

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr William Clark, a prisoner at HMP Wormwood Scrubs, on 27 December 2024

A report by the Prisons and Probation Ombudsman

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

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

T | 020 7633 4100

OUR VISION

To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.

WHAT WE DO



WHAT WE VALUE



© Crown copyright, 2026

This report is licensed under the terms of the Open Government Licence v3.0. To view this licence, visit nationalarchives.gov.uk/doc/open-government-licence/version/3

Where we have identified any third-party copyright information you will need to obtain permission from the copyright holders concerned.

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.

If my office is to best assist His Majesty's Prison and Probation Service (HMPPS) in ensuring the standard of care received by those within service remit is appropriate, our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.

Mr William Clark died of multidrug toxicity on 27 December 2024 at HMP Wormwood Scrubs. He was 57 years old. I offer my condolences to Mr Clark's family and friends.

Seven medications Mr Clark was not prescribed were found in his system. Senior leaders acknowledge the illicit drug economy problems at the prison. However, more needs to be done to tackle prescription medication being traded and diverted as well as ensuring that the prison has sufficient resources to effectively tackle drug supply and demand.

Mr Clark was sentenced in 2006 to a sentence of imprisonment for public protection (IPP). This investigation found that there are no policies in place at Wormwood Scrubs to support those with an IPP sentence. I am concerned that the prison is failing to reflect HMPPS' directions on the IPP sentence and the work that should be done to support these prisoners. Mr Clark could also have been better supported with a dedicated key worker.

There was also a significant and unacceptable delay in radioing an emergency code and starting CPR when staff found Mr Clark unresponsive.

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

Adrian Usher
Prisons and Probation Ombudsman

February 2026

Contents

Summary	1
The Investigation Process.....	4
Background Information.....	5
Key Events.....	8
Findings	17

Summary

Events

1. In 2006, Mr William Clark was sentenced to imprisonment for public protection (IPP), with a tariff of 5 years and 18 days. He was released in September 2017 and recalled to prison in March 2018. He was re-released in May 2021. In February 2022, Mr Clark was recalled to prison and taken to Wormwood Scrubs having been charged with his partner's murder. This charge was subsequently dropped in September.
2. Staff assessed Mr Clark as a risk to himself when he arrived at prison and started Prison Service suicide and self-harm support measures, known as ACCT. They closed these the following month. In June 2022, Mr Clark tested positive for cocaine and benzodiazepines. The following month, Mr Clark told staff he used non-prescribed medication and drugs. Staff referred him to the drug and alcohol service but he later declined to work with them.
3. Between April 2022 and February 2023, staff submitted intelligence reports indicating that Mr Clark might be involved in the supply of drugs in the prison.
4. Mr Clark's parole hearing was arranged for 6 March 2024. Mr Clark's community offender manager (COM) initially agreed to attend, and then two days later, requested an adjournment which was granted. Mr Clark declined to engage with his prison offender manager following this.
5. In March 2024, staff suspected Mr Clark to be under the influence of unknown substances three times. They also suspected him to be involved in supplying illicit drugs within the prison and receiving medication from another prisoner. In April, he tested positive for benzodiazepines and cannabinoids. Healthcare staff did not inform prison staff of the result.
6. At the beginning of June, Mr Clark said he had suicidal thoughts. Staff opened an ACCT but closed it the next day. Mr Clark was reviewed by substance use services on 11 June and engaged in four sessions with them between June and December. On 13 June, Mr Clark attended his parole hearing. He was informed on 27 June that the parole board had not directed his release.
7. Between June and December, staff noted that Mr Clark was a polite prisoner who followed the regime, collected his medication, attended weekly bible studies, and caused no issues.
8. On 27 December at 3.03pm, an officer went to Mr Clark's cell to unlock him to collect his medication but he was unresponsive. She went to tell the wing manager who told them to find another officer and return to the cell. They did so and radioed an emergency code four minutes after they had first found Mr Clark. Healthcare staff arrived shortly after and began CPR. Paramedics arrived at 3.17pm and pronounced Mr Clark's life extinct at 3.37pm.

Findings

9. Mr Clark died of multidrug toxicity, having been found with seven medications in his system that had not been prescribed to him and three that were. This included methadone at a potentially fatal level. We cannot say whether Mr Clark deliberately took these drugs to end his life but we have found no evidence that staff should have assessed him as a risk to himself when he died. However, we have highlighted some issues with the management of the ACCT which was briefly opened in June 2024.
10. It is impossible to determine how Mr Clark obtained the drugs which were not prescribed to him. However, the trading and diversion of medication at Wormwood Scrubs is not sufficiently managed or monitored. We have previously raised concerns that the Head of Drug Strategy is not sufficiently supported to effectively tackle drug use and we remain concerned that this is the case.
11. Since Mr Clark's death, we are pleased to note that staff are now encouraged to talk to every prisoner about the risks associated with taking non-prescribed medication. There have also been improvements in staff reporting and recording when they suspect a prisoner to be under the influence.
12. Wormwood Scrubs does not have a policy for the management of IPP prisoners, nor are IPP prisoners reflected in the safety strategy in line with national guidance. IPP prisoners are also not a priority group for key working as they should be and Mr Clark had only two sessions during his time at Wormwood Scrubs.
13. There was a delay of four minutes before staff radioed an emergency code when they found Mr Clark unresponsive and a further almost two minutes before they started CPR.
14. The clinical reviewer concluded that the healthcare provided to Mr Clark was mainly equivalent to that which would have been provided in the community. They shared our concerns about the management of medication queues and made some recommendations not related to Mr Clark's death that the Head of Healthcare will wish to consider.

Recommendations

- The Governor and Head of Healthcare should ensure there is dedicated officer oversight of medication queues. This should include a joint quality assurance process for monitoring medication queues and undertaking regular medication queue spot checks.
- The Prison Group Director should ensure that the Head of Drug Strategy is sufficiently supported to effectively tackle drug use.
- The Governor should ensure there is a robust IPP policy that reflects the HMPPS Action Plan for IPP prisoners. This should also be reflected in the safety strategy, to reflect HMPPS' Safety Policy Framework.

- The Governor should ensure IPP prisoners are a priority cohort for key working with a consistent, dedicated key worker with whom they can build a meaningful relationship.
- The Governor should satisfy herself through the implementation of a robust quality assurance process that staff are aware of their responsibilities during a medical emergency, including immediately calling the correct medical response code, entering the cell at the earliest possible opportunity, and beginning CPR without delay.

The Investigation Process

15. HMPPS notified us of Mr Clark's death on 27 December 2024.
 16. The initial investigator issued notices to staff and prisoners at HMP Wormwood Scrubs informing them of the investigation and asking anyone with relevant information to contact him. No one responded. The investigator obtained copies of relevant extracts from Mr Clark's prison and medical records.
 17. The investigator interviewed nine members of staff via Microsoft Teams between February and March 2025.
 18. In May 2025, once we had received the cause of death, the investigation was re-allocated to another. The investigator interviewed eight members of staff at Wormwood Scrubs and two members of staff via Microsoft Teams in July 2025.
 19. NHS England commissioned an independent clinical reviewer to review Mr Clark's clinical care at the prison. She attended all healthcare interviews and some interviews with prison staff.
 20. We informed HM Coroner for London West of the investigation. The Coroner gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.
 21. The Ombudsman's office contacted Mr Clark's sister to explain the investigation and to ask if she had any matters she wanted us to consider. She asked:
 - What medication Mr Clark was prescribed, whether he had this in his possession and how had he got the medication that was not prescribed to him?
 - Why did he not attend an ECG appointment that had been arranged for the day he died?
 - Whether sufficient consideration was given to Mr Clark's mental state by prison and healthcare staff, given he was an IPP prisoner?
- These questions are answered in this report and the clinical review.
22. Mr Clark's sister received a copy of the draft report. They did not make any comments.
 23. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies and their action plan is annexed to this report.

Background Information

HMP Wormwood Scrubs

24. HMP Wormwood Scrubs is a local male prison which accepts sentenced and remand prisoners over the age of 21 as well as young adults (18-21 years old) on remand only. Practice Plus Group (PPG) provides primary health care services. Barnet, Enfield and Haringey NHS Mental Health Trust provides mental health services. Forward Trust provides substance use services.

HM Inspectorate of Prisons

25. The most recent unannounced inspection of HMP Wormwood Scrubs was in June 2025. Inspectors reported a decline in the overall safety of the prison. They reported that over a third of prisoners were testing positive for illicit drugs, searching of staff and prisoners was not sufficiently thorough, and staff were not routinely wearing or activating body-worn video cameras during incidents. They also expressed concern that the time a prisoner spent out of cell was poor, with key work being deprioritised.

Independent Monitoring Board

26. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to May 2024, the IMB expressed concerns about the availability of illicit substances in the prison which significantly affected the safety, health and wellbeing of prisoners. They also reported that the key worker scheme had never been fully implemented, with pressures on resources being cited by leaders as the key cause.
27. The IMB also noted that staff were inconsistent in wearing body worn video cameras.

Previous deaths at HMP Wormwood Scrubs

28. Mr Clark was the twelfth prisoner to die at Wormwood Scrubs since December 2021. Of the previous deaths, three were self-inflicted, six were due to natural causes, one was drug related, and one the cause of which was not ascertained. There were no similarities between the findings in our investigation into Mr Clark's death and previous investigations. Up to the end of October 2025, there had been two further deaths: one due to natural causes and one self-inflicted.

Imprisonment for Public Protection (IPP) sentences

29. Imprisonment for Public Protection (IPP) sentences were introduced in 2005 and abolished in 2012. They were intended to protect the public against offenders whose crimes were not serious enough to merit a normal life sentence, but who could only be released once they had served their minimum tariff and had demonstrated to the satisfaction of the Parole Board that they had sufficiently reduced their risk. The abolition was not applied retrospectively. As of March 2025,

there are about 2,500 IPP prisoners, of which around 1,000 are beyond their tariff but have never been released.

30. In September 2022, the Justice Select Committee (JSC) published a report of its review of IPP sentences. The JSC found that the indefinite nature of the sentence contributed to feelings of hopelessness and despair that had resulted in high levels of self-harm and some suicides within the IPP population. They recommended that all IPP prisoners be re-sentenced.
31. In February 2023, the Government announced that it would not re-sentence IPP prisoners. In response to the JSC report, the Ministry of Justice (MOJ) and HMPPS published a new IPP action plan in April 2023. The aim of the plan is to focus on ensuring that HMPPS processes support IPP prisoners to “maximise their prospects of achieving a safe and sustainable release”.
32. In September 2023, we issued a Learning Lessons Bulletin on the self-inflicted deaths of IPP prisoners after 2022 saw the highest number of these deaths since the sentence was introduced. We concluded that an IPP sentence should be considered as a potential risk factor for suicide and self-harm. We also identified a number of risk triggers associated with IPP prisoners including parole hearings, prison transfers and change in security categorisation.
33. HMPPS published an annual review of the IPP action plan in November 2024. They announced the restructure of the IPP action plan to place a greater emphasis on front line delivery and change. New workstreams contained within the plan include staff development and awareness equipping front-line staff with the knowledge and tools to manage cases and support those serving IPP sentences, delivering robust oversight of safety practice to reduce the likelihood of self-harm, self-inflicted death and violence, and ensuring that appropriate policies and processes are in place to enable staff to deliver effective front-line management of cases.

The Key Worker Scheme

34. The key worker scheme was introduced in the men’s prison estate in 2018. It provides prisoners with an allocated officer that they can meet regularly to discuss how they are and any day-to-day issues they would like to address. Improving safety is a key aim of the scheme. All adult male prisoners should have around 45 minutes of key work each week, including a meaningful conversation with their allocated officer.
35. In recent years, due to exceptional staffing and capacity pressures in parts of the estate, some prisons are delivering adapted versions of the key work scheme while they work towards full implementation. Any adaptations, and steps being taken to increase delivery, should be set out in the prison’s overarching Regime Progression Plan which is agreed locally by Prison Group Directors and Executive Directors and updated in line with resource availability.

Controlled Drugs

36. Controlled substances, commonly referred to as controlled drugs, require strict legal controls. This is because they may cause serious problems like dependence and

harm if not used properly. Controlled substances are defined in the Use of Drugs Act 1971. They include methadone, pregabalin, and codeine.

37. In prisons, these medications should never be held in a prisoner's possession. They are highly addictive and must be administered according to national clinical guidelines.

The Parole Board

38. A prisoner can apply to the Parole Board for release from prison and/or a move to a different category prison. They can only apply for release from prison if they have served the minimum tariff on their sentence. Reports will be produced by the prisoner's prison offender manager, community offender manager, and any other involved professional as requested by the Parole Board to assist their decision making. A prisoner may also be assessed by a psychologist for a Parole Risk Assessment.

Key Events

Background

39. In 2006, Mr William Clark was sentenced to Imprisonment for Public Protection (IPP) for armed robbery. He had a tariff (minimum time he would spend in prison) of five years and 18 days. Mr Clark was released on licence in September 2017 and recalled in March 2018 following a further arrest for burglary. In September 2018, he was sentenced to two years and six months imprisonment. Mr Clark was released again in May 2021. In February 2022, he was arrested for the alleged murder of his partner and remanded to prison. Mr Clark had a long history of substance use. He was also prescribed pain relief for fibromyalgia (a chronic condition causing pain and fatigue) and abdominal pain. Mr Clark also had a history of depression for which he was prescribed antidepressants.

HMP Wormwood Scrubs

2022

40. On 19 February, Mr Clark was taken to HMP Wormwood Scrubs. Staff started Prison Service suicide and self-harm procedures, known as ACCT. Mr Clark appeared distraught and low in mood due to the death of his partner and his subsequent arrest for her murder.
41. Dr A, GP, reviewed Mr Clark in reception. Mr Clark disclosed regular use of crack cocaine and buprenorphine (used to treat opioid use) in the community. He tested positive for crack cocaine, opiates and buprenorphine. Dr A prescribed Mr Clark methadone to lessen his withdrawal symptoms, mirtazapine (an antidepressant) and a reducing dose of pregabalin (pain relief). The GP also referred him to Forward Trust (drug and alcohol service).
42. On 20 February, staff referred Mr Clark to the mental health team. The next day, mental health staff assessed him and decided that in-reach mental health services were not appropriate for Mr Clark and discharged him.
43. On 23 February, Forward Trust staff assessed Mr Clark who denied any drug or alcohol issues and declined involvement with them. Mr Clark told a substance use nurse that he did not want to continue methadone and felt he could manage his condition with co-codamol (pain relief medication). Dr A agreed and prescribed co-codamol. On 9 March, staff closed Mr Clark's ACCT.
44. Between 2 March and 22 June, Dr A and Professor A, Consultant Psychiatrist and Addiction Medicine Specialist, monitored Mr Clark's pregabalin prescription. They agreed that Mr Clark did not fit the National Institute for Health and Care Excellence (NICE) guidelines for pregabalin prescribing in prisons and should start reducing his prescription. On 22 June, Professor A began reducing Mr Clark's pregabalin. Mr Clark was no longer prescribed pregabalin after August 2022.

45. On 29 June, an officer completed Mr Clark's first key working session. He expressed frustration at being recalled to custody but was keeping busy with his wing job.
46. On 30 June, staff received the result of an earlier mandatory drugs test (taken on 14 June) which was positive for cocaine and benzodiazepines (sedatives). Mr Clark attended a disciplinary hearing and received a loss of privileges.
47. On 1 July, Mr Clark told a substance use nurse he was using non-prescribed medication and substances on the wing. He asked for support from Forward Trust. The nurse referred Mr Clark to Forward Trust the same day. Forward Trust met Mr Clark on 6 July and he confirmed he would like to engage with them. Forward Trust did not see Mr Clark again until 8 September when he stopped a Forward Trust recovery worker and told them that he did not have issues with drugs and alcohol and did not need their support.
48. On 4 August, during a key working session, Mr Clark told an officer that he had found it difficult returning to prison and this was why he had tested positive for drugs. On 27 September, the police confirmed that the murder charge had resulted in no further action. However, because Mr Clark had been sentenced to IPP, the Parole Board needed to direct his release, so he remained in prison.
49. On 22 November, Ms A, probation officer, was allocated as Mr Clark's Prison Offender Manager (POM). She sent a letter to Mr Clark on 25 November outlining her role and arranging a meeting with him in December. Ms A attempted to conduct an appointment with Mr Clark in person on 16 December but he refused to engage.
50. On 20 January 2023, Ms A met Mr Clark for the first time and they agreed to have monthly appointments.

2023

51. Between April 2022 and February 2023, staff submitted intelligence reports indicating that Mr Clark might be involved in the supply of drugs in the prison. Mr Clark had received payments from family members of other prisoners, and one family member contacted the prison to advise them that Mr Clark was supplying drugs on the wing. Wing managers were advised to monitor prisoner relationships. The drug detection dogs also indicated that confidential legal mail addressed to Mr Clark might be contaminated with an illicit substance.
52. On 5 February 2023, staff submitted an intelligence report that Mr Clark appeared under the influence of alcohol.
53. On 24 March, Ms A met Mr Clark who was initially resistant to engaging and described feeling disillusioned with 'the system'. However, they discussed his sentence plan objectives and agreed to find a way to work together. Mr Clark engaged in further appointments with Ms A on 21 April, 4 May and 26 June. Ms A regularly sent letters to Mr Clark updating him on the status of his parole hearing and sending relevant information to him.
54. In July, Ms A contacted several prisons asking them to accept Mr Clark as a transfer so that he could engage in accredited offending behaviour programmes, as

they were not available at Wormwood Scrubs. Mr Clark did not fit the criteria for two of these prisons and required further assessment at others.

55. On 21 September, Dr B, GP, sent a task to the mental health team requesting them to see Mr Clark. There was no additional information available regarding this referral or evidence that it was actioned.
56. On 12 October, Ms B, community offender manager (COM), visited Mr Clark at Wormwood Scrubs. Mr Clark declined to see Ms B.
57. On 1 November, Dr C, GP, completed a mood review with Mr Clark. Mr Clark expressed feeling lethargic, low in mood, with a poor appetite, and struggling with bereavement. Mr Clark denied thoughts of suicide or self-harm. The same day, Ms C, probation officer, was allocated as Mr Clark's new COM.
58. On 30 November, Reverend A, prison chaplain, recorded that Mr Clark was very low in mood, and was dispirited by his IPP status. There is no record that Reverend A took any action following this contact.

2024

59. On 9 January 2024, Ms A sent a message to Mr Clark advising him that she was going on planned long term leave. She informed him that his case may be re-allocated and advised him how to contact the probation department if necessary. She also informed Mr Clark that he had been allocated a new COM.
60. A parole hearing was arranged for 12 March 2024. On 8 March, Ms C contacted the Parole Board to request an adjournment. Ms C had been on long term leave and did not feel she had sufficient time to prepare for a parole hearing nor to contact Mr Clark. The hearing was adjourned until 12 June.
61. On 16 March, healthcare staff raised concerns with prison staff that Mr Clark was hanging around the medication hatch throughout the day as he was friends with the healthcare representatives (prisoners assigned to assist healthcare staff to encourage prisoner attendance at medical appointments and to collect medication). They requested that prison staff stop Mr Clark from spending time near the medication hatch. There is no evidence that any action was taken following this concern and it was not recorded in his prison record, only in probation records.
62. On 19 March, Mr A, probation officer, was allocated as Mr Clark's POM. He visited Mr Clark the same day. Mr Clark expressed his upset at being in prison on recall and wanted to get 'justice'. He agreed to see Mr A again. (Mr A attempted to see Mr Clark again on 29 April, 31 May, and 7 June. Mr Clark declined to engage with Mr A on each occasion, stating he felt too unwell to engage.)
63. On 20 March, Officer A noted on Mr Clark's prison record that he sometimes appeared under the influence and that this had been noted by several members of staff on different occasions. Officer A did not submit an intelligence report. He told the investigator during interview that he had witnessed Mr Clark under the influence on several occasions, primarily leading up to and following his parole hearing.

64. Later that day, Officer B suspected Mr Clark was under the influence while he was delivering evening meals, as he could not read the menu or find correct meals on trays. She returned him to his cell but did not report this to healthcare staff or submit an intelligence report.
65. On 22 March, Officer C suspected Mr Clark was under the influence in the evening. He returned him to his cell. He did not report this to healthcare staff or submit an intelligence report.
66. On 24 March, staff radioed a code blue (an emergency code indicating a prisoner had either stopped or was having difficulty breathing) as Mr Clark appeared under the influence of psychoactive substances (PS). There are limited notes about this incident. Mr Clark went to hospital and returned to Wormwood Scrubs on 26 March. The escorting officer informed healthcare staff that Mr Clark had discharged himself as the hospital had refused to give him opiate based medication.
67. On 26 March, Reverend A spoke to Mr Clark about his mood and behaviour. Mr Clark told Reverend A that the adjourned parole hearing had affected his morale and the pressure associated with being an IPP prisoner.
68. On 3 March and 22 April, staff submitted intelligence reports suggesting that Mr Clark was involved in supplying illicit drugs in the prison. There was limited information within these reports. Staff submitted another intelligence report in April that another prisoner was giving his medication to Mr Clark and that Mr Clark's mental health had deteriorated.
69. On 11 April, Mr Clark had a videolink appointment with Ms C. He said that he was waiting to work with Forward Trust and had been accessing support for his grief through the chaplaincy department.
70. On 23 April, Ms D, recovery worker, visited Mr Clark. Mr Clark told her that he wanted to engage with Forward Trust. Ms D sent a task to Forward Trust.
71. On 24 April, Dr C completed a mood review with Mr Clark. He diagnosed Mr Clark with Post Traumatic Stress Disorder (PTSD – symptoms can include nightmares, flashback and increased anxiety or irritability) and prescribed him paroxetine (used to treat depression and anxiety). He stopped Mr Clark's prescription for mirtazapine.
72. On 26 April, Mr Clark tested positive for benzodiazepines and cannabinoids following a healthcare initiated test. There is no record that prison staff were made aware of this or any further action was taken.
73. Between 12 April and 9 May, Ms E, trainee forensic psychologist, attempted to engage with Mr Clark on eight occasions to complete an addendum psychological risk assessment directed by the parole board. Ms E described Mr Clark as hesitant to engage, and Mr Clark repeatedly told Ms E he felt too unwell to proceed with the session. Mr Clark had not recently told anyone else he felt unwell.
74. On 20 May, Mr Clark attended a videolink appointment with Ms F, Forward Trust prison link worker. Mr Clark refused to speak to Ms F and sat in silence during the call.

75. On 24 May, Ms G, humanist chaplain, spoke with Mr Clark. He reported feeling frustrated with being an IPP prisoner. Ms G noted that he seemed better presented than during previous contacts.
76. On 6 June, Ms C visited Mr Clark in his cell. Ms C asked Mr Clark why he had been unwilling to see her or Mr A, and he replied that he had been unwell and remained so. Mr Clark said that he had not been feeling great following his recall and the death of his partner and would like some counselling. He also explained that he was choosing to remain in his cell as there had been suspicions of him using PS and he had lost his job for no reason. Mr Clark told Ms C that he might not attend his parole hearing and that 'maybe they [the Parole Board] will come to my cell and see me hung up'.
77. Ms C started ACCT procedures for Mr Clark with checks set at once per hour. Ms C arranged to see Mr Clark again on Monday 10 June. Ms C recorded her contact with Mr Clark on the digital probation system. These notes were not recorded on the digital prison system. There is no evidence that Ms C met Mr Clark on 10 June.
78. On 7 June, Supervising Officer (SO) A chaired Mr Clark's ACCT review, also attended by Nurse A from safer custody and Mr Clark. He denied any thoughts of suicide, stating that his probation officer did not know him and took his comments the wrong way. He expressed frustration at being an IPP prisoner. They discussed Mr Clark's upcoming parole hearing on 13 June, and he said he was feeling hopeful. SO A agreed to speak with the housing team and to follow up an application for employment, and Nurse A agreed to chase referrals to Forward Trust and mental health. Mr Clark ended the meeting by stating he had never considered taking his own life. They agreed to close the ACCT as Mr Clark had no thoughts of suicide. Nurse A noted in her records that there were no notes in Mr Clark's prison record regarding Ms C's concerns and the handwritten concern form was hard to read, so they were unaware of the specific comments made by Mr Clark. A chaplain checked in with Mr Clark following the ACCT review. Mr Clark stated he was not in the mood for a long chat and raised no issues.
79. On 8 June, Nurse A referred Mr Clark to Forward Trust and noted that Mr Clark was on a waiting list to be reviewed by psychology. On 10 June, she requested a mood review for Mr Clark as he did not feel his medication was effective.
80. On 11 June, Ms H, recovery worker, completed Mr Clark's Forward Trust assessment. They discussed poly drug use, tolerance, and overdose. Mr Clark was accepted for support and allocated to Ms I, recovery worker, on 21 June. Ms I attempted to engage with Mr Clark on six occasions between 1 July and 19 December. Mr Clark engaged in four of these sessions, and they discussed harm minimisation, relapse prevention, poly drug use, and PS use. Ms I told the investigator that Mr Clark disclosed his main issue related to drugs was crack cocaine. Ms I did not recall discussing the trading of medication with Mr Clark.
81. Mr Clark attended his parole hearing on 13 June. On 27 June, Mr A gave Mr Clark the parole decision letter in his cell. The panel had not directed his release and were not recommending his transfer to open conditions. The panel concluded that Mr Clark had outstanding core risk reduction work to complete, and there was a chance he would abscond. Mr A attempted to discuss the decision with Mr Clark but he told him to leave the cell and said he did not want to work with Mr A. Mr A

informed wing staff of the interaction who agreed to check Mr Clark twice a day and begin ACCT procedures if necessary. There are no records of these agreed additional checks.

82. On 2 July, Dr C completed a mood review with Mr Clark. Mr Clark said he continued to struggle with sleep, lack of energy, poor appetite, and feeling low. Dr C increased his medication and planned to review him in three to four weeks.
83. On 16 July, Officer D recorded that Mr Clark had not looked under the influence recently and seemed to be in a better place. However, she also noted that he associated with prisoners who were known to use drugs.
84. On 22 August, Mr Clark attended the Lifer/IPP forum, chaired by Ms J, Head of Offender Management Unit (OMU). Mr Clark explained that he had not received any information regarding the Parole Board's decision and did not want to engage with anyone. Mr Clark did not attend the forum again.
85. On 4 November, Mr Clark attended the psychology group for managing emotions. He attended four subsequent sessions in November and December. Following completion, staff referred him to the anxiety and depression group.
86. On 5 November, Mr A attempted to give Mr Clark a letter from the Parole Board. Mr Clark declined to engage with Mr A, telling him that he did not want to work with him and would be getting a new solicitor to gain his release.
87. Between 4 June and 24 December, prison staff made 22 general entries in Mr Clark's digital prison record. Within these, they described Mr Clark as a polite prisoner who followed the regime, collected his medication, attended weekly bible studies, and caused no issues or concerns. In five entries, staff noted that he associated with a few other prisoners on the landing without issue. There were no records indicating that Mr Clark was suspected of being under the influence during this period.
88. During interview, Officer A told the investigator that Mr Clark regularly attended church and that this was his support network. He explained that he frequently witnessed Mr Clark under the influence, and this was primarily leading up to his parole hearing, including the adjourned hearing, and following receipt of the Parole Board's decision not to direct his release. Officer A believed Mr Clark was depressed and anxious. Officer A considered referring Mr Clark for mental health support but felt that he was engaging with church activities and this was his support. Officer A said he would have referred Mr Clark for mental health support or started ACCT procedures if he had stopped engaging with the church.
89. During interview, Reverend A told us that Mr Clark had a good relationship with chaplaincy staff. Mr Clark was a devout Christian and regularly attended church, bible studies, and church activities. Reverend A had witnessed Mr Clark under the influence and expressed his concern to Mr Clark about this but did not submit any intelligence reports.
90. Mr Clark did not have any visits during his time at Wormwood Scrubs and only made one telephone call, lasting 35 seconds on 15 December.

27 December 2024

91. The investigator obtained copies of relevant extracts from Mr Clark's prison and medical records, CCTV footage, recordings of staff radio communications from 27 December and records held by the London Ambulance Service. The following account has been taken from all sources.
92. Staff unlocked Mr Clark's cell door at 8.32am. Mr Clark went in and out of his cell, speaking to prisoners on the wing. At 9.20am, Mr Clark went into his cell and did not come out again. At 9.28am, another prisoner passed Mr Clark a drink at his door and an officer locked the cell door. At 10.08am, a prisoner went to speak to an officer and returned to Mr Clark's cell with the officer. The officer looked into the cell briefly and moved on. Between 10.14am and 10.27am, three prisoners went to Mr Clark's cell door which remained locked. It is unclear if the prisoners got a response from Mr Clark. The prison was unable to identify who these prisoners were so we have not interviewed them.
93. At 11.15am, Officer E took Mr Clark his lunch in his cell. Officer E told the investigator that Mr Clark was on his bed and pointed at the officer to put the food on the bed which he did and left the cell and locked it. Officer E did a routine check of all prisoners and, at 11.31am, got to Mr Clark's cell. He spent a minute banging on Mr Clark's door, looking through the cell observation panel, and looking around the wing. He told the investigator that, despite his prolonged time at Mr Clark's cell door, Mr Clark was laying on his bed. He said he asked Mr Clark if he was okay and Mr Clark said, "yes". The officer then moved on to continue the check of the remaining cells on the landing. At 11.33am, Officer E returned to Mr Clark's cell with Officer A. Officer E asked Officer A to check on Mr Clark as Mr Clark was on his bed and, although he had responded, Officer E did not know Mr Clark and wanted someone who knew Mr Clark to check he was okay. Officer A looked into the cell through the observation panel and called to Mr Clark who he said responded verbally that he was okay. Both officers left the landing ten seconds later.
94. At 3.03pm, Officer F unlocked Mr Clark's cell and told him to collect his medication. She entered the cell and saw Mr Clark leant over the bed with his knees on the floor. She asked him if he was collecting his medication and he did not respond. Officer F touched Mr Clark and his arm moved. She told us she did not think he was dead, but she knew something was wrong. She left the cell and the landing at 3.04pm. She did not call a code blue or use her radio to call for staff assistance.
95. Officer F went to SO B's office on the wing. Officer F told the investigator that she told SO B that Mr Clark, "did not look right". SO B told the investigator that Officer F told her that she had not got a response from Mr Clark. SO B told Officer F to find Officer A and return to Mr Clark's cell.
96. At 3.06pm, Officer F and Officer A entered Mr Clark's cell. Officer A called to Mr Clark who did not respond. He touched Mr Clark's neck which was cold. At 3.07pm, Officer A radioed a code blue and SO B entered the cell seven seconds later. Officer A and SO B laid Mr Clark on the floor and put him in the recovery position. Healthcare staff arrived one minute and 39 seconds later, and further healthcare staff arrived with the emergency medical bag shortly afterwards. Nurse B told Officer A to start CPR while healthcare staff inserted an airway and attached the defibrillator. At 3.11pm, officers carried Mr Clark out of the cell onto the landing so

they had more room to treat him. Officers and healthcare staff continued CPR. At 3.17pm, paramedics arrived and pronounced Mr Clark's life extinct at 3.37pm.

Contact with Mr Clark's family

97. The prison appointed Custodial Manager (CM) A as the family liaison officer. At 7.25pm, CM A and Mr B, Deputy Governor, arrived at the address listed for Mr Clark's sister, his next of kin. Mr Clark's sister was not at the address, but his mother and aunt were present. Mr B decided that, due to the time elapsed since Mr Clark's death and the possibility of family members finding out about Mr Clark's death indirectly, they would inform Mr Clark's mother and aunt. They did this and got Mr Clark's sister's contact details. They arrived at Mr Clark's sister's address at 8.30pm and broke the news of Mr Clark's death and offered their condolences.
98. The prison contributed to Mr Clark's funeral costs in line with national instructions.

Support for prisoners and staff

99. Postvention is a joint HMPPS and Samaritans initiative that aims to ensure a consistent approach to providing staff and prisoner support following all deaths in custody. Postvention procedures should be initiated immediately after every self-inflicted death and on a case-by-case basis after all other types of death. Key elements of postvention care include a hot debrief for staff involved in the emergency response and engaging Listeners (prisoners trained by the Samaritans to provide confidential peer-support) to identify prisoners most affected by the death.
100. After Mr Clark's death, Mr C, Deputy Head of Safety, 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.
101. The investigator has reviewed notes from the hot debrief, conducted at approximately 4.00pm. These state that staff were informed of support services on offer, including the care team, and line management support. Officer A did not recall attending a debrief and did not feel he had been offered adequate support following Mr Clark's death. However, the written record of the debrief states that Officer A was present. Officer E also expressed concern that he had not been offered support, particularly given he had only been in the job for three months.
102. The prison posted notices informing other prisoners of Mr Clark's death and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Clark's death.

Post-mortem report

103. The pathologist concluded that Mr Clark died of multidrug toxicity.
104. The toxicology report detected the presence of methadone within the range encountered in fatalities. Olanzapine (an antipsychotic), mirtazapine (an antidepressant), dihydrocodeine (an opioid painkiller), quetiapine (an antipsychotic), gabapentin (used to treat seizures) and sertraline (an antidepressant) were also in

Mr Clark's system either at a therapeutic level or higher than therapeutic level. None of these medications were prescribed to Mr Clark. The toxicology report also detected paracetamol, codeine, and paroxetine, which were prescribed to Mr Clark.

Findings

Drug Use

105. Drugs are an issue across all prisons, and we acknowledge the huge challenges in reducing supply and demand. Mr Clark's toxicology report showed that he had seven different medications in his system that were not prescribed to him. Two of these are controlled substances (methadone and gabapentin) that are strictly regulated in prison and are never given to prisoners in their own possession. This means that prisoners prescribed these medications must take them in front of healthcare staff who conduct a brief mouth check to confirm the tablet has been swallowed. In addition, methadone is only available in liquid form. It has a specific dispensing process undertaken by two pharmacy staff who watch the prisoner drink the methadone and ensure that they drink 200ml of water afterwards.
106. It is impossible to determine with any certainty how Mr Clark acquired these medications. It is particularly difficult to understand how he had methadone in his system at a level potentially associated with fatalities when he was not prescribed the drug and it is only given in liquid form. Mr Clark may have obtained these medications from other prisoners to whom they were prescribed or they may have been illicitly brought into the prison.

Trading and Diversion of Medication

107. Mr D, Head of Healthcare, and Ms K, Head of Drug Strategy and Healthcare Partnership told us that there are known issues with the monitoring of medication hatches on the wings. Mr D and Ms K said that there should always be a prison officer monitoring the medication hatch queue to ensure that prisoners are not diverting and trading their medication. However, SO B, Officer A, and Officer F all told us that there was not always someone available to monitor the medication queue.
108. Ms K has tried to tackle this issue by conducting briefings with staff about the importance of monitoring medication queues, inviting residential managers and custodial managers to drug strategy meetings, and conducting spot checks on medication queues to see if they were being monitored. Ms K said that since she has increased communication around the risk of medication diversion, there has been an increase in associated intelligence reports. She accepted that more needs to be done to tackle this issue.
109. Mr D told us that healthcare staff do weekly random spot checks on prisoners' in possession medication by going to their cells and asking to see their medication. If staff do a spot check and there is a discrepancy, staff re-assess whether the prisoner should have their medication in their possession.
110. We recognise that the Head of Drug Strategy and Head of Healthcare are aware of the issue of medication diversion and trading, and particularly the issue of monitoring medication hatches. We are also satisfied that they are working together to identify solutions. However, Mr Clark had multiple controlled drugs and high-level medications in his system which caused his death. The clinical reviewer noted that they were unclear if the situation had been resolved or whether there was now a

more effective process for monitoring medication queues in place. Immediate action needs to be taken to prevent further instances of such significant misuse of prescription medication. We recommend:

The Governor and Head of Healthcare should ensure there is dedicated officer oversight of medication queues. This should include a joint quality assurance process for monitoring medication queues and undertaking regular medication queue spot checks.

Supply and Demand Reduction at Wormwood Scrubs

111. Ms K told the investigator that the Governor takes a whole prison approach to drug strategy, bringing in several initiatives, primarily with a focus on harm minimisation and building recovery. They have moved the incentivised substance free living (ISFL) wing to create a separate ISFL community-based wing, with a separate head of function and dedicated staff. Ms K has also tried to increase awareness and reporting of those found under the influence, to improve how they are assessing those moving to the ISFL and improving how they are completing drug use surveys for prisoners.
112. Ms L, Head of Security, has also taken steps to tackle drug ingress at Wormwood Scrubs. Actions include increasing perimeter patrols, liaison with local police to increase external patrols and checks, having a dedicated phone line to the police for drone incursions, and changing the processing of incoming legal mail. While Wormwood Scrubs does have Enhanced Gate Security (EGS - advanced measures used to strengthen the control of entry into the prison, such as X-ray scanners and metal detectors), this remains limited by staff resource. Ms L also regularly trains staff around security and sends out a monthly security brief bulletin.
113. We are satisfied that Ms K and Ms L are sufficiently sighted on the ingress of illicit drugs into Wormwood Scrubs and are taking appropriate steps to try to reduce drug supply.
114. In June 2024, we expressed concern that drug strategy was not the sole function of the Head of Drug Strategy at Wormwood Scrubs and that there was a lack of dedicated support for drug strategy. We recommended that the Governor should ensure that the Head of Drug Strategy was sufficiently supported to effectively tackle drug use. HMPPS responded in August 2025, indicating that a regional drug strategy lead had been appointed by the prison and they had introduced a regional drug strategy meeting to improve networking and sharing of intelligence and best practice.
115. We are concerned that Ms K still has insufficient dedicated support to effectively undertake new initiatives and to tackle evolving threats. Ms K is responsible for managing the provision of healthcare, drug recovery wings, and the development and implementation of the local drug strategy. She has operational staff overseeing the management of the drug recovery wings, however she has no staff allocated to support managing provision of healthcare or the development and implementation of the local drug strategy. We therefore escalate our recommendation:

The Prison Group Director should ensure that the Head of Drug Strategy is sufficiently supported to effectively tackle drug use.

Substance misuse support

116. On arrival at Wormwood Scrubs in February 2022, Mr Clark disclosed his drug use in the community. On 1 July, Mr Clark also told a substance use nurse that he had been using non-prescribed medication and substances. There are five further entries on Mr Clark's digital prison record relating to his use of drugs, including three entries in March 2024 when he was suspected to be under the influence and once in July when he was taken to hospital. Aside from one entry, staff did not record what they suspected Mr Clark to be under the influence of.
117. Mr Clark was seen by Forward Trust for initial review or assessment seven times. On some occasions, he denied any drug or alcohol issues and declined to engage with them. On other occasions, Mr Clark agreed to work with Forward Trust, but staff took no further action. On 21 June, Mr Clark was allocated a recovery worker, Ms I, and engaged in four sessions. During these sessions, they did not discuss misuse of prescription medication.
118. We are satisfied that Mr Clark was appropriately referred to Forward Trust on several occasions. Working with Forward Trust is voluntary, and Mr Clark could not be forced to engage. However, not speaking to Mr Clark about the misuse of prescription medication was a missed opportunity. Ms I told us that since Mr Clark's death, staff are encouraged to talk to every prisoner they engage with about trading medication. We therefore make no recommendation.

Under the influence policy

119. During interview, Officer A and Reverend A told the investigator about instances where they witnessed Mr Clark under the influence. At the time, neither had informed healthcare staff or submitted an intelligence report. Officer F also told us that it is common for prisoners to be under the influence of drugs on the wings.
120. The lack of sharing of information, and particularly of submitting intelligence reports or referring to healthcare staff, make it difficult for staff, and particularly senior leaders, to have an accurate overview of drug use at Wormwood Scrubs.
121. Ms K recognised that there was an issue of under-reporting of those under the influence. Ms K has taken action to tackle this, including working with the Forward Trust Service Manager, presenting at all-staff briefings, and sharing leaflets and weekly bulletins around building recovery, supporting those with addiction and what staff should do when someone is under the influence. Ms K told us that the reporting of prisoners being under the influence has since increased, as have referrals to Forward Trust and the submission of intelligence reports. We therefore make no recommendation.

Assessment and Management of Suicide and Self Harm

122. At the time of Mr Clark's death, Prison Service Instruction (PSI) 64/2011, governed staff responsibilities regarding suicide and self-harm prevention procedures. It required all staff who have contact with prisoners to be aware of the risk factors and triggers that might increase the risk of suicide and self-harm and take appropriate action. Any prisoner identified as at risk of suicide and self-harm must be managed

under ACCT procedures. This PSI was replaced by the Prison Safety Policy Framework in January 2025 in which the guidance for managing prisoners at risk to themselves remains largely unchanged.

123. Mr Clark had several risk factors for suicide and self-harm. He was an IPP prisoner, who had been recalled for the murder of his partner. He later also had his parole hearing adjourned due to probation availability which caused him additional stress and he was subsequently found unsuitable for release or a move to open conditions. Although there is no evidence that Mr Clark's death was intentional, it cannot be ruled out. However, we are satisfied that there does not appear to have been any indication that Mr Clark was a particular risk to himself in the time immediately before his death or that staff should have started ACCT procedures around the time of his death.
124. Despite this, there were some issues with the management of Mr Clark's ACCT six months before he died which the Governor will want to be aware of:
 - When Ms C opened the ACCT, she recorded most of the relevant information about the nature of her concerns in probation records which prison staff do not have access to.
 - The next day, prison staff prematurely closed Mr Clark's ACCT, without access to this information. Mr Clark was anxious about his parole hearing in six days and staff had not completed the support actions detailed in the ACCT careplan as they should have done.

IPP

125. The Howard League for Penal Reform published their report, 'Ending the detention of people on IPP sentences: expert recommendations' in June 2025. They highlighted that at the end of 2024 there were 1045 people serving IPP sentences who had never been released, and a further 1569 people on IPP sentences in prison who had been released and recalled. They described the psychologically harmful impact of the IPP sentence, leaving people in a state of hopelessness and detrimentally impacting their mental health. These findings were also reflected in our learning lessons bulletin, 'Self-inflicted deaths in IPP prisoners', published in September 2023. This found that an IPP sentence should be considered a potential risk factor for suicide and self-harm, with prisoners struggling with their uncertain status leading to a potential lack of trust in the system.
126. As of the end of March 2025, 94 people on IPP sentences had taken their own lives in prison. The Howard League welcomed HMPPS' Action Plan to support IPP prisoner progression but highlighted that 30% of those in prison on IPP sentences were not in a suitable prison to meet their needs to progress.
127. Wormwood Scrubs does not have an IPP policy. Ms M, Head of OMU and lead for IPP, told us that she did not think Wormwood Scrubs was suitable for IPP prisoners. That may be, but at the end of July 2025, there were 10 prisoners serving IPP sentences at Wormwood Scrubs. Given this, the prison needs a policy setting out what is expected for IPP prisoners.

128. Prison Service Instruction (PSI) 64/2011, *Safer Custody*, did not mention IPP prisoners. The updated Prison Safety Policy Framework, which came into effect in January 2025, recognises that IPP prisoners are at heightened risk of harm to themselves or others. It sets out that Governors are expected to ensure that there is a whole prison approach to safety that is understood by every prison function, and that staff are equipped to carry out their roles and are given access to the right training and support.
129. Mr E, Head of Safety, told us that there was a general commitment from Wormwood Scrubs to, “try and do more for IPP prisoners” but he also said that the prison was not suitable for those serving IPP sentences. Mr E could not identify any specific actions he was taking to improve support for these prisoners. He said he had not introduced any specific actions as he did not want to be held accountable if they failed. Mr E did not convince us that he would take appropriate action to meet the needs of the IPP cohort at Wormwood Scrubs. We therefore make the following recommendation:

The Governor should ensure there is a robust IPP policy that reflects the HMPPS Action Plan for IPP prisoners. This should also be reflected in the safety strategy, to reflect HMPPS’ Safety Policy Framework.

Parole

130. Mr Clark was recalled by the probation service in February 2022. As Mr Clark was an IPP prisoner, he required direction by the Parole Board to be re-released. A parole hearing was arranged for 12 March 2024. On 8 March, Ms C requested an adjournment which was granted, with the next hearing arranged for 13 June. Ms C’s manager was aware that she was on a period of extended leave before the scheduled parole hearing on 12 March. Reverend A and Officer A believed that Mr Clark’s parole was a particular trigger for Mr Clark. It is reasonable to assume that any last-minute adjournment caused Mr Clark undue stress.
131. Ms A worked hard to build a relationship of trust with Mr Clark. It is unfortunate that she had a period of long-term leave from Wormwood Scrubs. It does not appear that Mr A was able to develop a similar relationship of trust, albeit we recognise he made several attempts to engage Mr Clark.
132. Ms A referred Mr Clark to several prisons to complete accredited programmes requested by the Parole Board. Given the operational capacity crisis and the lack of accredited programme availability, we are satisfied that Ms A took reasonable steps to progress Mr Clark’s sentence plan.

Key working

133. Under the Offender Management in Custody (OMiC) model, every prisoner should have a dedicated key worker with whom they have weekly contact. Due to exceptional staffing and capacity pressures, some prisons have been delivering adapted versions of the key work scheme while they worked towards full implementation. The HMPPS Action Plan sets out that IPP prisoners are a specific group that should receive a 45-minute key work session with a dedicated key worker every week.

134. At Wormwood Scrubs, those on remand or looking for employment are considered priority prisoners to receive key working. IPP prisoners are not considered part of the priority cohort to receive key working sessions. This is contrary to the HMPPS IPP Action Plan. The IMB reported in their latest report that the key worker scheme has never been fully implemented at Wormwood Scrubs.
135. Mr Clark only received two key work sessions in June and August 2022. While he engaged with weekly bible study sessions, regularly attended church, had positive relationships with chaplaincy staff and was engaged in counselling with Ms G we consider that this demonstrates that he might additionally have benefitted from the support of a key worker. We recommend:

The Governor should ensure IPP prisoners are a priority cohort for key working with a consistent, dedicated key worker with whom they can build a meaningful relationship.

Emergency Response

136. Officer F did not radio an emergency code as she should have done when she found Mr Clark unresponsive. She said that, as she was on her own, she thought she should go and get another member of staff. Officer F knew that she should radio a code blue if a prisoner was unresponsive, but said that she had been told she had used it incorrectly in the past when a prisoner was under the influence, so this had made her more reluctant to do so.
137. When Officer F told SO B in the wing office that Mr Clark was unresponsive, SO B did not advise her to radio a code blue but told her to find another officer and return to the cell. Officer F did so and the other officer immediately radioed a code blue. This meant there was a four-minute delay in radioing a code blue. Staff did not start CPR until told to do so when healthcare staff arrived one minute and 39 seconds later. SO B said that her priority was locking up the other prisoners on the wing, Officer F said that she was at the cell door and thought that Mr Clark was dead and Officer A could not explain why he had not started CPR immediately.
138. Any delay in starting CPR can be detrimental to the outcome for the prisoner, so the overall delay of nearly six minutes between staff first discovering Mr Clark unresponsive and starting CPR is of serious concern. Since Mr Clark's death, the prison has not investigated the cause of these delays or taken action to ensure they do not happen again, which is both surprising and concerning. This is the second time in the last three years that we have identified issues relating to staff not carrying out their responsibilities during an emergency event. Therefore, we recommend:

The Governor should satisfy herself through the implementation of a robust quality assurance process that staff are aware of their responsibilities during a medical emergency, including immediately calling the correct medical response code, entering the cell at the earliest possible opportunity, and beginning CPR without delay.

139. The first two officers who responded to the emergency were wearing BWVCs and the SO was unsure whether she was wearing one. No one turned their camera on. Staff gave various explanations about this including saying it was not their

immediate thought and that there was a fine balance between recording an incident and preserving the dignity of the prisoner. The Body Worn Video Cameras (BWVC) Policy Framework states that staff must consider sensitivities of the circumstances and should consider non-intrusive capturing of medical interventions. Staff should maintain audio capture where video capture is assessed as inappropriate. HMIP also found that staff were not routinely wearing or activating their BWVCs during emergency incidents at Wormwood Scrubs.

140. Ms L and Mr E recognised that this has been an issue at the prison. They are working together and with the staff trade union to increase the number of staff collecting BWVCs and activating them appropriately. They have introduced a process that control room staff remind staff to activate cameras during emergencies. Ms L and Mr E also attend incidents personally and remind staff to turn their cameras on, and they have sent out two notices to staff to remind them of their responsibilities. We therefore make no recommendation but experience tells us that changing staff culture requires maintained focus.

Clinical Care

141. The clinical reviewer concluded that the healthcare provided to Mr Clark was mainly equivalent to that which would have been provided in the community. However, she noted that there was poor oversight of medication queues and a lack of sharp focus on all sources of medication diversion, which was unacceptable.
142. The clinical reviewer made recommendations not related to Mr Clark's cause of death that the Head of Healthcare will wish to consider.

Governor to note

Staff Support

143. Both Officer A and Officer E said they did not feel supported following the death of Mr Clark. The Governor will want to consider how support is offered to staff following serious incidents.

Inquest

The inquest into Mr Clark's death ended on 14 August 2026 and concluded that Mr Clark's death was drug related. The jury recognised failures with Mr Clark's location at Wormwood Scrubs as an IPP prisoner, the failure to adequately oversee medication queues, under reporting of those suspected of being under the influence, and a delay in calling a code blue by staff who discovered Mr Clark. However, they concluded that none of these failures more than minimally, trivially, or negligibly contributed to Mr Clark's death.



Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

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

T | 020 7633 4100