Investigation into the death of a man whilst in the custody of HMP Wormwood Scrubs in December 2010

Report by the Prisons and Probation Ombudsman for England and Wales

September 2012

This report considers the circumstances surrounding the death of a man at HMP Wormwood Scrubs in December 2010. The man was found hanging in his cell in the prison's segregation unit shortly after 2.30am. He was on remand and had been at Wormwood Scrubs since 30 October, and in the segregation unit from the evening of 1 December.

I offer my sincere condolences to his family and all those who knew him. I am sorry that my report has been delayed and regret the additional distress which this may have caused.

The investigation was conducted on my behalf by a senior investigator. The governing Governor of Wormwood Scrubs and his staff co-operated fully with the investigation. A review of the man's clinical care was provided by clinical reviewer on behalf of Hammersmith and Fulham Primary Care Trust.

The man was arrested in October 2010, and remanded into custody at Wormwood Scrubs after a court appearance two days later. He was not considered a risk of harm to himself when he arrived. In November, he received two warnings about his behaviour, and on 1 December, he was taken to the segregation unit under restraint after it was alleged that he attempted to assault a prison officer. He told two members of prison staff that his brother had recently taken his own life, and mentioned the same issue during a telephone call to his partner. He died overnight on 2/3 December.

Concerns about whether the member of staff responsible for the segregation unit performed his duties properly were addressed as part of a separate police investigation. However, reference is also made to these matters in this report. The investigation also considers the quality of information provided to the prison when the man arrived, the control and restraint used on 1 December, his time in the segregation unit, the response to some distressing news that he received, the events during the night of his death, and the emergency response. I have also considered medical matters raised by the clinical review, and issues raised by his family. Ten recommendations are made related to these areas in the expectation that this will assist the prison to improve its practice in future.

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.

Nigel Newcomen CBE
Prisons and Probation Ombudsman **September 2012**

CONTENTS

Summary

The investigation process

HMP Wormwood Scrubs

Key events

Issues

Conclusion

Recommendations

SUMMARY

1. The man was arrested late in the evening in October 2010. He arrived at Harrow Police Station shortly before midnight. He remained in a police cell until 30 October, when he appeared in court. Whilst in the court cells, he said he was going to kill himself, and a decision was made that he should be monitored every five minutes. The information was recorded in his escort record, though not prominently.

2. After his court appearance, the man was remanded to HMP Wormwood Scrubs. Various reception procedures and checks were carried out, including an initial health screening and a cell sharing risk assessment (CSRA). No immediate risks were identified. The man saw a doctor on the same evening regarding his ongoing medication, which included fluoxetine for depression. The next day, he saw a nurse for a secondary health screening. On 1 November, the man moved from the first night centre to the induction unit.

3. On 7 November, the man refused to collect his medication because he wanted to leave the treatment room with it, rather than take it in the presence of the nurse. It is unclear if this was an ongoing problem. Twelve days later, he suffered a cut above his right eyebrow, and said he had lost consciousness whilst exercising in his cell. The injury was treated with stitches, and the man did not require admission to the inpatient unit.

4. The man was issued with behaviour warnings on 23 and 26 November. The first warning related to him being abusive to a prison officer. The second was about the misuse of his cell alarm bell. Also on 26 November, he appeared in court. The case was adjourned and he returned to Wormwood Scrubs.

5. On 30 November, the man made a telephone call to his partner and tried to confirm information he had heard on the unit that his brother had taken his own life. His partner clearly knew what he was talking about, but had not heard of his death. The man had, some days earlier, spoken to someone by telephone, though it is not clear if he was referring to the same person.

6. On the same day, the man spoke to a member from the prison chaplaincy, and told him the news he had received about his brother. He said he did not have any credit for the telephone and so had not been able to speak to family members about the news. The member from the prison chaplaincy did not record the content of the conversation in the chaplaincy journal and there is no evidence to suggest that he made other members of staff aware of the issue.

7. The man allegedly attempted to assault a prison officer in the early evening of 1 December. He was restrained and taken to the segregation unit. He told the visiting doctor that he had a headache and was given paracetamol for pain relief. Although he was upset about being restrained and removed from his wing, there were no major concerns about him during the overnight period.

8. On 2 December, a different doctor saw the man. She said that he complained of aches and pains from the restraint techniques that had been used on him the previous day. Ibupofen was prescribed for pain relief. The man also told

the doctor that he had trouble sleeping because he had learned of the recent death of his brother. The doctor prescribed sleeping tablets and made a note of his comments in the clinical record. She did not explore the matter further with the man, and she did not make other members of staff aware of the issue.

9. During the afternoon of 2 December, the man attempted to place three telephone calls but was not successful. Later in the afternoon, he was issued with paperwork for adjudication after his alleged breach of the prison rules (the attempted assault of an officer). His case was to be heard the next morning.

10. The man was not checked as often during the overnight period as the segregation unit occurrence sheet suggested. He used his cell alarm on a number of occasions, and it was not always answered promptly. On the final occasion, his alarm was active from 11.54pm and he was not checked until 2.37am on the day he was found. At this point, he was seen in the cell with a ligature around his neck, and the alarm was raised.

11. The response from other prison officers, nurses and paramedics was swift. When the cell was opened, a continuous and lengthy resuscitation effort began. This was, however, ultimately unsuccessful, and the man's death was pronounced at 3.20am.

12. We have investigated the quality of information arriving at the prison, the control and restraint used on 1 December, the man's time in the segregation unit, the distressing news that he received, the events during the night of his death, and the emergency response. We have also considered medical matters raised by the clinical reviewer, and issued raised by the man's family. There are ten recommendations about these matters.

THE INVESTIGATION PROCESS

13. One of my senior investigators was appointed to conduct the investigation. Notices of the investigation were sent to the prison for distribution and display, giving staff and prisoners the opportunity to contact the investigator with any relevant information. One prisoner contacted the investigator to ask about the Ombudsman's independence and the scope of the investigation.

14. The investigator visited HMP Wormwood Scrubs to open the investigation on 6 December 2010. He met the prison's liaison officer, and the head of safer prisons. In addition, the investigator met a number of prison officers working on different residential units, as well as members of healthcare staff.

15. During the opening visit, the investigator visited D wing and the segregation unit, the two places were the man had spent most of his time whilst at the prison. He also collected copies of documents relating to the man's time in custody.

16. In addition to the documents collected at the opening visit, the investigator was later provided with a copy and transcript of the closed circuit television (CCTV) footage from the night of 2/3 December. He did not watch the entire seven hours of footage in its entirety, but viewed the emergency response and satisfied himself that the transcript provided an accurate record of the footage. There was no CCTV coverage of the control and restraint incident from 1 December. He was also provided with transcripts of the telephone calls that the man had made whilst at Wormwood Scrubs.

17. The investigator checked the PPO case management system to try and corroborate the man's account that his brother had taken his own life in a prison in the North of England. There were no matching records for any prison in England and Wales.

18. The investigator liaised with Detective Sergeant (DS) from the Metropolitan Police with regard to a concurrent criminal investigation regarding the conduct of a member of the prison's staff. The DS kept him informed of his investigation.

19. The investigator contacted Her Majesty's Coroner for West London, to inform her of the investigation and to request a copy of the post-mortem report. This document was provided to the investigator in May 2011.

20. As part of the investigation, the investigator interviewed 15 members of staff working at Wormwood Scrubs. The interviews were recorded and transcripts are included as annexes to this report.

21. Following the man's death, the officer who was responsible for patrolling the segregation unit was suspended from duty, and a police investigation into his actions was opened. It was therefore not possible to interview him as part of this investigation. Information about his actions on the night of the man's death has been obtained from the CCTV footage.

22. In addition to the formal interviews, the investigator wrote to the members of staff who had been working on the segregation unit on 1 and 2 December, and asked them to recall any specific interactions that they had with the man. The responses, where appropriate, are included within my report.

23. One of the Ombudsman's family liaison officers (FLOs) contacted three different branches of the man's family to explain the purpose of the investigation and provide them with an opportunity to raise any questions about the care that the man received in prison. The Ombudsman's family liaison officer and the investigator subsequently met with the man's mother and her ex-partner, and their legal representative. A number of questions and concerns were raised during this meeting, and they are summarised as follows:

- The member of staff responsible for the segregation unit on the night of the man's death might have important information about the circumstances, information that was not available to anybody else. The family members were keen for the person to be interviewed as part of the investigation.
- The staff member on the segregation unit had held a long conversation with another prisoner on the same night. The family members wanted to know if this had been about the man.
- The man's family members asked whether the member of staff working on the segregation unit on the night of the man's death was known to have any history with him, or had previously had issues with him.
- The failure to pass on information was of concern to the family members. They made specific reference to the man's conversations with members of staff about his brother having killed himself.
- The man's family members were concerned about his transfer to the segregation unit, the reasons for it, and the methods of restraining him. They were also worried that he man had been the victim of bullying and had engineered his removal to the segregation unit as a way of separating himself from other prisoners.
- Reports of faulty cell alarms in the segregation unit were of concern to the man's family members.
- The man's family members asked the investigator to look into whether conversations in the segregation unit could be overheard through closed cell doors.

24. We do our best to answer the family's questions in the report, which we hope will help them to better understand the circumstances of the man's death.

25. Hammersmith and Fulham Primary Care Trust (PCT) initially appointed clinical reviewer A to lead a clinical review panel into the man's care whilst in custody and to provide a review. The purpose of a clinical review is to examine the medical care that a prisoner received in custody, which should be of an equivalent standard to what might have been expected in the community. The clinical reviewer had access to the man's medical records and attended a number of interviews with the investigator. During re-organisation of the PCT, the clinical reviewer left her role. The review panel was then led by clinical reviewer B. Clinical reviewer B was given access to the transcripts of all the interviews, and the investigator made him aware of

issues that had already been identified. The clinical review was not provided to the investigator until November 2011. The findings are summarised within this report and the full review is included as an annex. We apologise for the delay.

Response to the draft report

26. As part of the consultation period, a draft version of this report was considered by the man's family, and by the National Offender Management Service (NOMS) and HMP Wormwood Scrubs.

27. In response to feedback received from NOMS and Wormwood Scrubs, a number of amendments were made. Most significantly, references to the man attempting to assault a prison officer were changed to appropriately reflect that this was an allegation. The position around self-harm and suicide warning forms and escort contractors was clarified, as was the completion of the cell sharing risk assessment (CSRA).

28. The man's family members responded through their legal representative. They requested information from a number of other potential witnesses, as well as additional documentation. Responding by letter, the investigator explained that, having consulted with the coroner's officer, he was satisfied that additional information from witnesses could be adequately provided during the inquest process. Furthermore, arrangements for the disclosure of documents were arranged by the coroner.

29. Wormwood Scrubs and NOMS accepted the ten recommendations. The responses can be found on pages 45 and 46.

HMP WORMWOOD SCRUBS

30. HMP Wormwood Scrubs is a large local prison in West London. It can accommodate more than 1,200 adult male prisoners. As a local prison, its population is transient and demanding, with high numbers of prisoners arriving from court with a variety of immediate needs. In addition to the five residential units, there is an induction unit, an inpatient healthcare centre, and a dedicated drug stabilisation unit. The prison also has a segregation unit where prisoners can be located, either for disciplinary reasons or for their own protection.

Her Majesty's Inspectorate of Prisons

31. Prior to the man's death, the most recent inspection of Wormwood Scrubs took place in June 2008, more than two years before he spent time there. At that time, the inspection team were "disappointed" by what they found. The Inspectorate's tests around a 'healthy prison' focused on safety, respect, purposeful activity and resettlement, and showed that the prison was performing reasonably well in terms of respect and resettlement, but not performing sufficiently well regarding safety and purposeful activity.

32. A further follow-up inspection took place in June 2011, more than six months after the man's death. The Chief Inspector concluded that the prison was safer than at the time of the last inspection, with supportive first night and induction arrangements. He said there had been "a number of deaths since the last inspection and the prison had a good focus on learning the lessons that arose".

33. Regarding the 'healthy prison' test, the inspectors found that in June 2011, the prison was performing reasonably well in terms of safety, respect and resettlement. It was still not performing sufficiently well in terms of purposeful activity.

34. In respect of the use of force, the inspection team found that:

> "Levels of use of force were not high, with an average of 21 incidents a month in the year to date. However, this included significant spikes, with actual monthly figures varying from 15 to 32 and a high proportion for non-compliance. The lack of trends analysis meant this was not being picked up and acted on. Too many records were incomplete, often missing accounts from one or more of the officers involved in the incident, and most had no [form] indicating whether the prisoner had received any injuries. In most cases, force appeared to have been appropriately employed, although some required further enquiry, but there was no quality assurance of records by managers to identify these cases."

35. When reporting on the segregation unit, the inspection team found that:

> "Prisoners were positive about their treatment by staff, who were professional and supportive. During one incident, staff dealt with one unpredictable and violent prisoner in a competent and caring way. CCTV cameras recorded all incidents on the unit and films were routinely

> scrutinised by unit managers to ensure that staff had acted appropriately. Unit managers were highly visible and clearly sought to create a positive and professional environment."

Independent Monitoring Board

36. All prisons have an Independent Monitoring Board (IMB) made up of volunteers from the community in which the prison is located. IMBs must satisfy themselves as to the humane and just treatment of people held in custody, and they report to the Secretary of State for Justice annually. At the time of writing, the most recent report that was available to my investigator covered the period June 2009 to May 2010. The Board reported reception screening processes and induction had improved since their previous report, staff-prisoner relations had remained generally good, and the segregation unit had continued to set standards in its care of difficult prisoners. With specific regard to the segregation unit, the report contained the following:

> "The Board continues to be impressed by the professional way in which segregation unit staff deal with a wide range of prisoners including those with very challenging behaviour … and those on [self-harm monitoring procedures]. The regime is as humane and purposeful as it can be. The Board notes that towards the end of the reporting year, the use of the segregation unit remained at a high level with some extremely disturbed individuals."

Previous deaths at Wormwood Scrubs

37. This office has been responsible for investigating deaths in prison custody since April 2004. Prior to the man's death, we have investigated 17 self-inflicted deaths at Wormwood Scrubs. Three of these deaths occurred in 2004, three in 2005, one in 2006, three in 2007, three in 2008, three in 2009, and in March 2010. We have investigated three previous self-inflicted deaths in the segregation unit, the most recent from 2005.

38. After a death in September 2008, this office made recommendations about the availability of salient information about prisoners during the reception process. The same issue is discussed as part of this report.

KEY EVENTS

39. The man was arrested late in the evening in October 2010. He arrived at the police station shortly before midnight. A doctor was called to see him shortly before 1.00am on 29 October. The reasons for this were not recorded, and neither were the details of the doctor, who arrived shortly before 3.00am. A note was made on the man's medical record that he was to be observed every 30 minutes, although the reasons for this decision were not specified.

40. There is little information about what happened to the man for much of the next day. At 5.53pm, a note was made on his medical form to say that he had asked to see a doctor because he felt very depressed. When the doctor arrived at 7.55pm, the man refused to speak to him. The doctor considered that the man was fit for detention, interview, transfer and charge. There was no indication of any increased risk of self-harm or suicide (it was stated on the form as 'standard') but the doctor recorded the need for the man to be checked every hour. At around 5.30am on 30 October, the man was seen by another doctor who prescribed a single 75mg dose of Zantac. This medication is normally prescribed for the treatment of indigestion or heartburn. It was administered at 7.00am.

41. Later the same morning, the man was taken from the police station to the court. The person escort record (PER) is a document that accompanies a prisoner during transfer, and contains relevant information about him. The front page of the document lists a number of risk factors and invites the person completing it to note the 'details of current and relevant risk'. The form was completed the previous evening, in advance of the man's transfer to court. It was recorded that the man was violent, concealed knives, and was a drug user. No risk of suicide or self-harm was noted. At the bottom of the form, a section covers medical and mental health risks. In these boxes, a note was made that the man used Zantac for a possible stomach ulcer, and that he had claimed to be depressed and had asked to see a doctor, but refused to speak to him.

42. According to the PER, the man appeared in court at 10.44am. At 11.11am, his court appearance ended, and he was remanded in custody until his next court appearance, scheduled for 26 November. He initially returned to a cell at the court, to await transfer to a prison.

43. At 11.13am, Senior Custody Officer (SCO) A noted the following on the PER: "Stated when came out of court was going to kill himself. Placed on five minute watch." Subsequent notes on the PER suggest that the man was checked regularly whilst in a cell at the court, although this was not always at five-minute intervals. The front page of the PER was not updated to indicate any risk of suicide or self-harm, and there is no evidence to suggest that a separate warning form to highlight these risks was completed.

Reception into HMP Wormwood Scrubs

44. The man was taken from the court to HMP Wormwood Scrubs. He arrived at 1.25pm. Officer A completed a checklist regarding documents that had been

received relating to risks of suicide, self-harm and violence. He confirmed on the checklist that there was no warning about these issues on the PER, and that there was no self-harm and suicide warning form.

45. As part of the normal reception process, the man underwent a health screening. This was conducted by Nurse A and involved a number of questions about various aspects of physical and mental health. During interview with the investigator, the nurse said he had access to the man's PER during the assessment, but relied only on information contained on the front page. He therefore did not know what the man had said about suicide after his court appearance. The nurse asked the man about suicide and self-harm as part of the health screening, but did not feel that he presented a risk. The man did, however, say that he suffered from depression and was taking fluoxetine. In terms of physical health, he reported stomach problems for which he was prescribed lansoprazole.

46. Another part of the reception process for newly arriving prisoners is the cell sharing risk assessment (CSRA). The primary purpose of this assessment is to identify any risks associated with the prisoner sharing a cell. The form is completed in part by a prison officer and in part by the nurse responsible for the health screening. Neither member of staff thought the man presented any risks to a potential cellmate or himself. He was therefore assessed as low risk and suitable for cell sharing. However, in the 'additional information' box, the prison officer completing the assessment noted that the man had "previously tried to overdose three to four years ago". The CSRA also indicated that the man had not been convicted for a racial or homophobic crime, but a personal summary form (part of the induction process) completed the same day reported a conviction in 2009 for racially aggravated assault.

47. Nurse A explained during interview that not every prisoner arriving at Wormwood Scrubs sees a doctor as part of the reception process. However, if prisoners have medical needs or require prescription medication, they will be referred to see a doctor. Because of the issues the man raised during the reception screening process, he was referred to Dr A, who saw him a short time later. The doctor told the investigator that the man was quiet but in a good mood, and denied any thoughts of suicide or self-harm. He told the doctor that he suffered from depression and a gastric ulcer. The doctor prescribed 20mg of omeprazole (a commonly used medication for various gastric problems) daily, and 20mg of fluoxetine (a popular anti-depressant medication) daily.

48. Following the reception processes, the man was placed in a single cell in the first night centre.

49. The next morning, 31 October, the man again saw Nurse A for a secondary health screening. This is a more detailed health assessment than the one completed upon arrival, and helps to assess longer term medical needs. The nurse told my investigator that the man presented in the same way as on the previous day, and did not offer any further significant information. He did not have concerns about the man in respect of suicide or self-harm.

50. On 1 November, the man moved from the first night centre to B wing, the induction unit. For the next six days he continued to live on the wing without incident. On 7 November, Nurse B wrote in the man's electronic clinical record that he went to the treatment room for his medication, and wanted to take it away with him. The nurse noted that, when she explained to the man that he had to take the tablet in her presence, he became upset and walked away, saying she had refused to give him his medication. It is unclear from the clinical record whether this was an isolated incident, or part of an ongoing issue around the man collecting his medication.

51. On the morning of 9 November, the man made a telephone call to his mother. They talked for five minutes about various subjects, and his mother seemed very supportive.

52. The man attempted to make telephone calls on the morning and afternoon of 12 November, but reached a voicemail service. He did not leave messages.

53. On the afternoon of 14 November, the man spoke to his mother by telephone. The conversation again seemed pleasant and supportive. The next day, he moved to a single cell on D wing.

54. There was nothing of particular note or concern in the man's prison record until 19 November, when Officer A completed a 'report of injury' form. On this form, he stated that he had responded to the man's cell alarm bell and saw that he was holding a cloth to his face. When the man removed the cloth, the officer saw that he had "an open cut above his right eye that was bleeding quite heavily". The officer called for assistance from medical personnel. The man told the officer that he had lost consciousness whilst exercising in his cell, and that the injury must have been the result of him falling over.

55. Dr B attended the man's cell and took him to the healthcare centre for treatment. He noted in the clinical record that the injury was the result of an accidental fall. He treated the cut with four stitches to be removed seven days later. The doctor also prescribed pain relief medication for the man. It was not considered necessary for the man to be admitted to the healthcare unit, and so he returned to his cell on D wing.

56. Shortly after 4.00pm the next day, Dr C saw the man for a follow-up appointment. She told the investigator that the man "had no symptoms of any significant follow-on from a head injury – he hadn't got a headache, his vision was fine and he had no vomiting". She said the wound was clean and healing and that the man felt the whole affair was "a fuss over nothing". The doctor went on to say that she thought the injury was very minor, and that as well as suffering no symptoms, the man had not lost consciousness. (Though the man had said he lost consciousness during the incident, the doctor was not aware of this fact.)

57. The same afternoon, the man made two telephone calls but reached a voicemail service and did not leave messages.

58. On the afternoon of 22 November, the man left voicemail messages for his partner and his mother. The next morning, he left another message for his mother.

59. The same day, a behaviour warning was issued to the man by Officer B. During interview with my investigator, the officer spoke of his general impressions of the man prior to the behaviour warning. He recalled that the man was a generally quiet man who did not come to the attention of officers on a regular basis. Although he socialised with a small number of prisoners, he mostly kept to himself and spent much of his time in his cell. Regarding, the behaviour warning, the officer wrote the following on the warning form:

> "Incentives and Earned Privileges warning given for using rude and abusive language against my person. Prisoner stated I am a fool and idiot when I unlocked him for lunch and that I should have unlocked him for the doctor. I tried to explain to him that the treatment room will inform us when they want him unlocked. This type of behaviour is unacceptable and will not be tolerated."

60. During interview, Officer B added that the man had used abusive language, and was loud and aggressive in his demeanour.

61. The Incentives and Earned Privileges (IEP) scheme is used by all prisons in England and Wales, and operates on the principle that certain privileges are added or removed in response to a prisoner's behaviour and contribution to the prison regime. There are three levels: basic, standard and enhanced. The default level for prisoners entering custody is standard. Up to three behavioural warnings within a period of 28 days will result in demotion to basic level. The first warning that the man received on 23 November would not have had a material impact on him at that time, other than to move him one step closer to a loss of privileges if he continued to behave in an unacceptable manner.

62. The man complained of having trouble sleeping the same day, and was prescribed zopiclone (a sleeping tablet). Three tablets were issued, with one to be taken nightly. There was no indication that this was intended to be an ongoing prescription, or that the causes of his trouble sleeping were discussed.

63. On 24 November, two stitches were removed from above his eye. Nurse C noted in the clinical record that two had already fallen out. The same afternoon, the man spoke with his mother by telephone. As with the previous calls, this appeared to be supportive and covered a range of subjects, including the man's injury. He told his mother that he had been attempting handstand press-ups in his cell and had slipped. They also talked about the circumstances of his alleged offence, and the possibilities of him being convicted and serving a sentence. They spoke again the same evening. The man said he intended to secure employment in the prison, and also talked about the possibility of him receiving an indeterminate sentence for public protection. Such sentences require prisoners to serve a minimum tariff, and they are released only when the Parole Board believes that their risk of harm has reduced.

64. The next evening, the man again spoke to his mother by telephone. They talked about his possible sentence. The man no longer believed that an indeterminate sentence was a realistic possibility, and they spoke about the prospect of him being released after his next court appearance on 10 December.

65. On the morning of 26 November, Officer Support Grade (OSG) A made an entry in the electronic prisoner record. An OSG is a member of prison staff at a grade below that of prison officer. The OSG stated that she had issued the man with a final behavioural warning for misuse of his cell alarm bell and becoming abusive. There was no further explanation given of the circumstances, and there was no copy of the warning form in the records given to my investigator.

66. Later the same morning, the man was escorted to the court. He arrived at 9.20am and was detained in a cell until shortly after 3.00pm, when he appeared before the court. The man's case was adjourned until 10 December. He was remanded in custody, and the vehicle escorting him back to the prison left the court building at 4.00pm. The only risk indicators noted on his PER for the journey between the prison and the court were his record of violence and unspecified 'mental health issues'.

67. On the afternoon of 28 November, the man made a telephone call but reached a voicemail service. He did not leave a message. A short time later, he spoke to someone for almost eight minutes. They talked about a range of subjects, and the man was again concerned about the possibility of an indeterminate sentence.

68. The next afternoon, the man again spoke to the person he had spoken to the previous day by telephone. They spoke about some things that had been happening outside the prison to people they both knew, and also about music they enjoyed.

69. The man then spoke to his partner. This seemed to be a supportive call in some respects, but in others was perhaps less harmonious. The man asked his partner to bring their young son to the prison for a visit, but she was reluctant to do so. He also told her what she could say so that the charges against him would be dropped. His partner agreed to this and they both appeared to believe that he would be released on 10 December. Following the call to his partner, the man made a short telephone call to his mother.

70. On 30 November, one of the prison's governors, wrote in the electronic prisoner record that the man had attended his office to complain about the staff on D4 landing, following the receipt of his warning form. The prison's governor told the man that the warning for misusing his cell alarm bell was "right and proper". In response, the man said he intended to make a complaint about the prison's governor.

71. The same morning, the man spoke to his partner for ten minutes by telephone. She told him that she had been trying to arrange a visit but could not get through on the numbers she had been given. She also remained

reluctant for their son to visit the prison. The man said he needed to see his children because he was facing a very long sentence, possibly life imprisonment. They spoke about the man's partner moving to a different area, and about property such as CDs and a CD player that she could send into the prison for him.

72. After speaking to his partner, the man spoke to his mother for nearly five minutes. They talked about the relationship between the man and his partner, his court appearance, and the possibility of him being sentenced.

73. At 3.38pm, the man made a telephone call to his partner. She told him that she had arranged a visit for Friday the same week (3 December) and intended to bring the children. After a short conversation about the logistics of sending property into the prison, the man asked if he's brother had died.

74. The conversation continued around this issue. The man's partner did not appear to know what had happened in advance of the telephone call. Before the end of the call, the visit was again mentioned and the man said he had no credit left and would not be able to make a telephone call the next day. This was the last time the man spoke to anyone by telephone.

75. The same afternoon, the member of the prison chaplaincy saw the man. In an email sent to the prison's safer custody manager on 4 December – the day after the man's death – he outlined the circumstances of his meeting, saying:

> "I met briefly with the man on the afternoon of 30 November. I did so in response to a note left on my desk asking me to visit him. When I met with the man he told me that he had heard that his brother … had taken his life the previous week in a prison up north.
>
> "He was upset at the news and when I asked him how he had found out about his brother, he told me that he had heard from 'someone on the wing'. He was concerned that he didn't have any money on his PIN for a phone call, but said that he would probably get this by Thursday [two days later]. He planned to contact his family then to get more details/information. He seemed okay about this. I told him I would call with him on Saturday and that if he hadn't been able to make contact with his family by then, I would do so for him. I asked if he was alright and he said he was. He gave no indication of being anything other than moderately upset at the news – no tears etc, just a quiet stoicism."

76. The member of the prison chaplaincy had left the employ of the prison by the time the investigator conducted interviews. It is unclear what action, if any, was taken in response to what the man said about his brother. Certainly, there is no indication that the information was more widely disseminated amongst wing staff.

77. With regard to the issue of making a telephone call, all prisons operate a PIN telephone system. Prisoners have a personal account and can make telephone calls to authorised numbers. They are able to transfer money from their personal spending accounts to purchase credit for the PIN telephone system. There is no evidence to suggest that consideration was given to

ways in which the man might make a call about the information he had heard on the wing. Neither the member of the prison chaplaincy nor the man appear to have brought the matter, and the fact that the man could not make a telephone call to verify or disprove what he had heard, to the attention of staff working on the wing.

78. There was nothing recorded in the chaplaincy journal to suggest that the member of the prison chaplaincy had seen the man.

Alleged attempted assault, control and restraint, and removal to the segregation unit

79. Shortly after 6.30pm on 1 December, the man attended the office on D4 landing. Officer C was sitting at the desk, and Officer D was standing in the doorway. During interview, Officer C told the investigator that the man wanted him to sort out his canteen (referring to items that he had ordered from the prison 'shop'). He said that the man was aggressive, threatening and abusive, and that his attempts to calm him down and explain the situation did not work. Officer C went on to say that the man made a fist and moved towards him with the intention of hitting him. Officer C, still in a seated position, pushed the man away before Officer D came to his assistance.

80. Officer D recalled the situation similarly. He said that he was standing in the doorway when the man entered the office, and that he observed the man swearing and being verbally abusive to Officer C. He told the investigator that another prisoner had asked him to open his cell door, but he asked them to wait because he did not feel comfortable leaving the situation. He said: "I could feel something was going to happen the way the heated discussion was, and all of a sudden I saw him go towards Mr C." Officer D said that the man had raised his fist and that Officer C pushed him away.

81. Officer D recalled the way in which he intervened, grabbing the man from behind in what he described as a bear hug. He said the two of them struggled as he tried to manoeuvre the man away from Officer C, who he felt remained in danger. Officer D and the man fell to the floor on the wing landing, just outside the office.

82. In a situation such as the one described above, approved control and restraint techniques are used in order to immobilise the prisoner using the minimum amount of force necessary. Three officers are required to perform effective control and restraint, with each officer taking control of one of the prisoner's body parts, typically the head and both arms. At the time of the man and Officer D falling to the floor, there was only one other officer – Officer C – on the scene. Officer D told the investigator:

> "I shouted for staff assistance because he was struggling with us and then I believe the officers [from the landing below] came running up … and that's when the alarm bell was raised. I had control of his head at the time. Officer E took control of his left arm and Mr C took control of his right arm. I believe because it was such a confined space we decided to sit him

up, so as we sat him up I still had control of his head and as we sat him up, passed the head forward to Officer F who took over from me."

83. Officer C described how, after the man and Officer D fell over, the man did not become compliant. He continued to struggle and shout abuse. Officer C said he took control of the man's right arm, using an approved 'locking' technique to prevent the man from using the arm to cause injury.

84. Other officers told the investigator how they became aware of the situation. Officer F explained that he was in the office on D3 landing, directly below the office where the altercation took place. He said he heard raised voices and some sort of physical commotion from the office above, and so decided to go up to D4 landing to investigate what was happening. This was not in response to an alarm bell or a call for staff to attend, but because of what he heard. He described as follows what he saw upon arriving on D4 landing:

> "The officers were a few yards from the top of the stairs and when I looked I saw, I believe Officer D was sort of against the railings directly outside the door and the man was in front of him so he would have been between Officer D and the office, and Officer C was on the other side of the man, and there was a struggle going on and they were trying to, you know, restrain him."

85. He went on to say that Officer D was trying to control he man's upper body, whilst Officer C attempted to secure an arm lock. However, the man had his left arm free and was continuing to fight and struggle with the officers. My investigator asked Officer E about how officers in such a situation make decisions about their individual roles and what techniques should be used. He said:

> "As regards to what position you put them in it very much depends. I mean there are certain systems of working, certain techniques and certain commands to restrain someone. In the man's case he was sort of flailing around and the first step is always to immobilise someone. It's not like you can just dive in and straightaway have someone in a control and lock of some description. You want to immobilise arms and head and legs and whatever if he's lashing out, and then once he's stopped and he's immobilised and he's not a particular threat, he's not, you know, at that moment capable of doing too much harm, then that's when you start talking to each other and converting into some sort of control and lock."

86. When describing his direct involvement in the control and restraint, Officer E said:

> "Obviously, my concern was to be part of that three man team and do it safely for the man's sake and for the staff's sake. I believe I took control of his left arm, which he was swinging around because nobody had control of [it]. At the time he was still struggling, he wasn't complying, he wouldn't cease his attempts to struggle [and] it was quite difficult to gain control and lock on him. At this point we decided to take him to the ground which we did, which gave us, you know, a lot more leverage in terms of being able to get into a control and lock and sort of subdue him."

87. Officer E went on to describe the procedure for taking a prisoner to the ground from a standing position. He said that the two officers holding the prisoner's arms use their body weight to drive the prisoner towards the ground, whilst the lead officer, supports and guides the prisoner's head so that their hands, rather than the prisoner's head, hits the ground first. He said this was what happened with the man, who was taken to the ground face down, and that at this point he stopped struggling but continued to be verbally aggressive.

88. Officer F recalled the incident in a slightly different way. She told my investigator that she was on D3 landing and heard unusual noises from the landing above her. When she arrived on D4 landing, she recalled seeing Officers C and Officer D struggling to restrain the man. She said she took control of the man's head, but was very soon relieved by Officer B, who had arrived on the landing. Officer F did not mention Officer E's involvement. However, Officer B recalled that when he arrived, the man was being restrained by Officers C, E and F.

89. After the man had been taken to the ground, Principal Officer (PO) A arrived on D4 landing and was apprised of the situation by the members of staff already present. Officer F recalled that the man continued to be aggressive and verbally abusive, particularly towards Officer C, and had to be taken to the ground a second time.

90. Although it is unclear at what precise moment the man was taken from a standing position to the ground, it seems that his head was supported by Officer D on both occasions. It was later supported by Officer F, and finally by Officer B. All three officers said that, to their best of their knowledge, the man did not sustain any injuries during the control and restraint process. Officer D acknowledged the possibility that the man could have hit his head during the initial fall, shortly after he attempted to strike Officer C.

91. Handcuffs were applied to the man, who was removed from D wing and taken to the segregation unit. A prisoner who is to be charged with an offence against discipline may, under Prison Rule 53A, be kept apart from other prisoners pending the governor's first inquiry or determination. At 7.05pm, the duty governor, gave written authority for the man to be segregated under this rule. Upon his arrival in the segregation unit, the man was placed in cell S2-84. There is CCTV footage of the man's arrival in the segregation unit, the search procedure, and his interaction with the duty governor. Although the investigator has not seen this footage, a transcript of it suggests that the man appeared calm and compliant.

92. A form entitled 'first night observation' was completed by Officer G, who wrote on the form: "He [the man] claims he has received a head injury in the process of being restrained. A duty doctor has been called to see him."

93. Prison Service Order (PSO) 1700 requires Governors to ensure that an initial segregation health screening is conducted for any prisoner who is segregated. The primary purpose of this screening is to assess a prisoner's ability to cope with the effects of being segregated. The man's health screening was conducted by Dr A. The screening asks questions about

whether the prisoner is awaiting transfer to a secure setting, whether they have self-harmed during the period in custody, and whether they present as acutely unwell. The doctor answered 'no' to each of these questions, answered 'yes' to a question about whether the prisoner would be able to cope with a period of segregation, and indicated that no healthcare intervention was required.

94. Dr A told the investigator that the man was angry about the control and restraint that had been used. He felt that too much force had been exerted, and complained of a headache. The doctor said he did not observe any injuries and that the man did not complain of any. He explained to the investigator the steps he would take if he observed that a prisoner had suffered injuries. In response to the man saying he had a headache, the doctor prescribed paracetamol and asked for him to be reviewed the next day. With regard to the health screening, the doctor told the investigator that the man did not present in a way that gave him cause for concern in terms of his mental well-being.

95. The duty governor signed the health screening form to acknowledge that he had read it and authorised the man's detention in the segregation unit.

96. Officer G wrote in the man's segregation history sheet that "he was very upset about being restrained but no immediate concern at present". The time was not specified.

97. No concerns about the man were recorded during the overnight period.

98. The next morning, the man saw Dr C. Prisoners on the segregation unit are routinely seen daily by a doctor. During interview with my investigator, the doctor said that the man told her he was not able to sleep well because his brother had killed himself in prison a few days earlier. The investigator asked the doctor if the man had said any more about this matter or the circumstances surrounding it. She said:

> "No he didn't, no, he didn't seem to want to. Maybe I should have asked him more about it but I didn't because it didn't seem necessary, and sometimes, people, you can sense they want to talk about something and other times they don't want to, and I accepted the fact that he perhaps wasn't in a mood to chat about that. I hoped that if he wanted to talk about it he felt able to but he didn't and so I agreed to sleeping tablets which seemed to be the main thing that was concerning him at the time."

99. The investigator went on to ask about the man's demeanour, about whether he appeared upset or distressed. Dr C said he was calm and pleasant, and she had no reason to think that he posed any risk of harm to himself.

100. Dr C also recalled that the man asked for pain relief medication because he was "aching all over" following control and restraint the previous day. The investigator asked whether the man had made any allegations regarding being assaulted. She said:

> “He didn’t allege any particular … assault but he just felt, as I think you can do, just a bit bruised and achy from having been restrained but he didn’t expand on that and say that anybody assaulted him as such, no.”

101. As a result of the consultation, Dr C prescribed zopiclone once daily for three days, and ibuprofen to be taken three times daily.

102. Explaining the way in which such consultations take place, Dr C said that cell doors are opened, and that she either enters the cell or talks to prisoners from the doorway. She recalled being with the man for between five and ten minutes.

103. The information that the man had given regarding his brother was noted in the clinical record. My investigator asked Dr C whether there were any procedures in place for disseminating the information more widely, so that members of staff without access to the clinical record could still be made aware of the information. She said:

> “Well, when I do my round I’m accompanied by a prison officer and a nurse, so the officer could well have heard that conversation and would know about it through that, and I believe the chaplaincy go and see the prisoners in the segregation unit as well, so whether they would have talked to him about a possible bereavement, but other than that no because in theory what we’re told is confidential, so not that I’m aware of.”

104. Shortly after 3.00pm, the man attempted to place two telephone calls to his brother and a call to his mother. None of these three calls were successful. His PIN phone account had been credited with £3.00 the same morning, and so he had the funds necessary to make telephone calls. It therefore seems that the calls were not answered.

105. There is little further information about the man on 2 December. Officer G wrote in the segregation history sheet: “Positive and compliant, no problems through the day. Collected his meals but no exercise due to bad weather.”

106. At 4.45pm, Officer H issued a ‘notice of report’ to the man. The officer explained the procedure for issuing such paperwork, its purpose, and the timescales involved. He said the notice had to be issued to the man within 48 hours of the incident. The notice specified the section of the Prison Rules that the man was alleged to have breached. In this case, it was Prison Rule 51, paragraph 25(a), which relates to attempting to commit an assault. The circumstances of the charge were briefly outlined. The notice specified that the man’s case would be heard the following morning at 9.30am.

107. In addition to the notice, Officer H also gave the man, as part of the paperwork, an A4 piece of paper headed ‘Prisoner’s statement’. Underneath the heading, it specifies: “You may use this sheet if you wish to make a written reply. Please ask for more paper if you need it.” The remainder of the page is blank. A further document, entitled ‘What happens when you are put on report’ and containing 15 paragraphs about the process, was issued to the man.

108. Officer H recalled visiting the man's cell to issue the paperwork, but could not remember if the man was in bed or standing at the door. He told the man that his case would be heard at 9.30am. He told the investigator that, as the night went on the man became frustrated because he did not have any tobacco. Around 9.00pm, the man was shouting to a prisoner across the wing, asking for tobacco. The other prisoner initially responded to the man but eventually ignored him.

109. The investigator sent an email to all of the segregation unit staff who were working on 1 and 2 December, asking if they had any significant interactions with the man. Of those who replied, only Officer G recalled anything specific. He said that the man had been unhappy with the choices of evening meal, as there was only a vegetarian meal apart from the halal option. The man requested a halal meal rather than vegetarian, and Officer G explained that he would have to wait and see if there were any left. The man agreed to this and returned to his cell. When other prisoners had collected their meals, Officer G offered a halal meal to the man. Officer G said in his email that the man was grateful and pleasant, and that this was his last interaction with the man.

110. The segregation unit has an occurrence book which involves a new sheet for each day. Each sheet contains details of the members of staff working on the unit, the unit manager, the duty governor, and the doctor completing rounds. It has a list of all prisoners housed in the segregation unit, as well as a list of specific occurrences. The man's name does not appear in the list of prisoners for 1 December. The log of occurrences mentions his arrival on the unit at 7.00pm, and a roll count at 7.30pm confirmed the number of prisoners on the unit as 15. However, there are only 14 prisoners listed, and all of the overnight checks show a roll of 14. Similarly, on 2 December, the man is not listed. The roll count at 7.45pm showed the number of prisoners as 14. Only 13 prisoners are listed. The overnight checks all show a roll of 15.

Overnight on 2/3 December

111. OSG B was responsible for patrolling the segregation unit overnight on 2/3 December. As mentioned earlier, an OSG is a member of prison staff at a grade below that of prison officer. The information he recorded about his patrols on the segregation unit paperwork, as well as that given in his statement to the Governor on 3 December, is unreliable. As such, the following sequence of events has been compiled from other sources, primarily the closed circuit television (CCTV) covering the segregation unit and interviews with other members of staff.

112. The time stamp on the CCTV footage provided by the prison is 18 minutes ahead of the actual time. The timings have therefore been corrected in this report in order to accurately reflect the times at which events occurred.

113. Prisoners in the segregation unit should be checked at least hourly, and these checks recorded on the unit paperwork.

114. Each cell has an alarm bell system. Prisoners can trigger the alarm using a button inside the cell. An audible warning indicates that an alarm has been activated, and a light above the cell in question illuminates. A wall panel on

the landing also illuminates. The audible warning can be temporarily silenced using a switch on the landing control panel, but the only way to deactivate the alarm permanently is to press a button outside the corresponding cell. Even after deactivation, the alarm can be triggered again if the prisoner presses the button inside the cell.

115. The CCTV footage commences at 8.41pm. It covers the upper landing of the segregation unit, including the area outside the man's cell. It does not show the cell's interior. The man's cell alarm light was not activated at this time, and there were no movements on the landing until 9.03pm, when OSG B conducted checks at all cells. Such checks do not normally involve entering cells, as prisoners can be seen through the observation panel in the cell door. During the cell checks, OSG B was at the man's cell for approximately five seconds.

116. At 9.20pm, OSG B attended a different cell on the unit and spoke to the prisoner for around two minutes. He briefly attended a number of other cells to carry out routine duties. Lights on the landing were dimmed at 9.24pm.

117. There was no further movement on the landing for 37 minutes. OSG B indicated on the segregation unit paperwork that he completed a full cell check at 9.45pm. This is not seen on the CCTV footage. At 10.01pm, the alarm light for a cell on the landing illuminated (not the man's). Six minutes later, OSG B attended the landing and looked into the cell in question. He walked away and off the landing without deactivating the cell alarm.

118. A further 57 minutes passed without any movement on the landing. OSG B recorded on the paperwork a full cell check at 10.38pm, but this was not seen on the CCTV footage.

119. At 11.05pm, the man's cell alarm light illuminated. (At this point, he had last been checked two hours earlier.) The other cell alarm light remained on, and had been lit for an hour. At 11.10pm, OSG B appeared on the landing accompanied by a trainee OSG who was observing the night shift. Between 11.10pm and 11.12pm, OSG B attended all cells on the landing and looked into them through the observation panels. He deactivated the alarm at the other cell, and deactivated the alarm at the man's cell. He did not appear to speak to either of the prisoners whose alarms had been triggered. Two seconds after OSG B left the man's cell, the light illuminated again. Less than a minute later, at 11.13pm, another cell alarm was triggered (not the one that had been activated earlier).

120. There was no movement on the landing for 18 minutes. At 11.31pm, OSG B appeared on the landing, attended one of the cells with an active alarm (not the man's) and looked into the cell. After taking a couple of steps away from the cell, he stopped and appeared to be talking into his radio. OSG B did not deactivate the alarm, nor did he check the man's cell. He left the landing but immediately returned with the trainee officer.

121. OSG B indicated on the segregation unit paperwork that he completed a full cell check at 11.32pm, but this was not seen on the CCTV footage. (He had, however, completed such a check 20 minutes earlier.)

122. OSG B and the trainee officer returned to the cell (not the man's) with the active alarm, and looked through the observation panel. They were at the cell for approximately 90 seconds before walking away and down the landing. They did not look into or pay any attention to the other cells they passed, including the man's cell, where the alarm remained active. As they passed the man's cell, OSG B deactivated the cell alarm without looking into the cell. At this point, the alarm had been active for 22 minutes since it was deactivated the first time.

123. At 11.35pm – one minute after the man's cell alarm was deactivated and four minutes after OSG B had talked into his radio – other members of staff attended the unit. The OSG and the trainee officer walked downstairs and off the landing whilst other officers remained at the other cell (not the man's). At 11.38pm, officers entered the cell.

124. One minute later, the man's cell alarm was again activated.

125. At 11.46pm, staff members left the cell that they had previously entered. The investigator interviewed Officer I, who had attended at that time. He said the prisoner in the cell had harmed himself by cutting his wrists, and that a nurse treated his injuries in the cell. SO A who was in charge of the prison overnight, had also attended. He told the investigator that the prisoner's problem "was being addressed at that time, and he co-operated with us and we settled him down, and that's about it".

126. When the members of staff left the other prisoner's cell, they went downstairs and left the landing. Officer J, who had also attended, instead walked along the landing and past the man's cell. At 11.47pm, an officer attended the cell where the incident of self-harm had occurred. A few seconds later, the officer attended the man's cell and looked through the observation panel. Thirteen seconds later, he turned off the cell alarm and walked away. The alarm was immediately reactivated, suggesting that the man was standing at the cell door (where the button is located). Within one minute, the last of the additional officers left the landing (and the unit).

127. There were no further movements for the next seven minutes. At 11.54pm, OSG B attended the man's cell and turned off the alarm. He stood at the door and appeared to speak with the man. OSG B left the cell door 22 seconds later. After another seven seconds, the cell alarm was once again activated.

128. At 11.56pm, the alarm for the cell where the prisoner had previously self-harmed was activated. Two minutes later, OSG B attended this cell, deactivated the alarm, and appeared to talk to the prisoner through the observation panel for nine minutes. He left the cell and the landing at 12.07am on 3 December. (The man's alarm remained active.) Less than one minute later, OSG B returned to the other prisoner's cell and remained at the door for a further 34 minutes.

129. OSG B indicated on the segregation unit paperwork that he had conducted a full cell check at 12.29am, but this was not seen on the CCTV footage. At this time, he was outside the cell where the self-harm had previously occurred.

130. At 12.41am, OSG B left the cell and the landing. One minute later, the alarm was activated again. The OSG returned to the other prisoner's cell (the person who had previously harmed himself) at 12.44am, and remained there for a further 50 minutes. He deactivated the alarm at 1.30am. He recorded on the segregation unit paperwork that he completed a full cell check at 1.25am, but the CCTV footage showed him at this time outside the same cell as before.

131. OSG B left the cell and the landing at 1.34am. The man's cell light remained illuminated, the alarm having been activated one hour and 40 minutes earlier. There was no further movement for the next one hour and three minutes, during which time the man's cell light remained illuminated. Although the OSG indicated that he completed full cell checks at 2.20am and 2.21am, this was not seen on the CCTV footage.

132. At 2.37am, OSG B attended the man's cell and deactivated the alarm before looking through the observation panel. By this point, the man's cell alarm had been active for two hours and 43 minutes (since 11.54pm). This was also the most recent time that he had been observed in his cell. (Some other prisoners on the unit had not been observed since 11.12pm the previous evening.)

133. Twenty-two seconds after arriving at the cell, OSG B spoke on his radio. Other members of staff described to the investigator their recollection of the radio message and their reactions to it. Officers I and Officer K were in the B wing office when they heard the radio message. Both recalled that the nature of the message was a 'code 1'. Officer I said that such a code indicates a very serious situation, whereas Officer K went further and said it suggests that a prisoner has been found hanging. The two officers said that they immediately made their way to the segregation unit.

134. Officer L and SO A also described the radio message to the investigator. Officer L said she understood that a 'code 1' referred to an attempted hanging. She was located one floor above the segregation unit and immediately made her way downstairs when she heard the message. SO A told the investigator that the radio message suggested an "extreme" situation with the possibility of loss of life. He was in a central office and immediately made his way to the segregation unit.

135. The first nurse on the scene and the second nurse on the scene were in the healthcare unit when they heard the radio message. Although medical assistance was not specifically requested, both nurses understood that the radio code indicated a very serious situation and so decided to make their way to the segregation unit. The first nurse on the scene went straight to the segregation unit, whilst the second nurse on the scene stopped to pick up a bag containing emergency equipment, and a defibrillator (a piece of medical equipment that monitors heart activity, provides audible prompts about the administration of emergency life support, and delivers an electric shock if necessary).

136. Officers I and Officer K were the first to arrive at the segregation unit. The CCTV footage shows that they arrived at 2.39am. Officer I told the investigator that when he arrived, OSG B was standing outside the locked cell door. The CCTV footage showed him leaving the vicinity as the two officers arrived. Officer I approached the cell and looked through the observation panel. He described to the investigator that he saw the man on his knees, facing away from the cell door, with bed sheets tied around his neck. Officer K sent a radio message to the prison's control room to say he was entering the cell, and then used his keys to unlock the cell door. This happened around 20 seconds after the two officers arrived on the landing.

137. Officer I told the investigator that he and Officer K entered the cell. Officer I took the man's weight whilst Officer K attempted to use his anti-ligature knife (a bladed tool carried by prison officers to enable them to cut through ligatures). However, because the ligature was made of a whole bed sheet and tied tightly, the tool was not effective. Officer K loosened the ligature and lifted it over the man's head. Officer L arrived as this was happening. (The CCTV shows her arriving four seconds after Officers I and K entered the cell.)

138. Officer K explained that the ligature was removed and that the man was placed on his back on the floor of the cell. Officer I said:

> "Then he was placed on his back. I then expected to get a response, so basically put him in the recovery position and basically while I put him in the recovery position I was expecting a response. So then I was basically checking for a response on his carotid artery, basically looking at him and just expecting a cough, a sound, a response. So there was no response."

139. At 2.39am, 29 seconds after the two officers had entered the cell, four further members of staff arrived. They included SO A, who told the investigator that he saw the officers looking at what he considered to be an unresponsive prisoner. He also explained the method that the man had apparently used, and said that a chair from the cell had been wedged upside down behind a heating pipe that ran across the back wall of the cell, close to the floor. The bed sheet had then been tied to one of the chair legs. The SO explained as follows the way in which he checked for signs of life and made a decision to commence cardio-pulmonary resuscitation (CPR):

> "First of all, we shouted to see if the person can hear, we just tried to observe if his chest is going up and down, tried to feel if there is any sign of breath by putting our face or hand near his nose or mouth, so all those factors were being taken into consideration. And he was just still. At that point there was, I remember I must have checked his pulse but there was no sign at all and it would have taken me five seconds or ten seconds. And based on that … I and Officer I were first-aid trained and … we both saw each other and said we need to give him CPR. And because we always summon for medical help, it should have arrived very soon anyway; just as a precaution we started to do CPR."

140. SO A went on to explain that he began administering chest compressions, whilst Officer I took responsibility for rescue breaths. Around 30 seconds after the SO arrived on the landing, OSG B returned to the cell area. Other

members of staff could be seen on the CCTV footage removing items of furniture from the cell, presumably to make more room.

141. At 2.40am, less than one minute after SO B and other members of staff had reached the cell, the first nurse on the scene arrived and entered the cell. She told the investigator that two officers were already performing chest compressions and rescue breaths.

142. Almost one minute later, the first nurse on the scene left the cell. A further 30 seconds later, she returned with the second nurse on the scene and the emergency medical equipment. At this point, five minutes and 23 seconds had passed since OSG B's initial radio message.

143. The two nurses recalled that Officer I was relieved of the rescue breaths, and an oxygen cylinder, ambu-bag and mask were used instead. These are pieces of medical equipment which can facilitate artificial breaths more effectively than mouth-to-mouth resuscitation, and can provide pure oxygen. The first nurse on the scene administered oxygen using the ambu-bag. The SO continued to administer chest compressions.

144. The two nurses had different recollections of the role of the defibrillator in the CPR efforts. The first nurse on the scene said that, although nurses had been trained in the use of the defibrillator, they did not use it unless a doctor was present. The second nurse on the scene said she was unpacking the defibrillator when the paramedics arrived. (This issue is explored in more detail in the next section of the report.)

145. Paramedics arrived at the cell at 2.45am, just over two minutes after the nurses had taken the medical equipment to the cell, and seven minutes and 39 seconds after the initial radio message. A number of staff members, including OSG B, were outside the cell at this time.

146. SO A told the investigator that he continued to provide chest compressions for a few minutes after the paramedics arrived, but was then relieved by one of them. Resuscitation attempts continued.

147. At 2.46am, the alarm for the cell where the prisoner had previously self-harmed was activated. OSG B attended the cell and deactivated the alarm one minute later. He was at the cell for approximately ten seconds before returning to the vicinity of the man's cell. Thirty-five seconds later, the cell alarm was again activated.

148. At 2.51am, further ambulance personnel arrived and entered the man's cell. Three minutes later, OSG B attended the other cell, looked in, and deactivated the alarm. Twelve seconds afterwards, he left the cell and the upper landing, but returned to the vicinity of the man's cell less than a minute later.

149. Officer M began a log of people attending the landing and the cell at 2.55am. At the same time, the other cell alarm was reactivated. At 2.59am, OSG B walked past the cell and went downstairs. Three minutes later, Officer J, who had arrived on the unit, attended the cell. He remained there for around ten

seconds but did not deactivate the alarm. At 3.04am, OSG B attended the landing and walked past the cell. A few seconds later, he attended a different cell, whose alarm had not been activated, and looked through the observation panel. He then returned to the vicinity of the man's cell.

150. Resuscitation attempts had been ongoing throughout this period. OSG B left the landing at 3.06am. At 3.10am, air ambulance personnel, including a doctor, arrived at the cell.

151. OSG B recorded on the segregation unit paperwork that he had completed a full cell check at 3.13am, but this was not seen on the CCTV footage. He returned briefly to the vicinity of the man's cell at 3.15am but left ten seconds later.

152. The man's death was pronounced by the doctor at 3.20am. All members of staff left the cell, which was sealed at 3.44am.

Events following the man's death

153. Officer I was asked to take over the running of the segregation unit after the man's death. He told the investigator that OSG B was in shock. He explained that he checked the prisoners on the unit as required, paying particular attention to those who were known to present a risk of suicide or self-harm.

154. OSG B recorded in the segregation unit paperwork that he completed full cell checks at 4.10am, 5.06am , 6.00am and 6.55am. He could not have completed any such checks, as he was not on duty in the unit during this time period. In his incident report statement, completed at 6.00am on 3 December, he stated:

> "The man had been pressing his cell buzzer and asking for a cigarette. I told him that I don't smoke and I had no cigarette, he continued pressing his buzzer and asking for a cigarette."

155. He then went on to detail what happened when he attended the cell and found the man with a ligature around his neck.

156. The form entitled 'Prisoner's statement' had been issued the previous afternoon as part of his charge paperwork. It was mostly blank in order that the man could provide a written reply if he wished to do so. After his deathl, it was found in his cell with the following message:

> "My last thoughts, to my wife and my little boys, I love you so very very much, never forget that, and [partner's name], don't tell the boys how it happened. Thank you."

157. The man had signed the form and dated it 3 December. Underneath, he wrote:

> "P.S. Ring the police and have the screw Officer C charged for an assault for which he had made on me two days previous to this occasion."

158. A ‘hot debrief’ was held at 8.00am the same morning, and was chaired by the governing Governor. Members of staff who were involved in the emergency response attended the debrief. The purpose of the meeting was to talk about what had happened, the emergency response, and offer support to members of staff who might need it.

159. Notices to staff and prisoners were issued on the same morning. They outlined the circumstances of the man’s death, and explained the avenues of support available to prisoners and members of staff.

Informing the man’s family about his death

160. The duty governor telephoned an officer at 4.00am on 3 December to inform him that the man had died and that he would act as family liaison officer. The family liaison officer arrived at the prison at 5.00am to see the members of staff available and collate information about the man’s next of kin. He established that the man’s partner was due to visit him later that day. He agreed that police officers would accompany him and the appointed deputy family liaison officer and co-ordinating chaplain, to the man’s partner’s home address. They left the prison at 9.10am and arrived at the address at 9.50am. The police officers waited in the car.

161. The family liaison officer and the appointed deputy family liaison officer informed the man’s partner of his death. She was extremely distraught and upset, and initially refused them entry to her property. When she let them in, the two members of staff explained the circumstances of the man’s death. His partner was extremely upset and asked the officers to leave. They did so at 10.05am, but before leaving they left their contact details, those of the undertakers and coroner, and a booklet on bereavement.

162. At 10.45am and 10.50am the same morning, the family liaison officer and the deputy family liaison officer received telephone calls from relatives of the man, asking about the circumstances of his death.

163. The family liaison officer telephoned the man’s mother at 11.12am to inform her of his death and the surrounding circumstances.

Further liaison with the man’s family

164. On 4 December, the head of safer prisons, received a call from someone acting on behalf of the man’s stepmother and father, who were making funeral arrangements and wanted to know when his body would be released. He provided the caller with the coroner’s details, explained the process of formal identification, and the role of the family liaison officers. The head of safer prisons also explained that the prison would normally make a contribution to the funeral expenses. He outlined the role of the Ombudsman’s office and the investigation that would take place.

165. On 5 December, the deputy liaison officer twice attempted to contact the man’s partner by telephone, but there was no reply and she did not leave a message. Later that day, she telephoned the man’s father. He was keen to know every detail of what happened to the man in the hours and minutes

before his death, and she explained the role of the Ombudsman's office in such proceedings. She gave as much information as she could to the man's father, and also explained this report would contain considerable detail about the circumstances surrounding his death.

Post-mortem and funeral

166. A post-mortem examination of the man's body was conducted by the consultant forensic pathologist, on 6 December. Other than marks on his neck from the ligature and "a pale post-mortem type pressure marks" on the jaw and neck which were "consistent with the effects of the airway mask", there was no evidence of recent injuries.

167. Toxicological analysis was completed and it was found that the man had taken fluoxetine, zopiclone and ibuprofen. All were at a level consistent with the approved therapeutic dose. No other drugs were detected.

168. The consultant forensic pathologist stated the following:

> "I note the circumstances of [the man's] death. He was found with a sheet wound around his neck, which was attached to a chair. It does not appear that he was hanging, but he had managed to apply pressure to his neck by this mechanism. Apart from a pallid mark towards the front of his neck there was no evidence of any significant skin or deeper soft tissue injury to the neck. These negative findings would be in keeping with the use of a relatively broad soft ligature to apply pressure to the neck. In the absence of complete suspension there may be little resulting injury to the tissues of the neck particularly if the ligature is removed rapidly after death."

169. The consultant forensic pathologist concluded that the medical cause of the man's death was compression of the neck.

170. The man's funeral took place on 28 January 2011 in Wolverhampton.

ISSUES

Information available during the reception process

171. Before prisoners arrive in the reception area of a prison, information about them has already been collected by other people in other locations. When the man arrived at Wormwood Scrubs on 30 October 2010, he had already been in contact with the police and had appeared in court.

172. During the man's time in police custody, he said he felt depressed and asked to see a doctor. However, he then refused to see the doctor. He was also prescribed medication for a stomach complaint.

173. The person escort record (PER) is a document that accompanies a prisoner during transfer. It includes a risk indicator form. This comprises a single page and is designed to show the known risks presented by a prisoner. The form was started on 29 October, in preparation for the man's transfer to court the following day. It was updated to include the information about the man claiming to be depressed, and his refusal to see the doctor. The information about the medication he had been prescribed was also included. One part of the form asks about the 'current and relevant risk' of suicide or self-harm. The officer completing the form wrote 'no' in response to this question.

174. When the man was at court, an electronic 'record of events' page was regularly updated. At 11.13am, the SCO officer reported that the man had said he was going to kill himself, and that he was to be observed every five minutes. There was no update to the risk indicator form and no new warning form to suggest a risk of suicide or self-harm. A separate warning form specifically for highlighting issues of self-harm and suicide is available to escort contractors and should be completed where such a risk exists.

175. The man arrived at Wormwood Scrubs at 1.25pm. He was seen by a nurse and prison officers. Nurse A told the investigator that, whilst he had access to the PER, he did not necessarily read every document, and relied heavily on the risk indicator form to inform him whether there had been any recorded risks of suicide or self-harm.

176. The PER, when it arrived at Wormwood Scrubs with the man, did contain the 'record of events' page that had been completed at court, including the information that the man had said he was going to kill himself. However, the information was not prominent within the PER. Even on the 'record of events' page, the relevant entry was amongst 26 others made during the man's time in court. It would not have been immediately apparent that there was information of particular significance within the document.

177. Given the number of people arriving at a prison such as Wormwood Scrubs at any given time, the workload pressures of a prison reception environment, and the number of individual documents arriving with prisoners, it is not reasonable to suggest that nurses completing the reception health screening process should always read the PER from cover to cover. The risk indicator form is a relatively simple, single page document that allows known risks to be easily communicated. This form should be used to highlight the risk of suicide

and self-harm, as well as separate, individual suicide and self-harm warning forms that immediately draw attention to the nature of the risk. Reception staff cannot be expected to be aware of issues that are not given any prominence within the PER.

178. The clinical reviewer commented on this issue in his clinical review. Regarding Nurse A's admission that he read only the prominent part of the PER, the clinical reviewer said:

> "He thus missed the suicide threat contained in a later page. If blame is to be apportioned here I would place it firmly on the construction of the PER. The most important piece of information is buried in a later page."

179. In addition to the quality of information arriving into the prison, there are concerns about how effectively available information is shared between different disciplines during the reception process. This issue was covered in a PPO report following a death in 2008, and we return to the matter here.

180. As is almost always the case when prisoners arrive from court rather than from another prison, the reception health screening relied heavily on the man's disclosure during the assessment. In response to this, and the failure to see the information from court, Nurse A did not record any concerns about suicide or self-harm.

181. The man saw a doctor as part of the reception process, and he mentioned that he was prescribed fluoxetine for depression. This prescription was renewed so that his medication could continue during his time in custody.

182. The officer completing the cell sharing risk assessment (CSRA) noted on the form that the man had "previously tried to overdose three to four years ago". The nurse had access to the CSRA and indeed had to complete a section of it, and so had the information about the previous overdose available to him. However, no mention of it was made in the clinical record.

183. The issue of concern is that various pieces of information were gathered by different people but do not appear to have been considered in conjunction with one another. At the police station, the man said he felt depressed. At court, he said he was going to kill himself. He told a doctor during the reception process that he was depressed and was prescribed fluoxetine. The CSRA contained information that he had previously tried to overdose. Yet, when the man left the prison's reception area, he was considered a low risk in terms of suicide and self-harm.

184. It is impossible to say whether the man presented an actual risk of self-harm or suicide at the time of his reception into Wormwood Scrubs. Members of staff completing assessments rely not only on the information available to them, but their observations of the prisoner during their interaction with them. The issue here is not that the man was considered a low risk to himself, but that the available information was not used when making the assessment.

185. The problem of information not being properly communicated to the prison, and further information not being effectively communicated between different

disciplines, has been a frequent theme of PPO reports, particularly where the reception process is concerned. It is essential that, when specific information is available, it is considered as part of the risk assessment process. We are aware that this issue is being considered in depth by the Ministerial Board on Deaths in Custody, and will ensure that they see a copy of this report. However, we also believe that two recommendations should be made in order to improve local practices:

The Governor should work with local criminal justice partners to ensure that all information about the risk of suicide and self-harm is recorded prominently on the relevant documentation.

The Governor and Head of Healthcare should ensure that members of staff record any information regarding suicide and self harm prominently on prison-generated documents.

Control and restraint

186. On 1 December, control and restraint techniques were used against the man after he allegedly attempted to assault Officer C. After he was restrained, the man was removed to the segregation unit. When he arrived in the segregation unit, he said he had suffered a head injury during the restraint. In the note that was found in the man's cell after his death, he wrote that Officer C had in fact assaulted him.

187. The man interviewed five members of staff who were involved in the incident on 1 December, as well as the doctors who saw him in the segregation unit. Regarding the altercation that resulted in control and restraint being used, Officers C and D gave consistent accounts of what had happened. Both officers reported that the man had been verbally abusive before attempting to strike Officer C.

188. The officers provided detailed accounts of the control and restraint. They were questioned about the approved techniques that they used, and about the man's welfare during the process, by the investigator. The process of restraining the man appears to have been appropriate. Officers consistently reported that the man continued to struggle and resist against them, and that this necessitated him being taken to the ground on two occasions. When he became compliant, he was taken to the segregation unit, although he continued to be verbally abusive to Officer C.

189. When control and restraint techniques are used, the members of staff involved are required to make written statements on a specific form entitled 'Annex A: Use of force'. The paperwork given to the investigator suggests that although some members of staff completed such forms, not all those involved did so. One officer had written an incident statement on a different type of form, but there were no written statements from some people who had direct involvement.

190. The use of control and restraint techniques is a serious and hopefully infrequent occurrence. Whilst there is no suggestion that the techniques were

deployed inappropriately on this occasion, it is imperative that paperwork outlining the circumstances and justifying the action taken is completed in full.

The Governor should ensure that members of staff involved in control and restraint complete the 'Annex A: Use of force form'.

191. When the man arrived at the segregation unit, he complained that he had sustained a head injury during the control and restraint. The investigator asked the members of staff involved in the incident about this, but they did not recall this happening. Officer D conceded that it was possible the man had hit his head when they fell over. Dr A, who attended the segregation unit on the evening of 1 December, said the man felt that too much force had been exerted. He complained of a headache but did not report any specific injuries. Dr A did not observe any injuries to the man's head. Dr C saw the man the next morning. She told the investigator that the man had complained of aches and pains resulting from being restrained, but not of a specific injury. On both 1 and 2 December, the man was prescribed pain relief medication.

192. Although the man claimed to have suffered a head injury when he first arrived in the segregation unit, there is no evidence to suggest that this was the case. He had two opportunities to report an injury to a doctor, but did not do so. The post-mortem report conducted after his death did not reveal any injuries that could have been attributed to the control and restraint process.

193. When the investigator and the Ombudsman's liaison officer with the man's family, his mother expressed concerns that her son had deliberately engineered his removal to the segregation unit. She said that one year before the man's death another family member had been facing his first time in prison, and was scared he might be bullied. The man had told this family member that if anything like that should happen, his best course of action would be to threaten an assault against a prison officer, as this would result in him being removed to the segregation unit, where he would be safer. The man's mother was therefore concerned that her son's actions on 1 December were an attempt to protect himself from bullying.

194. The investigator reviewed the man's prison records, including his security intelligence file. There was nothing to suggest that he was the victim of bullying. Several members of staff were interviewed, who said that the man associated with a small number of other prisoners but was mostly quiet and spent a lot of time in his cell. There was, though, no suggestion that he was being victimised by other prisoners. There is no evidence to suggest that the cut the man sustained above his eye on 19 November was anything other than accidental. He was in a locked single cell at the time, and he later described during a telephone call the type of exercise that he was attempting when he sustained the injury.

The response to the man's distressing news

195. On 30 November, the man spoke to his partner and told her he had heard that his brother had committed suicide. The same day, he spoke to a member of the prison chaplaincy team and repeated the same information, saying that

the person in question was his brother. When he saw Dr C on 2 December, he again repeated that his brother had committed suicide a few days earlier.

196. When the investigator and the Ombudsman's family liaison officer visited the man's family, his mother said that to the best of her knowledge, the information that the man had received about his brother was not true. The investigator was also unable to corroborate the information after examining the PPO's case management system. However, if the man believed it to be true at the time, it may well have been particularly distressing. The main issue of concern is what happened to the information that the man gave to two members of staff, and whether he was afforded the opportunity to verify what he had heard.

197. From the information that is available, it seems likely that the man believed that what he had heard about his brother was true. It is not clear who told him, but during a telephone call to his partner he mentioned that it was a prisoner on the wing. The man's partner had not heard anything about the issue, and so the telephone call ended, when his PIN phone credit ran out, with him apparently still believing that his brother had died.

198. When the man saw the member of the prison chaplaincy team he gave him the same information about his brother. In his email written after the man's death, the member of the prison chaplaincy team recalled that the man was "moderately upset" and said he did not have any PIN phone credit to call his family. The man explained that he would have credit in two days' time and would attempt to make contact with his family then.

199. It does not appear that the member of the prison chaplaincy team took any further action in response to the information given to him by the man. He did not record the meeting or the nature of the conversation in the chaplaincy journal, or on the electronic prisoner record. There is no evidence to suggest that he made members of staff working on D wing aware of what the man had told him. In his email, he said he told the man that he would call to see him four days later (Saturday 4 December).

200. On 2 December, Dr C saw the man, not because he had asked to see her but as part of her segregation unit rounds. He told her that he was having trouble sleeping because of the recent death of his brother. The doctor told the investigator that the man did not seem upset or distressed, and that he was calm and polite. She prescribed sleeping tablets and made a note of their conversation in the clinical record. She did not inform members of staff working in the segregation unit about the conversation, and said that the information was medically confidential.

201. It would appear that the two members of staff to whom the man spoke about his brother's apparent death were rather relaxed about the information they were given. The member of the prison chaplaincy team did not seem concerned about the prospect of the man having to wait two days to speak to his family members and find out more information. The doctor treated the associated symptoms (lack of sleep) but did not explore the others ways in which the information might have affected the man. Neither member of staff made active efforts to bring the matter to the attention of other people.

202. It must be acknowledged that the member of the prison chaplaincy team and Dr C were the people who actually spoke to the man about the issue. They were the only ones able to judge his appearance and demeanour at the time, and they did not think there was sufficient reason to be concerned about his mental well-being or about his risk of suicide and self-harm. That said, it seems patently obvious that the news of the death of a close relative might be distressing. It would have been sensible to disseminate this information to members of staff likely to come into contact with the man on a regular basis, such as unit officers. In addition to offering support if required, officers on the unit might also have been able to facilitate a telephone call between the man and his family members, despite his lack of PIN phone credit.

203. Dr C said the information given to her by the man was confidential and that she could not have passed it to officers on the unit. However, given the upsetting nature of the information and its potential to have an adverse impact on the man's mental health, it would have been prudent to make others aware of what had been discussed, perhaps after discussion with the healthcare manager. In any case, the doctor acknowledged she was accompanied by a prison officer during her visits to prisoners on the segregation unit, who could easily overhear the nature of the conversations taking place. Despite the doctor's concerns around confidentiality, it seems there was no real attempt to keep the discussions private in the first place.

204. It is clear that neither the member of the prison chaplaincy team or Dr C thought that the man presented an imminent risk in terms of suicide or self-harm. It is also very easy to be aware of risks in retrospect. Furthermore, the man could have spoken to unit officers himself about the issue and asked them to facilitate a telephone call. Nevertheless, it is concerning that the information was neither properly recorded nor more available to other members of staff.

The Governor and the Head of Healthcare should ensure that members of staff appropriately record and share information, particularly when it concerns issues of potential risk.

The segregation unit

205. In general, the man's removal to the segregation unit was well documented. There were, however, some minor administrative errors and omissions on documents such as the initial segregation health screening (where the authorising manager had failed to properly complete the form). Regarding the segregation history sheet, two entries were made on the same form and the dates written where the time would normally be entered. These are minor oversights and would not have had a material effect.

206. More worrying was the omission of the man's name from the list of prisoners in the segregation unit on both 1 and 2 December. The list of occurrences makes reference to him arriving at 7.00pm. There are 14 names listed, and the overnight roll checks suggest there were 14 prisoners on the unit, although the man's name does not appear. The same form for the following day also omits the man's name. There are 13 names listed, and the overnight

roll checks suggest that there were 15 prisoners on the unit (though these checks are known to be unreliable, as is discussed in a later section of this report). It is strange that the man's name was not listed on 2 December, as he spent the whole day in the segregation unit, having arrived the previous evening.

The Governor should ensure that the list of prisoners in the segregation unit occurrence book accurately reflects the prisoners in the unit.

207. A representative from the Independent Monitoring Board (IMB) ordinarily visits the segregation unit daily. According to the sign-in book for the unit, there was no such visit on 2 December. Whilst we do not make a recommendation in this area, it would be advisable for the Governor to instruct staff that, where specific reasons exist for visits not taking place, they are recorded in the unit's occurrence book.

Events during the night of 2/3 December

208. OSG B was responsible for patrolling the segregation unit overnight on 2/3 December. His movements during the night are reported in considerable detail in the Key Events section of this report. The information that he provided on the segregation unit occurrence sheet regarding his cell checks is inconsistent with what is seen on the CCTV footage of the unit.

209. It is not necessary to again recount OSG B's movements in great detail. Suffice to say, he did not carry out roll checks at the times that he recorded on the occurrence sheet. The fact that some of the times provided were after the man's death, when OSG B was not even working on the unit, suggest that his entries on the occurrence sheet were completed in advance, rather than representing a record of what he had actually done.

210. Although OSG B was seen to complete some checks on cells, they were not conducted hourly, as should be the case for the segregation unit. A prisoner on the unit harmed himself around 11.30pm, and this took up a considerable portion of OSG B's time, to some extent during the incident but more significantly afterwards, when he spent a long period of time talking to the prisoner. However, even before this incident arose, OSG B had failed to conduct cell checks hourly.

211. The CCTV footage shows that the man's cell alarm was active for the following periods: 11.05pm to 11.12pm, 11.12pm to 11.34pm, 11.39pm to 11.47pm, 11.47pm to 11.54pm, and 11.54pm to 2.37am. It was, in effect, active almost continuously from 11.05pm. OSG B did not check the man's cell at all between 11.54pm and 2.37am.

212. When a cell alarm is activated, a light illuminates above the cell door. A light also illuminates on a panel on the ground floor of the unit, and an audible buzzing noise is triggered. A button on the panel can be used to silence the audible warning temporarily, but it is supposed to re-activate automatically five minutes later, if the alarm has not been de-activated. The only way to cancel the alarm is to press a button outside the corresponding cell.

213. The CCTV footage does not contain sound, so it is impossible to be certain about whether the audible warning was working properly on the night in question. Duty Governor A, the safer custody manager, told the investigator that, after the man's death, he found evidence that the buzzer could be permanently disabled from the panel, although it was not supposed to function in such a way. Cell alarms were active for long periods on the night of 2/3 December, and it seems unlikely that OSG B listened to audible buzzing for a protracted period or repeatedly muted it. If the warning buzzer was disabled, there is no evidence to suggest that this was necessarily the work of OSG B.

214. Duty Governor A told the investigator that, after he discovered the problem, he made modifications to the alarm panels on all the units at Wormwood Scrubs to ensure that the audible warnings could not be permanently disabled.

The Governor should ensure that sufficient modifications have been made to the alarm panels and that the audible warning system cannot be circumvented.

215. Regardless of the audible warning, the cell alarm system also triggers a light above the corresponding cell door. These lights are readily apparent, particularly during the night when other lighting on the unit has been dimmed. At the very least, even without other systems working correctly, OSG B should have seen the cell alarm warning lights during hourly checks. There is little evidence to suggest that he did not respond to cell alarms because he failed to see the lights above cell doors. On a number of occasions, OSG B walked directly past cells, including the man's, when the alarm light was lit. He also cancelled alarms without actually looking into the cells.

216. It must be acknowledged that the man had previously misused his cell alarm bell. OSG B said in his statement that the man had used it during the night to ask for tobacco. Another officer said that, earlier the same evening, the man had been shouting and asking other prisoners for tobacco. Members of staff are presented with difficulties when prisoners use the cell alarm system for non-urgent matters. Twice, the man activated his cell alarm as soon as it had been cancelled, and on a third occasion he waited only five minutes. Regardless of this, the man should have been checked at least hourly, and he was not. Clearly, he was alive at 11.54pm, when he activated his cell alarm. He was not checked until 2.37am, when he was found with a ligature around his neck.

217. The segregation unit was clearly not run effectively on the night of 2/3 December. OSG B was suspended from duty and subject to a criminal investigation for failing to properly complete his duties. Whilst this investigation did not find any evidence that the problem was more widespread, it would be wise for the Governor to check that other members of staff are carrying out their duties properly.

The Governor should ensure that all members of staff, and particularly those working on units alone overnight, fully understand their responsibilities and are working effectively.

218. On a related note, there is scope for general consideration of whether OSGs, who have not had the same level of training as prison officers, should have the responsibility of patrolling the segregation unit, a place that contains difficult, challenging and refractory prisoners.

The Governor should ensure that the segregation unit is supervised overnight by appropriately qualified officer.

The emergency response

219. The man was not checked between 11.54pm and 2.37am. It is therefore impossible to ascertain how long he had the ligature around his neck before the alarm was raised. When OSG B looked into the man's cell, he immediately conveyed a radio message to make other members of staff aware of a very serious situation.

220. The response from other prison officers, nurses and paramedics was swift. Two prison officers arrived within two minutes of the radio message and entered the cell. Several other members of staff arrived seconds later. A resuscitation effort was underway even before the first nurse arrived at 2.40am, three minutes after the radio message. Paramedics arrived at the cell eight minutes after the alarm was raised, and further medical personnel arrived six minutes later. Attempts at resuscitation continued until a doctor arrived at pronounced the man's death.

221. The first nurse on the scene told the investigator during interview that whilst a defibrillator was taken to the man's cell, it was not used. She explained that although the nurses were trained in the use of the defibrillator, this was limited to assisting a doctor. The nurse said that she had been shown "how and when to use it" but would not do so without a doctor present.

222. The second nurse on the scene recalled the situation in a slightly different way. She confirmed that a defibrillator was taken to the cell, but said that the paramedics arrived as she was unpacking it and so there was not time to use it. The CCTV footage showed that the paramedics indeed arrived only two minutes after the nurses took the medical equipment into the cell.

223. The type of defibrillator used in prisons has clear instructions and uses audible voice prompts to aid people in their effective use. They are designed so that people without medical training can use them if an emergency situation arises. It is very surprising that medical professionals working in the prison, who have been trained in the use of the defibrillator, do not feel that they are able to use it without the presence of a doctor. Indeed, doctors do not routinely work in the prison overnight and so there would inevitably be a completely unnecessary delay in the use of life-saving equipment should this practice continue.

224. In this particular case, paramedics arrived at the man's cell very quickly and so there was no major delay. However, in other situations, the use of a defibrillator by nurses working in the prison could be critical, as the window of opportunity for successful resuscitation following cardiac arrest is short.

225. The clinical reviewer also drew attention to this issue in his clinical review. He reported that additional training and confidence building is required, and that nurses would need to attend annual refresher courses.

The Head of Healthcare should ensure that nurses working in the prison are trained to use defibrillators and feel confident using them without supervision.

Clinical issues

226. The main issues raised by the clinical reviewer in his review of the man's care are covered by other areas of this report. In particular, the clinical reviewer was critical of the different forms used as part of the PER, and the resulting possibility for confusion. He was concerned that, on this occasion, an important piece of information was not given a prominent position. The clinical reviewer also mentioned that the various disciplines within the prison used different systems of record keeping, leading to an approach that was not effectively integrated.

227. In addition to the issues already covered, the clinical reviewer found that the clinical record did not always contain sufficient justification about why particular medications had been prescribed. He also thought that on some occasions, there was not enough information and context given in the entries made by medical staff. During consultations, doctors did not always have access to the clinical record, such as when Dr C saw the man on 2 December.

228. There were instances of the clinical record not being consulted, despite relevant information being contained within it. When the man sustained a head injury on 19 November, Dr C saw him for a follow-up consultation. A form had been completed with details of the injury, but the doctor told the investigator that she did not see this form before she spoke to the man. As a result, the doctor's understanding was that the man had not lost consciousness during the incident, when he had reported the previous evening that he had.

The Head of Healthcare should ensure that entries in the clinical record are comprehensive, that decisions taken are fully justified, and that clinicians consult the record before appointments with prisoners.

Issues raised by the man's family

229. Most of the issues raised by the man's family members have been covered above. It was unfortunately not possible to interview OSG B as part of the investigation, as a criminal investigation remained active as the time of writing. As such, no further information can be provided about the nature of his conversations with the man and other prisoners on the night of 2/3 December.

230. The man's family members asked whether it was possible to overhear conversations that were taking place in cells within the segregation unit. Cells in the segregation unit accommodate one prisoner, and so conversations

would not be taking place between prisoners in a single cell. As for conversations taking place between a prisoner in a cell and someone else outside the door, this is probably dependent on the volume of the conversation. Certainly, cells are not soundproof, and it is possible to hear what prisoners are saying even when the doors are closed. Officer H told the investigator that, during the evening of 2 December, the man was shouting to another prisoner on the unit through his closed cell door, in an attempt to obtain tobacco. It is, therefore, possible to hear conversations when cell doors are closed, but the extent to which they can be heard very much depends on the individual circumstances.

CONCLUSION

231. The man was arrested and remanded to Wormwood Scrubs two days later. Although he had intimated suicide whilst at court, this was not considered as part of his reception screening process at the prison. He did not necessarily pose a high risk to himself at that time; indeed, he remained at the prison for the next month without major incident.

232. The man received two warnings about his behaviour during November. On 30 November, he made a telephone call to his partner and said he had received information that a man with the same name as his brother had died. His partner knew who the man was referring to, but did not have any further information. The man spoke to a member of staff from the chaplaincy about the same issue and identified the person as his brother.

233. On 1 December, the man was restrained after he allegedly attempted to assault a prison officer. He was taken to the segregation unit. The next day, he saw a doctor and repeated the information about his brother. The doctor made a note in the man's clinical record, but she did not pass the information to anyone else.

234. During the night of 2/3 December, the officer responsible for carrying out patrols did not check the prisoners in the segregation unit as frequently as he should have done. He also failed to respond to cell alarms in a timely fashion. The man's cell alarm was active almost continuously from shortly after 11.00pm. After 11.54pm, he was not checked again until 2.37am, when he was found with a ligature around his neck. When the alarm was raised, there was a swift response and a sustained resuscitation effort, but this was ultimately unsuccessful.

235. It is, of course, impossible to know what led the man to take his life. During telephone calls, he had expressed concerns about the possibility of receiving a long and potentially indeterminate sentence. It is clear that he was worried by this prospect. Over the course of two days, he went from living on D wing, albeit with two behaviour warnings, to learning of the apparent death of his brother, allegedly attempting to assault an officer, and being removed to the segregation unit. Although he was observed to be calm, pleasant and polite on 2 December, it is possible that the turn of events had a detrimental effect on his state of mind.

RECOMMENDATIONS

1. The Governor should work with local criminal justice partners to ensure that all information about the risk of suicide and self-harm is recorded prominently on the relevant documentation.

   The recommendation was accepted. Internal reception processes have been enhanced to ensure the relevant information is picked up and acted upon in the appropriate manner. All outgoing information is written on the PER and handed over to the receiving agency. This is monitored and any deviation from this policy is investigated and reported to the governing Governor.

2. The Governor and Head of Healthcare should ensure that members of staff record any information regarding suicide and self harm prominently on prison-generated documents.

   The recommendation was accepted. All information regarding self-harm is recording on the PER (as per current policy) for outgoing prisoners.

   All medical staff will again receive mental health awareness training. Care management programme and primary mental health staff will provide training for all new members of staff during induction, to ensure that both prison and healthcare staff are aware of the need for the exchange of appropriate information.

3. The Governor should ensure that members of staff involved in control and restraint complete the 'Annex A: Use of force form'.

   The recommendation was accepted. The control and restraint coordinator monitors use of force paperwork. Where items are missing, they are chased and members of staff are required to return completed forms. Any non-compliance to this procedure is reported to the head of safer custody to escalate to functional heads and ensure completion.

4. The Governor and the Head of Healthcare should ensure that members of staff appropriately record and share information, particularly when it concerns issues of potential risk.

   The recommendation was accepted. All members of staff will attend annual ACCT refresher training. There will also be in-house training in the sharing of information and documentation for all healthcare staff.

5. The Governor should ensure that the list of prisoners in the segregation unit occurrence book accurately reflects the prisoners in the unit.

   The recommendation was accepted. A notice to staff regarding the importance of keeping a correct roll in all residential areas will be published, reinforcing the correct procedures to be followed.

6. The Governor should ensure that sufficient modifications have been made to the alarm panels and that the audible warning system cannot be circumvented.

The recommendation was accepted. The cell call systems located in the segregation and healthcare units have been changed and do not allow the muting of the audible alarm. All repeater panels on the landings have had their silence buttons disconnected. The only way to silence the call system is to attend the cell and press the button at the cell door.

7. The Governor should ensure that all members of staff, and particularly those working on units alone overnight, fully understand their responsibilities and are working effectively.

   The recommendation was accepted. All members of staff working within the prison receive a night folder containing a briefing about their duties and responsibilities. A review of the folder will be undertaken to ensure it is relevant and up to date with current policy and practice. All new members of staff undergo a training and induction package prior to taking up their post.

8. The Governor should ensure that the segregation unit is staffed overnight by an appropriately qualified officer.

   The recommendation was accepted. A profile review has been completed and the decision made to replace the operational support grade role with a prison officer in the segregation unit.

9. The Head of Healthcare should ensure that nurses working in the prison are trained to use defibrillators and feel confident using them without supervision.

   The recommendation was accepted. All healthcare staff receive basic life support training during induction and then on a yearly basis. This training is mandatory. Clinical staff complete intermediate life support training and attend refresher training yearly.

10. The Head of Healthcare should ensure that entries in the clinical record are comprehensive, that decisions taken are fully justified, and that clinicians consult the record before appointments with prisoners.

    The recommendation was accepted. A records audit will be completed. In-house training regarding record keeping standards will take place.

    Computer terminal access has been improved in all residential areas, allowing clinical records to be accessed by medical staff in more locations.