Investigation into the Death of a man at HMP Wormwood Scrubs, on 28 August 2004

Report by the Prisons and Probation Ombudsman for England and Wales

March 2005

This is the report of an investigation into the death of a man. He died at Charing Cross Hospital on 28 August 2004, shortly after an apparent attempt on his own life whilst in the custody of HMP Wormwood Scrubs.

The investigator and my office have already expressed their condolences to his family and I would like to add mine. The loss of a son is always a tragedy, especially in circumstances such as those described in this report.

The investigation was carried out on my behalf by an investigator from the prison service and I am very grateful for his efforts. His report has been edited to conform more to the preferred format of my office. However, the content and, most especially, the recommendations of the report are those originally made by the investigator, although I am pleased to endorse them. Fundamental to the investigation were the two clinical reviews which were commissioned. The first was conducted by a Clinical Nurse Specialist in Substance Misuse who was asked to comment on the appropriateness of the man's drug treatment programme and identify any issues of concern. The second was undertaken by a doctor from the Primary Care Trust and he considered the wider aspects of the man's medical treatment whilst in prison custody. I am thankful to them both for their part in the investigation.

The man had lived in this country since 1991. For several years before his death, he had used drugs on a daily basis and begun to commit offences. His visa had expired and social security benefits had been withdrawn.

He had been at Wormwood Scrubs for just 13 days before it appears he made a serious attempt to take his own life. It was only by the good efforts of prison staff that he began to breathe unaided. Unfortunately, despite prompt hospital treatment, his recovery was short lived and life support was withdrawn eight days later.

Generally, the prison provided him with appropriate support but there are a number of local recommendations. I would like to thank the Governor of Wormwood Scrubs and all the staff involved for their assistance and cooperation with this investigation.

He was found hanging just a quarter of an hour after cannabis was found hidden in his cell. However, it was the absence of another drug – nicotine – that seems to have caused him most anguish. I was struck on reading this report by the number of times he requested tobacco.

In his clinical review, the Clinical Nurse Specialist in Substance Misuse calls upon the authorities to consider the management of nicotine withdrawal in custody. I think that is the most important recommendation to emerge from these sad events.

Stephen Shaw CBE
Prisons and Probation Ombudsman

March 2005

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GLOSSARY OF TERMS

Association	Prisoners recreation period / time out of cell
C.N.A.	Certified Normal Accommodation: The number of prisoners a prison can hold without a degree of overcrowding
CPN	Clinical Psychiatric Nurse
CPR	Pertaining to heart and chest resuscitation
Day Care Centre	Organized activity / meeting place within the establishment for prisoners who have mental health problems
DDN	Dual Diagnosis Nurse
DIC	Death in Custody
F2050	Main Core Record
F2052SH	Form raised when a prisoner is judged to be at risk of self-harm or suicide
GOV	Governor (Senior Managers)
HCO	Healthcare Officer
HCPO	Healthcare Principal Officer
History Sheet	Prisoner's Wing Record
HMCIP	Her Majesty's Chief Inspector of Prisons
Hot debrief	Debriefing of staff involved in an incident as soon as practical after the incident has occurred.
IMB	Independent Monitoring Board (Formally BOV)
IMR	Inmate Medical Record
IMSU	Incident Management Support Unit
In-reach Team	Department / Medical Staff responsible for healthcare of prisoners suffering from mental health problems.
IRS	Incident Reporting System
LIDS	Local Inmate Database System (Computer Record)
Listener	A prisoner volunteer especially trained by the Samaritans to listen and support other prisoners who are in need or despair
MHA	Mental Health Act
Normal Location	Prisoner's location in main wing / accommodation area of prison
OCA	Operational capacity: The number of prisoners a prison can hold allowing for a degree of overcrowding
Offr	Officer
Orderly Officer	Principal Officer responsible for ensuring the prison regime is running correctly. Responsible for the management of Incidents
Oscar One	Radio Call sign for Orderly Officer
OSG	Officer Support Grade (Prison Officer Auxiliary)

PICT	Post Incident Care Team – Volunteer Staff who offer support to colleagues that have been involved in traumatic incidents
PO	Principal Officer
POA	Prison Officer's Association (Union)
SMTCO	Substance Misuse Through-care Co-ordinator
SN	Staff Nurse
SO	Senior Officer
SOCO	Scenes of Crime Officer
SSN	Senior Staff Nurse
Treatment	Office or room where medical staff administer treatment to prisoners or Room dispense medication

Prisoner Status:

Remand	Period held in custody prior to Magistrates Court hearing
Trial	Period held in custody committed for trial at Crown Court

SUMMARY

1. On the instruction of the Prisons and Probation Ombudsman an investigation has been conducted into the tragic death of a man, a prisoner at HMP Wormwood Scrubs.

2. At 11:07 am on 20 August 2004, he was found suspended in his cell by a ligature within the prison's Healthcare Unit. The establishment's emergency procedures were activated and prison medical staff attended the scene. He was taken by ambulance to Charing Cross Hospital where, on arrival, he was assessed and provided further treatment to aid his recovery. He was placed on life support equipment.

3. Unfortunately, he failed to regain consciousness and it was assessed that it was not possible to sustain his life without life support equipment. The prognosis for him was extremely poor and he was not expected to recover.

4. HMP Wormwood Scrubs informed Feltham Magistrates' Court of this prognosis and on 26 August he was given bail. Following medical advice, support equipment was withdrawn and he died two days later on 28 August.

5. The investigation has revealed good practice on the part of both mainstream and Healthcare staff. However, there are also lessons to be learned in terms of managing incidents and liaising with prisoners' families.

6. The clinical reviews focus on the withdrawal of the man from the detoxification programme and other aspects of his medical needs.

BACKGROUND

7. The man was born in Somalia and arrived in this country in 1991 as an asylum seeker, having fled his native land due to the civil unrest. His visa expired on 10 April 2003. He described himself to a Probation Officer as being mentally well, but walked with a pronounced limp due to contacting polio as a child for which he continued to take medication. From 1998, he said he began to use drugs on a daily basis and his offending behaviour began shortly afterwards, the majority of offences being theft or shoplifting. Police records state that he used many recorded aliases and five different dates of birth were recorded.

8. He served three short prison sentences prior to his last. The records for the first two are missing, but those for the third suggest that it was uneventful and there are no records of him having been considered to have been at risk of self-harm. His licence expired on 7 December 2003 and eight months later he was charged again. He was convicted on 6 August 2004 and remanded in custody to HMP Wormwood Scrubs at approximately 6:53 pm the same day. He was due to be sentenced on 26 August.

HMP WORMWOOD SCRUBS

9. Wormwood Scrubs is a Victorian prison for adult men, both remand and sentenced, situated in West London and with a maximum population of 1,239. It predominantly serves the London Courts and has an extremely high reception and discharge rate averaging around 40 new prisoners each weekday. On 20 August 2004, when the man apparently attempted to take his life, there were 1,203 prisoners resident at first unlock.

10. The overall establishment rating is three (four being the highest standard and one being the lowest). The rating is established from a number of factors including performance against area targets, Prison Service national Standards, and independent inspection by Her Majesty's Chief Inspector of Prisons. In relation to National Standards the prison attained marks of 85% for both security and non-security standards. The most recent Standards Audit rated the Suicide Awareness and Self-harm procedures as good.

11. There have been three previous apparently self-inflicted deaths at Wormwood Scrubs within the last two years.

12. Following her most recent inspection in November 2003, HMCIP commented that almost all of the recommendations regarding self-harm and suicide had either been fully addressed or were being responded to. The following recommendations were made:

- there should be at least one appropriately decorated and furnished Listener suite capable of accommodating a prisoner and two Listeners overnight
- work to create five safer cells should be completed
- the range of support mechanisms and specialist services available to those at risk of self-harm should be expanded
- the rank and workload of the Safer Custody Officer should be reviewed
- staff should have sufficient contact with prisoners to enable them to assess and monitor changes in mood or behaviour and thereby anticipate and prevent incidents of self-harm.

13. The first recommendation has been implemented and a day centre for self-harming and suicidal prisoners has also been established. The original work to create safer cells was undertaken but the standard was insufficient and further attention is necessary before they can be brought into use. A second Safer Custody Officer has been appointed and staff have been given individual copies of a booklet outlining the signs and procedures for responding to potential or actual incidents of self-harm.

CONDUCT OF THE INVESTIGATION

14. The investigator visited the prison shortly after the man's death and met the Deputy Governor, the Independent Monitoring Board and representatives of the Prison Officers' Association. The man's prison records were provided, including the medical records.

15. Formal interviews were conducted with 17 staff, and another eight were spoken to informally.

16. Unfortunately, the prisoner who found the man was unwell and unavailable for interview.

SEQUENCE OF EVENTS

17. This section of the report lists the significant events of the man's period in custody and the events of 20 August.

8 Aug 03	Four months imprisonment at HMP Wormwood Scrubs.
7 Oct 03	Released on Licence from prison
5 Aug 04	Arrested for shoplifting taken to Hounslow Police Station
6 Aug 04	Attended Feltham Magistrates' Court: Convicted but unsentenced
6 Aug 04	Received into custody at HMP Wormwood Scrubs
6 Aug 04	Located into prison's First Night Centre
7 Aug 04	Medical review in FNC & Assessment by Detox team
8 Aug 04	Re-location to Conibeere Unit and detox programme
9 Aug 04	Observed to be concealing medication. Removed from detox programme
9 Aug 04	Examined by GP: Suspicion of TB – Tests ordered
10 Aug 04	Moved to Healthcare Unit
18 Aug 04	Nursed in cell due to non-compliance of wearing facemask
18 Aug 04	Banging on cell door, shouting and up all night
19 Aug 04	Nursed in cell due to non-compliance of wearing facemask
19 Aug 04	Banging on cell door, shouting and up all night
20 Aug 04 10:25	Unauthorised article observed being pulled into cell
20 Aug 04 10:30	Search conducted of the man's cell and cannabis found
20 Aug 04 10:50	The man returned to cell
20 Aug 04 11:00	The man spoken to by a Nurse
20 Aug 04 11:07	Alarm raised by the prisoner when the man discovered
20 Aug 04 11:12	H3 Landing alarm bell pressed by staff running to cell
20 Aug 04 11:14	H3 staff call Comms room and advise CPR being given
20 Aug 04 11:15	Comms room requests an ambulance
20 Aug 04 11:25	Ambulance arrives at establishment
20 Aug 04 11:46	Ambulance leave establishment with the man and two staff
28 Aug 04	The man died in Charing Cross Hospital.

KEY FINDINGS

Reception

18. The man was received at Wormwood Scrubs at approximately 6:53pm on 6 August 2004 from Feltham Magistrates' Court, convicted and awaiting sentence for theft. Records from the police and escort company indicate that he was not considered to be at risk of self-harm. He was received at Reception, and seen by Healthcare staff who conducted the First Reception Health Screen. His drug test gave a positive result for cocaine, morphine and cannabis. He said in the interview that he had a drug dependency problem, was losing weight and had experienced problems with a chest infection. The record notes that he looked thin. He was asked if he had ever self-harmed or had any mental health problems, and reported that he had not. He was referred to the prison doctor.

19. The prison doctor examined the man the same evening and, knowing his history of substance misuse, prescribed medication to sustain him until the drug detoxification team could formally assess him over the following days. He was then allocated to the prison's First Night Centre, where he was interviewed for the Cell Risk Assessment Form and assessed as low risk and suitable for shared cell location. The assessment was confirmed by Healthcare staff who also indicated that there were no concerns about self-harm.

20. His records do not refer to any events the following day, however he would have participated in the induction programme. Later he was seen again by a prison doctor or Healthcare worker and identified for the detoxification unit aimed to address substance misuse. He signed a consent form agreeing to take part in the programme and abide by the conditions of admittance to the Drug Treatment Unit (the Conibeere Unit).

Conibeere Unit and CARAT assessment

21. The Conibeere Unit is a residential area within the prison, accommodating prisoners referred for drug or substance detoxification. There are 51 beds, 46 of which are allocated to prisoners who are detoxifying. Attendance is voluntary. There are strict guidelines for compliance in place and all prisoners are required to sign a compact. A subutex detoxification regime lasts for 12 days, methadone for ten to 15 days and codiazeproxide withdrawal from alcohol for up to nine days.

22. He was admitted to the unit on Sunday 8 August and was assessed by one of the permanent nursing staff who told him of the requirement to comply with medication. He began the subutex detoxification programme. The next day he was interviewed by a member of the CARATs Team. The team are not involved in decisions about referrals to the Conibeere Unit or the prescribing of medication. Their role is to provide support and information about harm minimisation, relapse prevention and drug awareness. A member of the team recorded that the man said he wanted to change his

lifestyle because he was afraid for his health and that he was ready to take up all offers of support both inside prison and in the community. In interview she said that she addressed his immediate needs and provided leaflets to explain the support that was available. She said that she found him very pleasant and that he listened to what she was saying. On completion of her interview, she filed her assessment form and marked it for the drug worker's attention on her return. The man was a resident of Ealing, whose council funded a drug worker to work with prisoners from their borough. He was referred to her for ongoing support but was not seen until 18 August when she returned from annual leave.

23. During administration of medication later on Monday 9 August, the Dispensing Nurse observed that he attempted to conceal his medication which was in contravention of the unit rules. In interview, she said that the unit has a zero tolerance policy, which she said he broke as he took the medication out of his mouth and attempted to conceal it. He was interviewed by the prison doctor and taken off the subutex programme.

24. Instead the doctor prescribed a programme of symptomatic relief medication, though it was not actually administered that day. Symptomatic relief would mean that any complaints, such as stomach ache, would be responded to with medication to relieve that problem. The Dispensing Nurse said that she was subsequently informed by another nurse that TB was suspected. The diagnosis of TB could only be confirmed by testing sputum samples on three consecutive days. As a precaution against infecting other prisoners and staff, he was provided with a face mask to wear outside his cell. He was seen again by a doctor at 5:00pm later that day regarding the weight loss and other complaints. Sputum, blood samples and a chest X-ray were ordered.

25. Because medical investigations were continuing and he was only on the second day of the detoxification programme, the Dispensing Nurse said that it was recognised that he was not fit for normal location and it was decided that he should be moved from the Conibeere Unit into the Healthcare Unit. Unfortunately no beds were available and so he remained overnight on the Conibeere Unit. Later he gave a sputum sample and was moved during the afternoon of 10 August to a single cell on H3 landing in Healthcare.

Healthcare Unit

26. The Healthcare Unit has 17 beds. The Unit Manager said in interview that it is a short-term acute unit for mentally or physically ill prisoners who cannot function on normal location. It also provides post-operative care and refers prisoners either to outside hospital or in-reach facilities. Prisoners in Healthcare are seen by the doctor twice per week. Each patient is allocated a key worker who is responsible for making entries in the individual's daily nursing record. The Unit Manager said that it was practice in Healthcare for key workers to be told of any incidents, which they would then write up.

27. On admission, the man was assessed again and the care plan stated that he was to continue with sputum testing and, until a diagnosis was given, he should stay in a single cell and continue to wear the face mask whenever he was outside it. The daily nursing records from admission on 10 August indicate that he was reasonably settled.

Medical and nursing staff should be reminded to initiate infection control procedures as soon as an infection is suspected.

28. The day that he moved to Healthcare, he was seen again by the CARATs worker. In interview, she said that this had been a quick meeting, but that she recalled speaking to him and he appeared to be fine. She also said that, when she saw him, she was unaware of his failure to comply with the requirements of the Conibeere Unit and that he was waiting to move out to Healthcare. She said that there was no formal system to inform the CARATs team that a prisoner had been removed from detoxification.

A protocol should be developed by Healthcare managers to provide immediate referral to the CARATs team for prisoners who are removed from detoxification programmes.

29. The Dispensing Nurse told the investigators that she returned to duty on 17 August and was told of difficulties obtaining sputum samples from the man. She said that when she saw him he was jovial, laughing and mixing with other prisoners. She said that, later that day or the next, she had occasion to remind him of the smoking policy in Healthcare as she had found him stubbing out a cigarette on the landing which was not permitted. On another occasion, he took his face mask off when outside his cell and she told him he would need to remain in the cell because of his suspected TB status. In interview, both she and another Nurse said that Healthcare did not have an official policy about patients wearing face masks, but that it would be expected in accordance with directions from the TB Nurse.

Healthcare should revise and implement its policy for the control of infectious diseases as soon as possible.

30. On 18 August, the drugs worker visited the man to offer support and complete documentation to enable future assistance to be provided. The nursing record for the day says that he did not comply with the requirement to wear the face mask. A similar entry was made in the landing observation book and he was returned to his cell. It appears that this was not the first time that it had happened and, in interview, the HCSO confirmed that she repeatedly asked him to wear the mask. She said that, for the safety of other prisoners, there was no alternative but to return to his cell. She said this meant that he was nursed in his cell, but that he came out for a shower and could come out for exercise if wearing the face mask. The HCSO said that the man said he would comply with the requirement if he was given a cigarette but that she refused to do so.

31. There is a later record that, at lunch time, he threw his tea and then his lunch through the door hatch of his cell saying it was not enough for him.

He was kept in his cell as a result. In interview, a Nurse confirmed that she made the entry in the nursing record, but that she did not recall him being returned to or nursed in his cell. She said that she did recall the incident of food being thrown and said that some of it stuck to the ceiling. During the night he was recorded as being very noisy most of the time, banging on the door and demanding tobacco.

32. The entry for 19 August states that he was still noisy and was banging the door and hatch, shouting and very demanding. Again he was kept in his cell all day. He was quiet and more polite as the day went on. The Nurse confirmed that the laboratory mislaid one of the sputum samples and so it was not tested and a repeat was required. That night, he was disturbed again and the record states that he was up the whole night, shouting, screaming and banging on the door.

Events of 20 August 2004

33. The Nurse said that the next day, 20 August, she went to explain to him that the sample needed to be repeated and went to his cell to give him a sputum pot. However when she returned to collect it, he said that he had given it to one of her colleagues. The HCSO confirmed that the Nurse was unsuccessful in obtaining the sample and said that she returned to the office and reported that he continued to refuse to wear the face mask. She asked her colleagues about the sample but none of them had collected it and so she took a further pot to him, which he declined. The nursing record says that he was very noisy in the morning and that he wanted cigarettes.

34. At 10:30 am, staff on the landing were told by officers from A Wing that they had seen something being pulled on a line from outside of the window and into E3-09, which was the man's cell. The HCSO alerted the HCPO and went to the cell together with the Nurse. He was taken to an adjacent area and given a rub down search before remaining with the HCPO. The HCPO described the man as being quite calm whilst this was going on. The senior officer and nurse carried out the search and cannabis was found by the HCSO in the toilet area. The man was shown the cannabis and denied that it was his. He was told that he would be placed on Governor's report for possession of the drug. The HCPO said in interview that the man started talking incoherently and very quickly, but he had not considered that he was mentally ill. He thought that the man was trying to block out what was being said to him as though it was nothing to do with him. The HCSO said that the search continued and a long piece of twine was discovered in the mattress. She said that when it was shown to him, he became upset and angry. He began to chant, which she said was like praying, but that he was not distressed or crying.

35. At 10:50am, the search was completed, the man was returned to his cell and locked in again. The staff returned to their duties, the HCPO going to the Security Office and the HCSO to the Healthcare office to complete the paperwork for the search and the Governor's report.

36. The Nurse went to the man's cell at approximately 11:00 am as she wanted to ask again for a sputum sample. In interview, she said she thought that, after the search, he might have been more amenable. She said that when she got to the cell, she saw him lying on the floor but that she thought he was alright, even though he didn't respond to her. She did not think he was unconscious, but that he just chose to ignore her. She left the area.

37. At approximately 11:07 am, another prisoner from H3 landing informed a Nurse that he had discovered the man hanging in his cell. In his police statement he said that when he was returning to his own cell, H3-10, he looked into the man's adjacent cell and saw him. He said that the man appeared to be standing against the back wall with his back towards the window. He thought this strange and approached the door. When he looked inside he saw that there were white laces round the man's neck and that he seemed to be staring upwards. The prisoner told the police that he shouted for help and two members of staff arrived.

38. The Nurse alerted the HCSO and together they went to the cell and saw the man suspended by a ligature attached to the window bars. The Nurse and the HCSO entered the cell with the prisoner. The prisoner told the police that, when he saw that the staff were having difficulty he untied the laces from the window frame so that the man could be lifted to the floor. The HCSO said in interview that she thought that the ligature had been looped rather than tied against the man's neck. The ligature was untied, and together they laid him on the cell floor. The Nurse said that she checked for vital signs after but was unable to find any response. She immediately commenced CPR and the HCSO asked for the prisoner to be taken from the cell and looked after.

39. Other staff from the unit, including the Unit Manager, responded to the alarm and emergency resuscitation equipment was taken to the scene. Eight members of the prison's Healthcare staff and a prison doctor attended the scene. The Unit Manager said that he was a First Aid trainer at the prison and he asked for the emergency bag. He used the proxymeter to measure oxygen but found that there were no signs of life. They continued to administer CPR and requested an ambulance, a request which the prison's communication log shows being made at 11:15 am.

40. Meanwhile staff carried on with CPR and found a response when the man began to breathe again. The Nurse said that she began chest compressions whilst the Unit Manager carried out mouth to mouth resuscitation. This continued for about ten minutes and then another Nurse took over from her, although she was in attendance. On interview, she said that she realised that more oxygen would be needed, and went to H2 landing to get some. When she returned she helped to monitor the man's vital signs and closed his eyes to protect them.

41. The operational governor responsible for Healthcare was on H2 landing when the alarm sounded and went to the scene. He said that he saw the staff in the cell and that they needed room to move. He marshalled others away. He considered that it was a medical matter which Healthcare staff were dealing

with, and so he remained outside the cell throughout. He was there when the prison doctor and the duty governor arrived. The operational governor for Healthcare said that he did not consider that he had taken charge of the scene but that the orderly officer had done so. He said that his part was only to ask whether the man was alive when he left the prison, and that he also informed the duty governor of what was happening.

42. The prison doctor arrived at the cell and he also checked for the man's pulse and breathing. He said in interview that the procedures appeared to be being carried out correctly and so he allowed staff to continue with their interventions.

43. The Assist Orderly Officer also attended the scene when he heard the alarm. He did not think that any staff were managing the scene outside the cell, and the Orderly Officer of the day stated that he had not taken on the role either.

The Governor should remind all staff of their roles and responsibilities during an incident, including that of a designated person in charge of the scene.

44. The prison's communication log records that the ambulance arrived some ten minutes later at 11:25 and the paramedics were escorted to the Healthcare Unit. On their arrival at the scene, responsibility for the medical care of the man was passed to the ambulance staff. The Unit Manager prepared a letter to accompany the man to the hospital. When the ambulance left the prison, he was alive. A risk assessment was completed and two staff were identified to accompany him and provide the hospital bed watch.

After the incident

45. The log goes on to state that the ambulance left the prison with the man at 11.46 am. Two members of staff accompanied him and he was taken to Charing Cross Hospital.

46. At 12:50 pm, the Head of Healthcare telephoned the man's family to inform them of his admission to this hospital. In interview, he said that at first the man's mother did not seem to understand that it was a serious matter and he felt that this might have been because English was not her first language. He suggested to her that she might like to attend the hospital herself.

47. Later, all the medical staff involved in the incident were spoken to by the unit's managers and confirmed that they were alright. The Governor spoke to the staff involved and their names were also passed to a Governor who was taking over as duty governor and was also a member of the prison's Staff Care team.

48. A formal debriefing meeting did not take place after the incident but the Governor said that all staff were spoken to personally instead. He said that he served the prisoners' meals so that staff could compose themselves. Another Governor said that he did not call a debrief as some of the staff had gone off duty by the time he arrived.

The prison's contingency plans should include a formal debrief after all such incidents, which should always include the Staff Care team amongst those attending.

49. The prison's security department secured the cell in case the man did not survive and the police were required to attend. Subsequently information was received from the hospital that the prognosis for him was poor, and the police were informed.

50. An Officer said that he was the escort when the man received his CT scan and had asked nursing staff about his condition. He was told that the prognosis was not good and so made contact with the prison to inform them. He contacted the prison again to report that family members had arrived, but he did not speak to them directly. The Officer said that he had not asked for a member of the prison's management team to come to the hospital, and that none of them had done so during his period of duty. The attendance of a member of the prison management team could have improved the information available to the family and also provided support for staff who were placed in a potentially difficult situation.

A member of the management team should attend the hospital in all such situations to provide support and information for the next of kin and the staff.

51. The Governor said that he was duty governor that weekend and he asked the HCPO to visit the hospital and liaise with the man's family. The HCPO said in interview that he was asked to introduce himself to the family, offer condolences, a contact number and any information. He was unaware of what the role entailed as well as being ignorant that funeral expenses were available.

Staff should be selected for the role of family liaison who have not been directly involved in the incident and they should be fully trained beforehand. Full records of contact with families should be kept and senior managers should provide all necessary support.

52. The Governor said that information about the man's condition came to him from the escorts or from the HCPO who reported to him each day after he returned from the hospital.

53. The man was due to attend Feltham Magistrates' Court on 26 August and so the Governor informed them of the incident and of the man's poor prognosis. A formal request was made for bail and this was granted later in the day. When bail was confirmed all prison staff were withdrawn from the hospital. However, later that day the Governor received a further warrant from the court, which directed that the man should remain in the prison's custody. He telephoned the Clerk of the Court for an explanation and the Clerk subsequently confirmed that the judges had agreed to bail. The Orderly Officer was informed and the Governor believed that he then removed the escort.

54. Despite the efforts of hospital staff, the man died on 28 August in Charing Cross Hospital.

COMPLIANCE WITH PRISON PROCEDURES

55. Wormwood Scrubs has a Suicide Prevention policy entitled "Caring for prisoners at risk of self-harm", which is comprehensive and generally conforms to current Prison Service Directions. It outlines the systems for monitoring F2052SH records and these are also satisfactory. However, the policy is dated July 2003 and has not been reviewed recently. In interview, the prison's Suicide Prevention Coordinator said that he intended to review it following the investigation into the man's death.

The prison's Suicide Prevention policy should be reviewed after all such incidents and again when investigation reports are received.

56. The prison also has contingency orders covering suicides and incidents of self-harm. These were comprehensive and complied with Prison Service requirements.

57. The investigation team also reviewed the Healthcare Unit's infection control policy. It was encouraging that the policy was available. However it only contained general guidance and did not include specific advice for prisoners either suspected of having infections such as tuberculosis or diagnosed with the same. For example, the policy does not refer to the requirement of prisoners suspected of having TB to wear a face mask. In interview the prison's TB nurse said that the policy was being reviewed and would be extended to include these situations.

CONCLUSIONS

Reception

58. This was not the first time that the man had been in custody and he was likely to have been familiar with the prison's regime as well as the support available to assist with withdrawal from drugs. He was correctly processed through reception, including the Healthcare screening which identified his drug dependency and appropriate medication was prescribed to meet his immediate needs. He was appropriately placed in the First Night Centre and then in the Conibeere Unit.

59. However, it is of concern that, despite giving his medical history to doctors at the police station, on reception and at the review of 7 August, it was only at 5:00pm on 9 August, after his removal from the detoxification programme, that the first suggestion was made that TB should be considered. By this time, he had been at the prison for three days and would have come into contact with numerous prisoners and staff. This was the first time that preventative actions, such as wearing a face mask, were ordered.

Removal from the detoxification programme

60. Prior to reception into the Conibeere Unit, the man was informed that attempts to conceal medication would result in withdrawal from the subutex detoxification programme, and this was reiterated on reception. The policy recognises the danger of medicines being available to other prisoners. When a nurse observed his attempt to hide his medication, he was referred to the doctor who correctly ordered his withdrawal.

Healthcare

61. The man was appropriately moved to the Healthcare Centre, where he had better access to medical staff and it was easier to provide the isolation necessary to reduce the risk of cross-infection. There were no problems during his first days in Healthcare; however, after more than 10 days staff had still not managed to have three sputum samples tested, which could have meant that he might have received more appropriate treatment, or been freed of the requirement to wear the face mask. The delays with the tests meant that he was nursed under a restrictive regime for the whole of his time in Healthcare. He was told that association would have been permitted had he been wearing the mask, but as he refused to do so he was locked in his cell for much of the time and withdrawn from the company of fellow prisoners, neither of which would have improved his mental health. Healthcare staff had a duty to protect the health of others, but more timely and efficient treatment for the man would have been to his benefit. Furthermore it is not apparent that he received an early explanation for the delays which could have helped to alleviate his frustration with his situation.

62. Increasingly he refused to cooperate with the requirement to wear a face mask and so he was confined to his cell for medical reasons. He was

informed that normal association would be available to him if he wore the mask, but did not cooperate. It would have been preferable for the unit to have had an infection control policy which stipulated this requirement, and for the decision to have been formalised by the doctor or a case review.

63. It seems that the man felt short of tobacco and that he attempted to negotiate increased cigarettes in exchange for wearing the face mask. Prisoners in Healthcare receive their canteen on Monday.

Searching the cell

64. Staff described the cell search as being carried out according to approved procedures, including their response to the unauthorised property found there.

Medical intervention

65. When the man was discovered hanging in his cell, the other prisoner, Healthcare and wing staff responded quickly and effectively, to the extent that their efforts improved his condition to one where signs of life were present. The intervention by prison medical staff was also of a high standard and greatly increased his chance of survival. The ambulance was requested and arrived promptly and an escort was arranged so that he could be taken immediately to hospital.

Management of the incident

66. Notwithstanding the efficiency with which staff responded to the incident, it appears that no one manager took charge of the whole situation. As a result an incident log was not commenced, although it should have provided important evidence. Although staff responded promptly and professionally, including sealing the cell to preserve evidence, this appears to have been the result of individual initiative rather than any organised contingency plan.

Staff debrief

67. The man was alive when he left the prison and staff had duties in respect of the other prisoners. Even though several managers spoke individually to staff, a formal debrief was not carried out. The debrief would have been an opportunity to provide staff support, identify emerging issues and any action to be taken, including assistance for the other prisoners.

Contact with the family

68. Prompt contact was made with the man's family. However on recognising that English was not their first language, they might have benefited from the use of an interpreter. Fortunately the information was received correctly and his family arrived at the hospital promptly.

69. No management staff went to the hospital where they could have offered support and provided information. Escort staff and a Healthcare officer were

left unsupported to deal with any issues which might have arisen. Not only did this mean that the prison's obligations to the family were not fulfilled, but staff were also placed in a potentially difficult position.

70. One member of staff was asked to act as the prison's liaison officer, but did so without a proper awareness of what the role involved and without making any record of his contacts with the family. He carried out the duties to the best of his ability, but without full knowledge, for example without appreciating the support available to cover funeral expenses.

71. The member of staff selected for the role had been involved in the initial response to the incident and had delivered CPR. This was inadvisable as it placed him in a position which might compromise future evidence to the coroner. In selecting the particular member of staff for the role, the prison failed in its duty of care to him.

Release on bail

72. The prison correctly informed the courts of the man's attempt to take his life and there appears to have been a breakdown in communication as to whether and when bail would be granted. No documents have been provided to the investigation team which would verify the decisions and the authority for them.

RECOMMENDATIONS

All the recommendations of the investigation team are directed to the Governor of Wormwood Scrubs.

1 Medical and nursing staff should be reminded to initiate infection control procedures as soon as an infection is suspected.

2 A protocol should be developed by Healthcare managers to provide immediate referral to the CARAT team for prisoners who are removed from detoxification programmes.

3 Healthcare managers should revise and implement its policy for the control of infectious diseases as soon as possible.

4 The Governor should remind all staff of their roles and responsibilities during an incident, including that of a designated person in charge of the scene.

5 The prison's contingency plans should include a formal debrief after all such incidents, which should always include the Staff Care team amongst those attending.

6 A member of the management team should attend the hospital in all such situations to provide support and information for the next of kin and the staff.

7 Staff should be selected for the role of family liaison who have not been directly involved in the incident and they should be fully trained beforehand. Full records of contact with families should be kept and senior managers should provide all necessary support.

8 The prison's Suicide Prevention policy should be reviewed after all such incidents and again when investigation reports are received.

9 The recommendations of both clinical reviews should be implemented.

GOOD PRACTICE

The Governor should commend the efforts of all staff involved in delivering CPR to the man and recognise their attempts to revive him. The prisoner who discovered the man should also be commended.