

**Investigation into the circumstances surrounding the
death of a man, after being released from the custody of
HMP Wormwood Scrubs, on 26 August 2005**

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

October 2006

This is the report of an investigation into the death of a man. The man died on 26 August 2005, at the age of 27, in hospital. He had been a prisoner at HMP Wormwood Scrubs where he was found on 1 April 2005, hanging from furniture in his cell. On the first date he was a convicted prisoner at Wormwood Scrubs, awaiting transfer to an Immigration Removal Centre. By the time of his death, four months later, the Immigration Service had agreed that he should be temporarily released from custody.

I offer my sincere condolences to the man's family. This is a very difficult time for them, aggravated by the distance from London to their home in India.

Two investigators from my office conducted the investigation. A clinician who also works for my office chaired a review panel to assess the quality of clinical care given to the man. I regret the time this investigation report has taken to complete.

I am grateful for the assistance my colleagues received from the staff and management of Wormwood Scrubs. I also acknowledge the help of the West Hammersmith Police, who carried out their own enquiry into the man's death and shared their information with me. Unfortunately, due to their individual circumstances, I have been unable to interview three significant people: the man's cellmate, the officer who found him and the nurse responsible for responding to healthcare emergencies that day. The coroner may wish to consider calling the members of staff to answer questions at the inquest.

I am concerned by the apparent delay in response by healthcare staff. In contrast, family liaison in the aftermath of this tragedy has been handled particularly well.

Stephen Shaw CBE
Prisons and Probation Ombudsman

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SUMMARY

This is the report of an investigation into the death of a man. The man was aged 26 when he died on 26 August 2005 in hospital. Some four months earlier, on 1 April, he had been found hanging in his cell at HMP Wormwood Scrubs.

The man had been at Wormwood Scrubs since 24 January 2005. During the reception procedure, he told staff that he had pulmonary tuberculosis and he was referred to the doctor. He was admitted to the healthcare wing and, as a precautionary measure, was kept in isolation until it was confirmed that he was not contagious. The man did not like this arrangement and threatened to kill himself if it continued. Staff opened a F2052SH, which is a document designed to co-ordinate the care and observation of a prisoner who is vulnerable to suicide or self-harm. It was closed two days later, and there were no further visible signs that the man was vulnerable to suicide or self-harm.

Some 16 days after entering prison, the man moved to a residential wing where he appeared to fit in well. He shared a cell with another prisoner, also from the Punjab region of India. Staff remembers the man as likeable and cheeky, and remembered him singing and playing the guitar.

On the morning of 1 April, a member of staff found the man crying in his cell, and it appeared that he had split up with his girlfriend. The man gave the officer the impression that she had given evidence against him in court. The officer spoke with him for few minutes, and the man reassured him that he was alright. However, when the officer returned almost 90 minutes later, the man had hanged himself from cell furniture.

The man was resuscitated by the wing Principal Officer (PO) and taken by ambulance to hospital. Although he showed some signs of recovery during the months that followed, progress was very gradual. Sadly, on 26 August he died. The post mortem concluded that the cause of death was pneumonia, hypoxic brain injury and hanging.

This report focuses on the man's time in prison custody and evaluates the systems in place to establish whether they were (and are) fully effective. I make five recommendations and endorse the 18 recommendations of the clinical review panel.

THE INVESTIGATION PROCESS

1. The investigation into the man's death was conducted by two of my staff. They visited the prison and were shown the wing where the man was located.
2. The investigators issued notices to staff and prisoners, inviting anyone with information relating to the man's death to make themselves known. Given the transient population of Wormwood Scrubs and the five months that had elapsed since the events leading to his death, it is not surprising that nobody responded to the notice.
3. My investigators also spoke to the Chair of the Independent Monitoring Board (IMB), the Prison Officers' Association (POA), one of the prison chaplains, and various other members of staff, including the Safer Custody Manager. My investigators formally interviewed ten prison staff involved in the events surrounding the man's death. In addition my investigators informally spoke to a number of staff and prisoners. These conversations confirmed what my investigators were told formally.
4. The prison gave my investigators full access to all the documentation surrounding the man's time in prison. The police also provided copies of the documents and statements in their possession. My investigators obtained further information from the immigration and court services.
5. My investigators were able to communicate with the man's father and brother in India, using an interpreter. The family gave a little background information, and had no issues they wanted to raise. They decided that, due to the distance, they would not ask for a copy of my investigation report, and instead elected to concentrate on the future.
6. During the investigation it became apparent that the man's cell-mate should be interviewed. However, he was returned to India on 6 May. My investigators have not been able to contact him.
7. Another person whom my investigators were not able to interview was the hotel one emergency response on 1 April. (This meant that, if medical assistance was required, he should respond, assess the situation and begin any treatment, before deciding on the next course of action.) As hotel one's arrival was delayed and he arrived after other medical staff and the paramedics, the Governor commissioned an internal investigation. In the course of that investigation, the man detailed hotel one became ill and subsequently retired from the Prison Service. My investigators have not been able to interview him, but have had sight of the internal investigation report.
8. Additionally, my investigators were unable to speak to the officer who found the man hanging in his cell. He submitted a comprehensive statement to the police and I rely on that information, as he was on long term sick leave at the time of the investigation and has since been dismissed due to an unrelated disciplinary incident.

BACKGROUND

The man

9. The man was born in India on 3 November 1978, making him 26 years old when he died. He had no known dependants. Apart from a girlfriend, I am not certain whether he had other friends or family in the United Kingdom, but I have been able to establish that his father and younger brother live in the Punjab region of India.
10. According to his father and brother, the man left India between four and six years ago. This was against the wishes of the family. They parted on bad terms, as the man sold some of his family's land to fund his travel with the aim of earning a living in the UK. However, he sent no money back to his family as his father and brother had expected.
11. It is unclear to the family how long the man had been in the UK. His brother suspected that he may have visited other countries beforehand, and little is known about his stay. When he arrived at Wormwood Scrubs, he said that his home address was in Birmingham, although the court warrant had an address in Southall, and the police charge sheet had an address in Hayes. He said that had been employed as a builder or bricklayer.
12. On 3 December 2004, the man failed to surrender to the Magistrates' Court, having been bailed previously. On 21 January 2005, he was arrested and appeared before the Magistrates' Court three days later. He was further charged with failing to surrender himself from bail and was remanded in custody. The following day a warrant was issued, which confirmed that he was to be detained, because he admitted that he was an illegal immigrant. When interviewed by Immigration Officers, the man said that he left India in or around 2001, and travelled to France where he worked as a builder for about two years. In about December 2003, he arrived in the UK without a passport and knowingly avoided detection by Immigration Officers.

HMP Wormwood Scrubs

13. HMP Wormwood Scrubs is a large Victorian prison in West London. It has a maximum population of 1,229 prisoners. 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, 1,154 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.
14. Prisoners are held in a mixture of single and double cells. A typical cell contains either a single or bunk bed and a sink and toilet. Additionally, there is one freestanding locker and chair for each prisoner.
15. The overall establishment rating at the time was three (four being the highest and one the lowest). The prison is now rated as four. This rating is

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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 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%.

16. Following the previous 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, the Chief Inspector 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.

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17. Recommendations were made for further improvements:

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- there should be at least one appropriately decorated and furnished Listener suite capable of accommodating a prisoner and two Listeners overnight;
- work to create five safer cells should be completed;
- the range of support mechanisms and specialist services available to those who are at risk of self-harm or suicide should be expanded;
- the rank and workload of the Safer Custody Officer should be reviewed;
- 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.

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18. My investigators found that 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 has been issued with their own booklet outlining the signs and procedures to follow when dealing with prisoners who are at risk of harming themselves.

Healthcare Centre

19. The healthcare centre is located on two floors (H2 and H3). The out-patient and day centre are located on H2. The in-patient unit is located on H3 and has 17 beds, 12 of which are single cells. H3 includes a gymnasium and relaxation room.
20. Healthcare provision includes 24-hour doctor and psychiatrist, a dentist, hepatitis clinic, pharmacy, visiting surgeon (minor surgery only), GP surgeries and nurse triage. More serious conditions are referred to the local hospital.

21. For emergencies, the prison operates a medical code system. If emergency medical assistance is required, then the detailed hotel one call-sign responds, assesses the situation and commences any treatment, before deciding on the next course of action. Hotel one is available 24-hours a day and is contactable from the communications room via the UHF radio. On 1 April 2005, this was a hospital officer who was employed by the prison and had been a hospital officer since 1992.

F2052SH – Self-Harm at Risk Form

22. Prison Service suicide and self-harm procedures are set out in Prison Service Order (PSO) 2700. At the time of the man's death, Wormwood Scrubs operated the F2052SH system, which has since been replaced by ACCT (Assessment, Care in Custody and Teamwork). The F2052SH is used when a prisoner is identified as being vulnerable to self-harm or suicide. The aim of the system is to enable staff from all disciplines to work together to create a safe and caring environment, where distress is minimised and those prisoners who are distressed feel they are able to ask for help. It should identify individual need and offer individualised care and support before, during and after crisis.
23. Staff are taught to recognise the signals that a prisoner who is in distress may display. When a member of staff is concerned they open an F2052SH document which triggers a care planning process. The prisoner is encouraged to talk about their problems, which staff attempt to diminish using a care plan, combined with extra support and possibly observation.
24. In relation to the processing of an F2052SH, the Order says that when an F2052SH is opened, the manager of the unit where the prisoner resides must:
- decide, in consultation with healthcare staff, whether to manage the prisoner on the residential unit or refer initially to the Healthcare Centre (HCC), and document reasons;
 - ensure that, where available, prisoners on an open F2052SH have been offered the opportunity to talk to a Listener and/or Samaritan;
 - ensure a case review is held within 72 hours, and document a summary of the review and agreed support plan.
25. A support plan must be drawn up and agreed. Multi-disciplinary case reviews must be held as necessary, including in the event of a further act of self-harm. The F2052SH should be closed following a case review and when the prisoner appears to be coping satisfactorily. The case review will agree after-care or follow-up requirements.

Follow-up to deaths in custody

26. PSO 2710 gives instructions on action to be taken following a death in custody, including the support arrangements for staff and prisoners. The order says that priority must be given to communicating the facts about the death to prisoners and staff. It says it may be useful to issue a written statement to prisoners to defuse rumour and myth, but that this will depend on local judgement. Any prisoner who may have been particularly affected by the death should be offered support.
27. A record should be kept of all those entering where the prisoner died. There should be an immediate post-incident debrief (a 'hot debrief') of staff involved before they go off duty. A senior member of staff should act as a de-briefer and a duty care team member identified and, if necessary, called in on duty. (PSO 2710, Chapter 5.)

KEY EVENTS

24 January 2005 to 31 March 2005

28. On 24 January 2005, the man appeared before Magistrates' Court. At 3:03pm, the Magistrates remanded the man in custody until 24 February, when he would appear before the court via video link. The Prisoner Escort Record was completed by the police and there were no known issues or warnings that the receiving agencies needed to be aware of. He arrived at Wormwood Scrubs at 6:50pm. On arrival, he told staff that he had been living in Birmingham. He did not name anybody as his next of kin.
29. The man was given a healthcare assessment in reception where he said that he had no mental health concerns; he had never deliberately harmed himself or attempted suicide, and had never used illegal drugs. No history of asthma, epilepsy, diabetes, chest pain, sickle cell disease, or allergies was identified. He told prison staff that he was on medication for pulmonary tuberculosis (TB) and was referred to the doctor. However, the man appeared not to remember when his next follow-up appointment was, or what medication he was currently taking. The screening noted no other concerns regarding his physical health. No details were taken of his doctor or consultant, and no health information was requested from outside sources. He was admitted to the prison healthcare, and placed in isolation as a precaution.
30. Initially, the man appeared distressed and upset being held in isolation. the man told staff that he had already spent a long time in isolation in Ealing Hospital, where he said he had completed two months of a six month course of treatment (although this was not verified), and also whilst in police custody. He felt he was cured and did not need medication or to be isolated. Records show that the staff did their best to reassure him and treat him sensitively.
31. On 25 January, the man said that he would kill himself and a F2052SH was opened. Prison staff spoke at length with the man, explaining why he was being isolated and questioning the reasons why he threatened suicide. The F2052SH was closed following a case review on 27 January in which the man reassured staff that he had no suicidal or self harm intentions. The case was reviewed by three nurses and an appropriate support plan was developed.
32. On 10 February, the medical team were content that the man's TB was not infectious and allowed him to move from healthcare to A wing, from where he later moved to E wing.
33. The man was assaulted by another prisoner on 12 February. He was examined by the prison doctor and, due to an eye injury, was immediately referred to a specialist eye hospital. The man returned from hospital after treatment and was issued with his medication.
34. On 30 March, the man was sentenced to three months imprisonment by the Magistrates' Court. Because of the time spent on remand, this effectively meant that he had served his sentence. However, as he was identified as an

immigration offender, he remained in prison, pending transfer to an Immigration Removal Centre.

35. The man did not show any signs of depression or suicidal tendencies during the time between the F2052SH being closed on 27 January and 1 April. Apart from the assault he suffered and his sentencing, there are no incidents of note for this period.
36. The wing Senior Officer (SO) knew the man reasonably well, as she had seen him on the wing for about six weeks. The wing SO told my investigators that the man was a quiet prisoner, whom she remembered as cheeky and who sang and played the guitar. She said that he stood out because of his nature. The wing SO said that, although the man's English was not perfect, he could hold a lengthy conversation without much difficulty. She knew of prisoners on the wing who were willing and able to interpret for him, but they were not needed. However, my investigators have been unable to say with certainty how much the man could read or write in English.
37. The wing SO partially recalled a conversation she had with the man, which she thought was on 31 March after he had been to court. He left her with the impression that there was an issue with his girlfriend and his court appearance. The wing SO was unsure whether his girlfriend had given evidence against him, or had attended court with somebody else who had given evidence against him. The wing SO did not think that the issue made the man vulnerable to suicide or self-harm.

1 April 2005

38. On 1 April, at about 8:30am, those prisoners allocated for work or activities left E-wing. Those who did not need to leave the wing were locked in their cells until about 10:00am, when they were unlocked for wing based association. An officer was detailed to work on the second landing (E2) where the man was located in cell seven, with another prisoner.
39. Having unlocked the landing, and assisted the supervision of prisoners leaving the wing, the E2 landing officer returned to lock the man's cell at about 8:45am. The cell mate had gone to work, and so the man was on his own. He was facing away from the door, hunched over his guitar as if he had just been playing it. When he turned to speak to the E2 landing officer, the man appeared upset as if he had been crying. The man was reluctant to talk, but when persuaded to, he opened up and said that he was missing his girlfriend whom he no longer saw. He said that she was at court, and he thought that she had given evidence against him. They spoke together for a few minutes, but when the E2 landing officer offered to arrange for him to speak to someone else, the man insisted that he was alright and so the E2 landing officer continued with his other duties.
40. At 9:30am, there was a staff briefing meeting for 20 minutes. At the meeting, the E2 landing officer told his colleagues about the conversation with the man so that they could all keep an eye on him. The E2 landing officer recorded the

conversation in the observation book, and agreed to check on the man throughout the morning. About ten minutes later, after the record was completed, the announcement to unlock the cells was given.

41. It was during the unlocking routine that the E2 landing officer discovered the man hanging by a ligature made from a torn prison bed sheet. The ligature was tied to a metal chair, which bridged the gap between two columns, each made from two wooden cell lockers placed on top of each other. Officer Tinubu immediately raised the alarm by shouting and pressing the alarm bell. This was timed by the Communications Room at 10:14am. The alarm bell alerted the Duty Governor, the Orderly Officer and the Emergency Medical Response to attend the E2 landing. All three members of staff used their radios to acknowledge the request.
42. Upon hearing an alarm bell, hotel one should collect the emergency response bag from the wing, and immediately attend the scene. The response bag contains oxygen, airways, sphygmomanometer, dressings, gloves, face mask. The healthcare emergency response bag contains the same, and also a pulse oximeter. There is also a separate defibrillator bag in healthcare.
43. The orderly officer responded quickly from C wing which is 20 to 30 yards away. Shortly after arriving, he used his radio to tell the Communications Room that the alarm bell was a Code One, which meant that a prisoner was hanging. His message was timed by the Communications Room at 10:16am, and one minute later the Communications Room telephoned 999 to ask for an ambulance.
44. The E2 landing officer and an officer that responded first went into the cell, where the E2 landing officer supported the man's weight and they untied the ligature. Due to lack of space in the cell, which was made more restricted by excess furniture, the man was carried outside and placed on the landing. Principal Officer (PO) and SO were in a meeting on E wing when they heard the emergency call and responded immediately. They arrived at the cell whilst the officers were still supporting the man, and assisted removing the ligature and taking him on to the landing.
45. At this point those prisoners who had been unlocked for association were returned to their cells. When the prisoners were let out for association later that day, Listeners were made available on the wing for prisoners affected by the man's actions. (Listeners are prisoners trained by the Samaritans, to listen and support prisoners who need to talk.)
46. Once outside the cell, the wing PO checked the man's vital signs. He could not detect a pulse or breathing, and so began to administer cardio pulmonary resuscitation (CPR). The wing SO was concerned that neither hotel one nor other healthcare staff had arrived, and so made a further call on her radio to repeat the request for emergency medical assistance. Everybody at the scene expected that hotel one should have arrived to provide medical assistance by this stage. The wing SO repeated her request a number of times. The security SO responded and assessed the situation. He is not a

member of Healthcare, but helpfully decided to go to healthcare to search for a doctor.

47. Enroute, the security SO a nurse and doctor, who had been on B wing and heard the radio messages. They had decided to attend, even though neither was hotel one. They arrived between five and ten minutes after resuscitation had commenced. The nurse assisted the wing PO with CPR, whilst the doctor checked the man's vital signs and was able to detect a faint pulse using a stethoscope and a defibrillator. The defibrillator indicated that they should continue CPR.
48. At 10:23am, a paramedic car arrived at the prison and was shown directly to the cell, arriving at 10:30am. CPR continued until the paramedics arrived and took over. An ambulance arrived at 10:27am, and the air ambulance crew arrived shortly afterwards at 10:45am, having landed on Scrubs Common, and were taken directly to the man. At 11:00am, the man left the wing and at 11:02am another paramedic car arrived. At 11:14am, the man left the prison and was taken to hospital. At 4:45pm, the man was moved to the Intensive Care Unit at another hospital.
49. Hotel one had arrived on the wing by the time the man was removed. It is not known when he arrived, but it is clear that he played no part in administering CPR, and he did not bring the emergency response bag.
50. The security SO recalls a note being attached to the man's watch. He vaguely remembers the note said how sorry the man was for what he had done. However, this note cannot be found. The police do not have it and the prison are unable to locate it or remember what happened to it.
51. The cell door was secured with a security lock, and the cell was treated as a potential crime scene until the police arrived. The staff who administered CPR submitted comprehensive statements to the Governor, providing a detailed account of the discovery and management of what had occurred. Hotel one did not make a statement. Other paperwork was completed subsequently to record events in accordance with the local contingency plans for a death in custody.
52. That day, a governor contacted the Immigration Service, to explain what had happened and that the prison had been holding the man in custody pending his transfer to a Removal Centre. The Immigration Service agreed to temporarily release the man from custody, with the expectation that he should report to them on 2 May, by which time it was hoped that he would be fit. At that point, the prison withdrew the escort staff, and left the man in the care of the hospital staff.
53. A PO was appointed as the prison's Family Liaison Officer (FLO). I spoke with him on several occasions personally in the aftermath of the events of 1 April. From 1 April onwards, the PLO made considerable efforts to trace a member of the man's family.

2 April 2005 to 26 August 2005

54. A consultant at the hospital judged that the man's prognosis was bleak as, although he was breathing unassisted, there was no brain activity. Because the man was no longer a convicted prisoner, he was not accompanied by bedwatch officers and no physical restraints were in place.
55. At 9:30am on 4 April, the Governor chaired a 'debrief' for staff. It appears that all staff involved were able to attend and discuss what had occurred. The Staff Care team was made available to staff, and Listeners were made available to any prisoner affected by the man's attempted suicide.
56. By 11 April, the man was stable and had shown some signs of improvement. On 13 April, he had shown a further slight improvement, and his condition was reported as stable.
57. On 20 April, the prison was able to speak to the man's father and brother in India. The man's brother told the FLO that he had last heard from the man about a month earlier. The man said that he had intended to marry his girlfriend, but her father had accused him of doing wrong, and threatened to kill him after he was deported to India. The FLO told my investigators that he considered that this was a realistic threat.
58. During May and June, there was a little improvement in the man's condition. By the end of June, he was more alert and was receiving physiotherapy, but was still unable to talk. The man could not eat or drink and had no control over his bladder and bowels. However, he did not require specific medical care. The hospital was looking to move him to a place where he could receive 24 hour residential care.
59. On 3 August, the man was transferred to another hospital and on 15 August he returned to the original hospital. His condition had not changed and remained stable and he was due to move to a rehabilitation unit. However, the man died on 26 August.
60. There was no formal announcement at the prison and staff learnt of the man's death principally by word of mouth.
61. The post mortem concluded that the man died from:
 - 1a. Pneumonia,
 - 1b. Hypoxic Brain Injury and
 - 1c. Hanging.
62. The post mortem showed that there were no defensive marks or evidence that a third party had been involved in the man's death. The police investigation confirmed that there are no third parties involved and that there are no criminal issues.

FINDINGS AND CONCLUSIONS

Emergency Response

63. Much of this section of the report is based on information gathered in the course of the prison's internal investigation into the delayed arrival of hotel one, the emergency healthcare officer.
64. The first officer to arrive at the man's cell was who was not carrying a radio and so raised the alarm by shouting and pressing the alarm bell. Shortly after he arrived, the orderly officer used his radio to inform the Communications Room that there was a Code 1 emergency. The radio call was timed as two minutes after the first call, and it was this which informed other staff of the nature of the emergency and the response which was required.

The Governor should ensure that the issue of radios is reviewed, to satisfy himself that all those who might require one for an emergency are issued with and carry them.

65. The ligature was made from a prison bed sheet, which is the most common means of suspension in prison. On this occasion, the ligature was easily slipped off and removed. However, had it not been so easy to remove by hand, it would have taken precious time for staff to leave the cell to collect the special cut-down scissors from the office. It would be better and safer for staff working with prisoners to be issued with a pair of cut-down scissors, or a fish-knife, which are specifically designed for the purpose of cutting ligatures. I note that the Prison Service is shortly to issue a mandatory instruction requiring staff to carry such equipment. I commend this initiative following previous recommendations from my investigations.
66. The staff who attended the man's cell said that an inordinately long time passed before hotel one arrived. The communications log does not state the time that any healthcare staff arrived. It also makes no reference to requests for medical assistance after 10:17am, although almost all the staff at the scene referred to the wing SO's repeated requests for medical assistance. The record of the debrief shows that there was a lot of criticism directed at healthcare for not arriving earlier. One member of staff said that it took eleven and a half minutes for healthcare to arrive.
67. On his Incident Report Form, one of the SO's who responded said that it took healthcare "some ten minutes" to respond to the incident, but hotel one estimates that it took him four to five minutes to arrive. The wing SO does not remember which member of healthcare staff arrived first, but remembers thinking that the Nurse was hotel one, rather than the man who was. Given the passage of time and poor record keeping it is impossible to be exact about how long it took any healthcare staff, and particularly hotel one, to arrive at the man's cell. The internal investigation judges that it took around ten minutes for hotel one to arrive.

68. The investigation found contradictory evidence about what hotel one was doing when the original alarm bell went off. During the internal interview with hotel one, he said that he was on the third landing of healthcare and then walked briskly over to E-wing. When the internal investigator completed the walk, it took her exactly three minutes. At the debrief, hotel one said that when he originally heard the alarm bell he thought it was for information only, and that at the time he was on his way from visits to healthcare. Although this is not mentioned in the debrief minutes, all the staff questioned by thought that hotel one had been escorting prisoners back from visits to healthcare when he first heard the alarm bell.
69. The Head of Healthcare said that there are no written down procedures to detail the roles and responsibilities of hotel one. She believed that it was common sense that hotel one should not escort prisoners, as they are supposed to be available to provide an immediate response to a healthcare emergency.
70. The Head of Healthcare also said that she was concerned about the competency of hospital officers to perform the role of hotel one, as they do not have the same level of ongoing training as nursing staff. The Head of Healthcare said that hotel one trained to be a hospital officer in 1992, since when he had received no additional healthcare training, apart from annual resuscitation training. Hotel one told said that, when he arrived at the man's cell, he did not take over administering CPR as he knew that the wing PO was a physical education instructor and would have received better resuscitation training than his own.
71. Once the alarm was raised, the response was immediate and the wing PO began to administering emergency aid within minutes of the man being found. The clinical review and some staff during interview questioned the fact that the wing PO commenced CPR on his own. Guidelines say that it is acceptable for one person to administer CPR for up to 15 minutes. In this case, the wing PO did so for ten minutes, before being joined by a nurse. It is to his credit that the man was revived and lived a further five months. If the wing PO had not acted as he did, I am sure that the man would have died on 1 April.
72. I too judge that hotel one took an unacceptably long time to reach the cell. When asked by my investigators, the security SO was quite clear that hotel one was not on E2 landing when the paramedics arrived at 10:30am, which is 16 minutes after the alarm was first raised. I think that the internal investigation's conclusions may be too generous, and it is just as likely that hotel one took over 20 minutes to arrive. When he did arrive, he did not participate in the attempts to resuscitate the man, and neither did he bring the emergency response bag with him. Nobody else considered it necessary to collect the emergency bag, as they assumed that hotel one was on the way with the emergency bag.
73. In other circumstances, I would have recommended a Prison Service disciplinary investigation into the actions of hotel one. However, as he has

since retired, I restrict my recommendation to the need for clarification of the role and responsibilities of hotel one.

There must be clearly written and published guidance and procedures for staff acting as hotel one. These should state that emergency response staff must not be used to escort prisoners or undertake any other duty which would prevent them from responding immediately to an alarm bell or medical emergency.

Suicide Awareness

74. Wormwood Scrubs prison's local "Suicide Prevention Strategy" is a comprehensive policy document, which is consistent with national policy. In this case, a F2052SH document was properly opened when the man threatened to kill himself if he remained in isolation. The document was appropriately closed two days later, after staff had observed him and the man had reflected on his situation. This review was correctly managed. I do not link the decision to close the F2052SH on 27 January with the man's decision to hang himself three months later. On 1 April, when the man was distressed, the E2 landing officer spoke to him, offered further assistance, told his colleagues and agreed to go back to see him. Sadly, these good intentions were insufficient, as within two hours the man had piled the furniture in the cell on top of each other and hanged himself.

Cell Furniture

75. The man used four cell lockers to build two columns to support a metal chair wedged against the ceiling, which he used as the ligature point. The cell was a double cell, and therefore should have been furnished with two lockers. However, over time the occupants of the cell had managed to acquire two further lockers. The excess furniture should have been removed by staff during routine cell checks. As well as providing a ligature point (although I acknowledge this was not the only one available), the surplus furniture hindered the staff responding to the emergency.

The Governor should ensure that the routine fabric checks include consideration of the amount of furniture in a cell, with excesses being removed.

Medical Care

76. The clinical review panel concludes that, during the man's time at Wormwood Scrubs, the healthcare team did their best to treat him for TB and to care for him sensitively. Their apparent lack of understanding regarding TB treatment might have resulted in them being over cautious, but certainly did not adversely affect the final outcome. It was necessary to refer the man to outside hospital twice, and this was organised straightaway.

Events following the man's suicide attempt and death

77. PSO 2710 requires that the hot debrief involves staff only involved in the incident itself. This happened and it appears that all staff involved were able to contribute.
78. Staff at the prison played an important role in resuscitating the man and many followed his progress and were saddened by his later death. I feel that given this investment from staff, the Governor should review the manner in which news of this nature is communicated to staff.
79. The note that the security SO remembers being attached to the man's watch cannot be found. It seems likely this was an important piece of evidence and should have been preserved.

The Governor, in partnership with the police liaison officer, should review procedures for the preservation of evidence.

80. The reports submitted to the Governor by staff involved contained detailed accounts. This was particularly helpful to my investigators when they tried to piece together the sequence of events, and prevented some staff being formally interviewed needlessly. Hotel one played no active part in the resuscitation and he did not submit a report.

The Governor should remind staff that, if they attend an incident, they must submit an incident report.

Contact with the man's family

81. The FLO made a determined and ultimately successful search for the man's father and brother in India. After 20 days, the news of the man's attempted suicide and his condition was passed to his family. The FLO provided periodic updates, and broke the sad news of the man's death to his family. This appears to have been handled compassionately, sensitively and appropriately.

Assessment

82. The man appears to have been cared for appropriately, and seemed to be coping adequately. He was in a double cell, with a prisoner from the same part of India. Although he could hold a conversation in English, staff also knew prisoners on the wing who could translate for him.
83. The man's brother told the FLO that the man believed his life was in danger, from the parents of his girlfriend, when he returned to India. It seems likely that when the man appeared in court on 30 March, he knew that the sentence of three months meant that deportation would follow in due course. If he genuinely believed the threat made by his girlfriend's parents, it may help explain his actions two days later. Although he had previously threatened self-harm, I have identified no other trigger factors.

RECOMMENDATIONS

- 1. The Governor should ensure that the issue of radios is reviewed, to satisfy himself that all those who might require one for an emergency are issued with and carry them.**
- 2. There must be clearly written and published guidance and procedures for staff acting as hotel one. These should state that emergency response staff must not be used to escort prisoners or undertake any other duty which would prevent them from responding immediately to an alarm bell or medical emergency.**
- 3. The Governor should ensure that the routine fabric checks include consideration of the amount of furniture in a cell, with excesses being removed.**
- 4. The Governor, in partnership with the police liaison officer, should review procedures for the preservation of evidence.**
- 5. The Governor should remind staff that, if they attend an incident, they must submit an incident report.**

SUMMARY OF CLINICAL REVIEW RECOMMENDATIONS

First Reception Health Screen

1. A general comments section added to the reception screen form would enable the reception nurse to communicate important information and/or the reasons for the form being incomplete, e.g. language difficulties – interpreter required.

Documentation

2. Review policy and implementation of standards for record keeping.
3. Healthcare staff should be reminded about the importance of thorough documentation and record keeping. Following entries in the clinical records, staff should be reminded to sign, print their name and designation. It would be good practice to enter the date and time also.
4. The policy for completion of incident forms should be revised and communicated to all staff.

Past Medical History

5. Hospital/GP records should be requested as a matter of course for prisoners with a custodial sentence of more than a few months and always for prisoners with a past medical history which necessitates continuation of care/treatment.

Care provision for TB sufferers - National

6. A national policy for the treatment of prisoners suffering from TB should be established. This should include access to:
 - the patient's named case manager
 - the Consultant in Communicable Disease Control
 - access to the London TB register, which is available on the NHS website for prison healthcare staff
 - TB nurse at Pentonville Prison to share information.

Update training

7. All prison staff should be up-dated in CPR in line with Resuscitation Council UK guidelines to ensure that all attending members are competent to administer effective CPR to patients.
8. CPR and First Aid at Work Course content to be reviewed to ensure that it includes specific information about events which may occur in the prison environment.

Communication

9. Improve levels of communication within the multidisciplinary team to ensure that a continuity of prescribed care is delivered.

Care provision for TB Sufferers - Local

10. A clear written local policy and procedure for the treatment of patients with TB should be developed and used in conjunction with the national policy suggested above. Training should be targeted across all professional groups.

Duty of Care

11. Healthcare workers should be reminded of their duty of care to their patients and their responsibility to provide safe and competent care. Healthcare workers should be reminded that attention to detail/ cross referencing records when receiving information and prescribing medication/care is vital.

Emergency response

12. Revision of policy regarding hotel one response (e.g. should the emergency bag always be collected and taken to the incident by hotel one). The staff member acting as hotel one should be capable of administering first aid treatment.

Provision of equipment

13. The cost of supplying pocket masks should be re-visited and every attempt made to ensure that all staff at least have access to one should they require it.

Staff debrief

14. The debrief policy should be revised to ensure that debriefs are co-ordinated by the duty governor with staff support and welfare and chaplaincy being involved where required. A written account of debriefs should be made either at the time or as soon as possible following it.

Identified good practice

The Action/Plan part of the Care Plan completed on 25 January 2005 demonstrates a holistic approach to nursing care and is an example of good practice.

The recommendations within this clinical review are made in order to facilitate best practice and improvement in overall care for prisoners and patients.