Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Isaiah Olugosi, a prisoner at HMP Wormwood Scrubs, on 28 March 2022

A report by the Prisons and Probation Ombudsman

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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

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 Isaiah Olugosi died on 28 March 2022 at HMP Wormwood Scrubs from asphyxiation due to hanging. He was 39 years old. I offer my condolences to Mr Olugosi's family and friends.

Mr Olugosi had some significant risk factors for suicide and self-harm, including his relationship breakdown, the prospect of a long prison sentence and a high-profile crime. There were missed opportunities to correctly identify his risk of suicide and self-harm and offer him appropriate support.

There were even more significant failings on the night he died. The night patrol did not complete the required checks and, most distressingly, Mr Olugosi's wife was unable to alert the prison to his suicidal state despite telephoning and attending the prison in person. It is utterly unacceptable that family members should be unable to raise the alarm at a prison when they have serious concerns for a prisoner's welfare.

The clinical reviewer found that the clinical care Mr Olugosi received was not always equivalent to that he could have expected in the community. This involved missed appointments due to staffing issues, waiting too long for psychological input and staff failing to identify that Mr Olugosi was not taking his anti-depressants.

In addition, the post-mortem found cocaine metabolites in Mr Olugosi's system. I am concerned that the prison does not have sufficient resources to enable it to effectively tackle drug supply and demand.

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 **August 2026**

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Summary

Events

1. On 3 September 2020, Mr Isaiah Olugosi was remanded into custody charged with a number of counts of conspiracy to commit fraud, conspiracy to facilitate the travel of another person with a view to exploitation, possession of articles for use in fraud and transferring criminal property. He was taken to HMP Wormwood Scrubs the same day.

2. Mr Olugosi had previously been in prison for four months in 2013. He had no significant history of mental health issues, no recorded substance misuse and no history of attempted suicide or self-harm.

3. From May 2021, Mr Olugosi worked with the substance misuse team after he contacted them and said he had drug and alcohol issues from before he was remanded to prison. He subsequently ran a Narcotics Anonymous (NA) group for prisoners on his wing.

4. On 30 November 2021, Mr Olugosi told a member of the prison mental health team that he was feeling down and having negative thoughts. Two days later he was referred for a mood review but one was not completed.

5. On 3 February 2022, Mr Olugosi told a passing GP that he had not had his promised mood review and the GP completed one ad hoc which showed Mr Olugosi was moderately depressed. Mr Olugosi said his wife wanted a divorce and he was worried about the length of sentence he would receive.

6. On 24 February and 23 March a nurse completed mood reviews but did not ask Mr Olugosi whether he had any thoughts of suicide or self-harm.

7. On 27 March, Mr Olugosi's wife became extremely concerned for his welfare after she spoke to him on a mobile phone at about 9.00pm. She tried unsuccessfully to contact the prison, firstly by telephone and then by driving to the prison and pressing the buzzer on the main gate.

8. Another prisoner found Mr Olugosi hanged in his cell at about 8.54am the next morning. Staff called a code blue (an emergency code when a prisoner is not breathing or having difficulty breathing) and attempted to give Mr Olugosi cardio-pulmonary resuscitation (CPR). The prison paramedic arrived three minutes later and told them to stop as Mr Olugosi had died.

9. After Mr Olugosi's death the prison established that the main switchboard number had diverted to an unmanned office during the night instead of the control room as it should have done. The buzzer on the gate was found not to be working.

10. The post-mortem report concluded that the cause of Mr Olugosi's death was hanging. There were cocaine metabolites in his system when he died.

Findings

11. Mr Olugosi had some significant risk factors associated with an increased risk of suicide and self-harm, including relationship breakdown, the prospect of a long prison sentence and a high-profile crime. Mr Olugosi waited too long for a mood review and his significant risk factors were not shared with safer custody or wing staff. His two mood reviews in February and March 2022 were not held in private, nor were they compliant with clinical guidance. These were missed opportunities to potentially identify that Mr Olugosi was at risk of suicide and self-harm.

12. The night patrol officer failed to complete the required check (known as the evening roll count) of prisoners on D Wing on the evening of 27 March 2022. He also failed to complete an adequate check on Mr Olugosi during the early morning roll check on 28 March. The officer who unlocked Mr Olugosi at 8.15am that morning did not complete a welfare check as he should have done.

13. There was no way for a member of the public to contact the prison to raise concerns about a prisoner at Wormwood Scrubs during the night of 27/28 March. This was unacceptable.

14. Staff gave Mr Olugosi CPR despite signs unequivocally associated with death.

15. The clinical care provided to Mr Olugosi was not always equivalent to that he could have expected in the community. He missed two telephone and two in person appointments when he was being investigated for urological cancer due to communication failures and staff shortages. A requested neurology appointment was never received and the follow up was inadequate. Mr Olugosi also waited much longer than acceptable for GP appointments and psychological therapies. Healthcare and pharmacy staff failed to identify that Mr Olugosi was not taking his antidepressants and the policy on this was unclear.

16. The Head of Drug Strategy is not sufficiently resourced to effectively tackle drug demand and supply at the prison.

Recommendations

- The Head of Healthcare should ensure that all mood reviews are undertaken in line with NICE guidance, using an agreed format which includes the broader risk factors for suicide in prison and which clearly assesses any changes in presentation between reviews.

- The Head of Healthcare should review the current process for sharing risk related information between healthcare and prison staff to assure themselves that relevant information is promptly shared in an auditable way.

- The Governor should introduce a robust quality assurance process to satisfy herself that that all staff look through the observation panel before unlocking cells.

- The Governor should ensure that the prison has a contingency plan covering what to do when members of the public arrive at the prison in night state, concerned about the welfare of a prisoner.

- The Governor and Head of Healthcare should continue to provide regular training on resuscitation which includes supporting staff to make appropriate decisions about when not to resuscitate.
- The Head of Healthcare should ensure that all staff are aware of their responsibilities in relation to patients who omit doses of a medication. Where there are significant failures in the administration of medicines the Head of Healthcare should ensure these are reported as critical incidents.
- The Governor should ensure that the Head of Drug Strategy is sufficiently resourced to effectively tackle drug misuse.

The Investigation Process

17. HMPPS notified us of Mr Olugosi's death on 28 March 2022.

18. 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 her. No one responded.

19. The investigator visited Wormwood Scrubs on 5 April 2022. She obtained copies of relevant extracts from Mr Olugosi's prison and medical records.

20. The investigator interviewed 13 members of staff and one prisoner at Wormwood Scrubs between April and August 2022. The former deputy governor provided a statement about actions taken by the prison after Mr Olugosi died.

21. NHS England commissioned a clinical reviewer to review Mr Olugosi's clinical care at the prison. The investigator and clinical reviewer jointly interviewed clinical staff. The clinical reviewer produced an initial report in February 2023. Due to concerns about a conflict of interest that questioned the clinical reviewer's independence, NHS England commissioned another clinical reviewer to provide a second review. We received this review in December 2023. We apologise for the delay in issuing the initial report as a result. We received the Prison Service response to our recommendations in November 2025, some nine months after the Coroner's Inquest. The publication of the final report was further delayed by the sickness absence of the investigator. We apologise for this additional delay.

22. We informed HM Coroner for West London of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

23. The investigator met Mr Olugosi's wife at her solicitor's office, to explain the investigation and to ask if she had any matters she wanted the investigation to consider. Mr Olugosi's wife shared a number of concerns about his care in Wormwood Scrubs which we have addressed in this report. The investigator interviewed Mr Olugosi's wife as she was a witness to some of the events on the day he died. We have annexed the transcript of the interview to this report.

24. After receiving our initial report Mr Olugosi's wife reiterated that she was highly upset and aggrieved by her treatment by the prison on the morning of Mr Olugosi's death. In particular, she had great difficulty in contacting the prison by telephone. She said on the single occasion her call was answered she had asked to speak to a Governor and had been put through to voicemail. She said her confidence in the prison had been further undermined by misinformation given to them by prison staff including the Governor. For example, the prison had told her that Mr Olugosi was found hanged by staff and that all the required checks were done on the night of 27/28 March, and neither were true. We have sent her a copy of this report.

Background Information

25. HMP Wormwood Scrubs is a category B local male prison. The prison accepts sentenced and remand prisoners over the age of 21, as well as young adults (18-21 years old) on remand only. The prison has five main wings, with two wings providing single-cell accommodation.

26. Practice Plus Group provides physical health services, and Barnet, Enfield and Haringey Mental Health Trust provides mental health services. The Forward Trust is contracted to provide psycho-social substance misuse services and talking therapy under the Adult Improving Access to Psychological Therapies programme (IAPT).

HM Inspectorate of Prisons

27. The most recent inspection of HMP Wormwood Scrubs was in June 2021. Inspectors reported that the prison was a much safer, cleaner and better organised prison than it had been. Health services were led by a strong management team, including a new Head of Healthcare. There were several vacancies but strategic recruitment was taking place and staff accessed appropriate training. They noted that there was a comprehensive range of mental health services but routine appointments took place outside of the agreed timescales because of a doubling in referrals over the last year. Inspectors noted that Atrium ran counselling services and had recently increased their provision to three counsellors. An improving access to psychological therapies (IAPT) practitioner from Forward Trust supported 20 prisoners with mild to moderate psychological problems.

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 May 2023, the IMB reported that chronic staffing issues impacted the prison in many areas, including the cancellation of scheduled hospital appointments and provision of an effective mental health service. Waiting times for routine mental health assessments had increased.

Previous deaths at HMP Wormwood Scrubs

29. Mr Olugosi's death was the sixth self-inflicted death at Wormwood Scrubs since March 2019. There were four other deaths during this period from natural causes. Since Mr Olugosi's death there have been seven further deaths up to March 2024. Three of these were self-inflicted, three due to natural causes and two from as yet undetermined causes.

30. In our investigation of a self-inflicted death in 2020, we recommended that the Governor should ensure that roll checks and welfare checks are conducted in line with local policy after the investigation found that:

    - an officer did not complete a roll check on the morning the prisoner was found dead; and

- another officer did not conduct welfare checks during morning unlock.

Mr Olugosi's death was the third death since 2015 in which a member of staff was disciplined for not properly completing roll checks.

31. In our investigations of deaths in November 2020, August 2021, October 2021, December 2021, February 2023 and July 2023, we found that resuscitation efforts had been inappropriate as the person had died.

Key Events

2020

32. On 3 September 2020, Mr Isaiah Olugosi was remanded into custody charged with a number of counts of conspiracy to commit fraud, conspiracy to facilitate the travel of another person with a view to exploitation, possession of articles for use in fraud and transferring criminal property. He was taken to HMP Wormwood Scrubs the same day. Mr Olugosi had previously been in prison for four months in 2013.

33. Mr Olugosi told a nurse at an initial health assessment that he had no mental health history, did not drink alcohol or use drugs and had never had any thoughts of self-harm. His clinical records showed that he had been prescribed Citalopram (an antidepressant) in 2011 for low mood and relationship issues. Mr Olugosi had no other history of mental ill-health and no recorded history of alcohol or substance misuse.

34. On 18 September, Mr Olugosi moved from the induction unit to D4 landing. D4 is a single cell landing for prisoners with trusted jobs. Mr Olugosi tested negative in voluntary drug tests in November and December 2020.

2021

35. In January 2021, Mr Olugosi was given a job working in the D Wing store and received numerous positive entries for his hard work on his electronic prison record (NOMIS).

36. On 24 February, an intelligence report (IR) recorded that store workers were rumoured to be selling items to other prisoners and it appeared that Mr Olugosi had received money from the relative of another prisoner on 15 February.

37. On 23 March, Mr Olugosi told Dr A, a GP, that he had abdominal pain, reduced appetite and had lost weight. A urine sample contained blood and protein, indicating a possible infection, and so a second sample was sent to a pathology laboratory for further tests. Dr A prescribed Mr Olugosi antibiotics in the meantime. Another urine test on 13 April still showed signs of infection. Another sample was sent to the pathology laboratory after the prison discovered the original sample had not been received. Mr Olugosi was prescribed more antibiotics.

38. On 29 March, Mr Olugosi told a nurse he had felt dizzy when getting out of bed and had fallen and hit his nose on his cell toilet. His clinical observations were normal and there was no sign of concussion. The nurse dressed a wound on his nose and gave him some painkillers.

39. On 29 and 31 March, two different IRs showed that the Financial Intelligence Unit (FIU) had rejected two payments to Mr Olugosi because they suspected they related to the illicit economy in the prison.

40. On 1 April, another IR showed that an officer had noticed more than one payment from possible relatives of other D Wing prisoners on Mr Olugosi's prison account. On 2 April, the FIU stopped another payment to Mr Olugosi from the same source

that had attempted to pay him on 29 and 31 March. Mr Olugosi continued to work in the D Wing store and received numerous positive entries about his work on his prison record. (The Head of Security told us that Mr Olugosi was thought to be playing a small role in illicit activity at the prison and did not meet the threshold for more serious intervention.)

41. On 6 April, Mr Olugosi reported suffering another dizzy spell and said he had hit his head after falling in the shower. Dr A examined him and referred Mr Olugosi to a neurologist in case he had Micturition Syncope (a blackout caused by a drop in blood pressure after urination) or epilepsy. He also advised Mr Olugosi to consider moving to a shared cell so his cellmate could keep an eye on him.

42. Dr B, the duty GP, reviewed Mr Olugosi the next day. Mr Olugosi said he had considered the advice to share a cell but had decided to stay in a single cell. Mr Olugosi's clinical record indicated that the neurology referral had been made and a task was set for administrative staff to follow it up weekly.

43. On 12 April 2021, Mr Olugosi applied to become a Listener (a prisoner trained by The Samaritans to provide confidential peer support). The following day he passed the Health and Safety and Food Safety courses as part of a training course to work in the Escape Café (the staff restaurant).

44. On 20 April, Dr A told Mr Olugosi that the pathology laboratory tests had not shown any infection in his urine. He sent an urgent referral to hospital for Mr Olugosi to see a specialist from the urology team in case the blood in his urine indicated a kidney stone or urological cancer. He also ordered blood tests for Mr Olugosi.

45. On 21 and 28 April, Mr Olugosi's clinical record indicated that administrative staff chased up his neurology referral. The records contained no further reference to the referral and an appointment was never received. The task to chase it up was stopped on 16 June but the record does not explain why. Mr Olugosi reported no other dizzy spells and there is no indication he asked about the neurology appointment.

46. On 29 April, Ms A, a substance misuse worker assessed Mr Olugosi after he made an application to see someone from The Forward Trust. He told her that he had a history of alcohol, cannabis and cocaine issues and had been spending £150 a day on his habit in the community. He asked for some reading material and said he would complete some in-cell packs. Ms A did not question this information despite Mr Olugosi having no recorded history of drug or alcohol use.

47. On 4 May, Mr Olugosi attended a urology appointment at hospital. An ultrasound of his abdomen appeared normal but tissue samples were taken for biopsy.

48. Officer A completed a key work session with Mr Olugosi the same day. Mr Olugosi told Officer A about his visit to hospital and that he was awaiting test results. He said he had been working with The Forward Trust to address drug and alcohol issues and was being trained for a job in the Escape Café. He said he maintained contact with his wife and children via phone calls, letters and visits via video conference (introduced during the pandemic).

49. On 15 May, Officer B noted that Mr Olugosi continued to run the wing store very well and was a positive influence on the wing. On 17 May, Mr Olugosi was accepted for the Listener selection process and allocated to the Right Course programme in the Escape Café (a programme usually for prisoners coming up to release that offers training and provides employment in the hospitality industry on release).

50. On 20 May, Mr Olugosi was convicted. He was not given a date for sentencing as the trials of his co-defendants were ongoing.

51. On 21 May, Mr Olugosi told Ms A that he was feeling stressed because his barrister had told him to expect at least a fourteen-year sentence, which was longer than he had initially expected. Mr Olugosi said he had coping strategies and was going to attend a NA meeting to de-stress and talk about his worries. Ms A said she thought he seemed better after their discussion. She was not concerned about him and did not consider a referral to the mental health team or share the information with anyone else in the prison.

52. On 25 May, the hospital urology team called the prison healthcare centre expecting to have a telephone consultation with Mr Olugosi about further tests he was due to have at hospital. The healthcare team had no record that Mr Olugosi had an appointment and so he had not been brought to the healthcare centre. The telephone appointment was subsequently re-booked for 28 June and a face-to-face appointment at the urology clinic made for 5 July.

53. On 26 May, Mr Olugosi successfully completed the Listener selection process.

54. On 28 June, Mr Olugosi missed his telephone appointment with the urology team because there were not enough officers available to escort him. He also missed his hospital appointment on 5 July for the same reason. The appointment was re-booked for 15 July but was cancelled by the urology team and re-booked again for 20 July. Mr Olugosi missed this appointment too because officers were unaware an escort was required. The appointment was re-booked again for 3 August and Dr A liaised with Mr A, the Deputy Governor, to ensure that it took place. Mr Olugosi was discharged from the urology team after the appointment as the tests showed nothing of concern.

55. On 4 August, Mr Olugosi had an altercation with another prisoner in the Escape Café. Mr Olugosi said the prisoner had threatened him with a knife. Intelligence was received that the argument might have been over money. The security department analysed the intelligence and referred the matter to safer custody to attempt mediation between the two men. There is no record of whether this mediation took place. Mr Olugosi was suspended from his job but allowed to complete the courses he was taking and on 1 September, he was awarded a Level 2 Certificate in professional food and beverage service skills.

56. Ms B, the then Safer Custody Hub manager, told the investigator that the incident in the Escape Café had led staff to reassess Mr Olugosi's suitability for a trusted job. At about the same time she was given intelligence that Listeners on D4 landing were supplying other prisoners with psychoactive substances (PS) although Mr Olugosi was not mentioned specifically. Given the level of trust placed in Listeners and the fact that the incident in the Escape Café had involved a dispute over money, she decided to suspend Mr Olugosi from his role as a Listener.

57. Ms B said Mr Olugosi was very upset when she told him of her decision. She explained that Listeners had to have an unblemished record. She reassured him that he could continue to run the NA group on D4 and that she would review her decision in a few months and that if he had not been involved in any more incidents he would be reinstated as a Listener. Ms B said that all Listeners had a weekly debrief with a Samaritan. Although these meetings were confidential, the Samaritan always told her if they had concerns about a Listener's mental well-being. She said that no Samaritan had ever raised any concerns about Mr Olugosi's mental well-being with her. (We understand that Mr Olugosi had received verbal reassurance that he would be reinstated as a Listener in the weeks before he died.)

58. On 28 September, Mr Olugosi was given the trusted job of wing cleaner.

59. On 11 October, Ms C, a substance misuse worker, completed a welfare check on Mr Olugosi. She congratulated him on being abstinent from alcohol for over a year. Mr Olugosi said he was proud of the work he was doing facilitating the NA group on his wing but would like to do some work on his own issues and asked for some in-cell packs to complete.

60. On 8 November, the Dedicated Search Team (DST) completed an intelligence led search of Mr Olugosi's cell. They found two X-Box gaming consoles, a 30m extension cable, a George Foreman grill, broken furniture and a quantity of sexually explicit photographs. All the items were confiscated.

61. Ms C saw Mr Olugosi for another welfare check on 19 November. Mr Olugosi said he was due to go to court in December (the trial of his co-defendants was ongoing) and asked for a supporting letter from The Forward Trust evidencing his engagement with the service. Ms C gave him an in-cell pack and told him she would check in again with him in December.

62. Ms D, Mr Olugosi's wife, told the investigator that on 28 November she had become very worried that Mr Olugosi was suicidal after speaking to him on the telephone. She said she logged her concerns with the police online using the 101 service.

63. On 30 November, Mr B, an IAPT (talking therapy for anxiety and depression) worker, said Mr Olugosi asked to speak to him as he saw him in passing. Mr Olugosi said he was feeling down and having negative thoughts. Mr B put Mr Olugosi on the list for the mental health triage meeting and asked wing staff to check on Mr Olugosi later that day. There is no record that this took place.

64. Mr B checked Mr Olugosi the next day. Mr Olugosi said he was feeling better after their chat the previous day. On 2 December, Mr Olugosi was discussed at the mental health triage meeting and added to the waiting list for a mood review (a non-urgent review by the GP for depression).

65. On 20 December, an officer noted that Mr Olugosi was very quiet and not in his normal mood.

2022

66. On 5 January, Ms C saw Mr Olugosi for a check-in. He said he was doing well and told her his court case had been adjourned. Ms C left Mr Olugosi with an alcohol

misuse in-cell pack and said she would check in with him again before he went to court. She saw him again on 11 January as she clearly expected Mr Olugosi to attend court the following day but Mr Olugosi said he was not going to court then after all.

67. On 3 February, Mr Olugosi stopped Dr A in passing and said he was still waiting for a mood review appointment. He said he had negative thoughts, was ruminating on his situation and felt down. He said his wife wanted a divorce and he was facing a long sentence. Mr Olugosi asked for antidepressants. Dr A completed a Patient Health Questionnaire (PHQ) 9 (a standard tool to gauge the level of depression by asking patients to score their mood over the previous two weeks). Mr Olugosi scored 10 indicating he was moderately depressed. He said he had felt down, depressed or hopeless on more than half the days and felt like he was a failure nearly every day, but he said he had not felt suicidal or like harming himself. Dr A prescribed Citalopram, referred Mr Olugosi to the IAPT service and planned to review him again in three weeks.

68. On 10 February, Mr Olugosi's co-defendants were convicted at Snaresbrook Crown Court and a sentencing date for everyone involved was set between 18 and 22 April.

69. Officer C worked on D Wing. He said that Mr Olugosi had been affected by news reports of his offences and had appeared to be a bit down. He thought this had coincided with Mr Olugosi getting closer to his sentencing.

70. On 24 February, Nurse A saw Mr Olugosi for a mood review. She spoke to him at his open cell door with a member of staff who was shadowing her for work experience. She noted that he had only had one dose of Citalopram. Mr Olugosi said he had only been made aware of his prescription the day before when an officer told him he was on the medication list. Nurse A said Mr Olugosi told her he was under some stress. His wife wanted a separation and she had been the recipient of a significant amount of press attention which had resulted in her moving house. Mr Olugosi said they were still in touch and the relationship was amicable.

71. Nurse A did not ask Mr Olugosi specifically whether he had any thoughts of suicide or self-harm. She said that she did not believe he was significantly depressed but was anxious about his current situation. She did not think Mr Olugosi needed to be monitored under Prison Service suicide and self-harm monitoring procedures (known as ACCT). Nurse A said she agreed with Mr Olugosi that she would review him again in three or four weeks.

72. On 8 March, Mr Olugosi was discussed at the mental health triage meeting in response to the referral to IAPT by Dr A on 3 February. On 18 March, he was added to the IAPT waiting list. At interview Ms A said that the IAPT waiting list at this point was nine months. All prisoners on the waiting list were sent letters informing them of the likely delay before they would be seen.

73. On 23 March, Nurse A saw Mr Olugosi for his follow up mood review. She said she spoke to Mr Olugosi on D Wing with the same colleague who was again shadowing her. Mr Olugosi was chatting to his friends. Nurse A said it was obvious Mr Olugosi was very popular. He said he had been taking his Citalopram but had not noticed

any difference in his mood. Nurse A reminded him he had started on a low dose and said she would increase it.

74. Prisoner A told the investigator that he had been good friends with Mr Olugosi since Mr Olugosi arrived on D4 landing. He said that 26 March was Mr Olugosi's birthday. He got Mr Olugosi some presents, they made some food together, played chess and other games. He said Mr Olugosi had seemed very happy.

27 March 2022

75. The investigator watched CCTV footage from 8.45am on 27 March. Using all of the available evidence provided by the prison and London Ambulance Service records we have calculated that the CCTV clock was approximately two minutes ahead of the correct time on 27 March. The times below represent our calculation of the real time.

76. CCTV showed Mr Olugosi walking around the landing interacting with other prisoners. At one point he collected a chess set from his cell. He completed his servery orderly job handing out lunch to the other prisoners, cleaned his cell and spent some time socialising with Prisoner A. Just before 4.30pm, Mr Olugosi looked visibly frustrated. Prisoner A told the investigator he had wanted to have a shower before he was locked in his cell but had not been allowed to. Just after 4.30pm, a female officer locked Mr Olugosi in his cell for the night.

77. Prisoner A said Mr Olugosi had seemed fine that day. Just before they were locked in their cells for the night Mr Olugosi said to him, "I love you Cuz, I'm very grateful for everything". He said when he looked back on the exchange with the benefit of hindsight, he thought Mr Olugosi was saying goodbye to him.

78. At about 6.55pm, Officer C looked through Mr Olugosi's observation panel as part of roll check. Officer C said he told Mr Olugosi he would see him tomorrow and Mr Olugosi said "Yes, see you Gov." He said Mr Olugosi seemed his normal self and was sitting quietly on his bed.

79. Ms D told the investigator that she communicated with Mr Olugosi via an illicit mobile phone (this was removed from Mr Olugosi's cell by police after his death and sealed as evidence). She spoke to him at some point between 8.00pm and 9.00pm. She said Mr Olugosi was extremely upset. They had separated quite recently and he said he did not think she would ever forgive him. He said he had had enough and "couldn't do this anymore". Ms D said she was extremely worried about Mr Olugosi

80. Ms D provided the investigator with details of her calls. She called 999 and asked for the police at 9.01pm. She said she made it clear that Mr Olugosi was a suicide risk and the police said they would contact the prison. The investigator asked for the police records of Ms Chapman's 999 calls but they declined to provide them to her. Ms D said she was convinced Mr Olugosi was going to kill himself so rather than sit and wait for the police to call back, she drove to the prison.

81. The night patrol officer on each wing starts their shift at 9.00pm and is required to complete the evening roll count before 10.00pm. CCTV showed that Operational Support Grade (OSG) A, the D Wing night patrol officer, did not complete the

evening roll count. The signed roll for 27 March showed that he informed the night orderly officer that he had counted 228 prisoners on D wing. (The investigator informed the prison of this finding during the investigation. OSG A was dismissed following a disciplinary investigation in September 2022. We therefore did not interview him.)

82. Ms D said she arrived at Wormwood Scrubs at about 11.15pm. She repeatedly rang the buzzer next to the gate but no one answered. She looked up the prison contact details on her phone and the website said to ring the main switchboard number in case of emergency at night. (The main switchboard number should divert to the communications room at night because this is the only place staff are permanently situated.)

83. Ms D said no one answered. Her mobile phone call log showed she rang the prison at 11.18pm, 11.20pm and 11.21pm. At 11.22pm she rang 999 again and eventually got through to Hammersmith police. She said the police advised her to keep pressing the buzzer. They told her that the prison knew she was there. Ms D said she remained outside the prison still occasionally pressing the buzzer until about 1.30am when she drove home. She said the police did not call her back.

84. Operational Support Grade (OSG) B was on duty in the communications room which is directly above the gate where the buzzer is situated from 10.30pm that night. OSG B said he and the communications officer were not required to actively monitor the CCTV cameras covering the gate unless there was an incident, although they sometimes noticed things if the cameras happened to be pointing in the right direction when something happened.

85. OSG B said the main switchboard number went through to the gate during the day and diverted to the communications room during night state. He said for a significant period before that night, no calls had been received in the communications room during the night and the phone did not ring that night.

86. He said that people sometimes turned up at the gate during the night and pressed the buzzer. There is an intercom in the communications room to answer the buzzer but the intercom was not working that night so there was no way of answering it. He said he remembered a woman being outside the gate and could see her trying to use the intercom but the whole system was dead. He said he or Officer D, the communications officer, had told CM A the night orderly officer (the person in charge of running the prison at night).

87. CM A said she did not remember anyone informing her that there was a woman outside the gate that night. Officer D said he was not aware that there was an intercom in the communications room that allowed them to answer the buzzer.

88. At about 3.35am, OSG A completed the early morning count of prisoners on D Wing. He looked briefly through the observation panels of the cells near Mr Olugosi's but only glanced at Mr Olugosi's cell door as he passed. It is not possible to tell from the angle of the CCTV footage whether Mr Olugosi's observation panel was open. OSG A did not use a torch or turn the night light on in the cell.

Events of 28 March 2022

89. At midnight on 27 March, the clocks went forward an hour at the start of British Summer Time. The time on the CCTV clock is therefore one hour behind from midnight onwards. We have adjusted the times below accordingly.

90. At about 8.15am on 28 March, CCTV showed Officer C unlocked Mr Olugosi's cell but did not stop at his door. Officer C said that the expectation was that he should look through the observation panel before unlocking prisoners but that sometimes he did not do this if he was under time pressure. He said he was the only officer on duty on D4 landing that morning and had to get the off-wing workers up and off the wing so as not to delay the regime for the other prisoners.

91. At about 8.54am, CCTV showed Prisoner A went to Mr Olugosi's cell. He ran out again immediately and banged on the door of the cell next door. Prisoner A said he went to check on Mr Olugosi because it was unusual that he was not out on the landing by then. He said he saw Mr Olugosi's feet off the floor and that he was hanging from the light.

92. Officer C said he was calling the off-wing workers to start going downstairs to D1 landing when he noticed a commotion outside Mr Olugosi's cell. Thinking an assault was in progress he called for staff and ran to Mr Olugosi's cell. He saw Mr Olugosi suspended from the ceiling light by a sheet. He called again for staff and then jumped on to Mr Olugosi's bed and used his cut down tool to cut the sheet from the light. Officer C said Mr Olugosi was in rigor mortis and he did not start cardio-pulmonary resuscitation (CPR).

93. Prisoner A said he was first aid trained and he tried to give Mr Olugosi CPR. He said Mr Olugosi was extremely stiff. His legs did not move and his chest was so hard he could feel no movement when he tried to do chest compressions.

94. A female officer pressed the general alarm when Officer C first called for staff. She entered Mr Olugosi's cell seconds after Officer C and then radioed a code blue emergency. The control room officer called an ambulance immediately at 8.54am. He was put on hold by London Ambulance Service until 8.56am, when an ambulance was dispatched with the highest priority.

95. CM B entered the cell seconds after the female officer. He said the cell was full of people including three prisoners. Two of them left immediately but he had to persuade Prisoner A to leave. He said Mr Olugosi was laid on his back partly on the bed. He was very stiff and he was unable to move him to the floor so he started CPR anyway.

96. CCTV showed Nurse B arrived at 8.56am carrying a medical grab bag containing airways, equipment to complete clinical observations and dressings. Nurse B was not the dedicated emergency response nurse that day but responded to the code blue because she was on D Wing giving out medication.

97. Nurse B said it was obvious that Mr Olugosi had been dead for some time. CM B had started CPR and she radioed for more healthcare staff and a defibrillator. An officer arrived with the big emergency response bag about four and a half minutes later. Nurse B said she attached the defibrillator and, when it advised to continue

CPR, she continued CPR. She said she knew Mr Olugosi was dead but had not wanted to make the decision not to do CPR on her own as she was worried about the legal implications of a person dying in prison custody.

98. Nurse C, a trained paramedic, arrived two minutes after Nurse B at 9.00am. He said he tried to move Mr Olugosi to the floor but as soon as he touched him, he realised signs of rigor mortis were present. After checking for a pulse, he told the other staff to stop CPR as Mr Olugosi had died. Ambulance paramedics arrived at Mr Olugosi's cell about nine minutes later. At 9.14am, they officially recognised that Mr Olugosi had died.

Contact with Mr Olugosi's family

99. Ms D said that she rang the Wormwood Scrubs Safer Custody hotline at 9.10am and left a voicemail saying she was concerned about Mr Olugosi. She then began driving back to the prison. At 9.53am, as she was on the motorway, a relative of Prisoner A called her and told her Mr Olugosi had died. She drove back home and called the prison several times. She could not remember who she spoke to but someone told her that a family liaison officer would call her. By 11.50am no one had called so she rang the prison again and after over ten minutes on hold was put through to Ms E, the Governor. Ms E told her that Mr A, the Deputy Governor was about 20 minutes from her house.

100. Mr A and Ms F, a family liaison officer, arrived about an hour later. Ms D said Mr A explained that Ms F would be her point of contact going forward. Ms D said later the same day Ms F rang her to say she would be on holiday for a week. Ms D said she found this especially distressing given her issues contacting the prison the previous night.

101. Ms D contacted Ms G, Deputy Family Liaison Officer, on 29 March. She spoke to Ms E on 6 April and visited the prison to see Mr Olugosi's cell on 11 April.

102. The prison offered a financial contribution to Mr Olugosi's funeral in line with national policy.

Support for prisoners and staff

103. After Mr Olugosi's death, Ms H, a senior prison manager, debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

104. The prison posted notices informing other prisoners of Mr Olugosi's death, and to offer support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Olugosi's death. Prisoner A told the investigator that he had been well supported by staff.

Investigation by the prison into Ms D's attempts to contact the prison on 27/28 March

105. The prison identified that the telephone number that the main switchboard number diverted to during the night was not the communication room number but that of an

office that was not staffed. They took a number of immediate contingency measures including advertising the communications room direct dial number on the government website, updating the prison's voicemail and putting up signs outside the gate. The fault was rectified on 3 April 2022 and the prison completed several successful test calls. Despite requests to the telephone provider the prison were not able to identify how long the fault had gone undetected.

Post-mortem report

106. The pathologist concluded Mr Olugosi died from ligature suspension. Toxicology tests showed the presence of cocaine metabolites in Mr Olugosi's system at a level that did not indicate use immediately prior to death.

Inquest

107. On 17 February 2025, the Coroner's Inquest determined Mr Olugosi's medical cause of death was asphyxiation due to hanging. The jury returned a narrative verdict of suicide and found that a number of failings contributed to Mr Olugosi's death including failures to:

- record a telephone call from the police on 28 November 2021 that Mr Olugosi's wife was concerned he was suicidal;
- maintain adequate staffing of the IAPT programme;
- carry out an appropriate mood review on 23 March 2022;
- maintain a telephone system by which the prison was contactable by members of the public and/or the police during the night;
- maintain a buzzer/intercom system by which an attendee outside the prison gate could speak to the control room during the night;
- carry out an evening roll check on Mr Olugosi on 27 March 2022; and
- make an effective morning roll check on Mr Olugosi on 28 March.

Findings

Assessment of risk

108. Mr Olugosi had some significant risk factors associated with increased risk of suicide and self-harm, including relationship breakdown, the prospect of a long prison sentence and a high-profile crime. The first recorded indication that Mr Olugosi might be at risk of harming himself was on 30 November 2021, when he told a member of healthcare staff that he was feeling down and having negative thoughts. He was referred to the GP for a mood review within two working days, but nothing resulted. Eventually some two months later, on 3 February 2022, Mr Olugosi saw the GP in passing who completed a mood review ad hoc. We consider this was an unacceptable delay.

109. Mr Olugosi told the GP that his wife wanted a divorce and he was expecting a long sentence. He said he had felt down, depressed or hopeless on more than half the days in the preceding fortnight and felt like he was a failure nearly every day. He said he had no thoughts of suicide or self-harm. The GP did not share these significant risk factors with the wing or the safer custody team and we consider that this was a missed opportunity to adequately support Mr Olugosi. Both Mr Olugosi's subsequent mood reviews took place on the wing in the presence of another person rather than one to one in a confidential space. On the second occasion, five days before Mr Olugosi's death, the mood review took place in the wing kitchen with other prisoners able to interrupt at will.

110. Mr Olugosi did not fit the criteria for secondary mental healthcare, and the waiting time for the IAPT service was nine months. As Mr Olugosi's risk factors had not been shared with the wing or safer custody, the mood reviews were one of very few opportunities to correctly identify his risk. We do not consider that the location of these mood reviews was likely to encourage Mr Olugosi to speak frankly about his feelings and the nurse that conducted them did not ask him about suicide or self-harm. At interview, she said that she did not follow a set pattern or template when conducting mood reviews.

111. The clinical reviewer echoed our concerns that the location of the mood reviews was not sufficiently private or conducive to a therapeutic environment. She also noted that they did not follow an agreed format in line with National Institute for Health and Care Excellence (NICE) guidance and did not ask all the necessary questions, including about suicidal thoughts. This meant there was no way of clearly assessing any change in Mr Olugosi's presentation. We endorse the following recommendation from the clinical reviewer:

The Head of Healthcare should ensure that all mood reviews are undertaken in line with NICE guidance, using an agreed format which includes the broader risk factors for suicide in prison and which clearly assesses any changes in presentation between reviews.

We also recommend:

The Head of Healthcare should review the current process for sharing risk related information between healthcare and prison staff to assure themselves that relevant information is promptly shared in an auditable way.

Roll check on 27 and 28 March

112. Prison Service Instruction (PSI) 24/2011, which covers management and security at nights, requires prisons to set out their night operating procedures in their local security strategy. Wormwood Scrubs' local instructions require their night patrol officers to complete two roll checks – at the start of their duty at 9.00pm and at 5.30am on weekdays. The instructions specify that the purpose of the check is threefold – to confirm that the roll is correct, that every prisoner is in their correct cell and to check the welfare of every prisoner. They require the night patrol to obtain a clear view of the prisoner's face and hold them accountable for any prisoners they check and sign for.

113. CCTV showed that OSG A did not complete a roll check on D Wing at the start of his duty on 27 March and falsified records to say that he had done so. When completing the 5.30am check, he did not look through Mr Olugosi's observation panel and therefore did not comply with the prison's expectations. The investigator brought this to the attention of the prison, and they held a disciplinary investigation. As a result, OSG A was dismissed from his employment in September 2022. We make no further recommendation.

114. We note that the evening roll check should have taken place at about the time when Ms D had become extremely worried for her husband's welfare. This might have been the only opportunity to identify that Mr Olugosi was in sufficient distress to take his own life.

115. Mr Olugosi's was the third death since 2015 in which we identified missing or inadequate roll checks as an issue. However, this has not been the case in the eight deaths at the prison since Mr Olugosi died. We are therefore satisfied that this is no longer a systemic issue and make no recommendation, but the Governor will want to continue to monitor the situation. We did not refer the falsification of records by OSG A to the police at the time the issue came to light. We have since amended our processes to ensure that incidents of falsified entries are routinely referred to the relevant police force.

Welfare checks at unlock

116. The Prison Officer Entry Level Training (POELT) manual instructs staff to physically check that prisoners are present in their cells before they unlock the door. PSI 75/2011, *Residential Services*, requires all prisons to have a clearly understood system in place for staff to assure themselves of the well-being of prisoners during or shortly after unlock. The PSI deems it unacceptable for staff completing morning unlock not to notice that a prisoner has died overnight.

117. CCTV showed that Officer C did look through the observation panels of some cells on D4 landing before unlocking the doors, however he did not look through Mr Olugosi's. He told the investigator that there were times when he was under pressure and would not check every prisoner before unlocking the cell. He also

varied his practice depending on the particular prisoner's habits. This practice was endorsed by the POA representative present during his interview.

118. We consider that it is fundamental to prisoner safety that staff always satisfy themselves that each prisoner is alive and well before they unlock their cell door. Equally, it is fundamental to staff safety and the security of the prison that staff satisfy themselves that the prisoner is not intending to harm them once the door is unlocked. We make the following recommendation:

The Governor should introduce a robust quality assurance process to satisfy herself that that all staff look through the observation panel before unlocking cells.

Ms D's attempts to contact the prison on 27/28 March

119. The distress Ms D must have experienced when she was unable to contact staff at Wormwood Scrubs on 27/28 March to warn them that Mr Olugosi was suicidal is unimaginable. That she should have been unable to make contact despite also driving a considerable distance to make her concerns known in person is unacceptable. We were not given access to her police calls but we presume the police also tried and failed to contact the prison. Regardless of the reasons for the telephone and buzzer not working, no prison should be completely uncontactable in night state – especially given the vulnerability of prisoners at night when they are locked in their cells for long periods. We heard evidence from the control room officers that a significant proportion of calls received in night state since the telephone was reconnected to the correct number are from family members concerned about the welfare of their relatives.

120. The prison put several contingency measures in place after Mr Olugosi died and held a timely investigation into the cause of the problem. It is apparent, however, that they do not have a contingency plan for worried relatives coming to the prison in person. Although this is unlikely to be a regular occurrence we think it sensible that they do so. Had Ms D managed to contact the prison that night, Mr Olugosi might still be alive. We recommend:

The Governor should devise a contingency plan covering what to do when members of the public arrive at the prison in night state, concerned about the welfare of a prisoner.

Emergency response

Code blue

121. Officer C did not radio a code blue. We understand that Officer C was keen to cut Mr Olugosi's ligature and had a number of prisoners shouting to him for help. However, another officer pressed the general alarm and the first officer who responded radioed a code blue within a few seconds. Calling a code blue has not been an issue in subsequent investigations. We are therefore satisfied that there is not a systemic issue at the prison with emergency codes.

Resuscitation

122. In September 2016, the National Medical Director at NHS England wrote to Heads of Healthcare for prisons to introduce new guidance to help staff understand when not to perform cardiopulmonary resuscitation (CPR). This guidance was designed to address concerns about inappropriate resuscitation following a sudden death in prison. It was taken from the European Resuscitation Council Guidelines which states, "Resuscitation is inappropriate and should not be provided when there is clear evidence that it will be futile." They define examples of futility as including the presence of rigor mortis. The European Guidelines were updated in May 2021, but the same principles apply.

123. Mr Olugosi was clearly in rigor mortis when he was discovered and staff present recognised that he had been dead for some time, including Nurse B, the first nurse on scene. CM B, who started CPR, said he understood that he should start CPR and continue until a medical professional told him to stop. Nurse B said she was unsure of the legal implications of not continuing CPR. We understand from the Head of Healthcare that Nurse B subsequently received individual training on resuscitation.

124. CPR was also given to prisoners who had clearly died at Wormwood Scrubs in November 2020, August 2021, October 2021, December 2021, February 2023 and July 2023. In their action plan in response to the death in November 2020, the prison accepted a recommendation that staff were given clear guidance about when resuscitation is appropriate and circulated guidance to staff. In May 2022, we repeated the recommendation and the prison responded by recirculating the guidance and said they were planning an emergency response awareness week in September 2022 with mock scenarios, training and staff briefings. Focus weeks consisting of additional awareness training have continued and are open to prison and healthcare staff. Additional training was provided to staff after the deaths in February and July 2023.

125. We acknowledge that responding to a death can be traumatic for all concerned and it is not easy to make decisions in such a high-pressure situation. We also acknowledge that the prison has made efforts to increase staff confidence and awareness about when CPR is not appropriate. Evidently, as two of the deaths at Wormwood Scrubs in 2023 showed, more work needs to be done in this area. Trying to resuscitate someone who is clearly dead is traumatic for staff, undignified for the deceased and distressing for the family. We recommend that:

    The Governor and Head of Healthcare should continue to provide regular training on resuscitation which includes supporting staff to make appropriate decisions about when not to resuscitate.

Clinical care

126. The clinical reviewer found that the healthcare provided to Mr Olugosi was not always equivalent to that he could have expected in the community. He missed two telephone and two in person appointments when he was being investigated for urological cancer due to communications failures and staff shortages. A requested neurology appointment was never received and the follow up was inadequate. Mr Olugosi also waited much longer than acceptable for GP appointments and

psychological therapies. Healthcare and pharmacy staff failed to identify that Mr Olugosi was not taking his antidepressants and the policy on this was unclear.

127. The clinical reviewer concluded that, although none of the failures in Mr Olugosi's care appeared to have had a significant impact on his health outcomes, they were serious issues that might cause major health risks to other patients if repeated.

We endorse the clinical reviewer's (slightly amended) recommendation:

The Head of Healthcare should ensure that all staff are aware of their responsibilities in relation to patients who omit doses of a medication. Where there are significant failures in the administration of medicines the Head of Healthcare should ensure these are reported as critical incidents.

Drug supply and demand reduction at Wormwood Scrubs

128. Mr Olugosi's medical record did not indicate that he used illegal drugs. He first told staff that he had used drugs in the community in April 2021. There was no evidence that Mr Olugosi was using illicit substances at Wormwood Scrubs and he claimed to be abstinent in his sessions with The Forward Trust. However post-mortem toxicology showed that he had taken cocaine, although not immediately before he died.

129. The investigator spoke to Mr C, the Head of Drug Strategy and Health. As well as having responsibility for drug strategy, Mr C's role covers management of the 55-bed detoxification unit and inpatient unit.

130. Mr C said there was not currently a known problem with cocaine in the prison but they faced significant challenges in reducing the supply and demand for other drugs, especially psychoactive substances. In particular, staff shortages combined with high prisoner numbers meant that searching was significantly compromised. The substance misuse team was only 50% staffed. Prisoner focus groups regularly highlighted the lack of regime as a cause of drug use. Mr C had good support from the Governor, the Area Safety Lead, the police and other heads of function. Mr C has a dedicated team of officers that work on both the detoxification and inpatient units but no staff dedicated to working with him on drug strategy and this had delayed several initiatives to reduce supply and demand.

131. Drugs are an issue across all prisons and we acknowledge the huge challenges in reducing supply and demand. We are satisfied that Mr C is fully sighted on the challenges at Wormwood Scrubs, however, drug strategy is not his sole function and we are concerned that the lack of dedicated support has led to ground being lost on some initiatives. The threat from drugs is constantly evolving and more can always be done, it is therefore critical that prisons are able to move at pace to counter new threats. We therefore recommend that:

The Governor should ensure that the Head of Drug Strategy is sufficiently resourced to effectively tackle drug misuse.

Governor to Note

132. While we do not consider that it was relevant to Mr Olugosi's death, it was evident that Mr Olugosi was, at different times, suspected of being involved in the illicit economy in prison. Security intelligence from the Financial Intelligence Unit (FIU) indicated other prisoners had paid him money, he had a number of prohibited items in his cell, he was in possession of a mobile phone and the toxicology report showed he had taken cocaine at some point. Only the intelligence from FIU was available at the time he was appointed as a Listener, a trusted position that potentially gave him access to his more vulnerable peers. The Governor will wish to assure herself that the vetting procedures for all Listener applicants are sufficiently robust. We also note that there did not appear to be any vetting of Mr Olugosi's suitability to run a narcotics anonymous group on D Wing.

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