate Transformation Programme, Woodhill will transition to a category B training prison (albeit one retaining the current level of perimeter security and a number of specialist units). Woodhill will lose its remand function entirely, and the courts it currently serves will move to HMP Bullingdon and HMP Peterborough. House Units 1 to 5 will hold category B prisoners only, and the Operational Capacity of the prison will fall by around 100. The changes will be phased in, and should be completed by the end of March 2018.

23. All things being equal, this re-roling of Woodhill will have a very significant impact on the prison including in relation to self-harm and suicide. The number of receptions will fall substantially, and staff will be faced with a much more stable population.

24. In light of this change in function, I have not felt it sensible to include formal recommendations in this report. I have tried to focus on the bigger picture, and my advice takes the form of findings and judgements throughout the text.

25. The most recent inspection by HM Chief Inspector of Prisons (September 2015) said that previous inspections had repeatedly raised concerns about the prison, especially in respect of the support of prisoners at risk of suicide and self-ham and the poor provision of purposeful activity. However, this latest inspection had found "real improvements", albeit the number of deaths was "an unacceptable toll". The Chief Inspector said too many prisoners were arriving late into the evening, many first night cells were dirty and poorly equipped, and recommendations from the PPO "had not been implemented with sufficient rigour".

26. In respect of suicide and self-harm prevention, the Chief Inspector said there were too few Listeners (prisoners trained by the Samaritans to help those in distress), there was "no sophisticated prison-wide approach to safer custody", and caremaps completed as part of the ACCT process "were particularly weak, and were rarely updated".

First impressions

27. My initial visit on 9 March 2017 was the first time I had stepped inside Woodhill for nearly a decade. I found many things to welcome. Woodhill did not feel like a prison in crisis. The staff were unfailingly kind and professional. The prison was largely litter and graffiti-free; it was certainly not unkempt or un-cared for. I heard little or no shouting from cell windows. And relationships between staff and prisoners appeared mutually courteous.

28. As on previous visits, I was impressed by the good design of the houseblocks which provide excellent visibility, much light, and reasonable living space. The cells were reasonably clean, but I remain bemused that

when the prison was built just a quarter of a century ago it was considered acceptable for the toilet to be separated off from the rest of the cell simply with a curtain. When two men are sharing, such arrangements are simply not decent.[3]

29. However, I was immediately struck by the number of prisoners on open ACCT documents (approaching 10 per cent of the total unlock on this first visit), and that no fewer than six of these prisoners were on constant watch. I did not believe that these numbers were sustainable, and it was obvious that they would be having a significant impact upon the wider regime.

30. Despite these figures, Woodhill had no safer cells (as House Unit 5 was out of commission) and no dedicated Listener suite. I am aware of plans to remedy these gaps, and hope they can be implemented speedily.

31. It was also manifest that the prison was facing acute staffing difficulties. This embraced both the overall number of vacancies, the levels of overtime, the reliance upon cross-deployment (staff routinely being asked to work on different Units) and detached duty (staff transferred temporarily from other prisons), and the relative inexperience of those in post.

32. I was subsequently told that some 40 per cent of officers had been in post for less than a year, while the prison remained critically short of both officers and OSGs.

33. This staff shortage manifested itself in cutbacks to the regime, and clearly affected the extent to which prisoners and staff could get to know one another. In a telling anecdote, the secretary and chairman of the POA later told me that they could go onto house units and not know the names of the staff working there.

34. The Head of Healthcare, [redacted], also told me about turnover amongst healthcare staff and the difficulties of recruitment. There was a shortage of time to attend to patients' needs.[4]

35. It was also evident that large numbers of prisoners had mental health issues, problems with dependency on drink and drugs, and a range of

[3] No double cells will survive Woodhill's conversion to a category B training prison.

[4] The Care Quality Commission report on Woodhill's healthcare found the primary healthcare team operated with a 51 per cent vacancy rate in September 2016, and the mental health team was insufficient to meet the needs of Woodhill's population. The report commended the provider, Central and North West London NHS Foundation Trust (CNWL) for extending the cover it offers at weekends, without waiting to be commissioned to do so, as an example of outstanding practice.

other vulnerabilities. Even those with acute needs might find themselves housed on the normal housing units.

36. During this first visit, I spoke with one prisoner on House Unit 1B (the First Night Centre) whose immediate needs (access to phone numbers) were not being met. Thereafter, I spent more time on House Unit 1B than anywhere else in the prison. In general, the atmosphere was relaxed, and I saw a lot of staff-prisoner interaction. However, it is acknowledged by Woodhill that the First Night Centre is also used as a convenient location for those prisoners whose behaviour has been unacceptable on other Units. It is also acknowledged that this practice is undesirable, and scarcely creates the best environment for new arrivals. I hope it can be ended.

37. I shall return to many of these themes in the pages that follow. However, the central concern of everyone to whom I have spoken has been the lack of consistent staffing.

Suicide prevention policy

38. The two key policy documents in respect of keeping prisoners safe are PSI 64/2011, Management of prisoners at risk of harm to self, to others and from others (Safer Custody), and PSI 07/2015, Early Days in Custody – Reception in, First Night in Custody, and Induction to Custody. Both PSIs list risk factors for self-harm and suicide. These include early days in custody, young age, previous self-harm, impulsiveness, being charged with a violent offence, and a history of mental health problems.

39. Prisoners must be asked relevant questions on reception in order to assess their risk, and all staff are expected to be alert to the potential for suicide and self-harm, including opening an ACCT form if required.

40. I note that PSI 64/2011 lists no fewer than 26 risk factors for suicide (page 18) and a non-exhaustive list of eleven possible triggers (page 20). There can be few if any prisoners to whom none of these factors or triggers applies. Indeed, the mental health criterion would include over half the entire prison population, given that the document acknowledges that: "The majority of prisoners have one or more mental illnesses. Some will also have a personality disorder and/or a learning disability."

41. PSI 07/2015 lists 12 categories of prisoners who may pose an enhanced risk of suicide and self-harm. Again, the list would include the majority of prisoners.

42. To some extent, the fact that few prisoners do not exhibit any risk factors is a reminder that potentially they are all potentially at risk. However, as the *Joint review of the self-inflicted deaths in custody at HMP Woodhill* pointed out, there is not currently a validated tool for accurately identifying prisoners who are at an increased rate of self-harm and/or

suicide: "The problem with all the tools that are currently used is that they generate too many false positives (i.e. the prisoners are wrongly identified as being at increased risk of self-harm/suicide) or too many false negatives (i.e. prisoners who are at high risk of self-harm/suicide are not identified by the tool)."

43. Of the list of factors in PSI 64/2011, the review said: "Unfortunately, a significant number of the fixed risk factors within those lists would apply to the majority of prisoners on reception to prison. They are therefore not necessarily helpful in identifying prisoners at high risk of suicide and/or self-harm."

44. This does not render the list of risk factors as redundant, and they fulfil a useful educative function for staff. However, at their next iteration it is for consideration whether the list of factors could be amalgamated (is there a worthwhile distinction between hopeless, worthless and powerless, for example?)

45. In contrast, I am surprised that the list of risk factors does not refer explicitly to previous acts of self-harm or attempted suicide.

What I was told

46. I have long made it my practice to seek an impartial view of a prison from its Independent Monitoring Board. I am most grateful to the chair of the Woodhill IMB, [redacted], for agreeing to meet with me.

47. [redacted] said that cross-deployment had proved disastrous, and that the Benchmarking and Fair and Sustainable initiatives – that had seen senior staff leave and staffing levels fall – had demoralised the remaining staff. Some members of staff were now "run ragged", and mainstream activities like ensuring canteen, Pinphones and property were routinely not sorted out. She said that some prisoners regarded ACCT as a way of getting things done.

48. The Board's 2016 annual report had called upon the Minister to undertake an urgent review of staffing levels in prisons, to ensure that they are set at a level, "which will enable a full regime that is decent, safe and rehabilitative to be delivered". The report also asked the Minister "to consider ways to avoid cuts to spending in prisons, which can only lead to an impoverished regime, less safe environments and a failure of the rehabilitation culture".

49. The Board had also written to the Secretary of State for Justice on 3 and 24 February 2017, raising concerns about what was described as a "deepening crisis at the prison". Although covering a variety of issues, staffing issues were at the heart of the Board's letters. The first said:

> "The continued and worsening staffing problems have led to the most restrictive regime cuts and restrictions that anyone can remember in the prison's history. This combined with overcrowding, high numbers of extremely challenging prisoners and rapidly worsening environments due to an appalling maintenance/repair service from [redacted], are a toxic and dangerous mix."[5]

50. The second letter criticised the imposition of policies designed to reduce costs:

> "The Board has repeatedly, year after year, raised concerns that the driving forward of these policies, regardless of the wider and long term impact, would result in what can be seen today. The position now is that the staffing levels are too low for the prison to deliver a full regime to men who are held in custody. All prisoners are spending unacceptably long periods of time locked up."

51. The Minister's response (dated 30 March 2017) acknowledged that the regime was "unsatisfactory". He set out action designed to improve recruitment and retention, "a long running issue at HMP Woodhill".

52. I was surprised and disappointed to learn that the IMB currently has only six members. While I appreciate the difficulties of recruiting to this most unfashionable form of voluntary work, I would hope that the Ministry of Justice itself would have an early warning system for when Board membership dips too low.

53. I met with the Chief Inspector, Mr Peter Clarke, on 21 March. He had not personally visited Woodhill, but drew my attention to the Inspectorate's findings in relation to the numbers of staff. He said that the use of new psychoactive substances (NPS) was a "game changer" (a phrase first used by the Ombudsman). At Woodhill, I was introduced to the concept of Spice Watch - special observations of prisoners believed to have used NPS and exhibiting unpredictable behaviour in consequence.

54. I asked the Chief Inspector if he could point me towards good practice examples of first night and/or induction processes, and a member of his team subsequently sent me a list of good practice points from recent inspection reports. These included details of the record of induction booklet in use at HMP Parc ("a good initiative that enabled a thorough and robust risk assessment"). HMP Whatton was commended for something called the 'bus to bed' exercise and resulting action plan that "had enhanced the reception and first night process and improved outcomes for new arrivals". HMP Warren Hill was said to have a Reception that was

[5] I have made no assessment of my own, but can confirm that criticism of [redacted] was a feature of many of my conversations with Woodhill staff.

"particularly welcoming". Staff were friendly and professional and processes were swift: "There was a very good focus on keeping people safe on their first night, the prison used peer workers well and induction arrangements were good."

55. I have long felt that the Prison Service does not do enough to share and learn from its own good practice. It may be that other prisons can be encouraged to discover more about what is done at Parc, Whatton and Warren Hill.

56. As an integral part of my review, I also had a long meeting with the chairman and secretary of the local branch of the Prison Officers' Association, [redacted] and [redacted]. They drew my attention to the situation they said had obtained on the night of 7 March when on House Unit 4 there had been no fewer than 17 open ACCT documents, requiring a total of 29 ACCT checks per hour. They said that regularly at night there were insufficient staff to unlock a prisoner in distress, something they had shared with the Minister. (The POA has made proposals to the Acting Governor in respect of how the staffing complement should adapt to the number of open ACCT documents. I do not believe I can sensibly comment on the specific proposals.)

57. It was acknowledged that risk aversion was behind the rise in the number of ACCT documents ("Everyone is frightened of being the next one in court").[6] Staff were anxious about working nights. There was no contingency within the actual staffing levels, and no consistency in who worked where.

58. Like many of those with whom I spoke at Woodhill, the union felt that staff received no credit for the lives they saved.

59. Other issues raised included the virtual impossibility of new staff being able to afford to buy a home locally, and industrial relations issues involving the uplift in some offers' remuneration, and levels of overtime working.

60. My meeting with the Chair of the Independent Advisory Committee on Deaths in Custody, Ms Juliet Lyon, focussed in part upon issues of staffing at Woodhill: the number of vacancies, the number of staff on detached duty, the proportion of staff still within their probationary period. I am

[6] At the Task Force meeting I attended on 7 April, there was a very impressive presentation by [redacted] from HMP Manchester of research she had conducted entitled Self-inflicted deaths and risk prevention processes: staff and prisoner attitudes and experiences at HMP Woodhill. She quoted a staff member of one of the focus groups she had run as saying: "Practice becomes defensive not defensible and actually people engage in a mentality of 'I'm doing this so I'm covered.'" Another said: "Even now … when I'm actually writing stuff … on C-NOMIS, and I'm trying to care, I actually find myself thinking, 'how will this look in Coroner's Court?'" I encountered many such comments myself. Inquests were perceived as adversarial in nature.

also grateful to Ms Lyon for sharing with me the details of a meeting she held with Listeners and Insiders at Woodhill at the end of 2016. The concerns of these prisoners included the number of unexpected lockdowns, the lack of continuity in staffing, the quality of assessments on arrival, access to prescribed medication, the quality of the food[7], and the availability of paid work.

The views of HM Coroner

61. I also benefited from a long discussion with Mr Tom Osborne, Senior Coroner for Milton Keynes, on 31 March. I was very pleased to learn that Mr Osborne had agreed to visit Woodhill and that the Milton Keynes Suicide Prevention Plan, to be launched later this year, will include the prison.

62. The Coroner said he welcomed Woodhill's Early Days in Custody booklet (see below, paragraph 84), and the processes that it supports. He said it was his impression that ACCT was still not operated well.

63. Amongst other things, I focussed on the responses to Mr Osborne's regulation 28 reports.[8] The reports and responses can be summarised as follows:

Mr Brock (died 10 November 2013)

The regulation 28 report was addressed to the Minister for Prisons and concentrated upon staff shortages. The reply was from an official and emphasised the basis on which the Benchmarking process had been carried out. On shortages, the reply said: "It is recognised that HMP Woodhill is currently experiencing a high number of vacancies across all grades. This is being addressed via local and national recruitment drives along with staff working at HMP Woodhill on detached duty."

[7] I cannot comment on the quality of the food, but I can observe that the timing of the evening meal (around 4.20 pm during the week and 4.00pm at weekends) is not something that would have been considered acceptable in the past. Prisoners are issued with breakfast packs, but it is hardly surprising that most of these are consumed during the hours of lock-up after the evening meal has been served.

[8] Paragraph 7 of Schedule 5, Coroners and Justice Act 2009, places Coroners under a duty to make reports to a person, organisation, local authority or government department or agency where the Coroner believes that action should be taken to prevent future deaths. The procedures to be followed in relation to the Reports to Prevent Future Deaths (PFDs) are in Regulations 28 and 29 of the Coroners (investigations) Regulations 2013.

Mr Brown (died 19 July 2015)

The regulation 28 report was addressed to the Governor and the Minister. The thrust of the letter was the Coroner's fear that PPO recommendations were not being implemented. The response from an official referred to the establishment of the Task Force to conduct a review of safer custody processes at the prison, chaired by the DDC, Mr Vince, and the monthly forum, chaired by the Deputy Governor, to monitor progress on the actions taken in response to all recommendations relating to the series of deaths.

Mr Byrne (died 27 February 2015)

The Coroner issued three regulation 28 reports. One was to the chief executive of the healthcare provider, CNWL, regarding the role of healthcare staff in risk assessing prisoners. One was to the Governor, asking for an urgent review of the PPO proposal for the introduction of a formal risk assessment process. And one was to the chief executive of the then National Offender Management Service (NOMS) calling for a comprehensive review of suicide prevention in light of the Ombudsman's finding that staff continued to fail to identify or properly assess the risk of suicide and self-harm in newly arrived prisoners. The NOMS reply cited the various reviews of safer custody and healthcare services that had been commissioned. The response also cited the introduction of a new record (then known as the Entry to Custody Risk Assessment (ECRA), subsequently the Early Days in Custody (EDIC) process). This was the most comprehensive of the responses I have seen, and I infer that the Coroner's three reports acted as a catalyst for the actions taken by NOMS during 2016.

Mr Farrar (died 12 December 2013)

The regulation 28 report was addressed to the Minister for Prisons and concerned the absence of a formal risk assessment tool. The official response referred back to the response offered after the death of Mr Scarlett (see below), and that further action had been taken locally: "In brief the staff involved in the reception and first night processes have been reminded of the need to gather all relevant information, and of the factors that they should consider when assessing risk. The risk assessment process used by healthcare staff has also been improved and staff trained in its use."

Mr Scarlett[9] *(died 22 May 2013)*

The regulation 28 report was addressed to the chief executive of NOMS and concerned the absence of a risk assessment tool. The official reply set

[9] The inquest jury concluded that Mr Scarlett died from hanging as a result of an accident.

out the requirements under PSI 74/2011 in respect of healthcare screening and safer custody: "Any identified risks are communicated to the relevant prison staff, and when a prisoner is assessed as presenting a risk of suicide or self-harm, an ACCT is opened." The response also set out the actions taken locally, including the issuing of notices to staff, and the establishment of new procedures to manage those prisoners on ACTT who were assessed as having complex needs.

Mr Turvey (died 29 December 2015)

The regulation 28 report was addressed to the Governor of Woodhill and concerned prisoners' families' access to a confidential phone line. The reply from an official said that this was in place, and gave details of work to improve awareness of it amongst prisoners and their families.

Mr Walker (died 27 December 2011)

The regulation 28 report was addressed to the Governor and concerned staff not waiting for healthcare to call an ambulance when a prisoner needed emergency transfer to hospital. The response said that an instruction had been issued to staff to ensure that ambulances were called immediately that a life-threatening situation was discovered, and that NOMS would issue a bulletin on this point to all establishments.

64. I think I may fairly observe that most of the replies were rather anodyne. However, my principal concern is that responses were treated as official correspondence rather than receiving a reply from the person to whom the reports were addressed.

65. While I entirely understand that officials would prepare the responses to rule 28 reports, I think that both due respect to the Coroner – and a sense of ownership by Ministers and their senior advisers – is better demonstrated if they are signed off at that level rather than by an official of whom the Coroner has never heard.

66. In the case of one of the Woodhill reports, the Coroner was actually acquainted with the relevant Minister as he was his local Member of Parliament.

Prisons and Probation Ombudsman (PPO) reports

67. One of my key tasks was to try to distil the principal findings from each of the PPO reports into the deaths that have occurred.[10] I take the main concerns of each report to be as follows:

[10] Some reports are still in preparation. It is worth noting that almost all the deaths involved ligaturing, usually with torn bedsheets. I asked the MoJ if there had been any progress in developing bedding that was less likely to tear but was told that, while discussions had been held, no satisfactory solution had yet been identified.

Mr Basalat (died 11 December 2016)[11]

Poor completion of Early Days in Custody booklet
Failure of healthcare staff to ensure all information is available before completing an assessment
Failure of nursing staff to record all interactions with prisoners in the medical record

Mr Brock (died 10 November 2013)

Failure to check the PER (Person Escort Record) for recent risk factors
Speed of medical response

Mr Brown (died 19 July 2015)

Mental health team shortages
ACCT processes
Tackling bullying

Mr Byrne (died 27 February 2015)

Failure to identify risk at Reception and subsequently
Mental health referrals
Emergency response
Contacting next of kin

Mr Cameron (died 28 April 2016)

Mental health referrals
Notifying next of kin
Possible role of NPS

Mr Dunkley (died 2 August 2016)

Staffing shortages
Poor ACCT procedures
Failure to adhere to previous PPO recommendations
Problems in notifying next of kin

Mr Farrar (died 12 December 2013)

Failure to identify risk on reception
Emergency response
Contacting next of kin

[11] I have only seen a draft of this report.

Mr Hunter (died 26 May 2013)

Excessive emphasis on personal presentation when assessing risk rather than balancing all known risk factors
Staff shortages at night
Emergency response

Mr Latham[12] (died 27 November 2015)

Poor ACCT procedures – insufficient checks and checks carried out at predictable intervals
Concerns over the process for entering a cell in the Close Supervision Centre at night

Mr Liorancas (died 28 January 2012)

Failure to take account of all risk factors
Failure to manage detoxification programme
Clinical record keeping

Mr Morris[13] (died 26 June 2016)

Availability of NPS
Application of ACCT processes

Mr Polubinski (died 31 January 2016)

ACCT procedures
Mental health referrals
Absence of personal officer scheme in the early days in custody and at other vulnerable periods

Mr Rayner (died 25 August 2016)

ACCT assessments: Too much reliance on how prisoner appears and not on known risk factors
Poor completion of Early Days in Custody booklet

Mr Harper (died 4 April 2014)

ACCT procedures
Emergency response

[12] Mr Latham was born a male, but had asked to be treated as a transgender prisoner and to be known as Joanne Latham. Following his death, I understand that his family has asked for his original gender to be respected.

[13] Mr Morris was the third of the 20 prisoners who have died whose self-declared religion was Mormon.

Mr Scarlett (died 22 May 2013)

Failure to identify and consider all risk factors
ACCT processes
Relationship between ACCT and IEP processes[14]
Use of double cell[15]
Emergency response

Mr Turvey (died 29 December 2015)

Lack of staff continuity in House Units
Problems with emergency response
Absence of a personal officer scheme[16]
Failure to implement previous PPO recommendations

Mr Walker (died 27 December 2011)

Sharing of information
Risk assessment
Family liaison
Emergency response

Mr White (died 14 October 2014)

Poor ACCT procedures
Poor emergency response
Mental health referrals
Access to illicit drugs

68. It will be seen that particular issues have recurred in the PPO reports: the identification of risk factors, ACCT processes, staff shortages (both generally and amongst members of the mental health team), emergency codes and procedures, notification of next of kin.

[14] The PPO Learning Lessons bulletin rightly refers to the "cumulative impact of restrictions due to segregation, adjudication punishments, IEP levels and access to work … Lack of activity or lack of income can leave prisoners vulnerable."

[15] The presence of a top bunk in a shared cell offers an obvious ligature point. In my view, no prisoner subject to ACCT processes should ever be in single occupation of a shared cell.

[16] The extent to which a properly functioning personal officer scheme is feasible in Woodhill at the moment merits greater consideration than I have been able to give to it in this review. The fundamental issue is the extent to which prisoners' basic needs are met, and how well the staff know the prisoners in their charge. Given the overall staffing situation, there is a danger that a personal officer scheme might even have the perverse effect of delaying attention to basic needs.

69. I discussed the reports and findings with both the Ombudsman himself, and separately with the Deputy Ombudsman responsible for fatal incident investigations, [redacted], and two investigators, [redacted] It was acknowledged that medical response had been vastly improved[17], although the prison's speed in notifying next of kin still gave cause for concern.

70. Although PPO investigators had formed a generally favourable impression of Woodhill staff, I was told that meaningful communication with prisoners was a weakness. Staff were moved around too much and did not know the Units on which they were working or the prisoners in their care.

71. In line with a theme emerging from the individual investigation reports, I was told that too much emphasis was placed upon how prisoners presented rather than upon their risk factors. As a rule of thumb, it was stressed that few prisoners take their own lives who have not shown self-harming behaviours in the past.

72. The Ombudsman himself, Mr Nigel Newcomen, emphasised the importance of the ACCT process, and drew my attention to a recommendation he had made in his previous annual report for a fundamental review of ACCT.[18]

73. I have read the DDC's response to the PPO following the recommendation in the report on the death of Mr Turvey that he should assure himself that Woodhill has effectively implemented all PPO recommendations. The response said that eight of the 44 recommendations had been fully implemented, with a further 29 implemented and generally effective with minor non-compliance. Six were said to have been partially implemented (but not yet achieving a consistently satisfactory outcome) and one had not yet been implemented (as Woodhill currently has no safer cells in use).

My observations in Woodhill

(i) Reception

74. On 6 April, I conducted observations in Woodhill's Reception. As noted above, the prison was locking out (refusing to accept new receptions) from 6.00pm.

[17] My discussions in Woodhill itself have given me confidence that the ambulance route into and out of the prison is now well understood, and that undue delays are avoided. This was confirmed by what happened on the night of 9 May (see below, paragraph 113).

[18] As with the Chief Inspector, I asked the PPO for examples of good practice. The Ombudsman's investigators had told me that ACCT procedures were in good shape in HMP Exeter, and that at HMP New Hall mental health assessments were integral to the ACCT process.

75. Even so, it was apparent that it was a very busy and intense environment.

76. Listeners and Insiders were in attendance.[19]

77. I was pleased by the speed with which prisoners were transferred from the vans in which they had arrived, and the initial pat-down search, wanding, and use of the BOSS chair, were all done quickly and professionally.

78. The Supervising Officer at the desk sensibly deployed a standard set of comments and questions, but applied them with wit and sensitivity. He made a special effort to tell first-time prisoners to forget everything they had previously seen or heard about prison life, and that staff were there to help and assist. I felt this sympathetically met the mandatory requirement in paragraph 3.37 of PSI 07/2015 that staff must reassure prisoners that safer custody is a high priority.

79. Indeed, although I was not conducting a formal audit, I felt that the terms of the Reception and First Night Checklist in PSI 07/2015 was generally well met. However, the Supervising Officer told me that problems that have beset the Prison Service for many years, such as the inadequate transfer of information between the various parts of the criminal justice system, still recur with depressing frequency.

80. Unfortunately, after the initial conversation at the desk, prisoners then ended up in a holding cell as there were insufficient members of staff to escort them to the First Night Centre to be seen by the nurse. So far as I could see, twelve or more of the men were left waiting, one of whom had been sick on the floor. It is arguable that a member of healthcare staff could have been called down to Reception given that prisoners were not moving through. It is also questionable, therefore, whether reception on the night in question met the requirement in the PSI that prisoners should not be held in holding rooms "any longer than is necessary … before moving on to their first night location".

81. I made brief notes on those entering the prison:

    Prisoner A

    Foreign national, spoke very little English. He was shown pre-printed questions in Albanian. Virtually no information obtained.

[19] The recruitment and retention of Listeners and Insiders presents evident difficulties in prisons with a high turnover of prisoners. The numbers seemed adequate at the time of this review, and I was hugely impressed by the enthusiasm they demonstrated for their responsibilities.

Prisoner B

Appeared very miserable. Previous history of self-harm and mental health problems. He said he had been prescribed Subutex at HMP Peterborough but it was explained that Subutex is not available at Woodhill.

Prisoner C

Had simply returned from court on a short sentence. A former orderly, he was essentially waved through to the holding room.

Prisoner D

On recall from licence.[20] Acknowledged past depressive illness and problems with alcohol.

Prisoner E

Desperate for a smoker's pack. No other issues mentioned.

Prisoner F

Said he was detoxing, and the PER said he had self-harmed at court. Fearful of other prisoners on the First Night Centre and Detoxification Unit (I assume because he had drug debts of some kind). A member of the Safer Custody team in reception decided that an ACCT would be opened only if Prisoner F was located on one of those units. Otherwise he seemed to be content, and it was suspected that the self-harming at court (which had not been immediately life-threatening) had been instrumental rather than an expression of distress.

Prisoner G

On remand. Speech largely incoherent. Said he did not sleep well.

Prisoner H

Return from court. History of drug abuse. Said he wanted a smoke.

Prisoner I

Serving short sentence. Detoxing. Previously on an ACCT.

[20] Recall is an acknowledged risk factor. It is also widely believed that some former prisoners engineer their recall from licence as a means of secreting drugs or NPS into prison.

Prisoner J

36 day sentence. History of substance abuse (drugs and alcohol). Said he suffered from depression.

Prisoner K

First time in prison. On remand for serious offence. Given the booklet, *Welcome to HMP Woodhill*.[21]

Prisoner L

Return from court. Notified of disciplinary charge for cannabis.

Prisoner M

Another return from court. Said that the judge had made a mistake.

Prisoner N

Young. First time in custody. Sentence of 14 months. Some bravado. Commendably given slightly longer time at the desk.

Prisoner O

Return from court. Again, more or less waved through to the holding room.

82. In total 15 men came through Reception in the space of less than two hours. Overall, I felt that Reception was meeting the requirements of PSI 07/2015 that prisoners are treated with decency and with regard for their and others' safety and well-being, and that the guiding principle was a duty of care. As I have said, I felt that the Supervising Officer did well in trying to put people at their ease

83. The other thing that emerged very strongly was that virtually all the prisoners exhibited one or more risk factors for suicide and self-harm.

(ii) The Early Days in Custody process

84. Woodhill has channelled its induction process around a booklet – the Early Days in Custody (EDIC) document. This has already gone through several iterations, but appears popular with staff and has been welcomed by the Coroner. It has separate sections to be completed by the Reception Supervising Officer, and then on the first and second day interviews

[21] I judged this to be a well-written and well-designed booklet. The front cover includes the words: "First time in prison? There's one thing we want to say … You're going to be ok … Don't be afraid – Woodhill is a safe prison …"

leading up to discharge from induction after five days. To those of us of a certain vintage, the booklet appears to serve the functions of a wing file.

85. I sat in on a number of day 2 EDIC interviews. Not that this is its aim, but amongst the merits of the process is that it provides quality work for officers. Broadly speaking, I felt it was also successful in helping to identify and action prisoners' immediate needs. For example, the first interview ensured the prisoner was issued with a Qur'an, could arrange visits and had credit on his Pinphone account. Another prisoner had been wrongly recorded as a smoker and been allocated a shared cell with someone who did smoke. Another had 'welfare' needs relating to the failed attempts by his partner to transfer money as private cash.

86. Each interview lasted approximately ten minutes.

87. I also attended an EDIC review – a multi-disciplinary review conducted on all EDIC documents. There were no fewer than seven staff present (three uniformed staff, a nurse and a mental health nurse, and two members of staff from the Westminster Drug Project responsible for Woodhill's detoxification wing[22]). One member of staff was checking and adding information on C-NOMIS; another was doing likewise on the healthcare database SystmOne.

88. Overall, the process appeared extremely thorough, albeit expensive of staff time. Indeed, it would have been even more expensive had the meeting been attended by anyone from the offender management unit.

89. Out of respect for patient confidentiality, I did not ask to attend any of the primary or mental health screens that are completed within 24 hours of reception. The Care Quality Commission has judged that the screens are comprehensive (notwithstanding its concern about staffing shortages, and the requirement placed upon the provider, CNWL, to take action to provide more than a 'crisis' service to patients with mental health needs).

(iii) ACCT assessments and reviews

90. I observed one ACCT assessment (in the segregation unit). This was conducted to a very high standard indeed.

91. I also observed four ACCT reviews[23] and set out my findings below.

92. One ACCT review was carried out in the Healthcare Unit (ACU). The young man in question was very emotionally labile, and was on constant

[22] An inspection of the services provided by the Westminster Drug Project at Woodhill by the Care Quality Commission published in December 2016 was extremely favourable.

[23] At Woodhill, all ACCTs are reviewed by a Custodial Manager or Governor. On one day in March, I am told that there were no fewer than 30 reviews in the same day.

watch. He had very many cuts to his arms, although most appeared to be superficial.

93. Present were the case manager (a governor grade), a psychiatrist, and a mental health nurse. The outcome was to retain the young man on constant watch, and the actions were to try to trace his property, for the governor to contact his solicitor, and for the young man to see a priest.

94. The review was well conducted, and lasted around half an hour. The young man himself was encouraged to participate. However, I observed that there was quite a lot of extraneous noise in the healthcare centre that was not conducive to the review.

95. I also sat in on a review carried out in the segregation unit. There was a long wait for anyone from healthcare to attend (despite my presence being used as an inducement), and eventually a member of healthcare staff who was attending the segregation unit for another reason was persuaded to take part.

96. A third review resulted in the ACCT form being closed after 24 hours. The prisoner had relevant risk factors (mental health and drugs), but it appeared he had never actually self-harmed except for punching a wall five years earlier.

97. The fourth review concerned a young man who had been in custody eleven days but was still without his smoker's pack (smoking is to be phased out of Woodhill later this year), and had not had his initial phone call. The substance misuse nurse was present, so the review was multi-disciplinary on paper. However, this was not the reality as in practice she contributed not a single word. I was told this was far from unusual.

98. In this case, the ACCT process was identifying and remedying shortfalls in the induction process. It was suggested (as by the IMB, see paragraph 47) that some prisoners manipulate ACCT for this reason, although I cannot verify this myself.

99. I was also told, and it was my own experience, that there were frequently long waits for a nurse to attend reviews (thereby tying up the time of both assessor and reviewer).[24]

100. I did not attend any reviews in House Unit 6 (which, amongst other things, houses the Close Supervision Centre for prisoners deemed

[24] The CQC report on Woodhill's healthcare reported: "We were told that requests by operational prison staff for nurses to attend an ACCT review could sometimes be difficult, for example, if reviews were scheduled to take place during medicines administration. However, discussions were taking place between the prison safer custody team and the trust [CNWL] to improve the timings of ACCT reviews to ensure nursing staff could attend." It would seem that those discussions have yet to solve the problem.

particularly dangerous and disruptive). However, I discussed ACCT procedures with staff in the CSC. At the time in question, there were two prisoners on open ACCTs – one a prolific self-harmer who inserts items into his stomach and other parts of his body.

101. The additional numbers of staff available mean that House Unit 6 is the one part of the prison where ACCT reviews are genuinely multi-disciplinary (with input from psychology, offender management unit, mental health, etc). Indeed, I was told that reviews routinely lasted an hour or so.[25]

102. The vulnerability of prisoners on House Unit 6 speaks for itself because some can only be unlocked when a Supervising Officer and six other staff are present in personal protection kit. The need to find this number of staff, especially at night, could mean it would take up to 30 minutes to achieve.

103. It is many years since I had last visited the CSC, and the regime has undoubtedly improved in that time. However, I was told that restrictions were frequent as the officers are re-allocated to other Units to meet staffing shortfalls. There is limited time out of cell at weekends, and no evening association at all.

(iv) Night-time procedures

104. I carried out observations on House Unit 1B (the First Night Centre) throughout the night of 9 May 2017.

105. The healthcare nurse was still present on the Unit at 22:40, carrying out the first night interviews. I was told that there were occasions when this went on until after midnight. Late receptions into the prison (arguably a consequence of the escort contract) present evident dangers.

106. Once the lights were turned off at 22:45, the Unit was very quiet until the morning. Indeed, it is a feature of Woodhill that there is little shouting from cell windows and few instances of loud music disturbing others.

107. The roll on House Unit 1B was 76, including two category A prisoners (on whom regular checks must be made throughout the night). Eleven prisoners were on open ACCT documents, with varying levels of observations required.

[25] One member of staff suggested that ACCT reviews should be recorded, given the limited space available to record the outcomes on the ACCT document itself.

108. Compared with most nights, there was an additional member of staff on each unit throughout the prison – two officers and one OSG. Even so, the staff appeared permanently busy, whether carrying out their observations or writing up what had been done. A lot of time was also spent re-keying information into C-NOMIS. I was told that 'pegging' (a method of auditing staff members' movements at night) was no longer employed.

109. I read entries in many of the open ACCT documents, and was content that they were being completed properly. However, details in many initial prison documents are of course only as good as what the prisoner says. The next of kin details given in one open ACCT looked scanty and inaccurate. When I checked the next day, there was no street with the name provided anywhere in the city concerned.

110. During the night, I also visited every other Unit in the company of the Night Orderly Officer.

111. It would, I think, come as a surprise to most members of the public that the overwhelming focus of staff activity at night is suicide prevention. I was told: "The job at night is to keep prisoners alive."

112. Unusually, on the night in question there were just two prisoners throughout the gaol on constant watch. At around 4:30am, one of those prisoners suddenly leapt from his bed and self-harmed with a ligature. It goes without saying that opening cells at night presents special challenges in all prisons, but particularly those with category A prisoners. Unit staff do not have any keys on them, save for an emergency cell key kept in a sealed pouch.

113. Fortunately, there were sufficient members of staff available on this particular night for the cell door to be opened reasonably quickly. I understand the prisoner's injuries were not life-threatening, but he was taken by ambulance to hospital.

114. The prisoner in question has been on constant watch more-or-less continually for approaching 12 months.

(*v) The segregation unit*

115. I visited Woodhill's segregation unit on two occasions. On the day I made my formal observations, four out of 13 prisoners in the segregation unit were on open ACCTs.

116. One man was subject to three observations an hour, one to two observations an hour, and one was on hourly observations. The other prisoner was housed in the constant watch cell. This must be a particularly bleak environment, being quiet and lacking in stimulation. I believe this cell should be re-located.

117. The undesirability of housing prisoners on open ACCTs in segregation is widely acknowledged. PSI 64/2011 says this should only occur "in exceptional circumstances" – a phrase repeated in the PPO Lessons Learned bulletin, *Self-inflicted deaths of prisoners 2013/14*. HM Inspectorate of Prisons' *Expectations* document says at section 1.13 that "Prisoners on open care and support plans (ACCTs) are only held in segregation in exceptional circumstances and where necessary to ensure their own safety or the safety of others."

118. Staffing levels in the segregation unit were especially tight. In nearly 40 years of visiting prisons, I had never previously entered a segregation unit and found no-one in the office for five to ten minutes after my arrival.

119. In 2016, across England and Wales seven prisoners took their own lives while in segregation (this compares with eight in 2013, seven in 2014, and four in 2015). Reducing the number of prisoners on open ACCTs in segregation at Woodhill should be a priority.

(vi) Review of closed ACCTs

120. I carried out an audit of a number of closed ACCT documents on 3 May. My contemporaneous notes are as follows:

Case 1

ACCT open for just one day. The first and only case review was not multi-disciplinary. The post-closure review was nearly a month after the closure of the document itself.

Case 2

ACCT open for nearly a month. Both the first and subsequent eight case reviews were multi-disciplinary. The Governor's ACCT Quality Check List had found some omissions and the following was noted: "Lack of recorded quality conversations. Majority of entries are observations not conversations."

Case 3

ACCT open for one day only. The record of the Assessment Interview included "Cut his own head … He does not feel banging his head on the wall is an act of self harm. He does it to relieve his stress."[26]

[26] PSI 64/2011 does not distinguish between life-threatening and other forms of self-harm.

The first review was multi-disciplinary. The post-closure interview was three months (sic) after closure of the form.

Case 4

Another ACCT open for one day only. (The prisoner was still a teenager, and it was his first time in custody.)

Case 5

Yet another ACCT that was open for one day only. The prisoner had said he would self-harm (presumably while going through Reception) leading to the form being opened.

Case 6

The ACCT had been open for two days following the prisoner's gate arrest. There was no post closure interview form as the prisoner had refused to complete it.

The record of the Assessment Interview said the prisoner would not engage with the first night process or the ACCT assessment. He had previously been on an ACCT, but there was evidence of violence to others rather than self-harm.

As with a number of the documents I reviewed, no photograph of the prisoner was attached to the ACCT.

The Concern and Keep Safe form had been ticked for very low mood. This text had been added: "He will not engage with the nurse so she would like him to be on an ACCT."

Case 7

The prisoner had been recalled to custody and had mental health problems. The ACCT had been open for nearly one month.

The first case review had not been multi-disciplinary but subsequent ones had both healthcare and uniformed staff present.

121. This was a small sample, and it might be unwise to draw too many conclusions. I also have no benchmark from ACCT documents in other prisons. However, the fact that four of the seven ACCTs had been open for just one day does indicate significant risk aversion at Woodhill that, by distorting staff resources, may actually add to risk.

122. It is also apparent that not all paperwork was properly completed, and that most reviews were at best bi-disciplinary. I was told that the presence of healthcare was highest at the first review and declined

thereafter. However, as I have observed earlier, the presence of a member of healthcare does not guarantee his or her involvement. In any event, it was suggested that there are particular difficulties in ensuring that ACCT reviews are multi-disciplinary at the weekend. I imagine this must be the case in most prisons.

123. None of the documents I reviewed showed the involvement of the offender management unit, although I am told that offender supervisors do attend on occasion.

124. I am personally less concerned about the lateness of two of the post-closure interviews, although manifestly this was not in line with the mandatory requirements of the PSI which say a post-closure interview must be held within seven days. This problem, amongst others, had been identified in the NOMS Safer Custody Audit of May 2015.[27] However, my own view is that this is an aspect of the PSI that is unnecessarily prescriptive.

125. At Woodhill, the Immediate Action Plan section of the ACCT must be completed by the Orderly Officer. It was separately acknowledged to me that, not infrequently, this was not done within the hour as required by the PSI.

Findings

126. In considering the tragic series of deaths in Woodhill, I am required under my terms of reference to assess the actions taken locally, nationally, and by the Secretary of State for Justice. But before doing so, I would like to say something about the context of prison suicide and the concept of 'clustering' (the concentration of self-inflicted deaths in particular institutions).

127. Suicide is the biggest single cause of death amongst men aged under 45. The rate of self-inflicted death in the community has been on an upward path for the past decade.

128. Those with acknowledged risk factors – low socio-economic status, relationship breakdowns, addictions, mental health problems – are disproportionately represented in the prison population.

129. According to the Ministry of Justice's *Safety in Custody Statistics Bulletin*, the rate of self-inflicted death in prison has doubled since 2012. There were 119 self-inflicted deaths in prisons in England and Wales, an increase of 29 on the year before. The likelihood of self-inflicted death in prison is between seven and ten times the likelihood of suicide among the general population, and the ratio has been widening.

[27] Overall, Woodhill was given an Assurance Rating of Moderate.

130. Prisons like Woodhill, taking prisoners on remand or at the start of their sentence, are significantly more likely to experience suicide and self-harm than gaols with a stable long-term population.

131. The Chair of the Independent Advisory Committee on Deaths in Custody, Ms Juliet Lyon, told me that one of the things that she and her colleagues wish to focus on in their work programme is the phenomenon of clustering.

132. I think this could prove very valuable, and would simply add these thoughts. Clustering of deaths does indeed occur in prisons as it does in the community (there has been recent press comment on the number of suicides amongst students at Bristol University, for example), and the reasons are many and complex. However, it is little understood by media commentators (as well, I suspect, by the public) that clustering can occur randomly. Indeed, statistical theory would suggest that clustering is to be expected (this is known as the clustering illusion – a failure to recognise that clusters arising in small samples can be random as well as non-random).

133. Clustering also occurs in families – having a relative who has taken their own life being an acknowledged risk factor for suicide. Again, many factors may be at play but it is likely that one is a reduction in inhibition.

134. Such a reduction in inhibition (sometimes wrongly and unhelpfully described as 'copy cat' behaviour) is also likely to occur in prisons, and it is this that explains the Prison Service's practice of reviewing all live ACCTs automatically if a death occurs. I do not know if any assessment has ever been made of the effectiveness of so doing.

135. Although little discussed, the ethnic, cultural and religious mix of the prison population may also affect the number of acts of self-harm and suicide in a particular gaol. To take one example, both in this country and in the United States black prisoners have significantly lower rates of suicide than white prisoners. All things being equal, a lower incidence of suicide attempts can therefore be anticipated in prisons with higher proportions of black prisoners.[28]

136. I now offer my assessment of the actions taken locally, nationally, and by the Secretary of State.

[28] There is no mention of ethnicity in the risk factors set out in PSI 64/2011, but perhaps it is better considered as a correlate.

(i) Local Actions

137. I have earlier discussed aspects of Woodhill's reception and induction arrangements, the current absence of safer cells and a Listener suite, and praised the positive staff culture (and generally good relationships between staff and prisoners). I am content that reception and first night processes (better thought-of as first week processes) are generally sound, and are designed to provide appropriate care and support for newly arrived prisoners.

138. I am also content that Woodhill's training programme prioritises safer custody training, and that the proportion of prisoner-facing staff who are fully up to date with this training is now more than three-quarters.

139. The Acting Governor's Witness Statement for the Judicial Review also set out a range of 'softer' training and communication events that I do not need to repeat here. The plain fact of the matter is that no one visiting Woodhill at the present time could be under any illusions as to the absolute focus upon the prevention of suicide and self-harm. It seems to me that the challenge is to maintain that focus while at the same time having the confidence to reduce the use of formal ACCT processes to something like the norm for other local prisons.

140. The Deputy Governor chairs a monthly Death in Custody meeting to ensure a regular review of all recommendations made by the PPO and the Coroner. Ms Marfleet's Witness Statement also detailed the management and other quality checks applied to the delivery of ACCT procedures. Again, these are symptomatic of the prison's concentration upon ensuring that the number of deaths experienced in the past few years cannot and will not be repeated.

141. Ms Marfleet referred in her Statement to "a whole prison approach to safety which I have not seen to this extent in any other establishment I have worked in." I would go further. The emphasis upon prisoner safety is one I have not encountered in nearly four decades of visiting, writing about, and overseeing prisons.

142. I now offer my own specific comments on ACCT processes, the use of constant watch, and staff familiarity with emergency codes.

(a) ACCT processes

143. Criticisms of the quality of caremaps, the failure to consider all risk factors when determining a prisoner's risk of suicide and self-harm, the failure to hold multi-disciplinary case reviews with a consistent case manager, and full and accurate completion of ACCT documentation, were features of the internal Safer Custody Review conducted in January 2016.

144. My own observations would be little different. The caremaps seem to focus on everyday needs: transfers, property, healthcare etc. To some degree the ACCT process has taken over from what should be provided routinely (whether under a Personal Officer scheme or otherwise).

145. It is also apparent from my short review of closed ACCT documents that not all paperwork is properly completed, and that most reviews are at best bi-disciplinary.

146. I believe these weaknesses derive very largely from a risk-averse over-reliance upon ACCT. In the first four months of the year, no fewer than 330 ACCT documents had been opened (the figure is for 3 May).

(b) Constant watch

147. I have already observed that I think the levels of constant watch at Woodhill are unsustainable. Half a dozen prisoners on constant watch represents some 18 members of staff per day.

148. Constant watch is used in psychiatric hospitals and in other prisons, but it is acknowledged to be very draining on staff (especially if the prisoner is asleep or uncommunicative, and at night) and potentially demeaning to the prisoner.

149. PSI 64/2011 says:

> "*Constant supervision must only be used at times of acute crisis and for the shortest time possible.* The process of being constantly supervised by a member of staff can be de-humanising which may increase risk."

150. I therefore asked if the Prison Service had figures for the levels of constant watch in other gaols. The figures I was given for 9 March 2017 were as follows:

HMP Manchester	0
HMP Belmarsh	0
HMP Wormwood Scrubs	0
HMP Birmingham	0
HMP Liverpool	2

151. I need say no more about the degree of risk aversion that Woodhill's practice currently represents. I hope that both the overall number of ACCTs and the overall number of observations (including constant watch) can be significantly reduced.

(c) Emergency Codes

152. The Prison Service's policy in respect of Medical Emergency Response Codes is set out in PSI 03/2013. This followed a series of PPO investigation reports (both under my name and those of my two successors) expressing concern that time that was literally vital could be lost if prison staff were unclear as to the procedures to follow in the event of a medical emergency.

153. The PSI allows for local practice to differ, but suggests that Code Red should be used for blood/burns and Code Blue for breathing/collapses. Woodhill employs the recommended nomenclature.

154. The nature of my review means that I cannot provide an authoritative judgement on the extent to which all members of Woodhill staff are familiar with the relevant emergency codes (Code Red and Code Blue). Given the continued recruitment of new staff, and their relative inexperience as a whole, this is an ongoing process.

155. I can say that at the first meeting at Woodhill that I attended on 9 March it was reported that a Code Red had been called inappropriately the night before. According to Annex A of the PSI, Code Red should only be called in the event of a severe loss of blood, not for injuries that are more minor.

156. Accordingly, absolute assurance that PSI 03/2013 (Medical Emergency Response Codes) is fully understood and implemented cannot be given.

(ii) Actions taken nationally

157. I have drawn upon the Witness Statement provided by Mr Richard Vince in respect of the Judicial Review to bring me up to date with developments taken nationally. The Statement draws attention to the internal Safer Custody Review and the Joint Review commissioned in association with the NHS, and to the establishment of the Task Force.

158. The principal aim of the Task Force is to monitor progress against the action plan generated by the two reviews. I have not had the capacity to conduct a review of all the workstreams covered by the Task Force. However, it was clear from the meeting I attended that it has developed its role to take a wider view of the impact of staffing, regime and culture upon the levels of suicide and self-harm.

159. The action plan overseen by the Task Force seems comprehensive and is monitored using standard management processes. The meetings are very well attended, and the minutes and other papers I have seen are of a very high standard.

160. Mr Vince's Statement says that money has also been found to provide training for additional ACCT assessors and the installation of three safer cells, and for related purposes.

161. It draws attention to the national Suicide and Self-Harm Reduction Project, established by the then National Offender Management Service in April 2016. I have not carried out any review of this Project or its many workstreams.

162. However, taken together, I do not see how this can be regarded as other than a robust and focussed approach to the tragedies at Woodhill. But unless or until the staffing situation at the prison is stabilised, the vulnerability to further deaths or 'near misses' will remain.

163. I also observe that ACCT was designed at a time when the number of staff in prisons was significantly higher than it is today, and when the prison population was significantly lower. For example, of the first case review (to be held within 24 hours of the ACCT being opened, and usually immediately after the Assessment Interview), PSI has a mandatory action that the review must:

> "Be attended and chaired by the Residential Manager, or equivalent and/or the Case Manager (if different), the Assessor, whenever possible, a member of staff who knows the prisoner e.g. wing officer, the person who raised the initial concern, healthcare, and any other member of staff who has or will have contact with the at-risk prisoner and who can contribute to their support and care e.g. staff from Probation, Education, CARATS, psychology etc."

164. A genuinely multi-disciplinary review with this number of participants is simply a practical impossibility in Woodhill. I imagine this will apply to the vast majority of prisons.

165. To put it at its mildest, it is not healthy for what is practicable to diverge so wildly from what is described as a mandatory action in a policy document.

(iii) Actions taken by the Secretary of State

166. My terms of reference expressly invite me to consider the actions being taken by the Secretary of State for Justice, but I think I should do so with some caution given that I am submitting my report at the time of a General Election campaign. Nevertheless, I found much to be welcomed in the White Paper, *Prison Safety and Reform*, Cm 9350, published in November 2016, and in the subsequent Prisons and Courts Bill that fell because of the dissolution of Parliament further to the calling of the Election.

167. Given what I have said in this report about the shortage of staff at Woodhill and the pressures this places on those in post, I welcome the emphasis in the White Paper in providing frontline staff with "the time and tools they need to supervise and support offenders" and "boosting staff numbers".

168. I particularly welcome the commitment to "reconsider staffing levels" given the more than 20 per cent reduction in the planned complement of frontline Band 2 to 5 operational staff that took place at Woodhill between March 2012 and March 2016.

169. However, in providing financial incentives to improve recruitment, the Government must be careful not to create financial disincentives to staff seeking promotion. I saw signs of this in Woodhill, with staff openly saying that promotion opportunities would not be pursued if the consequence would be a reduction in take home pay.

170. The White Paper says that the Incentives and Earned Privileges Scheme restricts governors' discretion in recognising positive behaviour (and "has become a punitive measure"). I agree, and am concerned by the numbers of prisoners on basic regime who self-harm or take their own lives. However, the Government may itself wish to think if it could show more radicalism in incentivising prisoners to take part in programmes and activities designed to reduce reoffending. A shorter time in custody would be the greatest single incentive for prisoners to engage constructively, as well as providing a welcome reduction in the size of the prison population as a whole.

171. Having been away from prisons for seven years, perhaps I may also say that I was struck by how little progress had been made to introduce new technology. The reliance on paper forms (the PER, the ACCT, property cards, Woodhill's EDIC booklet, for example) looks increasingly out of step with the world at large. ACCT seems to receive no help from the Prison Service's IT systems. I witnessed the laborious process of entering observations into the ACCT document and then re-keying much of the same information into C-NOMIS. Data entered onto the healthcare database SystmOne also plays no part.

172. At the same time, permitting prisoners greater access to modern technology would also be the best possible preparation for life on the outside, as well as providing new opportunities for in-cell learning.

Conclusions

173. It is not for me to say whether in the past there was a failure at Woodhill to respond to Coronial and PPO recommendations. What I can say is that, as of today, there is a quite remarkable focus upon prisoner safety.

174. However, that has coincided with a culture of risk aversion (influenced both by the number of deaths and the external reaction to them) that itself both places great strain upon ACCT processes and diminishes the wider regime.

175. My review has uncovered continuing weaknesses in ACCT procedures that are unlikely to be overcome until the number of open ACCTs returns to something like the average for prisons with similar populations. This will not happen overnight.

176. It is perhaps in the nature of inquests and investigations that they focus more on systems and processes than on an institution's wider culture and performance. My own view is that safer custody is less a matter of whether ACCT is followed to the letter, and more to do with staff-prisoner relationships, the wider regime, time spent out of cell, and the whole decency agenda.

177. The chapter on ACCT in PSI 64/2011 beginning on page 26 says:

> "Good staff/prisoner relationships are integral to reducing risk. Other factors which are fundamental to reducing risk are regular participation in regime activities, positive family and peer relationships, and referral to appropriate specialist services such as mental health in reach."

178. Likewise, referring to the issue of churn (first receptions and transfers as a proportion of average population), PSI 64/2011 acknowledges that the risk "may be mitigated by increasing time out of cell, access to employment and education and/or increased staff contact."

179. It is in exactly these areas that Woodhill is suffering (as I saw illustrated in the number of regime tasks that were cancelled on the prison's Daily Briefing sheets). The reason it is suffering is because of the mismatch between the numbers of staff in post and what is required to deliver a full regime.

180. There are thus two over-riding lessons from this review that I can address as much to the Secretary of State and to HM Prison and Probation Service nationally, as to the local management at Woodhill.

181. First, I believe that ACCT remains a world-class system. But it does not and perhaps now cannot operate as its authors intended.

182. Second, the combination of reductions in the complement and difficulties of recruitment and retention have resulted in a completely unacceptable situation at Woodhill. These staffing pressures have been allowed to persist for far too long.

183. I have visited many bad, sick or failing prisons in the past. Woodhill is not any of those – far from it. But as of today, it has understandably been defined by its failures – the deaths of 20 men while in its care since 2011. If the staffing position can be remedied, and with a new role, I hope that in time Woodhill may increasingly be defined by its successes.

Stephen Shaw

May 2017

Annex 1: The men who have died

Name	Date of Death	Age	Status	Wing	Length of Time in Custody	ACCT	1st Time in Custody	Time Found	Ethnicity
Jason Basalat	11/12/16	52	Untried	1B	2 days	No	No	08:09	White British
David Rayner	25/08/16	41	Untried	2A	3 days	Yes	Yes	17:03	White British
Daniel Dunkley	02/08/16	35	Sentenced	2A	12 days	Yes	No	14:38	White British
Thomas Morris	26/06/16	31	Sentenced	4A	157 days	Yes	No	00:22	White British
Michael Cameron	28/04/16	45	Untried	1B	9 days	Yes	Yes	08:15	Mixed White/Black
Robert Fenlon	05/03/16	35	Untried	4A	142 days	Yes	No	10:45	White British
Ireneusz Polubinski	31/01/16	58	Convicted unsentenced	4B	26 days	No	Yes	11:43	White Other
Simon Turvey	29/12/15	27	Convicted Unsentenced	4B	180 days	No	Yes	05:44	White British
Edward Latham	27/11/15	38	Sentenced	6A	15yrs 11m	Yes	Not known	05:28	White British
Ian Brown	19/07/15	44	Convicted unsentenced	3B	180 days	No	Yes	13:09	White British
Ryan Harvey	08/05/15	23	Convicted Unsentenced	1B	14 days	Yes	No	22:00	White British
Daniel Byrne	27/02/15	28	Untried	1B	7 days	Yes	No	12:57	White British
Jonathan White	14/10/15	37	Untried	2B	244 days	No	No	07:12	White British
Dwane Harper	04/04/14	32	Sentenced	Seg	231 days	No	No	03:36	White British
Stephen Farrar	12/12/13	25	Untried	2A	69 days	No	No	19:05	White British
Sean Brock	10/11/13	21	Untried	1B	3 days	No	No	10:15	White British
David Hunter	26/05/13	28	Sentenced	1B	2 days	No	No	05:04	Black Caribbean
Kevin Scarlett	22/05/13	30	Untried	5	128 days	Yes	No	13:55	White British
Rimvydas Liorancas	28/01/12	37	Untried	1	9 days	No		08:52	White Other
Martin Walker	27/12/11	33	Sentenced	1B	106 days	No		19:00	White British

Annex 2: Commissioning note

INDEPENDENT PROFESSIONAL ADVICE ON THE PREVENTION OF SELF-INFLICTED DEATHS AND SELF-HARM AT HMP WOODHILL

1. After no self-inflicted deaths at Woodhill in 2010, and one each in 2011 and 2012, there have been four in 2013, two in 2014, five in 2015 and seven in 2016 to date. The number of incidents of self-harm has also increased through this period, from 209 in 2010 to 406 in 2015.

Terms of reference

2. You are commissioned to undertake a focused analysis of the documentation relating to the deaths at Woodhill since 2013, including:
    - the reports of the Prisons and Probation Ombudsman's investigations;
    - the action plans provided by Woodhill to the PPO in response to recommendations made in those reports;
    - the reports to prevent future deaths from the Coroner;
    - the responses from Woodhill to the Coroner in respect of issues raised in those reports;
    - the internal reviews commissioned in early 2016 by the Deputy Director of Custody and jointly by the Governor and healthcare commissioners and providers;

3. You should consider also relevant reports, both about the prison, such as the report of an unannounced inspection by HM Inspectorate of Prisons in September 2015 and the most recent internal audit report, and more generally, such as the Learning Lessons bulletins produced by the Prisons and Probation Ombudsman.

4. Significant action has been taken to address the matters of concern raised in the above reports and reviews and there are additional steps that are planned. These are set out in the action plan that is being overseen by the DDC's taskforce, the DDC's report to the PPO, the statements provided by the Governor and DDC for forthcoming judicial review proceedings, as well as in the recent White Paper on Prison Safety and Reform. With reference to these documents and those references above you are asked, in respect of Woodhill, to:
    - review the level of compliance with Prison Service Instructions 64/2011 Safer Custody, 7/2015 Early Days in Custody and 3/2013 Medical Emergency Response Codes;
    - assess the effectiveness of the steps that have been and are being taken to improve compliance with these PSIs;
    - identify any further steps that could be taken to improve compliance;
    - assess the way in which learning from the recent deaths has been captured, disseminated and acted upon;
    - assess the effectiveness of the action that is being taken to reduce the level of self-inflicted deaths and self-harm; and

- identify any further action that could be taken to prevent self-inflicted deaths and self-harm.

5. You are asked to consider the actions that are being taken at three levels:
   - locally by the Governor and relevant partners and providers of services;
   - by the National Offender Management Service and relevant regional and national partners; and
   - by the Secretary of State for Justice.

Disclosure of documents

6. Any documents disclosed to you by the Secretary of State will be provided in confidence for the purpose of this work and will be subject to redaction where necessary, for example for security reasons or to comply with the Data Protection Act 1998 (DPA) (see paragraphs 7-9 below).

Data Protection Act 1998 (DPA)

7. As part of your work you will have to make substantive decisions about the purposes for and means by which personal data that you have collected is processed. Consequently, you will be a data controller in relation to that personal data and you must register as a data controller if you have not already done so.

8. There will need to be technical and physical security conditions in place to safeguard the security of the data including when it is transferred, stored, used and destroyed.

9. Annex A sets out additional information about the DPA and further information can be found on the Information Commissioner's (ICO) website at http://www.ico.gov.uk/for_organisations/data_protection.aspx

Timetable

10. Please set out your advice in a report that should be submitted to the Secretary of State by 31 May 2017.

Support to the investigation

11. You will be provided with administrative support to assist you with this work.

12. If you have any questions about your commission and terms of reference, please contact me.

[redacted]
Head of Safer Custody & Public Protection Group, Ministry of Justice