Investigation into the circumstances surrounding the death of a man at HMP Wormwood Scrubs in July 2008

Report by the Prisons and Probation Ombudsman for England and Wales

October 2009

This is the report of an investigation into the death of a man. He was found hanging in his cell at HMP Wormwood Scrubs in July 2008. He was 32 years old.

I would like to offer my sincere condolences to the man's family for their loss. I hope that my report addresses the concerns that they have raised. I must apologise for the time taken to issue this report, but the investigation was widened to include interviews with staff at HMP Chelmsford (the prison where he was prior to his transfer to Wormwood Scrubs).

The investigation was carried out on my behalf by one of my investigators. A clinical review was carried out by a clinical reviewer from the local Primary Care Trust. I would like to thank the Governor of Wormwood Scrubs and his staff, in particular the Liaison Officer and the prison's Family Liaison Officer for their co-operation and assistance. I know the family very much appreciated the prison's Family Liaison Officer's support. I would also like to thank the Governor of Chelmsford and their Liaison Officer .

The man was transferred to Wormwood Scrubs from the healthcare centre at HMP Chelmsford following a court appearance in July 2008. It is evident that information contained within his medical file was not reviewed by healthcare staff at Wormwood Scrubs, and he was located in a residential wing. During his short time at the prison, he did not come to the attention of staff and appeared to settle in well. The weekend routine at Wormwood Scrubs does not require a check to be carried out to ensure the safety and wellbeing of prisoners at the start of the day. This almost certainly resulted in a delay in finding him; although it is unlikely this made a difference to the outcome.

My report makes a recommendation with regard to the weekend routine at Wormwood Scrubs. I make four further recommendations for consideration by the Governor regarding reception procedures, staff training and support. I have made three recommendations to the Governor of Chelmsford including improving the accuracy of prisoner records. I also make a recommendation to the local Primary Care Trust to ensure that medical tests are carried out and reviewed in a timely manner.

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.

Stephen Shaw CBE
Prisons and Probation Ombudsman **October 2009**

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SUMMARY

The man was found hanging from a bed sheet attached to an upended bed frame at HMP Wormwood Scrubs in July 2008.

He had a long history of offending that started when he was 14 years old. He received his first custodial sentence when he was 17.

Having been released on parole licence in January 2008, the man was arrested in May having committed further offences. His licence was revoked and he was returned to custody in HMP Chelmsford.

Whilst at Chelmsford, the man cooperated with staff and gave no cause for concern until he allegedly assaulted prison staff on 20 June. He was segregated and charged with a disciplinary offence that was later referred to the police.

Nine days later, he was recorded as starting to display signs of paranoia. He was allegedly threatening staff and, in view of the recent unprovoked assault, it was decided that a senior officer and three prison officers should be present whenever he was unlocked. The Prison Service refers to this arrangement as a three man unlock.

The man was assessed by a mental health nurse and a psychiatrist who both had concerns about him. It was decided to move him to healthcare so that he could be monitored and observed more closely. (This is the first record of him having any contact with psychiatric services.) He was further assessed by a number of psychiatrists while in healthcare who requested blood and drug tests to aid their diagnosis. My investigator could not find any record of the tests being carried out.

The man was still located in healthcare on a three person unlock when he left Chelmsford to attend Chelmsford Crown Court in May. He was sentenced to two years and four months imprisonment and sent to HMP Wormwood Scrubs that evening. On arrival, he signed a disclaimer saying that he did not want to wait to see a doctor and that he was healthy and did not require any medication. As a result, he was not seen by a doctor and a health screen was not carried out. There is also no note of his medical record being reviewed by any of the healthcare staff at Wormwood Scrubs.

Reception staff completed a cell sharing risk assessment using information provided by the man. They did not take account of any documentation that accompanied him, and assessed him as being a low risk. However, someone did notice an entry in his prison file that referred to the three man unlock in place at Chelmsford. As it was late in the evening, it was decided to continue the three man unlock until the information could be checked the following day. (The three man unlock came to an end once staff at Wormwood Scrubs had spoken to staff at Chelmsford.) The man was allocated to D wing which contains single cell accommodation and is reserved for prisoners who require additional supervision or support.

During his time on D wing, the man kept himself to himself. He applied for work and training courses and did not give the staff any cause for concern. It appears that his behaviour, both at Chelmsford and Wormwood Scrubs, did not give any indication

that he intended to take his own life. He consistently denied having any mental health problems or thoughts of harming himself.

On the day of his death, the man was last checked at 5.30am. The procedures at Wormwood Scrubs do not require a roll check when the day staff come on duty. On a Sunday, only prisoners who have asked to attend church or require medication are unlocked in the morning. When he was found at 11.40am, rigor mortis had already set in. This indicates that he had been dead for some time.

THE INVESTIGATION PROCESS

1. The investigation was conducted on my behalf by my investigator. On her initial visit to HMP Wormwood Scrubs, she met staff and visited the cell where the man died. Notices were issued to staff and prisoners informing them of the investigation and inviting anyone who had information relating to his death to contact her.

2. My investigator reviewed the man's prison and health records in addition to other documentation, including police witness statements. Interviews were conducted with seven members of staff at Wormwood Scrubs on 11 and 12 September 2008. My investigator also visited HMP Chelmsford, where the man was held until his transfer on 10 July, to interview two members of staff: a Charge nurse and an Officer, who had had recent contact with him.

3. I commissioned a clinical review from the local Primary Care Trust (PCT) which was carried out by the clinical reviewer. The clinical reviewer accompanied my investigator during interviews held at Wormwood Scrubs on 11 September. Once completed, the clinical review was checked for factual accuracy by a stakeholder review panel. I would like to thank the clinical reviewer for her helpful review.

4. One of my Family Liaison Officers (FLOs) made contact with the man's family to explain the purpose of my investigation and invite them to raise any concerns they wished to be considered and addressed. The FLO visited his family at their home on 1 September. During the visit, the family raised a number of issues, some of which the FLO was able to address during their meeting.

5. Other issues raised by the family are addressed within this report. They are:

    - Whether he spent time in the segregation unit and why?
    - Details of any medication he received.
    - Whether any mental health issues had been identified and if so were they managed appropriately?
    - Who were his last visits with?
    - What date was he arrested and taken to Chelmsford?
    - How long he spent at Chelmsford?
    - What was he arrested for?
    - When would he have been released?
    - Was he on the healthcare unit and if so why?
    - Did he go to outside hospital at all?
    - The family had received a letter saying that he had been pounced on by officers and sustained a fractured shoulder.
    - What courses did he take at Chelmsford and Wormwood Scrubs?
    - In a letter the family received after his death, he said he was scared.
    - Whether he left a suicide note.

6. The man's mother also asked about a telephone call she received at the end of June 2008 from someone claiming to be a prison officer from Chelmsford. He had said that the man wanted him to call her to tell her that he loved her. The man's mother told him to tell her son that she loved him too. Understandably, the man's mother wanted to know who had made the call. Unfortunately, there is no record of the conversation in his file and my investigator could not establish the identity of the caller.

7. I hope that my report helps the man's family better understand what happened to him in the time leading up to his death.

HMP WORMWOOD SCRUBS

8. HMP Wormwood Scrubs is a large category B local male prison predominantly serving the courts of North West London. It was built between 1875 and 1891 and can now hold up to 1,239 convicted and remand prisoners.

9. Healthcare at the prison is commissioned by the local Primary Care Trust. There is a 17 bed inpatient facility which provides 24 hour care.

10. D wing has single cell accommodation for 244 prisoners on four floors. It houses approximately 60 per cent of those prisoners assessed as high or medium security risk. It also houses "difficult to manage" prisoners, who often bring additional staff pressures. In recognition of these pressures, the Governor increased the staffing levels on the unit in March 2008.

Cell Sharing Risk Assessment (CRSA)

11. The CSRA document is completed by reception staff when a prisoner first arrives at a prison. It is intended to ensure that unsuitable prisoners do not share cells (for example, a known racist with a prisoner from a visible ethnic minority, or a mentally disturbed prisoner with one who is known to be violent).

Her Majesty's Chief Inspector of Prisons's report

12. Wormwood Scrubs was most recently inspected during a full unannounced inspection in June 2008. In her subsequent report, the Chief Inspector said:

> **"**Wormwood Scrubs, like many other large local prisons, operated under considerable pressure. It was taking in around 300 prisoners a week ... often arriving late.
>
> "… overall we found that the prison was no longer performing sufficiently well in relation to safety. Reception, first night and induction procedures were not sufficiently supportive or consistent, and staff involvement in these key areas was limited."

The Chief Inspector did note some good initiatives in relation to violence reduction and suicide prevention. However, she also commented that:

> "… in general staff were insufficiently proactive, and did not appear to know their prisoners. Entries in wing history sheets were poor, and in effect there was no personal officer scheme."

Independent Monitoring Board (IMB) report

13. An IMB is appointed to each prison by the Secretary of State for Justice. Its members are wholly independent of the Prison Service and the prison's management team. Each IMB is required to produce an annual report to the Secretary of State about the prison, highlighting good practice and areas of concern.

14. The latest report from the IMB for Wormwood Scrubs covers the period June 2007 to May 2008. The report highlighted the IMB's concerns regarding reception procedures:

> "[The IMB] remains very concerned about the late arrival of prisoners. With the vast majority arriving at the same late hour essential procedures such as searching, health screening and risk assessment are happening under great pressure."

21. Since my office began investigating deaths in custody in 2004 there have been 19 deaths at Wormwood Scrubs, both self inflicted and from natural causes. There were two self inflicted and two natural cause deaths in 2008, and one natural cause death to date in 2009. Previous recommendations in my reports have covered matters including healthcare reception procedures, record keeping and communication.

HMP CHELMSFORD

22. HMP Chelmsford is a category B local prison first built in 1830. Originally a county jail with four wings, the prison has been extended twice and currently has an operational capacity of 695. Prisoners are held on six main wings. There is a two storey healthcare centre that has 12 inpatient beds.

23. The healthcare service is provided by the local Primary Care Trust, who also provide a mental health in-reach service. A psychiatrist from the local mental health trust provides two sessions a week. A mental health in-reach team of three full-time Registered Mental Nurses (RMNs) and a qualified counsellor, also from the local mental health trust, run a day care unit.

24. The latest inspection by HM Chief Inspector of prisons. carried out in July 2007, looked at the quality of record keeping within the health care centre:

> "The entries in notes we examined, especially from the GPs, psychiatrists and mental health nursing team, were of a good standard, although signatures were not always legible."

KEY FINDINGS

25. The man was released on licence from HMP The Mount in January 2008. As part of his licence requirements, he had to be "well behaved, [and] not commit any offence". The licence period was due to finish in June 2008.

26. However, in May 2008, the man was arrested and taken to Loughton Police Station where he was held in custody. He was charged with burglary and taking a vehicle without the owner's consent (TWOC).

27. In the police custody suite, the man claimed to have taken cocaine that day. He was assessed by a worker at the Drug Intervention Programme who completed a Drug Intervention Record with him. During this assessment, the man said that he had learning difficulties and dyslexia but had had no contact with any mental health services. He claimed to have taken cocaine only once but regularly took cannabis and drank alcohol. He said that he had started drinking alcohol when he was 10 and started taking drugs when he was 20. He also said he had nowhere to live and had been sleeping in the streets when arrested.

28. The worker at the Drug Intervention Programme recorded in the Intervention Record that the man should be referred for housing advice and to the Counselling, Assessment, Referral, Advice and Throughcare team (CARATS), for one to one counselling and group work. (The CARATs team are a group of trained staff working in every prison who provide counselling, assessment, referrals on to specialist support, advice and throughcare for prisoners who are drug users). The worker at the Drug Intervention Programme also recommended that the man should be offered a mentoring service, in order that there was someone to offer him personal support when he was released.

29. As a result of the new charges, the man's licence was revoked and he was returned to custody at HMP Chelmsford in May to serve the rest of his sentence. He was also remanded to appear in court in July, to answer to the charges of burglary and TWOC. His Prisoner Escort Record (PER), completed by the police at Loughton Custody Suite and given to staff at Chelmsford, stated that he had disclosed a risk of medical and mental health issues and noted potential depression.

30. During the reception health assessment later that day, the man said that he had taken cocaine and crack but gave no indication of how often he took them. He denied any history of mental health problems or contact with psychiatric services in the past. The man did complain of pain in his right shoulder, a complaint that he repeated on a number of occasions in the following weeks. (He asked to see the doctor but subsequently failed to attend an appointment on 3 June.)

31. The cell sharing risk assessment was also completed on 30 May. The man confirmed that he did not have any mental health problems. He said that he had not harmed himself. He was assessed as low risk.

32. A worker from the CARATs team saw the man in June to complete a full assessment. He told her that he took cocaine weekly and cannabis and alcohol daily. The CARATs worker worked on the basis that he was, at that time, due for release in June, the last day of his earlier sentence. She made urgent referrals on his behalf to NACRO (a charity which helps offenders settle back into the community) for housing support, and the Waltham Forest Drug Intervention Team for assistance with his drug problems. She also arranged for him to attend a "Motivation to Change" group work session within the prison. (The man successfully completed this session in June.)

33. The man saw the doctor in June regarding the pain in his shoulder. No specific cause for the pain was noted in his medical records. The medical records do not suggest that he went to an outside hospital at any time. The prison doctor prescribed Diclofenac (a common anti-inflammatory drug) for the pain.

34. In June, the man was visited by a solicitor of Galbraith Branley, Solicitors. Following this visit, he assaulted four members of staff in the visits room and had to be restrained. He was taken to A unit (the segregation unit) and placed on a disciplinary report. (There is no record of the outcome of the alleged assault, which was delayed as it was referred to the police.) The solicitor told my investigator that her visit with the man had been positive and he had been in good spirits. She had not noticed any tension between him and the staff, and was surprised to hear of the assault that followed.

35. The man was seen by a nurse or doctor every day whilst in A unit, and did not cause any concern until 29 June when his mental state started to deteriorate. A letter he had sent to his solicitor was intercepted and read by an Officer whilst he was monitoring mail. (It is not known whether this letter was clearly marked or whether opening the letter breached Prison Rule 39, which provides for correspondence between prisoners and their legal representatives to be treated as privileged. This means that such correspondence must not be opened, read or stopped, except in special circumstances.) The letter contained a number of allegations against various members of staff and requested help with a transfer to another prison. This letter was subsequently sent to the solicitor, but the man's mail and telephone calls were then monitored. The man also continued to complain about his shoulder but refused medication whilst in A unit as, for safety reasons, he was not allowed to keep the whole blister pack.

36. According to the man's medical notes, A unit staff raised concerns that he was accusing them of bullying him. He kept his head covered to stop them "putting thoughts into him", his mirror covered to "protect him", and covered his food with tobacco and carefully torn paper. Staff assessed his risk of violence to be high and he was placed on a three man unlock, which meant that a senior officer and three prison officers had to be present whenever he was unlocked. He was also referred to the prison mental health team.

37. The charge nurse and a consultant psychiatrist (the name is illegible in the notes) assessed the man on 30 June. The man admitted to covering himself,

his mirror, and his food to 'protect' himself. He again denied having any mental health problems and was recorded as saying that he did not abuse drugs. He also denied having any ideas of harming himself. The consultant diagnosed possible paranoid psychosis which could have been drug induced.

38. The consultant arranged for the man to transfer to healthcare as an inpatient for a period of closer observation and assessment. The medical notes record that the consultant asked for a drug test and for his previous medical history to be obtained from his doctor and from previous periods in custody. My investigator could not find any record of these requests being carried out.

39. The man was transferred to healthcare the same day and the three man unlock was maintained. He was seen by the doctor on 3 July for the pain in his shoulder and diagnosed with muscle spasm. The doctor asked that routine blood tests be conducted. There is no record of these tests being taken either.

40. In July, the man was reviewed by another psychiatrist. He continued to be suspicious of staff and had written to his solicitor complaining that staff were putting something into his food. The psychiatrist recommended continuation of the observation and assessment.

41. Four days later, the man was seen by two further psychiatrists, who noted an improvement in his mental state. He again denied having any history of mental health problems or violence, and said that he had never seen a psychiatrist. He denied attacking staff, saying that they had attacked him, and he also denied using illegal drugs. The two doctors recommended that the observation in healthcare should continue.

42. The man attended Chelmsford Crown Court in July. There is no record of any healthcare assessment taking place prior to him leaving healthcare at Chelmsford prison to attend court. The PER completed by prison staff stated that there was no known medical risk, but highlighted issues of violence, the concealment of weapons, and escape risk, as well as drug and alcohol issues. This would have been the document received by HMP Wormwood Scrubs later that day.

43. The man was sentenced to two years and four months imprisonment in July and transferred to Wormwood Scrubs. (His non-parole date was now August 2009 and his Licence Expiry Date and Sentence Expiry Date were June 2010.) It is not clear why he did not return to Chelmsford, although this was probably due to the limited space available there (and there would have been no reason for him to return to Chelmsford unless it had been indicated on the PER form. If a pre-arranged transfer had been arranged a full brief to the new establishment would have taken place). He arrived at Wormwood Scrubs at 7.17pm as one of a group of 12 prisoners. He was the last one to be seen by the night nurse who briefly checked whether he had any health problems. He signed a disclaimer stating that he did not want to wait to see the doctor. He said that he was healthy and did not require medication. It appears that no

formal health assessment was conducted either at this stage or the following day.

44. It is clear that the healthcare staff at Wormwood Scrubs had access to the man's medical records as the entry documenting the disclaimer was made as a continuation of the notes recorded at Chelmsford on the same page. My investigator, however, could find no evidence of any review of his medical record or any formal health screen conducted at Wormwood Scrubs.

45. The practice at Wormwood Scrubs is that only prisoners coming into custody for the first time are given a health screening assessment. Any other prisoner who says they have no physical or mental health problems does not have their medical record reviewed. Given that immediately prior to transfer the man was located in healthcare at Chelmsford so that his mental state could be assessed, the lack of review raises some concern.

46. In July, a governor at Chelmsford had agreed to the continuation of the three man unlock. This entry was clearly read by staff at Wormwood Scrubs as it was decided to continue this arrangement when the man arrived there, despite the cell sharing risk assessment rating him as a low risk. The CSRA was completed by an Officer and was compiled solely from information provided by the man himself. It was not signed by either healthcare staff or the duty manager, and took no account of the information recorded on the PER form. The prison reception procedure states:

> "At all times refer to PER as to previous risk and always state on cell sharing risk assessment any comments made."

This does not appear to have been followed.

47. As it was late in the evening, the security procedures were maintained until the information could be checked with Chelmsford the following day. The man was located onto D wing which contains only single cells and tends to be used for higher risk prisoners. The three man unlock was taken off the following day and his wing file recorded him as having "been assessed as low risk". The duty doctor did note the disclaimer in the man's medical record on 11 July but did not see him. The doctor's signature in the notes is illegible.

48. The same day, the man was seen by a second CARATs worker, but he declined their services. Later, he asked to see the doctor, and an appointment was recorded in the medical file as being booked. However, there is no note in his medical records to confirm whether the appointment actually took place.

49. The man spoke to his sister on the telephone on 13 July. He made a number of calls over the next few days to other numbers which were not connected as they were not on his list of approved telephone numbers. (Prisoners are allowed a limited number of numbers that they can call.) The prison could not supply a transcript of the call to his sister as all recordings are deleted after 90 days (and this was not saved by the prison). There is no record of him

receiving any visitors whilst at Wormwood Scrubs, and his last recorded visit was the legal visit on 20 June at Chelmsford.

50. On 17 July, the man telephoned his offender manager (probation officer) of Essex Probation Area, to say that he would be out soon. The probation officer was concerned by the call as he knew the man was not due for release and contacted a worker of the probation department at Wormwood Scrubs. A probation officer at the prison went to see the man the next day. The man said he was fine and had no intention of harming himself. The prison probation officer reminded him of the Listener scheme if he wished to speak to anyone in confidence. (Listeners are prisoners who have been specially selected and trained by the Samaritans to offer confidential support to other prisoners.) He also advised him that he could ask to see a counsellor.

51. An application form was received from the man on 18 July requesting work as a reception cleaner and asking to join a painting and decorating course. The outcome of his applications is unknown but he was interviewed by a workshop instructor. No date is recorded for the interview nor is there any information regarding the man's suitability for the workshop.

52. On the afternoon of Saturday 19 July, the man called an unknown mobile telephone number which was not answered. There is no record of how he spent the day, but it is likely that he was out of his cell for some time in the afternoon as he was able to make the call.

53. A prison officer, who works permanent night duty and was on duty in D wing on the night of 19 July, said in her police statement that she checked all prisoners on D wing at 5.30am. The man appeared to be fit and well at this time.

Events on in July

54. Day staff begin work at 7.45am at weekends at Wormwood Scrubs. They do not conduct a roll check when they come on duty. On Sundays, only prisoners who require medication or have asked to attend church services are unlocked. Everyone else remains in their cell until they are unlocked for lunch at approximately 11.30am. The man was not receiving medication, was in a single cell, and had not asked to go to church.

55. An Officer was the man's landing officer in July. (The man was in cell D 3.77 on the third landing.) Each landing took turns in being unlocked for lunch first and, on 20 July, the third landing was unlocked last.

56. In interview for this investigation, the landing officer said he looked through the man's door flap at approximately 11.40am. He could see that he was hanging by a bed sheet from a leg of the upended bed frame at the far end of the cell. The landing officer raised the alarm by shouting to his colleagues and immediately went into the cell. He used a ligature knife (a knife specially designed to cut through ligatures, which is carried by all prison officers) to cut him down, and laid him on the floor.

57. Another officer followed the landing officer into the cell and advised the control room that they had a “Code One” emergency. (This is an emergency call to all staff, including healthcare, to attend the scene of the emergency.) The control room initially received a message that the location was C wing which caused some confusion to the staff responding to the alarm. The correct location was given by a further officer. I do not believe that this short delay was significant.

58. The duty doctor and a prison nurse arrived in the man’s cell at 11.47am. His arms were held upwards indicating that rigor mortis had set in. His eyes were open and he was very cold to the touch. The duty doctor decided that resuscitation should not be attempted and confirmed the man’s death at 11.47am. The paramedics arrived in the cell at 11.55am and confirmed the duty doctor’s decision. The man was formally pronounced dead by the police forensic medical expert at 13.37pm. He had not left any note to explain his actions.

59. Other prisoners were informed of the man’s death and offered support from Listeners, Samaritans and the chaplaincy. He had not been in the prison very long and had kept himself to himself, but his fellow prisoners expressed sadness and concern.

60. Following the man’s death, the contingency plans for a death in custody were implemented. Staff attended a debrief later that afternoon held by a Governor and were offered support. One officer questioned whether the landing officer should have entered the cell alone. As they had been the first staff to enter the man’s cell, the landing officer and the Officer were debriefed and offered support separately by the Governor.

61. A Principal Officer (PO) was appointed as the prison’s family liaison officer. The man was recorded as being of no fixed abode when he arrived at Wormwood Scrubs and the name and address of his next of kin was not known. The prison found his father’s details, as he had been listed as his next of kin from a previous time in custody. The police checked the electoral roll but found the address to be incorrect.

62. A record of the man’s telephone calls provided a number for his sister. The prison’s family liaison officer made contact with her that afternoon and he and another Governor visited the family the following day. The prison’s family liaison officer remained in contact with the man’s family offering support and assistance, which I understand was very much appreciated.

63. The man’s mother and her partner visited the prison on 24 July. The prison chaplain conducted a blessing with them in the man’s cell. The Governor offered to contribute towards the funeral costs, and sent flowers to the man’s funeral on behalf of staff and prisoners. The man’s family told us they also appreciated this.

64. One of the officers involved in the discovery of the man was very shaken by his experience, although he said that he felt very well supported immediately afterwards. A Principal Officer telephoned him at home on the Sunday evening and suggested that he went to stay with someone for the night, which he did. The next day, the officer telephoned the prison to say that he would not be in but would be back on Tuesday. His line manager contacted him on Monday to check he was alright. The officer subsequently received a letter from the prison stating that the Monday he had taken off was an unauthorised absence and he would be deducted one day's pay.

65. A post mortem examination took place in July 2008. The report, which was not received by my investigator until May 2009, suggested that two razor blades and two bottles of alcohol were present within the man's cell when he was discovered. This was new evidence that the investigator had previously been unaware of. Although I do not make a formal recommendation, I draw this to the Governor's attention. The post mortem report concluded that the man died by hanging.

ISSUES

At HMP Chelmsford

66. The man denied having any history of mental health problems when asked during his reception screening at HMP Chelmsford on 30 May. His only medical complaint was that he had a pain in his right shoulder.

67. There are very few entries in the man's prison files following his reception. This suggests that he did not give any cause for concern until the seemingly unprovoked assault on staff on 20 June. My investigator was unable to establish any reason for the man's actions. The assault was referred to the police and the investigation was outstanding at the time of his death.

    A letter sent by the man to his solicitor on the same day was read by a Prison Officer on a routine check of the mail. Prison Rule 39 states that legal mail should not be read by prison staff, except in exceptional circumstances, however it is not known whether the letter was clearly marked as a rule 39 letter.

68. It is noted in the man's medical record that he started to accuse staff of bullying him on 29 June, and that he had started to display signs of paranoia. He kept his head covered to prevent staff putting thoughts into him, the mirror covered to protect himself, and covered his food with tobacco. His behaviour, combined with the assault, led to the decision to have three prison officers and a senior officer present whenever he was unlocked.

69. The man was assessed by the charge nurse and a consultant psychiatrist on 30 June. He confirmed that his behaviour was intended to protect himself and again denied having any mental health problems. He also denied any history of drug abuse and ideas of self harm.

70. The consultant arranged for the man to be transferred to healthcare and asked that his previous medical history be obtained and a drug screen undertaken. There is no record of either request being followed up. The resulting information self-evidently might have assisted the diagnosis and treatment of his symptoms.

71. The man was examined by a doctor on 2 July for the ongoing pain in his shoulder. The doctor is recorded in the medical records as requesting routine blood tests which would have assisted in diagnosis of any underlying rheumatic causes for the pain. Again, there is no evidence that these tests were done.

    The local Primary Care Trust should ensure that, when a doctor or consultant requests tests or information to be obtained, the request is accurately recorded, actioned in a timely manner and the results are clearly documented.

The Head of Healthcare at HMP Chelmsford should ensure that all entries in official prison records are clearly signed, dated, and the author's name printed.

72. The man was transferred to healthcare for a period of observation and monitoring of his mental state. Entries in the Care Plan records are sparse. My investigator could find no entries at all between 21 and 29 June. As there is no numbering system, she was unable to clarify whether this was because there were no entries (which seems unlikely), or because pages are missing.

The Head of Healthcare at HMP Chelmsford should ensure that a method is in place to safeguard loose pages in documents to ensure an accurate audit trail of information and events.

73. The man left healthcare at Chelmsford to attend Crown Court in July. At this time he was still on the three man unlock and still in healthcare under observation for his mental state. My investigator was therefore concerned to find that there was no record of any healthcare assessment prior to his transfer. I share her concern. The PER completed by Chelmsford staff, which was their primary method of passing essential information about the man to those taking responsibility for his care and custody, states that there was no known medical risk. Yet he had been located on healthcare for ten days immediately before going to court because of serious concerns about his mental health.

The Governor of HMP Chelmsford should ensure that accurate and complete documentation accompanies prisoners whenever they are discharged to court or transferred to other establishments.

At HMP Wormwood Scrubs

Reception Procedures

74. The man arrived at Wormwood Scrubs at 7.17pm on 10 July with 11 other prisoners. Both the Chief Inspector of Prisons and the prison's Independent Monitoring Board have criticised the late arrival of prisoners at Wormwood Scrubs in their latest reports. I have the same concerns. The man was the last to see the nurse that evening. He signed a disclaimer stating that he did not wish to wait to see the duty doctor and that he was healthy and did not require any medication.

75. The night nurse would have had access to the man's medical records but does not appear to have taken account of his recent medical history. The fact that the disclaimer was signed is recorded in the medical record on 11 July, together with a request for him to see the doctor for a medical problem. There is no record of this appointment taking place. The medical record has a second entry on 11 July by the duty doctor with an illegible signature, again noting the disclaimer.

76. The practice at Wormwood Scrubs is that only prisoners who are coming into custody for the first time are given a full health screening. If a prisoner states that they have no medical or mental problems, their medical record is not reviewed. This meant that the man's recent medical history, documented from his time in Chelmsford, was not considered. If the practice had been different, his mental illness would have been noted, risk factors could have been identified, and closer monitoring and support provided. Instead, no risk was identified that he was at risk of harming himself.

The Governor and the Head of Healthcare at HMP Wormwood Scrubs should ensure that a prisoner's medical record is always reviewed as part of the reception procedures.

77. The cell sharing risk assessment completed by the Officer on 10 July was based solely on information provided by the man. It took no account of information included in the PER form regarding his recent history of assaulting and threatening staff which may have altered his risk rating. Paragraph six of the Prison Service Instruction (PSI) "Cell Sharing and Risk Assessment/Risk of Harm to Others" states:

> "The Prisoner escort record (PER), warrant, probation records, OASys and previous convictions must be consulted, if available, when the cell sharing risk assessment form is being completed."

The Governor of Wormwood Scrubs should ensure that Cell Sharing Risk Assessments are completed in line with the provisions of the relevant Prison Service Instruction.

78. On 17 July, the man telephoned his offender manager. The man said he would be "out soon" which gave the offender manager cause for concern as

the man's release date was over 12 months away. The offender manager followed good practice and advised a worker from the prison's probation department of his concern.

79. The man was seen the following day by another probation officer in the prison. He said he was fine and was not at any risk of harming himself. He was reminded of the Listener scheme and of the availability of professional counsellors if he needed anyone to talk to.

80. There is no record of any consideration being given to opening an ACCT document at this stage. (The ACCT procedure requires any member of staff who identifies concerns about a prisoner they believe to be at risk of suicide or harming themselves to take action and record their actions.) I judge that there was insufficient information to suggest that an ACCT document should have been opened at this time, and I am satisfied that the probation officer's response was reasonable and proportionate.

Roll check procedure

81. A night duty officer was on duty on D wing on the night in July. In her police statement, she remembered conducting her roll check to ensure all prisoners were present and well at approximately 5.30am. This was the last time the man was seen alive.

82. There is no requirement for a roll check to be conducted by the day staff when they take over from the night staff. At weekends, the day staff start their shift at 7.45am. As I have noted, on Sunday mornings only prisoners who have asked to attend church or require medication are unlocked. The majority are not unlocked until lunchtime. The Governor will wish to satisfy himself that these arrangements are sound.

The Governor should consider reviewing the times of roll checks at weekends to ensure that prisoners are checked at regular intervals.

83. The landing officer was responsible for unlocking prisoners for their lunch. He found the man hanging at approximately 11.40am. The landing officer raised the alarm by shouting to his colleagues on another landing.

84. He then immediately entered the cell to cut the man down. Local Instruction 2.77, which is entitled "Nights - Opening Cells", dated 1 February 2006, states:

> "3. Where there is, or appears to be, immediate danger to life, cells may be unlocked without the authority of the Night Orderly Officer.
> 4. Where there is, or appears to be, immediate danger to life, cells may be unlocked with one member of staff."

85. As I have said earlier, at the staff debrief an officer criticised the landing officer for entering the cell alone. I do not believe such criticism to be well founded. In the circumstances, I believe that the landing officer acted entirely

correctly in entering the cell as quickly as possible. The man was in a single cell and the wing was being unlocked for lunch so there were other staff around.

The Governor should ensure all staff are aware of the circumstances in which they may unlock cells by themselves.

Resuscitation

86. It was evident from the visible onset of rigor mortis that the man had been dead for some time, and that the duty doctor was correct to instruct that resuscitation should not be attempted. This follows the guidance provided in Prison Service Order 2700 Annex 13A, which says that resuscitation must be attempted unless rigor mortis has clearly set in (which was the case here).

Staff support

87. Following the man's death, the contingency plans for a death in custody were activated and appropriate notifications made. Staff were appropriately de-briefed and the majority felt well supported by management and the care team. Prisoners were informed of his death and were also offered appropriate support.

88. There was some confusion about one officer's absence from duty the following day and how this should have been recorded. The officer thought he had been told to take time off if he needed it, but the prison recorded him as being on an unauthorised absence. On his return, the officer was given assistance to fill in the required forms to have the day recorded as sick leave.

89. The local system for such absence is to complete the paperwork for a sickness absence and then apply for it to be treated as special leave. This process seems cumbersome and insensitive in the circumstances.

The Governor should review the procedures for authorising staff absence following traumatic events and ensure all staff are advised of their entitlements and the procedure to be followed.

Family liaison

90. When he arrived at Chelmsford, the man was recorded in his prison file as having no fixed abode and no next of kin. This was also the case when he arrived at Wormwood Scrubs. This made it difficult to trace his family to inform them of his death. The prison's family liaison officer did manage to find out the telephone number of the man's sister through checking his telephone records.

91. The prison's family liaison officer visited the family on two occasions and arranged for members of the family to visit the prison and say a prayer in the man's cell. The family told my office that the support offered by the prison's family liaison officer had been "brilliant". I commend his actions.

CONCLUSION

92. Whilst at HMP Chelmsford, the man was regularly monitored by healthcare staff, and by psychiatrists. He was re-located in the prison's healthcare unit until he went to court and was transferred to Wormwood Scrubs on 10 July 2008. Despite this, on reception at Wormwood Scrubs he was neither seen nor assessed by a member of healthcare as it is their policy only to see prisoners who are in custody for the first time. (In addition, the man signed a disclaimer to say that he did not wish to see the prison doctor.) This was unfortunate as staff were not aware of how closely he had been assessed at Chelmsford, and healthcare staff do not appear to have reviewed his medical records. As a consequence, they remained unaware of his mental health problems.

93. However, during his brief time at Wormwood Scrubs, the man did not give staff any cause for concern regarding his well being and appeared to be engaging with prison life. He asked to work as a cleaner and to join a painting and decorating course. This seems to suggest that he was attempting to engage in prison life and perhaps looking to the future.

94. The weekend roll check procedures at Wormwood Scrubs meant that the last time the man was checked by staff was at approximately 5.30am on the Sunday morning. As he had not requested to attend church and did not require medication, he was not due to be unlocked for lunch until approximately 11.30am, which is when he was found. Although I do not suggest that an earlier roll check would have made a difference to the outcome, I am uncomfortable that a prisoner remains unchecked for such a long time on a weekend.

95. I have considered whether, had Wormwood Scrubs received and acted upon all the information about the man's mental health, his death could have been avoided. Manifestly, it is not possible to be certain about these things. The investigation has shown that his behaviour was unpredictable and that he was inconsistent with the information he gave to prisons, police and probation. What can be said is that he denied any mental health problems or involvement with psychiatric services. He said he had not harmed himself in the past. He declined CARATs at Wormwood Scrubs and did not appear to display any behaviour that would have caused staff to raise an ACCT for him. He appeared to have settled in the prison satisfactorily. Despite my serious concerns about the lack of continuity in healthcare between Chelmsford and Wormwood Scrubs, I do not consider that anyone could reasonably have predicted the actions that led to the man's death.

RECOMMENDATIONS

For the Governor of HMP Chelmsford

1. The Governor and Head of Healthcare at HMP Chelmsford should ensure that all entries in official prison records are clearly signed, dated, and the author's name printed.

2. The Head of Healthcare at HMP Chelmsford should ensure that a method is in place to safeguard loose pages in documents to ensure an accurate audit trail of information and events.

3. The Governor of HMP Chelmsford should ensure that accurate and complete documentation accompanies prisoners whenever they are discharged to court or transferred to other establishments.

For the Governor of HMP Wormwood Scrubs

1. The Governor and the Head of Healthcare at HMP Wormwood Scrubs should ensure that a prisoner's medical record is always reviewed as part of the reception procedures.

2. The Governor should ensure that Cell Sharing Risk Assessments are completed in line with the provisions of the relevant Prison Service Instruction.

3. The Governor should consider reviewing the times of roll checks at weekends to ensure that prisoners are checked at regular intervals.

4. The Governor should ensure all staff are aware of the circumstances in which they may unlock cells by themselves.

5. The Governor should review the procedures for authorising staff absence following traumatic events and ensure all staff are advised of their entitlements and the procedure to be followed.

For the Primary Care Trust

1. The local Primary Care Trust should introduce a system to ensure that, when a doctor or consultant requests tests or information to be obtained, the request is accurately recorded, actioned in a timely manner and the results are clearly documented.