Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Thomas Morris a prisoner at HMP Woodhill on 26 June 2016

A report by the Prisons and Probation Ombudsman
Nigel Newcomen CBE

PO Box 70769
London, SE1P 4XY
Email: mail@ppo.gsi.gov.uk
Web: www.ppo.gov.uk
T | 020 7633 4100
F | 020 7633 4141

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*

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 Thomas Morris was found hanged in his cell at HMP Woodhill on 26 June 2016. He was 31 years old. I offer my condolences to Mr Morris' family and friends.

Staff at Woodhill appropriately identified that Mr Morris was at risk of suicide and self-harm at various points during his time in custody, including at the time of his death when it was clear that Mr Morris was struggling with his mental health and vulnerable. I am concerned that staff missed opportunities to offer Mr Morris sufficient support in the days before his death. He readily admitted to frequent and continuing use of New Psychoactive Substances (NPS) before and during his time at Woodhill, despite support from the substance misuse team and receiving punishments for their use. Clearly the prison is taking steps to tackle NPS use but the apparently ready availability of the drugs remains a concern.

Mr Morris was the eleventh apparently self-inflicted death at Woodhill since 2014 and, yet again, I raise concerns about the assessment and management of prisoners' risk of suicide and self-harm at the prison. The Deputy Director of Custody for the High Security Estate has, rightly, set up a task force to review and improve safety at the prison; clearly urgent action is required. I await the update on the work of the task force which I have previously requested.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman **June 2017**

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Summary

Events

1. On 21 January 2016, Mr Morris was remanded to HMP Woodhill charged with several offences, including theft and burglary. He had a history of drug and alcohol use, was diagnosed with depression and behavioural problems and was taking antidepressants. Mr Morris was moved to the prison's drug rehabilitation unit and was prescribed methadone. In February, he was sentenced to 78 weeks imprisonment.

2. Mr Morris sought mental health support but then missed appointments for a mental health assessment. He was finally assessed on 16 March and the mental health team concluded that he could be managed by the primary care team.

3. Between February and April, Mr Morris received behaviour warnings for a series of relatively low level instances of rule breaking. He was also suspected of and acknowledged frequently using illicit drugs including New Psychoactive Substances (NPS). In line with the local substance misuse policy, he was placed on basic regime with reduced privileges. His substance misuse worker tried to engage him in preventative work, but Mr Morris often failed to complete the work set.

4. On 19 April, Mr Morris told his substance misuse worker that he had suicidal thoughts, so she began Prison Service suicide and self-harm prevention procedures (known as ACCT). Staff ended ACCT procedures the next day.

5. On 15 May, Mr Morris tried to hang himself and staff began ACCT procedures again. He displayed high levels of paranoia and said that he could feel things crawling under his skin. He was assessed by a psychiatrist, who did not diagnose a serious mental illness. On 15 June, staff ended ACCT procedures.

6. On 19 June, Mr Morris threw his television over the unit landing because he said it was sending him messages. He was paranoid about other prisoners and staff thinking, despite reassurances, that he was at risk and he asked to move units. Staff moved him to a single cell on House Unit 4A but did not consider that he needed monitoring under ACCT procedures. On 21 June, a prison chaplain became concerned about Mr Morris' demeanour and staff began ACCT monitoring. At an ACCT review on 22 June, Mr Morris said he was in physical pain because of things crawling beneath his skin. The staff at the ACCT review assessed Mr Morris as at a raised risk of suicide and self-harm, with checks to be carried out once an hour.

7. At about 12.20am on 26 June, an officer found Mr Morris hanged with a sheet tied around his neck and to the window bars. Staff began resuscitation and called an ambulance. Paramedics continued resuscitation but at about 1.30am, concluded that Mr Morris had died.

Findings

8. Mr Morris went into prison with complex needs – a dual diagnosis of substance misuse and mental health issues, compounded by low level challenging behaviour. We found evidence of good practice from both mental health and substance misuse services which offered Mr Morris appropriate support. However, although Mr Morris acknowledged the harmful effects of illicit drugs on his mental health, he continued to use them. Woodhill has clearly taken steps to devise a local substance misuse policy and the substance misuse team is engaged in tackling the problem. However, the ready availability of illicit drugs at the prison remains problematic and supply and demand must be tackled effectively.

9. Mr Morris was subject to ACCT suicide and self-harm prevention procedures at the time of his death and we identified some weaknesses in the management of those procedures. Mr Morris' mental health and behaviour deteriorated suddenly and he was clearly vulnerable and troubled. He was new to the house unit, in a single cell on basic regime. We consider that he should have been subject to more frequent checks. While we acknowledge that this might not have prevented him from taking his life, it would have offered him more support. We are also concerned that staff did not effectively identify actions to support him.

10. After Mr Morris died, some prisoners said that staff had goaded or bullied him the night before his death. We spoke to as many of the identified prisoners and staff as we could about the allegations, but did not discover any concrete evidence that staff had acted inappropriately in the days before his death.

Recommendations

- The Governor should ensure that prison staff manage prisoners at risk of suicide or self-harm in line with national guidelines, including:
    - setting levels of observations which are appropriately adjusted as the perceived risk changes, and that these checks are irregular to prevent the prisoner anticipating when they will occur;
    - setting caremap actions which are specific and meaningful, aimed at reducing prisoners' risks and are actively followed up.

- The Governor should ensure there is an effective and well implemented substance misuse strategy to help reduce the availability and demand for new psychoactive substances**.**

The Investigation Process

11. 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. One prisoner made contact by letter.

12. NHS England commissioned a clinical reviewer to review Mr Morris' clinical care at the prison.

13. The investigator visited Woodhill on 4 July 2016. She obtained copies of relevant extracts from Mr Morris' prison and medical records. She later interviewed 14 members of staff, three prisoners and one former prisoner.

14. We informed HM Coroner for Milton Keynes of the investigation and have sent him a copy of this report. The post-mortem and toxicology reports were not available at the time the report was published.

15. One of the Ombudsman's family liaison officers contacted Mr Morris' father to explain the investigation. Mr Morris' father was concerned about the length of time his son remained on the lowest level of privileges and the appropriateness of his location within the prison. He said staff and prisoners had raised concerns about his son's mental health, including in a petition signed by prisoners after his death, and he asked for these issues to be addressed as part of the investigation. The legal representative acting for Mr Morris' family suggested the names of potential witnesses and provided copies of letters between Mr Morris' father and Woodhill, and Mr Morris and his father for information.

16. Mr Morris' family received a copy of the initial report. They raised a number of issues that do not impact on the factual accuracy of this report and have been addressed through separate correspondence.

Background Information

HMP Woodhill

17. HMP Woodhill is both a local prison and a high security prison. It can hold more than 800 men. Central and North West London NHS Foundation Trust provide all health services at the prison. Westminster Drug Project provides drug and alcohol support services.

HM Inspectorate of Prisons

18. The most recent inspection of HMP Woodhill was in September 2015. Inspectors found that staffing levels were better than they often found elsewhere in the prison estate, although the prison was heavily reliant on officers drafted in from other prisons and new recruits. Mental health services had been hit by staff shortages and waits to see the mental health team were too long.

19. Inspectors were very concerned about the high number of self-inflicted deaths (at that time there had been nine since 2012) and felt there was not a sufficiently whole-prison approach to understanding and addressing the contributory and preventative factors in prisoners' overall experience. Inspectors found the quality of ACCT documentation was inconsistent, often failing to address underlying causes. Caremaps were not always updated and failed to include all steps to address underlying issues. Inspectors recommended that the prison review the effectiveness of the drug strategy to ensure all relevant departments work together to reduce the availability of drugs and including New Psychoactive Substances (NPS).

Independent Monitoring Board

20. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its annual report for the year ending May 2015, the IMB commented that the stability of the prison was fragile and severe staff shortages remained a concern. They felt the loss of experienced staff would impact on the mentoring and support of new staff joining the prison. The IMB said that more staff training was needed to improve the management of ACCT monitoring procedures. They commented that the prison had all but abandoned the personal officer scheme and that this meant the loss of an early opportunity to identify prisoners who may be at risk of suicide or self-harm.

Previous deaths at HMP Woodhill

21. Mr Morris' was the eleventh self-inflicted death at Woodhill since the start of 2014. Since Mr Morris' death, three more prisoners have apparently taken their own lives and there is continued considerable concern within the National Offender Management Service, who have instructed the Deputy Director of Custody to set up a task force to review and improve safety at the prison, and from the Coroner about the number of deaths at Woodhill. In November 2016, the High Court gave the families of prisoners who took

their lives at Woodhill permission to pursue a claim against the prison Governor and the Secretary of State for failing to reduce the suicide rate at the prison.

22. In many of our investigations since 2014, including this one, we have criticised aspects of the prison's management of ACCT procedures. In an investigation report which we shared with the National Offender Management Service in June 2016 and which we published in September, we asked the Deputy Director of Custody to assure himself that the prison had effectively implemented all of the recommendations made by the Prisons and Probation Ombudsman in the last five years and provide a report within three months. We are still waiting for the report.

Assessment, Care in Custody and Teamwork

23. 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.

24. 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 multidisciplinary review meetings involving the prisoner. As part of the process, a caremap (plan of care, support and intervention) is put in place. The ACCT plan should not be closed until all the actions of the caremap have been completed.

25. 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

New Psychoactive Substances (NPS)

26. New psychoactive substances, previously known as 'legal highs' are an increasing problem across the prison estate. They are difficult to detect and can affect people in a number of ways including increasing heart rate, raising blood pressure, reducing blood supply to the heart and vomiting. Prisoners under the influence of NPS can present with marked levels of disinhibition, heightened energy levels, a high tolerance of pain and a potential for violence. Besides emerging evidence of such dangers to physical health, there is potential for precipitating or exacerbating the deterioration of mental health with links to suicide or self-harm.

27. In July 2015, we published a Learning Lessons Bulletin about the use of NPS and its dangers, including its close association with debt, bullying and violence. The bulletin identified the need for better awareness among staff and prisoners of the dangers of NPS; the need for more effective drug supply reduction strategies; better monitoring by drug treatment services; and effective violence reduction strategies.

28. NOMS now has in place provisions that enable prisoners to be tested for specified non-controlled psychoactive substances as part of established mandatory drugs testing arrangements. Testing has begun, and NOMS continue to analyse data about drug use in prison to ensure new versions of NPS are included in the testing process.

Incentives and Earned Privileges (IEP) scheme

29. Each prison has an Incentives and Earned Privileges scheme which aims to encourage and reward responsible behaviour, encourage sentenced prisoners to engage in activities designed to reduce the risk of re-offending 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 to wear their own clothes. There are four levels, entry, basic, standard and enhanced.

Key Events

30. On 21 January 2016, Mr Morris was remanded to HMP Woodhill charged with a number of offences including theft, burglary and failing to meet the requirements of previous sentences. He had been in prison before and had last been released from Woodhill in July 2015. On reception, he was assessed as withdrawing from drugs and alcohol. He said he had depression and was taking antidepressants, but said he had no thoughts of suicide or self-harm. A prison doctor prescribed mirtazapine (an antidepressant) and a nine day course of chlordiazepoxide medication to treat his alcohol withdrawal symptoms.

31. On 22 January, the substance misuse specialist GP noted that Mr Morris had severe withdrawal symptoms and had tested positive for opiates, cocaine and benzodiazepines. Mr Morris told her that he had used Spice (a new psychoactive substance) in the last 28 days and that he had suffered a seizure from alcohol withdrawal the previous week. Mr Morris said that he had a history of mental health problems and a diagnosis of behavioural disorder, as well as low mood and anxiety. He said he had no thoughts of suicide or self-harm. She prescribed methadone (an opiate substitute) and vitamins in addition to the medication that had been prescribed the night before. Mr Morris was moved to House Unit 2A, the drug rehabilitation unit. On 25 January, Mr Morris was also prescribed quetiapine (an antipsychotic medication) after his community GP surgery confirmed his prescription.

32. On 25 January, a mental health nurse had a brief conversation with Mr Morris on the unit. She recorded in Mr Morris' medical record that he had mental and behavioural disorders due to drug misuse. At Mr Morris' request, she arranged to carry out an initial mental health assessment on 4 February. Mr Morris subsequently missed two appointments with her on 4 and 11 February.

33. On 29 January, the NOMIS electronic prisoner record system records that Mr Morris told an officer that he felt suicidal at times and asked to be referred to the mental health team. An officer spoke to Mr Morris who said that he just wanted a smoker's pack and an appointment with mental health. The officer did not consider in the circumstances that Mr Morris needed the support of suicide and self-harm monitoring arrangements (known as ACCT). It is not clear whether the officer referred Mr Morris to the mental health team.

34. On 4 February, the substance misuse support team began to slowly reduce Mr Morris' dose of methadone (known as detoxification). Mr Morris told his substance misuse worker that he was committed to changing his drug using behaviour. On 29 February, Mr Morris was sentenced to 78 weeks imprisonment.

35. In February and March, Mr Morris received three warnings under the Incentives and Earned Privileges scheme (IEP) for low level rule breaking. On 13 March, after one of the warnings, a nurse referred Mr Morris to the mental health team for assessment because he expressed paranoid

thoughts about other prisoners – he said he had problems with other prisoners at work, then said this was all in his head.

36. On 16 March, a worker from the mental health team assessed Mr Morris. Mr Morris said that he was experiencing paranoia and anxiety and she advised him to engage in education and employment and gave him some information on anxiety. On 18 March, the mental health multidisciplinary team meeting (attended by substance misuse and mental health staff) discussed Mr Morris and concluded that there was no obvious role for the mental health team at the time.

37. On 30 March, Mr Morris stole two packets of biscuits from the prison kitchen. The next day, he pleaded guilty at a disciplinary hearing. The manager who chaired the hearing suspended Mr Morris' punishment for three months.

38. Mr Morris' father sent an undated letter to the prison expressing concerns about his son's mental health. On 18 April, a manager replied that Mr Morris was being supported and making use of the services available to him.

39. On 19 April, Mr Morris told his substance misuse worker that he had thoughts of suicide and she immediately began ACCT procedures. She wrote that Mr Morris seemed paranoid and his behaviour was strange. He said he felt numb and sometimes did not know if things were real. Mr Morris also told her that he had attempted suicide in the community in December 2015. He said that he had been using Spice heavily since arriving at Woodhill. At this time, Mr Morris was on 25ml per day of methadone, reducing by 1ml daily. She told us that Mr Morris often said that he wanted to tackle his drug use and understood that it had a detrimental effect on his mental health but then did not engage with the work she tried to complete with him.

40. Later that day, an officer assessed Mr Morris as part of ACCT procedures. Mr Morris told the officer that he knew some of his feelings were because he was withdrawing from illicit drugs. He said that he had no intention of ending his life, although it had crossed his mind, and he said he felt isolated. The officer recommended that ACCT monitoring should remain in place until he was more stable.

41. On 20 April, a prison manager chaired the first ACCT review with Mr Morris and a worker from the substance misuse service. The group decided to end ACCT monitoring because they did not think it was the best way to support Mr Morris. She recorded on the ACCT caremap that they would refer Mr Morris for a mental health assessment and that he would be allocated a personal officer, who he had a good rapport with. She recorded that Mr Morris was happy with the outcome and he was particularly pleased that a specific officer was to be his personal officer. There is no evidence that the specific action of a mental health referral was made as a result of this ACCT review.

42. The officer told the investigator that he was never told that he had been appointed as Mr Morris' personal officer, and that he normally worked on

House Unit 2B (a standard unit) while Mr Morris was on 2A. He said that he did not undertake any personal officer work with Mr Morris.

43. On 22 April, a worker from the substance misuse team assessed Mr Morris after officers reported that he might have used an illicit substance. She recorded no concerns about Mr Morris but suggested that staff check him every 15 minutes. Later, Mr Morris told the substance misuse specialist GP that he had used Spice. In accordance with the prison's new psychoactive substances (NPS) policy, staff downgraded Mr Morris from standard to basic level under the IEP scheme, which meant he lost some privileges such as having a television in his cell and the chance to mix with other prisoners during periods of unlock. The next day, officers suspected Mr Morris of being under the influence of Spice again and checked him every 15 minutes. In line with the local policy, healthcare staff withheld his methadone for three days to reduce the risk of an accidental overdose.

44. On 25 April, Mr Morris told his substance misuse worker that he had been using Spice again. She said that Mr Morris had attended a group for prisoners using Spice that she had referred him to, and continued to say that he wanted to address his illicit drug use. After their meeting, she wrote to the mental health team to raise her concerns about Mr Morris' mental health and asked if the mental health team could assess him on the house unit if he failed to attend his appointments. Although the mental health nurse told the investigator that prisoners can be seen on their house unit if they fail to attend mental health appointments, there is no evidence that this happened after Mr Morris missed his appointment on 26 April.

45. On 1 and 2 May, Mr Morris received two further IEP warnings for having a television hidden in his cell while on basic regime. He received another two warnings on 15 May for being disrespectful to staff. He had been on basic regime for some three weeks, but staff concluded that he should remain on basic regime for a further seven days.

46. Later on 15 May, another prisoner saw Mr Morris attempting to hang himself from the window bars in his cell and intervened. Mr Morris refused to let healthcare staff assess him, but staff recorded that he had ligature marks around his neck. Staff began ACCT monitoring and moved Mr Morris to a shared cell and checked him once an hour. During the initial assessment, Mr Morris said that he was fed up with being on basic regime and that he did not believe his medication was working. He said that he was very anxious because he could feel things crawling in his head, and had constant headaches and night terrors.

47. At the ACCT review on 16 May, a Supervising Officer (SO), a nurse and a practitioner from the substance misuse team assessed Mr Morris' risk of suicide or self-harm as low and recorded on the ACCT caremap that he should see a psychiatrist and work towards a return to standard regime. Later that day, a GP examined Mr Morris, who complained of numerous ailments including generalised pain and feeling that things were crawling under his skin. The GP prescribed amitriptyline (another antidepressant) as well as the mirtazapine he was already prescribed.

48. On 22 May, Mr Morris was upgraded from basic to standard regime.

49. On 27 May, Mr Morris' father wrote again to the prison because he had learnt that Mr Morris had attempted suicide. He asked for information about his son's current condition. Mr Morris' father received two replies from the prison – one from the Business Hub and the other from the deputy mental health lead. In both replies, staff said that they did not have Mr Morris' consent to disclose information to his father. They wrote that Mr Morris' healthcare needs were being met and that he was engaging positively with healthcare services. There is no record that anyone from the healthcare department discussed with Mr Morris that his father had written and was worried, or sought Mr Morris' consent to give his father more information. Phone calls between Mr Morris and his father suggest that Mr Morris was keen for his father to speak to healthcare staff about his mental health treatment.

50. On 2 June, a prison psychiatrist assessed Mr Morris after staff raised concerns. She concluded that Mr Morris was suffering from anxiety due to harmful substance misuse, and that he had underlying personality difficulties. She reviewed his medication and stopped his prescription for quetiapine at his request, and suggested he attend a managing emotions group. He was placed on the group's waiting list.

51. On 4 June, a nurse suspected that Mr Morris had taken Spice and again withheld his medication for clinical reasons. The substance misuse worker saw Mr Morris and was again concerned about his paranoia and general mental health. She went to talk to mental health staff who said that Mr Morris had been assessed by the psychiatrist and would be referred to the managing emotions group.

52. On 15 June, a SO chaired an ACCT review with a substance misuse worker and Mr Morris. In advance of the review, the SO had asked that someone from the mental health team attend. On 8 June, a worker from the substance misuse team emailed that Mr Morris had been seen by a psychiatrist and was not being managed by the mental health team. She wrote that primary healthcare colleagues should attend Mr Morris' ACCT reviews instead. Mr Morris had not made any further suicide attempts and had not self-harmed so the group assessed his risk as low and ended ACCT monitoring. A post-closure review was arranged for 21 June. Although there had been seven case reviews since 16 May, no one had made any further entries in his caremap and the actions set by a previous SO had been completed.

53. Also on 15 June, Mr Morris' application for release on Home Detention Curfew was refused. It is not clear how this information was relayed to Mr Morris.

54. Mr Morris received another IEP warning for attempting to hide his medication in his mouth on 18 June.

55. On 19 June, Mr Morris threw his television over the landing, narrowly missing some prisoners playing pool below. He said that the television had

been giving him messages and he expressed what staff regarded as paranoid thoughts. A SO told the investigator that, after Mr Morris threw his television, he asked several times to be moved from House Unit 2A as he was paranoid about what prisoners and staff thought of him and his actions. She said that she, a senior prison manager and a manager spoke to Mr Morris and agreed that a move to another wing would give him a fresh start and help reduce his anxieties. The managers considered that Mr Morris should not share a cell because of his erratic behaviour. She said that this was intended to be a short-term arrangement, to be reviewed after a month. Mr Morris was moved to a single cell on House Unit 4A. Although his ACCT was in the post-closure phase, staff did not reopen it because Mr Morris said that he had no intention of harming himself. He was downgraded to the basic regime for throwing his television.

56. On 21 June, Mr Morris spoke to a chaplain in the chapel. Another prisoner was also present and Mr Morris told them there was something inside him trying to break out. The chaplain described Mr Morris as disturbed and tearful. The other prisoner, who knew Mr Morris before coming into prison, said that he was worried that Mr Morris' mental state was deteriorating. The chaplain said that he had talked to Mr Morris on several occasions and knew he tended to be anxious and paranoid, but was more concerned when he realised that Mr Morris had moved from the supportive environment of House Unit 2A to House Unit 4A.

57. As a result, the chaplain wrote to wing staff on House Units 2A and 4A and also filed an intelligence report outlining his concerns about Mr Morris' state of mind. He asked staff to monitor Mr Morris more closely because he was worried he might attempt suicide again. As a result of his concerns, staff began ACCT monitoring again. At the ACCT assessment interview, Mr Morris said that he was in physical pain because there was something under his skin and a constant droning in his head. He repeated that there was something that needed to come out of his body and said that this made him want to harm himself. He said that he did not want to die but that he needed medical help. Mr Morris remained on House Unit 4A in a single cell, where staff checked him once an hour, pending the first ACCT review.

58. On 22 June, a SO, a nurse and Mr Morris met for the first ACCT review. Before the review, the nurse from the mental health team spoke to Mr Morris. The SO told the investigator that the nurse could not come to the review, but they discussed Mr Morris and the nurse suggested that the SO refer Mr Morris for a mental health assessment and to the managing emotions group. The nurse no longer works at Woodhill but the investigator spoke to him by phone. He could not remember speaking to Mr Morris.

59. In the review, Mr Morris again said that he could see things moving under his skin and that he was in pain. He said that he had made numerous ligatures, as recently as 19 June, but that he did not want to die. He said he needed medical help and said that he was depressed and paranoid. A nurse (who is a qualified mental health nurse but is employed as a general nurse at Woodhill) said that, in her opinion, Mr Morris was delusional as a result of a mental health problem. She said that her primary concern was

about what he might do to release the things he believed were under his skin. The review assessed Mr Morris as at a raised risk of suicide and self-harm but left the frequency of staff checks unchanged at one an hour. A SO wrote in the caremap that Mr Morris should work with the mental health team and complete the managing emotions group work. There is no evidence that the staff referred Mr Morris to the mental health team, although he was due to see the prison psychologist on 27 June. Mr Morris was still in a single cell and on basic regime, so the SO gave him a radio.

60. On 23 June, a prison GP reviewed Mr Morris' substance misuse treatment plan and discussed how Mr Morris could complete his opiate detoxification. He did not discuss Mr Morris' Spice use. At this point he was receiving four millilitres of methadone a day. On 25 June, Mr Morris refused his afternoon medication, stating that he did not want or need them. None of the healthcare staff who saw him recorded any particular concerns about his mental health or risk to self.

61. On the evening of 25 June, an officer started her night shift on house unit 4A. She checked Mr Morris at 8.35pm, 9.35pm, 10.30pm and 11.30pm. At 11.30pm, she recorded in the ACCT plan that she had spoken to Mr Morris and he said he was okay.

62. At about 12.20am on 26 June, the officer checked Mr Morris and saw him sitting in the corner of the cell with a ligature made from a bed sheet tied around his neck and to the cell window bars. She tried to get a response from Mr Morris and immediately radioed a code blue (the emergency code which indicates that a prisoner is unconscious, not breathing, or is having difficulty breathing). The prison incident log recorded that she radioed the code blue at 12.22am. Two officers reached Mr Morris' cell almost immediately and the three officers went into Mr Morris' cell. They cut the ligature from around Mr Morris' neck and began resuscitation. Healthcare staff arrived at the cell shortly after.

63. Staff in the prison control room tried to call an ambulance but due to a fault with the external phone lines, could not do so. Eventually, they radioed the police and asked them to call an ambulance, which resulted in a delay of about nine minutes. The paramedics arrived at approximately 12:40am and continued the resuscitation attempt. At 1.28am, a prison GP concluded that Mr Morris had died.

64. A number of cards and poems were found in Mr Morris cell after his death. Mr Morris expressed paranoia in his writing saying, amongst other things, that everyone hated him. He said that he was going to a better place and asked his parents for forgiveness.

Prisoners concerns after Mr Morris' death

65. After Mr Morris' death, a number of prisoners on House Unit 2A signed a petition expressing concerns about Mr Morris' treatment. They were concerned that staff had moved him from House Unit 2A, where he was well supported, to a unit where he did not know anyone and was more isolated. They felt his death could have been prevented. The prisoner who started

the petition told the investigator that prisoners thought staff should have moved Mr Morris to the healthcare inpatient unit for appropriate support and observation.

66. Another prisoner told Mr Morris' family that officers had goaded Mr Morris through his cell door the night before his death. The investigator spoke to a prisoner, who was in the neighbouring cell at the time, and he said that he did not hear anything of concern that evening. The investigator was unable to trace the prisoner who had said that he had heard staff goading Mr Morris. However, a prisoner on House Unit 4A made a complaint to the Ombudsman alleging that he had been bullied and goaded by prison staff. He mentioned Mr Morris' death within his complaint and so the investigator interviewed him. He was concerned about bullying by a particular officer on House Unit 4A. The officer was on duty on the night before Mr Morris died and the investigator interviewed him. He could not recall having had any specific interaction with Mr Morris during his time on House Unit 4A and denied that he had been goading Mr Morris.

67. Mr Morris' family said that after Mr Morris' death another prisoner had assaulted an officer by spraying them with a mixture of faeces and urine. The family were told that the prisoner did this because he felt that the officer was in some way responsible for Mr Morris' death. The investigator interviewed an officer, the only member of staff who had been assaulted in this way in the wake of Mr Morris' death. He told the investigator that he had not had any interaction with Mr Morris. He said that he believed he was assaulted by the prisoner in relation to a separate incident which had nothing to do with Mr Morris' death.

Contact with Mr Morris' family

68. At about 9.00am on 26 June, a prison manager and an officer visited the home of Mr Morris' mother to break the news of Mr Morris' death. The prison contributed to the cost of Mr Morris' funeral, in line with Prison Service Instructions.

Support for prisoners and staff

69. After Mr Morris' death, a senior 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.

70. The prison posted notices informing other prisoners of Mr Morris' death, and offering support. Staff reviewed all prisoners assessed as at risk of suicide and self-harm, in case they had been adversely affected by Mr Morris' death.

Post-mortem report

71. The post-mortem gave the cause of Mr Morris' death as ligature suspension. Toxicological examinations found Mr Morris' prescribed medications in his body, but no synthetic cannabinoids or other illicit drugs.

Findings

Management of risk of suicide and self-harm

72. In the six months Mr Morris spent at Woodhill, prison staff assessed him as at risk of suicide and self-harm three times and monitored him under ACCT procedures, including at the time of his death. Prison Service Instruction (PSI) 64/2011, which covers safer custody, sets out some of the risks and triggers for suicide and self-harm, including a diagnosis of mental illness, substance misuse history, a history of suicide attempts and feeling desperate. At Woodhill, Mr Morris had a history of unpredictable and impulsive behaviour. He had received a number of IEP warnings and had been subject to basic regime several times; he had used illicit drugs including NPS while in prison and had expressed paranoid and delusional thoughts.

73. On 19 June, Mr Morris' behaviour and mental health became a cause for greater concern after he threw his television over the landing on House Unit 2A, where he had lived for some months. Staff on that unit told us that Mr Morris was popular with staff and other prisoners despite his occasionally challenging behaviour and that he was well supported there. However, they said that after throwing his television, he repeatedly asked to move units because he was worried other prisoners would be angry with him. We agree that the decision to move Mr Morris to House Unit 4A was reasonable, given his requests and anxiety. While Mr Morris had not expressed any thoughts of suicide or self-harm, we consider that it might have been prudent for staff to have begun ACCT procedures that day as his behaviour was out of the ordinary and he was moving to a unit where he did not have the level of support he was used to. However, staff did begin ACCT procedures on 21 June, after a chaplain raised concerns about Mr Morris' vulnerability.

74. A SO chaired the first ACCT review on 21 June, with a nurse. It is clear that Mr Morris' primary concern related to his perception that things were crawling beneath his skin, which indicated a deterioration in his mental health. We consider the mental health treatment he received at Woodhill in the next section. The staff said that they thought Mr Morris was at a raised, rather than high risk of suicide, and were concerned that he might self-harm to try to rid himself of the things under his skin. Although they recognised his raised risk, staff were only required to check Mr Morris once an hour – a low frequency of observations for someone who was so clearly vulnerable, was struggling to cope and who said he had made a number of ligatures in recent days. It is also a low frequency of observations for someone on basic regime and in a single cell, with only a radio to distract them, and new to the unit. The timing of the staff checks was predictable to the point that Mr Morris was, in all probability, able to anticipate when staff would next check him.

75. PSI 64/2011 instructs that ACCT caremaps should reflect the prisoner's needs, level of risk and the triggers for distress and that there should be detailed time-bound actions aimed at reducing the risk posed by the prisoner. Caremaps should be reviewed and updated at each case and the ACCT plan should not be

closed until caremap actions are completed. We have some concerns about the adequacy of Mr Morris' caremaps.

76. On 20 April, a SO identified that Mr Morris would benefit from having a named personal officer and recorded this on the caremap. However, it seems the officer in question was not informed and he carried out no personal officer work with Mr Morris. Because the review group ended ACCT monitoring that day, and there was no post-closure review, no one checked that the action had been completed. ACCT monitoring began for the second time on 15 May and remained open for a month. Although reviews were held at appropriate intervals, there was no input from the mental health team despite concerns about his mental health and no new caremap actions were added after 16 May, despite there being clear actions that might have helped Mr Morris. On 21 June, a SO's two caremap entries related to Mr Morris' contact with the mental health team. He did not identify any actions to help Mr Morris move back to standard regime, or to support him on an unfamiliar new unit.

77. While staff had recognised Mr Morris was troubled and vulnerable, and had taken some steps to support him, we conclude that, had they considered his risk holistically, they might have been better able to support him. Woodhill have experienced a high number of self-inflicted deaths since 2014 and the Deputy Director of Custody has set up a task force to address failings in how the prison assesses and manages prisoners at risk of suicide and self-harm. We have made a number of recommendations about the management of ACCT procedures at Woodhill since 2014, and it is disappointing to identify failures in how Mr Morris was managed. We make the following recommendation:

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

- **setting levels of observations which are appropriately adjusted as the perceived risk changes, and that these checks are irregular to prevent the prisoner anticipating when they will occur;**
- **setting caremap actions which are specific and meaningful, aimed at reducing prisoners' risks and are actively followed up.**

Mental healthcare

78. The clinical reviewer reviewed the clinical care that Mr Morris received at Woodhill. He concluded that Mr Morris was assessed a number of times by mental health practitioners, including a psychiatrist, and received appropriate mental healthcare. He was prescribed mental health medication, but mental health specialists generally agreed that Mr Morris could be managed by the primary care team rather than the mental health team.

79. Mental health specialists recorded and told us that they considered that the root of Mr Morris' mental health problems was his ongoing use of illicit drugs, including Spice. Mr Morris was working closely with his named substance misuse worker, but often failed to engage in the work she gave him. At the time of Mr Morris' death, there was no dual diagnosis policy for managing prisoners with substance misuse and mental health needs. However, we are aware that a

dual diagnosis policy subsequently came into effect in October 2016 and we therefore make no recommendation in relation to this finding.

Substance misuse

80. Mr Morris had a history of illicit substance use and lived on the prison's drug rehabilitation wing, House Unit 2A, for most of this sentence. Shortly after he arrived at Woodhill, Mr Morris began a methadone detoxification programme, which he had almost completed at the time of his death. As noted earlier, Mr Morris received a good level of support from his substance misuse worker. Although he said he was committed and eager to address his substance misuse, he clearly struggled to do so.

81. On several occasions, staff suspected that Mr Morris had taken illicit drugs, particularly NPS, and followed the local NPS policy correctly on each occasion. Mr Morris' substance misuse worker had referred him to and he had attended a prisoner group work session on NPS at Woodhill and he knew that they had a detrimental affect on his mental health. In Mr Morris' case, the prison approached his illicit drug use with a punitive approach (in line with the local policy) whilst offering continued support and interventions through the substance misuse team. While we are satisfied that the prison has taken some steps to address illicit drug use, we are concerned that Mr Morris' self-admitted heavy use of NPS indicates that the prison is not yet effectively managing supply and demand, and we make the following recommendation:

The Governor should ensure there is an effective and well implemented substance misuse strategy to help reduce the availability and demand for new psychoactive substances.

Alleged bullying by staff

82. After Mr Morris died, his family were told that he had been goaded by prison staff the night before he died. They were also told that a prisoner assaulted a member of staff with faeces and urine, allegedly in retaliation for Mr Morris' death. While we were able to interview some prisoners and officers in relation to these incidents, we have been unable to substantiate the allegation that Mr Morris' was bullied or goaded by staff.

Prisons & Probation Ombudsman
Independent Investigations

PO Box 70769
London, SE1P 4XY

Email: mail@ppo.gsi.gov.uk
Web: www.ppo.gov.uk

T | 020 7633 4100
F | 020 7633 4141