INVESTIGATION INTO THE CIRCUMSTANCES SURROUNDING THE DEATH OF A MAN AT HMP WORMWOOD SCRUBS IN FEBRUARY 2006

Report by the Prisons and Probation Ombudsman for England and Wales

January 2007

This is the report of an investigation into the death of a man in February 2006, whilst a prisoner at HMP Wormwood Scrubs. The man was on remand awaiting trial at the time of his death. He was 31 years old when he died.

I wish to offer my condolences to his family for their loss.

The investigation was conducted by two of my investigators. I would like to extend my thanks to the Governor and his staff at Wormwood Scrubs for their help and co-operation during this investigation.

A clinical review was undertaken by the Hammersmith and Fulham Primary Care Trust into the medical care that the man received. I am grateful to the review panel for their report.

I make no recommendations in this report as the result of my investigation into the man's death. However, I do commend the clinical review to the Governor and the Healthcare Manager at the prison, as it makes a number of general recommendations worthy of their consideration.

Stephen Shaw CBE
Prisons and Probation Ombudsman **January 2007**

CONTENTS

Summary

The man, a foreign national, was charged with murder and other serious offences in December 2005. He appeared at Magistrates Court the following day and was remanded into custody at Wormwood Scrubs for trial at the Criminal Court in March 2006.

During the reception process he told staff that he had no medical problems and that he had no thoughts of self-harm. He stayed in the First Night Centre until 19 December, when he was transferred onto B wing. He was happy to be sharing with a prisoner from his own country and in January became a landing cleaner. The man was seen as a polite and quiet prisoner.

On 26 January 2006, the man was moved onto C wing where he was initially unhappy as he had lost his job by moving. Staff noticed the fact that he was unhappy, spoke to him and quickly arranged for him to get a job on the hotplate. That involved helping to serve other prisoners on the wing their meals and cleaning up afterwards.

He appeared to get on well with his fellow prisoners and the staff. He told other prisoners that he was in custody for threats to kill, although his solicitor confirms that the man knew the true nature of the charges.

Other prisoners have said that over the last two or three days of his life, the man was unhappy. The staff did not notice any change in his mood and were not told by any prisoner.

On the evening of 18 February, the man returned to his cell after cleaning the hotplate. His cellmate saw him with a torn strip of green bed sheet, about eight feet long. He was tying one end of it to the window bars of the cell. When he was asked what he was doing, he dismissed it as nothing. He then sat and wrote two letters in his language which he placed in envelopes.

The man then asked his cellmate to play dominoes, which they did for about two hours. The man then rolled about 10 cigarettes and smoked them whilst watching television.

After they switched off the television and the main cell light, the man's cellmate saw that he was pacing the cell and crying. His cellmate told him to calm down, and went to sleep.

At 6.05 am the following morning, the man was discovered hanging from the cell ceiling light fitting by a strip of bed sheet. His hands were tied behind his back and his ankles were tied together, both with strips of bed sheet. He was taken down and staff attempted to resuscitate him. He was taken to hospital at 6.42 am and was pronounced dead soon after.

THE INVESTIGATION PROCESS

1. The investigation was opened by my investigators and the Governor and his staff produced the man's medical record and a large number of other documentation for examination. Notices were distributed around the establishment notifying staff and prisoners of the investigation, and a number of prison staff and prisoners were interviewed.

2. My investigators liaised with the police detective investing the death on behalf of Her Majesty's Coroner. They confirmed that they were investigating the death as a probable suicide and had ruled out the involvement of anyone else. My investigators were given copies of the police statements to assist with my investigation.

3. Her Majesty's Coroner was contacted to inform him of the nature and scope of my investigation. Upon completion, this report will be sent to the Coroner to assist with his enquiries into the man's death.

4. One of my family liaison officers contacted the man's partner to inform her of my investigation. Further attempts at contact have been made, but to date we have not been able to speak to any member of the man's family.

5. The Hammersmith and Fulham Primary Care Trust were informed of the man's death and the clinical review was undertaken by a panel.

HMP WORMWOOD SCRUBS

6. Wormwood Scrubs is a large inner London local prison, built in the late nineteenth century, it consists of five wings and a hospital wing. Since I was given the responsibility for investigating deaths in prisons in April 2004, there have been seven previous deaths at Wormwood Scrubs. Six of those deaths were apparently self-inflicted.

7. The report by Her Majesty's Chief Inspector of Prisons from November 2003 concludes in the section about preventing self-harm and suicide that the majority of concerns and recommendations arising from the last inspection had been or were in the process of being addressed.

8. There is a high foreign national population in the prison. The Inspectorate found that fourteen key documents, including the First Night Centre booklet, had been translated into 28 languages. A conclusion from the 2003 inspection report said, '*Attention to race relations had improved for the 63% minority ethnic population. A full-time diversity manager had been appointed and there were regular meetings of the race relations and diversity management team'.*

9. My investigators found that the staff were aware of the resources at their disposal to assist foreign national prisoners settle in to the prison regime and to have the opportunity to participate, as English speaking prisoners were able to.

KEY EVENTS

10. The man was received at Wormwood Scrubs, where his committal warrant, Prisoner Escort Risk form (PER) and other documents were checked.

11. He was able to read the reception documentation in his native language and was able to talk to an interpreter via 'Language line'. An entry in the F2052A Inmate History Record notes that he was very upset at first, but seemed a lot calmer afterwards. The prison officer also noted that the man wished to attend English classes and that the officer would write out the application for him. The officer said that he would find out if there were any other prisoners from his country with whom the man could share a cell. The man was also allowed a telephone call to his family to explain the prison's visiting procedure.

12. The man was seen by the reception nurse who completed the First Reception Health Screen form. 'No English' has been written on the top of the front sheet and a tick has been placed in the box marked 'convicted – not sentenced'. That was not correct as the man was on remand, prior to his trial and according to prisoners my investigators spoke to, the man could understand quite a lot of English and usually made himself understood.

13. The man indicated to the nurse that he had no physical or mental health problems, that he smoked, occasionally drank alcohol and did not use drugs. It was noted that he had no thoughts of self-harm and had not made any such attempts in the past.

14. A cell sharing risk assessment form was completed. Because of the offences the man was charged with, he was classified as a medium risk by the assessment officer. That meant that he was viewed as being of no immediate risk to others, but the situation would need to be reviewed regularly. The reception nurse classified him as a low risk on section three of the form and again indicated that no self-harm concerns had been raised. The same nurse completed the 'General Health Assessment' form the following day, and again no health issues were identified.

15. The man was located in a cell in the first night centre until 19 December, when he moved onto B wing. It was noted in his F2052A that he was happy to be sharing with a prisoner from his country.

16. On 9 January 2006, with the help of the landing staff, the man submitted a job application form and was quickly approved to be a landing cleaner. It was documented around that time, that he was polite and pleasant and complied with the prison regime.

17. On 26 January, as part of the man's normal progression through the prison, he was re-located to C wing, which is a remand wing. My

investigators interviewed the first wing officer who was in charge of the hotplate on C wing. The hotplate is the heated counter from where the prisoner's food is served. One of the jobs available on a wing for prisoners is to serve the meals from the hotplate and to clean it afterwards.

18. The first wing officer saw the man when he came onto the wing and noticed that he appeared upset. He and the second wing officer took the man into the office where he began to cry. When he was asked why he was upset, he replied that by moving to C wing he had lost his cleaning job. The officers calmed him down and arranged for him to work on the hotplate on the wing. The first wing officer said that when the man left the office he was happier and had stopped crying. The first wing officer was asked if he had considered opening an ACCT document because of the man's mood. He said that he did not then nor at any time since the man was happy working on the hotplate and the other prisoners liked him. He saw no discernable signs at that time or later that the man was at risk from self-harm. The officer said that although English was not the man's first language, he understood a lot and made himself understood.

19. The first wing officer asked a prisoner who also worked on the hotplate, to keep an eye on the man as he had been upset. As far as the staff were concerned, his mood improved and he appeared to be happy and a good worker.

20. On 2 February, a prisoner moved into the man's cell. After a couple of weeks he asked the man what he was in prison for. The man showed him a letter and pointed at the word 'murder'.

21. According to the prisoner in charge of the hotplate, sometime during the week before he died, the man was upset, saying that it was his first time in prison and that he was in for threats to kill, on remand. The prisoner in charge of the hotplate told him not to worry, adding that he'd get "six months tops" and that he had already done two.

22. On 16 February, the prisoner in charge of the hotplate said that the man came into his cell and showed him some papers indicating that he was charged with murder and drug offences. The man asked him what it meant. He was told not to worry and to speak to his solicitors. The man's cellmate said that on that Thursday or the next day, the man had told him that he would be getting out on Monday.

23. The prisoner in charge of the hotplate said that over the next few days the man was very upset, although this was not reported to staff, and the staff did not notice any change in his demeanour.

24. On Saturday, 18 February, the man did not go to work at lunchtime. His cellmate collected his food for him and he then stayed quietly in his cell for the afternoon. The prisoner in charge of the hotplate did not

make enquiries about why the man did not work that morning as he had more help than usual that day.

25. After the serving of the evening meal, the third wing officer asked the prisoner in charge of the hotplate whom he wanted to help clean the hotplate. He asked for the man and three other prisoners. The officer collected the man from his cell and noted that he was wearing his own clothes. He asked if he wanted to change into prison clothes to clean, but the man said it was ok. The officer now remembers the man as being different that evening, quieter than usual, but not upset in any way.

26. After the man returned to his cell, his cellmate says that he was standing by the cell window with a strip of torn green bed sheet about eight feet long. He had not seen it before and the man began to tie one end of it to the cell window. He asked what he was doing and the man replied, 'It's ok, it's ok, forget it'.

27. The man then wrote two letters, in his native language. He put one in a white envelope under his pillow and the other also in a white envelope; he placed in a plastic bag under the television.

28. The man then asked his cellmate if he wanted to play dominos. They played for nearly two hours. The man then rolled a number of cigarettes, about 10 which he placed on the table. The two men then watched football on the television and then the end of a film. Throughout, the man was smoking continuously, which was unusual. The cellmate commented on the fact, to which the man replied, 'I am smoking too much'.

29. They switched off the television at the end of the film and the main cell light. The cellmate could see by the toilet light which was on, that the man was walking around the cell and that he was crying. He said to him, 'what has happened, calm down, take it easy.' The man did not answer him, but sat on his bed and smoked another cigarette. The cellmate then fell asleep.

30. At about 6 am on Sunday 19 February, the Operational Support Grade (OSG) began her role check of the prisoners on C wing. As was her habit, she switched on the cell night lights to afford her a clear view of the prisoners in their cells. At 6.05 am, when she looked into Cell C1-75, she saw the body of a man facing towards her, hanging from the ceiling. She noted that there was no movement. The OSG closed the observation hatch and used her radio to call a 'code 1', which means that there is a serious incident, such as a hanging.

31. The senior officer (SO) who was the night orderly officer, and the duty officer ran to C wing, arriving very quickly after the call. The OSG told them that someone was hanging in the cell. The duty officer opened the cell door and saw the man hanging from the ceiling light fitting. He

had a noose around his neck made from green bed sheet. The officer also saw that the man's hands were tied behind his back and that his ankles were tied together, both with torn strips of bed sheet.

32. Both officers entered the cell and supported the man's weight by lifting his legs. The cellmate was woken by the commotion and looked up and said, 'Oh my God'. He untied the noose whilst the officers held the man. The officers carried the man out of the cell and laid him on the floor of the corridor.

33. The man's cellmate was taken out of the cell and placed in another cell with other prisoners.

34. The orderly officer asked the control room to contact the ambulance service and the police. He then checked for signs of life, but found none. He and one of the other officers, who had arrived, the fourth wing officer, began Cardio Pulmonary Resuscitation (CPR). The duty officer, unable to untie the knot securing the man's ankles together, fetched some scissors. By the time he returned, another officer had managed to undo the knot, but the duty officer used the scissors to cut the bed sheet securing the man's hands.

35. The healthcare officer, who had also arrived by this time, checked for a pulse, but found none. She put a Brookes airway into the man's mouth and then attached an 'ambubag' face mask over his mouth. The orderly officer continued chest compressions whilst the healthcare officer administered the oxygen.

36. The nurse notes in her statement that although they had no response to their CPR, the man was still very warm and so in her opinion he had not been hanging long.

37. The ambulance crew arrived at 6.12 am and placed a defibrillator on the man's chest and administered a shock. The ambulance crew continued to work on him before deciding at 6.42 am to take him to hospital. The man was pronounced dead at the hospital by the doctor at 7.05 am.

38. At 12.51 pm that afternoon, the police liaison officer (PLO), received the details of the man's next of kin from the officer in charge of the man's case. At 3.50 pm, the PLO, the prison Governor and the prison chaplain visited the man's partner to break the sad news of his death. The man had not supplied next of kin details to the prison.

39. The man's cellmate said that he was happy with the support and the way he had been treated since the man was found hanging in their cell.

40. My investigator spoke with the man's solicitor to clarify whether the man would have known on what charges he was remanded. The solicitor confirmed that all through the interviews at the police station

and later at court, the man was aware that he was accused of murder and other crimes. The documentation supplied from the court to the prison also makes this clear. I can not speculate as to why the man told fellow prisoners he was accused of a lesser crime until shortly before he died.

41. After the man's death, the cell was searched and the two letters were found. Both were written in his native language, one to his partner and the other to his solicitor. Both have been translated and they make it clear that the man intended to end his own life. He expressed the hope, that after his death, his innocence of the crimes of which he was accused will be proved.

42. Later that day, at 12.05 pm, the second prison officer answered a cell bell on C wing. The prisoner asked what was going on and when the officer answered, 'no comment', the prisoner claimed to have overheard the man's cellmate say, 'I'm going to hang him up and kill him'. This information was correctly recorded and later passed to the investigating police officers.

ISSUES

Understanding of English

43. Wormwood Scrubs is a busy local prison that holds a large number of foreign nationals. My investigators found that the Reception staff had literature and documentation in a multitude of languages, including that of the deceased man, to explain the various procedures new prisoners have to go through.

44. The clinical review panel noted that the Red Cross translation guide was used during the First Health Screen procedure for non-English speakers. They noted that the guide has not been validated as a medical assessment tool and recommended that greater use be made of other forms of translation available to the staff, such as language line or interpreters. I am aware that Haslar Detention Centre has the reception tool translated into a number of languages.

45. My investigators found that staff made efforts to try to locate another prisoner who spoke the same language, to help the man settle in. English was not the man's first language, but he appeared to have been able to communicate sufficiently to get his views across and to interact with staff and other prisoners.

Nature of charge

46. The clinical review panel and others have highlighted the man's apparent lack of understanding about the offences that he was accused of. As has been previously stated in the body of this report, his solicitor was confident that he knew the nature of the charges against him. During interviews at the police station and the court proceedings an interpreter would have been present to ensure his understanding. In addition the paperwork from the remanding court stated the offence of murder. It is clear from the letters that the man left, that he knew he was accused in connection with the death of someone.

Signs of distress

47. My investigators found the staff to be aware of their roles with regard to self-harm prevention. In the man's case, when staff on C wing saw that he was upset, they took him into the office and spoke to him. Having identified the apparent cause of his distress, they took steps to re-employ him, after which his mood seemed improved. None of the staff interviewed ever saw any signs that he intended to harm himself. Whilst some prisoners and his cellmate in particular, saw that he was upset and during his last evening, actually preparing the strip of bed sheet, they did not inform staff. This is not meant as a criticism of any particular person, but staff can only react if they are aware of a situation.

Response of staff

48. The officers and other staff who responded to the man's cell and administered CPR, acted properly and I believe made every effort to save his life. The clinical review panel note that no policy exists for resuscitation at Wormwood Scrubs. Such a policy is an NHS requirement. The review panel were informed that a policy is currently being drafted.

49. My investigators have spoken to the detective investigating this case on behalf of the Coroner. They asked specifically for his views with regards to the accusation made against the man's cellmate by another prisoner and the fact that the man's hands and feet were tied. The officer said that after conducting his investigation he had no doubts that no one else was involved in the man's death.

Recommendations

50. I have no recommendations specifically in relation to the death of this man. I would however commend the clinical review to the PCT, Governor and the Healthcare Manager which makes some recommendations intended to improve upon certain procedures.