

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

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

February 2011

This report considers the circumstances of the death of the man at Chelsea and Westminster Hospital in March 2010, whilst in the custody of HMP Wormwood Scrubs. The man had complex health needs. He had a serious physical illness, was mentally ill, refused medication and was monitored closely by staff due to the risk of self harm. The post mortem showed that he died from cancer.

I offer my condolences to his family and friends for their loss. My senior family liaison officer had contact with the man's family at the start of the investigation and explained the investigation process.

The investigation was carried out by one of my investigators. I would like to thank the governor and his staff for their co-operation during the course of our enquiries. I particularly thank the prison's liaison officer.

I also thank Hammersmith and Fulham Primary Care Trust for appointing a review panel. As the man died from natural causes, the findings of the clinical review play an essential part in my report. The review judges that the man received good care whilst he was in custody which was equitable to what he could have expected in the community.

I make two recommendations regarding formal mental capacity assessments and the appropriate levels of observation. I endorse the clinical review panel's comments about record keeping and clinical notes. I recognise the good practice adopted by Wormwood Scrubs in the use of restraints during the man's final days in hospital. I also endorse the clinical review panel's commendation of the quality of engagement between healthcare staff and the man.

The 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.

Jane Webb
Acting Prisons and Probation Ombudsman

February 2011

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SUMMARY

The man was born in June 1969 in Liverpool. He was single and had lived in the London area for a number of years. He had human immunodeficiency virus (HIV). He was diagnosed with advanced retroviral disease (AIDS) and suffered from mental illness. He had a history of using illicit drugs. The man was 41 years old when he died.

On 10 July 2009, the man was remanded into custody for conspiracy to supply drugs. He was sent to HMP Pentonville. On arrival at the prison he said that he had been diagnosed with AIDS and had refused to take the medication prescribed for his condition. He said he had a history of mental illness and self harm and had previously been treated in hospital.

As a result of the man's history of harming himself, he was closely monitored by the prison's suicide monitoring (Assessment, Care in Custody and Teamwork or ACCT) procedures and he continued to refuse to take his medication. The man appeared at Blackfriars Crown Court on 21 September, and was remanded back into custody. Instead of returning to Pentonville, he was sent to HMP Wandsworth where he continued to be closely monitored by staff. He was transferred to HMP Wormwood Scrubs on 11 December, still being monitored by the ACCT procedures.

The prison doctor referred the man to St George's Hospital on 14 February 2010 due to his poor health. He remained there for two days until he was transferred to the Chelsea and Westminster Hospital on 17 February.

On 8 March, he was told by hospital doctors that he had inoperable cancer. Five days later he contacted his family in Liverpool to inform them of the diagnosis and, due to a significant deterioration in his health, unrestricted family visits were permitted. The restraints were removed on 13 March and his family were present when he died two days later at 1.00am in March.

Wormwood Scrubs followed the requirements of Prison Service Order 2710 'Follow up to death in custody' and offered financial assistance towards the cost of the funeral.

In general I am satisfied that the care and attention the man received at Wormwood Scrubs was equitable to that he could have expected to receive in the community. However I draw the Director of Offender Management's attention to the man's moves around London prisons and the threat this posed to the continuity of care for a man with complex needs.

I make two recommendations regarding formal mental capacity assessments and the appropriate levels of observation. I draw the Head of Healthcare's attention to the clinical review panel's comments about record keeping and clinical notes. I would like to recognise the good practice adopted by Wormwood Scrubs in the use of restraints during his final days in hospital. I also commend the quality of engagement between healthcare staff at Wormwood Scrubs and the man.

THE INVESTIGATION PROCESS

1. The investigation was opened on 16 March 2010 when my investigator issued notices to staff and prisoners. The notices included an invitation to those who wished to submit information relating to the man's death to make themselves known. No prisoners came forward as a result. My investigator visited Wormwood Scrubs on 26 March and was given a copy of the man's prison records.
2. Hammersmith and Fulham Primary Care Trust (PCT) asked to chair a review panel to carry out a review of the man's clinical care. I am grateful to them for undertaking this review. The investigator discussed aspects of the man's treatment with both staff at Wormwood Scrubs and with the clinical review panel.
3. The investigator contacted Her Majesty's Coroner for Westminster to inform her of the nature and scope of my investigation and to request a copy of the post mortem report. Upon completion, my report will be sent to HM Coroner to assist her enquiries into the man's death.
4. One of my family liaison officers contacted the man's parents at the beginning of the investigation. They told my family liaison officer that they did not have any concerns about the treatment and care that their son received.

HMP WORMWOOD SCRUBS

5. HMP Wormwood Scrubs is a local prison that accepts all suitable male prisoners over the age of 21 from the courts in its catchment area. The establishment has five main wings and a number of smaller dedicated units. A and B wings manage both remand and sentenced prisoners. C wing accommodates prisoners on the Intensive Drug Treatment System that offers enhanced support for offenders with substance misuse problems.
6. Her Majesty's Chief Inspector of Prisons, conducted a full unannounced inspection of Wormwood Scrubs between 9 and 13 June 2008. The Chief Inspector's report judged that progress that the prison had made since her previous inspection had halted in 2005, and there had been "an appreciable drift" in all the key areas namely safety, respect, purposeful activity and resettlement. However, the report acknowledged the difficulties the prison faced in coping with constant daily pressure.
7. Each prison in England and Wales is also monitored by an Independent Monitoring Board (IMB) formed of volunteers from the local community. IMB members have full access to every prisoner and all parts of the prison. The Board produces an annual report, with the most recent available for Wormwood Scrubs was for the period 1 June 2008 to 31 May 2009. The report made the following comments concerning healthcare:

"The Board is greatly relieved that the PCT has funded the post of a second doctor to be available in the First Night Centre for reception screening. The PCT has funded a refurbishment of primary clinics including the dental suite.

"The number of prisoners attending primary clinics has recently been restricted to 20 per am and pm session, following a security review. This, along with absences from those scheduled to attend due to illness, visits, court appearances etc, has resulted in lower numbers of patients seen at each session. The Board has raised the issue with the Governor."

8. The IMB had specific concerns about the recruitment and retention of healthcare staff and stated the following in the report:

"Once again the recruitment of permanent nursing and GP staff has proved problematic and health services in the prison are heavily reliant on agency staff. This is unsatisfactory and does not represent parity of treatment with those outside prison."

9. The IMB also considered aspects of safer custody and made the following comments in the report:

"The Board is represented at meetings of the Suicide Prevention Committee. The Suicide Prevention Co-ordinator has been in post some time and has an in-depth knowledge of the policy and procedures. Residential staff are aware of the risks of self-harm and suicide.

“There have been 5 deaths in custody in the reporting year. On each occasion the Chair or Vice Chair was informed and attended the prison. The Board is satisfied that in each case the situation was handled appropriately.”

10. The rules that govern all aspects of running a prison are set out in a series of documents called Prison Service Orders (PSOs). PSO 2700 – ‘Suicide prevention and self-harm management’ details prison procedures for looking after prisoners at risk of suicide or self harm. Assessment, Care in Custody and Teamwork (or ACCT) is the system used by prisons to identify, monitor and support prisoners at risk of self harm. The ACCT process is used in all prisons in England and Wales. Any member of staff can start the ACCT process, by raising a Concern and Keep Safe form, explaining the reasons for their concern. An Immediate Action Plan is written by the manager of the wing where the prisoner is located and within 24 hours an ACCT assessment is carried out by a member of staff who has the required training.
11. After the ACCT assessment has taken place, a multi-disciplinary ACCT case review is held to determine what measures can be taken to monitor and support the prisoner effectively. The prisoner attends the case review and is encouraged to contribute to the decisions being made. An ACCT CAREMAP is drawn up with details of each of the actions required to keep the prisoner safe and identifies who is responsible for carrying out each action. Case reviews are held at regular intervals, usually monthly, to review the actions and the prisoner’s level of risk.
12. On each occasion a prisoner is escorted outside the prison to hospital, a risk assessment considers the risk to the public, potential for escape and likelihood of outside assistance. The assessment informs the decision about the number of escorting officers and the type of restraint to be used (single cuffs or two metre long escort chain with a cuff at either end). It also determines the circumstances and the authority required for the restraints to be removed. The risk assessment is reviewed each day that a prisoner is in hospital and amended where necessary.

KEY EVENTS

13. The man was born in February in Liverpool. He was single and had lived in the London area for a number of years. He was HIV positive and diagnosed with AIDS. He had a history of mental illness and using illicit drugs.
14. On 10 July 2009, he appeared at Knightsbridge Crown Court and was remanded into custody for conspiracy to supply drugs. He was sent to HMP Pentonville. On arrival at the prison he was interviewed by a nurse for a first reception healthscreen. (A first reception healthscreen takes place every time a prisoner arrives at a prison to determine any immediate physical and mental health conditions that require treatment, substance misuse matters that need to be addressed, and any risk that the prisoner may pose of harming himself or attempting suicide.) The man said that he had been diagnosed with AIDS, and had refused to take the prescribed medication. He also said he had a history of mental illness, being prescribed citalopram (an anti-depressant) and had been treated at the Chelsea and Westminster Hospital. He also said that he had harmed himself since he was 17 years old.
15. As a result of his history of self harm, an Assessment, Care in Custody and Teamwork (ACCT) document was opened in accordance with PSO 2700. The ACCT monitoring remained in place until the man died eight months later. It was assessed that the man required hourly observations until the ACCT assessment was completed. He continued to refuse to take his medication.
16. The man appeared at Blackfriars Crown Court on 21 September, and he was further remanded into custody and sent to HMP Wandsworth. The ACCT had been transferred with him and the monitoring and support continued.
17. The next morning the first nurse who assessed the man who said that he had taken an overdose of tablets when he was at court. The nurse immediately sent him under escort to St George's Hospital. A risk assessment was completed which assessed that the man should be escorted by two officers. They applied an escort chain (a two metre chain with a cuff at either end) which was to be removed when he was being treated. At hospital the man told the doctor that he had taken 20 paracetamol tablets. Full blood tests were undertaken and the results were negative for paracetamol and the remaining tests were all normal.
18. The man returned from hospital at 1.00am on 23 September, and was seen by a second nurse. The nurse noted that he was very anxious, and explained the services that were available such as the chaplaincy and Samaritans. The nurse recorded that she would be referring him to the mental health team and the doctor.
19. The following evening a third nurse went to see the man in his cell as he complained of abdominal cramps. The nurse recorded in the medical records that when the man was offered medication he became verbally abusive and wanted a second opinion or to be sent to hospital. The nurse told him that no

doctor was on duty until the morning and that she was able to issue pain relief medication.

20. The first prison doctor saw the man the next morning, 25 September. The doctor recorded that the man said he was HIV positive and had stopped taking his prescribed medication some time ago as he wanted to die. He told the doctor that prior to entering custody he had used crystal meths (methamphetamine - a potent stimulant that affects the mechanisms responsible for regulating heart rate, body temperature, blood pressure, appetite, attention and mood), cocaine and Valium. He told the doctor that he had wanted to kill himself for months but had no plans to do so at the present time, although he was likely to harm himself. The doctor prescribed citalopram and diclofenac (a non-steroidal anti-inflammatory drug taken to reduce inflammation and as an analgesic for pain relief). He also referred the man to the mental health team.
21. Four days later the man saw a nurse from the mental health team. The nurse recorded that the man had a long history of depression, and he said he heard voices at times and felt quite fragile. He said that he had been treated by a consultant physician at the Chelsea and Westminster Hospital.
22. Later that same day a second prison doctor, saw the man as he had complained of abdominal pain in the liver area. The doctor recorded that the man did not tolerate the pain well and prescribed dihydrocodiene (an analgesic).
23. On 2 October, Wandsworth healthcare obtained a detailed medical history from the consultant physician, at the Chelsea and Westminster Hospital. It confirmed the man's medical and blood test history.
24. Ten days later a second mental health nurse assessed the man and produced a comprehensive report. It referred to his past psychiatric history, including that he had been prescribed citalopram. It also mentioned his history of drug and alcohol abuse, that he was diagnosed with HIV some 20 years ago and AIDS ten years ago. He had refused to take the prescribed medication, and had pancreatitis (inflammation of the pancreas) and abdominal pains. The nurse noted that the man had a history of self harm and assessed that he was at risk of accidental death due to his compulsive self harming behaviour. As a result of this assessment the ACCT support remained in place. However it is not clear from the medical records whether a nursing plan, taking into account his complex needs, was put into place.
25. On 19 October, the man appeared at Blackfriars Crown Court and was remanded back into custody. On return to prison he saw a fourth nurse who noted that the man had said he was fit and well. The next day the man failed to attend an appointment with a third prison doctor.
26. Two weeks later the second mental health nurse attempted to see the man but he refused to be seen because he said he was tired and did not want to get out of bed.

27. On 12 November, a fifth nurse saw the man who complained of abdominal pain, diarrhoea, vomiting and blurred vision. Because of these symptoms and the man's other medical conditions, he was admitted to hospital. A risk assessment was completed which repeated the same arrangements of a two officer escort and an escort chain which could be removed when he was being treated.
28. The man remained in hospital for five days. Various tests were conducted, and the escort officers recorded that he was well and comfortable. The hospital doctor concluded that no cause could be found to account for the symptoms described by the man. In addition he saw a member of the hospital psychiatry liaison team who assessed that he was mentally stable but needed to remain under observation because of likelihood that he would harm himself.
29. On 20 November, the man appeared in Blackfriars Crown Court and was remanded back into custody.
30. The fourth prison doctor to assess the man saw him on 21 November as he complained of pains in his abdomen and was concerned about his liver. The doctor told him that he had only been in hospital a few days earlier and, if something serious had been identified, the hospital would have given the necessary treatment and care. The doctor noted the man's refusal to take the medication prescribed for AIDS.
31. The same doctor saw the man two weeks later as he said he had vomited 20 times and was unable to digest any food. The doctor noted that the man had become quite dehydrated, his blood pressure was 91/70 and felt dizzy when he stood up. (The normal range for blood pressure is 100/70 to 140/90, although this does vary throughout the day depending on the individual's activities. A blood pressure reading of greater than 140/90 is classed as high and a reading of 90/60 or below is classed as low.) The doctor decided to re-admit him to hospital.
32. The risk assessment confirmed the same level of escort and the escort chain, to be removed when he was being treated. The man was taken to St George's Hospital but immediately discharged himself against the advice of hospital staff, and returned to prison.
33. On 10 December, the man saw a fifth prison doctor (the fifth to see him at Wandsworth), as he said he had vomited five times that day and had not eaten but had been drinking coffee. He told the doctor that the reason he discharged himself from hospital was because he heard voices talking about him (the voices were deemed to be a symptom of his mental health condition). The doctor noted that the ACCT was still open and considered that it should remain in place. The doctor prescribed Dioralyte (a rehydration salts drink).
34. The next day the man was transferred to HMP Wormwood Scrubs. The first doctor who saw him at reception and recorded his medical history, his medication and his refusal to take the drugs prescribed to treat his AIDS

condition. The doctor noted that the man was on an open ACCT and confirmed that this was appropriate and should continue. The doctor also referred the man to the mental health team. Again it is not clear from the medical records that a nursing care plan was put in place.

35. Four days later the first nurse from the mental health team at Wormwood Scrubs assessed the man who spoke about his mental health history, previous drugs misuse and his compulsion to harm himself. He also told the nurse that he hoped to be released from custody at his next court appearance. The nurse assessed that the ACCT monitoring should continue at the same level.
36. On 6 January 2010, the man appeared at Blackfriars Crown Court. He was further remanded into custody and returned to Wormwood Scrubs.
37. The next day a nurse saw the man in the treatment room as he had cut his left forearm superficially. He told the nurse that he had cut himself because the voices told him to do so. The nurse dressed the wounds and recorded that his blood pressure was 115/70. An ACCT review took place later that day and the level of observation remained unchanged.
38. Two days later the second doctor to assess him at Wormwood Scrubs saw the man and noted that the wounds on his arm were clean and redressed. The man told the doctor that he was hearing male voices that called him by name.
39. On 14 January, the man attempted to hang himself using bed sheets but was prevented from doing so by uniformed staff. The first doctor, who met the man at reception, was called to the wing to see him again. The doctor recorded in the medical records that the man was alert and laughed. When asked why he attempted to hang himself, the man replied that he did not know. The doctor admitted the man to the healthcare centre and put constant staff observations in place to protect his safety and wellbeing.
40. The next day a full ACCT review was undertaken by a third doctor he had not met before, a senior nurse, senior officer, an officer and the man. An ACCT care plan was put in place which included accommodation in a single gated cell (a cell without a door to provide full visibility of the prisoner), constant one to one supervision, a weekly review by a psychiatrist, encouragement to take his prescribed medication and to take part in unit activities.
41. On 18 January, another ACCT review took place. Present at the review were the first prison doctor, a matron, the senior nurse, a nurse, the senior officer, an officer and the man. (I note that several members of staff attended both reviews and that the man was present on both occasions.) They agreed that his risk of self harm had significantly reduced and the observations should be reduced from constant supervision to once per hour, with no other changes made. The man appeared at Blackfriars Crown Court later that day, and was remanded back into custody at Wormwood Scrubs.

42. In the days that followed the man remained in healthcare, the ACCT support conditions were reviewed regularly and the level of observation maintained. The man continued to refuse to take the medication prescribed for AIDS but did take his other medication and there were no more instances of self harm.
43. The fourth doctor to treat the man at Wormwood Scrubs, saw him on 8 February. The man told the doctor that it was painful to eat and he was not taking his AIDS medication because he wished to die. The doctor recorded that the man was able to walk but his abdomen was tender. He prescribed tramadol (for treatment of severe pain).
44. For the next five days the man continued to refuse the prescribed AIDS medication but did take his other prescribed medication. It was recorded in the medical records that he was suffering from hiccups. His ACCT conditions were reviewed regularly and the ACCT observation conditions remained unchanged.
45. On 14 February, the second doctor who saw the man again as the hiccups were continuous and he had not eaten anything for two days. The doctor recorded that the man's blood pressure was 104/68, he had a rash on his skin and pain in his abdomen. The doctor referred him back to St George's Hospital. The risk assessment confirmed the same level of restraints, that is two officers to escort the man and the escort chain, which could be removed when he was being treated.
46. The man remained at Hammersmith Hospital for two days until he was transferred to the Chelsea and Westminster Hospital on 17 February. Prison healthcare staff maintained contact with the hospital staff to obtain an update on the man's condition. Management checks were made to assess the bedwatch arrangements.
47. On 8 March, after three weeks in hospital, the man was told by the hospital doctors that he had inoperable cholangiocarcinoma (a cancer affecting the liver and bile duct system). He contacted his family in Liverpool to inform them of his diagnosis.
48. The man's health deteriorated and, on 13 March, the Governor authorised the removal of the restraints. The Governor also permitted unrestricted family visits to take place. The man's family were allowed to stay in the hospital on 14 March and were present when he died at 1.00am the next day.
49. Wormwood Scrubs followed the requirements of Prison Service Order 2710 'Follow up to death in custody' and offered financial assistance towards the cost of the funeral. In the days that followed, the prison family liaison officers maintained contact with the man's family.

ISSUES

Clinical care

50. The clinical review panel examined in depth the care the man received from the healthcare staff at Wormwood Scrubs, Wandsworth, Pentonville and external medical professionals. The review made the following comments:

“Based on the information available the panel would like to acknowledge that the man received appropriate care in accordance with his needs and also equitable to what he could have expected to receive in a community healthcare setting.

“The panel would like to commend prison healthcare staff for the quality of engagement that occurred between them and the man.”

51. Notwithstanding the reviewer’s approval of the man’s treatment, I note the number of London prisons that he was in and the effect this may have had on the continuity of his healthcare. I also note that he saw several doctors within each prison, including five at Wandsworth and another five at Wormwood Scrubs. It is not clear whether nursing care plans were prepared which, for a man with his complex needs, seems to me to be a notable omission. I draw these matters to the attention of the Director of Offender Management and suggest that the Regional Offender Health team considers whether there are adequate arrangements which provide consistent treatment.

Capacity to refuse treatment

52. The man was admitted to St Georges’ Hospital from 12 to 17 November 2009 as he complained of abdominal pain. The results of the assessment and tests conducted did not highlight the requirement for any further investigation. He was re-admitted to the same hospital on 9 December with the same symptoms but he discharged himself the next morning against medical advice. He exercised his right to refuse treatment and medication. Indeed, prior to coming into custody, he had refused to take the medication prescribed for AIDS and continued to do so whilst he was in custody.
53. The clinical review highlights that the man exercised his right to refuse treatment but made the following comment:

“The panel acknowledges that while the man exercised his rights to refuse medication/treatment and despite seeing a psychiatrist, a formal mental capacity assessment into the man’s refusal to take medication was not carried out.”

Prisoners who refuse medical treatment, and especially those diagnosed with a mental illness, should be properly assessed by a psychiatrist to ensure that, in the legal sense, they have the mental capacity to decide whether to accept treatment. I therefore make the following recommendation:

The Head of Healthcare should ensure that formal mental capacity assessments are conducted when a prisoner refuses medical treatment, and especially when the prisoner has a diagnosed mental illness.

Assessment, Care in Custody and Teamwork

54. PSO 2700 provides clear guidance for staff on the process to follow when a prisoner is assessed as at risk of harming himself and ACCT monitoring is put in place. In addition the Governor of Wormwood Scrubs issued Governor's Order 21/09 on 5 June 2009 for the attention and action of all staff which states the following:

“Levels of support and observation —this contains mandatory instructions.

“The levels of supervision are listed below and all members of staff should be familiar with them.

“Level 1; Constant supervision — where a designated person keeps a prisoner under constant visual observation and provides appropriate support for prisoners actively suicidal or where there has been recent self-harm with suicidal intent.

“Level 2: intermittent supervision — a designated person makes 5 checks per hour at irregular intervals of between 10 and 20 minutes apart. Daytime checks are interactive, night time are visual unless concern has been raised. This level of observation is for prisoners not considered actively suicidal but still a high risk or where there has been recent self-harm with some suicidal intent.

“Level 3: Unit supervision — where all staff monitor and provide discreet support recording at least one interactive record for each session with irregular checks throughout the night, (one on taking over, three at irregular times and one before handover). Prisoners on this level of observation are not considered high risk but may have self-harmed with little or no suicidal intent, or may have other risk factors e.g. depression.

“Levels of observation are initially determined by the manager completing page 2 of the ACCT and should be reviewed and recorded following any incident, and on subsequent reviews. Managers recording levels of observation need to state not only the level, but also the frequency of checks, i.e. ‘level 2 observations, five irregular checks per hour.’”

55. The ACCT was opened from the time the man entered custody until he was admitted to hospital in February 2010. I am satisfied that the ACCT process was correctly followed and, as a result, staff prevented the man from attempting to hang himself.

56. However, I am concerned that following the man's attempt to hang himself on 14 January 2010, the assessment of risk reduced the level of observations from constant supervision to hourly checks. This is opposite to the guidance in PSO 2700 and the local instruction from the Governor, which should have led to a gradual reduction in the levels of observation.

The Governor should ensure that staff adhere to PSO 2700 and local instructions regarding any reduction in the level of ACCT supervision.

Record keeping

57. The clinical review considered the standard of record keeping of the man's medical records and comments:

"An improvement in the quality of the documentation made using the electronic records keeping system (System1) was noted. A reiteration of staff responsibilities for record keeping as set out by professional regulatory bodies (General Medical Council and Nursing and Midwifery Council) and within local records management policies and record keeping standards is recommended.

"The documentation sent to the panel did not include the man's Genito-Urinary Medicine (GUM) clinical notes. Whilst the panel recognises it is historical practice for GUM services records to be kept separate from other records, the panel review would not have been completed without the panel obtaining these records. The panel were fortunate to have the presence of a GUM consultant who was familiar with the man's case, following a few inpatient admissions at St George's Hospital, and was able to give an account."

I endorse the Clinical Review Panel's recommendation that:

The Head of Healthcare should ensure that staff are reminded of the responsibilities for record keeping as set out by professional regulatory bodies General Medical Council and Nursing and Midwifery Council and within local records management policies.

Use of restraints

58. Unfortunately there have been too many reports in which the Ombudsman has criticised the level of restraints used when prisoners are taken to outside hospital. It is pleasing to recognise the good practice adopted by Wormwood Scrubs to ensure that the man was treated with dignity and respect in the final two days before his death. This coincided with his family's visits and I hope that removing the restraints and the escort officers made a difficult situation easier to bear.

CONCLUSION

59. I judge that attention was paid to the man's health needs and appropriate treatment and care was provided. I accept the opinion of the clinical review panel that the standard of care the man received in prison was equitable to that which he could have expected to receive in the community.
60. The man exercised his right to refuse medication and treatment. However there was no formal assessment of his mental capacity to make such decisions, given his known mental illness, despite frequent contact with health professionals. In my view, his capacity to refuse treatment should have been formally assessed by a psychiatrist.
61. He was correctly placed on the ACCT suicide monitoring process due to his history of self harm. In many ways, and despite moving between prisons, the ACCT arrangements worked well and certainly, in the main, kept the man safe. I am concerned however that the safeguards of the PSO and the local instruction were not used before the level of ACCT supervision was reduced from constant to once an hour..
62. I believe that the man was treated with dignity and respect both at Wormwood Scrubs and when he was in hospital, especially when the restraints were removed in his last days. Following his death I am satisfied that Wormwood Scrubs appropriately followed the guidance given in PSO 2710, 'Follow up to death in custody'.

RECOMMENDATIONS

1. The Head of Healthcare should ensure that formal mental capacity assessments are conducted when a prisoner refuses medical treatment, and especially when the prisoner has a diagnosed mental illness.

Partially accepted. There has to be a clear distinction between prisoners refusing life threatening treatment and those who refused non life threatening. It would not be possible to carry out assessments on every prisoner who refuses medication on an ad hoc basis but it would be appropriate to conduct such an assessment to assess an individual who has serious underlying medical conditions or who is terminally ill. We will develop a protocol to explain this.

2. The Governor should ensure that staff adhere to PSO 2700 and local instructions regarding any reduction in the level of ACCT supervision..

Not Accepted. Having consulted the relevant PSO and sought advice from the national policy department (Safer Custody Group) they have confirmed that the guidance contained within PSO 2700 on the reduction of any level of supervision is exactly that, guidance. It was emphasised that it is a matter for the ACCT Multi-disciplinary Review Team to set the level of supervision as their risk assessment demands.

3. The Head of Healthcare should ensure that staff are reminded of the responsibilities for record keeping as set out by professional regulatory bodies General Medical Council and Nursing and Midwifery Council and within local records management policies.

Accepted. The NMC are currently sending out updated information to all staff on the register regarding record keeping responsibilities. We will also locally send out reminders to both staff on the NMC and GMC registers.

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