# Investigation into the circumstances surrounding the death of a man at HMP Wormwood Scrubs in April 2009

**Report by the Prisons and Probation Ombudsman for England and Wales**

**November 2010**

This is the report of an investigation into the death of a man in April 2009, at HMP Wormwood Scrubs. He had been in prison for just seven days. He was located in a gated cell in the healthcare centre where he was found hanging from pipes in his cell, having made the ligature with a strip of blanket specifically designed not to tear.

I would like to offer my sincere condolences to the man's family. I must apologise for the delay in issuing my report and for any additional distress this may have caused. A draft of this report was translated and sent to the family.

The investigation was led by one of my colleagues assisted by a fellow investigator. I would like to thank the Governor and his then Safer Custody lead for the assistance they gave the investigation team. In particular, my colleague received good support from a senior officer (SO) throughout the investigation process.

I must also acknowledge the assistance of Hammersmith and Fulham Primary Care Trust (PCT), who reviewed the clinical care received by the man during his short time at Wormwood Scrubs. The PCT set up a clinical review panel and volunteered the services of two clinical reviewers for joint clinical interviews. I am grateful to them for their work.

The man was a foreign national (originally from Azerbaijan and a Muslim, although he claimed to be Russian and a Jew). However, no one from the prison's foreign national team spoke to him. He told other staff that he did not understand why he was in prison. In fact, he was facing a serious charge at the time of his remand and it was possible that he would be deported.

The man was assessed as at risk of attempting suicide or self harm the morning after he arrived at Wormwood Scrubs. He was located in a gated cell in the healthcare centre and given alternative (previously known as 'protective') clothing. According to National Offender Management Service (NOMS) policy, such measures should be used strictly as a measure of last resort. However, the man was only made subject to low frequency observations (three times daily and five observations overnight). I explore at length these judgements and make a total of 15 recommendations. Reflecting the seriousness of my findings, I will send a copy of my report to the Chief Operating Officer of NOMS.

This man's death was the first of three self-inflicted deaths in Wormwood Scrubs in 2009. The circumstances of the second of those deaths have matters in common with the facts related here. My investigation teams have worked closely together to ensure that lessons are learned.

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

**Jane Webb**
**Acting Prisons and Probation Ombudsman** **November 2010**

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## SUMMARY


On 14 April, the man was remanded to HMP Wormwood Scrubs. He was charged with threatening to kill a close family member. Using a false name, he told staff that he was Russian and Jewish. Although it was not his first language, he spoke some English and staff said in interview that they understood what he was saying.

The man explained that he had been treated for his mental health, but could not recall the details. A request was made for his medical records to be retrieved from a hospital in East London. After his reception healthscreen, the man was taken to the first night centre where he stayed overnight.

Following his secondary healthscreen, the man was made subject to suicide prevention measures. During an assessment shortly after the risk was identified, he told staff that he did not think he would leave prison alive. He was assessed as at raised risk of self harm and made subject to half hourly observations, pending admission to the healthcare centre. Before he was moved, a locum staff grade psychiatrist assessed the man and agreed that he was at risk of self harm and would benefit from monitoring in the inpatients unit. (As a locum staff grade psychiatrist, the doctor was qualified to provide intermediate psychiatric cover for the healthcare centre at Wormwood Scrubs.)

A cord loop was discovered tucked into the man's clothing as he arrived on the inpatients unit. Staff removed the loop and an entry was made in his medical record four hours later, but no other reference was made in the man's files. A suicide prevention case review was held just after he arrived in the unit. The review was chaired by the senior officer of the healthcare centre, and attended by the psychiatrist and two nurses. It was agreed that the man should go into a gated cell, dress in alternative clothing, and observations should be recorded at least three times a day and five times overnight. (When a cell is used as a "gated cell", the door is locked against the internal wall and only a gate remains in place which allows constant supervision. "Alternative clothing" is made of strong material which should not rip for use as a ligature.)

Over the next few days, the man continued to talk of dying in prison, and said that he wanted to die by not eating. He was visited by a chaplain three times and spoke at length about his frustration at being in custody. Arrangements were made for him to make an international telephone call to his mother and he made a court appearance. A further case review was held on 20 April, as part of the mental health service's ward round. No officers or governors attended the review and no changes were made to the man's suicide prevention support plan. It was noted that an interpreter should be invited to attend the next case review, which was due to take place on 23 April.

Another prisoner in the healthcare centre was constantly supervised by staff on the day of the man's death. The man who died told the agency nurse carrying out the constant supervision that he was looking for any opportunity

to kill himself. An entry was made to that effect in the man's suicide prevention document late that morning and the agency nurse spoke to the nurse in charge. The nurse in charge encouraged him to keep a closer eye on the man than the minimum requirements set out in the suicide prevention support plan.

Healthcare was seriously short staffed that afternoon and evening. During the evening shift, there were no officers and only one nurse in charge, and one agency nurse continuing with the constant supervision. While a prisoner was being escorted from reception to the healthcare centre, the escorting officers noticed the man hanging in his cell. He had used an alternative safer custody blanket (made from the same material as the alternative clothing) attached to the pipes in his cell.

In this report, I examine safer custody procedures at Wormwood Scrubs and make several recommendations. I make two national recommendations about the use of gated cells and alternative clothing. I also consider the support that the man received as a foreign national prisoner.

## THE INVESTIGATION PROCESS

1. I appointed one of my colleagues to lead the investigation into the man's death. She was assisted by another investigator. My colleague visited Wormwood Scrubs on 28 April 2009, accompanied by her colleague. My investigator met her liaison officer who had arranged for the man's files to be copied ready for collection. She also met a representative from the Independent Monitoring Board (IMB), none of whose members had met the man, but who shared overall impressions of the prison. The local branch of the Prison Officers' Association held a meeting in their office to give my investigator an opportunity to explain the remit of her investigation and to invite trade union representatives to accompany interviewees. My investigator met the Deputy Governor because the Governor was unavailable. My investigator and her colleague were shown around the prison and met staff on the healthcare centre.

2. I am grateful to Hammersmith and Fulham PCT for their clinical review of the time that the man spent in prison. Two of their clinical reviewers also accompanied my investigation team to conduct interviews with staff and assist with clinical matters. My investigator was kept informed of the progress of the clinical review and was consulted on the review. She attended a clinical review panel meeting towards the end of the process and I am grateful to the PCT for taking on board her comments. The clinical review is the first annex to this investigation report.

3. Once the prison had made contact with the family, the prison's family liaison officer passed their details to my investigator. One of my own family liaison officers wrote a translated letter to the family in England to explain the investigation process. Although the family did not have any specific concerns about the man's care, they wanted to see the investigation report. My family liaison officer also wrote to the man's mother in Azerbaijan. I trust that this report addresses the questions his family may have and helps them better understand the events leading to the man's death.

4. After a review of the paperwork, my investigator arranged to attend Wormwood Scrubs again to interview staff. She interviewed 13 members of staff, but no prisoners contacted her with information.

5. My investigator met the inspector leading the investigation for Hammersmith and Fulham Police. I am grateful to the police for their time and co-operation. They shared photographs of the cell after the man's death and statements they had taken from staff about the emergency response.

6. As concerns arose throughout the investigation process, my investigator fed back to the Safer Custody Manager and confirmed her findings in writing to the Governor. Due to the seriousness of the

findings, she also discussed the circumstances of the man's death with the NOMS Safer Custody and Offender Policy team's lead for safer custody. I am grateful to her for her advice throughout the investigation.

7. A copy of this report was issued in draft for consultation with the family, NOMS, the PCT and the Coroner. The family received a translated copy of the draft report. Following the issue of this report, my investigator and Deputy Ombudsman met the NOMS Safer Custody Offender Policy lead for London, Wormwood Scrubs' Head of Healthcare and the Safer Custody leads to discuss their feedback. I am grateful for the comments I received, some of which have resulted in amendments to the report before its finalisation.

## HMP WORMWOOD SCRUBS

8. HMP Wormwood Scrubs is a large local prison in West London. It can accommodate 1,281 adult males in its five wings. As a local prison, its population is transient and demanding, with high numbers of prisoners arriving from court with a variety of immediate needs including detoxification. The healthcare centre is divided into a large outpatients area and a 17-bed inpatients unit, predominantly accommodating prisoners with mental health conditions.

9. Her Majesty's Chief Inspector of Prisons carried out a full unannounced inspection of the prison in June 2008. In her report of this inspection, she recognised:

   > "Wormwood Scrubs was subject to constant daily pressure and it required considerable work by both managers and staff simply to ensure its successful day-to-day operation."

   Nevertheless, her team were "disappointed" by their findings during the inspection. Significantly, the prison failed to meet any of their tests of a healthy prison: safety, respect, purposeful activity and resettlement.

10. Reception, first night and induction procedures were described in the inspection report as "not sufficiently supportive or consistent" and "underdeveloped and poorly organised". (The man was only on the first night centre for one night and transferred to the healthcare centre the following morning.)

11. The Chief Inspector found that the inpatients unit was a "reasonable environment, but had a minimal therapeutic regime". The investigation team also found the regime surprisingly more limited in the inpatients unit than elsewhere in the prison. My investigation team judged that the physical environment was poor, and characterised by tension between PCT healthcare professionals and uniformed prison staff.

12. Every prison has an Independent Monitoring Board (IMB) made up of volunteers who monitor day-to-day life in prison and ensure proper standards of decency and care are maintained. In their annual report for 2008-09, the chair of the Wormwood Scrubs IMB wrote of their concern that "healthcare services are heavily reliant on agency staff". The clinical review panel and my investigation team echo those concerns and I will discuss the impact of staff shortages on the care that the man received.

13. The IMB attend suicide prevention meetings and said in their 2008-09 report that "residential staff are aware of the risks of self harm and suicide". The report did not comment on the use of gated cells or alternative clothing in the healthcare centre. When my investigator spoke to the IMB at the beginning of the investigation, she was told that

no one had recorded any contact with the man despite his being in a gated cell and in alternative clothing.

14. The man's death was the first of three self-inflicted deaths at Wormwood Scrubs in 2009. There are significant shared lessons identified between the second death in custody and the man's death, especially in relation to safer custody.

**Hammersmith PCT and Prison Service staff**

15. In January 2007, the employment of all healthcare professionals was transferred from the Prison Service to Hammersmith and Fulham PCT. At this time, some officers who were employed by the Prison Service were also qualified healthcare professionals and had access to healthcare records. These officers were line managed by the Head of Healthcare who became a PCT employee. In September 2008, the Prison Service and the PCT confirmed that officers would be employed solely by the Prison Service and would no longer have a healthcare function.

16. During interviews for this investigation, my team found that the arrangement resulted in the separation of medical matters from the general care of prisoners in the healthcare centre. Officers had become demoralised because they perceived that their role had diminished, and nurses were protective of medical information considered "medical in confidence". The impact on the regime in the healthcare centre was clear. The investigation team were told that officers did not carry out constant supervision for prisoners, and described it as a "healthcare problem", with the result that the shortage of nursing staff was compounded (a particular problem in the events surrounding the man's death). When my investigator asked why a prisoner dressed in alternative clothing had shoelaces in his trainers, she was told that it was a "discipline matter".

17. Officers were based in a separate office to the nurses and were not involved in ward rounds. Communication between officers and healthcare professionals was undermined by the re-profiling of staff in the healthcare centre. It is my view that poor communication and lack of support between officers and nurses affected the care that the man received in the last week of his life.

**Assessment, Care in Custody and Teamwork (ACCT)**

18. Prisons are run under a series of documents called Prison Service Orders (or PSOs). PSO 2700 governs procedures for looking after prisoners at risk of suicide or self harm. Assessment, Care in Custody and Teamwork (or ACCT) is the system used to identify, monitor and support prisoners at risk of self harm. The ACCT process is used in all prisons in England and Wales. Any member of staff can start the ACCT process by raising a Concern and Keep Safe form, explaining

the reasons for their concern. An Immediate Action Plan is written by the manager of the wing where the prisoner is located, and within 24 hours an ACCT assessment is carried out by a member of staff who has the required training.

19. After the ACCT assessment has taken place, a multi-disciplinary ACCT case review is held to determine what measures can be taken to monitor and support the prisoner effectively. The prisoner attends the case review and is encouraged to contribute to the decisions being made. An ACCT CAREMAP is drawn up with details of each of the actions necessary to keep the prisoner safe and who is responsible for carrying out each action. Case reviews are held at regular intervals, usually monthly, to review the actions and the prisoner's level of risk.

**Gated cells**

20. PSO 2700 refers to gated cells as "constant supervision cells", and this is what they are called in Wormwood Scrubs' suicide prevention policy. Instead of a door on the cell, there is a gate which enables a member of staff to see the prisoner at all times.

21. According to the guidance, gated cells are used where a prisoner requires constant supervision. They enable a severely distressed/at risk prisoner to receive individual support from a member of staff sitting outside the cell. A prisoner should remain in a gated cell for the shortest time possible because it compromises their privacy and dignity. (The man was accommodated in a gated cell despite the low level of ACCT observations deemed necessary.)

**Alternative clothing**

22. Alternative clothing (previously known as protective or anti-tear clothing) is made from a strong material that makes it difficult to tear. It is used when a prisoner may use his clothing to harm himself or others.

23. When a prisoner is issued with alternative clothing, their own clothes should be taken away from them, including their shoelaces. PSO 2700 and Wormwood Scrubs' own suicide prevention policy describe the removal of a prisoner's own clothes and their replacement by alternative clothing as a "measure of last resort". The PSO demands that alternative clothing "must only be used for the shortest possible time". It is national policy, echoed in Wormwood Scrubs' own suicide prevention policy, that an enhanced case review should be held with more senior prison staff for all prisoners who are on an open ACCT document and wearing alternative clothing.

## KEY EVENTS

### The man's remand

24. The man was charged by police with assaulting and threatening to kill a close family member in April 2009. While at a police station, he told officers that he had suffered a number of injuries during his previous military career. He said he was suffering from stomach and lower back pain, and took medication three times a day although he could not remember what it was. He refused to be examined by the police doctor or to sign his property record.

25. The next morning, the man appeared at a Magistrates' Court. He was remanded into the custody of HMP Wormwood Scrubs until the next court appearance on 16 April. His remand warrant recorded his false name and his religion as Jewish.

26. A Prisoner Escort Record (PER) is opened every time a prisoner is escorted between court and prison to record any significant information about the journey and to communicate risk factors to escorting staff, for example risk to self or others. The man's PER indicated that he was violent and had a medical condition. There were no other known risks.

27. However, there was a note that the man was on an electronic tag. My investigation team discovered from the police after his death that the man was tagged as a result of an international arrest warrant issued for an alleged offence abroad. Despite this warrant, he had thus far been allowed to remain in the United Kingdom (UK) because his family depended on him. The electronic tag was removed when he was taken into custody.

28. Upon arrival at Wormwood Scrubs, the man was interviewed for his first reception healthscreen. (A first reception healthscreen takes place every time a prisoner enters prison. Its purpose is to determine any immediate physical and mental health conditions that require treatment, substance misuse matters that need to be addressed, and any risk that the prisoner may pose of harming himself or attempting suicide.) At the healthscreen, the man said he had been in prison before, but could not recall when. (He had used several different names, so it is possible that he had been in prison before despite there being no record in his name.)

29. When the nurse asked about his health, the man said that he had visited his doctor two weeks previously, but again could not remember anything about it. He also said he was taking medication prescribed by a hospital for stress. He told the nurse that he had received treatment from a psychiatrist for stress before coming into prison, so he was referred for a mental health assessment. He said that he had never tried to harm himself and "denied any suicidal thoughts", although he described how unhappy he was living in the United Kingdom. The man

said that he had lost his appetite during the previous two weeks and had not eaten properly. He was referred to the doctor for his physical health as the nurse had noted he looked “unfit” and complained of “back pain”. The nurse then noted that the man’s medical record: “please get information from GP tomorrow. Appears in satisfactory health – now!” After the healthscreen, he was located in a double cell on his own in the first night centre, where he stayed overnight.

30. A nurse carried out a secondary healthscreen the following morning in the first night centre. The nurse explained to my investigator that the screen is “related to health promotion”, for example whether the prisoner wants to stop smoking or requires any vaccinations. The nurse remembered that the man, “at first sounded very quiet, a bit disorientated and he was a bit tearful as well which then raised some concerns”. The nurse was concerned that the man was distracted during the screen and could not describe his medical problems. The man told the nurse that he did not want to live any more. The nurse raised a Concern and Keep Safe form, the first stage of the ACCT process.

31. After a Concern and Keep Safe form is raised, an ACCT assessor must interview the prisoner. The nurse assessed the man as requiring hourly observations until his ACCT assessment had been completed. A prison officer was the duty ACCT assessor that day and was already on the first night centre when the nurse finished the man’s healthscreen. (The officer was on the first night centre because he had just finished an ACCT assessment of another prisoner.) The nurse explained his concern about the man and gave the officer the opened ACCT document.

32. During interview for this investigation, the ACCT assessor assured my investigator that, although the man’s English was not fluent, he was able to talk about what was worrying him. The man told the ACCT assessor that he was unhappy about his personal circumstances and that he was taking “much medication”, although he still could not remember what he had been prescribed. When asked whether he had any current intentions of committing suicide, the man told the ACCT assessor that he had never harmed himself before and was not thinking of hurting himself. However, the ACCT assessor recalled in interview: “he did not know if he would take his life when I asked him, but did say he did not think he would leave prison alive”. As an experienced ACCT assessor, the officer was concerned about the man’s welfare. During interview for this investigation, he explained:

> “I didn’t think at that stage that he was, I was going to walk out the room and he was going to kill himself but I had grave concerns that something was going to happen to him if we didn’t put into place some sort of action plan with him straightaway.”

33. After the ACCT assessment, the ACCT assessor chaired an ACCT case review. He told the investigation team that his priority was to relocate the man to the healthcare centre so that his mental health could be assessed. He was also particularly worried by the man's claims that he was not eating (although this was not recorded in the record of the ACCT assessment). The first night centre's senior officer also attended the case review but no healthcare staff were present. The senior officer for the first night centre agreed with the ACCT assessor that the man was at high risk of harming himself and that he should be checked every half an hour until he could be admitted to the healthcare centre. The ACCT assessor also referred the man to the mental health inreach team. After his assessment and case review, the man stayed on the healthcare centre over lunch but refused to eat his meal.

34. A doctor was employed through an agency to work as a locum staff grade psychiatrist at Wormwood Scrubs for three weeks during April 2009. Although he could not exactly remember when he started working at the prison, the locum psychiatrist told my investigation team that he thought it was on either 7 or 8 April. During interview, he told the investigation team that he was briefed about inreach practice by the consultant psychiatrist for the inreach service at the prison and shown around the prison by a Registered Mental Health Nurse (RMN) who was the community mental health nurse responsible for the inpatients unit. The locum psychiatrist said that he had only worked for one day in a prison before this assignment. The locum psychiatrist had no formal induction programme and was not trained in the ACCT process.

35. As the only psychiatrist on duty that day, he assessed whether the man needed to be admitted to the healthcare centre. In interview, the community mental health nurse remembered escorting the locum psychiatrist to the first night centre because he did not have keys to move around the prison. The nurse recalled meeting the man briefly, describing him as "respectful". The locum psychiatrist conducted his assessment in a private room, and recorded in the man's medical record that he was "quite low, crying, hopeless, pointless and suicidal thoughts (hanging)". He recorded that the man was "not eating or drinking". The locum psychiatrist told my investigator he thought that the man was at high risk of suicide and needed to be admitted to the healthcare centre for closer monitoring.

36. In his summary of the assessment in the man's medical record, the locum psychiatrist recorded that, not only should the man be admitted to the healthcare centre, he should be accommodated in a gated single cell in protective clothing. During interview, the locum psychiatrist explained that the use of a gated cell and protective clothing was "standard practice" at Wormwood Scrubs. He said that it would give staff an opportunity to assess the man's mental health, and he could be kept safe until the prison had received a clearer picture of his history. The locum psychiatrist prescribed the man anti-depressants and a

nutritional supplement to increase his vitamin intake while he claimed not to be eating.

**The healthcare centre**

37. Within an hour of the assessment, the man was admitted to the healthcare centre. When he arrived, the locum psychiatrist, a nurse and the community mental health nurse started an ACCT case review. A senior officer manages prison staff on the healthcare centre. She told my investigator that she noticed an ACCT case review happening in the inpatients unit at about 4.00pm. She was concerned because the case manager was an agency psychiatrist. Noticing that he was not familiar with ACCT documents, she stepped in to manage the case review.

38. During the case review, the senior officer who manages prison staff on the healthcare centre noted that the man was experiencing "a number of domestic and social issues, which have escalated over a period of time". He told staff that he felt "safer" in the healthcare centre and the decision to put him in "gated cell with protective clothing" was agreed by the multidisciplinary team who assessed him as raised risk. Prison Service Order (PSO) 2700 – suicide prevention and self harm management prohibits the use of a gated cell for any prisoner not on constant supervision. Nevertheless, the locum psychiatrist recorded on the front of the man's ACCT document that he should be checked three times a day and five times at night, described by the senior officer as "basic routine observation". During interview, the locum psychiatrist explained:

> "… we had lots of inmates on [the inpatient unit in the healthcare centre] who had expressed ideas of self-harm who were not necessarily on constant watch. We felt that the combination of gated cell, protective clothing, being on an ACCT watch, with staff on the wing constantly was enough to manage that risk."

The locum psychiatrist went on to say that being in a gated cell and protective clothing was "like constant monitoring" and that he felt he had "eliminated" the risk of the man hurting himself.

39. The senior officer who manages prison staff on the healthcare centre recorded in the man's ACCT document that he was "unaware he was attending court" the following day. During interview, she said that he understood he had to return to court but did not know when his appearance would be. When she told the man that the appearance was the next day, "he didn't seem shocked or worried about it unduly".

40. At 8.25pm that evening, a Registered Mental Health Nurse wrote an entry in his medical record summarising the reason for the man's transfer to the healthcare centre. (The signature was not legible and, despite my investigator's request, the PCT has not identified the nurse

who made the entry.) The nurse recorded that the decision had been made by the inreach team and described the man as "settled and no further thought of suicide or self harm expressed". The entry concludes by mentioning "a cord loop hidden underneath his jogging suit top" which was discovered when the man arrived on the unit. There is no other reference to the discovery of this ligature and no one my investigator spoke to was aware that the "cord loop" had been discovered. The senior officer who manages prison staff on the healthcare centre explained that officers cannot read prisoners' medical records because they are considered "medical in confidence". She said she had not read the entry but would have expected something like that to have been drawn to her attention.

41. The man was given Zopiclone (to promote sleep), settled down at about 10.00pm and slept through the night. There are five observations recorded in his ACCT ongoing record. All noted that he was asleep.

42. The following day, the man appeared at a Magistrates' Court. His Prisoner Escort Record (PER) noted that he was at risk of suicide or self harm and that he was in "strip clothing" while at the prison. Escort and court staff recorded checks every ten minutes. The man's next court appearance was scheduled for 14 May, just under a month later, and he was remanded back to Wormwood Scrubs. He went back to the healthcare centre and was again accommodated in a gated cell wearing alternative clothing. An officer recorded in his ACCT ongoing record that the man "appeared calm in mood and manner".

43. The next morning, a Sister from the chaplaincy visited the man on the healthcare centre. She explained to my investigator that the chaplaincy team sees all new prisoners to explain their role. When she met the man and realised that he was on an ACCT document, she spent more time talking to him. During their discussion, the man told her that he was anxious to speak to his mother in Russia. He told the chaplain that he "was not eating and refusing lunch", but would eat again after he had spoken with his mother. The Sister asked the senior officer who manages prison staff on the healthcare centre to arrange an international telephone call.

44. The senior officer spoke to the first night centre where international telephone calls could be made. She arranged for the man to make a call to his mother that afternoon. She told my investigation team that the man was very grateful, and became tearful and started praying when he learned he could speak to his mother. The telephone call took place at about 2.00pm on the first night centre.

45. When the man got back to the healthcare centre, the officer who had recorded in his ACCT ongoing record that he appeared calm in mood and manner chaired an ACCT case review with the man and a nurse. During interview with the investigation team she explained that the

case review would usually have been part of the inreach ward round, but “it got quite sort of into the mid afternoon and we decided to do it because they weren’t coming up to see him as we thought, we have to do it anyway”.

46. The officer who recorded in his ACCT ongoing record that the man appeared calm in mood and manner said that she was not prepared to change the ACCT observations without a doctor present, but held the review because it was due and to check if there were any further measures that could be taken to reduce the man’s risk to himself. She told my investigation team that the only change she was prepared to make was to increase the observation levels to constant supervision. She said that she thought the man “was feeling better” after the telephone conversation with his mother. She recorded that the man was “vulnerable”, “feels lost”, but had told her that he felt able to “talk problems through with staff”. She recorded that his level of risk was the “same” as had been recorded at the previous case review. He was due to see the inreach team on 20 April, so his observations were to remain the same until then (three interactions during the day and five observations overnight). The man ate his teatime meal that evening.

47. The following morning (Saturday 18 April), the man ate his breakfast. He told the officer who had recorded in his ACCT ongoing record that the man appeared calm in mood and manner that he had no thoughts of hurting himself. Later that morning, the Sister from the chaplaincy visited the man at his cell. He told her that he had managed to speak to his mother but that she was in hospital. The sister from the chaplaincy said she was confused about how he was able to speak to his mother if she was in hospital, but was pleased that he felt better having made the call. She was concerned that, as an Orthodox Jew, he would have special dietary requirements. The Sister from the chaplaincy said she would arrange with the rabbi for the man to have two kosher meals a day. In the meantime, the kitchen had agreed to give him one kosher meal a day. (In fact, it was discovered after his death that the man was a Muslim and would not have required kosher meals.) The Sister from the chaplaincy told my investigator that she remembered the man as “talking, talking, talking and angry”. When asked whether he was upset by the conditions he was accommodated in (the gated cell and the alternative clothing), the Sister from the chaplaincy said she thought he would have been “agitated” regardless of the conditions he was in. His concern was the circumstances that had led to his imprisonment.

48. The man threw away his lunch. He spent the afternoon out of his cell speaking with other prisoners who were living in the healthcare centre. The officer who had recorded in his ACCT ongoing record that the man appeared calm in mood and manner noted his “very good verbal response” as he spoke to prisoners and staff about his court case. It is not recorded whether he ate his dinner, but he asked for sleeping tablets which were prescribed.

49. On Sunday, the man collected his lunch but refused to eat it. He asked for a headache tablet but an RMN refused until he had eaten some of his food. The nurse told the man that “a headache can be caused by hunger”. He spent the afternoon mixing with other prisoners again. He was given a nutritional supplement that night and slept through the night.

50. The next inreach ward round took place on the eve of the man’s death. The ACCT process was combined with the ward round and a case review was held at the same time. The case review was chaired by the locum psychiatrist, an RGN and an RMN. There were no officers present for the ACCT case review. In her record of the case review, the RGN recorded that the man was “still expressing thoughts of self harm/suicide by not eating”. She noted that he had “minimal interaction with anyone”, despite the entries in the ACCT ongoing record observing him associating with prisoners in the healthcare centre. She also recorded that he had said, “I pray every night to die”.

51. The locum psychiatrist recorded in the continuous clinical record that the man, “still feels suicidal, wants to starve himself to death”. However, he was accepting nutritional supplements. The locum psychiatrist continued the prescription of anti-depressants (Citalopram) and added five milligrams of Olanzapine (an anti-psychotic). The level of ACCT observations were to continue until the next ward round four days later.

52. The locum psychiatrist asked for an interpreter to be present at the next ward round, which also would have functioned as a case review. During interview, he explained his request to my investigator:

> “He spoke some English but he was not fluent and I just felt that, in fact he spoke better than a few other patients we had on the unit but I just felt that he deserved to have an interpreter so that we’ll get a complete history.”

53. That afternoon another member of the chaplaincy team visited the man and spoke to him about his frustration at being in prison. He told her that he “did not understand the criminal justice system in this country”. He wanted the police to “listen to his story”, rather than accept the statement of the victim. She thought the man was able to express himself and was mainly “angry” during their exchange. She was not concerned that he was particularly at risk of self harm, and she would have visited him again had that been the case. After her visit, the man again spent the afternoon out of his cell, associating with other prisoners. Again, he refused to eat his dinner that evening but accepted some of the nutritional supplement. He slept through the night.

### The day of the man’s death

54. The RGN who was part of the case review on the eve of the man’s death came on duty at 7.45am. She was due to work until 9.15pm that evening. Ordinarily, there would be two nurses assigned to the inpatients unit and one nurse assigned to the segregation unit. On the day of the man’s death, the RGN was working on the inpatients unit with an agency nurse to assist her, who had worked on the unit “once or twice” and was assigned to constantly supervise another prisoner. The RGN described the shift as “busy”. During interview, she explained:

> “… it was just basically me and I had 16 patients to look after and then one other patient who is in another unit that was coming to have his medication there and everything else on the unit as well. And then lunchtime we had this guy who was then brought up at 5.30pm, you know, getting phone calls about him, where he was on the wing and you know they were saying they wanted to bring him over to us. But then, that particular day as well we didn’t have any spaces because there was some spaces that were out of order, so we had to get the bio hazard team … up to come there and then clean up the cells and that sort of stuff. But it was quite a busy day for both the nurses and the officers because there were only two officers on duty.”

55. The RGN made an entry in the man’s ACCT ongoing record when she came on duty, observing that he was asleep. Later that morning, he had a long conversation with the agency nurse. Unfortunately, despite the investigation team’s request, the agency nurse was not available to be interviewed for this investigation. He recorded his conversation with the man in detail in the ACCT ongoing record. Notably, he wrote:

> “[The man] is expressing active suicidal ideation. He said he is looking for a small chance so that he can commit suicide. He pointed to the handle on the door saying, “that is my chance”. Despite all reassurance given he insists he wants to commit suicide.”

56. The agency nurse spoke to the nurse in charge, the RGN, about his concerns. Although the investigation team could not speak to the agency nurse, he did record a summary of the conversation as follows:

> “I discussed this with the nurse in charge and she suggested that there is a need to keep a closer watch on him. There is the minimum of three times daily agreed by the team but this needs to be increased because of his active suicidal ideations.”

However, the man's ACCT observations remained at three observations a day and five overnight. His level of risk was not revised.

57. During her interview with my investigation team, the RGN said that the agency nurse told her that the man was "expressing thoughts of self harm and suicide". She discussed with the nurse whether his presentation had changed since the ACCT case review the previous day and they agreed that it had not. She explained to the agency nurse that the number of ACCT observations was set at the minimum number of "quality conversations" needed to support the prisoner, "but we always have to keep a close eye on any patient who is at risk of self harm and suicide". She told my investigation team that she encouraged the agency nurse to check the man more frequently than the required observations, if he needed support.

58. The RGN said that typically only the doctor made the decision to increase or decrease ACCT observations. She said that a multidisciplinary team, including officers and healthcare professionals, can increase observations but this tends not to happen in practice. She said that nurses would be carrying out general observations hourly as a matter of routine. She was satisfied that the risk the man posed to himself was minimised because he was in a gated cell and dressed in alternative clothing.

59. The agency nurse made a subsequent entry in the man's ACCT ongoing record at 11.40am, when he noticed him lying on his bed. At midday, he collected his lunch from the servery, but no one saw him eating it. The agency nurse noted that the man went back to bed having collected his lunch and that his "dietary intake remains nearly nil". According to his ACCT ongoing record, the man spent some of the afternoon watching television.

60. At 5.00pm, the RGN recorded that the man was still expressing thoughts of self harm and suicidal ideation. She noted that he was collecting his food but still refused to eat it. There were insufficient officers on duty to unlock the prisoners on the inpatients unit for association that afternoon, which meant that none of them had left their cells, other than to collect meals, since 5.00pm the previous afternoon.

61. One of the two officers on duty that afternoon was the senior officer who manages prison staff on the healthcare centre. Despite being the senior officer on duty, she did not check the man's ACCT record and had not seen the entry written by the agency nurse earlier in the day. In interview, she said she would have held a case conference if she had noticed the entry before her shift had finished. The agency nurse did not speak to the senior officer about his concerns, having raised them with the RGN.

62. The senior officer finished her shift at 5.00pm (at the same time the RGN made her entry in the man's ACCT document). Ordinarily there would have been three officers working in the inpatients unit during an evening shift. However, because of staff shortage and illness, there were no officers on duty that evening. The RGN was given a radio and told that she could request assistance if she needed it via the communications room. The RGN and the agency nurse (assigned to constantly supervise another prisoner) were the only two staff working in the inpatients unit during the evening shift.

63. At the start of the evening shift, the RGN was contacted by officers in reception asking for a prisoner to be admitted on constant supervision because he was at risk of self harm. The RGN contacted the bio hazard team to clean a cell in preparation for the prisoner, because there were no other cells available. She co-ordinated the bio hazard team's visit.

64. The RGN explained to the investigation team that only healthcare professionals can carry out constant supervision because of the recent division between staff employed by the Primary Care Trust and the Prison Service. The RGN then spent a good deal of time arranging healthcare cover to conduct constant supervision with the newly arrived prisoner, leaving only the agency nurse in the healthcare centre carrying out constant supervision for another prisoner.

65. The RGN managed to secure the services of a healthcare assistant from 7.00pm to carry out the constant supervision of the prisoner who arrived that afternoon. The RGN was the only member of staff available to dispense medication and respond to prisoners' requests. She said that she had to calm one angry prisoner down and deal with another who was anxious. At the same time, the RGN had to make arrangements for the agency healthcare assistant to be allowed to enter the prison.

66. The RGN last saw the man at about 6.00pm. He wanted cold water and the RGN explained that he could get cold water from his cell. She said that she could get him hot water if he wanted it, but he took back his cup and walked over to the window. It was the last time she spoke to the man.

67. The cell where the agency nurse was carrying out the constant supervision was near the man's cell, but he was not able to see into it all the time. At about 6.55pm, the prisoner from reception was being escorted to the wing by two officers. As the officers walked past the man's cell, they glanced in and saw him hanging. He had torn a strip of his blanket and attached it to pipes. (The pipes had a plastic box fitted over them to prevent a ligature being threaded through the gap between the pipe and the wall, but it had come loose at the top.) His legs were off the floor and he was positioned by the gate.

68. One of the officers used his radio to make a “Code One” call, which means a medical emergency. The other officer went into the cell and supported the man’s weight. The RGN heard the code and saw the man hanging. She ran to the staff office, metres away, and collected the emergency grab bag and defibrillator. (A defibrillator is a machine that applies electrical impulses to the heart and advises whether there is any rhythm that might be stimulated.) When she returned to the cell, she helped one of the officers to support the man’s weight while the other officer cut the ligature. Having brought the man to the floor, the officer used his radio to request an ambulance.

69. Upon examination, the RGN found the man was not breathing and his pupils were dilated. She applied the defibrillator and was advised not to administer an electric shock. She started resuscitation. The paramedics arrived at the prison four minutes after the ambulance was called. Within two minutes, the paramedics got to the healthcare centre and assessed the man. They asked for a doctor to attend and, in the meantime, continued the resuscitation efforts. A doctor pronounced the man’s death at 7.46pm.

70. During their visit to a police station, the investigation team was given access to the photographs taken in the man’s cell after his death. It was clear from the photographs that the man was wearing the blue gown (considered to be safer clothing). However, he was also wearing elasticated tracksuit bottoms underneath the alternative gown, the type of trousers issued as standard by the prison.

**Family support**

71. Within ten minutes of the man’s death a governor was appointed to be the prison’s family liaison officer and went into Wormwood Scrubs to be briefed. During the briefing, the prison’s family liaison officer learned that the man had given a false name when he arrived at the prison, and his listed next of kin had left the country with no forward contact details. He contacted the police and asked them to trace the man’s real identity and next of kin. The police agreed to do this, but told the prison’s family liaison officer that he would receive no more information until the next morning.

72. The prison’s family liaison officer was not working the day after the man‘s death but resumed his efforts to locate the man’s family the day after that. The police still had no information about the man’s family, although were continuing to try to trace them. The prison’s family liaison officer used the telephone record to establish that the man had called Azerbaijan to speak to his mother. He contacted the Azerbaijani embassy, who asked that he put his request in writing. The embassy eventually agreed to contact the family on the prison’s behalf. Over the next three days, the prison’s family liaison officer recorded several attempts to confirm that the next of kin had been told about the man’s death.

73. It was not until 27 April that representatives from Azerbaijan's Ministry of Justice visited the man's family in their home to break the news. Later that morning, the prison's family liaison officer was telephoned by a friend of the man's brother who spoke English. Once the police had confirmed the man's brother's identity, the prison's family liaison officer arranged for him to visit the prison and collect his property.

74. As the man had told staff he was Jewish when he arrived at the prison, the prison's family liaison officer checked with a Rabbi who was a member of the chaplaincy team whether any special measures needed to be taken for his burial. The Rabbi said he would need the man's family to confirm that they wanted a Jewish burial before one could be arranged.

75. After the man's death, the prison's family liaison officer has had some ongoing contact with the man's brother, although there was some difficulty with communication because of the language barrier. It emerged that the man was in fact Muslim, not Jewish, and therefore was buried according to his faith.

**Prisoner support**

76. The man who died was in Wormwood Scrubs for only seven days, six of which were spent in the healthcare centre. Although he did not have the opportunity to form any friendships, the senior officer who manages prison staff on the healthcare centre described other prisoners on the healthcare centre as "shocked" and "taken aback" by his death. A case review was held for every prisoner subject to ACCT monitoring. The day after the man's death, the chaplaincy team visited the healthcare centre to support the inpatients. Officers reassured prisoners that they could speak to them with any concerns.

**Staff support**

77. The tension between healthcare staff and officers in the healthcare centre was obvious to my investigation team throughout this investigation. This will be explored in more detail later in this report. The locum psychiatrist told the investigation team that a debrief was held the day after the man's death, which he attended. The RGN did not attend the debrief, but said that she had been supported through occupational health services. The agency nurse did not attend the debrief either and, as an agency nurse, never returned to the prison. The PCT tried to track the agency nurse for the purpose of this investigation but without success. The locum psychiatrist said that he received no ongoing support from the PCT following the man's death. Officers told my investigator that they understood how to access staff care and welfare services though the prison, but relied more on each other for support.

78. Given their role in the circumstances leading to the man's death, I am surprised that neither the agency nurse nor the RGN attended the hot debrief. However, I understand that the RGN preferred to take advantage of individual support services and I am satisfied that proper efforts were made to trace the agency nurse, albeit without success.

## ISSUES

79. After the man's arrival at the prison, he was assessed and located in the first night centre. During his secondary healthscreen, a nurse was concerned about the man's risk to himself and started ACCT procedures. Interim arrangements were put in place for monitoring him, before he was swiftly assessed by a qualified ACCT assessor. An experienced member of staff, the ACCT assessor appropriately recognised that the man needed to be monitored under ACCT, but thought he would also benefit from the enhanced care available in the healthcare centre.

80. However, this investigation found serious concerns about safer custody procedures at Wormwood Scrubs, particularly in the healthcare environment. Later in this section, I will consider the use of a gated cell and alternative clothing for a prisoner who did not need constant supervision, the safeguards that should have been in place for a prisoner subject to such measures, communication between healthcare staff and officers, and staffing levels in the healthcare centre.

### Medical records

81. During his first reception healthscreen, the man told the nurse that he had received treatment for his mental health in the community. The nurse observed that the man was "disoriented" during the healthscreen and "not straight to the point". As the man was unclear about the nature of his medication or treatment in the community, it was noted that his medical records should be requested from the hospital he had attended in East London. There is no record that such a request was actually made, and in fact his records were never retrieved. The man was in prison for six days after this initial assessment. It was not acceptable that his community medical records had not been requested in that time given his level of risk and the difficulty he had in recalling the details of his treatment.

82. The failure to retrieve his medical records meant that the man's medical treatment was compromised. He was prescribed anti-depressant medication by the locum psychiatrist after his assessment on 15 April. I agree with the clinical review panel that anti-depressant medication must be used "in a controlled manner". The clinical review panel has commented at length on the appropriateness of the man's prescription, and I commend this to the attention of the Head of Healthcare. I am concerned that medication was prescribed with no knowledge of the prisoner's medical history. I agree with the clinical review panel's recommendation:

**The Head of Healthcare should review the systems and processes for accessing clinical records held by community care providers to ensure appropriate and timely request, retrieval and review by healthcare staff.**

### Gated cell

83. The man spent six of the seven nights he stayed at Wormwood Scrubs in a gated cell in the healthcare centre. He was in a gated cell when he died. However, he was not under constant supervision. The locum psychiatrist decided to locate the man in a gated cell to keep him safe until a full assessment of his mental health could be carried out. The locum psychiatrist described it as "standard practice" to accommodate a prisoner not under constant supervision in a gated cell in alternative clothing. (I will discuss the use of alternative clothing in the next section.)

84. Prison Service Order (PSO) 2700 prohibits the use of a gated cell for any prisoner who is not subject to constant supervision. A gated cell affords a prisoner no privacy and does little to promote their dignity. The man should either have been subject to constant supervision or accommodated in an ordinary cell. In fact, he was in a gated cell on what the senior officer described as "just a basic routine observation for anybody on an ACCT" (that is, a minimum of three recorded observations during the day and at least five overnight).

85. When my investigator asked the Head of Healthcare at Wormwood Scrubs why PSO 2700 had not been followed, she said, "hand on heart that until all of this happened I actually wasn't aware of that in the Prison Service Order". It is a matter of self-evident concern that someone in such an important role was not familiar with the details of the PSO and the implications when holding someone subject to ACCT procedures in the healthcare centre. The investigation found that other healthcare staff were also unaware that prisoners must be under constant supervision to be accommodated in a gated cell. In fact, the locum psychiatrist told my investigator that he understood prisoners on lower level of observations were accommodated in such a cell as "standard practice".

86. The lead consultant psychiatrist at Wormwood Scrubs has been employed since October 2006 to conduct five mental health clinics a week. He was on leave when the man was at Wormwood Scrubs, but he briefed the locum psychiatrist on his duties before he went on leave. During interview for this investigation, the lead consultant psychiatrist explained that he had always located prisoners in gated cells and was not aware of the restrictions in the PSO:

> " … until after the incident, not since I arrived here in October 2006 was I made aware … the officers and nurses as well they happily went along with that, whenever people were put in a gated cell without being on constant observation."

87. My investigator was concerned about the use of gated cell following her opening visit. She observed two prisoners accommodated in gated

cells with alternative clothing. She contacted the lead in NOMS Safer Custody and Offender Policy group (SCOP), who leads policy work related to PSO 2700. She set out NOMS policy position for the use of gated cells as follows:

> "Policy does not support the use of a gated cell (with the gate in place) for a prisoner at risk of self harm, without the added support of constant supervision arrangements. PSO 2700 states gated cells are for use where a prisoner requires constant supervision and their use (when the gate is in place) to house prisoners without constant supervision requirements is prohibited."

88. The lead on policy work related to PSO 2700 assured my investigator that she would raise the practice with the London Regional Office for them to take forward with the prison. My investigator asked the senior officer who was her liaison officer and the safer custody senior officer at Wormwood Scrubs how frequently the gated cell was used for prisoners not subject to constant supervision. The liaison officer initially agreed to gather that information, but was later instructed that there was no requirement to do so and told my investigator that it would not be possible. No mention is made of prisoners subject to constant supervision or accommodated in gated cells in the prison's monthly Suicide Prevention Policy Meeting minutes between February 2009 and April 2009. It is therefore not possible to determine how common the practice is.

89. In line with normal procedure, the investigation team fed back their findings to the management team at the prison and wrote to the Governor with a summary of those findings. In his response to the feedback letter the Governor of Wormwood Scrubs, wrote as follows:

> "Since the death of [the man], there has been a significant amount of work carried out with the PCT staff regarding the use of the gated observation cells and protective clothing. Clear guidelines have been published to all staff and meetings have been held with the mental health team to instruct them in the proper application of PSO 2700 and the local Suicide Prevention policy … Wormwood Scrubs no longer holds any prisoner in a gated observation cell unless they are assessed as needing constant supervision under the ACCT processes."

90. During interview, the consultant psychiatrist also reassured the investigation team that since the man's death prisoners were not in gated cells unless they were subject to constant supervision. He explained that this has led to an increase in the number of prisoners on constant supervision, rather than a decrease in the use of the gated cell. As information about the use of gated cells is not routinely collected, it is not possible to validate the consultant psychiatrist's observations.

91. The investigation team was sent the Governor's Order which was issued after the man's death and the investigator's feedback in June 2009. Among other things, the Governor reminded staff that gated cells were "a measure of last resort" and should be used as specified in PSO 2700.

92. As I noted earlier, the man was the first of two prisoners to die in the healthcare centre at Wormwood Scrubs in 2009. The second death also involved a prisoner who had been in a gated cell, subject to constant supervision, and had been dressed in alternative clothing. At the time of his death, the prisoner was not in a gated cell and was subject to hourly observations, but there were lessons to be learned in relation to the management of constant supervision. This death is subject to a separate investigation but the two investigation teams have worked together to ensure a co-ordinated approach.

93. Given the two deaths in such similar circumstances, and in light of the acknowledged difficulties of challenging and changing long-standing practices, I judge that the following formal recommendation may be helpful:

**The NOMS Safer Custody and Offender Policy group and the Director of Offender Management should work with the Governor and the Primary Care Trust to ensure that gated cells are used only in line with Prison Service Order 2700.**

**Alternative clothing**

94. The man was given alternative clothing when he was located in the healthcare centre. He was issued with a blue gown and two blankets made of the same strong material, which is intended to make the garments difficult to tear into strips for use as ligatures.

95. Wormwood Scrubs' own suicide prevention policy describes the use of alternative clothing as "a measure of last resort". As well as underlining that alternative clothing should be used for "the shortest possible time", PSO 2700 also describes it as a measure of last resort. It goes on to require:

> "Decisions to remove all of a prisoner's normal clothing and issue alternative clothing (e.g. anti-tear or forensic/paper suit) must always be made by the case review team on an individual basis and only when the prisoner's behaviour is believed to be life threatening. For example, all prisoners placed in special accommodation should retain their normal clothing unless the case review determines otherwise."

96. The clear requirements surrounding the use of alternative clothing were echoed by the SCOP lead for safer custody. She set out the following position:

> "The removal of normal clothing from an at risk prisoner is covered in PSO 2700 and also in PSO 1700 and is generally considered to be a measure of last resort; as such there is a requirement for such a decision to be taken only when the prisoner's behaviour is believed to be life threatening."

As the man was not subject to constant supervision, the threshold cannot have been met.

97. The locum psychiatrist decided that the man should wear alternative clothing. During his interview with my investigation team, he said that he had made that decision so that the man's opportunity to harm himself would be limited. He said he had understood from nursing staff that it was common practice for prisoners to be dressed in alternative clothing, and he had observed a number of prisoners in such clothing during his brief time at Wormwood Scrubs.

98. As I mentioned above, the Head of Healthcare told my investigator that she was unaware of the details of the Prison Service Order concerning gated cells or alternative clothing. It is perhaps not surprising, therefore, that her staff were equally unaware of these provisions. The RGN described the gated cell and alternative clothing as something that was used "quite frequently". She told my investigator that patients would be put in a gated cell and protective clothing initially, and over time their care would be "stepped down". For example, she said after a case review "you maybe get them off the clothes into normal clothing then look at closing the gate".

99. The RGN told my investigator that alternative clothing was being used less frequently since the man's death. The senior officer who manages prison staff on the healthcare centre agreed that the use of alternative clothing had changed. However, during her interview with my investigator nearly two months after the man died, the senior officer told my investigation team about a prisoner not subject to constant supervision who was nevertheless in alternative clothing.

100. I understand that the locum psychiatrist decided to dress the man in alternative clothing to keep him safe. However, I am very disappointed that alternative clothing was not used as a measure of last resort in accordance with the requirements of PSO 2700 and Wormwood Scrubs' own suicide prevention policy.

101. As mentioned earlier, the use of alternative clothing was the subject of a Governor's Order in June 2009. However, once more I judge that a formal recommendation to reinforce that Order may be helpful:

**The Governor must ensure that alternative clothing is only used as a measure of last resort.**

102. The photographs taken by the police after his death showed that the man was dressed in alternative clothing (a gown) but was also wearing tracksuit bottoms underneath. When my investigator opened the investigation, she noticed two prisoners in a gated cell dressed in alternative clothing. She drew the senior officer's attention to the shoelaces that one of the prisoners had in his shoes, contrary to the strict rules of alternative clothing.

103. Alternative clothing is a measure of last resort, but there are occasions where the prisoner's risk of harm is so great they such clothing is necessary for their own protection. However, there are safeguards in place for such occasions. The lead from SCOP explained to my investigator:

> "… prisoners must not be left in alternative clothing during any activities that bring them into contact with other prisoners during the day PSO 2700 is clear that where there will be contact with other prisoners, normal clothing must be issued and increased levels of observation relied upon to reduce suicide risk instead."

104. The senior officer explained that officers in the healthcare centre issued prisoners with tracksuit bottoms and a sweatshirt for periods of association. When they return to their cells, the senior officer told the investigator that the prisoners dress themselves. She said, "good practice is to search them, especially for the underwear because that can easily be missed". The RGN was clear that it was "not [healthcare staff's] responsibility to carry out any searches" and remains the officers' responsibility.

105. Given the frequent use of alternative clothing in the healthcare centre at Wormwood Scrubs, I am surprised that there were no systems in place to ensure that prisoners dress and undress when they leave association. The locum psychiatrist's original decision to give the man alternative clothing was supposed to remove the risk that he would harm himself. The elasticated tracksuit bottoms rendered the increased safety of the undignified alternative clothing redundant.

**The Governor must ensure that systems are in place for the safe use of alternative clothing, when it is necessary.**

**Managing measures of last resort**

106. The man who died tore a strip of the alternative blanket, specifically designed not to tear, and used it as a ligature. In his cell, pipes running down the wall by the gate had been boxed in with plastic to prevent prisoners tying a ligature around them and thus make them safer. The plastic box was not flush to the ceiling, and it was this point to which

the man attached his ligature. Two recommendations follow from these facts:

**The Governor will wish to assure himself that any weaknesses in the cell fabric that result in avoidable ligature points are removed.**

**The NOMS Safer Custody and Offender Policy group will wish to consider if the current anti-tear fabrics in use are the best currently available.**

107. Healthcare staff explained to my investigator that prisoners were put in alternative clothing and gated cells to remove the risk of self harm, while they were fully monitored and assessed. They would gradually decrease these measures as they gained a clearer understanding of the prisoner's level of risk. The dignity and privacy of prisoners is undermined by these measures and I expect their use to be subject to the closest scrutiny. It is clear from this investigation that such measures do not – and perhaps cannot – remove all risk of suicide.

108. The use of a gated cell is listed as a measure of last resort in PSO 2700. However, the assumption is that a prisoner in a gated cell is on constant supervision. Therefore, all of the safeguards that are required by the Prison Service Order apply to a prisoner who is on constant supervision rather than in a gated cell.

109. However, safeguards do apply to any prisoner who is dressed in alternative clothing. PSO 2700 instructs: "Placing an at-risk prisoner in alternative clothing must trigger enhanced care." The requirements of enhanced care are set out in a later chapter in the Prison Service Order and are intended to assist prisoners who are at a time of crisis and to offer management support to staff delivering their care. As discussed above, the use of alternative clothing in this man's case was not a measure of last resort, but a starting point from which his care would be de-escalated. Nevertheless, the use of alternative clothing meant that the PSO requirements applied in his case.

110. The enhanced ACCT case review team should have been made up by a governor, a member of the mental health team or a doctor, the healthcare manager, an appropriate psychologist, and the man's key worker. Such a review should have taken place within four hours of the decision to use alternative clothing. The investigation team interviewed the Head of Safer Prisons. He said that he visited the healthcare centre as part of his role, but expected the Safer Custody Manager in his team to visit more frequently. Neither a governor nor the Head of Healthcare attended the case review on 15 April when the man was admitted to the healthcare centre and the decision made to put him in alternative clothing.

111. The Safer Custody Manager is of the appropriate grade to discharge the requirements of the enhanced case review in PSO 2700. Despite

his frequent visits to the healthcare centre, there is no entry in the man's ACCT document to suggest that the Safer Custody Manager had any involvement in his care. During his visits to healthcare, the Safer Custody Manager would have seen the man in a gated cell in alternative clothing, and I am surprised that he did not enquire further about his situation.

112. After the initial enhanced case review, subsequent reviews are based on need - but are required at least weekly. The next ACCT case review for the man took place on 20 April, less than a week after the initial review. Again, it was not attended by the Head of Healthcare or a governor. It is well understood that alternative clothing was not being used in line with the requirements of PSO 2700 as a measure of last resort. However, I do expect that in future the use of gated cells and alternative clothing is complemented by the required safeguards described in PSO 2700.

**As the Governor strengthens processes around the use of gated cells, constant supervision and alternative clothing, he should ensure that staff follow the requirements of enhanced care as set out in Prison Service Order 2700.**

113. The investigator met two members of the Independent Monitoring Board (IMB) during her opening visit. She asked them to check their records for any contact with the man. A member of the IMB is required to visit healthcare regularly as part of monitoring, yet no record was made of speaking to the man despite the conditions in which he was held. I recognise that it was not unusual in the healthcare centre at the time of the man's death for prisoners to be kept in a gated cell and alternative clothing. Nevertheless, I hope this report can be shared with the IMB to inform their efforts to ensure that standards of care and decency are maintained.

114. Also during her opening visit, my investigator asked how many prisoners had been in a gated cell or in alternative clothing in the previous three months at Wormwood Scrubs. The liaison officer told her that use of the gated cell and alternative clothing was not monitored in that way, and no such information was available. The investigator requested that for the three months following the opening visit, such information be collated to inform this investigation. The request was declined on the grounds that there is no requirement to gather such data routinely.

115. Having personally conducted and overseen investigations in very many prisons, I know that the use of constant supervision, gated cells and alternative clothing differs very significantly between establishments. I am surprised that the use of gated cells and alternative clothing is not more closely monitored. As measures of last resort, the task of gathering data on their use should not prove burdensome.

**The National Offender Management Service should consider monitoring the use of gated cells and alternative clothing as part of its Safer Custody strategy.**

**Communication in the healthcare centre**

116. The decision to place the man in a gated cell and protective clothing was made by the locum psychiatrist. It was then discussed at the subsequent ACCT case review attended by the senior officer who manages prison staff on the healthcare centre, a nurse and the community mental health nurse responsible for the inpatients unit. When asked how she became involved in the case review, the senior officer told the investigation team that it was not planned. She said that she noticed the man's ACCT document when he arrived in the healthcare centre. She said that she was concerned that the locum psychiatrist, with limited prison experience, was chairing the ACCT case review and wanted to give him additional support.

117. When asked whether she agreed with the decisions made at the review, the senior officer said: "well that was mainly the doctor and the nursing staff." She went on to raise concerns about the role officers play in the ACCT process for inpatients. She said that ACCT case reviews were often carried out as part of the twice-weekly ward round. Despite most of the healthcare officers being medically qualified, their role changed at the end of 2008. Previously, officers contributed to the medical care of prisoners and accessed their medical records, but this was restricted when their role changed. Officers were no longer allowed to attend ward rounds because of the medical nature of the discussion. This effectively meant that officers were not routinely able to attend ACCT case reviews.

118. The ACCT process is multidisciplinary. The daily contact with officers provides an insight into an individual's state of mind. Experienced officers, such as those on the healthcare centre in Wormwood Scrubs, are in a good position to suggest actions and activities to support prisoners and reduce their risk.

**The Head of Healthcare must ensure that officers are invited to attend ACCT case reviews.**

119. The senior officer who manages prison staff on the healthcare centre also told my investigator that she was unaware that a "cord loop" had been found underneath the man's "jogging suit top" when he arrived in the healthcare centre on 15 April. As the senior officer in charge of the unit, she expected to be made aware of significant information such as the discovery of a potential ligature. She said that she had not seen the entry in the man's medical record because it was "medical in confidence" and kept in a separate office that officers cannot access. Although the entry was not made until 8.25pm, it refers to the discovery of the "cord loop" as taking place on the man's arrival in the healthcare

centre. The case review chaired by the senior officer took place after the man had been accommodated in the unit. Such a significant discovery should be sufficient to trigger a case review in its own right. In this instance, it should have informed the case review that took place shortly after his arrival, and arguably would have affected the assessment of the man's level of risk and level of observations.

120. I have commented many times on the way the principle of medical confidentiality should be applied. When information has implications for the safety of the prisoner, the presumption must be that it is shared with all those involved in his care. However, in this instance not only did the senior officer not know about the hidden ligature, the locum psychiatrist told my investigator that he had not been told about the cord loop either. It is both surprising and disappointing that such an important find was not recorded in the ACCT document.

**The Head of Healthcare must remind staff of the importance of recording information about risk of harm in both the patient's clinical record and the ACCT document.**

121. I am also disappointed that staff did not discuss such a significant finding among themselves, regardless of their discipline. During the investigation, my team became increasingly concerned about the relationship between healthcare staff and officers. There was evidence of poor communication, with each discipline choosing to occupy separate offices in the healthcare centre. I agree with the clinical review panel that there was a "non-integrated approach to care planning and provision on the inpatient unit". During interview with a mental health nurse who attended the man's first case review, the investigation team were told, "staff are constantly stressed because of very constrained resources ... There is a lack of cooperation between the prison staff and clinical staff."

122. I believe this had an impact on the care that the man received during his stay in the centre. The investigation team fed back their concerns to the Governor during the course of the investigation. He made the following response:

> "There have been identified failures in the communication between the staff completing the two different roles within the Healthcare Department however, there has been a huge improvement in this area and both groups are seeing themselves more as a team with the primary aim of patient care. More work is being carried out including regular monthly team meetings and fortnightly [inpatient unit] operational meetings between the middle management team."

123. I am pleased that this matter has been taken forward as a matter of priority, and understand that the situation seemed to have improved by the time of my subsequent investigation into the second death in the

healthcare centre in 2009. I understand the pressures that officers and healthcare staff work under, but in such circumstances the support they can offer each other is crucial.

**The Governor and the Head of Healthcare should continue to promote team work among staff based in the healthcare centre.**

**Staffing levels**

124. In their report, the clinical review panel comment that - despite a recent recruitment campaign - staff vacancy rates for healthcare staff at Wormwood Scrubs are at 47 per cent, almost half the required workforce. The locum psychiatrist is a locum staff grade psychiatrist. He was assigned to cover his equivalent grade psychiatrist for three weeks. However, the consultant psychiatrist for the inreach service at the prison and therefore senior to the locum psychiatrist, also took leave at that time and arranged for remote cover in case of emergencies. This meant that the locum psychiatrist was the only psychiatrist available at the time that the man was at Wormwood Scrubs. The locum psychiatrist was given a telephone number for the consultant psychiatrist's colleague at a Mental Health Trust and asked to contact her if he needed additional support.

125. All healthcare staff told the investigation team that the majority of prisoners in the healthcare inpatients unit have mental health problems. Psychiatric support is fundamental to such prisoners' care plans. I am disappointed that the cover for two psychiatrists fell to one, less experienced and more junior psychiatrist, with little additional support. I agree with the clinical review panel's recommendation:

**The Head of Healthcare, lead GP and Consultant Psychiatrist are asked to review the current arrangements for temporary staff supervision. These must be explicit and take into account the level of skill and relevant experience of these staff.**

126. The locum psychiatrist explained in interview that he had very limited experience in a prison (one day in an open prison some time before he worked at Wormwood Scrubs). He told the investigation team that his induction constituted a briefing from the consultant psychiatrist prior to his leave, and a briefing from the senior nurse practitioner. He did not receive ACCT training nor any information about the requirements of working in a prison environment. As he was not a full time employee at the prison, he did not carry keys and had to be escorted by a member of the nursing team.

127. The locum psychiatrist told the investigation team that the inreach service supported him well during his time at Wormwood Scrubs. He acknowledged his limited prison experience but felt he had sufficient understanding of the ACCT process and Prison Service requirements to provide cover to an adequate standard. When asked if he used the

contact number given to him for emergencies, he told the investigation team that he only used it after the man's death. The clinical review panel shared my concerns at the information given to agency staff. I endorse the following recommendation:

**The Head of Healthcare, Consultant Psychiatrist, Lead GP and Clinical Governance should review the current local induction policy to ensure it contains treatment, referral, communication, and escalation of care guidelines.**

128. On the evening of the man's death, the RGN and the agency nurse were the only two members of staff working in the healthcare centre. There are supposed to be three officers on duty during the evening shift. However, due to high levels of staff sickness and a training programme elsewhere in the prison, there were no officers supporting the RGN in healthcare on the evening of the man's death.

129. In interview, the RGN described the busy evening shift she worked that evening. The other nurse on duty with her was an agency nurse who was employed to carry out constant supervision on another prisoner in the unit. I understand that efforts were made to recruit additional healthcare staff and that the PCT have had difficulties attracting staff to work in prison healthcare. However, I am disappointed that no officer was detailed to work in the healthcare centre that evening. There is no doubt that the small number of staff in the healthcare centre on the evening of the man's death affected the care that the man received. He was able to take his life in a gated cell without staff noticing. I do not think that the RGN was personally at fault. Rather, there were simply not enough staff to effectively discharge the prison's duty of care to healthcare inpatients.

130. When the investigation team communicated this concern to the Governor, he responded:

> "The officer staffing levels were short that evening due to high levels of sickness and the necessity for some staff to attend Control & Restraint training. When there are no discipline officers available to work in the healthcare, the provision is that the PCT nurses manage patient care whilst they are locked in their cells. There has been no reoccurrence of this problem since 11th May 2009 when the staffing levels were increased to allow adequate cover for shortfalls."

I hope that the Governor will continue to monitor the staffing levels in the healthcare centre.

**Under exceptional circumstances, when the minimum staffing levels cannot be met, the Governor and the Head of Healthcare must ensure that at least one officer is detailed to work in the healthcare centre for every shift.**

**ACCT observations**

131. I have already explained that the man should have been subject to constant supervision as he was located in a gated cell. At the time of his death, the locum psychiatrist had recorded that staff should engage in at least three meaningful interactions with the man during the day and observations should be made a minimum of five times during the night.

132. On the morning of his death, the agency nurse recorded serious concerns about the man's risk of self harm. The man had said that he was looking for a "small chance to commit suicide" and indicated that the door handle of the gated cell was his chance. The agency nurse recorded the conversation in the ACCT document and discussed his concerns with the RGN. The agency nurse recorded that the RGN advised that observation levels should be increased. However, no ACCT case review was held and the man's observations were not altered.

133. Unfortunately, the agency nurse was not available for interview for this investigation. However, the RGN recalled the conversation she had with the agency nurse that day. She said that she had explained the required level of observations was the minimum and the agency nurse could speak to the man more often. She told the investigation team that she would not normally hold a case review without a doctor for a prisoner in a gated cell and alternative clothing. The RGN said that she knew that the man's case would be looked at the following morning during the ward round when the doctor would be present. The RGN said that she could have exceptionally held a case review, but she thought that the man's risk was reduced due to his situation in the gated cell and alternative clothing.

134. I am concerned that a prisoner's level of risk would not normally be reassessed without the presence of a doctor. All staff, healthcare and officers, should feel empowered to change the level of support for prisoners in the ACCT process.

135. I am also concerned at the reliance on a single member of staff (the psychiatrist next on duty) to make decisions about the level of risk that each prisoner poses to himself. Although I recognise how busy she was that afternoon, I am surprised that the RGN did not consider the man's claims to be sufficiently serious to trigger a case review. Staff of any discipline and grade, officers or healthcare, should feel confident about contributing to the ACCT process.

**The Governor and the Head of Healthcare should satisfy themselves that staff are confident in ACCT procedures, including considering refresher training for all staff.**

### Foreign national prisoners

136. The man who died was from Azerbaijan and a Muslim. He reported to staff that he was Russian and a Jew. In general, staff said he communicated reasonably well but that he struggled with English.

137. I commend the senior officer who manages prison staff on the healthcare centre for arranging for the man to make an international telephone call to his mother when he needed extra support. And in previous investigation reports I have commented on the good work done by the Foreign National team at Wormwood Scrubs. However, the man had no contact with the Foreign National team during his short time in prison. Following the investigator's feedback to the Governor in this respect, he responded:

> "The Foreign National Team meet with all Foreign National Prisoners during their induction period but, due to his location in the Healthcare, [the man] was missed. Work is being carried out with the induction team to ensure that this does not occur in the future."

I am pleased that the Foreign National team are routinely involved in the induction process. I am grateful to agree with the Governor for ensuring that those prisoners who are located in the healthcare centre soon after arrival due to their increased vulnerability are not overlooked.

138. Despite staff assurances that the man was able to communicate effectively, the locum psychiatrist asked for an interpreter to be present for his next ACCT case review. When asked about this in interview, the locum psychiatrist said he thought it would give the man an opportunity to speak more freely about what was on his mind. Staff reported that the availability of interpreters and the translation service was never problematic. Although the man seemed able to communicate well, nuances are often missed when speaking in a different language. I hope that in future cases there might be earlier consideration of involving an interpreter in ACCT case reviews.

### Food refusal

139. The man told staff that he did not want to eat because he "wanted to die". The investigation team asked the RGN whether she had observed that he was not eating or drinking. She said that the man would claim not to be eating, but would take some bread or drink some tea.

140. The locum psychiatrist was concerned about the man's claims not to be eating or drinking. He prescribed a protein drink (Ensure) to

supplement his meals, which the man drank. The locum psychiatrist said that "it was not like he was not eating at all … he was not eating adequately". The locum psychiatrist was confident that the prescription of Ensure was appropriate to manage the man's poor dietary intake.

141. I agree with the clinical review panel's recommendation that food charts should be started for prisoners who refuse food and drink for prolonged periods of time. I understand from the man's records that he often claimed he wanted to die through not eating. However, I also note the occasions when he ate. Had he completely refused food for a prolonged period, I would have expected a food refusal log to have been started by staff. It is a requirement that staff start a formal food refusal chart after three days of food refusal.

142. As his records show that he drank Ensure and ate on several occasions, it seems that there was not a period of three days or more when he refused food completely. However, I cannot determine that the monitoring of the man's dietary intake was recorded adequately in the ACCT document and his clinical record as entries were not consistently made at each meal time. I acknowledge that there is no requirement to monitor a prisoner whose food refusal has not been absolute for three days or longer. Nevertheless, given the seriousness of the man's claim to refuse food because he "wanted to die", it might have been prudent to have opened a food refusal log.

## CONCLUSION

143. Shortly after the man arrived at HMP Wormwood Scrubs he told staff that he would die in prison. Staff quickly identified him as at risk of self harm and assessed his needs. The decision to accommodate him in a gated cell in alternative clothing was undoubtedly made with the best of intentions to reduce his opportunities for harming himself. However, there is no substitute for a co-ordinated multi-disciplinary approach to supporting a prisoner at risk of self harm, and this was lacking.

144. I am disappointed by what this investigation has revealed about safer custody procedures at Wormwood Scrubs at the time of the man's death. The challenges of delivering individualised care in such a large local prison are evident. However, I hope that the Governor, Head of Healthcare and PCT will work together to bring the establishment in line with the expectations of NOMS in providing a safe and decent environment for all prisoners.

## RECOMMENDATIONS

1. The Head of Healthcare should review the systems and processes for accessing clinical records held by community care providers to ensure appropriate and timely request, retrieval and review by healthcare staff.

   *The Head of Healthcare partially accepted this recommendation. In her response, she wrote:*

   *This is normal practice, however we do rely on the prisoner to give us all the relevant contact information in terms of name known by. On this occasion we were not afforded [the man's] name – he was in custody under another name and we were not informed otherwise until he had passed away.*

2. The NOMS Safer Custody and Offender Policy group and the Director of Offender Management should work with the Governor and the Primary Care Trust to ensure that gated cells are only used in line with Prison Service Order 2700.

   *The NOMS Safer Custody and Offender Policy Group and the Director of Offender Management accepted this recommendation and set out the following response in their action plan:*

   *a. A Governor's Order have been published identifying to all staff the necessary requirements when locating prisoners to or employing the use of a 'Gated' cell. This Order will be re-issued in May 2010.*

   *b. All prisoners located to gated cells, when used as such are now subject to Constant Supervision.*

   *c. A local Policy document 'Constant Supervision, Gated Observation Cells and Alternative Clothing' has been drafted and now agreed between the PCT HC Provider and Prison. This document provides clear guidance and instructions to staff from both organisations as what is required when directing / authorising a prisoner to be accommodated into a gated cell.*

   *d. Staff from the PCT HC Provider and Prison will attend a presentation of the document's contents to be delivered jointly by the prisons Safer Custody Manager and Modern Matron responsible for the inpatient unit to ensure the document and its contents are fully understood.*

   *e. A log has been implemented within the healthcare inpatient unit to record all prisoners placed on Constant Supervision. The log will record under whose authority this action was initiated and the times and dates of when the subsequent Enhanced Case Reviews take place. This log will be used as a prompt to unit staff to ensure that the later takes place within required timeframes.*

*f. Compliance to this recommendation and the proposed action will be monitored by the Safer Custody Manager and H3 Modern Matron by means of Action Point 2(e) above.*

*The prison have informed this office that these actions were all completed by the end of May 2010, apart from the last action at (f) which is ongoing.*

3. The Governor must ensure that alternative clothing is only used as a measure of last resort.

   *The Governor accepted this recommendation. In his response, he referred to the actions listed under recommendation 2, but went onto note the following ongoing actions:*

   *a. The Local policy 'Constant Supervision, Gated Observation Cells and Alternative Clothing' includes at Para 6 of the document directions as to the use of Alternative clothing and emphasises that this option should only be used as "a measure of last resort". The Paragraph also refers the reader to Chapter 8.9 of PSO 2700 and operational instructions 2 and 24 of the suicide prevention policy for further clarification.*

   *b. Compliance to this recommendation and the proposed action will be monitored by the Safer Custody Manager and H3 Modern Matron by means of Action Point 2(e) above.*

4. The Governor must ensure that systems are in place for the safe use of alternative clothing, when it is necessary.

   *Again, the Governor accepted this recommendation, noting the following actions, in addition to those listed under recommendation 2:*

   *a. The Local policy 'Constant Supervision, Gated Observation Cells and Alternative Clothing' includes at Para 4 (f – m) and at Para 5 & 6 instructions of how a prisoner should be managed whilst monitored under Constant Supervision and whilst in alternative clothing.*

   *b. Instructions referred to at 4.b. above have been compiled into a reference / information pack for issue to the staff members responsible for conducting observations of the prisoner.*

   *c. A review of current stock of Alternative clothing has been carried out within the prison Healthcare Inpatient unit and the Segregation Unit. Instructions have been issued that all worn and unserviceable items should be replaced from the establishment stores, where a stock of new and unused clothing is held.*

*d. The Safer Custody Co-ordinator will carry out random checks of this clothing to ensure that this action is ongoing. Any incidents of the discovery of unserviceable clothing will be reported through the Safer Custody Manager to the relevant Functional Head for appropriate follow up action.*

5. The Governor will wish to assure himself that any weaknesses in the cell fabric that result in avoidable ligature points are removed.

*The Governor only partially accepted this recommendation, with the following response:*

*a. Gated cells within the Healthcare Inpatient Unit are not fitted to Safer Cell specifications. There exist therefore, as with most other cells on the unit a number of possible ligature points within the cell. However, the risk of a prisoner being afforded sufficient time to secure such a ligature is now considered minimal by the fact that if in a gated cell he will be subject to Constant Supervision.*

*b. Having stated the above (5.a) the Safer Custody Team in conjunction with the establishment works department have reviewed the fabric of the gated cell accommodation in the healthcare unit with a view to limiting the possibility of ligature points and in particular the ligature point that the man used. Initial materials used to seal the gap between the lock back / pipes and the wall proved unsuccessful and a more substantial covering will be employed.*

*c. The lack of 'Safer Cell' accommodation within the inpatient unit has been recognised. A successful bid was therefore made and funding provided to convert two existing cells on the unit to Safer Cell specifications. These are now in place and provide a safe step-down ability for prisoners being removed from Constant Supervision.*

5. The NOMS Safer Custody and Offender Policy group will wish to consider if the current anti-tear fabrics in use are the best currently available.

*The NOMS Safer Custody and Offender Policy group have accepted this recommendation, with the following response:*

*Regime Services are keeping the use of anti-tear fabrics under review taking into account any new products that come onto the market.*

7. As the Governor strengthens processes around the use of gated cells, constant supervision and alternative clothing, he should ensure that staff follow the requirements of enhanced care as set out in Prison Service Order 2700.

*The Governor accepted this recommendation and referred to the action points set out in response to recommendation 2.*

8. The National Offender Management Service should consider monitoring the use of gated cells and alternative clothing as part of its Safer Custody strategy.

   *The National Offender Management Service initially partially accepted this recommendation. In their first response, they wrote "The use of gated cells and alternative clothing is monitored on an individual basis." However, in discussions with the investigation team, they have since accepted this recommendation and agreed to at least "consider" the broader monitoring the use of gated cells and alternative clothing as part of the Safer Custody strategy.*

9. The Head of Healthcare must ensure that officers are invited to attend ACCT case reviews.

   *The Head of Healthcare accepted this recommendation, again referring to the actions set out under recommendation 2, above. In addition, she set out the following actions:*

   *a. An information sharing protocol has now been agreed between the PCT and prison, which will allow all medical information to be shared between clinical and those discipline staff signed up to the document. The Governor has directed that it be a condition of working within the healthcare inpatient unit that all Officers agree to sign up to this protocol. This will in effect remove any perceived barriers to Officers attending Ward Round discussions and will cement a multidisciplinary team approach to all care pathways.*

   *b. The agreement has been submitted to the Prison Staff Association (POA) who have stated that they have no objections to the contents of the protocol or to their members signing it.*

   *c. A joint PCT / Prison Management approach is to be employed to implement the protocol. All H3 unit prison discipline staff will receive a presentation as to the protocol's contents and meaning. They will then be invited to sign up to the document.*

   *d. The Safer Custody Team, in conjunction with the PCT Management will monitor future ACCT reviews to ensure compliance.*

10. The Head of Healthcare must remind staff of the importance of recording information about risk of harm in both the patient's clinical record and the ACCT document.

   *The Head of Healthcare accepted this recommendation, with the following response:*

*Refresher training to be organised again for all staff. Notice to staff to be circulated amongst all healthcare staff and the importance of the ACCT document reinforced.*

11. The Governor and the Head of Healthcare must continue to promote team work among staff based in the healthcare centre.

    *The Governor and the Head of Healthcare accepted this recommendation, and planned the following actions to address it:*

    *a. Regular H3 Team meetings have been organised to ensure that staff from both disciplines share common problems and contribute to their resolutions.*

    *b. All staff have been encouraged to share the unit's landing office as the main focal workstation for unit staff.*

    *c. PCT and Prison Managers continue to monitor the situation and work towards a more integrated workforce. It is hoped that with the introduction of the Information sharing protocol this will enhance this process.*

12. The Head of Healthcare, lead GP and Consultant Psychiatrist are asked to review the current arrangements for temporary staff supervision. These must be explicit and take into account the level of skill and relevant experience of these staff.

    *The Head of Healthcare, lead GP and Consultant Psychiatrist accepted this recommendation, with the following action:*

    *Current induction document to be reviewed and amended where necessary to reflect supervision arrangements and escalation lines.*

13. The Head of Healthcare, Consultant Psychiatrist, Lead GP and Clinical Governance should review the current local induction policy to ensure it contains treatment, referral, communication, and escalation of care guidelines.

    *The Head of Healthcare, Consultant Psychiatrist, Lead GP and Clinical Governance accepted this recommendation, agreeing to review the current induction document and amend where necessary.*

14. Under exceptional circumstances, when the minimum staffing levels cannot be met, the Governor and the Head of Healthcare must ensure that at least one officer is detailed to work in the healthcare centre for every shift.

    *The Governor and the Head of Healthcare partially accepted this recommendation, and set out the following three-part response:*

*a. At the time of the man's death the PCT had commissioned Discipline Officer coverage for periods only when prisoners located on that unit were out of their cells on activities. Officer coverage has now been extended to cover patrol periods and the Officer group increased. Since this increase there have been no reoccurrences of no Officer being on duty in the unit during the day / evenings periods.*

*b. Where necessary the establishment's Orderly Officer has deployed Discipline Officers to supplement H3 Unit staffing in order to maintain sufficient Officer cover.*

*c. Night cover for the unit remains the responsibility of the PCT Nursing staff, with Discipline Officer response supplied from the main prison night compliment as required.*

15. The Governor and the Head of Healthcare should satisfy themselves that staff are confident in ACCT procedures, including considering refresher training for all staff.

*The Governor and the Head of Healthcare accepted this recommendation and set out the following actions to implement it:*

*a. All staff within the unit will be refreshed in the ACCT procedures.*

*b. Work is currently underway to organise training of Nurses and Nursing Assistants from the main agency which supplies staff to the PCT / Prison. This training will cover all aspects of Constant Supervision and the ACCT process.*