Investigation into the circumstances surrounding the death of a man in August 2009 at hospital whilst in the custody of HMP Wormwood Scrubs

Report by the Prisons and Probation Ombudsman for England and Wales

March 2011

This is the report of an investigation into the death of a man who died in August 2009 at hospital whilst in the custody of HMP Wormwood Scrubs. On 18 August 2009 at 7.20am, he was found unconscious in his cell on the healthcare unit having suffocated himself with a plastic bin liner. Staff started cardio pulmonary resuscitation and he was transferred by emergency ambulance to hospital. He died at a later date. He was 22 years old.

I offer my sincere condolences to the man's family and everyone touched by his death. I must apologise for the delay in issuing this report and any additional distress that this might have caused.

My colleagues conducted the investigation on my behalf. A review of the man's medical care was commissioned from the local Primary Care Trust. Their review was undertaken by a panel of clinicians and clinical managers, chaired by a clinical reviewer. I am grateful to the panel for their valuable contribution and the report is the first annex to this investigation report. Regrettably, the clinical review which is instrumental to the findings of the investigation, was only received in August 2010. The review raises concerns that go beyond my terms of reference, including the appropriateness of the man's remand, and mental health provision in courts. As such, a copy of this report will be forwarded to the Lord Chancellor for his consideration.

The man came into prison from a mental health hospital where he was being assessed and treated prior to being remanded in custody. Following his reception into Wormwood Scrubs, he was assessed and, given his past mental health history, he was accommodated on the healthcare centre for close monitoring.

During his time in the healthcare centre, the man often refused meals, and I consider the measures put in place to monitor his diet. I also examine the use of constant supervision and alternative clothing, as well as the general use of safer custody measures. Some of the issues raised in this investigation are similar to others raised at Wormwood Scrubs. I recognise the significant progress they have made in safer custody. Nevertheless, I make 12 recommendations, several of which are repeated from an earlier investigation.

I would like to thank the Governor of Wormwood Scrubs and his staff for their cooperation. I am particularly grateful to the Senior Officer who acted as the liaison officer.

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.

Jane Webb
Acting Prisons and Probation Ombudsman **March 2011**

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SUMMARY

The man was allegedly involved in a near fatal stabbing in June 2009. He was arrested by police on 3 July and held overnight in police custody. He was quickly assessed as having a serious mental health condition and was in need of assessment and treatment. Following police questioning, he was admitted to a mental health unit at hospital, where he remained for two weeks.

On 14 July, the man was assessed as fit to be interviewed by police and two days later he was taken to the police station, accompanied by his father, and questioned regarding the alleged offence. He returned to the mental health unit until his court appearance on Saturday 18 July. The court appearance was scheduled for a weekend, and hospital staff recommended to the judge that he should be remanded into hospital for a report on his mental health condition. Nevertheless, he was remanded to the custody of Wormwood Scrubs, due to the seriousness of the offence.

The consultant psychiatrist who had been caring for the man at hospital contacted the prison to inform them of his condition. By coincidence, the psychiatrist was employed at the prison when he was not at the hospital. Following his recommendation, the man was accommodated in the inpatients' healthcare unit in a gated cell and made subject to constant supervision.

Two days later, on Monday 20 July, he was assessed for any risk of suicide and self harm and seen by the psychiatrist on his ward round. The psychiatrist recorded that he should remain in a gated cell but wear his own clothes, rather than "alternative prison clothing" (which is designed not to tear and used to prevent someone harming themselves with their own clothes). A multidisciplinary review designed to assess his level of risk was held later that morning and it was agreed that he should stay on constant supervision, but that he should wear alternative clothing. There is no record of how long he wore the alternative clothing and my investigation team have been unable to establish the facts.

The man remained on constant supervision for 13 days, until 30 July. Following a ward round and a case review, it was agreed that his risk of hurting himself had reduced from "high" to "low", so his observations could be reduced from constant to once an hour.

Throughout his time at the prison, he was observed pacing his cell for long periods. Staff tried to talk to him but with limited success. Records were made that he was not eating regularly, but it was only after a nurse noted that his weight had fallen by three kilograms in three weeks that formal monitoring started. His dietary intake was only monitored for one morning and one afternoon.

The man remained on hourly observations until 18 August. That morning, he was found slumped on the floor of his cell by a nurse. The officer in charge of the prison was called to the healthcare centre because the nurse did not think she could go into the cell without his permission. Two nurses started

resuscitation efforts until the ambulance arrived. After the paramedics had treated him, he was taken to hospital. He remained in a critical condition for six days in hospital, and was then pronounced dead.

I examine the use of constant supervision and the reduction of the man's observations to hourly. I also look at the use of alternative clothing and the safeguards that should be in place when such extreme safer custody measures are used. I consider the monitoring of his diet. I acknowledge that there has been significant work in safer custody at Wormwood Scrubs since his time at the prison. Nevertheless, I make 12 recommendations.

THE INVESTIGATION PROCESS

1. The Ombudsman's office was notified of the man's death in August 2009 and the investigation was allocated to one of my investigators. He visited Wormwood Scrubs to open the investigation on 27 August and reviewed the man's prison files and medical record. Copies of all relevant documents relating to his time at custody were forwarded to the investigator.

2. The Ombudsman's notices of investigation and terms of reference were sent to the prison. However, no prisoner or staff member responded to those notices. The investigative team, joined by clinicians from the clinical review team, conducted interviews with staff at the prison in October, December 2009, and January 2010. On 13 April 2010, an Assistant Ombudsman, a Consultant Forensic Psychiatrist (also the clinical reviewer), a colleague who interviewed the general manager of healthcare services and the consultant forensic psychiatrist.

3. The local Primary Care Trust (PCT) appointed a panel to review the medical care the man received whilst at Wormwood Scrubs. The final version of the clinical review was received in August 2010. The length of time taken by the clinical review has caused the report to be delayed. However, I am grateful for the thorough and comprehensive report and their involvement of my office throughout the clinical review process.

4. The investigator obtained the medical records relating to the man's time in hospital prior to being charged. My colleague met a senior investigating officer from the Metropolitan Police to discuss any possible issues which may have a bearing on our investigation. I am grateful for the police co-operation with my investigation.

5. Her Majesty's Coroner for Hammersmith and Fulham was informed of the nature and scope of my investigation and asked for a copy of the post mortem report.

6. One of my family liaison officers contacted the man's family to invite them to be involved with the investigation process. The family liaison officer spoke to the man's father who asked to be notified in writing. On 11 March 2010, the Assistant Ombudsman and the family liaison officer met the man's father and explained the investigation process to him. Another FLO from my office took over the family liaison role and contacted the man's father and his legal representatives. The family took the opportunity to comment on the report when it was issued at draft stage and their comments are reflected throughout this final version.

HMP WORMWOOD SCRUBS

7. HMP Wormwood Scrubs is a local prison, principally serving the courts of West London. It has a maximum capacity of 1,277 prisoners and holds remand and convicted adult males. The prison holds a high number of foreign nationals due to the proximity of Heathrow airport. There are five main residential wings together with an inpatient healthcare facility. The man was accommodated on this facility.

8. Healthcare services are commissioned through the local Primary Care Trust (PCT). Wormwood Scrubs has an inpatient healthcare unit that is staffed by qualified nurses, healthcare assistants and discipline officers. The nursing staff have a range of skills including mental health and a nurse qualified to prescribe medication. Medical cover is provided by two doctors on a daily sessional basis. An electronic records system has been introduced but, at the time of the man's death, staff relied on a paper based system.

9. Her Majesty's Chief Inspector of Prisons made a full unannounced inspection of Wormwood Scrubs in June 2008. The Chief Inspector's report judged that the progress made since her previous inspection had halted and there had been "an appreciable drift" in all key areas namely safety, respect, purposeful activity and resettlement. However, the Chief Inspector acknowledged the difficulties coping with constant daily pressures.

10. The inspection highlighted problems with the reception, first night and induction procedures, which were found to be "not sufficiently supportive or consistent". The health centre was judged to have improved, but staffing was still an issue. In September 2007, the healthcare department was placed under special measures as part of the PCT's improvement plan. ("Special measures" is a status applied to the health centre when it falls below the standard of care considered acceptable by the PCT.)

11. In response to the draft investigation report, the family brought my attention to the following extract from the inspection:

> "Ten prisoners were waiting for [National Health Service] mental health beds. Most had been waiting over a month, with one referred three months previously … There appeared to be no sense of urgency in ensuring that these patients were moved expeditiously."

Further to this finding, the Chief Inspector went on to recommend that "prisoners who need assessment by specialist mental health services should be seen within seven days and transferred expeditiously as clinically indicated".

12. Each prison in England and Wales is monitored by an Independent Monitoring Board (IMB). (Members of the IMB are drawn from the local community and monitor the day to day routines of the prison.) In their last published report they noted similar concerns to those of the HM Chief Inspector of Prisons. They particularly noted that staff shortages were an ongoing cause for concern.

13. Over the last two years there have been six self inflicted deaths at Wormwood Scrubs. An investigation into another suicide in the healthcare centre which took place in April 2009 resulted in recommendations regarding healthcare staffing levels, the use of alternative clothing, ligature points and suicide monitoring procedures.

Assessment, Care in Custody and Teamwork (ACCT)

14. Prisons are run under a series of documents called Prison Service Orders (or PSOs). PSO 2700 governs the procedures for looking after prisoners at risk of suicide or self harm. Assessment, Care in Custody and Teamwork (or ACCT) is the system used to identify, monitor and support prisoners at risk of self harm. 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.

15. After the ACCT assessment has taken place, a multi-disciplinary (involving staff from a range of backgrounds such as health and discipline) 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 necessary to keep the prisoner safe and 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.

16. When the prisoner's level of risk has been agreed, those present must determine how frequently staff should carry out observations. Constant supervision is the highest level of observation and is when a prisoner is supervised by a designated member of staff on a one-to-one basis, remaining in view at all times. If a prisoner is not assessed as at high risk of self harm and in need of constant supervision, they can be checked intermittently. Such checks can be made at any frequency, from five times an hour to three times a day, depending on a prisoner's assessed level of risk. Where possible, staff carrying out such observations should engage the prisoner in a meaningful interaction, rather than just observing them.

Gated cells

17. PSO 2700 refers to gated cells as "constant supervision cells", and this is what they are called in Wormwood Scrubs' suicide prevention policy. Instead of a door on the cell, there is a gate which enables a member of staff to see the prisoner at all times. At Wormwood Scrubs, the gate of their constant supervision cells can be locked back to enable the door and change the cell into a normal cell. (The man did not change cells after he was admitted to the inpatients but the gate was used to make it a constant supervision cell, then the gate was secured so that the cell became a normal cell with a door.)

18. According to the guidance, gated cells are used where a prisoner requires constant supervision. They enable a severely distressed/at

risk prisoner to receive individual support from a member of staff sitting outside the cell. A prisoner should remain in a gated cell for the shortest time possible because it compromises their privacy and dignity.

Alternative clothing

19. Alternative clothing (previously known as protective or anti-tear clothing) is made from a strong material that makes it difficult to tear. It is used when a prisoner may use his clothing to harm himself or others.

20. When a prisoner is issued with alternative clothing, their own clothes should be taken away from them, including their shoelaces. PSO 2700 and Wormwood Scrubs' own suicide prevention policy describe the removal of a prisoner's own clothes and their replacement by alternative clothing as a "measure of last resort". The PSO demands that alternative clothing "must only be used for the shortest possible time". It is national policy, echoed in Wormwood Scrub's own suicide prevention policy, that an enhanced case review should be held with more senior prison staff for all prisoners who are on an open ACCT document and wearing alternative clothing.

KEY EVENTS

21. The man was a 22 year old man who lived at home with his parents in London. He had a history of cannabis use, which his father felt led to mental health problems. With the encouragement of his father, he received treatment as a voluntary out patient in the local area.

22. On 29 June 2009, a woman was stabbed causing near fatal injuries. Several days later, the man was identified by police as the suspect and arrested on 3 July. Following an assessment at a police station, where two psychiatrists judged him as presenting "features of psychosis" and "mood difficulties", he was detained under the Mental Health Act. He was taken to a Centre for Mental Health, under the supervision of a consultant psychiatrist.

23. Between Saturday 4 July and Tuesday 14 July, the man was assessed as not fit to face police questioning. During this period he was treated and observed by members of nursing, psychiatric and therapy staff at the Centre. According to the clinical review, records describe his activities of daily living and his interactions with staff and other patients at the Centre. While there was no evidence of risk of harm to himself or others, the overall picture of his mental state was mixed. It was characterised by anxiety, distraction, being withdrawn and having difficulty engaging in group or individual activities. The clinical review comments that the records also describe the physical manifestations of his unrest - notably rhythmic pacing "up and down from wall to door", with "rocking from side to side".

24. On Tuesday 14 July, the man was assessed by the psychiatric intensive care units consultant psychiatrist as fit for interview by the police, with the understanding that he would remain under the care of mental health services and not stay overnight in the police station.

25. The man was taken to a police station for the first of these interviews on Thursday 16 July 2009. He was accompanied by nursing staff from the psychiatric intensive care unit (as he was still detained under Section 2 of the Mental Health Act 1983). Following this interview, he returned to the Centre pending a subsequent police and court appearance on Friday 17 July.

26. The man's court appearance was rescheduled to Saturday 18 July. The consultant psychiatrist requested that he remain in the care of the Centre. However, the police and the Crown Prosecution Service (CPS) objected on the grounds that the hospital did not have sufficient security given the charges he faced.

27. On Saturday 18 July, he was taken to Magistrates' Court charged with attempted murder and was remanded into custody at Wormwood Scrubs. According to the clinical review, the decision to remand him to prison was not supported clinically. The consultant psychiatrist at the

Centre had offered to keep a bed available for him, “in his best interests”. A mental health court diversion team attend court on weekdays, but were not in attendance on that Saturday. (These teams are multi-disciplinary and their aim is to divert prisoners with mental health conditions away from the criminal justice system and into health and social care sectors.)

28. The man arrived at Wormwood Scrubs at approximately 2.30pm where he was assessed by nursing staff in reception. During the healthscreen, Nurse A identified that he had a long term mental health history, had recently been diagnosed as suffering from schizophrenia, and was taking medication to treat his condition. (Schizophrenia is a mental disorder characterized by a disintegration of the process of thinking and of emotional responsiveness.[1] It most commonly manifests as auditory hallucinations, paranoid or bizarre delusions, or disorganized speech and thinking, and it is accompanied by significant social or occupational dysfunction.) The nurse also noted that he had been an in-patient at the psychiatric intensive care unit at the Centre for Mental Health until the day of his remand.

29. Immediately after the first reception healthscreen, Nurse A raised a Concern and Keep Safe form, the first stage of the ACCT process. On the form, the nurse indicated that the man had been demonstrating “unusual behaviour or talk” and wrote:

> “Transferred in from the Centre via Court.
> Was on <u>one to one</u> observation.
> <u>One to One maintained</u> till further review.
> mental health history.”

The consultant psychiatrist had telephoned Wormwood Scrubs to alert staff to the man’s arrival and on his advice he was admitted to the healthcare wing.

30. The man was moved to a gated cell and placed on constant supervision in the healthcare centre. When a prisoner has an open ACCT document, staff record a prisoner’s behaviour and significant conversations with the prisoner in an ongoing record. By 5.00pm that afternoon, it was recorded that he was settled in his cell in the healthcare centre. He paced up and down the cell until 6.45pm when he fell asleep on his bed. The following morning, he woke at 6.00am and resumed pacing his cell, occasionally resting on his bed. His ongoing record reflects that he spent much of the day either pacing in his cell or resting on his bed. Staff recorded that he ate the meals that he was given. He spoke to member of staff on observation duty at 5.00pm that Sunday afternoon. He told the member of staff about the offence he had been charged with.

31. On the day that the man arrived and admitted to the healthcare centre, Nurse B completed the first nursing care plan at Wormwood Scrubs. The nurse identified that the plan was to “assess [the man’s]’s mental

state closely as he is danger to others (stabbed a nurse at hospital". In fact, there is no evidence to suggest that he was involved in such an attack at the mental health secure hospital.

32. On 20 July at 5.30am, it was noted that the man had slept well but was now pacing his cell while eating his breakfast. At 10.00am, Officer A undertook an ACCT assessment interview with him. He told the officer he had no thoughts of self harm and felt alright. However, on completion of the assessment, the officer noted that he continued to pace his cell and despite good eye contact, "displayed a sense of strange behaviour". The consultant psychiatrist visited him and prescribed Risperidone (an anti-psychotic medication prescribed to him when he was in hospital).

33. At 11.00am, the psychiatrist carried out a ward round, reviewing all the prisoners in the inpatients unit with mental health problems. At the same time as the ward round, he convened a multidisciplinary case review, attended by Staff Nurse B, SN C and Officer B. The review panel wrote,

> "seen by multi-disciplinary team during ward round, vague in presentation answered no to all questions, poses a high risk to himself and others and he is impulsive in behaviour. Continue 1:1 observation and strip clothing [alternative clothing] day and night."

34. Alternative clothing is described by the Prison Service Order as "measures of last resort" in PSO 2700. Although the record of the case review said that the man was to "continue" to wear alternative clothing, there is no record of the decision to place him in alternative clothing before that date. In fact, an entry in his clinical record the night before referred to him as wearing "normal clothing". (A measure of last resort should only be used when all other options have been exhausted to keep a prisoner safe. When measures of last resort are used or a prisoner has been subject to constant supervision for eight days, an enhanced case review is required. The PSO identifies the senior personnel who should be involved in the review team, which I discuss below. Despite being subject to constant supervision for 13 days and dressed in alternative clothing, an enhanced case review was not convened to discuss his care at any point during his time at Wormwood Scrubs.)

35. Senior Staff Nurse (SN) C completed an immediate action plan, which is supposed to be completed no longer than 24 hours after someone is identified as being at risk. The nurse followed the psychiatrist's advice that the man should be in a single gated cell on "constant observation". Furthermore, it was written that a Listener and the Samaritans telephone should be made available to him should he wish to use one. (A Listener is a prisoner trained by the Samaritans to offer confidential support and assistance to prisoners in crisis. The Samaritans

telephone is a dedicated telephone for prisoners wishing to speak to a Samaritan.)

36. A nursing care plan was prepared and filed in the man's medical record. As well as the care plan, to which officers would not routinely have access, an ACCT CAREMAP was drawn up, detailing measures needed to support him while he remained at risk of harming himself. Similar actions were recorded in both documents and included the requirement for all staff in the inpatients' unit to "engage in a 1:1 chat to explore his thoughts and experience". The aim of the nursing care plan was described as "to maintain a safe environment. To maintain his safety and the safety of others", as well as continued monitoring of his mental state and prescription of medication.

37. Staff observed that the man continued to repeatedly pace his cell, occasionally resting, for the following three days, until 23 July when he was seen during a ward round and for his ACCT case review. The review panel of four members of healthcare staff included the psychiatrist, SN C and Officer B. The panel noted that his behaviour was still unpredictable; however he denied any thoughts of self harm or suicidal ideas. Constant supervision was to be continued. There is no mention of whether he was still wearing alternative clothing at this review, in the record of the ward round or the ACCT ongoing record.

38. On 24 July, it is recorded in the ACCT that the man refused both his breakfast and lunch meals, however he communicated well with Healthcare Assistant (HCA) A who was observing him. He told the HCA about his family history and schooling. He said that he got on well with other pupils at primary and secondary school, even if he did not enjoy studying. He had not stayed in touch with any of his school friends. He ate his evening meal in his cell at 5.00pm and went to sleep shortly afterwards.

39. The following day, the man woke early and continued to pace his cell, although he ate some breakfast cereal. At 9.40am, he was taken to the visits hall to see his family. He ate some snacks during the visit. On returning to his cell at 10.45am, he told the member of staff doing constant supervision that he had enjoyed his family's visit. After eating his lunch, he was visited by a chaplain from the chaplaincy team who encouraged him to go out for exercise or read. When he told her that he did not want to do either of these things, the chaplain suggested that he might like playing cards. "He showed interest" so she noted in his ongoing record that she would get some cards for him. Staff observed that he continued to intermittently pace in his cell and rest. He ate all his meal and then went to sleep.

40. On 26 July, the man's cell sharing risk assessment was reviewed as a matter of routine. (This form is designed to determine a prisoner's risk of harm to others.) The risk review was completed by Officer C who noted that he had "stabbed a nurse in hospital" and gone on to threaten

members of the public. The officer suggested that his risk was raised from medium to high as a result of this information. (It appears this information was false, and there may have been confusion about the alleged victim. There is nothing in the records to suggest he attacked a nurse whilst in the Centre.) The risk review was agreed by a duty governor and the man was considered to pose a high risk to others if he were to share a cell. As he was already in a single cell, the assessment did not affect any plans for his ACCT document or medical treatment. It was recorded that he was conversing well with HCA A, asking questions about his alleged offence and speaking about the visit he had with his family. He collected his lunch and his dinner that day, and ate both while sitting on his bed.

41. The following day the consultant psychiatrist visited the man in his cell as part of a scheduled ward round. He told the psychiatrist that he was feeling "all right" and denied that he was hearing voices. However, he was guarded throughout the visit and seemed vague and evasive. An ACCT case review including the psychiatrist, Officer B and two members of the healthcare staff took place at the same time as the ward round. The team agreed that he should remain on constant supervision as his behaviour was unpredictable and he "needs further assessment". Again, no mention was made of whether he was wearing alternative clothing at the time of the case review. At midday, he ate lunch while pacing his cell. He continued to pace until 3.30pm when he laid down on his bed and fell asleep. He slept through the usual meal time, but was offered something "to eat for the night" when he finally woke at 10.30pm. He declined food and went back to sleep.

42. The man continued to pace his cell for most of the morning on 28 July. By 11.00am, he appeared to go to sleep and spent the rest of the day in bed. He refused his lunch and evening meals, although his canteen (items from the prison shop) was delivered at 6.30pm and he ate chocolate and sweets. At 9.00am the next day, he came out of his cell and collected his breakfast; however he did not eat it. He refused his lunch meal despite encouragement from staff doing constant supervision. At 2.45pm, HCA B recorded a conversation, as follows:

> "[the man] says that he's alright each time I ask him but from my own observation, he is not because since morning till this time he has not eaten anything. He is only lying down sometimes sleeping and most of the time pacing around the cell from one end to another."

43. The man's refusal of food was also noted in his clinical record, as follows: "except the anorexia he's generally alright". Neither the ACCT CAREMAP nor the nursing care plan were adjusted to refer to his food refusal. He accepted a pudding from his evening meal at 4.45pm, but refused the main course.

44. On 30 July, the man received a visit from his family in the morning. He was recorded as "communicating well with them" and no concerns were raised during the visit. The consultant psychiatrist again visited him in his cell as part of his twice weekly ward round. The psychiatrist wrote in the medical notes that the man denied any suicidal behaviour, engaged in conversation and was seemingly not depressed. He assessed him as at "low suicide risk". The ward round formed the basis for the fourth ACCT case review. The case review was chaired by the psychiatrist and attended by Nurse D, SN C, Officer B, a member of the mental health team and the man himself. He told those present that he was feeling better and not thinking about harming himself. The multidisciplinary team agreed that he appeared to be brighter in mood following his visit, and assessed him as at low risk of harming himself. The team decided to take him off constant supervision. However, he would remain on the healthcare wing and be checked hourly by staff.

45. Two days later, whilst still continuing with his usual pattern of pacing and resting, he left his cell to associate with other prisoners on the healthcare wing. (Association is the time when prisoners spend time out of their cells.) There was some improvement in his interaction with staff and he asked for some biscuits which he ate with tea. Although staff gave him biscuits, they also encouraged him to take his meals and he said he would try to eat some of them.

46. The man's medical notes and ongoing record recorded that on 2 August he refused all meals except for a choc-ice cream. He told staff that he was not starving himself and was not hungry. Unlike the previous day, he would not engage with the staff member carrying out the ACCT observations, despite their efforts to talk to him.

47. The consultant psychiatrist's routine ward round took place on the morning of 3 August. An ACCT case review was held shortly afterwards, with a prison doctor, the psychiatrist, Officer B and two members of healthcare staff, together with the man. He told the team that he was sleeping well, his appetite was alright and he had no thoughts of self harm. (However the psychiatrist later wrote in his medical notes that he was not eating well.) When asked about his future, he responded "I don't know". Again, he was assessed as low risk and those present agreed to continue with hourly observations and the same medication. There was still no mention of whether he was wearing alternative clothing. In his record of the ward round, the psychiatrist noted that he had to follow up the man's transfer to a mental health secure unit. There is a note in his ongoing record that he ate his meal at 5.00pm that evening.

48. The following day the man was noted to be pacing and sleeping however, in the morning, he spent some time out on association. He declined his lunch that day and there is no record as to whether he ate his evening meal. On 5 August, he had a visit from his family which he

enjoyed but later he refused his lunch. He took part in association during the afternoon and ate "some food" in the evening.

49. On 6 August, the consultant psychiatrist saw the man during a ward round. He was very vague during the consultation and said he was worried about his court appearance. He asked the psychiatrist how long he was likely to be in prison and the psychiatrist responded "it might take a few months" to get a transfer to a mental health secure unit. The man said that "he did not mind" being in prison for a few months. He said that he did not have any thoughts of harming himself. The psychiatrist concluded that the man's ACCT document should remain the same and his treatment plan should continue. That evening, he took part in association, although there is no record about whether he ate his evening meal.

50. The man refused his breakfast the next day. He was visited by a chaplain from the chaplaincy team, who asked him about his eating:

> "He said he couldn't remember when he last ate. He said he's not eating because he's not hungry. I encouraged him to eat at least a little at every meal."

51. Although he was polite to staff, it was observed that he was "not interacting with other inmates", but did play a game of pool. When he declined lunch, he told a healthcare assistant that he would eat his evening meal. Nevertheless, he refused the meal but ate his dessert.

52. There was no note as to whether he ate his breakfast or lunch the next day. He was again observed not engaging with other prisoners during association time on 8 August, and only had dessert for his evening meal. A similar pattern of pacing, sleeping and poor appetite continued over the next few days. However, he did participate in association time and played pool with other prisoners.

53. The man refused breakfast and lunch on 10 August. He had custard and a cake for dinner. At 8.00pm, Registered General Nurse (RGN) A recorded that he approached her in the treatment room for a private conversation. She asked him why he was not eating much. When he said that he just did not like eating, she told him that he had lost three kilograms in weight since he was admitted to the healthcare wing. He went on to say, although he was not on hunger strike, his lack of appetite was due to his belief that he was innocent of his alleged offence. He then said that it was a "joke". The nurse wrote that his food and fluid intake should be monitored and to continue to engage him in wing activities. A form entitled "24 fluid balance chart" was started that day and recorded that he had drunk a cup of water at 3.00pm and noted the dessert he had eaten. There is no other information recorded on the chart and my investigation team has found no further evidence that it was used on subsequent days.

54. On 11 August, Nurse E recorded that the man had eaten “pudding only, NO meals”. His food refusal was also noted in his ACCT ongoing record.

55. The consultant psychiatrist visited him on 13 August as part of his ward round. He told the psychiatrist he was on hunger strike and was only eating puddings. The psychiatrist noted that he was still “guarded and evasive”. The psychiatrist wrote that the hourly observations should continue and he should remain on the healthcare wing. An ACCT case review was convened shortly afterwards. He told the multidisciplinary case review he was on hunger strike because he was innocent and was only eating puddings. It was noted that the hourly ACCT observations would continue and a chart to monitor his fluid and food intake should be started. (My investigation team has not seen any evidence of a second chart.) His next case review was scheduled for 20 August.

56. The man refused his lunch on the following two days, but did accept puddings in the evening. His behaviour pattern remained the same and he spent some time on the landing during association time nevertheless, he would pace between the wing and his cell and did not speak to other prisoners.

57. On 16 August, RGN A spoke to him at 3.30pm. He told the nurse that he was still on hunger strike although he had been observed eating lunch. She noted that there were 14 unopened breakfast cereal packs in his cell. When asked about this, he said he did not want to eat. At this point, she started a care plan, “to encourage him to maintain good food and fluid intake” and “to encourage him to stop his hunger strike”. She identified that nurses needed to monitor food and fluid intake, check his weight weekly and continue trying to encourage him to “verbalise his feelings”. Still, there is no evidence that a food and fluid chart were started. He denied any thoughts of self harm. The following day, he refused his lunch but ate his evening meal. This was recorded in the ACCT ongoing record, but my investigation team has not seen a food or fluid monitoring chart for that day.

18 August

58. Staff recorded in the man’s ACCT ongoing record and medical record that he spent the night of 17 and early morning of 18 August sleeping and was checked hourly throughout that night. At hourly intervals throughout the night, Nurse E recorded that he was asleep throughout the night until 6.00am when he was pacing about his cell. At 7.00am, the nurse noted that he was still pacing.

59. At 7.25am, Nurse C arrived early for work on the healthcare wing. He began a visual head count of the prisoners on the wing prior to taking over from Nurse E. When he got to the man’s cell, he saw him lying on

the floor. He could not see his head and called to him but he did not respond.

60. He was joined by Nurse E, but neither was able to get any response from the man. He went to the healthcare office to telephone the orderly office to get help to unlock the cell. (He did not have a cell key on his key chain.)

61. The Orderly Officer, Principal Officer (PO) A immediately responded, together with two officers. On arrival at the healthcare wing, the PO went to the man's cell. He opened the door and saw him lying on the floor with a black plastic bin liner over his head. He immediately removed the bin liner and turned him on to his back. The principal officer called a code one alert over the radio to the communications room. (A code one alert is a serious incident where an emergency ambulance is needed.) Nurses C and E immediately started cardio pulmonary resuscitation (CPR).

62. Nurse C asked Nurse E to collect the emergency bag, which contained equipment for breathing emergencies. An ambubag is a hand-held device used to provide positive pressure ventilation to a patient who is not breathing or who is breathing inadequately. The ambubag "seemed to be ineffective", so Nurse E took over CPR from Nurse C while he got oxygen from the nurse's office. Oxygen was then given via a mask and a pulse rate was noted to be between 80 - 90 beats per minute (normal range is between 60 -100 beats per minute). A defibrillator (a machine that sends a shock the heart) was attached to the man's chest, however it advised against shocking.

63. The nurses continued with CPR until the ambulance crew arrived at 7.43am when the paramedics took over the resuscitation and both nurses left the cell. The ambulance crew requested a second ambulance and continued with CPR. On arrival of the second ambulance crew, the man was escorted by two prison officers, unconscious, without restraints being used, to hospital at 8.05am.

64. On arrival at hospital, the man was given medication to induce a coma. He was moved to the hospital's critical care unit (CCU) and placed on a ventilator. His ACCT form was taken to the hospital and prison staff continued with the observation entries.

65. A chaplain and PO B were told of the man's attempted suicide at 10.40am and appointed as family liaison officers. At 10.51 am, the chaplain telephoned the man's father and informed him of his son's transfer to hospital.

66. She arranged to visit the family and take them to hospital as they could not drive. She collected the family at 12.25pm and arrived at hospital at 25 minutes later. The family were immediately taken to the CCU where they waited to see a doctor.

67. At 1.30pm, a doctor and two nurses spoke to the family and explained their son's present condition and the medical tests that had been undertaken. After this meeting they were taken to his bedside. The family left the hospital at 3.00pm.

68. The following day, hospital staff withdrew the sedation medication. The man did not regain consciousness and he remained in a critical condition on a ventilator. His condition did not change over the next two days.

69. On 20 August, PO B met the family, including their youngest son, at the hospital. The CCU consultant had asked to meet them with two clinical nurses present to offer support. The consultant explained their son's current condition and told them that his prognosis was poor. There was severe pressure and damage to the brain due to oxygen starvation. Their son's chance of survival was weak and his life expectancy was only a few days. This information came as a great shock to the family. After spending time with with their son, the PO took the family home in a taxi.

70. The chaplain and PO B maintained regular contact with the man's family and ensured they were supported in their visits to the hospital. The ACCT document was suspended on 23 August on the instruction of the duty governor. The man died the next day at 1.15pm, when his ventilator was switched off.

71. Following his death, the family were contacted again to see if there was anything that they needed and to offer support. However, the family were too upset to speak to the liaison officers and said they would be in touch.

72. On 25 August, the chaplain spoke to the man's father. Although the prison offered to pay the funeral costs, the family did not pass on the necessary information for them to do so. Furthermore, the father did not want any representation from the prison at the funeral and did not know whether he wanted to visit the prison, but would collect his son's possessions.

ISSUES

Clinical care

73. The local PCT set up a review panel to examine the clinical care the man received whilst in Wormwood Scrubs. The clinical reviewer was the panel chair. The clinical review is the first annex to this investigation report.

74. I am grateful to the PCT for the full consideration they gave to the care that the man received from the moment of his arrest by the police. The remit of my own investigation is more limited. I can only comment on the time that he was in prison custody, from his remand at Wormwood Scrubs until his death, less than two months later.

75. The clinical review panel identify seven key issues in their report, as follows:

- His remand to prison, rather than a mental health setting
- the time it took for the urgent mental health referral to be processed
- use of alternative clothing
- access to therapeutic interventions in the healthcare centre
- the decision to decrease his levels of ACCT observation
- primary care services working alongside secondary care services
- management of food refusal.

Remand in custody

76. The review examines the circumstances surrounding the man's remand to custody. It was the panel's view that "the nature and degree of his mental disorder were such that he required hospital treatment". They go on to recommend that the PCT and Mental Health Trust should review current arrangements to divert prisoners with mental health conditions from court. His court appearance was on a Saturday, and at weekends there are no services to arrange referrals to mental health services. I agree that his care should not have been compromised by his appearance at court. I also commend the recommendations made by the clinical review panel to the attention of the mental health trust and the PCT, although they lie outside my remit. I therefore will ensure a copy of this report is sent to the Lord Chancellor for his consideration.

Referral to a psychiatric secure unit

77. It is also outside of my remit to comment on the time taken for the man's urgent referral to a mental secure mental health unit to be actioned. The clinical review examines this matter and recognises the pressure on spaces in such units. However, as the clinical review underlines, he suffered from a severe and enduring mental health condition that required hospital admission. Although staff made clear

efforts to engage with him (as discussed in later section of this report), a prison healthcare centre cannot deliver the same level of therapeutic care of a dedicated mental health unit. The clinical review recommends that the Strategic Health Authority consider options to streamline referrals to enable urgent access to secure mental health beds.

78. The clinical review recognises the importance of therapeutic interventions for prisoners with mental health conditions. I recognise the limitations of delivering therapeutic interventions in a prison setting. As I have already said, I do not believe that prison is the appropriate environment to treat those with severe and enduring mental illness. However, a high proportion of prisoners in the inpatients' unit are accommodated there as a result of a mental health condition. I therefore endorse the clinical review's recommendation:

The Head of Healthcare should work with the head of Safer Custody to review the availability of therapeutic interventions on the healthcare wing, including available space, staffing and a comparison with therapeutic interventions available elsewhere in the prison.

79. The clinical review panel found that there was "limited evidence of shared care arrangements between primary care medical services [that is local doctors] and secondary care mental health services [that is hospital services]". Later in this report, I comment on the improvements in communication between healthcare staff and officers. A co-ordinated multidisciplinary approach is essential to the effective healthcare of a prisoner with the man's complex set of medical needs. I share the concerns outlined in the clinical review and endorse the following recommendation:

The PCT and Mental Health Trust should work together to ensure that the delivery of primary and secondary care is integrated.

Identifying the man's level of risk

80. Before the man's arrival at Wormwood Scrubs, the consultant psychiatrist contacted staff to alert them of his mental health needs and that he should be subject to constant supervision. The nurse who completed the first reception healthscreen as soon as he arrived at the prison, raised a Concern and Keep Safe form.

81. "Prison Service Order (PSO) 3050 – continuity of healthcare for prisoners" identifies the transfer of patients into prison as a "vulnerable point of the system" designed to ensure prisoners' care is not interrupted by a change of setting. (PSOs set out the rules by which prisons are run.) Undoubtedly the involvement of the psychiatrist in the man's care in hospital and his employment at the prison smoothed this transfer. I recognise the efforts of the psychiatrist to alert the prison to

the man’s serious mental health condition and risk to himself and others which demonstrated good practice in line with the Prison Service Order.

Safer Custody

Wearing alternative clothing

82. Following his ward round on 20 July, the consultant psychiatrist wrote that the man should continue to be accommodated in a gated cell "with clothes". The record of the ACCT case review that took place that same day recorded that he was to wear "strip clothing day and night". There is no further mention of him wearing alternative clothing in his ACCT document, either the ongoing record or case reviews.

83. The use of alternative clothing is described as "a measure of last resort" in PSO 2700 because it compromises a prisoner's dignity. The prisoner cannot retain their own personal possessions and clothing, which can lead to a feeling of isolation and increase feelings of suicide or self harm. The garments worn as alternative clothing are necessarily basic and the nature of the material is such that it is not as comfortable as a prisoner's own clothes.

84. I made a recommendation in a previous investigation at the prison for the Governor to ensure that alternative clothing was only used when absolutely necessary. As I wrote in my report of that case, according to the National Offender Management Service (NOMS) lead for suicide and self harm prevention, such clothing should only be used if a prisoner is at risk of harming himself using his own clothes. The man was assessed as at high risk of self harm or attempted suicide. There was no record of him using his own clothes to harm himself, although I recognise that his behaviour was described by many staff that came into contact with him as "unpredictable".

85. I cannot determine how long the man was in alternative clothing for from his records. I accept that he might not have been wearing it for very long. I also acknowledge that the decision to use alternative clothing was made by a multidisciplinary team. However, I am still concerned at the readiness of staff to use alternative clothing, despite my previous recommendation. It is an important recommendation. Failure to implement it cannot have helped his wellbeing. I am therefore taking the unusual step of drawing my recommendation to the attention of the Chief Executive of the National Offender Management Service.

86. I understand from ongoing contact with the prison that staff have received training about the use of alternative clothing. The use of these measures has fallen dramatically in the six months before my report was issued. Nevertheless, I repeat my recommendation here:

The Governor must ensure that alternative clothing is only used as a measure of last resort.

87. It is not clear from his records, either clinical or his ACCT document, when the man was in alternative clothing. Staff interviewed as part of this investigation recalled that he was in alternative clothing at some point, but could not remember exactly when.

88. As I have explained above, alternative clothing is only to be used when it is absolutely necessary. I am concerned that no clear record was made of the decision to give his his normal clothing. If the appropriate safeguards had been in place (as I will discuss below) there could be no doubt about how long he wore alternative clothing for. As I have made this recommendation before, I suggest that the Governor devises an audit system to ensure that the use of alternative clothing is clearly documented. Again, I am pleased to learn that an audit system has been put into place since his death.

The Governor should ensure that the use of alternative clothing is appropriately documented and monitored in his prison.

Enhanced case reviews

89. Alternative clothing is described in PSO 2700 as a "measure of last resort". If a prisoner is subject to constant supervision for eight days or more or subject to a measure of last resort, an enhanced case review must be convened to discuss their care and find ways of de-escalating the prisoner's crisis to stop the use of these measures at the earliest possible opportunity. The man was subject to constant supervision from 18 July until 30 July, that is 13 days. He was dressed in alternative clothing on arrival, although there is no further mention of alternative clothing after this and it is not clear when or whether he was given back his own clothing. Under either of these conditions, his care should have been discussed at an enhanced case review.

90. The requirements of an enhanced case review are set out in PSO 2700, as follows:

> "The enhanced case-review team will involve all relevant disciplines and include more specialists and a higher level of operational manager than a typical ACCT case review team. *The enhanced case review team must include an Operational F Grade Manager (or above)* and where possible the involvement of the following ought to be facilitated:
>
> "A member of the mental health team or doctor (where the prisoner is already in receipt of secondary mental health services, wherever possible this should be their mental health care co-ordinator).
>
> "The manager of the residential, healthcare, special unit or Segregation Unit on which the prisoner is located. If the prisoner has recently moved frequently between healthcare, Segregation

Unit and residential wing, representatives with experience of his/her behaviour from all locations should attend the first enhanced case review team meeting

"An appropriate psychologist. Psychologists, both clinical and forensic, often have valuable expertise in assessing and managing people with personality disorder and/or in behavioural management. Establishments SLA [service level agreement] with clinical and forensic psychology services may determine the level of service access.

"All specialists (e.g. education, Offender Manager/Supervisor) who work with the individual prisoner, including where involved with the prisoner;

"*The appropriate member of the multi-faith Chaplaincy team and a member of the IMB must also be invited to attend.*

"*The prisoner – as long as the Case Manager does not have reason to consider this inappropriate, in which case they must document the reason(s) – must also be invited to attend."*

(The sections of PSOs which are written in italics are mandatory instruction to staff. As this section of the PSO is in italics, it is mandatory.)

91. All of the man's ACCT case reviews were chaired by the consultant psychiatrist. As a senior member of the mental health team, his input was important for the ongoing care plan. As I have said above, I commented in a previous investigation that case reviews were often only attended by healthcare staff, rather than being multidisciplinary and including officers. I am pleased to note that healthcare staff and officers were present at all of the case reviews. The CAREMAP also reflected actions for all staff in the healthcare centre, officers and nurses, which reflected a more integrated approach to his care, as reflected in the prison's action plan following my previous investigation.

92. However, despite the Duty Governor's required daily visit to the wing, there are no entries in the man's ACCT ongoing record from a governor grade member of staff throughout the time that he was on constant supervision. No governor grade was recorded as attending the ACCT case reviews. As set out above, enhanced case reviews must be attended by a senior member of staff of at least governor grade.

93. A duty governor was a safer custody governor at the time of the investigation. His area of responsibility included overseeing the inpatients' unit, including managing the officers based there. When asked during interview about enhanced case reviews, he accepted that enhanced case reviews were not being convened in accordance with

the mandatory instruction I have set out above. During his interview, the governor explained that duty governors should have been attending enhanced case reviews, but they were not aware when they were taking place. This was echoed in the Governor's response to my investigator's preliminary feedback:

> "A Governor's Order has been drafted outlining the requirement to consult the Duty Governor when a gated cell or protective clothing is being considered for use. This will be issued to all prison service and PCT staff and will include the requirement for an Operational Manager to attend the enhanced case review."

94. During his interview, the governor told the investigation team that he had devised a system to notify duty governors of enhanced case reviews due. This system ensured cases were highlighted during the managers meeting that takes place every morning. This meeting is attended by the Head of Healthcare and is an opportunity for healthcare matters to be brought to the attention of other managers in the prison.

95. According to the mandatory instruction, chaplains should also be invited to all enhanced case reviews. Even ACCT case reviews for prisoners not subject to measures of last resort should be attended by chaplains, where they have had an input into that prisoner's care. A member of the chaplaincy visited the man daily and recorded regular conversations with him, so could have made a valuable contribution to the ACCT case review process. In his response to this point in my investigator's preliminary feedback letter, the Governor wrote: "it is intended to invite chaplaincy in the future to all case reviews and an order outlining this will be issued". From further discussions with the safer custody team at Wormwood Scrubs, I am pleased to learn that the situation at the time of issuing this draft that chaplains now regularly attend ACCT case reviews.

96. However, I am disappointed to find that the safeguards surrounding the use of measures of last resort or prolonged constant supervision were not introduced in line with the requirements of PSO 2700 following my previous recommendations. I am further surprised that staff spoken to during this investigation were not aware of the requirements of enhanced case reviews. I repeat the recommendation:

The Governor should ensure that staff follow the requirements of enhanced care as set out in Prison Service Order 2700.

97. The additional requirements of an enhanced case review, as opposed to a typical ACCT case review are set out later in the PSO:

> *" … it must also include a named key worker(s), strategies for encouraging pro-social behaviour, and agreed strategies for responding to each individual problem behaviour that the*

prisoner displays: both those behaviours that involve self-harm and those that involve anti-social behaviour."

98. Again, this section is written in italics and is a mandatory requirement. As in the previous investigation, the man did not have a key worker. However, I am satisfied that staff tried to engage with him throughout his time in the gated cell. The support of a more senior member of staff, that is a governor, may have made the demanding requirements of an enhanced case review, that is "strategies for responding to each individual problem behaviour" more achievable for those present.

ACCT training

99. Nurse C opened the man's ACCT document when he arrived on 18 July. The nurse is both a registered general nurse and mental health trained and has been practising in the UK since 1994, working on the inpatients' healthcare centre at Wormwood Scrubs since 2008. In interview for this investigation, he described his role as a senior staff nurse: "I assess, plan, implement and evaluate patient care, that includes risk assessment and I manage their care and engage them on a day to day basis". Despite working at the prison for over a year at the time of this investigation, he had not been ACCT trained. When asked about this at interview, the nurse explained:

> "Personally I have not been trained in the ACCT document because the environment where I've worked before, mostly risk assessment, is a very important part of my job, and I also see the ACCT document as a risk assessment document."

He went on to explain that he used his previous experience to manage patients on ACCT documents.

100. I am surprised that a long-term healthcare professional had not received ACCT training. I acknowledge that his judgement about the man's level of risk was informed by his significant mental health experience. However, ACCT is a multidisciplinary approach to supporting and monitoring prisoners at risk of self harm. It is designed to be used by officers and healthcare staff in prison to support prisoners at risk of self harm and suicide. Mental health treatment is often central to the care of prisoners at risk of suicide or self-harm, as it was in this case, but it is not the only consideration of an ACCT document.

The Head of Healthcare should ensure that all staff working in the healthcare centre have been trained in ACCT as a matter of priority.

ACCT case reviews and ward rounds

101. With the exception of Nurse C, all the staff interviewed told the investigation team that they had been trained in the ACCT process. The investigation team were reassured by staff that they understood the purpose of ACCT. I am reassured that officers and healthcare staff are aware of their roles and responsibilities in the multidisciplinary ACCT process.

102. When my investigator asked Officer C, an officer based in the healthcare centre, about her participation in ACCT case reviews, she explained:

> "… if the inmates are [in the inpatients unit] for mental health assessment [ACCT reviews] tend to be done on the in-reach ward round which would be our psychiatrist and in-reach would come in. We do get included now in that documentation …"

103. In the previous death in custody investigation that I completed at Wormwood Scrubs, I was concerned that officers were not routinely being involved in ACCT case reviews. I am pleased at the progress the prison had made at the time of this investigation.

104. For each ward round entry made in the man's clinical record, there is a corresponding ACCT case review. I was told by Officer C and the consultant psychiatrist that after each ward round discussion officers are invited in to discuss the ACCT support plan in a case review. The ward round was an opportunity for the psychiatrist to assess the man's medical and mental health needs and adjust his clinical treatment as necessary. The purpose of the ACCT case reviews was to review his risk of self harm or suicide and look at the support plan in place to ensure that it appropriately met his wider needs.

105. I understand that psychiatrist's time in the prison is limited. (He works there every Monday, as well as Wednesday, Thursday and Friday mornings.) I do not under-estimate the importance of the psychiatrist's contribution to an ACCT case review for a prisoner who he is treating or assessing. Nevertheless, I am concerned that the distinction between an ACCT case review and a ward round might have become blurred. Often the language used in the ward round was reflected in the note of the case review. In my previous investigation report, I commented that healthcare staff were too reliant on the decisions made by the psychiatrist about the ACCT process. I am satisfied that progress has been made in involving officers in case reviews. However, I am worried that the ACCT case review could be treated as an extension of the ward round, which could lead to undue weight given to the psychiatrist's assessment.

The Head of Healthcare and the Head of Safer Custody should review the practice of following ward rounds with ACCT case reviews.

Assessment of the man's level of risk

106. Subject to constant supervision from his arrival on 18 July until 30 July, the man was then assessed as "low risk". During his first ten days in custody his risk was assessed in three ACCT case reviews as 'high' risk. Following the multidisciplinary case review on 30 July, his level of supervision was changed from constant supervision to hourly observations. As set out above, the decision to reduce his level of supervision should have been made by an enhanced case review.

107. He was subject to constant supervision for his first 13 days at Wormwood Scrubs. Prison Service Guidance (in annex 8Y of PSO 2700) describes constant supervision as a "temporary arrangement", designed for prisoners in "acute suicidal crisis". If constant supervision is used, in accordance with requirements set out in the PSO, for "the shortest time possible", I am surprised that the "acute suicidal crisis" diminished so quickly and to such an extent that he could be assessed from high risk to low risk, without any stages in between.

108. The guidance suggests that, when a prisoner is subject to constant supervision for longer than a week, it might be a result of "a lack of confidence and fear of blame in staff". It is not possible for me to speculate about the level of risk that the man presented during his case reviews on the basis of his records. I trust that the introduction of enhanced case reviews in prison will increase staff confidence and ensure that constant supervision is indeed used for a short a time as possible, in accordance with national policy.

109. I am concerned that the man's observations were reduced from the highest level of supervision, constant supervision, directly to hourly observations because of his assessment as "low risk". In his interview for this investigation, the psychiatrist was asked about this decision and explained:

> "… there were no immediate and no obvious risks, because usually where there is some evidence of risk, we move a patient more slowly from say one-to-one [constant] observations onto hourly. They'll be on half-hourly or 15 minutes …"

110. As the consultant psychiatrist explained to my investigation team, the case review team could have reduced the man's observation levels more gradually. The difference between the level of support offered by constant supervision and hourly observations is considerable. In their response to the draft report, NOMS pointed out that the guidance to reduce observations gradually is not a mandatory instruction in PSO 2700. While I acknowledge that there is no mandatory requirement to gradually reduce observations in the order, the guidance is strong: "it is expected that levels of support will gradually drop as persons-at-risk are supported through their difficulties".

111. As I said before, I cannot determine the man's level of risk from his records alone and I make no judgement about whether or not he was low risk. However, I agree with the clinical review and I am surprised that the reduction in his level of observation was not less gradual. As I have already said, I understand that significant progress has been made in the operation of ACCT at Wormwood Scrubs since my previous investigation. Nevertheless, I make the following recommendation:

The Governor should remind staff of the guidance in the PSO to progressively reduce the level of a prisoner's observation when they are taken off constant supervision.

Frequency of ACCT observations

112. Observations were recorded every hour, on the hour in the man's ACCT ongoing record. Although the PSO does not require observations at irregular intervals, it is often built into local suicide prevention policies that observations should be made at irregular intervals. Wormwood Scrubs' own suicide prevention policy sets out:

> "The checks must not be spaced at regular and therefore predictable intervals. In the past, prisoners being checked at predictable intervals have killed themselves between supervision times."

113. Nurse C explained that, although staff had made entries in the man's ACCT document every hour, checks were made more frequently than that. Other staff told the investigation team that they were unaware of the requirement for checks to be irregular. I share the concern reflected in the prison's suicide prevention document, that regular checks provide prisoners with a predictable window of opportunity. When my investigation raised this concern with the Governor during the course of the investigation, he responded:

> "In respect of observations and checking on the hour every hour, this clearly creates a pattern which the prisoner can note and is contrary to all our instructions. Observations should be frequent and irregular. I have reinforced the correct procedure to all staff and future training will include this extremely important point."

The Head of Safer Custody should ensure that when a prisoner is subject to intermittent observations, checks are made irregularly and not at regular, predictable intervals.

Communication with healthcare staff

114. Another investigation at Wormwood Scrubs in the months before the man's death found that enhanced case reviews were not being held despite circumstances of the prisoner's care requiring it. The

investigation also revealed concerns about the use of alternative clothing and constant supervision in the prison. Following feedback, the Governor issued an Order reminding staff of the requirements of an enhanced case review. The Governor's Order was dated 5 June 2009, over two months before his death.

115. All the staff interviewed for this investigation were shown a copy of this order. The only staff who could definitely say they had seen and read it were discipline staff. No nursing staff were aware of it. It transpired that nursing staff cannot access the prison intranet and thus orders, instructions and information sent out via the prison's intranet cannot be accessed by those healthcare staff. I am always disappointed to repeat recommendations and repeat concerns between recommendations. I am pleased that the Governor took action following my previous investigation feedback but it is all the more concerning that those lessons had not been effectively shared with all of the relevant staff.

The Governor and the Head of Healthcare must ensure that all key messages issued by the prison's senior management team are followed by healthcare staff.

Food refusal

116. Throughout his time in Wormwood Scrubs, staff made entries about what the man was eating. Often he would refuse his meals, but then eat a pudding or eat something that his visitors had given to him. It is not possible to determine how long he went without food at any one time. It seems that on 27 and 28 July he ate almost none of his meals, but was recorded as having eaten sweets and chocolates.

117. Food refusal is not necessarily a form of self harm. Prisoners might refuse to eat as a form of protest or as a result of a medical condition. Prisoners cannot be forced to eat, and to do so could constitute an assault. However, food refusal could be a sign of withdrawal and hopelessness. In some cases, it has also been an indication of suicidal intent. It is not mandatory to monitor food refusal using the ACCT process, unless there is clear suicidal intent linked to the decision not to eat.

118. RGN A noted that the man had lost three kilograms in the short time he had been at the prison on 10 August. From his records, it looks as though she began a food/fluid chart following this conversation (although the date could be read as 13 August). The chart monitors from 8.00am that morning until 5.00pm that afternoon. In his case review on 13 August, he told those present that he was on "hunger strike because he is innocent". It was decided by those present that his dietary intake should be monitored, but no food/fluid chart was started. On 16 August, the RGN created a nursing care plan "to

encourage [the man] to maintain good food and fluid". Part of the identified 'Nursing Action' was to monitor his food/fluid intake.

119. From 10 August to 16 August, it was noted three times that staff should monitor the man's food and fluid intake. Nevertheless there was only one incomplete chart in his records and no complete charts. Officers and healthcare staff occasionally recorded whether he had eaten his meal, but this was not done methodically at every meal time. I cannot determine the extent to which his dietary intake was problematic on the basis of the records made available to the investigation team. However, I am surprised that the recommendations and care plans devised by staff in the inpatients' unit were not carried out. I agree with the clinical review team that any form of food refusal should be fully documented and make the following recommendation:

The Head of Healthcare must ensure that staff understand the importance of and are confident in methods of monitoring food and fluid intake.

Access by the man to a plastic bin liner

120. Black bin liners are used widely throughout the prison for both staff and prisoners to dispose of rubbish.

121. As they are considered to be at high risk of harming themselves, prisoners who are subject to constant supervision or are in alternative clothing are not issued with black bin liners. The man was subject to constant supervision and dressed in alternative clothing when he first arrived at the prison. Consequently, the investigation team were told by staff that he should not have had a bin liner in his cell when he first arrived at Wormwood Scrubs. There is no record of whether this is the case.

122. However, the removal of personal possessions and items from prisoners assessed as at risk of suicide or self harm can increase feelings of isolation and therefore increase their level of risk. Therefore, PSO 2700 requires that prisoners are given their personal possessions back at the earliest opportunity. When the man's risk was reduced from "high" to "low" on 30 July, it followed that his personal belongings would have been returned to him, along with the standard issue plastic bin liner. The investigation team has seen no evidence of when he was given his possessions back, including a bin liner. As his risk of suicide was assessed as low (a judgement which has been considered at length above), I do not consider it unreasonable that he had the bin liner in his cell.

123. Following the man's use of a bin liner in his attempted suicide and subsequent death, they were removed from all the cells in the inpatients' unit as a precautionary measure. Understandably, this caused significant hygiene issues for prisoners.

124. I received the following response from NOMS when I issued the draft report for their comment:

> " … plastic bags were removed from prisoners only located in H3 whilst risk reviews were being carried out on those patients and alternative waste containers for waste were being sought. Plastic bags were not removed from all cells in the establishment and are available, on request, for hygiene purposes."

125. In her response to the draft investigation report the Director of Operations for Central London Community Healthcare NHS Trust wrote that bin liners in the inpatients' unit "are distributed [for the disposal of rubbish] but then removed as soon as the task is completed".

126. The man's family wrote that they "strongly disagree with your findings that it was not unreasonable for him to have a bin liner in his cell". They point out that the Head of Healthcare was unaware that inpatient prisoners were left in possession of black bin liners. According to the family's response, both staff that accompanied the family to hospital told them that he should not have had a bin liner in his cell with him.

127. I understand the man's family's concerns. Conflicting information about the use of bin liners in Wormwood Scrubs has continued beyond the consultation phase of this investigation.

Issue and use of cell keys

128. When Nurse C entered the prison on the morning of the 18 August 2009, he was issued with a bunch of keys. The nurse told the investigation team in interview that cell keys were not included on this bunch:

> "On that day they didn't give me a cell key. The governor saw my key, the orderly saw my key, they didn't give me a cell key and I request them you know, they didn't give me a cell key on the day so I didn't have a cell key."

129. In NOMS' response to the draft report, the following system was explained:

> "All nursing staff allocated to work on [the inpatients'] unit were to draw keys which had a cell key included. A list of those working on that unit was provided to the gate as authority for those nurses to draw such keys. The nurse identified in the report as coming on duty that morning was included on that list."

The investigation team has not confirmed the system that was in operation or seen the list referred to in NOMS' response.

130. Nurse E, the night duty nurse, also had a bunch of keys which did not include a set of cell keys. She did however have a sealed pouch with a cell key in it for use in an emergency. Nurses C and E were the only two nurses on the inpatients' unit when the man was discovered.

131. Nurse E told the investigation team that she had not used the key in the pouch because she was under the impression that she could not break the seal without the permission of the orderly officer. In fact, it is local prison policy that she could have opened the pouch in the interests of saving lives. As a result of the nurse's misunderstanding, she waited for the orderly officer, PO A, to reach the inpatients' unit and open the cell. The principal officer estimated that it took a minute and a half from receiving Nurse E's telephone call to get to the inpatients' unit. I cannot comment on whether this would have altered the outcome for the man, although there is no doubt that every minute counts when responding to an emergency.

132. The issue of cell keys arose at the hot debrief (A meeting to debrief staff soon after a major incident) held after the man's death. At the meeting, staff were reminded that they can enter a cell using the sealed pouch cell key in an emergency. The investigation team were also told that the prison will increase the number of cell keys issued to staff. However, there will be occasions when there are not enough cell keys for everyone to have a key.

The Governor and the Head of Healthcare must ensure that there is always at least one member of staff in the healthcare centre with access to a cell key.

Resuscitation

133. Once PO A had opened the man's cell, he removed the plastic bag from over his head. Nurses C and E followed him into the cell and started resuscitation attempts. It is unfortunate that the ambubag appeared to be "ineffective". However, an alternative (oxygen cylinder) was found quickly because the man was located in the healthcare unit. The clinical review considered the resuscitation efforts to be in line with those required by the Resuscitation Council (UK). I agree that staff responded quickly and appropriately once they were in the cell. Understandably, the family are concerned about any delay that might have been caused by the ambubag being "ineffective".

Prison family liaison

134. The efforts of the prison family liaison officers, the Chaplain and PO B are to be commended. They worked hard to ensure the family were given all the help and consideration possible while the man was in a critical condition at hospital.

135. In their response to the draft investigation report, the family confirmed that the family liaison officers were “helpful and supportive”. However, they were concerned that they were not told by the liaison officers that the man’s organs could not be donated because he would be the subject of a post mortem examination. This affected the time it took to make the decision to turn off the life support machine.

136. The family liaison guidance annexed to PSO 2710 – follow up to deaths in custody outlines the importance of understanding procedures in relation to organ and tissue donation to explain this to families. I do not criticise the family liaison officers, but would remind them of the importance of providing families with as much information as possible at such difficult times.

Nursing care plan

137. In their response to the draft report, the man’s family’s legal representatives wrote of their concerns over an inaccurate observation in one of his nursing care plans. On 18 July, the day of his arrival at Wormwood Scrubs, Nurse B wrote that the man had “stabbed a nurse at hospital”. Unfortunately, I am unable to establish the source of this information, although I am assured by the family that it is not accurate. This allegation is repeated in the cell sharing risk review completed by Officer C on 26 July. In light of the seriousness of the allegations, I agree with the following extract taken from the family’s written response to the draft investigation report:

> “It is obviously extremely important that information noted on care plans and passed on to others in the prison is accurate as it will be relied upon and consequences will follow. A number of different nurses dealt with the man, some of them agency staff. They should have studied his care plan to ensure they were meeting his needs. They will all have seen that entry and although some of them may have known it was not true, some of them will not.”

CONCLUSION

138. I do not underestimate the difficulty of looking after someone with the man's complex needs in a prison environment. I share the concerns expressed in the clinical review that he found himself in a prison at all, as well as the length of time it was taking to action his urgent referral to a mental health setting. For these reasons the report is being sent to the Lord Chancellor.

139. This is not the first investigation I have carried out into the death of a prisoner in Wormwood Scrubs' inpatient unit. I am encouraged by the progress that was made between a death in April 2009 and the man's death, although my investigation discovered much work still to be done. I remain concerned by similar issues relating to the use of protective clothing, enhanced case reviews and the reduction of high to low risk in particular. Throughout the course of this investigation, my investigator was updated with the significant progress made in the delivery of safer custody at Wormwood Scrubs. Nevertheless, his care was compromised by the standard of safer custody during the time he was in the inpatients' unit.

RECOMMENDATIONS

1. The Head of Healthcare should work with the head of Safer Custody to review the availability of therapeutic interventions on the healthcare wing, including available space, staffing and a comparison with therapeutic interventions available elsewhere in the prison.

2. The PCT and Mental Health Trust should work together to ensure that the delivery of primary and secondary care is integrated.

3. The Governor must ensure that alternative clothing is only used as a measure of last resort.

4. The Governor should ensure that the use of alternative clothing is appropriately documented and monitored in his prison.

5. The Governor should ensure that staff follow the requirements of enhanced care as set out in Prison Service Order 2700.

6. The Head of Healthcare should ensure that all staff working in the healthcare centre have been trained in ACCT as a matter of priority.

7. The Head of Healthcare and the Head of Safer Custody should review the practice of following ward rounds with ACCT case reviews.

8. The Governor should remind staff of the guidance in the PSO to progressively reduce the level of a prisoner's observation when they are taken off constant supervision.

9. The Head of Safer Custody should ensure that when a prisoner is subject to intermittent observations, checks are made irregularly and not at regular, predictable intervals.

10. The Governor and the Head of Healthcare must ensure that all key messages issued by the prison's senior management team are followed by healthcare staff.

11. The Head of Healthcare must ensure that staff understand the importance of and are confident in methods of monitoring food and fluid intake.

12. The Governor and the Head of Healthcare must ensure that there is always at least one member of staff in the healthcare centre with access to a cell key.