

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# **Independent investigation into the death of Mr Peter Magloire, a prisoner at HMP Wormwood Scrubs, on 3 February 2023**

**A report by the Prisons and Probation Ombudsman**

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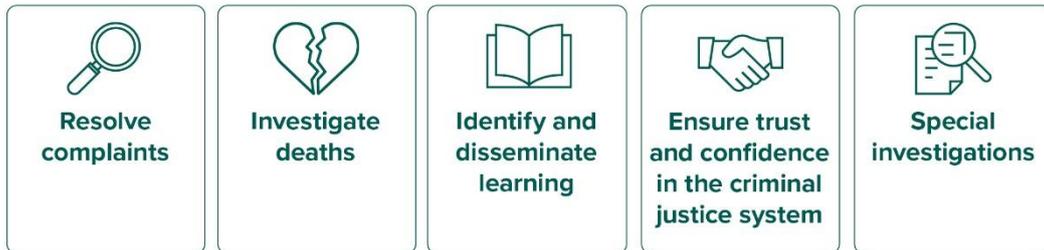
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## OUR VISION

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



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The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out independent investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

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 Peter Magloire, a black prisoner, died from an anoxic brain injury (a lack of oxygen to the brain) caused by asphyxiation on 3 February 2023, while a prisoner at HMP Wormwood Scrubs. He was 65 years old. I offer my condolences to his family and friends.

Mr Magloire was taken to hospital on 29 January after he was found unconscious in his cell, with a plastic bag tied around his head. At the time, Mr Magloire had spent 78 days in the segregation unit and was being monitored under suicide and self-harm prevention procedures, known as ACCT.

Mr Magloire had episodes of severe paranoia. He claimed to be under constant threat from other prisoners and staff because, he said, they knew about his offences. Mr Magloire harmed fellow prisoners so that he would be moved to the segregation unit as this was where he felt safest. He asked to be transferred to a prison which catered for his offender profile. Wormwood Scrubs should have done more to explore or facilitate this.

The clinical reviewer concluded that the overall care provided to Mr Magloire was not equivalent to that which he could have expected to receive in the community. She was concerned about the different perceptions among healthcare staff about the significance of his paranoid beliefs and the lack of a plan to identify and support his deteriorating mental health.

We identified issues with the processes for managing a prisoner subject to ACCT monitoring in the segregation unit. There were missed opportunities to use a multidisciplinary approach to resolve the challenges that Mr Magloire presented.

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**

**May 2025**

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## Summary

### Events

1. In January 2010, Mr Peter Magloire was convicted of serious historic sex offences. He was sentenced on 28 May 2010 and received a discretionary life sentence, with a minimum term of ten years.
2. Mr Magloire spent time in a number of prisons. He moved to HMP Isle of Wight on 12 April 2012, where he remained until 18 November 2021, when he was transferred to Three Bridges Medium Secure Unit in Uxbridge (a psychiatric hospital).
3. While at Three Bridges, medical professionals concluded that Mr Magloire did not have a mental illness but had had a psychotic episode which had resolved.
4. On 22 June 2022, Mr Magloire was discharged to HMP Wormwood Scrubs. He initially lived on a general wing but was later moved to the segregation unit (a small unit where prisoners are kept separate from the general population) because of his behaviour.
5. On 29 November, staff became concerned that Mr Magloire might try to harm himself. They monitored him under suicide and self-harm prevention procedures, known as ACCT. Later that day, Mr Magloire stabbed himself in the stomach and he was admitted to hospital for treatment.
6. On 2 December, Mr Magloire returned to the segregation unit. On 9 December, staff ended ACCT monitoring.
7. On 20 January 2023, a nurse opened a new ACCT due to concerns that Mr Magloire felt very low.
8. On 23 January, the prison consultant psychiatrist saw Mr Magloire and diagnosed that he was having a psychotic episode. He recommended that he should be admitted to the prison's inpatient unit (IPU). He also completed an urgent referral for Mr Magloire to be re-admitted to an NHS psychiatric hospital.
9. On 29 January, Mr Magloire was found in his cell with a plastic bag over his head which was tied around his neck. Prison and healthcare staff carried out life-saving treatment and Mr Magloire was taken by ambulance to hospital, where he was placed on life support.
10. On 3 February, Mr Magloire's life support was turned off and he died at 4.20pm.

### Findings

11. The clinical reviewer concluded that the care provided to Mr Magloire was not equivalent to that which he could have expected to receive in the community. She was concerned about the different perceptions among healthcare staff of the significance of his paranoid beliefs and the lack of a plan to support and respond to his deteriorating mental state.

12. Mr Magloire expressed concerns about his safety before he returned to Wormwood Scrubs, and the prison indicated that they would look to transfer him as soon as possible. However, Wormwood Scrubs did not take any action to transfer him until four months later. Once Mr Magloire became subject to a parole review, staff considered that he could not be moved so they made no further attempts to do so.
13. Given the challenges presented by Mr Magloire, it was imperative that staff from a number of disciplines worked together to manage the situation and identify a way forward. Yet, Mr Magloire's case was not always discussed at the weekly safety intervention meeting despite him meeting the criteria for this. We found instances where there could have been better collaboration between prison and mental health in-reach team colleagues.
14. We identified examples where ACCT and segregation processes were not followed and/or the paperwork was not completed properly.
15. There is no evidence that Wormwood Scrubs contributed to Mr Magloire's funeral expenses as they should have done.

## Recommendations

- The Head of Healthcare should ensure that the segregation policy has been developed and is implemented in line with their own action plan to include a process for identifying the most suitable clinician to attend the Segregation Review Board.
- The Governor should ensure that there are effective quality assurance arrangements in place so that she can be satisfied that both the Prison Safety Policy Framework (formerly PSI 64/2011) on ACCT monitoring and Prison Service Order (PSO) 1700 on segregation are being followed.
- The Governor should ensure that the agenda for the SIM includes consideration of the length of time a prisoner has been segregated.

## The Investigation Process

16. HMPPS notified us of Mr Magloire's death on 3 February 2023.
17. The 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.
18. The investigator visited Wormwood Scrubs on 4 and 5 April 2023. He obtained copies of relevant extracts from Mr Magloire's prison and medical records and documents from the ambulance services.
19. NHS England commissioned a clinical reviewer to review Mr Magloire's clinical care at the prison.
20. The investigator and clinical reviewer interviewed ten members of staff in person on 4 and 5 April. They conducted a further nine interviews remotely by Microsoft Teams on 18, 19, 20 and 24 April and 4 May.
21. Another investigator took over the investigation in July 2024.
22. We informed HM Coroner for Hammersmith, Fulham and Hounslow of the investigation. The Coroner confirmed the cause of Mr Magloire's death and told us that a post-mortem was not needed. We have sent the Coroner a copy of this report.
23. The Ombudsman's office contacted Mr Magloire's brother to explain the investigation and to ask if he had any matters he wanted us to consider. Mr Magloire's brother was concerned that the prison did not take the threat of harm (from others) to Mr Magloire seriously and he wanted to know why probation staff had notified members of the family about Mr Magloire's death.
24. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.
25. Mr Magloire's brother received a copy of the draft report. He did not make any comments.

## Background Information

### HMP Wormwood Scrubs

26. HMP Wormwood Scrubs is a category B local and resettlement prison holding remanded and sentenced adult men and young adults (aged 18-21 years). Practice Plus Group provides primary health care services. Barnet, Enfield and Haringey NHS Mental Health Trust provides mental health services. The prison has an inpatient unit.

### HM Inspectorate of Prisons

27. The last inspection of HMP Wormwood Scrubs was unannounced and took place in June 2021. Inspectors concluded that the prison was a much safer, cleaner and better organised prison than previously. They found that levels of self-harm had reduced substantially and were lower than comparable prisons. There had been a significant improvement in prisoners subject to ACCT feeling cared for by staff. Inspectors noted that discussions at the weekly safety intervention meeting about those presenting a high risk of concern did not always consider all relevant prisoners and the minutes lacked evidence of meaningful discussion and action. Inspectors found that the reasons for segregation lacked detail, the behaviour targets were often superficial and the ongoing segregation records were observational and did not demonstrate meaningful interaction.

### Independent Monitoring Board

28. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report for the year to 31 May 2023, the IMB reported that staff shortages and staff turnover had adversely impacted the provision of an effective mental health service and waiting times for routine mental health assessments had increased.
29. The IMB also noted that recorded self-harm had increased by 22% and the numbers of prisoners subject to ACCTs had also increased. They were concerned that prisoners with serious mental health issues were frequently kept in segregation, awaiting a move to the hospital wing due to a shortage of beds. They noted that while mental health staff regularly visited the segregation unit, the restricted conditions there made it unsuitable for those with severe mental health problems.

### Previous deaths at HMP Wormwood Scrubs

30. Mr Magloire was the eleventh prisoner to die at Wormwood Scrubs since February 2020. Of the previous deaths, six were self-inflicted and four were from natural causes. Since Mr Magloire's death up to February 2025, a further nine prisoners have died at Wormwood Scrubs, six from natural causes, one self-inflicted, two drug-related and one where the cause of death remains unascertained. There were no similarities between our investigation findings into Mr Magloire's death and our findings in the previous investigations.

## Assessment, Care in Custody and Teamwork

31. ACCT is the Prison Service care-planning system used to support prisoners at risk of suicide and 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. 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 carried out at irregular intervals to prevent the prisoner anticipating when they will occur. Regular multidisciplinary review meetings involving the prisoner should be held.

## Segregation

32. Segregation is when a prisoner is kept apart from other prisoners in the segregation unit. The criteria for segregating a prisoner are set out in the Prison Rules. Most commonly, prisoners are segregated under Prison Rule 45 on good order or discipline (where a prisoner has behaved in a way that prison staff consider would put others in danger or cause a problem for the prison) or for the prisoner's own interests/protection (if the prisoner or prison staff consider they are in danger).
33. Once a prisoner has moved to the segregation unit, the Segregation Review Board (SRB) must carry out regular reviews to assess if the prisoner should remain segregated. The SRB comprises a governor (the Chair), a healthcare representative, an ACCT case manager (where applicable) and the prisoner. An IMB member must also be invited, and every effort should be made to facilitate their attendance.
34. Prison Service Order (PSO) 1700 on segregation acknowledges the specific risks of holding vulnerable prisoners in segregation. It notes that rates of suicide among segregated prisoners are high, and that segregation should only be used as a last resort. Prisoners segregated for a continuous 30 days must have a care plan to support their mental wellbeing. If segregation goes beyond 42 and 84 days, the prison must seek authorisation from a senior manager in the Prison Group Director's office.

## Parole Process

35. The Generic Parole Process Policy Framework sets out the requirements and guidance for staff involved in the parole process (the process by which the Parole Board considers whether a prisoner is suitable for either a move to open conditions or release). It states that prisoners may be transferred during their Parole Board review to access a progression opportunity in line with their sentence plan or for security reasons. If the hearing date has been listed, a prisoner should not move unless the receiving establishment can accommodate arrangements for the prisoner to attend the hearing.

## Inpatient unit

36. The inpatient unit at Wormwood Scrubs comprises 17 beds, 12 of which are allocated for patients with complex mental health needs. The mental health in-reach

team, in consultation with senior healthcare managers in the prison, maintains the waiting list for the mental health allocation and decides who will be given a bed.

## Key Events

### Background

37. On 15 February 2008, Mr Peter Magloire was remanded to HMP Wormwood Scrubs, charged with serious historic sex offences, predominantly against family members. On 18 January 2010, Mr Magloire was convicted of the offences. On 28 May, he received a discretionary life sentence, with a minimum term of ten years. After short spells at HMP Bullingdon, HMP Wandsworth and HMP Brixton, Mr Magloire was transferred to HMP Isle of Wight on 12 April 2012, where he remained for nine years.
38. During this time, he had occasional contact with the mental health team due to episodes of paranoid and delusional thinking. This resulted in Mr Magloire becoming agitated and wanting to self-isolate. Mr Magloire was paranoid that family, prisoners and officers wanted to kill him because of his offences (there was no evidence that this was the case). Between these episodes, Mr Magloire engaged in the regime, mixed with other prisoners, and held a number of different jobs.
39. In September 2021, Mr Magloire told healthcare staff that he feared for his safety. Staff noted that he was paranoid about other prisoners planning to hurt him. Mr Magloire was moved to the healthcare unit for his own safety. A prison psychiatrist assessed that Mr Magloire had psychotic symptoms and a referral to a psychiatric hospital should be considered.
40. On 18 November 2021, Mr Magloire was sectioned under the Mental Health Act and sent to Three Bridges Psychiatric Hospital in London.

### 2022

41. On 17 May 2022, Wormwood Scrubs' Offender Management Unit (OMU) emailed a mental health manager in the community about Mr Magloire's imminent hospital discharge. They said that he could be discharged to Wormwood Scrubs, and they would try to move him on as soon as possible. The email did not give any further information. (Under the NHS policy, prisoners being discharged from secure hospitals are remitted to the nearest prison, unless they are a category A prisoner requiring a high secure prison.)
42. On 30 May, the mental health manager emailed the joint Head of Reducing Reoffending. She said that she had attended a meeting to discuss Mr Magloire's discharge to prison and aftercare services. She said that Mr Magloire was reluctant to go to Wormwood Scrubs and wanted to return to Isle of Wight. Mr Magloire had said he was worried that he would be placed on a standard wing and would be vulnerable because of his offences. She asked the Head to confirm he was happy for Mr Magloire to return to Wormwood Scrubs.
43. On 6 July, the joint Head of Reducing Reoffending responded and said there was no conflict of interest. He asked if a prison with a vulnerable prisoners' unit (VPU) would be better given his age, offence and concerns.

44. The Deputy Governor responded by email and said Wormwood Scrubs would take Mr Magloire in line with the remissions protocol.

### **HMP Wormwood Scrubs**

45. On 22 June, Mr Magloire was discharged from hospital to a standard wing at Wormwood Scrubs. The discharge letter stated that he had had a transient psychotic episode. He was not prescribed any medication.
46. On 30 June, a nurse from the mental health in-reach team (MHIRT) completed a mental health assessment. She noted Mr Magloire's mood was good, and he presented as stable.
47. On 6 July, Mr Magloire was discussed at the MHIRT referral meeting. It was agreed that he would receive monthly oversight from MHIRT and one of the prison's consultant psychiatrists would review him as a non-urgent appointment.
48. On 18 July, a prison psychiatrist reviewed Mr Magloire. She noted no evidence of serious mental illness and that his psychotic episode was in remission. However, she concluded that given his history of psychotic episodes and his recent discharge, MHIRT should retain oversight.
49. On 10 August, Mr Magloire said he was afraid to leave his cell as prisoners were planning to stab him.
50. On 12 August, Mr Magloire was moved to a different wing as he felt under threat.
51. On 18 August, Mr Magloire received a letter which stated that the Parole Board would review his case on 18 November 2022.
52. On 24 August, Mr Magloire was discussed at an MHIRT meeting. They agreed to discharge him from their caseload.
53. In September, a number of prison officers noted that Mr Magloire was refusing to leave his cell due to threats from other prisoners. He told officers there was a "bounty" on his head because of his previous offences.
54. On 19 September, Mr Magloire's brother contacted the prison. He reported that other prisoners had threatened Mr Magloire after they found out his previous offences.
55. On 24 September, a prison officer recorded that she thought Mr Magloire was having a mental breakdown. She said that she had completed a welfare check after Mr Magloire's brother's call. She noted she had exhausted all areas of information to corroborate his claims but had found no evidence he was under threat.
56. At approximately 11.20am on 27 September 2022, Mr Magloire was taken to the segregation unit after he allegedly sexually assaulted another prisoner. The matter was referred to the police.
57. On 29 September, the Head of Residence for D & E wing recorded that Mr Magloire wanted to stay in the segregation unit because he was at risk from people who knew his offences.

58. On 30 September, the Head of Residence chaired the Segregation Review Board (SRB) to review the decision to segregate Mr Magloire. A prison officer, a nurse and Mr Magloire attended. They recorded Mr Magloire should remain segregated because of the ongoing police investigation and that Mr Magloire felt unsafe on the wing.
59. Later that day, a nurse spoke to Mr Magloire who told her that the alleged sexual assault that he had been accused of was a “blessing” as he could get off the wing.
60. On 3 October, the MHIRT discussed the referral for Mr Magloire and agreed to refer him to the mental health team and to Improving Access to Psychological Therapies (IAPT) for anxiety and depression.
61. On 7 October, the joint Head of Reducing Reoffending chaired the SRB. A prison officer, nurse and Mr Magloire attended. It was noted that the police investigation was ongoing, and Mr Magloire felt down, anxious and worried that people wanted to hurt him.
62. That day, the Head of Residence for A and C wings and the kitchens chaired the SRB. Mr Magloire, a nurse, prison officer and an IMB observer attended. The Head wrote that Mr Magloire presented as paranoid and the MHIRT was aware.
63. On 21 October, Mr Magloire asked the Head of Residence for D and E wings if he could transfer to another prison. The Head noted that segregation staff should speak to OMU.
64. Later that day, there was an exchange of emails between Wormwood Scrubs’ OMU and HMP Isle of Wight. Wormwood Scrubs put Mr Magloire forward for a transfer, but Isle of Wight did not accept him on the basis that he was subject to a parole review.
65. On 27 October, a prison paramedic saw Mr Magloire as part of healthcare’s regular checks. Mr Magloire told her that he felt low and stressed due to threats from other prisoners and wanted to transfer to another prison. She noted that she discussed this with the Head of Residence for D and E wings.
66. Later that day, the Head of Residence for A and C wings chaired the SRB. The paperwork notes that only he and Mr Magloire attended, though the medical record shows that the prison paramedic was also there. The Head recorded that they discussed with Mr Magloire his location and the difficulty of transferring him to another prison because he was in the parole window. Mr Magloire was moved to the Conibeere Unit (a detoxification/stabilisation unit) that day. The Head updated Mr Magloire’s prison record to say that the move there was facilitated so that Mr Magloire could engage in the regime which would support a transfer out of the prison.
67. On 7 November, an alert was added to Mr Magloire’s prison record to state he was on a parole hold and should not be transferred. Later that day, the Head of the Offender Management Unit told Mr Magloire that he would try to transfer him to another prison.

68. At 8.00am on 9 November, a prison officer started ACCT procedures after Mr Magloire told her he was going to die that day. She recorded that he had given the cleaner a letter stating he would be murdered.
69. On 10 November, an ACCT case review took place. The case assessor did not attend the meeting. The Supervising Officer (SO) recorded that Mr Magloire engaged well and had no intention of suicide or self-harm. The SO concluded that while Mr Magloire's paranoia needed to be addressed, staff could stop ACCT procedures. The ACCT post-closure review form was not completed and one of the care plan actions was not complete.
70. On 11 November, Mr Magloire was placed on report for assaulting a prisoner.
71. On 12 November, Mr Magloire was sent to the segregation unit for the alleged assault under Prison Rule 53 (pending a disciplinary hearing). The disciplinary hearing was scheduled for 14 November, but it is not clear from the prison records if it took place. The Head of Early Days in Custody authorised Mr Magloire's segregation. It was not recorded on the relevant form or the accompanying initial health screen form that Mr Magloire was in the seven-day ACCT post-closure period.
72. On 14 November, Mr Magloire's brother contacted the prison to say that Mr Magloire was under constant threat and asked why he had not been transferred to another prison.
73. Later that day, the joint Head of Reducing Reoffending completed Mr Magloire's segregation paperwork. He changed the reason for segregation to Prison Rule 45 (good order or discipline) and noted that Mr Magloire had been segregated because he had allegedly assaulted another prisoner and the incident had been referred to the police. There was no reference that Mr Magloire was in his ACCT post-closure period, and we were not given any evidence that the mandated ACCT review or a defensible decision to segregate form was completed.
74. On 17 November, the Head of Early Days in Custody chaired an SRB review. The paperwork noted that Mr Magloire, three other prison staff and a forensic psychologist attended. The psychologist had been asked to complete a psychological risk assessment for Mr Magloire's parole review. In contrast to the SRB paperwork, the prison paramedic made an entry in the medical records to say that the SRB review had been held in Mr Magloire's absence because he had refused to attend.
75. Over the next few days, Mr Magloire repeatedly told officers that he was at risk of harm from other prisoners, and he refused to leave his cell because he was afraid.
76. On 28 November, Mr Magloire saw a prison GP. Mr Magloire told him that there was a conspiracy between the prisoners and officers to kill him and he asked to be moved from the segregation unit. The GP referred him to the MHIRT.

### **Events of 29 November 2022**

77. At approximately 10.50am, the prison paramedic saw Mr Magloire. She recorded that he refused his medications and believed staff and officers were going to harm

him. He told her that he would only leave his cell if he was dead, and he showed her two sharpened knives under his t-shirt. He said that if anyone opened his cell door, he would stab himself before they could kill him. She noted that she told officers this, completed a referral to the MHIRT and started ACCT monitoring.

78. That morning, a prison manager in the segregation unit with responsibility for disciplinary hearings authorised Mr Magloire's segregation following the ACCT procedures being opened. He agreed that Mr Magloire should remain in segregation on the basis that he was displaying ongoing paranoia and had said that he would not leave alive. No further reviews of this decision were documented.
79. Between 11.00am and 11.45am, an officer checked on Mr Magloire and recorded he was threatening to stab himself and was seen holding cutlery to his stomach.
80. At 11.30am, a SO completed the ACCT immediate action plan and noted that Mr Magloire should be checked every twelve minutes until he was fully assessed. In regard to other interventions, including the removal of items that can cause harm, the SO wrote 'n/b'. There is nothing to explain what this meant.
81. At approximately 12.05pm, the chaplain saw Mr Magloire who told him that staff were planning to kill him and showed him a plastic knife. The chaplain noted that he informed segregation staff.
82. At 2.15pm, a SO completed the ACCT assessment. She noted that Mr Magloire was paranoid and did not engage well. She said that after some time, he allowed staff to open the door and he showed them two self-inflicted stomach wounds.
83. At approximately 2.40pm, a prison manager, a SO and the prison paramedic completed an ACCT review at Mr Magloire's cell door. They said he was paranoid about staff and prisoners wanting to kill him. Mr Magloire showed staff a fresh self-inflicted wound. They noted that Mr Magloire eventually engaged and allowed the prison paramedic to assess his injuries. She decided he needed treatment, and he was sent to hospital. A member of the safer custody team told us that Mr Magloire was extremely paranoid at the time and had threatened to hurt staff if they opened the cell door and this was why staff had not removed the items from his cell.
84. On 30 November, the hospital trauma doctor contacted healthcare staff with concerns about Mr Magloire's mental health.
85. Later that day, the prison held their Safety Intervention Meeting (SIM, a weekly multidisciplinary safety risk meeting, chaired by a senior manager, which focuses on those who are deemed to pose a significant risk of self-harm or harm to others). There is no reference to Mr Magloire in the minutes.
86. On 1 December, officers completed an ACCT review with Mr Magloire in hospital. Healthcare staff did not attend. Mr Magloire talked about the threat he faced in prison. It was noted that healthcare staff would need to review him when he returned to prison. The ACCT support plan identified an action to refer Mr Magloire to the MHIRT.
87. At 11.40am, the prison paramedic emailed senior prison staff to say that Mr Magloire did not feel safe in the prison and needed to live in a VPU. She said she was very concerned that if he remained at Wormwood Scrubs, his cognitive ability

would deteriorate, and this would leave him at risk from others. She acknowledged that Mr Magloire was on a parole hold but felt a transfer should be explored because of his poor mental health. She said that prolonged periods of segregation were damaging to health, and this was affecting Mr Magloire. She confirmed that Mr Magloire would be added to the MHIRT's caseload.

88. That day, the Head of Residence for D and E wings and the Head of Segregation completed an SRB to authorise Mr Magloire's continued segregation when he returned to the prison. Healthcare staff did not attend.
89. At 5.47pm, the prison paramedic completed Mr Magloire's initial segregation healthcare screen in Mr Magloire's absence as he remained in hospital. She noted that mental health concerns had been raised, Mr Magloire had seen the MHIRT, he had no mental health diagnosis, and he was considered fit for segregation.

### **CSU at Wormwood Scrubs**

90. At approximately 9.00pm that day, Mr Magloire was discharged from hospital to Wormwood Scrubs' segregation unit. A nurse completed a second initial segregation healthcare screen. She noted that Mr Magloire should have gone to the IPU, but no beds were available. She wrote that Mr Magloire was showing signs of being acutely unwell and/or psychotic and noted his paranoid thought disorder. She concluded that Mr Magloire was able to cope with a period of segregation until a bed became available in the IPU and placed Mr Magloire under constant supervision.
91. At interview, the prison's consultant psychiatrist told the investigator that Mr Magloire should have been referred to the NHS for inpatient care following his discharge from hospital. This did not happen.
92. On 2 December, the prison paramedic emailed prison colleagues about Mr Magloire. She said he was not under the care of the MHIRT but there were concerns about his mental deterioration and behaviour. She said that he had asked to be on a VPU and as Wormwood Scrubs did not have one, this was harming his mental health.
93. A forensic psychologist responded to the email. She said that Mr Magloire was due to have a forensic psychology assessment as part of his parole process, and she was happy to arrange for the assessment to be completed at another prison. She concluded that the risk assessment should not be a barrier to him moving to a safer location.
94. Later that day, the Head of Early Days in Custody chaired an ACCT case review. A member from the MHIRT team attended. They recorded that Mr Magloire still did not feel safe in prison. He denied thoughts of self-harm. Mr Magloire's observations were reduced from constant supervision to hourly during the day and half hourly at night. They concluded that Mr Magloire was not at high risk of suicide or self-harm.
95. On 7 December, Mr Magloire was discussed at the MHIRT meeting. It was noted that his current state resembled his previous presentation before he was admitted to hospital. It was agreed that a psychiatrist would review him, and he would be allocated a psychiatric nurse.

96. That day, Mr Magloire was discussed at the SIM. It was noted that he had stabbed himself, he was very paranoid and remained a high risk to himself and others. The notes said the MHIRT had reviewed him, he had no mental health diagnosis, and his parole window was until the end of January. The psychologist noted that she told the custodial manager that Mr Magloire did not need to stay at Wormwood Scrubs if he needed to move for safety reasons.
97. On 8 December, a psychiatrist met Mr Magloire. She concluded that he presented with symptoms of psychotic relapse, and he did not have any insight into his mental condition. She noted that while Mr Magloire lacked the mental capacity to consent to treatment, she was going to prescribe him risperidone (a medication used to treat mental health conditions). She told the investigator that she had to try to treat him before she could refer him to the NHS to be assessed for inpatient care. She said he could not be transferred to the IPU as there was no space. She noted that Mr Magloire should remain on an ACCT and his risks should be managed through the ACCT process.
98. Mr Magloire was not listed on the IPU waiting list for 2, 9 and 23 December or 13 January.
99. On 9 December, the joint Head of Reducing Reoffending chaired an ACCT review. A prison officer and Mr Magloire attended. No one from the healthcare team or MHIRT were present. The Head noted that Mr Magloire had expressed no thoughts of suicide or self-harm over the past week but said his main threat was from staff and prisoners. They decided to end ACCT monitoring. The post-closure review was not completed, and it is not clear what progress was made with one of the care plan support actions.
100. On the morning of 14 December, a nurse reviewed Mr Magloire. She said that he reported no concerns, other than that he remained paranoid and felt unsafe. She incorrectly noted that Mr Magloire was on an ACCT and his risk remained low but that his risk would increase if he became distressed. She concluded that he should continue to be managed through the ACCT process and the MHIRT should review him every two weeks. The ACCT post-closure period was due to finish the next day.
101. Later that day, Mr Magloire was discussed at the MHIRT meeting. They noted that his care would be handed over to another psychiatrist, as the previous one had left Wormwood Scrubs. It was noted that Mr Magloire was at a high risk of self-harm and harm to others which was a different conclusion to the nurse's assessment earlier that day. There was no record that Mr Magloire's ACCT status was discussed.
102. On 15 December, the IAPT team reviewed the referral made on 24 October. They concluded that Mr Magloire was too high risk for IAPT, but he could be referred to them once he had stabilised.
103. Later that day, the prison paramedic saw Mr Magloire. She noted that he was not taking his antipsychotic medication.
104. At 2.15pm, the Head of Residence for D and E wings chaired the SRB meeting. Mr Magloire, the prison paramedic, the psychologist and two prison officers attended. They noted that Mr Magloire had stopped engaging in the regime as he was worried

someone would kill him. The Head recorded that the MHIRT would support him, and psychology would conduct a risk assessment as part of the parole process.

105. On 16 December, a nurse examined Mr Magloire. She updated his medical record and incorrectly noted that he was on an ACCT and his risk should be managed through the ACCT process.
106. On 20 December, a nurse spoke to Mr Magloire about him not taking his antipsychotic medication. She recorded that he told her he did not need to take it as he was not mentally ill. She noted she would refer Mr Magloire to the doctor and the MHIRT.
107. On 21 December, the Head of Segregation completed the application to continue to segregate a prisoner beyond 42 days. He wrote that Mr Magloire had said he would assault another prisoner if he was returned to standard location and the best option for him was to transfer out of Wormwood Scrubs, but this was not possible as he was on parole hold. He also wrote that Mr Magloire was deemed unsuitable for the IPU. There is no record to explain why he was unsuitable.
108. On 21 December, the London Prison Group Safety Lead authorised Mr Magloire's continued segregation.
109. On 25 December, a nurse saw Mr Magloire during segregation rounds. She recorded that he remained paranoid and was desperate to be transferred to another prison as he was scared for his life.
110. On 29 December, a prison manager chaired the SRB meeting. Mr Magloire, two other prison officers and an IMB observer attended. Healthcare staff did not attend, though the manager recorded that the prison paramedic contributed verbally beforehand. He noted that Mr Magloire would not consider moving to another unit and was not taking his antipsychotic medications.
111. On 5 January 2023, a nurse completed a mental health review with Mr Magloire. She noted that his presentation had improved, and he was no longer being monitored under ACCT procedures but continued to express paranoid beliefs. She concluded he would be monitored through fortnightly reviews.
112. On 11 January, the psychologist met Mr Magloire in connection with his psychological risk assessment. He was concerned for his safety and wanted to move to a prison for sex offenders.
113. That day, a nurse met Mr Magloire to complete a mental health assessment. She noted he appeared mentally stable and could articulate his issues. She recorded that he was taking his medications and had no side effects. However, at this time, Mr Magloire was refusing to take the antipsychotic medications. Mr Magloire was discussed at the MHIRT meeting, and they concluded that he was stable and could be seen monthly rather than fortnightly.
114. On 12 January, the joint Head of Reducing Reoffending chaired the SRB review. The paperwork did not indicate any other attendees, though an entry from the prison paramedic in the medical records about the SRB and the segregation daily record noted that Mr Magloire attended. The Head recorded that Mr Magloire was very quiet most of the time, he tried to manipulate staff to get vapes and harmed

himself by inserting objects into cuts in his arms. There is no corresponding entry about self-harm of this nature in the segregation log or medical records and Mr Magloire was not subject to ACCT monitoring.

115. On 15 January, a prison manager spoke to Mr Magloire during the segregation rounds. She noted he remained very paranoid and wanted a transfer. She told him that this depended on his parole status.
116. On 16 January, the psychologist met Mr Magloire and spoke about the police investigation into the two alleged incidents of assault. She recorded that Mr Magloire told her that he carried out the assaults so that he would be taken to the segregation unit.
117. On 18 January, a senior forensic psychologist emailed the Head of OMU and other prison staff to tell them that the previous psychologist had completed the psychological risk assessment and Mr Magloire did not need to stay at Wormwood Scrubs for forensic psychology purposes. The Head of Offender Management responded by email that as he was subject to a parole hearing and further reports, they could only move Mr Magloire if the receiving establishment could facilitate hearings. There is no evidence that staff at Wormwood Scrubs were actively seeking a prison that could facilitate the hearing.
118. On 19 January, the Head of Segregation chaired the SRB review. Mr Magloire, an SO, an IMB representative and a paramedic attended. It was noted that Mr Magloire was mostly quiet and passed notes to officers about forthcoming attacks. They recorded their concerns about his mental health and paranoia and said they would refer him to the MHIRT. (Mr Magloire was already under the care of the MHIRT.)
119. On 20 January, the joint Head of Reducing Reoffending spoke to Mr Magloire during segregation rounds. She noted that he was very down, and staff had said this was after a discussion about moving him out of segregation. Later that day, Mr Magloire told the chaplain he would not see him the next day as staff were planning to kill him using the showers.
120. At approximately 4.46pm, the prison paramedic started ACCT monitoring procedures. She noted that Mr Magloire appeared very low. She told the investigator that she felt that both prison and mental health staff dismissed her concerns about Mr Magloire's mental health and said there was nothing wrong with him: "It's Magloire, that's how he is" or "he is not under MHIRT".
121. At around 7.00pm, an officer completed the ACCT assessment. She noted that Mr Magloire had said he did not feel low but displayed an irrational fear of everything. She noted that his only expectation of the future was that he would be killed. She noted Mr Magloire had said he had no thoughts of suicide or self-harm and he had never harmed himself as it was against his religious beliefs.
122. At 8.15pm, the Deputy Governor chaired Mr Magloire's ACCT case review in Mr Magloire's cell. The officer provided a verbal handover and a nurse attended. It was noted that the Head of the MHIRT, the prison GP and a nurse had seen Mr Magloire earlier and had not identified any physical or mental health issues. Mr Magloire asked to be put under constant supervision to protect him from other people. There is no record that any action was taken.

123. The immediate action plan was not completed until 8.40pm. Observations were set for three conversations per day, supported by the segregation observations of an hourly check during the day and half hourly at night.
124. The joint Head of Reducing Reoffending completed the defensible decision paperwork for Mr Magloire to remain in segregation while on an ACCT. The document was dated 3 October but referred to his January 2023 segregation. The Head noted that he believed that if Mr Magloire was forced to leave segregation, it could provoke him to assault another prisoner. He said that to end his segregation, efforts should be made to integrate Mr Magloire with other prisoners.
125. On 23 January, a psychiatrist reviewed Mr Magloire. He noted that Mr Magloire had a degree of thought disorder and was preoccupied that there was a conspiracy to kill him. He noted that he planned to refer Mr Magloire to the NHS to be readmitted, he would prescribe him olanzapine (a medication to treat schizophrenia) and arrange for him to be moved to the IPU. He told the investigator that he was so concerned that he completed the hospital referral straight away. In his letter, he summarised the interactions between the healthcare team and Mr Magloire and wrote that "some staff do not pick up on the concerns very easily, whilst others are highly tuned into his psychosis".
126. Later that day, the Head of Security and Intelligence chaired the ACCT review. Mr Magloire, the prison paramedic, the prison's imam and a prison officer attended. The Head wrote that Mr Magloire talked about his fear of harm. He noted that the last time Mr Magloire had been so fixated on this conspiracy, he had harmed himself and Mr Magloire told him the feeling was "getting similar". He kept the ACCT open but did not think that Mr Magloire was at high risk of suicide or serious self-harm. A further review was scheduled for 30 January and observations were set at three conversations per hour in addition to the usual segregation observations.
127. The prison paramedic noted that Mr Magloire told them he felt "terrible" and said, "I've already asked God to forgive me. I hope it doesn't take too long. I know what's coming". She noted that Mr Magloire denied thoughts of suicide and self-harm but said he "felt like a mouse, trapped and can't get out".
128. That day, the Head of Segregation completed Mr Magloire's care plan and noted they planned to transfer him at the earliest opportunity to a long-term VPU but that was not possible due to his parole review. He said that he would benefit from being moved to standard location and they were looking into a phased reintegration. He said the outcome of his forensic assessments would be integrated into his care plan.
129. On 24 January, the Head of Segregation emailed a probation officer to ask if all parole reports had been submitted so that Mr Magloire could be transferred. The probation officer replied that there were no probation reports to submit but Mr Magloire's solicitor may need to submit his representations and the Head may need to check with psychology services.
130. On 25 January, the psychologist recorded that there was a discussion about Mr Magloire with the MHIRT in the SIM. It was noted that he was on an ACCT, and he had been referred to a psychiatric hospital and put on the IPU waiting list. However,

she noted there was speculation about whether he was already on the waiting list (he was not).

131. On 24 January, a nurse noted that Mr Magloire had refused to take olanzapine as it was an antipsychotic, and he did not have psychosis. The nurse sent a task to the mental health team to review him.
132. On 25 January, at the MHIRT case review meeting, it was recorded that the psychiatrist had completed a medical review and was referring Mr Magloire to the NHS. They said that he was to be added to the IPU waiting list and his reviews would be increased to weekly.
133. On 26 January, a nurse reviewed Mr Magloire's mental health care plan. She recorded that the referral to the NHS had been done on 23 January. She concluded his risk to self and others was low and incorrectly noted that he was not on an ACCT as it had been closed as he had no thoughts of suicide or self-harm. (At this point, Mr Magloire was on an ACCT.)
134. Over the next few days, Mr Magloire phoned his brother on multiple occasions to tell him how he was going to be killed and what was being planned.

### **Events of 29 January 2023**

135. On the morning of 29 January, officers checked on Mr Magloire at hourly intervals. Staff noted that Mr Magloire was awake, praying in his cell. The chaplain recorded in the ACCT document that Mr Magloire continued to talk about his anxieties.
136. At 12.40pm, a nurse saw Mr Magloire during a regular healthcare segregation round. The nurse noted that the SO had briefed her that there were no specific concerns about Mr Magloire. She noted no concerns about his physical or mental health. Mr Magloire told the nurse that he was not taking his medication as he did not have a mental illness.
137. Checks continued that day and at 4.30pm, an officer recorded that Mr Magloire was in good spirits.
138. At 4.53pm, an officer noted that Mr Magloire had engaged with the regime and had had a shower and medication.
139. At 8.00pm, an officer updated the ACCT record and noted that Mr Magloire raised no issues and was a very polite prisoner.
140. At approximately 8.50pm, an Officer Support Grade (OSG) started carrying out welfare checks. In his statement, he noted that when he reached Mr Magloire's door, he saw him on the floor, with a plastic bag over his head. He said he called a code blue promptly. (This triggers the control room to call an emergency ambulance and alerts prison staff of the incident.) A minute later, more officers arrived.
141. In his statement, Officer A said that he heard the code blue at 9.00pm and responded immediately. He said he and Officer B were the first to arrive. He said that they went into the cell and removed the plastic bag which was tied around Mr Magloire's neck. Officer A said Mr Magloire was not breathing, so he began CPR.

142. Ambulance records show that the control room phoned for an ambulance at 9.01pm.
143. In his statement, a CM said that he heard the code blue and made his way to the segregation unit. He said when he arrived, Officers A and B were already in the cell, assisting Mr Magloire.
144. At 9.02pm, two nurses arrived with the medical emergency bags. In her statement, one nurse recorded that she arrived within two minutes and Officer A had removed the plastic bag. She said Mr Magloire was warm, but she could not find a pulse. She said that they attached the defibrillator and inserted an I-gel (a tube to open the airway) to administer oxygen.
145. The ambulance arrived at the prison at 9.10pm, but they did not reach Mr Magloire until 9.14pm. The ambulance records noted that staff were not immediately available to escort the crew to Mr Magloire. On arrival, the paramedics took over resuscitation efforts. At 9.31pm, a second paramedic team arrived. Paramedics restored Mr Magloire's heartbeat, but he remained unconscious. He was taken by ambulance to hospital at 10.12pm and placed on life support.
146. A paramedic told the investigator that during the medication round the next day, one of the mental health nurses said, "He was a piece of shit anyway, doesn't matter" and an officer said, "Oh, do you want me to get Mr Magloire, oh, wait a minute, no I can't". We were not told the name of the officer, but the Head of MHIRT told us the nurse no longer worked at the prison.
147. On 3 February, hospital staff told healthcare staff that Mr Magloire's life support was going to be withdrawn. That afternoon, Mr Magloire's brother, the Head of Segregation and the imam visited Mr Magloire. At 4.20pm, life support was withdrawn, and Mr Magloire died.

### **Contact with Mr Magloire's family**

148. At 10.35pm on 29 January, the Deputy Governor contacted Mr Magloire's brother. (There is no further detail about the conversation in the records.) On 30 January, a SO was appointed as the family liaison officer, and she met Mr Magloire's brother at the hospital in the morning. She recorded that Mr Magloire's brother was told that Mr Magloire was on life support and was not expected to live. She recorded her contact with Mr Magloire's brother until 21 February. There are no further entries after that date and there are no entries in the log to indicate that the prison offered to contribute to funeral expenses.
149. The prison was unable to confirm if they had contributed to Mr Magloire's funeral expenses. They told the investigator that they always contribute to the funeral if the family want them to.

### **Support for prisoners and staff**

150. After Mr Magloire's death, the Deputy Governor 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. The prison

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

### **Post-mortem report**

151. The hospital established that Mr Magloire died from an anoxic brain injury (a lack of oxygen to the brain) caused by asphyxiation. The Coroner accepted the cause of death, and a post-mortem was not completed.

### **Inquest into Mr Magloire's death**

152. The inquest into Mr Magloire's death was held on 26 January 2026 and a verdict of suicide was recorded.
153. The coroner concluded that Mr Magloire's death was due to anoxic brain injury caused by asphyxiation.

## Findings

### Assessment of risk of suicide and self-harm

154. Prison Service Instruction (PSI) 64/2011 on safer custody (in place at the time of Mr Magloire's death and since replaced by the Prison Safety Policy Framework) states that ACCT case reviews should be multidisciplinary where possible, that a support plan should be completed at the first review, and that it must reflect the prisoner's needs, level of risk and the triggers of their distress.
155. Mr Magloire had clear risk factors for suicide including a history of serious mental health concerns, a history of self-harm and long term segregation. He was monitored using ACCT procedures on three occasions, including at the time of his death. We identified concerns about the quality of the ACCT. In all three ACCTs, Mr Magloire's care and support plans were poor and under-developed and where actions were identified, not all of them were completed before the ACCT was closed. There was no post-closure review completed for Mr Magloire's first two ACCTs, the ongoing record was not always completed in full, and the supervisor checks were not consistently carried out. Given Mr Magloire's presentation and behaviour, we would have expected more input from MHIRT at his ACCT case reviews. While the issues identified are unlikely to have contributed to Mr Magloire's death, we make a recommendation about ACCT later in this report.

### Segregation

156. At the time of Mr Magloire's death, he had been segregated for 83 days and the prison had carried out ten SRBs. PSO 1700 on segregation acknowledges the risks of holding vulnerable prisoners in segregation. It notes that rates of suicide among segregated prisoners is high, and that segregation should only be used as a last resort. Prisoners monitored under ACCT procedures can be segregated but only when they are such a risk to others that no other suitable location is appropriate and where all other options have been tried or are considered inappropriate.
157. The PSO sets out the process for a prisoner to move from segregation and the different pathways available, which include a return to standard location, a transfer to a VPU or to another establishment. PSO 1700 states that the SRB's role is to carefully consider all evidence and "all relevant issues" about extending segregation or removing the prisoner from segregation.
158. Following Mr Magloire's second period of segregation on 12 November 2022, there is little evidence in the SRB paperwork that the prison was considering all Mr Magloire's potential pathways out of the segregation unit. A care plan should have been created for him on 14 December, setting out how his mental health was being supported while in segregation. This was not completed until 23 January, even though concerns had already been raised about the impact of segregation on his mental health.
159. We found numerous issues with the segregation paperwork, including errors and omissions about who attended the meetings on 27 October, 17 November, 1 December 2022 and 12 January 2023. It was not recorded that Mr Magloire was in ACCT post-closure on 14 November and the ACCT case manager was not involved

in the SRB on 1 December. While healthcare staff attended the SRBs, the MHIRT did not once attend. Given Mr Magloire's psychological issues, this should have happened. We make the following recommendation:

**The Governor should ensure that there are effective quality assurance arrangements in place so that she can be satisfied that both the Prison Safety Policy Framework (formerly PSI 64/2011) on ACCT monitoring and PSO 1700 on segregation are being followed.**

### Transfer to another establishment

160. When Mr Magloire was discharged from hospital, he was sent to Wormwood Scrubs in line with HMPPS and NHS policies on the transfer and remission of adult prisoners. These state that the patient returning to prison will return to the nearest reception prison (unless the prisoner needs to be located in the high security estate). Mr Magloire expressed concern about returning to Wormwood Scrubs. He said he felt vulnerable due to the nature of his offences and that Wormwood Scrubs did not have a VPU. OMU were made aware of this and said they would look to move him on straight away. Mr Magloire repeatedly told staff that he wanted to be transferred to another prison and he told staff that he had assaulted other prisoners in order to be sent to the segregation unit.
161. We asked OMU to give us the details of all contacts or records relating to their attempts to transfer Mr Magloire. They provided us with emails sent in October 2022, four months after Mr Magloire arrived at Wormwood Scrubs. This request was refused by the other prison on the basis that Mr Magloire was on 'parole hold'.
162. Following his hospitalisation in November 2022, the mental health manager emailed colleagues about her concerns for Mr Magloire. She stated that it would be detrimental to him if he remained at Wormwood Scrubs, and she flagged the negative impact of someone remaining in segregation for a long period of time. The forensic psychologist responded to say that the necessary reports (for the parole process) could be completed at another prison, and this should not be a barrier to Mr Magloire moving to a safer location.
163. The investigator contacted HMPPS' Offender Flows and Configuration Team. They told the investigator that the National Allocation Protocol states: 'Transfers are possible while determinate and indeterminate sentence prisoners are in a parole review, however, they should only be pursued if it is considered to be in the best interests of their progression and does not interfere significantly with the parole process.'
164. The Generic Parole Process policy framework states, "prisoners may be transferred during their Parole Board review to access a progression opportunity only in line with their sentence plan or for security reasons".
165. We recognise that the situation with Mr Magloire was complex, especially given his mental health issues, his location in the segregation unit and being within the parole window. However, we are concerned that the prison did not try to move him either during his first four months – despite having said they would try to do so straightaway - and more crucially, when it became obvious that the decline in his behaviour and the deterioration in his mental health was largely attributable to his

fear of remaining in Wormwood Scrubs. It is evident that the staff involved in Mr Magloire's care, and indeed in other prisons where transfer was explored in 2022, all incorrectly believed that there was no option to transfer him due to his parole review.

166. We contacted HMPPS about our concerns that prison staff were not aware that a prisoner could be considered for a transfer in the parole window. They told us that they had already identified that this was a knowledge gap among prison staff and had issued guidance to all staff working in OMU and planned to issue further communications to include other HMPPS staff. We therefore make no recommendation.

### **Safety Intervention Meeting**

167. PSI 64/2011 details that some prisoners supported through ACCT who have particularly challenging needs may need to be referred to the SIM. The policy states that when a prisoner in the segregation unit is monitored under ACCT procedures, the case must be referred to the SIM.
168. The prison gave us copies of the five meetings in which Mr Magloire was discussed. However, he was not discussed in three meetings between November 2022 and February 2023, even though he was in the segregation unit, was subject to ACCT and on two occasions, had recently harmed himself. While they discussed Mr Magloire on 7 December 2022, the SIM did not discuss him again before he died and, in this period, he passed the 42 days in segregation point and was nearing the 84-day point.
169. Given the complexity of Mr Magloire's situation and the length of time he spent in segregation, he would have benefitted from the SIM discussing his case more regularly. We identified instances of confusion between healthcare and prison staff, for example, about whether Mr Magloire was suitable for the IPU or if he was on the waiting list. We therefore make the following recommendation:

**The Governor should ensure that the agenda for the SIM includes consideration of the length of time a prisoner has been segregated.**

### **Clinical care**

170. The clinical reviewer concluded that the care provided to Mr Magloire was not equivalent to that which he could have expected to receive in the community.
171. She said that in a community setting, a person discharged from hospital would return to their ordinary residence (where they lived before being admitted). In this case, Mr Magloire did not return to Isle of Wight, where he had lived for many years, and instead, was sent to Wormwood Scrubs. The clinical reviewer concluded that healthcare could not be equivalent in this respect.
172. The clinical reviewer identified that while the mental health team were very busy due to limited resources, she was concerned about the differences in staff perception about the significance of Mr Magloire's paranoid beliefs. She identified that the absence of a therapeutic relationship with him and an allocated nurse, the lack of a plan to identify and respond to his deteriorating mental state and the

limited support to move him to a more suitable environment meant that the care provided was not effective.

173. The clinical reviewer said that some staff saw Mr Magloire's behaviour as normal for him, while others were concerned that his mental health was deteriorating. The psychiatrist's referral to the NHS highlighted that some staff had not identified his concerns, while others were highly tuned to his psychosis. The prison paramedic told the investigator that she felt that mental health staff dismissed the concerns she raised about Mr Magloire's mental health, and they had concluded there was nothing wrong with him.

### **Inpatient unit**

174. Following Mr Magloire's discharge from hospital on 1 December when he was described as acutely unwell and when he had symptoms of a psychotic relapse on 8 December, healthcare staff could not transfer him to the IPU as there was no space and Mr Magloire had to remain segregated.
175. The healthcare team was unable to provide the admissions criteria for IPU and all of the IPU waiting lists for the period under consideration. Of the four lists they provided, Mr Magloire was not listed as needing a bed.
176. While we cannot know if a bed would have become available in time or that this would have led to a different outcome, we are concerned that Mr Magloire was not added to the waiting list once it was identified that he needed that level of care or indeed prioritised for a bed given his mental state and that staff considered he could not be transferred to another prison.

### **Joint working and communication**

177. Good communication and liaison between prison and healthcare staff is critical and ACCT and segregation processes need staff to work effectively together.
178. Healthcare staff did not attend Mr Magloire's ACCT reviews on 1 and 9 December. On 9 December, the decision was made to close the ACCT but just the day before, the psychiatrist had concluded that Mr Magloire was still at risk of suicide and self-harm and should be managed through the ACCT process.
179. In most instances, the prison paramedic attended the SRB meetings. While there are advantages in having the same person attending the meetings, the discussions focused on Mr Magloire's psychological issues rather than his physical health. It would therefore have been beneficial for someone from the MHIRT to have attended these reviews.
180. Communication broke down between prison and healthcare staff about Mr Magloire's ACCT status. On 14 and 16 December, when a nurse noted that Mr Magloire should continue to be managed under ACCT procedures, Mr Magloire was either in the ACCT post-closure period or not on an ACCT at all. She was also unaware that Mr Magloire was on an ACCT when she saw him on 26 January. We note that the healthcare team's operating procedure has since been revised to ensure that the most relevant clinician always attends an ACCT. This should mean

that the healthcare team will now be aware of a prisoner's ACCT status, and we therefore do not make a recommendation.

### **Action taken since Mr Magloire's death**

181. After Mr Magloire's death, Practice Plus Group and Barnet, Enfield and Haringey Mental Health Trust commissioned a patient safety incident investigation. They produced a report which identified areas for improvement which were converted into an action plan. In an update provided to the Ombudsman in November 2024, they confirmed that all actions have been completed.
182. The investigator asked healthcare staff to provide a copy of the revised operating procedures for healthcare's involvement in ACCT reviews and their new segregation policy. Staff were unable to provide a copy of their own segregation policy and they were unclear if it existed. We therefore make the following recommendation:

**The Head of Healthcare should ensure that the segregation policy has been developed and is implemented in line with their own action plan to include a process for identifying the most suitable clinician to attend the Segregation Review Board.**

183. Wormwood Scrubs confirmed that following Mr Magloire's death, all IPU referrals are now screened and co-ordinated through multidisciplinary team meetings and prioritisation is dynamic and based on the needs of the service user. For mental health admissions, decisions are made between the consultant psychiatrist, inpatient team leader and the mental health team leader and there is a process in place for referrals made out-of-hours. The healthcare team told us that a new role of Service Lead for Quality, Performance, Safety Transfer and Remissions has been implemented to support the patient flow from the IPU into NHS establishments.

### **Governor to note**

#### **Inappropriate comments**

184. A paramedic told us that a mental health nurse and an officer made highly inappropriate, offensive and unprofessional remarks about Mr Magloire following his death. The clinical reviewer reported this to the Head of the MHIRT at the time and was told that the nurse had been spoken to and had since resigned. We do not know what investigations were made into the comments allegedly made by the officer, but we bring this to the Governor's attention.

#### **Response to self-harm on 29 November**

185. PSI 64/2011 states that staff must be aware that the preservation of life is the first priority when managing at-risk prisoners. Justifiable decisions on when to go into a cell where life is endangered should be documented. However, there were three occasions when officers were told that Mr Magloire was threatening to harm himself with cutlery, and indeed he was able to make self-inflicted wounds requiring hospital attention. No action was taken to remove items from him, and no record was made to explain why the decision was made not to intervene.

### **Family liaison and record keeping**

186. The family liaison log only documented contact up to 21 February. It did not contain any information about the payment of Mr Magloire's funeral expenses or any subsequent contact with his next of kin. The prison was unable to confirm if they had made a financial contribution to the cost of Mr Magloire's funeral but told us that they always contributed to the cost of the funeral if a family wanted them to. The family liaison log should have covered this.

### **IMB representation at SRB meetings**

187. An IMB representative only attended two of the SRB meetings.

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