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

Report by the Prisons and Probation Ombudsman for England and Wales

September 2009

This is the report of an investigation into the circumstances of the death of a man in January 2008 at HMP Wormwood Scrubs. He had only been in prison for two days when he was found in his cell with a ligature around his neck attached to the window bars. The man was a Sri Lankan national.

I would like to offer my sincere condolences to the man's family and those touched by his death. I apologise for the delay in completing this report.

The investigation was undertaken on my behalf by my colleague. Both of us would like to thank the then Governor of Wormwood Scrubs, and the appointed Liaison Officer for their cooperation during the course of our enquiries. I am also grateful to the local Primary Care Trust for their review of the man's clinical care.

The man had arrived at Wormwood Scrubs on 18 January and was still in the first night centre when he died. He was worried about his physical health as he needed medication for a heart condition, and wanted to contact his family and friends. I have been pleased to learn that a doctor who spoke the same language went to great lengths to help, and also that the man was introduced to other prisoners who spoke Tamil. No other concerns were raised and I judge that there were no obvious warning signs as to the man's state of mind. I do not believe that his death could reasonably have been predicted.

Staff who attempted to save the man acted appropriately. However, I have made four recommendations in this report including one related to the speedy appointment of a family liaison officer following a death in custody and two about support for prisoners and staff. The remaining recommendation derives from the clinical review.

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

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

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SUMMARY

The man was remanded to HMP Wormwood Scrubs on 18 January 2008. He was from Sri Lanka and spoke little English. On arrival in prison he was concerned because he required medication for treatment of a heart condition. He was also anxious to speak with his sister and a friend. He was assessed by the prison doctor who made significant efforts to contact family and friends to ascertain the name of the medication the man required. The doctor referred him to a cardiologist, and in the meantime prescribed aspirin.

After being allocated a bed in a dormitory cell with four other prisoners, the man went through the formal processes on the first night centre, and spoke with an 'Insider' (a prisoner trained to help others, especially when they first enter custody). He also mixed with other Tamil speaking prisoners.

The following day, the man was able to speak to someone on the phone. In her response to the draft report, the man's sister said she did not speak with him. She feels strongly that had she spoken to him, she may have been able to help alleviate any anxiety he was feeling. No concerns were reported regarding the man's mental health, well being or mood. He was not deemed at risk of suicide or self harm.

During a night in January 2008, the man was issued with his aspirin and watched a film with other prisoners in his cell. At about 4.24am, one of the man's cellmates woke up to use the toilet. He found the man hanging from the window bars in the toilet area, and raised the alarm.

My investigation found that staff acted professionally and appropriately on finding the man and in their attempt to save his life. However, a family liaison officer could have been appointed more promptly, and as a consequence there was a delay in breaking the news of his death to the man's family. I also believe there was room for improvement in the way prisoners and staff were supported after the man's death.

THE INVESTIGATION PROCESS

1. I appointed my investigator to lead the investigation on my behalf. On her initial visit to HMP Wormwood Scrubs, she met the Governor and offered to meet with members of the local committee of the Prison Officers' Association (POA) and the Independent Monitoring Board (IMB). She was also given a tour of the prison, including the cell where the man died. Notices were issued to both prisoners and staff in Wormwood Scrubs inviting anyone who might have information relating to the man to make themself known to the inquiry. No one came forward as a result of these notices.

2. One of my Family Liaison Officers attempted to contact the man's family and maintained contact through the family solicitors. They were concerned about the man's time in Wormwood Scrubs and the general level of care he received.

3. My investigator interviewed prison staff and prisoners at Wormwood Scrubs, both formally and informally. She also examined the man's prison record, medical records and a series of prison documents. Of the four prisoners who shared a cell with the man, my investigator was only able to interview two. One of the prisoners had been released and the other transferred to another prison. My investigator wrote to both prisoners but received no response.

4. Closed circuit television (CCTV) footage from the first night centre was viewed by the police. However, it was accidentally wiped by the prison before my investigator was able to view it. The police reported no concerns about its content. The man's family commented that the absence of CCTV had made it more difficult to understand and accept the circumstances surrounding his death.

5. The local Primary Care Trust conducted a clinical review of the provision of the man's healthcare whilst in Wormwood Scrubs. I am grateful for their assistance.

HMP WORMWOOD SCRUBS

6. HMP Wormwood Scrubs is a category B local prison that holds adult males remanded into custody from the courts as well as convicted and sentenced prisoners**.**

7. Due to its proximity to Heathrow Airport, the prison accepts a significant number of foreign nationals being held on remand for illegal entry into the United Kingdom.

8. The prison was built between 1875 and 1891. It remained relatively unchanged until 1994, when a new hospital wing was completed. In 1996, two of the four wings were refurbished to modern standards and a fifth wing was completed.

9. HM Chief Inspector of Prisons conducted a short follow-up inspection of Wormwood Scrubs in October 2005. It had been noted in the Inspectorate's full inspection two years earlier that prisoners were returning from court late, and did not have time to settle into their environment before being locked up. The finding was repeated in the 2005 inspection. Many prisoners were still arriving after 9.00pm; on average this happened twice a week. As a consequence, staff were unable to provide a telephone call or shower for these prisoners.

10. However, the Chief Inspector found that the prison had good procedures and resources allocated to prevent suicide and self harm. The only area specified for improvement in 2005 was the provision of five safer cells (cells with reduced ligature points). At the time of the death of the man, the first night centre had two safer cells.

11. An additional recommendation was that all self-inflicted deaths should result in an action plan which draws on the lessons learned and to include clear timelines for their implementation.

12. There had been ten deaths by apparent suicide at Wormwood Scrubs between April 2004 and the man's death. Some of the findings regarding delays in contacting the man's next of kin and support for staff are similar to those I have made in previous investigations.

KEY EVENTS

13. The man was born in June 1978 and was a Sri Lankan Hindu. His first language was Tamil and he spoke very little English. He was detained at Heathrow Airport on 17 January 2008 for allegedly intending to travel with false documents. He appeared at Uxbridge Magistrates Court the following afternoon, and was remanded to Wormwood Scrubs until the date of his trial. It is unclear whether the man had spent much time in the United Kingdom, although he did have family living in London.

14. On his arrest at Heathrow, the man said that he suffered from a hole in the heart and that he was not a well man. Other than this condition, he was said to be in reasonable health. He was anxious to receive medication for his heart condition and to speak to his sister and friends by telephone.

15. It was noted on the Prisoner Escort Record (PER) that the man had mentioned having a heart condition. The police Forensic Medical Examiner (FME) agreed that the man was fit to be detained.

16. When he arrived at Wormwood Scrubs, the man underwent an initial health screen with a prison nurse. The prison doctor acted as an interpreter as he speaks Tamil. No risk of self-harm was identified during the health screen. They noted that the man's pulse was 75 beats per minute (which is slightly raised) and his blood pressure was 114/80 (this is within a normal range). The man said that he had a hole in the heart and was receiving medication, but was unable to specify the name of the medication. The nurse recorded that the man was anxious and his main concern was his medical problem. As a result, the man was referred to the doctor.

17. The man then spoke with the prison doctor in more depth. He told the doctor that he had been in hospital in Kandy, Sri Lanka, where he had been prescribed three tablet medications, but he could not name them. He also said that he had some chest pain and occasionally coughed up blood. On examination, he was found to have a heart murmur which was consistent with a hole in the heart. The prison doctor told my investigator that he was keen to ascertain the correct medication for the man, but had not been concerned about his mental health. He told my investigator that there were no obvious signs of mental illness, and he felt that the man had been very open with him.

18. The man also told the prison doctor that he had a sister in South London and that her number was on his mobile telephone. He had a piece of paper with the telephone number of a friend and appeared anxious that the friend be contacted. The prison doctor tried to contact the friend and left an answerphone message to say the man was in prison and gave a contact telephone number.

19. At 8.50pm, the man together with 16 other prisoners was escorted from reception to the first night centre by Officer Green. The staff had little time to spend with the prisoners and a prison officer told my investigator:

> "From what I recall the man didn't have any visible signs of being in distress, he didn't have any injury marks on him, there was no history of self harm, he wasn't known to the prison, I don't believe he'd been in Wormwood Scrubs before … The person on the desk would be going through the cell sharing risk assessments to check if there are any issues as regards sharing cells or whether the person has an ACCT document opened for them which is a suicide book basically. None of this was evident from the man at the time, it was myself who signed off the cell sharing risk assessment that he would go into a non-smoking dormitory with four other prisoners."

20. My investigator asked the prison officer about the rationale behind placing the man in a dormitory cell. The prison officer said that staff must consider whether someone is thought to be a high risk of harming others, whether they are racist or have mental health problems. If someone had a history of self harm or had said they were feeling depressed, staff would want them to share a cell with someone else. The prison officer explained that:

> "…the man's cell sharing risk assessment didn't indicate anything, so for our initial point at that time of night, he's safe to share with another person, the other people were safe to share with him and he was placed in a non-smoking dorm along with other four people that didn't smoke."

The man was allocated to cell X4-17, which he shared with four other prisoners.

21. The next morning (Saturday 19 January 2008), the prison officer undertook an induction talk with the new prisoners, with the help of a prison orderly. The prison orderly spoke limited Tamil, but he and the man both spoke some Hindi and were able to communicate. The prison orderly told my investigator that the man had been upset and wanted to see the doctor. He was concerned about his medication, and had had a nose bleed. He also wanted to make a telephone call.

22. The prison doctor told my investigator that he asked a nurse to go to reception to obtain the number for the man's sister from his mobile phone. The doctor then spoke to the sister to try and ascertain what medication he had been taking. She agreed to contact her family in Sri Lanka to see if they knew. In the meantime, the prison doctor prescribed aspirin and recorded that the man should be referred to see a cardiologist. The prison doctor explained that he had also told the man's sister how she could visit and given her the telephone number of the first night centre. She had wanted to speak with her brother but the doctor was unable to transfer a call

23. The prison officer recalled that the man was anxious and wanted to make a telephone call. There were other prisoners on the landing who spoke Tamil and he spent time talking with them. They told my investigator that the man was concerned about his medication. The prison officer said it took three attempts to get through on the phone, but on the third occasion the man

managed to speak with his friend. The prison doctor also spoke to the friend and explained the location of the prison, the visiting arrangements, and how to make calls into the prison to speak with the man.

24. By the time the man finished his phone call, the prison officer had finished duty. However, my investigator asked a second prison officer, who was also on duty at the time, how the man seemed after having made the call:

> "He seemed fine, quiet, distant but no more quiet and distant than the majority of other inmates we get in the prison. Obviously just reflecting and seeing what's going on. There were no major concerns."

25. The man spent the Saturday afternoon with other prisoners, including other foreign national prisoners who spoke the same language. He spent time sitting in the television room and playing pool. Tea was served around 4.30pm and prisoners then returned to their cells.

26. One prisoner who shared the dormitory with the man, said that they watched the film *The Italian Job* on television. At times the man laughed at the film. He sat with a second prisoner eating crisps and watching the film. The prisoner said that although the man did not speak English he seemed to be okay, would smile and attempt to communicate.

Events during the night of 19 - 20 January

27. Night staffing arrangements were that an Operational Support Grade (OSG) patrolled the first night centre. The OSG was supported by prison officers around the prison (code named 'Oscars') who would be summoned to attend incidents, and who also visited periodically to ensure that the appropriate checks were conducted. Also on site were two nurses, one based in the healthcare centre and the other who could be summoned to incidents. The healthcare centre is based directly above the first night centre.

28. Dormitory cells on the first night centre have close circuit television cameras (CCTV). The television showing the CCTV footage is in the wing office where the OSG is based when not conducting patrols or checks on prisoners. Staff are not required to watch the CCTV all night.

29. Neither the man nor those he shared the dormitory with were subject to increased observations for any purposes, such as being at risk of self harm. This meant that, unless called to the cell, the OSG would not have cause to look inside other than during the routine roll checks in the evening and the morning.

30. The OSG told my investigator he came on duty at around 9.00pm. He said that a healthcare nurse came onto the unit to issue medication. They went to the dormitory cell and the man was given his aspirin through the hatch in the door. The OSG could not remember anything significant about the interaction.

31. The OSG told my investigator that he conducted the roll check between 9.30pm and 10.00pm and checked that all the prisoners were in their cells. As well as the roll check, the OSG checked the prisoners who were subject to suicide and self harm monitoring and also answered the bells pressed by prisoners from their cells. He recalled that one particular prisoner was detoxifying from drugs and pressed his cell bell regularly during the night.

32. Some time after 4.00am, one of the man's cellmates got up to visit the toilet. He found that the door was wedged and so he had to pull hard to open it. On going into the cubicle, he found the man hanging from a ligature made from bedding and fastened to the window bars. The prisoner returned to the dormitory and woke the other prisoners. Together they pressed the cell bell to summon prison staff.

33. The OSG the cell bell was pressed at 4.24am and he responded to it. He was told by the prisoners that they thought the man had killed himself. The OSG raised the alarm by radio, calling 'code 1' to signify a hanging.

34. On hearing the code 1, the communications room asked all the Oscars to go to cell X4-17, and called for an ambulance to come to the establishment. Oscar 3 was the first to arrive, followed shortly afterwards by the healthcare nurse. The nurse had brought the emergency equipment and a defibrillator. Oscar 3 looked in the cell through the flap and counted four prisoners and then Oscar 4 arrived within seconds. Oscar 3 decided that they could safely enter the cell without the orderly officer. (When considering whether to enter a cell occupied by more than one prisoner, staff must assess whether there are any implications for their security.)

35. Oscars 3 and 4 and the healthcare nurse went into the toilet cubicle and saw the man hanging from the window bars. Oscar 3 held the man around the waist to support his weight. Oscar 4 tried to cut the ligature with his ligature knife. He told my investigator:

> "… because he'd used a full sheet I couldn't slice through cleanly. So I then took down the noose, took down the knot from the window and tried to pull it off but again it being too tight. So I had to saw through with my cut-down knife rather than just slice through."

36. They placed the man's body on the floor of the shower room and Oscar 3 and the healthcare nurse attempted cardio pulmonary resuscitation (CPR). The healthcare nurse told my investigator that she attached the defibrillator machine which instructed not to shock but to continue CPR.

37. Oscar 1, arrived shortly after CPR began and instructed Oscar 4 to begin a log of events. A third prison officer was instructed to go to the gate to meet the paramedics/ambulance and escort them through to the first night centre. Oscar 1 asked the communications room to ring the Duty Governor and to treat it as a 'death in custody', meaning that the prison's procedures would commence. He also arranged for the other prisoners to be taken to another dormitory cell.

38. The paramedics arrived at the prison gate and were escorted to the first night centre by the third prison officer, arriving at cell X4-17 at 4.31am. They took over CPR. The man was pronounced dead by the paramedic at 4.35am.

39. After the man died, another prisoner in a different part of the prison suffered heart problems. This meant that many of the staff left to deal with the situation, and two officers escorted him to hospital leaving a staff shortage.

40. A member of staff was appointed as the prison's Family Liaison Officer (FLO). He logged in his family liaison log that he was initially telephoned at home at 8.20am. As the man did not have an address in England it was difficult to identify his next of kin. The prison's FLO looked through the prison records and saw the mention of the man's sister. As he knew the area where the sister lived, he set off in that direction, the police having agreed to telephone him with the exact address. There was no reply at the home, and so the prison's FLO telephoned the man's sister and asked her to return home, where he told her of her brother's death. The prison's FLO continued to liaise with the family to return the man's belongings and offered expenses towards the funeral.

ISSUES

The First Night Centre

41. Staff told my investigators of the difficulties receiving prisoners into the prison late in the evening. They find it difficult to ensure that prisoners are appropriately assessed. Wormwood Scrubs had tried to address this by altering the shifts so that reception staff remained on duty longer. However, without a doctor on evening duty and with limited nursing provision, concerns remain about the safety of prisoners on their first night. In the case of the man, it seems that he was cared for appropriately. Nevertheless, the matter is worthy of comment, and something that the area manager may wish to pursue with the prisoner escort contractor.

Clinical Care

42. The man underwent the first reception health screen with a nurse and with the prison doctor acting as a translator. The man was asked about mental health problems and about his suicide or self harm history or any current feelings. He denied any thoughts of this nature. Although he appeared anxious, it appeared to be regarding his heart condition. The clinical review conducted by a panel from the local PCT concludes that the prison doctor's prescription of aspirin was appropriate, and the referral for a cardiology appointment was good practice.

43. The prison doctor further assessed the man the next day. The clinical review says:

> "The physical examination identified that the man's blood pressure, pulse rate, and body mass index were within normal limits. It should be noted that the current Part Two Health Screening Tool does not require the measurement of pulse rate, and that this action was considered to be good practice … Although it is recorded in the Don Gruben Health Screen (question four) that the man suffered from chest pain, there is no documented evidence of a guided physical assessment being performed."

44. The clinical review makes the following recommendation that I endorse:

The healthcare manager should introduce policies and frameworks for the quantification and, if necessary, emergency intervention for people experiencing angina, chest pain, and cardiac events.

45. The prison doctor and healthcare staff made considerable effort to trace the telephone numbers for the man's sister and his friend and try to identify his medication. Despite the considerable demands on a doctor's time in a busy prison such as Wormwood Scrubs, the prison doctor found time to speak with both of the man's contacts. It showed great diligence to go to these lengths to ascertain the man's medication and to assist the contact between the man and his loved ones.

46. I draw this to the healthcare manager's attention and suggest that the prison doctor should be recognised for the compassion and diligence he showed. Indeed, when the man's family commented on the draft report, they expressed their thanks for the level of care and empathy he showed to the man during the last days of his life.

47. In addition, the head of healthcare and the Governor will wish to consider in full the findings from the clinical review.

Emergency Response

48. Once the alarm was raised, staff arrived quickly at the man's cell. They acted appropriately by going inside as soon as two staff were available, rather than waiting for the night orderly officer. The officers and the healthcare nurse responded speedily and professionally in their attempts to save the man. All the contingency plans appear to have worked well, affording the prompt escort of the ambulance.

Family Liaison

49. The man was pronounced dead at 4.35am, but the appointment of the family liaison officer did not happen until nearly four hours later at 8.20am. Another prisoner had been taken ill after the man died, which meant that staff were deployed elsewhere and may have contributed to the delay making the appointment. However, I consider the delay to have been longer than it should have been.

50. I have had cause to raise questions regarding family liaison in previous investigations at Wormwood Scrubs.

    I recommend that the Governor should review procedures to ensure that a higher priority is given to appointing a family liaison officer and contacting the family after a death at the prison.

51. Once appointed, the prison's FLO acted appropriately in his attempts to contact the family and break the news of the man's death. However, it took some hours and the man's sister was not contacted until 1.30pm by telephone and 2.30pm in person at her home. It is considered best practice to break the news in person, and I do recognise the prison's FLO's efforts.

Support for staff and prisoners

52. My investigator interviewed two of the prisoners who shared a cell with the man and were responsible for finding him and alerting staff. They told my investigator they remained together in the first night centre for a few extra days where staff were supportive. It is well known that prisoners who know someone who has apparently taken their own life, may themselves be at a higher risk of harming themselves. By the time my investigator spoke to the two men, they had been moved to different house blocks where the staff were

unaware of their situation. Both prisoners appeared upset and asked my investigator to facilitate a meeting with the chaplaincy. It is my understanding that the chaplaincy has offered continuing support.

53. It is important that wing staff are made aware of prisoners' problems and experiences. One way of communicating such information would be for staff on the first night centre to make entries in the prisoner's history sheet.

I recommend that the Governor reminds staff of the importance of noting significant events in prisoners' wing history sheets.

54. Prison Service Order 2710 "Follow up to Deaths in Custody" states:

"There must always be a hot debrief immediately after the incident and provision for this should be made in local contingency plans. A senior member of staff must act as debriefer and a duty care team member must also attend."

55. Some staff told my investigator that they were offered support, but not that they attended a hot debrief. When the Prison Service responded to the draft report, they highlighted the fact that directly after dealing with the man they were required to deal with another emergency, preventing an immediate debrief. I accept this. However, the staff involved told my investigator that they did not hold a hot debrief at all. Therefore, I consider the following recommendation should still stand.

The Governor should ensure that all staff involved in a death in custody are invited to attend a hot debrief and are offered appropriate support.

Conclusion

56. In spite of the difficulties in communicating for someone with little English, the man was able to speak about his concerns with a Tamil speaking doctor and other prisoners. He was also enabled to telephone his friend. I conclude that appropriate assessments and observations were conducted, and attempts were made to deal with his concerns about his health. I do not believe that his death could reasonably have been foreseen.

RECOMMENDATIONS

1. The healthcare manager should introduce policies and frameworks for the quantification and, if necessary, emergency intervention for people experiencing angina, chest pain, and cardiac events.

   The Prison Service accepted this recommendation and said:
   "Patient Group Directives have been developed and are in the process of being rolled out to all the staff. An extensive education program is in place. The first cohort has occurred, and a second one is planned to commence at the end of March."

2. The Governor should review procedures to ensure that a higher priority is given to appointing a family liaison officer and contacting the family after a death at the prison.

   The Prison Service commented that they appointed a family liaison officer as soon as it became apparent that there were family to be contacted.

3. The Governor should remind staff of the importance of noting significant events in prisoners' wing history sheets.

   The Prison Service accepted this recommendation and said:
   "A Governor's Order will be issued reminding staff of the need to record and share significant information within Prisoner History Sheets."

4. The Governor should ensure that all staff involved in a death in custody are invited to attend a hot debrief and are offered appropriate support.

   The Prison Service accepted this recommendation and said:
   "All establishment Operational Managers will be reminded of the need to comply fully with this requirement of the prisons contingency plans for Deaths in Custody."