PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent Investigations

A Report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

Investigation into the death of a man at HMP Wormwood Scrubs in October 2012

Our Vision

'To be a leading, independent investigatory body,
a model to others, that makes a significant contribution to
safer, fairer custody and offender supervision'

This is the investigation report into the death of a man who was found unresponsive in his cell at HMP Wormwood Scrubs in October 2012. A pathologist has been unable to ascertain the cause of his death. He was 33 years old. I offer my condolences to his family and friends.

A clinical reviewer was appointed to review the clinical care the man received at the prison. Wormwood Scrubs cooperated fully with this investigation.

The man was arrested on 16 October 2012 and charged with theft. He suffered from schizophrenia and had a history of drug and alcohol misuse. In police custody, he was assessed as being at risk of suicide and self-harm and was constantly observed. When he arrived at Wormwood Scrubs, officers were concerned about his wellbeing. He was monitored under suicide prevention procedures and it was agreed he needed to be observed at least once every hour.

I am satisfied that the man was correctly assessed as at risk of suicide and self-harm when he arrived at the prison. However, I am concerned that there was a lack of clarity about recording decisions about his level of risk and about responsibilities for monitoring him. It is a very serious matter that, not for the first time at Wormwood Scrubs, prison officers did not undertake the required level of observations and that records about this appear to have been falsified. I understand that some disciplinary action has now been taken against the officer on duty during the night. Although we cannot know whether the outcome would have been any different, had the agreed level of checks been undertaken it is likely that his unresponsive state would have been discovered earlier which would have allowed some action to be taken which might possibly have saved him.

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 **January 2013**

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SUMMARY

1. The man was born in January 1966. He suffered from schizophrenia and had a history of drug and alcohol misuse. He had been in prison a number of times and was last released from a previous prison sentence on 14 January 2008.

2. On 15 October 2012, the man was held in police custody on a charge of theft. The police assessed him as at risk of self-harm and he was constantly watched. The police doctor prescribed him antipsychotic medication.

3. The next day, the man was remanded into custody at Wormwood Scrubs. When he arrived at the prison, staff noted that he had been on constant watch in police custody and immediately opened an ACCT plan (Prison Service suicide prevention procedures). The staff agreed that he should be monitored hourly. Observations were made and recorded correctly until the early hours of the morning, but then there were no checks between 3.30am to 6.00am and between 7.15am to 9.00am

4. At 9.00am, the man was found unresponsive in his cell. Prison nurses arrived almost immediately and an emergency ambulance was called. Although there were clear signs of rigor mortis the nurses attempted to resuscitate him. A prison doctor also attended. Paramedics arrived and shortly afterwards confirmed that he had died. The prison telephoned his partner to let her know he had died rather than ensuring staff went in person.

5. The investigation has identified that the ACCT checks were not correctly completed, the resuscitation attempts were not necessary in the circumstances and the man's partner should have been informed of his death in person. We make recommendations about these matters.

THE INVESTIGATION PROCESS

6. The investigator issued notices announcing the investigation to staff and prisoners at Wormwood Scrubs on 18 October 2012, inviting anyone with relevant information to contact him. No one came forward.

7. The investigator visited Wormwood Scrubs on 24 October 2012. During his visit he obtained the man's prison and health records and met the Governor.

8. A review of the man's clinical care in custody was carried out by a clinical reviewer on behalf of the local PCT.

9. The investigator informed the local coroner of the investigation. The report of the post-mortem examination was not available until 22 May 2013, during which time the investigation was suspended. We regret the consequent delay with the issue of this report. The investigation report has been sent to the coroner.

10. One of the Ombudsman's family liaison officers contacted the man's partner and explained the purpose of the investigation. She did have any specific issues she wished the investigation to take into account. She received a copy of the draft report. She did not make any comments.

HMP WORMWOOD SCRUBS

11. HMP Wormwood Scrubs is a large local prison in West London which can hold more than 1,200 adult male prisoners. In addition to the five main residential units, there is an induction unit, an inpatient healthcare centre, and a dedicated drug stabilisation unit.

Independent Monitoring Board

12. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who oversee all aspects of prison life to help ensure that prisoners are treated fairly and decently. In its most recent annual report (2011 to 2012) the IMB was concerned that further cuts to the prison's budget would affect the welfare of prisoners. The IMB noted that an increasing number of prisoners were arriving with alcohol misuse problems. The IMB reported that additional resources for healthcare services at the prison had made a positive impact.

Her Majesty's Inspectorate of Prisons

13. The most recent inspection of Wormwood Scrubs was an unannounced full follow-up inspection in June 2011. Inspectors found significant improvements in the identification of prisoners' substance misuse needs and co-ordinating their care. Reception and induction were described as generally appropriate, with good arrangements to ensure drug and alcohol dependent prisoners received quick treatment. Inspectors judged that ACCT procedures were satisfactory, with through initial assessments, but identified risk factors were often too vague and not translated into actions in care plans and followed up at reviews. No named or key officers were identified and there was often no continuity of case management, which meant that concerns identified at reviews were not always followed up at subsequent reviews.

14. Primary health care had improved as a result of effective leadership, and there was less reliance on agency staff. Inspectors found that most prisoners were able to see a doctor reasonably quickly.

Previous deaths at Wormwood Scrubs

15. There were four deaths at Wormwood Scrubs in 2010, and there were a further three deaths in 2012. Three of these deaths were self-inflicted. There were no significant similarities with the circumstances of the man's death, although in another one of these investigations we found that a member of staff had not completed ACCT checks as he had claimed.

Assessment Care in Custody and Teamwork

16. Assessment, Care in Custody and Teamwork (ACCT) is the Prison Service process for supporting and monitoring prisoners at risk of harming themselves. The purpose of the ACCT is to try to determine the level of risk posed, the steps that might be taken to reduce this and the extent to which staff need to monitor and supervise the prisoner. Checks should not be at predictable intervals to prevent the prisoner anticipating when they will occur. Part of the ACCT process involves assessing immediate needs and drawing up a caremap

to identify the prisoner’s most urgent issues and how they will be met. Regular multi-disciplinary reviews should be held. The ACCT plan should not be closed until all the actions of the caremap have been completed.

KEY EVENTS

17. The man was born in January 1966. He suffered from schizophrenia and had a history of drug and alcohol misuse. He had a custodial history dating back to 1983 and had been released from his most recent previous prison sentence on 14 January 2008.

18. On 15 October 2012, the man was arrested and held in police custody charged with theft. The police were concerned that he appeared to be under the influence of alcohol or drugs. He was assessed as at risk of suicide and self-harm and constantly watched during his time in police custody. A police doctor prescribed him diazepam (for anxiety disorders and alcohol withdrawal symptoms), dihydrocodiene (for moderate pain relief), olanzapine (for schizophrenia) and fluoxetine (an anti-depressant).

19. On 16 October, the man arrived at Magistrates' Court at 8.44am. The police had completed a Person Escort Form (PER) on which they noted that he had been on constant watch and suffered from schizophrenia. At 10.30am, a nurse and a doctor saw him and gave him 30mg dihydrocodiene and 20mg fluoxetine. He appeared in court at 11.45 and was remanded in custody until 23 October. A Prison Custody Officer (PCO) noted on the PER that he had no concerns about him.

20. When the man arrived at Wormwood Scrubs at 3.07pm, an ACCT was opened immediately because the information on the PER form suggested that he was at risk of suicide and self-harm. A Senior Officer (SO) saw him in reception and noted on the "Concern and Keep Safe" form that he had been on constant watch in police custody. He recorded that he should be monitored hourly until he was assessed.

21. At 4.23pm, a nurse saw the man to undertake an initial health screen. (A first reception health screen is to establish any immediate physical and mental health conditions that require treatment, substance misuse matters that need to be addressed, and any risk that the prisoner might pose of harming himself or attempting suicide.) The nurse recorded that he appeared shaky and anxious. He said that he was not suffering from withdrawal symptoms from alcohol or drugs and that he had no thoughts of self-harm but reported that he was currently hearing voices.

22. The man told the nurse that he did not drink and had stopped using drugs ten years earlier. The nurse noted the medication that he had taken since his arrest and recorded his blood pressure as 142/91. (The normal range for blood pressure is 100/70 to 140/90, although the pressure varies throughout the day. 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.) His weight was 77.5Kg. The nurse referred him to be seen by the doctor and the mental health team. No urine test for drugs was taken.

23. The nurse explained at interview that the man appeared anxious and nervous but then calmed down. He thought this was because of his mental illness. He referred him to be seen by the mental health team the next day. The nurse said he did not conduct a urine test as they are completed routinely only when a prisoner says they abuse drugs or are dependent on alcohol. The nurse said

that it was the doctor's decision, in conjunction with the duty governor, as to whether a prisoner needed to be constantly supervised because of his risk. He recorded in the ACCT document that he had seen him.

24. At 5.20pm, a prison doctor saw the man and recorded that he appeared nervous and shaky. She made an urgent referral for him to be seen by the mental health team and prescribed dihydrocodiene 30mg, diazepam 5mg, olanzapine 20mg and fluoxetine 20mg. She did not ask for a drugs test to be completed. At interview, she said that he appeared nervous and anxious at first but he soon calmed down during the consultation. She had no concerns. She said that when she saw him the level of his ACCT observations had already been set at hourly. She did not make any entry in the ACCT.

25. An officer completed the First Night Centre (FNC) Urgent Needs Assessment form which is used to identify immediate concerns about issues such as domestic arrangements, care of dependants, drug or alcohol issues and thoughts of self-harm or suicide. The man gave his personal details and the contact details of his nominated next of kin, his partner, and made a two minute phone call to her. The officer told the investigator that he was concerned about him as he appeared confused and distressed. He thought that there was "definitely something wrong" with him. He believed that he needed constant supervision so he asked the senior officer in the FNC to interview him.

26. A SO saw the man at approximately 6.30pm, to complete the Immediate Action Plan of the ACCT. The SO told the investigator that he was "shaking and all over the place" and told him that he had seen a woman floating at the windows. He said that he had been so concerned about him that he had telephoned a doctor to ask her to see him again. He said that she declined as she was content with her initial assessment. The doctor said she has no recollection of being contacted by the SO and this is not recorded on the ACCT document. The SO told the investigator that he felt that the man should have been placed on constant watch and admitted to the healthcare centre as an inpatient where he could have been monitored by nurses.

27. The man was allocated a safer cell (a cell designed to have as few ligature points as possible) in the first night centre, which he occupied on his own. He made a two minute telephone call and the SO told him about the Samaritans and Listener scheme (prisoners trained by the Samaritans to support other prisoners in distress). In the Immediate Action Plan, the SO noted that he should be referred to the mental health in-reach team. An assessment interview was planned for the following morning. The SO asked the duty governor to come and see him to determine whether he should be moved to the healthcare centre and constantly supervised.

28. The duty governor saw the man at 7.05pm. He said that the SO had contacted him as he was very concerned about the man's demeanour and risk of self-harm. He told the investigator that although he appeared confused and anxious when they spoke, he was satisfied that his risk of self-harm was low and agreed with the doctor's assessment that hourly observations were appropriate. (Although it was not the doctor who has set the level of observations.) The duty governor recorded this on the ACCT document, and also noted that he had removed the man's belt. The SO noted in his statement that he removed a television and an electric cable.

29. The ACCT document shows that the SO recorded that he checked the man at 8.05pm and 9.02pm and an officer checked him at 10.25pm. The SO noted that he was standing at the cell door and looked flustered. The officer recorded that the man communicated with him but seemed confused.

30. An officer was the sole officer on duty that during the night on the first night centre. He recorded in the ACCT that he checked on the man as follows:

> “11.20pm Standing in the middle of the his room I asked him how he was and he seemed a bit confused”
>
> “0:15am Pacing up and down the room when I asked him what he was doing he replied ‘who are you’, he seems quite distressed and appears to not know where he is.”
>
> “1.10am Sat on his bed talking to himself did not appear to acknowledge me when asked how he was.”

31. The officer noted that he made further checks at 2.10am, 3.10am, 4.05am, 5.05am, 6.05am and 7.05am. For each of these checks, he recorded that he saw the man “asleep on the floor and movement observed”

32. The SO told the investigator that he came on duty the next morning at approximately 7.45am and dealt with prisoners in reception going to court. He said he arrived on the first night centre at approximately 8.45am. No ACCT checks were done between 7.15am and 9.00am.

33. At 9.00am, an officer began to unlock the prisoners on the first night centre. When he opened the man’s cell, he found him curled up on the floor in the toilet area. He went into the cell and called to him but could not get a response. He then ran out of the cell and sought help from a nurse and a SO, who were both nearby.

34. The nurse examined the man and found he had no signs of life and that rigor mortis was clearly evident. The SO radioed for an emergency ambulance, at 9.06am, and two more nurses arrived with emergency equipment. The nurses began cardiopulmonary resuscitation and used an automated external defibrillator (AED), which advised that there was no shockable rhythm. (An AED monitors the heart rhythm and administers electrical shocks to the heart to restore the normal rhythm when necessary.)

35. Though it was apparent that the man was already dead when they arrived, the nurses continued cardiopulmonary resuscitation (CPR) in line with their nursing protocols. A doctor arrived shortly after. She did not examine him or advise that CPR should be stopped.

36. Paramedics arrived at 9.12am and took over the man’s care but at 9.18am pronounced that he had died.

Contact with the man's partner

37. The prison's community integration manager acted as the prison family liaison officer and at 10.00am telephoned the man's partner to inform her that he had died and offered support. The prison maintained contact with her in the days that followed and assisted with funeral expenses in line with national guidance.

Support for staff and prisoners

38. Prison Service instructions require a senior member of staff to hold a "hot debrief" meeting to offer reassurance, information and support for all the staff involved in an emergency. The duty governor chaired the hot debrief for the staff involved in the incident and the support of the local care team and the national Prison Service Employee Support Service was offered. After the man's death, prisoners were offered support from the prison chaplaincy team, IMB or the Samaritans. All prisoners who were being monitored on ACCT plans were reviewed in case they had been adversely affected by his death.

Post-mortem report

39. The post-mortem examination was conducted by a consultant forensic pathologist. He found that there was no evidence of an overdose of medication or any other substance, and no sign of any natural disease. He concluded that the cause of death was "unascertained".

ISSUES

Assessment of risk

40. We are satisfied that an appropriate decision was made to open an ACCT when the man arrived at Wormwood Scrubs. He had been remanded to custody. Being on remand is itself, a known risk factor for self-harm. He suffered from schizophrenia which is strongly associated with an increased risk of suicide, and had previously abused drugs and alcohol. While he was in police custody, he had been constantly observed because of concerns about his wellbeing.

41. Staff judgement is fundamental to the ACCT system. At its core, the system relies on staff using their experience and skills, as well as local and national assessment tools, to determine risk. However, they must balance this against the prisoner's known risk factors and their presentation.

42. The man's mental state and risk of self-harm or suicide were assessed by a nurse, doctor and duty governor, all of whom were aware that that he had been on constant observations while in police custody. They considered that it was appropriate for him to continue to be monitored under ACCT procedures. He was to be observed once an hour. It is clear that other members of staff, and in particular a SO and an officer, were very concerned about him. The SO considered that he needed constant supervision and asked the duty governor to review him for this reason. The duty governor was satisfied that hourly observations were appropriate. He said he agreed with doctor's assessment about this, although it was the SO in reception who had set the level of observations. Prison staff appeared to consider that the healthcare staff had set or agreed the level of observations when there is no evidence that they had considered them or that they were expected to do so.

43. While we are satisfied that the man did not meet the standard criteria for constant supervision which is usually in response to an immediate suicidal crisis, we are concerned that not all those involved in the decision making process documented their rationale for deciding the level of observations that were appropriate. There is no evidence that more frequent observations than hourly were considered once it had been decided that constant supervision was unnecessary. The duty governor seems to have at least partly based his decision on the misapprehension that this was what the doctor had agreed. Although he assessed him risk as low, he was allocated a safer cell and had his belt removed, which does not seem consistent with such an assessment. We therefore make the following recommendation:

    The Governor should ensure that all staff involved in the assessment of prisoners on ACCT correctly record the rationale and decision of the level of observation required.

44. It is not possible to know whether the outcome for the man would have been different had there been more frequent observations, especially as the cause of his death is not known and it appears it could have been very sudden. However, we are very concerned that there is a clear discrepancy in the record of ACCT checks. The CCTV footage shows that he was not checked between 3.30am and 6.00am, but an officer recorded on the ACCT document that

checks had been done at 4.05am and 5.05am. He was found dead at 9.00am with signs of rigor mortis. As it usually takes several hours for the onset of rigor mortis after someone has died there is also a question about the accuracy of the officer's entries after 6.00am. The pathologist estimated the time of death as between 3.00 and 5.00am.

45. The failure to conduct ACCT check as required is a very serious matter, even when it might not have affected the outcome. The police interviewed the officer as part of their investigation into the circumstances surrounding the man's death, but decided not take criminal proceedings. The Prison Service has now conducted an internal disciplinary investigation and taken action against the officer.

46. As well as the ACCT check which the officer was responsible for completing during the night shift, no checks were made between 7.15am and 9.00am after the day staff came on duty. This is another serious failing and it is a particular concern that this should happen in the first night centre when newly arrived prisoners are most vulnerable. As well as the man, there were other men in the first night centre subject to ACCT monitoring. There did not appear to be a clear system to assign responsibilities so that day staff coming on duty knew who had to undertake the ACCT checks.

47. In a previous investigation into a death at Wormwood Scrubs, we found that an officer in the segregation unit had not completed the appropriate checks and had falsified the ACCT document to suggest that he had. Again it was our review of CCTV footage which established that this was the case. It is highly concerning that some members of staff at the prison continue to risk the safety of prisoners for whom they are responsible by not making the required checks but recording that these have been done. That this has occurred in units in which the risk of suicide and self-harm is known to be elevated only heightens this concern. We consider that, to help prevent this, officers need to be aware that there is a possibility that this will be discovered through random checks of CCTV footage rather than when this office is investigating a death. It should also be clear who is responsible and thus accountable for ensuring that ACCT observations are completed. We make the following recommendation:

    ("In their response to the draft report, the Prison Service asked us to point out that the issues were first established by the police and the Safer Prisons team. As a result, in both cases, internal investigations and formal disciplinary hearings took place.")

    The Governor should ensure that all staff undertake ACCT observations as directed, that clear responsibilities for undertaking ACCT observations are assigned, and that managers carry out random checks of CCTV footage to help ensure this happens.

Clinical Care

48. The clinical reviewer made the following comments about the care that the man received at Wormwood Scrubs:

> "In summary he was a paranoid schizophrenic with a long and enduring history of drug and alcohol misuse.

"His current medication was: olanzapine 20mg once at night (an antipsychotic used in schizophrenia), fluoxetine 20mg once daily (an antidepressant) and dihydrocodeine 30mg to be given as required (an opiate derived pain-killer used for his leg pain). He also received occasional prescriptions of diazepam 5mg once at night (a benzodiazepine that is used as a sedative).

"This medication regime corresponded to his community GP and CMHT medical records."

49. The clinical reviewer comments that, on his arrival at Wormwood Scrubs, the man was referred as an urgent case to the prison mental health team (Inreach). This meant that he would have had a comprehensive health assessment the next day.

50. He concludes that the man received care that was equivalent with that in the wider community and that his death was natural, rapid and unexpected. The post-mortem concluded that the cause of death was "unascertained". In the circumstances we are satisfied that he received appropriate clinical care for his brief period at Wormwood Scrubs and his death could not have been foreseen or predicted.

Emergency Response

51. The clinical reviewer has commented on the emergency response as follows:

> "The attempted resuscitation of the man, who clearly was in rigor mortis, was very traumatic for the nursing staff. It was also not consistent with the principle that the deceased be treated with respect and dignity."

52. We agree with the clinical reviewer that the attempted resuscitation was unnecessary and distressing for the staff involved. We understand the commendable wish to attempt and continue resuscitation until death has been formally confirmed, but do not consider that healthcare staff should be required to carry out CPR in these circumstances. The European Resuscitation Council Guidelines for Resuscitation 2010 state that "Resuscitation is inappropriate and should not be provided when there is clear evidence that it will be futile …" We make the following recommendation:

The Prison Service should amend the instructions contained in PSI 64/2011 for emergency response to include the non-resuscitation of prisoners where there are clear signs of rigor mortis.

Family liaison

53. National guidance requires that the news of a prisoner's death is given in person by a trained member of Prison Service staff. Prison Service Instruction (PSI) 64/2011 "Management of prisoners at risk of harm to self, to others and from others (Safer Custody)" states:

> "Wherever possible, the FLO and another member of staff must visit in person the next of kin or nominated person to break the news of the

death. .Where the prisoner had been located a long distance from their next of kin consideration must be given to requesting the assistance of a FLO from the nearest prison."

54. The man's partner was told of his death over the phone which was inappropriate and not in line with Prison Service guidance. The prison could not have known his partner's circumstances or whether she had support available when she heard the news. We do not consider that she lived too far away for this to have been done in person by someone from the prison, who would have been best placed to explain the circumstances. Even if the distance was regarded as too far, there was no attempt to contact another prison or even the police so that the she could have been informed by someone in person.

55. In previous reports into deaths at Wormwood Scrubs we have made recommendations about following national guidance when notifying bereaved families of a death of a prisoner. We therefore repeat the following recommendation:

    The Governor should ensure that where possible staff from Wormwood Scrubs should visit the next of kin in person to break the news of a death unless the distance is so far that there are clear benefits in using family liaison officers from other prisons.

RECOMMENDATIONS

1. The Governor should ensure that all staff involved in the assessment of prisoners on ACCT correctly record the rationale and decision of the level of observation required.

2. The Governor should ensure that all staff undertake ACCT observations as directed, that clear responsibilities for undertaking ACCT observations are assigned, and that managers carry out random checks of CCTV footage to help ensure this happens.

3. The Prison Service should amend the instructions contained in PSI 64/2011 for emergency response to include the non-resuscitation of prisoners where there are clear signs of rigor mortis.

4. The Governor should ensure that where possible staff from Wormwood Scrubs should visit the next of kin in person to break the news of a death unless the distance is so far that there are clear benefits in using family liaison officers from other prisons.

ACTION PLAN: The Man – HMP Wormwood Scrubs

No	Recommendation	Accepted/Not accepted	Response	Target date for completion	Progress (to be updated after 6 months)
1	The Governor should ensure that all staff involved in the assessment of prisoners on ACCT correctly record the rationale and decision of the level of observation required.	Accepted	Staff will be issued a governors order outlining the need to include the rational and decisions in the case reviews, this will include the levels of observations and entries to be made in the ACCT.	28-02-2014	
2	The Governor should ensure that all staff undertake ACCT observations as directed, that clear responsibilities for undertaking ACCT observations are assigned, and that managers carry out random checks of CCTV footage to help ensure this happens.	Accepted	An order will be issued to all managers outlining the process for allocating staff responsible for ACCT checks. A process for reviewing CCTV in the segregation and FNC will be explored to monitor the frequency of the work required.	28-02-2014	

3	**NOMS** The Prison Service should amend the instructions contained in PSI 64/2011 for emergency response to include the non-resuscitation of prisoners where there are clear signs of rigor mortis.	Accepted	Further guidance will be developed in conjunction with NHS England and issued to all prisons.	31-12 -2014	
4	The Governor should ensure that where possible staff from Wormwood Scrubs should visit the next of kin in person to break the news of a death unless the distance is so far that there are clear benefits in using family liaison officers from other prisons.	Accepted	An FLO will be appointed to all DIC's and they will be required to visit in person the NOK.	Completed	