

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

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

September 2009

This is the report of the investigation into the apparently self-inflicted death of a man at HMP Wormwood Scrubs in September 2008. Two days before his death, he had been arrested by the police and held in their custody until he appeared in court the following day. He was sentenced to 26 weeks in prison and arrived at Wormwood Scrubs that evening. He had been in the prison just 16 hours when he died. The man was 28 years old.

I offer my sincere condolences to the man's mother, two sisters, partner and all those who knew him.

I appointed an investigator from my office to investigate the man's death on my behalf. She was assisted by another investigator. I would like to thank the then Governor of Wormwood Scrubs and the prison's investigation liaison officer for supporting the investigation process.

I am also grateful to the clinical review panel who reviewed the clinical care the man received at Wormwood Scrubs. They were commissioned by Hammersmith and Fulham Primary Care Trust.

Prior to his arrival at Wormwood Scrubs, the man had been held in police custody and, while at court, was in the custody of the private company, Serco. How information about the man's risk of harm to himself was transferred between agencies has been at the heart of this investigation. It is also the subject of an investigation by the Independent Police Complaints Commission (IPCC). This is the second time that the circumstances surrounding a death at Wormwood Scrubs have been investigated both by my office and the IPCC.

Staff in reception work under considerable pressure because of the number of prisoners they process each day. Nonetheless, safeguarding prisoners must continue to be their primary concern. There are clearly improvements that can be made to the prison's reception procedures and to communication between Prison Service and healthcare staff. Both I and the clinical review panel have made recommendations to that effect. I have made a similar recommendation in relation to a previous death at Wormwood Scrubs. I also repeat a recommendation about how the prison supports prisoners after a death in custody.

Sadly, this is the 14th apparently self-inflicted death to have occurred at Wormwood Scrubs since I took responsibility for investigating all deaths in prison custody in 2004. It is the second to have occurred in the first night centre. However, there are few similarities between the circumstances, other than those already mentioned.

Stephen Shaw CBE
Prisons and Probation Ombudsman

September 2009

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SUMMARY

The man was arrested by the police in September and held in their custody overnight. Whilst in police custody, he said he had nothing left to live for. He tied clothing around his neck and banged his head against his cell wall in attempts to harm himself. He was seen by three forensic medical examiners (FMEs - doctors who assess people in police custody). He told them that he was an alcoholic, was dependent on sedative drugs, and had consumed six cans of lager and taken heroin and cocaine that day. He complained of feeling anxious and being unable to sleep. The man was prescribed anti-anxiety medication and medicine to help him sleep. Only limited information about the level of risk the man posed to himself was provided on the documentation that accompanied him to court and then to HMP Wormwood Scrubs. The way in which the police passed forward information about his risk to himself is the subject of a separate investigation by the IPCC.

The following day, the man was in the custody of Serco. (Serco is a private company which is responsible for the escort of prisoners between police stations, courts and prisons within the London area.) He appeared at West London Magistrates' Court and was sentenced to 26 weeks in prison. He made no further attempts to harm himself during the day, although he complained of feeling anxious. He was assessed by a doctor who prescribed a sedative medication. But generally, Serco staff found him talkative and staff said he gave no cause for concern.

At about 6.00pm, the man arrived at Wormwood Scrubs to begin his sentence. Reception staff received information that he was at risk due to his substance use and attempts to harm himself. They were not aware of the extent of his worrying behaviour whilst in police custody, however. The medical record of his time in police custody was not read, either by Prison Service or healthcare staff.

Whilst in reception, the man's mental and physical health was assessed by a nurse. The nurse had not read any of the paperwork that accompanied him into the prison. The nurse recorded that the man had depression and was taking medication for this. He told the nurse that he was a "binge drinker", but denied being an alcoholic and said that he had not taken any drugs in the last month. No signs that he was withdrawing from substances were identified. The nurse asked about the bruise on the man's forehead. He said it had been inflicted during his arrest. The nurse decided that the man should see the doctor that night. However, he did not do so, and had not been assessed by a doctor prior to his death the following morning.

The man had spent time at Wormwood Scrubs before and had worked as a cleaner in the first night centre. He was moved to the centre after 9.00pm and met a member of staff and another of the cleaners whom he already knew. They both found him to be relaxed and in good spirits. Prisoners who shared a dormitory with him that night said he was talkative and energetic.

The following morning, the man appeared to be cheerful and spent time talking to staff and prisoners he knew. At about 10.30am, a member of staff realised she had not seen him for some time and began looking for him. She was joined by one of the unit cleaners who found him hanging from a window hinge in the toilet area of his dormitory. Staff quickly cut him down and began cardio-pulmonary resuscitation

(CPR). An ambulance was called and the paramedics continued efforts to revive him. The man was transferred to Charing Cross Hospital where he was pronounced dead at 11.44am. He was 28 years old when he died and had been at Wormwood Scrubs for just 16 hours.

This investigation has focussed on the reception processes in place at Wormwood Scrubs and how the man's mental health was assessed there. I make seven recommendations, most of which concentrate on these matters. The clinical review panel has made a further ten recommendations which I endorse.

THE INVESTIGATION PROCESS

1. My office was notified of the man's death on the day he died and the investigation was allocated to one of my investigators later that day. The investigator and her colleague visited Wormwood Scrubs to open the investigation four days later.
2. The investigator issued notices inviting staff and prisoners to contact her with any information they felt might be relevant to the investigation. No one responded to these notices. Two prisoners who had shared a dormitory in the first night centre with the man were interviewed at Wormwood Scrubs. An invitation to be interviewed was sent to the home address of another prisoner who had already been released, but he did not respond. The investigator and her colleague conducted interviews with staff and prisoners at the prison during October and November 2008. Hammersmith and Fulham Primary Care Trust (PCT) appointed a panel to review the medical care the man received whilst at Wormwood Scrubs.
3. The investigator was given copies of all the documents relating to the man's time at Wormwood Scrubs. They included his prison record, medical record and the staff incident reports written after his death. She was also provided with a copy of the closed circuit television (CCTV) footage covering the location and period of time in which he apparently took his life, and a recording of the telephone call he made on 12 August.
4. The investigator obtained the prison custody records relating to the man's previous sentence, served at Wormwood Scrubs and HMP Elmley, to see if they contained any relevant information. I am also grateful for the co-operation of the Metropolitan Police who shared information with us. Additionally, the investigator and an investigator from the IPCC met to discuss their respective inquiries.
5. Following the man's death, Serco conducted an investigation of their own into his time in their custody. I am very grateful to the company for sharing with the investigator both the investigation report and statements taken from staff involved. Doctors Direct, who provide medical assistance to people held in court cells, were contacted by telephone. The duty solicitor who saw the man whilst in police custody and the probation officer at West London Magistrates' Court were also contacted by telephone and assisted with the investigation.
6. HM Coroner was contacted to inform her of the nature and scope of my investigation and to request a copy of the post mortem report. Upon completion, this report will be sent to the Coroner to assist with her enquiries into the man's death.
7. One of my family liaison officers contacted the man's family to invite them to be involved in the investigation process. She spoke to the man's sister who raised a number of the family's concerns about his death. In particular, his family wished to know:
 - Whether Wormwood Scrubs received information from Kensington and Chelsea Police about the man's attempts to harm himself whilst in police

custody two days before his death. Further, if they had, why the man was not assessed as posing a high risk to himself and monitored accordingly.

- The purpose of the CCTV coverage of the first night centre dormitories and whether this was monitored by staff on the day he died.
- How the man was able to apparently take his own life given the proximity of the staff office to his dormitory.
- Whether staff at Wormwood Scrubs had accessed and considered the records from the man's previous sentence at the prison, and whether they were aware that he had received treatment for his alcohol use during that sentence.
- How the man's state of mind and risk to himself was assessed when he arrived at Wormwood Scrubs the day he died. The family were concerned that such assessments should be based on how he appeared and behaved, and not just what he said to staff.
- How healthcare and discipline staff investigated the cause of the man's bruised forehead on his arrival at Wormwood Scrubs.

I hope that my report addresses the family's concerns.

HMP WORMWOOD SCRUBS

8. HMP Wormwood Scrubs is a large local category B prison, predominantly serving the courts of North West London. It holds both convicted and remanded adult male prisoners. The prison has a fluid population with a high number of prisoners arriving at and leaving each day.
9. The prison underwent a full, unannounced inspection by Dame Anne Owers, HM Chief Inspector of Prisons, in June 2008. The inspection found that recent progress had been halted and that there had been “an appreciable drift in all our key areas – safety, respect, purposeful activity and resettlement”. The Chief Inspector noted, however, that Wormwood Scrubs, as a busy local jail, was operating under “considerable pressure”.
10. The inspection highlighted problems with the reception, first night and induction procedures, which were found to be “not sufficiently supportive or consistent”. The fact that prisoners were being held in court cells for some hours after they had been sentenced inevitably placed greater pressure on the prison’s reception staff, and both reception and first night procedures were found to be undermined by late arriving prisoners. The inspection also highlighted particularly unsafe practices for those prisoners withdrawing from substances.
11. The reception area was found to be untidy and, in some parts, dirty. While reception procedures were found to be “well-rehearsed”, the movement of prisoners there gave the impression of disorganisation. The Chief Inspector recommended that new arrivals be processed through reception “in an effective and orderly manner”.
12. The inspection did highlight, however, some good initiatives in relation to suicide prevention. The management of ACCT documents (Assessment, Care in Custody and Teamwork - the process by which prisoners at risk of suicide or self harm are monitored and supported) was generally good. Staff awareness of the risks of self harm and suicide was also good.
13. Each prison in England and Wales is monitored by an Independent Monitoring Board (IMB). Members of the IMB are drawn from the local community. They have access to each prisoner and every part of the prison. The last published report of the IMB for Wormwood Scrubs covers the period 1 June 2007 to 31 May 2008. The IMB noted similar concerns to HM Chief Inspector of Prisons, in particular the late arrival of prisoners to the prison and the knock on effect this had on searching, health screening and risk assessments. The Board reported that the late arrivals meant that the first night centre was also under pressure. Staff shortages were an ongoing cause for concern.

Reception

14. All prisoners leaving from or arriving at Wormwood Scrubs are processed through the reception area, including those who are returning to the prison after court hearings or hospital appointments. The prison processes approximately 60 receptions each day. The purpose of reception is to check the identity of, and

accompanying paperwork for, each prisoner and gather important information about their health, state of mind and risk – to themselves and others – before they are allocated a cell in the prison. Whilst in reception, new prisoners undergo a first reception healthscreen with a nurse (this is to identify any presenting physical or mental health issues that may need further assessment by the doctor or another specialist service). Staff also carry out a Cell Sharing Risk Assessment (CSRA - which assesses the risk a prisoner may pose to other prisoners and, thus, their suitability to share a cell). Where the nurse considers it necessary, prisoners should see the doctor whilst in reception.

First night centre

15. Newly arrived prisoners at Wormwood Scrubs generally spend their first night in the first night centre. If the centre is full, they may be located on one of the prison's main wings. The first night centre holds up to 29 new arrivals in a mix of single and double cells and dormitories (which have space for five prisoners). Whilst there, prisoners undergo an induction that gives them information about life at the prison. After one night, prisoners are normally allocated cells on the main wings.

Radio call signs

16. Staff at the prison use a series of radio call signs to alert other staff to an emergency. "Code 1" is used when there has been a hanging, or attempted hanging. "Code 2" indicates a collapse or someone who is unconscious, and "Code 3" indicates a major injury. The use of such codes enables healthcare staff to bring the right medical equipment.
17. Certain members of staff are allocated specific radio call signs whilst on duty. The orderly officer, with the call sign "Oscar 1", is the most senior member of uniformed staff on duty. The duty member of healthcare staff in the prison is given the call sign "Hotel 1". They are expected to respond to any emergency calls for assistance.

KEY EVENTS

18. The man was arrested by Kensington and Chelsea Police at 4.15pm two days before he died after committing an alleged assault. An entry on his police custody record (a computerised record of events whilst someone is held in police custody) made at 5.14pm indicates that he presented a risk to himself. He had “previously tried to self harm by tying clothing around neck whilst in custody and used plastic cutlery to try to harm himself.” As a result of this information, the man was placed in a police cell covered by CCTV and was checked every 30 minutes.
19. At 5.18pm, a police constable (PC) visited the man in his cell. The PC recorded that the man, “stated to me that he had nothing left to live for and that his life is going down hill so he might as well end it.” In his police statement, the PC said that the man was being constantly watched by police custody officers because of his risk to himself.
20. A FME examined the man at 6.24pm. He recorded that the man was an alcoholic who had “had six cans today. Had Heroin and Cocaine,” and that his breath smelt of alcohol. The FME recorded that he was not yet fit for interview or charge, and that he should be reassessed at 11.00pm.
21. About ten minutes later, the custody record notes that the man was threatening to bang his head on the cell walls. At 6.53pm, he was observed on CCTV to do so. Over the next hour, he was seen to move to the toilet area of his cell several times and tie items of his clothing around his neck. Some of the man’s clothing was removed by police officers to prevent him from harming himself.
22. A duty solicitor went to Kensington Police Station and saw the man at 10.43pm to offer legal advice. My investigator spoke to the solicitor by telephone as part of this investigation. He said that the man gave him no reason to be concerned, although he had told him that he was having problems at home that were “getting on top of him”. The solicitor did not represent the man in court the next day, and had no further contact with him.
23. The man was seen by another FME at 11.21pm who recorded that he suffered from anxiety, had family problems and had been “headbanging”. He was prescribed zopiclone (to help him sleep) and lorazepam (to treat his anxiety). The FME instructed that he be given more lorazepam at 7.00am.
24. At 12.50am the following morning, the man was charged with assault and was detained to appear at West London Magistrates’ Court later that day. During the early hours of the morning, the man complained of feeling increasingly anxious. He asked to see the FME again and to take the remainder of his prescribed lorazepam early. A third FME saw him at 5.46am and noted that he was “alcohol and benzodiazepam [a sedative drug] dependent” with occasional crack and heroin use. He recorded that the man was anxious about attending court, and allowed him to take the remainder of his lorazepam.

25. The responsibility for escorting detained persons or prisoners in London from police custody to court and then to prison is undertaken by a private company, Serco. Any prisoner being escorted must be accompanied by a Prisoner Escort Record (PER). The PER is designed to highlight the risks the escorted prisoner may pose to themselves and to others. The risks include likelihood of escape, physical and mental health, use of violence, substance use and suicide or self harm. The initial page of the PER (Part A) is completed by the police or the prison, depending on where the prisoner originates. The PER Part B serves as an ongoing record of the prisoner's time whilst being escorted and should be updated by escort staff during the day.
26. The man's PER was completed by a police officer in the custody suite at 2.50am. It showed that he was considered to be a risk and that he had drug and/or alcohol issues (it does not specify which) and was a suicide and self harm risk. A space is provided on the form for more detailed information about the nature of the risk. No further information was given about the man's risks or his behaviour whilst in police custody overnight.
27. In order to arrange for Serco to collect the man from the police station, a police officer faxed a Prisoner Collection Form to Serco headquarters. The officer indicated on the fax that the man was a suicide risk and had "attempted to self harm whilst in custody," and that he was dependent on alcohol. It is not clear whether this information was passed on to the Serco staff who collected him that day.
28. At 8.30am, two Serco prisoner custody officers (PCOs) arrived at Kensington Police Station to collect the man and take him to West London Magistrates' Court. Both provided statements during the Serco investigation which have been considered as part of this one. One of the PCOs said that he spoke to the custody sergeant at the police station and was given the paperwork relating to the man. He could not remember seeing any warning markers on the PER. He said that the custody sergeant did not make him aware of any concerns the police might have had about the man.
29. The second PCO said in her statement that she was responsible for searching the man at the police station before he was placed on the escort van. She remembered finding a screw in his pocket, which he said he had taken from the police cell. It seems that the PCO did not ask the man why he had taken the screw from the cell. The PCO said that the custody sergeant had not given her any additional information about the man and had not mentioned that there were any concerns about his behaviour whilst in police custody. The completion of the PER by the police at Kensington Police Station, and the handover of information between the police and Serco staff, are now the subject of an investigation by the IPCC.
30. Both PCOs described the man as talkative on the journey from the police station to court, and he gave neither any cause for concern. The second PCO was responsible for looking after prisoners in the cells on the van and said that the man talked to her throughout the journey. She said that, although she had all the

PERs with her during the journey, she could not remember seeing any of the warning markers on his form.

31. The man arrived at court at 9:50am. The senior custody officer (SCO) said in his statement that he remembered seeing that the box for self harm/suicide had been ticked on the man's PER. He asked the two PCOs who had escorted the man from the police station to court if the police had told them of any problems when they had collected him from the police station. Both said they had not been made aware of any issues.
32. The Serco investigation identified that Doctors Direct was contacted by telephone at 11.55am. A PCO working at the court that day recalled that the man had told him that he suffered from panic attacks and wanted to see a doctor. The PCO said in his statement that he asked his colleague, another PCO working at the court, to call Doctors Direct and arrange for a doctor to see the man. No record of the man's requesting to see a doctor or Doctors Direct being contacted was made on his PER Part B.
33. At 12.05pm, the man appeared in court, and by 12.18pm he had been sentenced to 26 weeks imprisonment and returned to his court cell. My investigator spoke to probation staff based at the court who confirmed that they did not assess him before his appearance.
34. A doctor arrived at West London Magistrates' Court to see the man at 1.40pm. No record of the doctor's visit was made on the PER Part B. However, Doctors Direct provided both the Serco investigators and my own investigator with a copy of the Medical Examination and Fees form, which was completed by the doctor who examined the man. The doctor spent ten minutes with him and recorded that he suffered with depression and prescribed diazepam. He assessed the man as fit to appear in court (although he had already appeared by this point) and fit to be transported by cellular vehicle.
35. When Serco staff identify a prisoner to be at risk of harming himself or attempting suicide, they should open a Suicide/Self Harm Warning Form. This serves to highlight the risk to the receiving prison. The guidance for completing the form requires that staff open a form if they "believe there is a current risk of suicide or self-harm" (the text is underlined in the guidance). In order to assess whether the risk is indeed current, "it is essential to speak to the prisoner". The guidance is clear that where a prisoner has attempted to harm themselves or commit suicide within the last month or since arrest, a warning form should "always" be opened. A Suicide/Self Harm Warning Form was not opened for the man.
36. During his time in court custody, the man was checked about every ten minutes by Serco staff. Staff who provided statements during the Serco investigation described him as being "pensive", and they often found him standing up in his cell or at his cell door. The second PCO who escorted the man from the police station to court said that she saw the man after he had been sentenced to custody. She thought that he seemed "upset because he had been sentenced but other than that he was fine." None of the Serco staff thought that he gave

them any cause to be concerned or gave any indications that he intended to harm himself.

37. The man was placed on an escort van and left West London Magistrates' Court for Wormwood Scrubs at 4.33pm. The van arrived at the prison at 5.20pm and he was handed over to prison staff at 5.59pm. Wormwood Scrubs received 59 prisoners on 11 September, 41 arriving between 5.00 and 7.00pm that day. The man was one of 31 new arrivals at the prison, with the remaining number being those returning to the prison after court hearings or similar.
38. The man had served part of a previous sentence at Wormwood Scrubs, before being transferred to HMP Elmley and released from there in August 2008. Staff had not had an opportunity to access the records relating to that sentence, which were held at Elmley, before he arrived that evening. They were not, therefore, aware of information in those records relating to his past attempts to harm himself while in the community or his dependence on alcohol.
39. A senior officer (SO) was in charge of reception on the day the man arrived. He was interviewed as part of this investigation. He said that he saw each prisoner who arrived. He checked the warrant (which accompanies each prisoner and ensures that they can be legally held in custody) and any accompanying paperwork, and confirmed some basic personal information with each one. (It was not possible to confirm, however, precisely which elements of the paperwork relating to the man the SO read.) My investigators were told that the man's paperwork included the warrant issued by West London Magistrates' Court confirming his sentence, the FME report covering his time in police custody, and his PER Parts A and B which noted his risk factors of alcohol and/or drug use and suicide and self harm.
40. The SO told my investigators that he would not have seen the information recorded on the man's PER as the form would have been passed straight to the officers who were responsible for dealing with prisoners' property. (One section of the PER relates to the property arriving with the prisoner.) He explained that, generally, where Serco staff had been informed about a prisoner's vulnerability or had concerns about someone in their care, a Suicide/Self-Harm Warning Form would be completed. This form would be a clear indication to the receiving prison that the prisoner was at risk of suicide or self harm. He said that, where no further information was provided on a PER or if a Suicide/Self-Harm Warning Form had not been completed, it was likely that staff would assume the risk indicators related to past behaviour rather than current concerns.
41. The FME report which accompanied the man into Wormwood Scrubs contained some information about his behaviour whilst in police custody and the medical treatment he had received during that time. The SO said that he might sometimes have a "quick look through" FME reports, but that he considered them to be "medical in confidence" and that it was more appropriate for medical staff to read and act on the information. The SO was asked what he would have done if he had seen the information contained in the FME report, including mention of the man banging his head on the police cell wall. He said that he would not have

been unduly concerned and would not necessarily have taken any action. He described this as quite common behaviour amongst prisoners.

42. Whilst in reception, the man underwent a Cell Sharing Risk Assessment (CSRA) to assess whether he would be suitable for sharing a cell with another prisoner. The CSRA was completed by an officer who was also interviewed by my investigators. The man told the officer completing the CSRA that he was currently dependent on drugs or alcohol (the form does not specify which), but said that he had never been monitored under suicide and self-harm prevention procedures in prison. He said that he had no concerns about sharing a cell, although he did say that he “can get frustrated quickly but is not violent”. The officer assessed the man as being of low risk and therefore suitable for sharing a cell.
43. The officer told my investigators that he would consider a range of information when completing the CSRA, including any accompanying paperwork, the prisoner’s body language and what the prisoner said to him. He described the man, whom he recognised from his previous sentence at Wormwood Scrubs, as relaxed. He remembered that he asked which members of staff were working in the first night centre. He said he would like to get back his job as a cleaner there. The officer was asked if he could recognise the signs of substance use and withdrawal. He said that he often interviewed prisoners who were clearly withdrawing from substances and that he had seen no such signs in the man.
44. The CSRA also contains a section which must be completed by a member of healthcare staff who should conduct a medical assessment of the prisoners’ risk to other prisoners. In theory, prisoners should not be allocated accommodation until healthcare staff have carried out their assessment. Staff in reception said that they were under pressure to allocate prisoners to cells in time for the evening roll check at 8:00pm. (The roll check is when all the prisoners in the prison are counted.) They said that sometimes, because of this pressure, the healthcare section of the CSRA would be completed with new receptions overnight on the first night centre. They explained that the nurse who completed the man’s CSRA only works night shifts (which start at 9:00pm) at the prison and was located on the first night centre on the day the man arrived. It appears, therefore, that the man was allocated to a dormitory (shared with four other new arrivals) without a member of healthcare staff assessing his risk to other prisoners. Later that evening, the nurse assessed the man as low risk and noted no concerns on his CSRA.
45. The nurse was interviewed by telephone in August 2009. She could not remember seeing the man on the night he arrived, nor whether she had read any other information about him prior to completing the CSRA. She explained, however, that she would carry out assessments with newly arrived prisoners on the first night centre, if they had not been completed in reception. The nurse said that if a prisoner was sleeping, or refused to be seen during the night, they would be assessed the following day. The nurse said that during her contact with prisoners she looks for signs that they may be at risk of harming themselves. She said that this includes looking at their body language, as well as how they present themselves. The nurse said that if she had any concerns about a

prisoner at night, she would share these with the orderly officer (the most senior member of staff on duty, who manages the prison overnight). If necessary, an ACCT would be opened.

46. The man was also seen by a nurse in reception who carried out the first reception healthscreen. The nurse was interviewed as part of the investigation. He explained that all new receptions at the prison would undergo the first reception healthscreen with a nurse. If the nurse thought it necessary, the new prisoner would then see a doctor. He said that reception was usually staffed by two nurses and a doctor, with one nurse conducting the healthscreen and one sitting in with the doctor.
47. The reception nurse told my investigators that healthcare staff in reception had recently been trialling a new system. In the past, they had waited to see prisoners after the CSRA had been completed and they had been searched, which could take some time. He explained that, under the new system, nurses would try and assess new arrivals as soon as they had seen the senior officer at the front desk. He said that the nurse would take prisoners from the holding room (where prisoners wait during the reception process) in no particular order and carry out the healthscreen in a small room behind the front desk. Healthcare staff thought that this new system would help to speed up the reception process so that prisoners could be moved to the first night centre or other wings in the prison more quickly.
48. The words "Seen without records" were written across the front of the man's first reception healthscreen and the reception nurse was asked about this. He explained that, under the new system, the nurse would not always have seen any of the prisoner's paperwork (including, for example, the FME report or the PER) before conducting the healthscreen. This meant that they would know nothing about the prisoner they were assessing and relied on what he told them. The nurse said he would expect the reception SO to notify him of any information indicating that the prisoner might be at risk of harming himself. The SO told my investigators that the paperwork was readily available to nursing staff and that they should be asking the senior officer for this before assessing prisoners. The reception nurse confirmed that he assessed the man without reading the FME report. This would have provided information on the man's substance use, anxiety and self harm behaviour, and the medical treatment he had received whilst in police custody.
49. The reception nurse said that he recognised the man because he had been in Wormwood Scrubs before. He described him as able to get on with staff and prisoners alike. On the day the man arrived, the reception nurse spent about ten minutes with him carrying out the first reception healthscreen.
50. The man told the reception nurse that he had seen his doctor recently because of his depression and to renew his prescription for medication. He said that he had been prescribed mirtazapine (for his depression) and zopiclone (to help him sleep). The nurse did not ask the man when he had last taken his medication. He explained that prisoners with existing medical conditions would be referred to the prison doctor who would then write any necessary prescriptions.

51. During the healthscreen interview, the man was asked if he had received any physical injuries over the past few days. He told the reception nurse that he had a bruised forehead received during his arrest by the police. (The Metropolitan Police told my investigator that they had found no evidence to suggest that the man received any injuries during his arrest. The bruise may have been caused by him banging his head on the cell wall whilst in police custody.) The reception nurse was not aware that the man had been banging his head. Other than his bruised forehead, the man said he had no other physical concerns. The reception nurse recorded that he “appears well”.
52. The man was then asked about his alcohol and drug use. He told the nurse that he was a “binge drinker” who usually drank about six cans of lager. The word daily had been written on the healthscreen and then crossed out. The nurse said that the man told him he did not drink every day. He recorded that the man had drunk about eight cans of lager in the week before coming into custody. He told the nurse that he was not an alcoholic.
53. My investigators asked what the reception nurse understood by the term “binge drinker”. He replied, “I think a binge drinker ... is someone who would drink, say maybe on a weekend basis but a lot.” According to the healthscreen guidance, any prisoner claiming to drink “about 20 units daily or showing signs of withdrawal” should be referred to the doctor or relevant clinic. My investigators asked the nurse if he had asked the man what strength lager he drank. He said that he had not. The nurse told my investigators he was not sure how to work out how many units of alcohol someone had been consuming. The man denied having used any drugs in the past month.
54. The reception nurse said that he knew what the physical signs of withdrawal from substances were and that he had not seen any in the man. He explained, however, that he had already decided to refer him to the doctor. He thought that the doctor would use the information contained in the healthscreen to probe the man further. He expected the doctor to question him about his alcohol use. The nurse explained that prisoners underwent drug tests if there was information confirming drug use, or if the nurse believed the prisoner used drugs. As he had not seen information detailing the man’s drug use, and he had denied using drugs, the nurse did not consider conducting a drug test on this occasion.
55. The healthscreen contains further questions about the prisoner’s mental health. The man said that he had received treatment from a psychiatrist in the past, because of his depression. He was asked if he had ever tried to harm himself, and told the nurse that he had whilst in the community. The nurse wrote, “cut himself on the wrists in 2003 due to alcohol”. As a result, he referred the man for a mental health assessment in line with the healthscreen guidance. The nurse recorded his impressions of the man’s behaviour and mental state on the healthscreen. He explained to my investigators that he considered the man’s body language and mood. He wrote that he “appears stable in mood. States no self harm thoughts. States he suffers from depression – on treatment.” The nurse said he would place a prisoner on an ACCT document if he felt it necessary, but he did not think that the man needed the support. He said in

interview, however, that he thought the doctor in reception would also assess him.

56. The man told the nurse that he suffered with insomnia and that he wanted to see a doctor. The nurse completed the final page of the healthscreen and recorded that the man needed to see the duty doctor and undergo a mental health assessment. He assessed the man as fit to be located anywhere in the prison and fit for work. The nurse also completed part of the secondary healthscreen with the man that evening. (The secondary healthscreen is intended to be completed within seven days of the prisoner's arrival in the establishment. It provides a second chance to assess their mental and physical health. During the secondary healthscreen, the prisoner's weight, height and blood pressure are taken and they are provided with health promotion information.)
57. The reception nurse was asked whether all prisoners referred to the doctor saw one whilst in reception. He explained that the doctor in reception was on duty until about 8:50pm each day. Because of the numbers and lateness of prisoners arriving in reception, he said the doctor sometimes went off duty before assessing all the prisoners referred to him. The nurse said that the paperwork for those prisoners needing to be seen would be placed in a pile, in no particular order of urgency or priority, on the doctor's desk. The doctor would then wait for the prisoners to be processed through reception and brought to him. If papers remained on the doctor's desk at the end of his shift, he would know there were prisoners who had not been assessed and would need to be seen the following day. When referring the man to the doctor, the reception nurse did not know whether he would, in fact, be examined that evening. The man did not see the doctor in reception on the day he arrived.
58. My investigators asked the reception nurse whether, given the medical issues highlighted in the healthscreen, the man would have received any medical attention overnight. He explained that, once the doctor had left the prison, the nurses working at night were reliant on a telephone service provided by Primecare. The Head of Offender Health Services explained to my investigator that this service was operated by nurses. The member of healthcare staff must explain the nature of the problem to the nurse, who can then refer them to a doctor or relevant specialist. The doctor or specialist can then issue a prescription if needed.
59. The reception nurse said that staff would generally only make use of the telephone service if a prisoner complained of a medical problem. He said that if the man did not complain of missing his medication or feeling unwell during the night, he would not receive any further medical attention until he was assessed by the doctor the following day.
60. There is no written record of the time the man was taken from reception to the first night centre. Given that he had not seen the doctor in reception (who leaves by 8:50pm), it can be assumed that he was moved to the centre after that time. He was allocated a bed in dormitory X4-15 with four other prisoners. The dormitory also contains a small bathroom area with a toilet, shower and washbasins.

61. An officer who works on the first night centre was asked about what newly arrived prisoners could expect from the centre. She explained that new arrivals were taken into a classroom. Staff, along with prisoners working as cleaners there and Insiders would give some information about what new arrivals could expect from their first few days at the prison. (Insiders are prisoners who have been trained to offer information about the prison to other prisoners.) New prisoners are told how to arrange visits from family and friends, and offered a telephone call to use either that evening or the next morning. They were allowed to have a shower if they wished and, if early enough, would have association (where prisoners are free to mix together) before being locked up in cells or the dormitories for the night.
62. In order to ensure this all takes place, the first night centre officer said that prisoners needed to arrive on the first night centre by about 7.30pm at the latest. At 8.00pm, prisoners were locked up for the night and staff had to carry out a roll check (a count of all prisoners in the centre). The officer explained that new receptions often arrived at the centre after 8.00pm, and indeed after 9.15pm when day staff have finished their shifts and night staff supervise the centre. A second officer, who also works on the first night centre, said that prisoners arriving after 9.15pm would probably be placed straight into cells or dormitories and locked up for the night. They would not receive information about the prison, be able to make a telephone call, or take a shower until the following morning. The first officer said that staff could use their discretion to an extent. If a prisoner seemed particularly anxious or urgently needed to speak to a family member or friend this could be arranged, or a member of staff could make the call on their behalf. She also said that all prisoners would be told how to access Listeners (prisoners trained and supervised by the Samaritans to offer confidential support to fellow prisoners) or the Samaritans by telephone on arrival on the centre.
63. The second officer said that one of the most important purposes of the first night centre is to identify those prisoners who are vulnerable, or a risk to themselves or to others. He said he thought he was good at recognising such prisoners. He explained it was about "... just breaking down barriers and talking to them and recognising what their body language is saying to me."
64. As the man had been at Wormwood Scrubs before and had worked on the first night centre as a cleaner, some staff there knew him quite well. The second officer was working on the unit on the day the man arrived. He told my investigators that he knew the man and had a "good rapport with him". He recognised him and asked, "What has happened this time?", the man told him that he had got into a fight with someone and that was why he had a bruised forehead. The second officer said that the bruise looked "serious" and his forehead appeared swollen. He said that he told the man to go and see the nurse who in turn referred him to see the doctor the next day. (This is not recorded in the man's records.)
65. The second officer said that the man seemed to be a little "anxious and embarrassed" at being back in the prison. He asked the second officer if he could have his job as a cleaner on the centre and the officer said he would see

what he could do. The man also asked to be moved to E wing, the resettlement wing for sentenced prisoners from the local area. In interview, the second officer was asked whether the man's mood seemed low. He said that he "didn't seem fazed whatsoever". My investigators also asked whether the man was showing any signs of withdrawing from alcohol or drugs. The officer explained that he was not medically qualified. He accepted, however, that during his time as a prison officer he had seen many people who were visibly withdrawing from substances and could identify some of the symptoms. He said the man had seemed anxious but thought he had not shown any physical signs of withdrawal. He said that the man had also seemed fine the following morning.

66. My investigators asked both first night centre officers what sort of information they usually received about prisoners on the first night centre. The first officer explained that staff generally only received the CSRA, which enabled them to decide where best to locate a new prisoner. She said that staff would normally know if prisoners came into Wormwood Scrubs on a Suicide/Self Harm Warning Form, or if an ACCT document had been opened in reception. Because the first reception healthscreen is viewed as "medical in confidence", discipline staff do not receive a copy.
67. The second officer said that staff on the first night centre would not have seen the man's PER because the information did not obviously relate to current concerns. He explained that if the PER recorded that the prisoner had recently made attempts at self harm:
- "... we'd individually interview him and say 'How are you feeling this time?' things like that. If we have concerns we'd open an ACCT form. If they're self-harmers or attempted self-harm in the police custody, things like that, an automatic ACCT form would be opened."
68. In reception, each new prisoner's file is stamped with a rubber stamp. This allows for issues identified during reception to be highlighted. It covers a range of potential difficulties and risks including self harm and suicide. Staff indicate identified risks or concerns by ticking boxes on the stamp. A space is provided for reception staff to write the date the prisoner enters the prison. The stamp in the man's history sheet has been left blank and no date has been entered. The two officers said that, on seeing this, they would assume that reception staff had not identified any risks or issues with the man.
69. Both officers were asked whether they knew that the man had problems with alcohol and drugs. Both said that, despite his having worked on the centre a few months previously, they had no knowledge of his substance abuse. They were both asked if they knew he had problems with depression. Again, they said they had not known this. The first officer said that the man had shown no signs of this during his last sentence at the prison. The second officer explained that, unless a prisoner chose to tell staff personal information, they would not generally find out as information given to medical staff was treated as "medical in confidence":

“... that’s where it breaks down with client confidentiality from the ... medical side of things ... If they [prisoners] are not willing to discuss it with us, we can’t pry into that area.”

70. A prisoner who was working as a cleaner on the first night centre was interviewed as part of this investigation. The prisoner knew the man quite well as they had shared a cell during the man’s last sentence at the prison several months previously. He said that, as soon as the man arrived at the centre, he and the other cleaners who knew him had made sure he had everything he needed. He remembered that the man had been laughing with them about his return to prison. He had told them that he had been expecting a much longer sentence. The prisoner described him as “cheerful”. He explained that prisoners did not always share personal information with their fellows. He did not know that the man had substance abuse problems or that he had depression.
71. My investigators asked the prisoner what he did if he thought a new prisoner was finding it hard to cope in prison. He explained that all of the centre cleaners spent a lot of time mixing with new arrivals, and that they were often able to spot those who were having problems. He said that staff often asked the cleaners to talk to such prisoners because they were not “uniform” and could provide reassurance. The prisoner said that, if he had concerns about a particular prisoner, he would tell a member of staff.
72. My investigators also interviewed two other prisoners who shared dormitory X4-15 with the man on their first night at Wormwood Scrubs. The first man had spent time in the prison before, but it was the second prisoner’s first experience of custody. They said they had spent about three hours in reception that evening. Both described reception staff as “rude”. The second prisoner (a foreign national prisoner from Albania) said that he did not speak or understand very much English. However, neither man could remember being asked any questions about how they were feeling and they did not remember seeing any healthcare staff on the day they arrived. The first prisoner who had shared the dormitory said that staff in the first night centre were “helpful”.
73. This prisoner met the man in the first night centre on the evening he arrived at the prison. He had never met him before. He described the man as a “pleasant guy” and said that he had been talking late into the night. He remembered the man saying that he had a bruise on his forehead because he had had a fight with someone. The first prisoner was asked about the man’s mood. He said that he had seemed comfortable in the centre because he knew some of the staff and cleaners there. The prisoner said he was “fine, he was alright, doing his press-ups, running around, make tea, smoke cigarettes, just [a] normal person.” He said that the five prisoners in the dormitory had been friendly to each other and had shared tobacco.
74. The second prisoner who shared the dormitory also met the man in their dormitory in the first night centre. He had never met him before. The second prisoner said that he did not talk to him very much because the man knew lots of other people there. He described him as being very talkative.

The day the man died

75. On the morning of the day the man died, staff in the first night centre continued the induction for new prisoners. In interview, the first officer explained that prisoners were unlocked at about 9.00am. They would be gathered in the classroom and would receive further information about the regime. Those prisoners who had arrived late the previous night would be issued with a Pinphone code. (All prisoners are given a unique code which, amongst other things, allows the prison to monitor and record the telephone calls they make. Calls are not routinely monitored by the security department but may be listened to at random or if there is a specific reason to do so.) They would then be allowed to make a telephone call. Those needing to see the nurse or doctor would do so. Prisoners would then be free to mix and relax until they were moved from the centre and given a cell on one of the wings.
76. The first officer told my investigators that the man had come straight to the staff office after being unlocked at 9.00am. This was the first time she had seen him since he had arrived at the prison the day before. The officer said she remembered him straightaway. She described how she and the second officer had “a laugh and a joke” with the man about the bruise on his forehead. She said that he told her he had headbutted something. She explained that, as she knew he was in prison for assault, she did not ask him for more information about the injury. The first officer described the man as being in “really good spirits” that morning.
77. The man asked the first officer if he could have his two minute telephone call, and said that he might need “a couple” of telephone calls. The officer said that she allowed him the first call. My investigators were provided with the man’s Pinphone records and a recording of the only call he made using his Pin code. He telephoned a friend at about 9:07am. The call lasted one minute. During the call, the man told his friend that he had a place in a rehabilitation centre. He asked his friend to give his mother £20 to bring to him when she visited. There was nothing in the conversation to suggest that the man was thinking of harming himself.
78. In his interview, the second officer remembered that the man had also asked him for a telephone call, which he allowed. The second officer recalled that there was no answer on the number he telephoned. The prison’s log of contact with the man’s family records that his aunt, who was visiting from abroad, told prison staff that the man had also called his mother’s telephone number at about 9.30am. As his mother had already left for work, he spoke briefly with his aunt. She said that the conversation was short but that the man had told her he was looking forward to seeing her.
79. Because the man had been in Wormwood Scrubs before, he asked the first officer if he could miss the induction session as he knew the information “inside out”. She agreed that he could. The prisoner who worked as a cleaner on the centre said that the man had spent time chatting with the centre cleaners. He remembered that he had asked him to wash his trainers for him, before he moved to the wing. He described him as “upbeat” and talking about getting a job as a

cleaner on the centre again. The prisoner said that he last saw the man at about 9.30am.

80. The two dormitories (except the bathroom areas), corridor and landings on the first night centre are covered by CCTV. The footage is screened on a small monitor in the staff office which the first officer said staff watched “intermittently”. The second officer explained:

“I’m not saying that somebody’s actually sitting there watching these monitors all the time, but if we have concerns with someone, now if somebody has triggered a concern or, take me for instance, now I would actually sit and monitor them if they were in that cell. Now if something’s not triggering you or you’ve not felt that there is a poor coper, yes you may look at it periodically but you wouldn’t monitor it all the time.”

81. My investigator was provided with a copy of the CCTV footage covering the man’s dormitory that morning. Between 9.12am and 9.48am (although it appears that the CCTV clock was approximately ten minutes fast), he can be seen going in and out of the dormitory bathroom ten times. He can also be seen pacing around the room. The last time the man was seen on the footage was at 9.49am, when he went into the bathroom, closing the door behind him. The recording does not show him taking a bedsheet, or any other items, in with him.
82. The staff office on the first night centre is about seven metres down the corridor from dormitory X4-15. The second officer told my investigator that, although the staff office was close by, mornings on the centre were very busy. He said that each member of staff had specific duties to complete and they might not actually spend much time in the office. Furthermore, unless staff had particular concerns about a prisoner, they would not keep an eye on them – either on the CCTV or in person. As staff had no concerns about the man, and he had acquaintances in the centre, they had no reason to watch him.
83. The reception nurse was based in the first night centre that morning. He told my investigators that he began work at 8.00am and started seeing prisoners to complete the secondary healthscreen. The nurse said that he called the man to the treatment room to weigh him at about 9.00am. He said that the man seemed “alright” and was talking to everyone. The reception nurse told him that he would see the doctor that morning. He explained that the doctor does not usually arrive at the first night centre until about 10.15am.
84. According to the nurse, he and the doctor began seeing prisoners in the centre at about 10.15am. After seeing about three prisoners, the nurse began to look for the man so he could be assessed by the doctor. The first officer told my investigators that the morning had been “chaotic”. At around 10.30am, she wanted to check that the man had given her the list of telephone numbers to be added to his Pin code. She walked around the unit looking for him, and asked the centre cleaners if they had seen him. They said they had not. The first officer checked dormitory X4-15 a couple of times, and spoke to another prisoner in there who said he had not seen the man. At this point, the first officer said that

she was distracted by another task. She began to look for the man again a few minutes later.

85. The first officer said that she went to the medical treatment room to check whether the man was being seen by the doctor. On discovering he was not, she and a third officer decided all the prisoners should be locked in their cells so a proper count and search for the man could be conducted. As she walked up the corridor, she saw the prisoner who worked as a cleaner who offered to help her look for him. It was now about 10.45am. The prisoner noticed that the door to the dormitory bathroom was shut. He went in and saw that one of the toilet doors was closed. He shouted the man's name. When he got no reply, he opened the toilet door. He found the man hanging from the window hinge at the back of the toilet. He had used a piece of a bedsheet to make a ligature.
86. The prisoner alerted the first officer who ran into the bathroom. On seeing the man, she called to the third officer for help. He and the second officer (who had also heard the first officer's calls for help) came into the toilet area. The third officer was not interviewed by my investigators but did make a statement to the police. He said that, while the second officer supported the weight of the man's body, he cut the ligature from around his neck using his anti-ligature knife. (Anti-ligature knives are designed to cut a ligature safely from around the neck. They are carried by all frontline staff.) They then laid him on the floor near the washbasins where there was more space. Whilst they did so, the first officer radioed the control room, alerting them to a "Code 1" (a hanging or attempted hanging) on the first night centre.
87. By this point, two other officers had also arrived in the bathroom. In his police statement, the second officer said that he checked the man for a pulse or any signs of life and found none. In his Incident Report Statement, the second of the two additional officers to arrive said that he took a face shield out of the pouch on his belt and placed it in the man's mouth. The officers then began cardio-pulmonary resuscitation (CPR), taking it in turns to administer breaths and compressions.
88. The reception nurse and the prison doctor were in the treatment room on the first night centre when an officer knocked on the door, alerting them to the emergency. The nurse told my investigators that they were the first members of healthcare staff to arrive in the dormitory. They found officers already carrying out CPR on the man. The reception nurse explained that there is no emergency medical bag on the first night centre. He returned to the treatment room to see if there were any supplies that could be used in the meantime.
89. The CCTV footage showed that two further members of healthcare staff, a healthcare worker (HCW) and a nurse arrived in dormitory X4-15 very shortly afterwards. My investigator was given copies of their Incident Report Statements, completed that day. The HCW reported that he had arrived and found that the emergency medical bag had not yet been brought from the healthcare centre. He said that he had left the dormitory to collect the bag. The second nurse to arrive spoke to my investigator by telephone. He confirmed that when he got to the dormitory he realised that there was no emergency medical

bag or defibrillator (a machine that can help to re-start the heart) in the first night centre. He told my investigator that he too had gone to the healthcare centre to collect this equipment. (The healthcare centre is located directly below the first night centre.)

90. The 'Hotel 1' that day, another nurse, also completed an Incident Report Statement. She said that she had arrived at the dormitory and found officers and the reception nurse and the doctor already performing CPR. She said that she assisted with the resuscitation attempts until the paramedics arrived.
91. A principal officer (PO) was the Orderly Officer that day. He was interviewed by my investigators. In interview, the PO said when he heard the "Code 1" call he quickly made his way to the first night centre. When he arrived at dormitory X4-15, people were already there working on the man. As Orderly Officer, it was the PO's responsibility to manage the situation. He said that an ambulance was automatically called by the control room on hearing the "Code 1" call. He sent staff to facilitate the ambulance's passage into the prison, and allocated a log keeper.
92. According to the London Ambulance Service report, the paramedics arrived in the dormitory at 10.58am and took over CPR. At 11.26am, the man was transferred to the ambulance and taken to Charing Cross Hospital. The PO asked two officers to accompany the man in the ambulance. No restraints were applied. Efforts to revive him continued throughout the journey to the hospital. The ambulance arrived at 11.35am. Sadly, the man was pronounced dead by a hospital doctor at 11.44am.

Support for prisoners

93. At least two other prisoners, the foreign national prisoner interviewed and the prisoner who was invited by letter to take part in the investigation, were present in the dormitory when the man was found. In their police statements, both said they were quickly moved out of the room by staff and placed in the dormitory next door. The prisoner who was written to said that they had been locked in the dormitory "for hours". Two governor grade members of staff told my investigator that they, and several other members of staff, had gone to the first night centre shortly after the man had been pronounced dead. They broke the news of his death to the other prisoners in the centre. Both said that they had spent time talking with individual prisoners and had offered the use of Listeners and the Samaritans telephone.
94. The second officer working on the first night centre said that, after the man had been taken into the ambulance, he had walked around the unit checking that prisoners were okay. He said that the prisoners who worked as cleaners on the unit were allowed to share cells with each other. He told my investigators that he had tried to reassure those prisoners who had been in dormitory X4-15 that they would get their property back in due course. (The dormitory had been locked and sealed as a potential crime scene in accordance with Prison Service Order (PSO) 2710.)

95. The prisoner who worked as a cleaner and had previously shared a cell with the man said that he had been very well supported following the man's death. He told my investigators that he and the other centre cleaners had gathered in one cell. He said that a member of staff had come to talk to them and check they were okay. The prisoner said that he had spoken to a member of the chaplaincy team on the day that man died, and was also offered the chance to speak to a Listener. He said that the support had been ongoing and that "every day they go by they're 'are you OK, everything alright?'"
96. My investigators asked both of the prisoners who had shared the dormitory with the man about the support they had received from staff following the man's death. The foreign national prisoner, who spoke and understood little English, said that no one from the prison had told him that the man had died. He said that he learnt about it when he was interviewed by the police later that day. He said that he was not offered, or did not understand that he was being offered, the chance to speak to a Listener or the Samaritans. He said that he had felt "very stressed" by what had happened, but did not say that he would have liked to talk to someone about how he felt.
97. The other prisoner said that staff had told prisoners that the man had died. He told my investigators that they had said that a Listener would be brought over to the first night centre to talk to prisoners individually. However, he said that this did not happen and he was not given the opportunity to talk to a Listener that day. This prisoner was interviewed two weeks after the man's death, but was clearly still feeling the effects. He said that he had been very shocked by what he had seen. He said that, the night before meeting my investigators, he had asked the officer on his wing if he could speak to a Listener. He told my investigators that the officer had said he could not.

Contact with the man's family

98. The then Governor of Wormwood Scrubs appointed another governor as the prison's family liaison officer at 11.15am on the day the man died. A fourth governor was appointed as his deputy. The family liaison officer provided my investigators with a copy of his log of contact with the man's family. He recorded that he initially tried to make contact by telephone with the man's mother, who was listed as his next of kin. At this point, medical staff were still working on the man and he hoped that members of his family might be able to get to Charing Cross Hospital quickly. The man's mother was at work, and so the family liaison officer spoke to the man's aunt. He asked that a message be given to the man's mother to contact the prison as soon as she could.
99. At 11.44am, when the man had been pronounced dead in hospital, the family liaison officer called the man's mother's home number again and was told she was on her way home. At 12.40pm, the family liaison officer and his deputy went to the man's mother's address. She was not yet home. At 1.20pm, the family liaison officer broke the news of the man's death to one of his sisters, who had arrived. The man's sister felt it would be better for her to tell her mother of his death. The family liaison officer and his deputy left some written information for the man's family and arranged to contact them the following day. After the draft

version of this report was issued, my investigator was informed that the family were unhappy with how news of the man's death was broken by the family liaison officer.

100. The family liaison officer and his deputy continued to have contact with the man's family. His sister told my own family liaison officer that the assistance and support the family had received from the deputy family liaison officer, in particular, had been helpful. The prison offered to assist with payment of the man's funeral costs. Some of his family had visited the prison and the dormitory in which he died. They also spoke to the prisoner who had found the man.

Support for staff

101. Shortly after the ambulance left the prison, another PO chaired a hot debrief which all of the staff who had been involved attended. (A hot debrief is the gathering together of staff involved in an incident to discuss what happened and identify any learning points. Such a debrief is a requirement of PSO 2710.) My investigators were provided with the minutes of the debrief. It appears that some members of staff who attended were not listed as being present in the minutes.
102. Generally, staff told my investigators that they had felt very well supported by the prison. The first and second officers working on the first night centre said that they had been approached by members of the prison's Care Team on the day that the man died. They also spoke to the prison Governor. The second officer said that he had received excellent ongoing support from the Care Team.
103. The reception nurse told my investigators that he had not been offered formal support from the prison. He said that although, healthcare staff supported each other following the man's death, he was not contacted by the Care Team.

ISSUES

Information sharing between agencies

104. Before arriving at Wormwood Scrubs the day before he died, the man had been in the custody of the Metropolitan Police and Serco. Whilst in police custody, he told staff that he intended to harm himself. He was seen to bang his head against the cell wall and tie clothing around his neck. He was assessed by three FMEs and saw a doctor whilst in Serco's custody. He was prescribed medication for anxiety and insomnia.
105. The police alerted Serco headquarters by fax that the man needed to be escorted to court the next day. The fax indicated that he had tried to harm himself whilst in police custody. The police also completed a PER which identified the man's risk of suicide and self harm and his substance use. No further information about the nature or seriousness of these risks was provided. The completion of the PER by the police and the way in which information about the man's risk to himself was passed to Serco staff is the subject of an investigation by the IPCC.
106. Serco conducted an investigation into the man's time in their custody. That investigation found that staff were not aware of his risk to himself. However, the investigation identified that Serco headquarters had received the police fax which mentioned that he might be at risk of suicide or self harm. It is not clear how, or if, this information was passed to the Serco staff who collected the man from police custody that day. Serco may wish to review their procedures to ensure that available risk-related information is passed to frontline staff. We will be sharing this investigation report with representatives from the Metropolitan Police Service, Serco and the IPCC.
107. My investigator has considered whether there was any information about the man's risk to himself that could reasonably have been passed by Serco staff to reception staff at Wormwood Scrubs. The Serco staff who had contact with him during the day were not aware that he had tried to harm himself in police custody and he made no further attempts during the day. His behaviour did not raise any concerns and so staff did not consider opening a Suicide/Self Harm Warning Form. The only information they had relating to his risk to himself was contained in the PER. This was handed to reception staff by Serco when the escort van arrived at the prison.
108. Hammersmith and Fulham PCT appointed a panel to review the clinical care the man received at Wormwood Scrubs. Their findings are reported in more detail below. However, they make one recommendation about information sharing between criminal justice agencies which I endorse.

Professionals within the wider Criminal Justice System should review their systems and processes of information handling and sharing to ensure receiving facilities have full and timely access to health related information.

The reception process

109. As noted previously, Wormwood Scrubs is a busy local jail. A large number of prisoners are processed through the reception area on a daily basis. Staff at the prison operate under pressure. In reception, they must balance efficiency with looking after the prisoners in their care. The man had been in the prison for just over 16 hours when he was found hanging. This investigation has, by necessity, concentrated on the procedures in place to look after newly arrived prisoners.
110. Interviews carried out during this investigation with reception and healthcare staff identified that, at the time of the man's arrival at the prison, reception processes were disorganised. This was particularly the case in respect of paperwork that accompanied prisoners into the prison. I believe that the systems described to my investigators were not compliant with the prison's own suicide and self harm policy, *Caring for Prisoners at Risk of Self-Harm*. (My investigators have been informed that this policy is under review. This report refers to the policy in place at the time of the man's death.)
111. Annex 1 of the policy, *Reception and First Night Procedures*, sets out the responsibilities of reception staff when information relating to risk of self harm or suicide is received. The annex makes particular mention of *Suicide/Self Harm Warning Forms*, but also mentions the PER. The annex indicates that it is the responsibility of the reception senior officer to "ensure the prisoner [who has been identified as a risk to themselves] is spoken to before being located in any holding area". *PSO 2700 Suicide Prevention and Self Harm Management*, paragraph 4.4.1, also provides guidance on how staff should respond to information on the PER. It advises that, where risks are highlighted but no further information is provided, reception staff should ask for a verbal handover from escort staff. Neither policy was followed on this occasion.
112. The reception SO told my investigators that he did not usually see, or take notice of, information on a PER unless it was brought to his attention. My investigators were not able, however, to identify which member of reception staff might take responsibility for reading and acting upon information contained in PERs. The man's PER indicated that he had substance use problems and posed a risk to himself. The SO said that, in the absence of any detailed information about those risks, he would assume that they were not current.
113. I appreciate that, when dealing with a high volume of prisoners, staff need to differentiate between those prisoners who currently pose a risk to themselves and those who may have in the past but do not do so any longer. However, I am concerned that the approach described to my investigators meant that reception staff missed a valuable opportunity to investigate the risks that the man posed to himself. It would have been sensible to explore with the man why he was considered a risk. It is possible that, had such further enquiries been made, the risk he posed to himself might have been identified. *PSO 1025 Communicating Information about Risks on Escort or transfer: The Prisoner Escort Record* provides guidance on handling information contained on a PER. Paragraph 3.2 includes the mandatory instruction that "*Reception staff must alert appropriate staff in the prison to any risks identified on the PER, e.g. healthcare and security*".

staff, duty governor/orderly officer.” The instruction was not followed on this occasion.

The Prison Service should consider how best to ensure indications of risk are properly evaluated.

114. The prison’s own policy also requires that available FME reports “should be consulted for evidence of self-harm or increased observations whilst in police custody”. The prison’s suicide and self harm policy does not specify which reception staff should take responsibility for reading the FME reports. It does not specify that this responsibility falls solely to healthcare staff. However, it clearly makes sense for healthcare staff to ensure that they have read any health related information available for newly arrived prisoners. It is important that they do so before they carry out the first reception healthscreen. This is discussed in more detail below. The SO said he did not routinely read the FME reports that accompanied prisoners into the prison as he viewed these as “medical in confidence”. In the interests of safeguarding prisoners, I believe that the senior reception officer might reasonably be expected to do so.
115. The prison’s own suicide and self harm policy directs that an ACCT “should be opened in **all cases of identified risk, threats of, or actual self-harm** irrespective of the perceived level of harm” (the text is made bold in the original document). My investigators asked the SO what action he would have taken had he known that the man had been attempting to harm himself whilst in police custody. I am disappointed by his response that he would not necessarily have taken any action. It is not clear whether this view is widely held among reception staff, or is particular to the SO, but in any case I make the following recommendation.

The Governor and the Head of Healthcare should ensure that all staff working in reception receive refresher training on the prison’s suicide and self harm policy as a matter of urgency.

116. The man was allocated a bed in a five bed dormitory on the first night centre. However, this investigation has identified that the decision about where to locate him was made before the healthcare element of the CSRA had been completed. This is an unsafe practice and should not be taking place.

The Governor and Head of Healthcare should ensure that both elements of the CSRA are completed in reception, or before a prisoner has been allocated accommodation within the prison.

Clinical care

117. During the course of the investigation, members of healthcare staff who had contact with the man were interviewed. My investigator also spoke to the Head of Offender Healthcare. Additionally, Hammersmith and Fulham PCT commissioned a panel to review the clinical care the man received at Wormwood Scrubs. It is a very detailed review which makes ten recommendations. I have included some of the recommendations made by the panel, however I endorse

them all. The remaining recommendations not included in my report have been addressed in a letter to the Chief Executive of the PCT. The full review and list of recommendations is attached as annex 1. The Governor and Head of Healthcare will wish to take notice of all of those recommendations.

118. Shortly before the man arrived at Wormwood Scrubs in September 2008, a new system had been introduced by healthcare staff in reception. Under this system, prisoners undergo the first reception healthscreen in no particular order. Interviews with staff indicated that the senior reception officer is not told which prisoner is being seen. The reception nurse explained that, under the new system, healthcare staff sometimes see prisoners without having read any accompanying paperwork such as the FME report. The reception nurse told my investigators that he had carried out the first reception healthscreen with the man without having seen any accompanying paperwork, although it appears that the FME report was available in reception. This provided some information on the man's attempts to harm himself whilst in police custody. It also detailed his substance use problems and the medical treatment he had received whilst in police and Serco custody. Clearly, this information would have assisted the reception nurse with his assessment of the man. Where such information is available for newly arrived prisoners, it seems obvious that it should be accessed.

The Head of Offender Healthcare should ensure that healthcare staff access any available paperwork prior to conducting a first reception healthscreen.

119. In addition, the clinical review panel recommend that information sharing between Prison Service and healthcare staff in reception is improved. I support that recommendation.

The Governor and Head of Healthcare should review the flow of information between disciplines during the reception process.

120. The clinical review panel makes two further recommendations that relate to reception processes. If health records from external agencies are not available when the first reception healthscreen is carried out, but become available at a later date, they should be reviewed by healthcare staff. Furthermore, the panel recommend that a system be put in place to ensure all offenders' previous medical and nursing records are assessed by a clinician within 24 hours of the offender arriving at the prison. I endorse both recommendations.

The Head of Offender Healthcare should ensure that reception health assessments are reviewed when new health related information is received from external agencies.

The Head of Offender Healthcare should introduce a system whereby all offenders' previous medical and nursing records are assessed by a clinician within 24 hours of the offender's arrival at the prison.

121. During the course of the investigation, my investigators considered whether the clinical assessment of the man's physical and mental health was reasonable.

During his first reception healthscreen, and indeed in his contact with other members of prison staff, the man presented as relaxed and confident. He told the reception nurse that he had depression and was taking medication. He said, when asked, that he did not feel suicidal and had no thoughts of harming himself. Without having seen the information in the FME report, the reception nurse had to rely on what the man told him. The nurse said that he would have opened an ACCT document had he had any concerns about the man. I believe that the reception nurse's assessment of the man's state of mind, given the information he had, was reasonable.

122. The first reception healthscreen is also intended to identify substance misuse issues. Prisoners who have substance misuse problems and may be beginning to suffer the effects of withdrawal are particularly at risk during their early days in custody. It is important, therefore, that they are quickly identified and offered the appropriate detoxification support. The reception nurse told my investigators that the man said he was a binge drinker but not an alcoholic. He said he was not sure how to calculate the number of units a prisoner had been consuming prior to arriving at the prison. I am concerned to find that a member of reception healthcare staff is not confident in assessing problematic alcohol consumption.

The Head of Healthcare should ensure that reception healthcare staff receive refresher training on the prison's Management of Alcohol Detoxification Guidelines within a specified timescale.

123. The man denied having used any drugs in the last month. He had told the FME that he was dependent on benzodiazepines. As the reception nurse had not seen this information, he was reliant on the man's own admission. The recommendation I have made earlier, concerning accessing FME reports and other accompanying paperwork, should avoid such a situation occurring in future.
124. According to Annex 1 of the prison's suicide and self harm policy, "the results of [the first reception healthscreen] will indicate whether a prisoner needs to see the doctor that night or whether he can be seen the following morning on the First Night Centre". The reception nurse recorded in the man's healthscreen that he needed to see the doctor. He knew the man was taking prescribed anti-depressants. He also told my investigators that he thought the doctor would investigate the man's substance use in more detail, and make any necessary prescriptions or referrals. The man told the reception nurse that he wanted to see the doctor. He did not see a doctor in reception that night, and had not seen one before he was found hanging the following morning. Had the man been assessed by a doctor on the day he arrived, the extent of his substance use, depression and risk to himself might have been further identified. The treatment he received from doctors at the police station and in court might also have been identified. It is, of course, not possible to say whether this would have prevented him from taking his life the following day. However, I believe that the man's first reception healthscreen indicated that he should see a doctor as a priority.
125. The reception nurse told my investigators that there was no system in place for prioritising referrals to the doctor, who was only available until 8:50pm each night. This is not in line with the guidance in the suicide and self harm policy. My

investigators have been told that, since the man's death, the PCT has funded an extra doctor to work in the reception and first night centre until 10.00pm. This means that new arrivals can be fast-tracked to the first night centre where they can undergo the healthscreen and see the doctor. I am pleased that this is the case, but I also make the following recommendation:

The Head of Healthcare should ensure that a system is in place for prioritising those prisoners who need to see a doctor quickly on their arrival in the prison.

126. The man's family asked my investigator to consider how the prison assessed his bruised forehead. This was probably caused by him banging his head against the police cell wall. During the first reception healthscreen, the nurse asked the man how the injury had occurred. He told him the nurse had received it during his arrest. Given that the nurse had not seen the FME report, I believe it was reasonable for him to take the man at his word. He also believed (although he did not know for certain) that the man would be assessed by the doctor that night, who might gather further information about the injury.
127. Staff at the first night centre who knew the man asked him about his bruised forehead on the night he arrived, and again the morning he died. On both occasions, he told them that he had received the injury during a fight. Staff in the centre did not see either the FME report or the first reception healthscreen and had no reason to doubt him. The second officer, who was concerned about the injury, told the man to see the nurse on the first night centre when he first arrived. The man's medical records do not show whether he did so. I am satisfied that staff at the first night centre could not reasonably have been expected to have done more to investigate the cause of this injury.

Assessment of risk on the first night centre

128. The man had spent time at Wormwood Scrubs a few months before his current sentence and had worked as a cleaner at the first night centre. Staff there who knew him said they were not aware that he had depression or had a problem with alcohol. The second officer saw him on the day he arrived. He found him to be relaxed. He saw no signs that the man was feeling low in mood or finding it difficult to cope. He also saw him the following morning and again had no concerns about him. The prisoner who had previously shared a cell with the man also saw him on the day he arrived and found him to be upbeat and happy to have received a relatively short sentence. The man gave him no cause to worry.
129. The first officer also knew the man. She saw him on the day he died and found him to be in good spirits. Both she and the second officer said they were experienced at spotting the signs of a vulnerable prisoner. They saw no such signs in the man. They received no indications from reception staff or healthcare that he posed any risk to himself. I am pleased that staff and cleaners in the first night centre appear to interact well with newly arrived prisoners. They are clearly concerned to support them through their first days at the prison. I believe that the man, who was a familiar face on the first night centre, probably benefited more than most newly arrived prisoners from that support.

130. The man's family were concerned that, although his dormitory in the first night centre was equipped with CCTV and was very close to the staff office, he was not monitored more closely. Staff explained to my investigators that the CCTV could be a useful aid if they had particular concerns about a prisoner. However, they said that it was not monitored 24 hours a day. I am satisfied that staff had no reason to suspect that the man might try to harm himself. Subsequently, they had no reason to monitor him on CCTV on the morning he died.
131. During the course of this investigation, however, it came to my investigator's notice that the quality of the CCTV footage provided following the man's death could be improved. The footage appears to be some ten minutes out of step with other incident reports, including the London Ambulance Service report. Furthermore, the footage does not provide a constant record of events as it skips forward by about a minute several times.

The Governor should arrange for the CCTV system in the first night centre to be tested and repaired if necessary.

The prison's response to finding the man hanging

132. The death of the man was the fourteenth apparently self inflicted death to have occurred at Wormwood Scrubs since 2004 and the second to have occurred in the first night centre. Officers there responded quickly and efficiently when he was discovered hanging. They and healthcare staff, who arrived in the dormitory shortly thereafter, began CPR quickly. I understand that the London Ambulance Service commended prison staff for their efforts to revive the man. I would like to add my own endorsement of that commendation and would be grateful if the Governor could share this with the staff concerned and with their managers.
133. The two members of healthcare staff who responded to the 'Code 1' call said that, on arriving at the dormitory, they had to return to the healthcare centre to collect the emergency medical bag. The Head of Offender Healthcare told the clinical review panel that an emergency bag was located in the first night centre. The reception nurse and the nurse who responded to the radio call told my investigators that there is no emergency medical bag on the first night centre. They said that it must be collected from the healthcare centre below on hearing the "Code 1".

The Head of Healthcare should ensure that an emergency medical bag is located in the first night centre.

Support to prisoners

134. My investigators interviewed three prisoners who had seen the man hanging or been in the room when he was found. This must have been a highly stressful experience and they were likely to have needed considerable support. Staff said that they had spoken to all the prisoners on the first night centre and had offered them support and access to Listeners. The prisoner who had previously shared a cell with the man said that he had been very well supported by staff following the

man's death. However, the two prisoners interviewed who had shared the dormitory with the man felt they had not been as well supported. One said that he was still feeling very stressed about what he had seen some two weeks after the man's death. He said that he asked to see a Listener the night before his interview with my investigators and had been told he could not. The foreign national prisoner did not speak or understand English well. He did not understand that he could speak to a Listener and seemed to be finding his experience at Wormwood Scrubs difficult.

The Governor should ensure that all prisoners, including foreign national prisoners, affected by a death in custody are offered the appropriate ongoing support.

CONCLUSION

135. The man who died had served custodial sentences before, including at Wormwood Scrubs, and was familiar with prison life. He was only at Wormwood Scrubs on this occasion for 16 hours before he died. He had previously attempted to harm himself whilst in police custody. The focus of this investigation has, by necessity, been on the procedures in place to identify and support prisoners at risk of suicide and self harm during their early hours and days in custody. The investigation found that reception procedures at the time of the man's death allowed opportunities to identify his risk to himself to be missed.
136. This report forms one part of a wider investigation into the man's death. There are clearly lessons to be learned about the flow of information between and within criminal justice agencies. Sadly, it appears that several chances to support the man were not taken.

RECOMMENDATIONS

The clinical review panel made ten recommendations, some of which have been incorporated into this report. The remaining recommendations have been addressed in a letter to the Chief Executive of the PCT. The Governor and Head of Healthcare will wish to take notice of the panel's full list of recommendations. The clinical review is attached as annex 1.

Following the distribution of the draft version of this report, the Prison Service provided a response to each of the recommendations made, which is included below.

Recommendations from the clinical review, incorporated in the investigation report:

1. Professionals within the wider Criminal Justice System should review their systems and processes of information handling and sharing to ensure receiving facilities have full and timely access to health related information.

A response will follow at a later date.

2. The Governor and Head of Healthcare should review the flow of information between disciplines during the reception process.

The Prison Service has accepted this recommendation.

3. The Head of Offender Healthcare should ensure that reception health assessments are reviewed when new health related information is received from external agencies.

The Prison Service has accepted this recommendation.

4. The Head of Offender Healthcare should introduce a system whereby all offenders' previous medical and nursing records are assessed by a clinician within 24 hours of the offender's arrival at the prison.

The Prison Service has accepted this recommendation.

5. The Head of Healthcare should ensure that an emergency medical bag is located in the first night centre.

The Prison Service has accepted this recommendation.

Recommendations made by the Ombudsman:

6. The Prison Service should consider how best to ensure indications of risk are properly evaluated.
7. The Governor and the Head of Healthcare should ensure that all staff working in reception receive refresher training on the prison's suicide and self harm policy as a matter of urgency.

The Prison Service has accepted this recommendation.

8. The Governor and Head of Healthcare should ensure that both elements of the CSRA are completed in reception, or before a prisoner has been allocated accommodation within the prison.

The Prison Service has accepted this recommendation.

9. The Head of Offender Healthcare should ensure that healthcare staff access any available paperwork prior to conducting a first reception healthscreen.

The Prison Service has accepted this recommendation.

10. The Head of Healthcare should ensure that reception healthcare staff receive refresher training on the prison's Management of Alcohol Detoxification Guidelines within a specified timescale.

The Prison Service has accepted this recommendation.

11. The Head of Healthcare should ensure that a system is in place for prioritising those prisoners who need to see a doctor quickly on their arrival in the prison.

The Prison Service has accepted this recommendation.

12. The Governor should arrange for the CCTV system in the first night centre to be tested and fixed if necessary.

The Prison Service has accepted this recommendation.

13. The Governor should ensure that all prisoners, including foreign national prisoners, affected by a death in custody are offered the appropriate ongoing support.

The Prison Service has accepted this recommendation.