Investigation into the circumstances surrounding the death of A Prisoner at HMP Wormwood Scrubs on 23 November 2004

Part 2 of 2

Report by the Prisons and Probation Ombudsman for England and Wales

September 2005

This is the report of an investigation into the circumstances surrounding the death of a male prisoner at HMP Wormwood Scrubs on 23 November 2004. The man was an Estonian national and was 33 years old.

The investigation was conducted under the terms of the transitional arrangements agreed between my office and the Prison Service, which came into effect on 1 April 2004. A Senior Manager, from the Prison Service London Area Office, has conducted the bulk of the investigative work on my behalf and a member of the PrisonService, also from London Area Office, assisted him. A Doctor conducted an independent clinical review.

I would like to add my sympathy and condolences to those already expressed by The Senior Prison Service Manager to the man's family and friends.

An senior investigator from my office, liaised with the Prison Service's Senior Investigating Officer throughout the investigation. A Family Liaison Officer, from my office was in contact with the man's wife.

I am grateful to the governing Governor of Wormwood Scrubs and his staff for the help the investigators received during the investigation. In many ways, this report reflects well on the care offered to the man by staff at Wormwood Scrubs. However, I have also included a number of important recommendations.

Stephen Shaw CBE
Prisons and Probation Ombudsman

July 2005

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Summary

1. On 5 December 2002, the man was convicted of murder and sentenced to a mandatory life sentence with a tariff of 11 years. It was his first custodial sentence. He had been remanded in custody since 16 May 2002 and held at HMP Brixton. He was sent to HMP Belmarsh after his next court appearance on 23 May 2002, and remained there whilst on remand, during the trial and subsequently after he was sentenced. Following sentence, he was allocated to a lifer centre and transferred to HMP Wormwood Scrubs on 12 May 2003.

2. The man had a history of harming himself and it is clear that considerable efforts were made by staff at both Belmarsh and Wormwood Scrubs to help him remain safe. It is clear that he believed he had been wrongly convicted of murder and that he should have been convicted of manslaughter.

3. The man had access to a personal officer and other staff at Wormwood Scrubs, but attempts at building up a close relationship with him were marred by his refusal to talk about almost anything other than what led him into custody. All members of staff who regularly dealt with him were aware that he was distressed about the circumstances leading to his conviction and were also aware of his lengthy history of harming himself. The staff interviewed as part of this investigation described the man as a difficult person to get to know, and said that he was obsessed with his criminal case and sentence. They indicated that he did not want any of their time, other than when he harmed himself. The man remained subject to F2052SH procedures (suicide and self harm prevention measures) for the majority of his time in custody, only coming off the increased monitoring seven weeks before he took his life.

4. Staff had not anticipated that the man would attempt a life threatening action of self-harm by hanging. Usually, he cut his arms. It was evident, from what the man told staff, that one of the main reasons he harmed himself was in an attempt to influence the terms of his custody. Staff stated that in the days before his death he seemed to be happy and gave no signs for concern.

5. All incidents of actual or potential risk recorded in the man's medical record were responded to by some offer of support. A full range of support, including a period of in patient care at Wormwood Scrubs healthcare centre, was given to the man at both Belmarsh and Wormwood Scrubs. Until September 2004, he did not respond for any substantial length of time to the support offered. However, from that date staff noticed that his outlook on life, especially in respect of his appeal, his personal hygiene and his demeanour all improved greatly. After being assessed at a case conference, he was considered to have made sufficient progress to be removed from F2052SH procedures on 18 September 2004.

6. In the early evening of 23 November, the man was found hanging his cell. Despite attempts to revive him, he was pronounced dead at 7:10pm.

7. The man had been subject to F2052SH monitoring procedures for virtually all his time in custody. He regularly self harmed, although his injuries were relatively superficial. He received good clinical care and other support.

8. The decision to remove the man from F2052SH monitoring seven weeks before his death was made at a case review at which just two members of staff were present. I do not criticise the decision itself - but am concerned that only two staff were involved.

9. I make a variety of other recommendations designed to improve the safety of prisoners at Wormwood Scrubs.

Conduct of the investigation

10. The investigation into the man's death was carried out under transitional arrangements between my office and the Prison Service. The Senior Manager from the Prison Service was appointed as the senior investigating officer. He was assisted by a colleague. A Senior Investigator from my office was appointed to liase with the investigation team.

11. The investigation began with an introductory meeting with the Deputy Governor of Wormwood Scrubs and a representative of the Independent Monitoring Board. A member of staff from the prison was appointed as the liaison officer , and he was later succeeded by another staff member. Notices were displayed to announce the investigation and invite prisoners and staff to contact the investigators.

12. Prison records, including the man's medical records, were made available together with relevant policies and procedures.

13. A clinical review was commissioned and undertaken by a Doctor.

14. Formal interviews were conducted with staff and the transcripts of the interviews are included as annexes to this report.

15. The man's family were visited in Estonia by officers of the Metropolitan Police. The police delivered a letter from my Family Liaison Officer.

16. Some of the man's correspondence was translated on behalf of the investigators.

The Man

17. The man was born in Estonia on 25 November 1970 to a Russian mother and an Uzbekistani father. He told staff that he had been taken into care at an early age due to his parents' alcohol problems. He indicated that he had language difficulties at school due to different languages being spoken at home. The man also had behavioural problems at school. He said that he had not been in contact with his father since 1993, that his mother was elderly, and that he kept in contact with her through his wife who lives in Estonia. He told prison staff that he came to the United Kingdom towards the end of 1996, but returned to Estonia between then and his arrest on 14 May 2002.

18. On 5 December 2002, the man was convicted of an offence of murder and was sentenced to life imprisonment. The tariff was 11 years. Upon conviction, he returned to Belmarsh where he had been held on remand, and on 12 May 2003 was transferred from there to HMP Wormwood Scrubs. During his time in custody the man regularly attended education classes to improve his English. Staff at the prison said he conversed reasonably well, was easy to understand and seemed to understand people who spoke in English to him.

19. The man had informed medical staff that he and his family had a history of mental illness. On a number of occasions, the doctors assessing him noted acts of self-harm and that there was a risk of further harm. However, they found little evidence of any underlying mental health issues. He was subject to F2052SH procedures almost constantly from 15 May 2002 to 18 September 2004. A case conference on 18 September decided that he had made sufficient progress to be removed from the procedures because his outlook on life, personal hygiene and demeanour had all greatly improved.

HMP Wormwood Scrubs

20. HMP Wormwood Scrubs is a large Victorian prison in West London. It has a maximum population of 1,229 prisoners, mostly held in single cells. The population is a mixture of adult male convicted and unconvicted prisoners, the average ratio being nine to five respectively. On the day of the man's death, 1,166 prisoners were held at the prison. The prison predominantly serves West London courts and has a high reception and discharge rate, averaging around 40 new prisoners each weekday. Of the convicted prisoners at the time of the man's death, over 100 were sentenced to life imprisonment. Since August 2004, as part of the re-roling of Wormwood Scrubs, life sentence prisoners have been gradually transferred to other prisons.

21. The overall establishment rating is three (four being the highest and one the lowest). This 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 (HMCIP). In relation to Prison Service National Standards, the establishment attained a rating of 'Good' for both non-security and security, which were both marked as above 80% during the most recent audit in March 2004. Suicide awareness and self-harm procedures were rated as 'Good', achieving a mark of 94%.

22. Following the most recent HMCIP inspection in November 2003, HM Chief Inspector wrote that, nearly two years on from the last inspection, she found a greatly improved prison, gradually implementing and consolidating fundamental changes with senior managers who were actively managing staff and wings. In areas such as the first night centre, the resettlement unit and drug strategy, there was evidence of real and sustained improvement. In respect of the prevention of self harm and suicide, HMCIP commented that almost all of the concerns and recommendations arising from the last inspection had been fully addressed or were in the process of being responded to.

23. Recommendations were made for further improvements:

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

24. Some progress has been made towards the recommendations. The range of support services has been augmented with the opening of a day centre for prisoners at risk of suicide or self harm. A second Safer Custody Officer has been

appointed, and all staff have been issued with their own booklet outlining the signs and procedures to follow when dealing with prisoners who are at risk of harming themselves.

Key Findings

Events from 12 May 2003 – 23 November 2004

25. On 12 May 2003, the man was transferred from Belmarsh to Wormwood Scrubs. He was serving a life sentence for murder, having stabbed his victim during a drinking session. On reception, a Nurse noted in his medical record that when the man arrived he told staff he was on anti-depressants. He was directed to see the duty doctor but told staff that he did not wish to do this.

26. The following week the man was granted an international telephone call to his wife in Estonia in lieu of a visit, and these telephone calls continued throughout his time in custody. Three days later he made a formal request to be repatriated to his own country, and was advised that his request had been forwarded to the appropriate unit of the Prison Service.

27. On 2 June he had another telephone call to his wife in Estonia. Later that month, the man met staff from the Citizens' Advice Bureau to discuss his appeal against conviction. There was an entry in his prison record that staff felt he was an intelligent man, and that he spent his time playing chess with other prisoners. He was given four airmail letters for his own use.

28. At around 10:00pm on 9 July, landing staff found the man in his cell with scratches to both his arms. Healthcare staff were called and recorded that he had superficial cuts to his arms and face, but there was no visible bleeding and no treatment was necessary. He was monitored during the night by staff and an F2052SH was opened. The man would not communicate and he appeared angry in his manner. He was interviewed by the doctor the following day, who recorded that the man was crying during the interview, and said that he could not take anymore, was feeling depressed and wanted to be repatriated. He said that he did not understand his murder charge and that prior to his arrest he tried to hang himself. The doctor noted that there was a homophobic element to the man's offence. He told the doctor that he slept very badly, was feeling tired, and had a poor appetite. He complained of being agitated, and the doctor assessed his condition as situational reaction depression, as a result of his solicitor's failure to come to see him the previous day. The doctor recorded that he should be referred to the Community Psychiatric Nurse (CPN) and to either the landing officer or probation to contact his solicitor. The F2052SH remained open.

29. The man had told staff prior to seeing the doctor that he would cut his arms if he did not get some nail clippers. However, there were no further incidents that month and on 22 July he made a further telephone call to his wife.

30. On 4 August at 3:50am, landing staff found the man in his cell with superficial cuts to his arms. Medical staff were called to see him but he refused treatment and was monitored during the night. The nurse stated that he had multiple self-inflicted lacerations to both arms. It was also noted that he was very angry about his sentence, and by this time had served a year and three months. He told the nurse that he could not cope with the tariff of 11 years. The man said that he was unclear of the trigger for this self-harm and he refused treatment. He cleaned his own

arms, the bleeding stopped and the wounds were superficial, and he stated that he did not want to see a doctor, but would like to be referred to the CPN. The F2052SH remained open.

31. The next day, he attempted unsuccessfully to make an international phone call and then tried to phone his embassy in lieu of his free international call on 6 August.

32. The man met the CPN on 7 August. The records state that the man advised that he attended school for the mentally ill during his childhood in Estonia, and that he had behavioural problems and learning difficulties. His appearance was described as slightly unkempt and he emitted a stale odour. He said he only showered once a week because he feared the others in the shower. The nurse described the man as being slightly agitated, but that he made good eye contact and was very demonstrative when emphasising points. He described him as excitable on occasions and elevated, with fluctuating speech rate and volume, and said that he felt distressed, stressed and hopeless. The man said that he felt he was having his thoughts blocked and that he was paranoid. He believed that there was a conspiracy against him involving devils and demons. He believed that he should have been convicted of manslaughter and not murder, and that he had been the victim of a terrible miscarriage of justice. The man told the CPN that he had reported to discipline staff that he heard voices in his head. The nurse also noted that his concentration was poor. The man stated that he did not want to see a psychiatrist because he did not want to be sent to Broadmoor, where he believed that he would be detained for longer. He appeared to be isolated with few friends, but did have some correspondence with his wife. He reported that he only slept for four to five hours per night and had a poor appetite.

33. The man was interviewed by a doctor on 11 August and stated that he was not happy, and was not sleeping or eating well, but was thinking about his trial all the time. He said he did not want to mix with criminals. The doctor recorded that the man had no early morning awakening and no diurnal variation in mood. He recorded that the man had suicidal ideation but had no intent. He had harmed himself by making superficial cuts to his forearms and face to show people he was distressed, but not with the intention of killing himself. The man said that he was planning to appeal against his conviction with the help of his solicitor and that, if the appeal failed, he would kill himself. He told the doctor that, when he was aged 12, he had stayed in a children's psychiatric hospital. He said he was not sure of the details but it had happened after he broke a glass in the classroom. He added that another boy was bullying him at school.

34. On 13 August, a healthcare nurse (HCN) saw the man and he stated he was feeling weak. It was discovered that he was not taking enough fluids or food, which the HCN advised him to do. The HCN said that the man was happy with the advice.

35. The following week, staff noted that the man was extremely upset at times. A Risk Assessment Indicator checklist was undertaken and this indicated that a trigger for self-harm was when he did not take the medication prescribed for him. He was referred to the Day Care Unit at Wormwood Scrubs and agreed to start attending from 1 September 2003.

36. The initial day care assessment noted that the man had a history of violence. He was convicted of murder and was intoxicated at the time the offence was committed. He had attempted suicide once by his own unconfirmed report, and he had superficially self-harmed by cutting, including two occasions at the prison. The man told the assessor that he was an inpatient in a hospital in Estonia, diagnosed with schizophrenia, but this was not confirmed. He also said, that he had concussion as a child. At the time of the assessment, he was not taking his medication, was on an open F2052SH, and wanting to go home. He was awaiting his appeal, and was anxious, unmotivated, with little contact with his wife and no visits. The man attended education and refused to seek employment in the prison. He only mixed with one other prisoner and had a poor concentration span and poor problem solving abilities. The assessment noted that he was not eating properly and lacked stamina. He was unable to express his feelings and was not keen to mix with other prisoners, but stated that he would like to attend the day care group each week.

37. At 11:15pm on 21 August, a HCN was called to see the man in his cell and found that he had made superficial cuts to his right forearm. This was the third time that he had harmed himself at the prison. The HCN cleaned the wounds, applied a dressing and the man was taken to a Listener (a prisoner trained by the Smaritans) to talk as he appeared to be very angry about being in prison. The F2052SH remained open.

38. On 28 August, medical staff assessed the man as a result of the comments on the records and observed that there were multiple superficial scratches to both his forearms. He said he felt he had been unfairly sentenced to life. He said his victim was a criminal who was trying to damage him and he killed him in self-defence. He was advised to appeal through his legal advisor.

39. As arranged, the man began to attend the day care centre on 1 September, but the following week he did not attend as he was asleep in his cell and three days later his attendance was reviewed. The man said that he did not wish to attend any more.

40. Later that month staff, noted that he remained a quiet individual who did not mix well with others, and that he was still on the F2052SH. He was still attending education classes in the afternoons, and was pleased about them.

41. On 25 September, the man harmed himself for the fourth time by cutting his left arm and was treated by medical staff before returning to his cell. They noted that he had superficial self-inflicted cuts to left arm. They stopped the bleeding and applied a dressing. They checked his vital signs and advised that he see the doctor in the next 24 hours.

42. The man harmed himself again two days later. Staff described him as an intelligent and able man, who was dismayed that he had lost his family, business and prospects, because of his sentence. It was recorded that he was angry with the system, and did not think that his sentence was fair or deserved. He was articulate

in Russian, had a wife and three children in Estonia, and expressed his appreciation for the staff interest.

43. The next week, on 16 October, staff discovered that the man had harmed himself again, the sixth time at the prison, and again called for healthcare staff to attend. He had numerous superficial lacerations on his left forearm and again commented that he was angry about his conviction and appeared to be grieving for his loss of life style. They discussed coping strategies with him and he was advised to take his medication, as he had not attended for treatment for several days. They also asked custody staff to arrange for him to see a Listener. The F2052SH remained open.

44. On 20 October, the man was interviewed by a Forensic Psychiatrist who observed that he was ambivalent about his future, but believed that it was possible that his conviction could be changed to manslaughter. The doctor noted that the man was lying in bed, was unkempt and malodorous. His room was smelly. His lunch was left on his plate and he demonstrated his disgust of the food by thumping it with his fist. The doctor observed that the man made moderate eye contact and rapport, and described him as presenting as theatrical, garrulous and articulate of speech with a low mood. He told the doctor that he had no immediate suicide plans but intimated that, if his appeal was unsuccessful, he would consider slashing his wrists or inhaling water, and that he would not tell staff when he was going to kill himself. The doctor noted that the man had no thought alienation, no persecution beliefs and no intimidating or visual hallucinations. He considered that he did not appear to be experiencing a depressive disorder and was not psychotic, but there continued to be a chronic risk of impulsive injurious behaviour, which might increase as he was not taking his medication.

45. The doctor's care plan directed that the man should have care from the CPN on a weekly basis. He should remain subject to F2052SH procedures, with staff encouragement to improve his personal hygiene and the monitoring of his dietary intake.

46. There was a further incident of the man harming himself on 25 October at 11.45pm and he again said that he was upset about his sentence. He was given an analgesic. The doctor checked the wounds two days later, noted that he had no real suicidal intent, and was not clinically depressed. The man harmed himself again on 2 November, the eighth occasion at the prison, causing lacerations to his right arm.

47. The doctor interviewed him about the incident, and commented that he continued to say that he was not guilty. The F2052SH remained open and staff noted that his moods were unstable. They said that he sometimes attended education classes in the afternoon, but otherwise spent the rest of his time alone in his cell. His personal hygiene was not good and he did not appear to be motivated to improve.

48. On 14 December, staff answered the man's cell call and found that he had again cut his wrists and forearms. A HCN attended and treated his wounds, and a blade was removed from his possession.

49. The following week, on 26 December, the man told staff that he wanted to die and showed staff a four-inch D- shaped cut in his left arm, which was the tenth such occurrence since his arrival at Wormwood Scrubs. The cut required sutures and the doctor examined the wound later that day and prescribed anti-biotics.

50. On 28 December, the man's personal officer, Officer completed his records and noted that he was not a very chatty person, and appeared to be quite down and did not take much lunch. The next day, the mental health nurse interviewed the man and assessed him as being depressed. He said that he was hearing voices and that he had sent a suicide note to his wife. He said that he had been on hunger strike. The nurse considered that his mental state had deteriorated and he required inpatient care. The man was described as being emotionally unstable and difficult to reassure. Further assessment was requested due to concerns over his mental state.

51. The man was admitted to the healthcare centre at the prison on 30 December because of the concerns over his frequent episodes of self-harm. On admission, he was adamant that he would end his life. He told nursing staff that he was hearing voices but would not say what they were saying. Later on in the day he told healthcare staff that he wanted to return to the wing, and said that he had been pretending to be suicidal. He was advised to remain in healthcare and see the doctor on 1 January 2004.

52. The man was interviewed the next day by the in-reach mental health nurse. He told the nurse that he had been pretending to be mentally ill and suicidal over the last few months after manufacturing his symptoms from studying a medical book. He said that he had been told by another prisoner that, if he could convince the authorities he was mentally ill, it might result in a psychiatric disposal and shorten his sentence. The man said that he had now accepted he had killed a man and would work towards his appeal. The nurse commented that he seemed rational.

53. On 1 January, the man cut himself again. The HCN stopped the bleeding, and cleaned and dressed the wounds. He complained of pain but refused medication and his vital signs were normal. The HCN also noted that the man had normal movement in his fingers. He was to be seen by the doctor within 24 hours for assessment and, in interview, the man told the doctor that he wanted to go back to the wing. The doctor advised him that he needed to be assessed further before this could happen. He declined to be assessed for the day centre, stating that he felt much better and, would not hurt himself. He continued to attend the education department and was referred to a counsellor. It was decided that he would be seen again for a further assessment.

54. On 5 January 2004, the manreturned to D wing and said he was happy to be back. The F2052SH remained open.

55. Two days later, a doctor conducted a mental health review of the man. He told him that he felt discontented about the sentence of life imprisonment. He told the doctor that he had started to play mad when he came to the prison, and that he harmed himself to bring people's attention to his case. He told the doctor that he

did not want to kill himself. The doctor's opinion was that the man was not mentally ill, he had no psychotic symptoms and had no recent history of suicide attempts.

56. The next week, the man was interviewed by two doctors for a mental health review. After reviewing him, they recorded that they had no concerns about his mental health and noted that he said that he would stop pretending to be mad and denied any thoughts of self-harm or suicide. He was said to have no intention of cutting himself and that he had come to terms with his situation. He wanted to go back to the wing. Their care plan included day care and an assessment by a psychologist.

57. As part of his education classes in January, the man wrote an essay in English about his life and described its various negative aspects.

58. The man was treated for problems with his elbow, which was infected, and he was given medication. A doctor also assessed him, and he again denied any thoughts of deliberate self-harm but admitted that when he cut himself he got more attention. He said that he was happy on the wing and had pulled himself out of the depression. The doctor recommended that the man should see the CPN. He was referred to the prison's mental health team, and it was noted that he had sensations in his left forearm which were believed to be stress related, and was reassured that he was satisfactory.

59. On 2 February, it was reported to security staff that the man had written a letter to his family in Russian in which he spoke of being badly treated and beaten by staff. The letter was translated by a member of the IMB. In it, the man also spoke of feelings of suicide. When the matter was raised by security staff, he stated that this was not the case. Security staff advised the wing staff to monitor the man closely.

60. Two weeks later, a psychological evaluation was undertaken by a psychologist and a psychiatrist as part of his life sentence review. The review was comprehensive and is included in full within his IMR. It noted that he had been on an open F2052SH ever since his arrest, that he had cut himself regularly and continually expressed a suicidal intent. It was the assessment of both the psychologist and psychiatrist that his self-harming behaviour and letter writing were attention seeking. During the assessment, the man indicated that he wanted to apologise to wing staff for the incidents when he harmed himself and for being a problem. He claimed again that he faked the mental health symptoms on the advice of a fellow prisoner who told him it might help reduce his sentence. They noted that he said that he wanted to be taken off the F2052SH and wanted to be a model prisoner.

61. The duty doctor assessed the man on 28 February and recorded that his manner was appropriate and polite, and he denied feeling suicidal. The doctor noted that he should remain subject to F2052SH.

62. The man informed staff on 31 March that he was going on hunger strike because he was illegally convicted and sentenced. The same day, he received a letter which said that the High Court would be setting a minimum term for his sentence, explaining when this would be done and how he could try to influence the outcome. At 5:15pm, he was seen by the wing senior officer who commented that he was

unhappy because he felt that his solicitor was not helping him. The senior officer advised the man that he would speak with the solicitor on his behalf the next day. Later, staff noted that he had scratched his face with a drawing pin. When asked why he had done this, he replied that he had done it in protest about his solicitor's attitude to him.

63. On 2 April, staff noted that when the man returned from a legal visit he was upset and crying, saying that he did not know what to do, and felt trapped and afraid. Apparently, he was upset because his solicitor did not turn up and the senior officer allowed him a telephone call to re-book the visit. The man insisted that, although he was feeling down, he did not want to harm himself or commit suicide. He also assured staff that, if he had these thoughts later, he would alert staff with his cell bell.

64. Six days later on 8 April at 9:30pm, the man rang the cell call and showed staff that he had cut his left wrist with a razor. This was the thirteenth recorded incident at the prison when he had harmed himself. Healthcare staff attended and noted that he had superficial cuts to his right forearm. The blades used to inflict the wound were removed from his cell and medical staff recorded that he refused treatment.

65. When the doctor saw him about the incident, he recorded that he was still preoccupied with his appeal and did not accept his sentence or environment. The man told the doctor that he scratched his forearm when thinking about his conviction and sentence. He denied any overt intention of self destruction self-destruction and said he had contact with his family. The doctor recommended that the man stay on the F2052SH and referred him to the CPN.

66. There was another incident on 27 May when the man was found by staff with scratches to his arms. It again appeared that he had done this using a razor. He told staff two days later that he still had difficulty accepting his sentence. He also said that he would consider harming himself to convince his appeal lawyers of his insanity. The F2052SH remained open.

67. The man cut his arms with a blade again on 6 June. Medical staff were called and found that the wounds were superficial and did not require stitches.

68. On 14 July, the man complained to the landing officer that he had pains in his chest. He was asked to go to the treatment room where medical staff took observations of all vital signs, which were good except that his blood pressure was low at 96/60. He told medical staff that he got chest and head pains on a regular basis, which had started about two years earlier. He refused to see the doctor but thanked the nurse and said that he was feeling better.

69. On 6 August, staff advised the man that his cell needed cleaning and that he needed a shower, but he did not agree to either. They also said that he had too many newspapers in his cell, which were a fire hazard. He said that he would move them later.

70. A psychiatric evaluation of the man was carried out on 17 August. The diagnosis was that he suffered from stress adjustment disorder symptoms, with a mixed

anxiety depressive pattern and also suicidal self-harm behaviour of an expressive and tension relieving character. The doctor noted that he had no previous record of a formal mental illness, substance misuse or dependency or inpatient care prior to his arrest. It was the doctor's opinion that his difficulties coming to terms with his offence, sentence and situation were increased by his poor communication skills, cultural isolation and poor educational skills. The doctor stated that he considered that the man would require continuous support and supervision by the outreach psychiatric service for the foreseeable future, and that he would be helped by attention to his educational and communication skills. He added that the man would also benefit from psychological assessment.

71. The warning about the state of his cell was repeated on 14 September, and the man was again told that his cell needed cleaning and he had too many newspapers.

72. On 18 September, some 15 weeks after the last occasion when the man harmed himself, the F2052SH was reviewed by a senior officer and a nurse who decided that he should be removed from it. The record indicates that the man had told them that he felt okay and knew that he would get his appeal, adding that his solicitor had told him he would get a retrial. The reviewing staff noted that he was in very good spirits. They commented that the man appeared to like being subject to F2052SH because he got attention from staff, and so they assured him that he would always get this support regardless of whether he was subject to the F2052SH or not. They decided to remove him from the F2052SH because he had not harmed himself since 6 June and because he assured them that he had no intention of doing so or of committing suicide. They noted in the care plan that the man was to be supported on the wing and they closed the F2052SH.

73. A Senior Officer confirmed to the investigators that, by this time, the man was much improved and his appearance, haircut and personal hygiene had all been attended to.

74. On 5 October, the man told staff that the person in the cell next to him was bullying him and giving him verbal abuse. Staff felt that the problem was due to his lack of cleanliness.

75. The man was visited by the Safer Custody Officer on 20 October. It was recorded that there were no issues of self-harm or problems with other prisoners.

76. On 25 October, the man applied for a transfer to HMP Swaleside. He was seen on 28 October by a psychologist and it was recorded that, after some apparent progress in the last few months, he seemed to be becoming more obsessive and seemingly paranoid about his case. He said that prison and healthcare staff were conspiring to destroy him.

77. An Officer worked during the weekend of 20 and 21 November. In interview with the investigators, he said that when he saw the man over the weekend he had a bright disposition and had come to tell him that he was being transferred the following week. The Officer said that he asked how he felt about the move, and the man had said that he was okay about it, and then changed the subject to the

appeal. However, on 22 November, he told staff that he was worried about the move and was reassured that he would meet prisoners he already knew. The man was also worried that he had not attended any courses and was advised that probation staff would be able to help him.

78. At about 8:00pm on 22 November, an Officer Support Grade (OSG) carried out the evening roll check. She already knew the man from working nights in the healthcare centre. She said that, at the roll check, he was sitting next to his bed and waved, smiled and said he was okay. The OSG said the man gave her no grounds for concern.

23 November 2004

79. At around 4:20pm on 23 November, a prisoner saw that the man had only taken a banana for his tea and that he had a red mark on the right hand side of his neck. The prisoner was concerned so he alerted an Officer to what he had seen.

80. The Officer went to see the man straight away and asked him to show her his neck. She asked him what the mark on his neck was but he kept on scratching it and said that it was a rash. She told the investigators that she asked him if he had reported it to healthcare, and he said that he had cream for it. She then asked him if she could check the rest of his neck. He came to her and allowed her to lift the denim jacket he was wearing so that she could have a look at the rest of his neck. No other marks were found and the Officer asked the man if he was okay, which he confirmed. She then switched the light back off, closed the door, and locked the cell. She returned to the prisoner to tell him what she had seen, and that the man had said that the mark on his neck was an irritation caused by his t-shirt. She finished counting the rest of the landing and left the landing at approximately 4:45pm.

81. At 6:00pm, staff finished their tea break and started evening activities, including giving out goods ordered from the prison shop.

82. Two Officers were working on the landing. The Officers went to the cells with a member of staff from Aramark, the firm contracted to run the prison shop, and together they opened the cell doors one by one. They started from cell number one with one of the Officer's reaching cell 23, which was the man's cell.

83. The Officer looked through the observation panel first before opening the cell door and saw that the man was hanging. She got her keys out and went in. She tried to lift the man, but could not because he was too heavy for her. She ran out and called to the other Officer who pushed the alarm, logged at 6:24pm, and ran to the cell. The Officer supported the man's body whilst the other Officer called to a Senior Officer (SO) for assistance.

84. An Officer and an Officer Support Grade (OSG) were on duty in the communications room and heard the alarm at 6:24pm. The OSG broadcast the alarm on the radio net and asked the duty governor, the orderly officer, a Principal Officer (PO) and the duty nurse, to attend the wing. The OSG also asked the orderly officer to let the communications room have the prisoner's details, which would be required by the ambulance service. This was necessary as, on occasions, the ambulance service would not otherwise despatch an ambulance to the prison.

85. The wing Officer returned to the cell and got a chair. He tried to undo the noose immediately behind the man's neck, but was unable to untie it. The man was hanging about 18 inches to two feet below the light fitting. The noose was made of a strip about an inch or an inch and a half wide, of bed sheeting.

86. An Officer heard the Officer's call and came to the cell to assist. The Officer stood on the chair and also tried to untie the knot. As he started to untie it, a third

Officer came into the cell and stepped onto the bed. This Officer managed to strip the light fitting and the man came free. A fourth Officer attended and also supported the man's weight. A fifth Officer arrived at the cell and escorted one of the wing Officer's away, as she was distressed.

87. Two Officer's removed the ligature from the light fitting and placed the man in the recovery position on the bed. One of the Officer's asked the other Officer to feel for a pulse but it was not found. The Officer said that they should start resuscitation, and two of the Officers present at the scene ran to the office to collect the suicide survival kit. As one of these Officers returned to the cell he took the resuscitator out of the box, opened the plastic bag, and placed the resuscitator on the man's mouth and nose. He was quickly followed into the cell by a Nurse, whose arrival was logged at 6:30pm, who took over and told the staff to move the man from the bed to the floor whilst she commenced cardio pulmonary resuscitation (CPR).

88. The duty governor and PO responded to the alarm at 6:24pm and supervised the incident. On arrival, the duty governor noted that the man's colour was white, his eyes were glazed, his fingers and lips were blue, and when he felt for a pulse it was not found. The PO started a log of events and ensured that contingency plans were initiated.

89. Two Nurses joined the Nurse in the man's cell shortly afterwards. Two of the Nurses present managed the CPR whilst the third Nurse passed equipment to them, including the defibrillator machine. The nurses noted that the man was not breathing and had no pulse, there was cyanosis slightly around his face, and he was still fairly warm to touch. When the machine was attached, there was no output at all from the man.

90. A Doctor and Senior Officer (SO) at the cell at 6:35pm and one of the Nurses then left the cell. The Dr. and two Nurses continued to work on the man until the paramedics arrived at 6:45pm with another Doctor a consultant at St Mary's Hospital Paddington, who took over the man's care. The Prison Doctor noted that there were marks on the anterior aspect of the man's neck, his pupils were dilated, his hands were cold, but his chest was a bit warm, and there was no obvious sign of a pulse. At 6:50pm, one of the Nurses left and at 6:51pm the last Nurse left as well.

91. The Doctor from St Mary's Hospital pronounced the man dead at 7:10pm. His body was placed back on the bed by the paramedics. The duty governor and the PO covered the man with a sheet, and the cell was sealed at 7:15pm by the PO.

92. When a second PO reached D wing, he was told by the SO everything was being dealt with. He mistakenly took this to mean that the prisoner was okay. As a result, at 6:27pm he told OSG in communications not to call an ambulance. However, the OSG later received a transmission from the duty governor suggesting that an ambulance had been called. This PO then realised the error and contacted the OSG who then called an ambulance at 6:40pm.

93. The PO arrived at the cell at 6:31pm. The ambulance was logged as arriving at the prison at 6:43pm and reaching the cell two minutes later. From then, the prison's death in custody plans were put into place, including contacting the police, the

Governor, the Independent Monitoring Board and the National Operations Unit. The ambulance left the prison at 7:30pm. At 8:20pm, another prisoner who was a friend of the man, was told of his death and offered support by staff. During the course of the evening a SO asked an Officer of the care team to attend to the staff involved, and some were seen. However, in interviews with the investigators, OSG in communications said that he still thought about the incident a lot, and had not taken up the offer of a meeting with the care team as the date offered was during his annual leave. One of the Officers also told the investigators that, later in the evening, she was allocated tasks which she felt less than able to complete.

94. On the evening of the man's death, the duty governor attempted to speak with the man's next of kin at his British address but was unsuccessful. Another governor took over the task the next day at 9:30am and took on the role of establishment family liaison officer. She contacted the Estonian Embassy and later that morning, a Detective Constable, (DC) informed her that the police would attempt to contact the man's family in Estonia. The embassy advised her that they required proof of death before they could use Interpol and this was provided at 1:20pm. At 5:25pm, she informed the man's legal advisor of his death. On 25 November, a DC informed her that he had contacted the man's family and advised them of his death.

95. In interviews, several members of staff expressed surprise that the man had taken his life, as they thought his mood had improved in recent weeks. For example, one Officer said he had spoken to him a few days earlier about the prospect of moving to Swaleside, and said that he seemed to be quite positive about it. A governor said that, in the last few weeks before his death, the man had appeared to have picked himself up, and improved his appearance so that staff felt that he was beginning to respond. A SO said that he was shocked at his death as he had thought that the man had turned a corner and was making steady progress. Another Officer also commented that the man had seemed to be happier when he returned to the wing and was removed from the F2052SH. He had noticed that another prisoner had arrived who spoke the same language and that they played chess together. He described the man as an insecure person, and said that he claimed to have been bullied into pleading guilty to the offence.

96. The man's personal officer and had known him all the time that he had been on D wing. As his personal officer, he was responsible for writing progress reports. He saw the man whenever he was at work and said that his responses varied. Sometimes he just gave a nod to acknowledge that he had spoken to him, and on other occasions would have a deep and lengthy conversation. He said that the man did not talk about commonplace topics such as football, and his only real talking point was his innocence and that he could not come to terms with the fact that he had committed a murder. He described the man as a very quiet person, who did not associate with many other prisoners.

97. The Personal Officer recalled that there was a change in the way the man looked after himself from September onwards, which had contributed to the decision to remove him from the F2052SH monitoring. He had been scruffy and unkempt, but had seemed to be improving. He had not been surprised when he was told the man had harmed himself, but was shocked when he found out that the severity had

resulted in his death. Previously, he thought that the man carried out minimal acts of self-harm, such as superficial surface cuts, which he thought were a means of crying out for attention. He said that the man was difficult to get on with but that he had not been a strain on staff.

98. Several officers confirmed that the man mixed with few other prisoners, one of them being a prisoner whom he first met in February 2004. In interview with the investigators, this prisoner said that they used to have regular conversations about prison life, politics in Britain and Russia, and his criminal case. Also they played chess together. He told the investigator that the man regularly spoke to him about suicide but had not done so when he saw him on 23 November. An Officer said that she thought the man used another prisoner as a source of information and advice about prison life and legal matters. This prisoner had reassured him about the transfer to Swaleside, where he would have cooking facilities. The prisoner himself confirmed to the investigators that the man talked about his difficulty coming to terms with his sentence. It was the prisoner's view that the man's death was inevitable, and that he was always threatening to kill himself and had spoken about committing suicide but not said when he would do it. The prisoner said that numerous other prisoners and staff had tried to help him with his problems.

Conclusions

99. In many respects, the medical care and supervision provided for the man were particularly attentive to his needs and were of a high standard. He seems to have been treated appropriately whilst at Wormwood Scrubs. The staff on the wing were all aware of his history of harming himself and acted in a proactive way to monitor him, even after the F2052SH was removed.

100. However, despite the man's long history of harming himself, and the number of different professionals involved at different stages, only two people undertook the final case review. It was this review, which took place on 18 September 2004 that authorised his removal from the F2052SH monitoring procedures. The man had been on F2052SH monitoring the whole time that he was in custody, except for the seven weeks between the review and his death.

101. There are a number of aspects of the response to the discovery of the man's death which were inadequate:
    I. when the man was found hanging in his cell, the staff who attended were not carrying anti-suicide knives.
    II. some staff were unsure where to go as no-one had been delegated to direct them to the correct place and the first on scene response appeared to lack direction and co-ordination
    III. the man was initially placed on the bed in the recovery position which is not a satisfactory place to administer emergency aid
    IV. it took the duty nurse six minutes to reach the cell and during this time no first aid was given
    V. the time taken before CPR was administered was too long
    VI. the orderly officer misunderstood information which delayed the calling of the ambulance by 16 minutes
    VII. the maintenance of the log of people entering and leaving the cell was handed to the police without proper authority having been given.

102. Deficiencies in staff training have also been identified. A significant number of the staff involved in the incident had not had suicide awareness training for more than two years and none of the first on scene staff were qualified in first aid. Also, the OSG in the communications room had not been formally trained for the post.

103. The protocols for calling the ambulance service and for providing patient details to the ambulance service are insufficiently precise to eliminate spurious or accidental delays, which might prejudice a prisoner's survival in a medical emergency.

104. Finally, the post incident care offered to staff involved in responding to the man's death was uncoordinated and in some cases insufficient, notably in respect of one of the Nurses and the OSG in communications.

Recommendations

1. The Governor should consider the issuing of ligature knives to frontline staff.

2. The Governor should ensure that all frontline staff are appropriately trained to give basic emergency aid, and are trained in suicide awareness.

3. The Governor should were operational commitments allow ensure that more than two staff are included in any case review which assesses prisoners on F2052SH.

4. The Governor should draw the findings of the report to the attention of the Ambulance Service to ensure that the need for patient details does not delay the dispatch of an ambulance to give emergency assistance to a prisoner.

5. In light of the findings of the report, the Governor should prepare an action plan designed to ensure:

    I. that all frontline staff are aware of where emergency aid equipment is stored and reminded of their duty to use the equipment to save life.

    II. that prison medical staff attend medical emergencies more quickly and that a scene of an incident is more effectively identified to staff.

    III. that a system is introduced for the manager in charge of the incident to identify all staff and prisoners in need of care and support post incident and pass a list of the same to the Care team and Chapliancy