PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent Investigations

Investigation into the circumstances surrounding the death of a man at HMP Wormwood Scrubs in January 2012

Report by the Prisons and Probation Ombudsman for England and Wales

July 2013

This is the report of an investigation into the death of a man, a prisoner at HMP Wormwood Scrubs. On 30 December 2011, he was found by his cellmate hanging in the toilet area of the cell. He was taken to hospital, but died a few days later in January 2012. I offer my condolences to his family and friends.

A clinical reviewer conducted a review of the man's medical care in custody on behalf of the local PCT. I apologise for the delay in issuing this report.

The man appears to have fallen under the radar of staff at Wormwood Scrubs. Other than being described as "quiet and compliant", very few entries were made in his records in the eight months he was at the prison. He spoke very little English on arrival, although this gradually improved as he attended language classes. Both staff and prisoners described him as a quiet man who mixed only with a small group of prisoners who spoke his language. Wormwood Scrubs does not have a personal officer scheme and, as a result, he did not have a named officer who got to know him and to whom he could turn with questions or concerns.

Had more attention been paid to the man, a number of risk factors might have been picked up: it was his first time in prison, he was on remand for serious domestic violence offence, he was facing a significant period in custody and he also required alcohol detoxification. Shortly, before his death he shared with probation staff his desire to see his children, but was told how difficult this would be given his offence. On the same day, his cellmate a fellow Tamil speaker, moved cells and was replaced by a Vietnamese prisoner with little English. He appears to have spent much of his final weeks in bed in his cell, paying little attention to personal hygiene, no longer associating with other prisoners and not attending religious services as he had done previously.

I agree with the clinical reviewer that a series of problems over time can be as significant as one major issue in causing people to harm themselves. Unfortunately, staff at Wormwood Scrubs did not pick up on the man's accumulating distress and there is a need for serious reflection as to how to avoid such situations in future.

The investigation also found conflicting views among staff about the emergency response and identifies a number of areas for improvement, including the need for better training and the routine deployment of defibrillators in cases such as this. Finally, the investigation found scope to improve debriefing arrangements for staff and to support families better when a seriously ill prisoner is admitted to hospital.

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 **July 2013**

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SUMMARY

1. The man was remanded into custody at Wormwood Scrubs on 30 April 2011. He came to the United Kingdom from Sri Lanka and was a naturalised British citizen. It was his first time in prison, he spoke little English and he was facing a charge of serious violence against his estranged wife. He spent the first week in the detoxification unit, undergoing an alcohol detoxification, then moved to C wing.

2. There is very little information in the man's prison records to indicate how he spent the next few months. He shared a cell with another Sri Lankan prisoner and mixed with a small group of other Tamil speakers. He spent a lot of time in his cell smoking. Although he went out on exercise and attended religious services, he became withdrawn and stopped doing so a few weeks before his death.

3. On 11 October, the man returned to court and received an indeterminate sentence for public protection (IPP) with a tariff of five years. His offender supervisor met him on 19 October to introduce herself and discuss his sentence. They used a telephone interpreter to talk to each other. She explained the IPP sentence and what he would have to do to be released. She told the investigator that she was not sure he understood what it meant to be an IPP prisoner.

4. The man's offender supervisor and offender manager held a Sentence Planning and Review meeting on 16 December. He told them that he wanted to see his children. They explained that he would have to make a request through a solicitor. They also told him that it was unlikely that he would ever be allowed further contact with his wife. On the same day, his cellmate moved and was replaced by a Vietnamese prisoner whose English was very limited.

5. Two weeks later, the man's cellmate returned to the cell to find him hanging in the toilet area. Prison and healthcare staff attempted to resuscitate him until paramedics took over treatment. Prison staff did not take a defibrillator to the cell. When the paramedics attached their defibrillator to him, it delivered a number of shocks to restart his heart. They then took him to a local hospital where he spent four days on a life support machine. Sadly, he never recovered consciousness and died.

6. The investigation found deficiencies in both the completion of healthcare records and the requesting of community medical records. There were also a number of static risk factors that ought to have received greater attention from staff and further issues emerged during his time in prison, which evidently distressed him. However, there is no personal officer scheme at Wormwood Scrubs, leaving the man with no named member of staff to whom he could turn with concerns. The investigation is also critical of the fact that a defibrillator was not immediately taken to the scene to aid resuscitation in spite of the nature of the emergency. Finally, concerns are expressed about weaknesses in arrangements for hot debriefs for staff involved in emergency incidents and arrangements for family contact.

THE INVESTIGATION PROCESS

7. The Ombudsman's office was notified of the man's death on 3 January 2012. The investigator issued notices inviting staff and prisoners to contact her with any relevant information. There was no response. She visited HMP Wormwood Scrubs on 6 January, where she met the Governor and members of the Independent Monitoring Board (IMB) and the Prison Officers' Association. She visited the man's cell and collected relevant documents.

8. The investigator interviewed a number of staff and prisoners at the prison on 8 and 16 February and 23 March. She gave verbal feedback on the progress of the investigation to the Governor after the interviews were completed. The local PCT commissioned a clinical reviewer to review the clinical care the man received at Wormwood Scrubs. We received the clinical review on 11 June 2012.

9. We notified Her Majesty's Coroner for West London about the investigation and she provided a copy of the post mortem and toxicology reports. The Coroner will receive a copy of this report. The investigator liaised with a Detective Sergeant (DS) from the Metropolitan Police and he kept her informed of his investigation. We are sorry that late receipt of the clinical review and pressure of work in this office has delayed completion of this report.

10. One of the Ombudsman's family liaison officers contacted the man's sister to explain the purpose of the investigation and invite her to ask any questions or raise concerns about the care her brother received in prison. The family did not respond but they will be given the opportunity to review the investigation report.

HMP WORMWOOD SCRUBS

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

Independent Monitoring Board

12. All prisons have an Independent Monitoring Board (IMB) made up of volunteers from the community in which the prison is located. IMBs monitor standards to help ensure prisoners are treated fairly and decently. They report to the Secretary of State for Justice annually. The most recent report available to the investigator at the time of writing covered the period 1June 2010 to 31 May 2011.

13. The report identified a number of positive aspects of the prison, including the number and quality of OASys assessments completed and improved staffing in healthcare that meant fewer agency nurses needed to be used. The report also identified a number of problems, including the lack of a personal officer scheme, which is an issue relevant to the man's circumstances. The Board was also critical of a requirement that to get a prison job prisoners had to pass a literacy test which they considered was unfair and discriminatory for those whose spoken and written English was poor.

Her Majesty's Inspectorate of Prisons

14. The most recent inspection of Wormwood Scrubs was an unannounced full follow-up inspection conducted 20 - 24 June 2011. The Chief Inspector concluded:

> "Wormwood Scrubs has risen to some formidable challenges. It is an improving prison that now has many of the basics right and has some innovative plans to address those areas that still need improvement. It is a safer and more decent place than in the past but it now needs to ensure that its plans for learning and skills and resettlement achieve a similar improvement."

15. Overall, inspectors found that the prison was performing reasonably well in terms of safety, respect and resettlement. However, it was still not performing sufficiently well in terms of purposeful activity.

16. The Chief Inspector also highlighted a number of issues pertinent to the man's time at the prison.

> "There was no personal officer or other named officer scheme to ensure that nominated officers had responsibility for identifying the

needs of specific prisoners and helping to meet them. P-Nomis case note entries did not provide a useful record of a prisoner's time at Wormwood Scrubs."

The impact of these issues is discussed later in the report. Inspectors noted that telephone interpreting services were little used, including in areas such as health care that required confidentiality. Prison staff relied heavily on other prisoners to interpret and some language groups felt isolated. The Chief Inspector also commented that:

> "All nurses had received intermediate life support training within the previous year. Prison staff in the key risk areas had also received training in the use of automated external defibrillation and some but not all had received emergency or first aid training."

17. The clinical reviewer discusses the issue of staff competence in their resuscitation of the man in his review. We also address the fact that staff did not take a defibrillator to his cell.

Previous deaths at Wormwood Scrubs

18. This office has been responsible for investigating deaths in prison custody since April 2004. Before the man's death, there had been 18 self-inflicted deaths at Wormwood Scrubs. Three of these deaths occurred in 2004, three in 2005, one in 2006, three in 2007, three in 2008, three in 2009, and one in March 2010.

19. The death of a prisoner in 2010 also involved staff not using a defibrillator in the treatment of a prisoner who had been found hanging. On that occasion, staff took a machine to the cell, but did not use it.

Sentence planning

20. Sentence planning is intended to ensure that the best possible decisions are taken in regard to a prisoner's needs and risks. It aims to facilitate continuity in decision-making between establishments, so that decisions are informed by as much information about the prisoner, as possible. Effective sentence planning should enable a prisoner to use his time constructively and avoid further offending on release.

21. The offender manager (formerly probation officer) is responsible for managing the sentence of the court and any risks posed by an offender, ensuring the sentence is delivered and if necessary enforced. When offenders are sentenced to custody, their offender manager maintains contact with them. In some cases, the offender manager attends sentence planning meetings in the prison to decide on the type of work required to address offending behaviour. The prison will allocate an Offender Supervisor to support achievement of the objectives in the sentence plan.

KEY EVENTS

22. On 30 April 2011, the man was remanded into custody at Magistrates' Court, charged with Grievous Bodily Harm (GBH) with intent. He was committed for trial at Crown Court and taken to Wormwood Scrubs. It was his first time in prison; he spoke virtually no English and was facing a charge of serious violence against his estranged wife. He originally came from Sri Lanka but was naturalised as a British citizen.

23. In reception at the prison, a nurse wrote in the medical records that it was the man's first time in prison. It is not clear from the records whether a professional interpretation service was used. The nurse noted that he had no concerns about his physical or mental health and he was not taking any medication. However, he reported a heart attack six months earlier. He said he had last seen his general practitioner (GP) six months earlier and had no outstanding appointments. The records do not indicate anything was done to obtain his GP records and investigate the reported heart problems.

24. The man told the nurse that he had no thoughts of suicide or harming himself. The nurse noted tremors but otherwise considered that he looked well. He asked whether he drank alcohol and, if so, how much. The man told him he drank half bottle or more of whisky each day (the nurse recorded this as 7-9 units per day). The nurse referred him to a prison doctor because of his alcohol use and heart problems.

25. A doctor assessed the man about an hour later. The doctor noted, "Heavy drinker - ½-1 bottle of whisky a day. Mentally stable, no MH [mental health] history, no thoughts of suicide/SH [self-harm]". He diagnosed alcohol abuse and prescribed chlordiazepoxide (Librium) for an alcohol detoxification process. There was no reference to his heart problems.

26. The man was then admitted to the detoxification unit where a nurse wrote that he was "settled" when admitted and that he was given the prescribed medication. For the next six days, he went through the alcohol detoxification process, with prescribed medication. Staff checked his pulse and blood pressure each day.

27. On 7 May, the man moved to C wing, which is used for prisoners with drug dependency or alcohol misuse problems. The prison's CARAT[1] team is based on C wing and were apparently in regular contact with him during his time there. However, there is very little information in his prison records about how he spent his time between May and September, when he was convicted of the offence. The P-Nomis (prisoner database) case notes for the period contain only administrative entries. The first entry by an officer about him is on 29 September, almost five months after his arrival on C wing.

28. The man shared a cell with another Sri Lankan prisoner and mixed with a small group of other Tamil speakers. He spent a lot of time in his cell, smoking but

[1] CARAT stands for Counselling Assessment Referral Advice and Throughcare and is a drug support service available in every prison in England and Wales.

went out on exercise and attended religious services. Officers described him as “quiet” in the case notes and when speaking to the investigator.

29. On 8 September, the man pleaded guilty to the charge of GBH and was further remanded in custody for the preparation of a pre-sentence report (a report written by an offender manager, formerly called a probation officer, who has interviewed the convicted person. It describes the person, their history and what led to the offences. It also includes a recommendation for sentencing and helps the judge to decide on what sentence to impose).

30. The man began English lessons in September, starting in the pre-entry class for absolute beginners. The class ran for four weeks, for three hours each weekday morning. One of his teachers told the investigator that he worked hard and passed assessments that allowed him to move to the level 1 class and then the level 2 class.

31. One of the few informative entries in the man’s case notes is dated 3 October. It states, “Has been absent from work the whole of last week and again today, and has no excuse. Therefore he is being dismissed”. However, he was in full-time education at this point; a fact highlighted in a previous entry in the case notes. (On 27 September a different officer had written, “Currently attends Education”.) For this alleged refusal to attend work, he received a warning. The only person to question the appropriateness of the warning was his offender supervisor when it came to her attention the following month. She noted:

> “I have spoken to Education and confirmed that he is not ready for a work allocation and that he will in fact have been allocated in error.”

He did not raise the issue with any of the staff but, as he had little understanding of English, it not clear whether he understood the warning nor why he received it.

32. On 11 October, the man returned to court and was given an indeterminate sentence for public protection (IPP) with a tariff of five years. IPP prisoners have no automatic right to release at the end of their sentence. After they have served the minimum length of time (the tariff) set by the judge, they have to show the Parole Board that their risk of re-offending has reduced. When the Parole Board is satisfied that the prisoner no longer poses a risk of harm in the community, they may approve his release.

33. On 14 October, after he was sentenced, a probation officer was assigned as his offender supervisor at the prison.

34. His offender supervisor met the man on 19 October to introduce herself and discuss his sentence. They used a telephone interpreter to talk to each other as his English, although improving, was not of a high enough level. She explained the way an IPP sentence works and what he would have to do to be considered for release. She told the investigator that she was not sure he understood what it meant to be an IPP prisoner. He did not say too much

about his offence, only that he felt the sentence was harsh and that he wanted to appeal.

35. On 15 November, the offender supervisor had her second meeting with the man, again using a telephone interpreter. She again explained about the IPP sentence but was still not sure he had understood what it meant for him. She also handed him a letter from the Public Protection Casework Team at the National Offender Management Service (NOMS) headquarters. It set out the important dates in his sentence, such as when his first Parole Board hearing would take place.

36. The offender supervisor then went through the judge's sentencing remarks to check that the man understood them. However, when they began to discuss his offence, the interpreter felt unable to continue and suggested it would be better to have an interpreter in the room with them. She paraphrased the rest of the judge's remarks and then ended the meeting.

37. A month later, on 16 December, the offender supervisor and the offender manager met the man for the sentence planning and review meeting, which is an important part of the offender management process. The offender manager had arranged for a Tamil interpreter to accompany her and this enabled the two probation officers to talk in depth with him.

38. On this occasion, speaking through the interpreter, the offender supervisor and offender manager were able to go into greater detail about the man's next few years in prison. They discussed his offence and the reasons for it, the risk he posed to other people and the offending behaviour courses that would best help him to understand and change his behaviour. The offender supervisor took notes of their discussion and listed the short and long-term objectives set. In the short term, he was expected to concentrate on further improving his English to be able to move to the courses he needed in the future, which were:

    - Victim awareness
    - Alcohol awareness
    - Healthy relationships programme (the focus is on domestic violence)
    - Anger management

    They also explained that, as the sentence planning board had met, he would shortly be transferred to another prison to continue his sentence.

39. The probation manager told the man that neither she nor his offender supervisor were happy with his attitude to his offence. The meeting notes state that he expressed some remorse but did not appear to understand the impact of his actions on his estranged wife and their children. He told them that he wanted to see his children. They explained that he would have to make a request through a solicitor and he was unlikely to ever be allowed future contact with his wife.

40. The investigator had sight of an email from the offender manager to the offender supervisor in February 2012, which suggested that shortly before the

man's death he had asked his family to arrange for his estranged wife and three children to visit him in prison. However, the date of the request was not recorded. They did not visit him.

41. After the man's death, the police investigators found papers in his cell. One was passed to the investigator and was headed, "To whom it may concern". It apologised for his "act of crime" and promised that it would not happen again. He then wrote:

> "I wish to say sorry for what happened and seek your kind help to arrange for me to see my children.
>
> Without seeing them, I feel really bad emotionally."

The letter is not dated and the location is noted at the top of the letter as C2-18, the cell that he moved to on 7 July.

42. Also on 16 December, the man's cellmate moved to a different cell. They had been cellmates for about five months and both spoke Tamil. The cellmate told police that he had asked to move cells, as he wanted to share with an English-speaking prisoner to improve his English. He said that he still saw the man, but only when he (the man) went to his cell.

43. The cellmate added that, for about a month before his death, the man stayed in his cell and smoked rather than going out on exercise as he used to and he was not as careful about his personal hygiene as he had been before. He later told a prison manager that the man had also stopped going to religious services about five weeks before his death. The man's new cellmate was Vietnamese.

30 December

44. Each day the prisoners on C wing have an hour out of their cell for what is generally called "domestics". Prisoners can make phone calls, shower, clean their cells, speak to staff and chat to friends. When prisoners leave their cell, they close the door behind them to prevent others entering while they are not there. If they want to go back into their cell, they must ask an officer to unlock the door. The man's cell was on landing two, which meant that his out of cell time was from 2.50 pm to 3.50 pm.

45. During this time, the man went up to his former cellmate on one of the landings. He gave him a piece of paper with his sister's telephone number on it and said that, as his former cellmate would soon be released from prison, he could contact her. He also returned some tobacco that his former cellmate had lent him. His former cellmate gave the tobacco back to him and the man walked off. His former cellmate said that his behaviour was normal and he was not worried about anything arising from their conversation.

46. Two officers were on duty on the man's landing that afternoon. At 3.20 pm, he asked Officer A to let him back into his cell. (The officer is sure of the time

because he had been asked the time by another prisoner just before the man approached him.) He unlocked the door and the man went into the cell. When asked by the investigator if the man had closed the door, he said he did not know as he had immediately walked away from the cell.

47. Officer A said that the man seemed the same as usual – unsmiling and quiet. Nothing he said or did gave him any cause for concern. Prisoners often asked to go back to their cells before the end of the domestics period.

48. At 3.50pm, the two officers began locking the other prisoners in their cells. They went along opposite landings. Officer B unlocked the man's cell to let in his cellmate, and continued along the landing to the next cell. Just as he was about to open it, he heard a loud and sustained banging on the door of the man's cell. He returned to the cell and saw the light that indicated the cell bell had been rung. Opening the observation hatch, he saw the cellmate in a very distressed state so he opened the door. The cellmate pointed to the toilet and the officer saw a figure standing at the back of the toilet area. He ran into the toilet and saw the man with a noose made from a bed sheet around his neck and attached to the window bars. There were also strips of sheet tied round his legs. He lifted him up and tried, without success, to remove the noose.

49. Officer B did not have a radio so left the cell to call for help. He ran along the landing until he saw a Senior Officer (SO) and another officer and shouted to them to come to the cell. As he returned to the cell, the cellmate clung onto him, so he told him to sit on the bed. Several other officers arrived to help and, while they tended to the man, Officer B took the cellmate to the senior officer's office and stayed to support him.

50. The SO told the investigator that he heard Officer B shout "Code 1", which is the emergency code for a prisoner who is found hanging. He went up onto the second landing and along to the cell. As he did so, he used his radio to call Code 1. At Wormwood Scrubs, when a Code 1 is called, staff in the control room automatically call an ambulance. The records show that this was done at 3.55pm.

51. The SO entered the cell, closely followed by an officer. He lifted the man while the officer cut the noose with his cut-down tool. They laid him in the recovery position on the toilet floor.

52. A nurse was working with a Healthcare Assistant (HCA) in the treatment room on C wing when she heard an alarm bell. She heard staff locking prisoners in their cells and then a Code 1 over her radio. She told the HCA to grab the bag of emergency equipment and went straight to the man's cell. She entered the cell and told the SO and officer to move him into the cell, where there was more room for staff to work on him.

53. Principal Officer (PO) A was the incident response manager (radio call sign Oscar 1) and PO B was Oscar 2. They heard the Code 1 call and went to the cell, arriving at the same time as the nurse. PO A instructed the staff who were not assisting to leave the cell.

54. The staff in the cell began cardiopulmonary resuscitation (CPR). At interview, both POs were critical of the nurse and HCA's actions. Their accounts of the resuscitation of the man differ from that of the nurse, particularly as to who took the lead in starting CPR and who got the necessary equipment from the emergency bags.

55. The two men described the nurse as distressed and upset. PO B said that he had to take over from her to assemble the ambu bag correctly. At interview, he said:

> "She shouted, 'Where's my bag, where's my bag. Get my bag somebody'. I assumed that meant the emergency bag and she'd forgotten to bring it with her. Shortly afterwards a second nurse appeared and she brought the emergency bag with her."

56. PO A said that the nurse stood in the cell and shouted for her bag. When she did not begin CPR, he told her that CPR should be started. PO B is a qualified nurse and used to teach first aid. He showed the other PO how to do chest compressions, which he continued to do until the paramedics arrived.

57. When interviewed, the nurse said she shouted to the HCA to bring the bag but it was to alert the HCA to the urgency of the situation and to deliver the bag quickly. She also checked the man's breathing and pulse and put an airway into his throat to help the oxygen reach his lungs. She was adamant that she asked for CPR to be started and, that once the HCA had taken the pieces of the ambu bag out of the emergency bag, she was the person who put the ambu bag together. Then, when the oxygen cylinder was attached to the facemask, PO B used it to give breaths to him.

58. While the officers carried out CPR, the nurse checked the man's blood pressure and blood sugar levels. She asked PO A if he wanted her to take over the chest compressions but he declined the offer. The nurse responsible for emergency response arrived and she handed over to her.

59. None of the healthcare staff brought a defibrillator to the cell, nor was one called for while they treated the man. (A defibrillator monitors heart activity, provides audible prompts about the administration of emergency life support, and delivers an electric shock if necessary.)

60. At 4.07 pm, the ambulance crew arrived with paramedics just behind them. They set up their equipment, including a defibrillator, and took over the treatment. The nurses and PO B left the cell but PO A stayed and held a drip that the ambulance crew set up. The defibrillator shocked the man a number of times (staff could not be sure how many times and London Ambulance Service records were not available to our investigation) and then instructed staff to continue with CPR.

61. The ambulance staff and paramedics then moved the man to the ambulance by stretcher. They left the prison at 5.14pm and went to the hospital. Two officers

accompanied him and no restraints were used at any time. They arrived at the hospital at 5.30pm. Staff started suicide and self-harm measures by opening an Assessment Care in Custody and Teamwork procedure (ACCT) document for him, in case he recovered and returned to prison. (The ACCT document describes the problems facing a prisoner at risk of harming himself and requires staff to design and implement a plan to give him the support he needs to help him through a period of crisis.)

62. PO C arrived on C wing and organised support for the man's current and previous cellmates. The current cellmate asked to leave the wing and managers arranged for him to spend the night in the First Night Centre. A senior manager visited him at 10.00pm and he said he was happy to be there. He was due to transfer to another prison a few days later. Staff asked if he wanted to postpone the move but he was eager to leave Wormwood Scrubs. Staff in the safer custody department spoke to their counterparts at the new prison and told them what had happened. He transferred shortly afterwards.

63. At 5.00pm, PO C spoke to the man's former cellmate and gave the news about him. The former cellmate was upset and surprised at his actions. He told the PO that, in his opinion, he "was suffering from personal issues i.e. access to his three children and the length of his sentence". The PO considered that the former cellmate did not need the additional support of an ACCT plan. He said that he would keep him updated about the man's condition, which he subsequently did.

64. Staff reviewed all the prisoners who were subject to ACCT monitoring and the deputy governor informed the local Samaritans group of what had happened.

65. Shortly afterwards, the duty governor held a hot debrief. This is a meeting of all the staff who were involved in finding and attempting to resuscitate the prisoner. The meeting should focus on reassurance, information sharing and how staff can support each other. Some, but not all, of the prison staff who had been involved in finding and attempting to resuscitate the man were there. PO C also attended, as he was a C wing manager and a member of the Care Team. Officer B raised the issue of support for the cellmate, which was organised as described earlier. The duty governor encouraged staff to make use of the Care Team and employee support service if they needed to. PO A and the healthcare staff were still at the cell and did not attend the meeting.

66. At 6.30 pm, senior managers held a meeting. The deputy governor, PO C, PO A, the SO and a number of other managers were present. The Deputy Governor appointed PO C as the family liaison officer (FLO). He asked him to get the man's next-of-kin details and liaise with hospital staff to get an update on his condition, and then visit and break the news to the family. The details were neither on P-Nomis nor on his personal record. Therefore, staff looked at the records on the prisoner telephone system and identified a sister whom he phoned regularly. He used this to obtain her address from the visitor records.

67. At hospital, the man had an X-ray and CT scan and medical staff put him under observation. At 7.20pm, a doctor told the escort staff that his chance of

recovery was low. At 8.15pm, staff moved him to intensive care and placed him on a life support unit.

68. PO C arranged to meet a Tamil-speaking police officer at the home of the man's sister. They arrived at 10.15 pm and spoke to her and several family members. Once he had broken the news to the family, he went to the hospital with them, remaining there until the early hours of the following morning.

69. Members of the man's family visited him frequently over the following days. This included his ex-wife and their children. His condition did not improve and, at the beginning of January 2012, he died.

70. Several family members visited the prison on 10 January. They met the Governor saw the man's cell and two of the men spoke to the former cellmate. One of the questions they asked him was whether the man had had any problems with the staff, to which he said no. PO C offered the family help with the funeral expenses. Two days later, the funeral took place and PO C attended on behalf of the prison.

ISSUES

Clinical care

71. The clinical reviewer believes that there were several indications that the man might be at risk of self-harm. He considers that the man was probably "a depressed man", pointing to his poor personal hygiene, lack of companionship and long periods in bed. He attributes this to his Tamil speaking cellmate moving out of the cell on16 December. When the sentence planning board on the same day is taken into account, he had to cope with a number of significant and stressful issues on a single day.

72. Despite the recognition of these issues in hindsight, the clinical reviewer concludes, "I do not believe this death in custody could have been anticipated". Staff recorded very little information about the man, so it is difficult to determine how well they knew him. However, if staff had some awareness of mental health issues and had also assessed the risk factors relevant to him and the possible cumulative effect on him, it could have been an opportunity to consider possible interventions such as a mental health assessment or whether he needed support through the ACCT process. We make the following recommendation in relation to mental health awareness.

    The Governor should provide mental health awareness training to all staff in contact with prisoners at Wormwood Scrubs.

Clinical records

73. The clinical reviewer lists a number of errors and omissions in the man's medical record and states that:

> "The Patient Record is deficient and fails to provide the prisoner's registration details or adequately detail entries within the record… Much more time and effort should be given to completing and updating the Patient Record. Clinical entries must be more orientated and contain useful and/or personal entries even if it is just to ascertain how prisoners feel. There should never be dated but blank entries."

    While acknowledging the very busy environment of the prison, we agree that it is important that staff obtain information from prisoners and complete clinical records as fully as possible. Nor is it clear from the record whether interpretation services were used when the man was seen by healthcare professionals. We make the following recommendation:

    The Head of Healthcare should ensure that healthcare staff fully complete patient records.

74. The man told the reception nurse of a heart attack six months earlier but said he had no outstanding GP or hospital appointments. It is good practice for prison healthcare staff to obtain a prisoner's medical records from his GP in the community. At Wormwood Scrubs this task is usually performed by the

pharmacist but he did not get the records. This meant that staff were unable to confirm the information from the man. Particularly as he told staff that he regularly drank to excess, it appears wholly inappropriate that they should have relied on the accuracy of his memory.

75. Fortunately, in the man's case, the omission to obtain the records was ultimately not a contributory factor in his death. However, in different circumstances, there could have been very serious consequences. Healthcare managers need to assure themselves that staff routinely and consistently obtain prisoners' GP records. We make the following recommendation:

The Head of Healthcare should ensure that prisoners' GP records are obtained and that management checks are put in place to audit this.

Staff contact with the man

76. Most prisons have a personal officer scheme. Each prison has its own way of delivering the scheme. Usually a certain number of prisoners are allocated to a named officer to whom they can go for advice or to resolve complaints and the officer is expected to get to know the prisoner and their personal circumstances. The officer completes reports on prisoners for whom they are responsible, ensures entries are made in their wing history files and offers general advice.

77. Wormwood Scrubs does not have such a scheme; an issue raised in the latest HMIP report on the prison. Inspectors commented:

> "There was still no personal officer or other scheme so that prisoners knew there was a named officer who had individual responsibility for them and whom they should contact as an initial point of reference for any concerns. Officers were expected to write entries in P-Nomis records for prisoners in particular groups of cells but the records we examined were almost entirely observational or functional."

78. Inspectors also assessed the quality of the entries and concluded:

> "… the electronic case note system on P-Nomis had been introduced. An analysis of entries showed that most were just observational or about behaviour, with the more frequent comments about poor behaviour. There were no comments about resettlement matters and none that demonstrated any awareness of family issues."

79. The two non-administrative entries in the man's case notes describe his behaviour. There is no evidence that any member of the wing staff ever made time to get to know him and the problems he had. We acknowledge that this would have been time consuming, as staff would have had to find a prisoner to translate or make use of the telephone interpreter service. However, this would have enabled them to write more than "Quiet and complaint [sic] to the regime". He had a number of personal issues and concerns but it was not until he spoke to his offender supervisor in November and at the sentence

planning meeting on 16 December 2011 that there is a record of him raising concerns about his family, in particular, his children.

80. The investigator discussed this with the SO. He told her that in 2011, instructions to staff were to make valid and comprehensive case note entries about interaction or any dealings with a prisoner throughout the core day. He added that they were expected to do so around twice a month.

81. The fact is that no officer made an entry in the man's case record to indicate that they had spoken to him between his arrival on C wing on 7 May and 27 September. The information about his time in prison comes from his education and offender management records. For much of the time, his English was too basic to allow easy conversation but this five month gap highlights a missed opportunity for wing staff to have given appropriate support to one of the prisoners in their care.

82. The SO said that in December 2011, C wing managers decided that staff contact with prisoners and their entries in the case notes were not working very well and developed a new procedure. The new system requires officers to list three quality entries on prisoners' case notes that are then checked by the senior officer. He assured the investigator that staff would be told to make sure that quieter prisoners, similar to the man, would be included in this process.

83. The man's needs were not well served during his time on C wing. He mixed with a few other Tamil-speaking prisoners and for some months he shared a cell with a Sri Lankan man. However, he appears to have been all but invisible to the staff, as evidenced by the paucity of entries in his case notes and that no one questioned the warning he received for failing to attend work when he was in full-time education. Also, the staff appeared unaware that he was spending more time in bed, his personal hygiene had slipped and he was no longer attending religious services. We therefore make the following recommendation:

The Governor should ensure that all prisoners have a named officer who should be aware of their individual needs, whom they can approach for assistance and who will make regular checks on their well-being, backed up by good quality entries in their case notes.

Suicide and self-harm prevention

84. PSO 2700, "Suicide Prevention and Self-harm Management", the guidance in place at the time of the man's death stated, "Remand and the early period of custody is a time of high risk of suicide and self-harm for the majority of prisoners". It also listed a number of groups/categories of prisoners who might be at a higher risk of self-harm. These included those on remand; those in prison for the first time; prisoners who have been accused of violent offences, particularly against a family member; those with a history of self-harm or attempted suicide; mental disorder; dependency on drugs/alcohol; or on remand; have been in care; and potential category A prisoners. He fell into a

number of these categories when he first arrived at Wormwood Scrubs, yet there is no indication that any consideration was given as to whether he should have been supported through the ACCT process in case he was at risk of suicide or self-harm The PSO also states, “There is a significant relationship between drug and/or alcohol withdrawal and suicide”.

85. The clinical reviewer suggests that prison staff should

> “…consider how to better manage vulnerability and risk where prisoners who may not have one incident that alerts to a potential problem, but where there may be a culmination of smaller events can be noted as needing to be addressed. This is especially true in recognising when prisoners’ mental health declines over time and the possible onset of clinical depression.”

86. We accept that there was little the man said or did while at Wormwood Scrubs to indicate that he was considering the action he took but prison staff made little attempt to communicate with him to try to ascertain his state of mind. On the evidence available, greater weight ought at least to have been given to the static risk factors exhibited by him, including the fact that this was his first time in prison, his serious violent offence against a family member and that he was withdrawing from alcohol.

87. The man was quiet, whose limited English may have made him quieter than otherwise he might have been. His former cellmate, who knew him best, was shocked by his action on 30 December. He appears to have kept his own counsel and only the letter quoted above, revealed his thoughts. However, given the number of risk factors that he presented, and which staff appear to have missed, the possibility of self-harm and or suicide ought to have been considered.

88. The clinical reviewer suggests:

> “There may be a case for applying a risk assessment score for opening an ACCT … which aggregates known risk factors.”

The risk factors, such as being new to the prison system, having a substance misuse problem and having a long sentence, when taken together may leave the prisoner in need of the support offered by an ACCT.

89. The risk factors are set out in Prison Service guidance, but prison staff did not get to know the man well enough to assess the extent to which these issues might have been affecting him, either in his early days or in the period up to his death. We make the following recommendation:

The Governor should ensure that all staff are aware of and take fully into account all the indicators that heighten a prisoner’s risk of self- harm or suicide and actively consider how to mitigate them, including through the ACCT process.

Resuscitation procedures

90. When interviewed, both the prison and healthcare staff described the same procedures used to administer CPR to the man. However, they disagreed about who carried out a number of the actions. In addition, the officers thought that the nurse became upset and distressed and said that the nurses were unable to start CPR promptly.

91. PO B made two assumptions about the healthcare staff. He assumed that the nurse was calling for the bag of equipment because she had forgotten it. However, the nurse told the investigator that she ran on ahead to the cell, having told the HCA to collect the emergency bags. She shouted to indicate to the HCA that the situation was urgent.

92. The second assumption was that the HCA was a trained nurse. She is a healthcare assistant, not a nurse and not trained to act as an emergency response nurse. The nurse asked her to get certain items out of the emergency bag and it may well have been that she was not familiar enough with the equipment to quickly select what was needed.

93. PO B also said:

> "She opened it [the bag of emergency equipment] and neither of them seemed particularly au fait with what they should be getting out of it or what they should be doing. I remember reaching into the bag and taking out the airway, which I passed to the first nurse who'd been present and she put it into the man's mouth. She then began trying to attach the mask to the ambu-bag but she was using the wrong one. I got the ambu-bag and put the mask correctly onto the bag and made sure it was connected to the oxygen and I started doing the ambu-bag … and PO A commenced chest compressions."

94. The nurse's description was very different:

> "I checked his breathing: I can't hear anything. So I tried to check his pulse, so I said 'OK, can you do CPR', so we started CPR immediately. … we just want to quickly start the heart and get some oxygen into him. So he was doing the CPR, I quickly, I mean raised up his head, put the Guedal airway in, connect the oxygen with Ambu bag, so we're giving him the breath and we started the CPR. He was doing the CPR for me and we're giving the two breaths and I was trying to just see if there're any signs of life."

95. The clinical reviewer notes that the nurses carried out a blood sugar test once CPR was underway:

> "A blood pressure monitoring machine was attached by the nurse and a reading recorded according to the transcript. If this is correct then it is likely that the prisoner was either never in cardiac arrest (in which case a carotid pulse would be palpable [felt]) or his heart recovered

> sometime during CPR. This is unclear from the transcripts and statements."

However, he cannot reconcile this with the actions of the paramedics as reported by PO A:

> "On the arrival of the first paramedic a new airway was established, intravenous drugs were administered, adrenalin in particular, and the patient received defibrillation… If this is correct it seems unlikely that a blood pressure would be present prior to this, conflicting with the statement above."

He recommends that:

> "Much more investment in training is required and those nurses hesitant and poor in the resuscitation procedure will require additional training."

96. Regardless of who did what, staff started CPR promptly and continued until the paramedics arrived. One of the GPs working in the prison was called to the cell and she observed what was happening. She told the investigator that, "CPR was being carried out, as far as I could see, to a very good, normal standard".

97. The conflicts of evidence suggest that, in addition to formal training, staff might benefit from practising resuscitation exercises to prepare them better for responding to Code 1 emergencies.

The Governor and Head of Healthcare should ensure that staff who carry out emergency response duties are fully trained and conversant with all the relevant equipment.

Defibrillator

98. The policy at Wormwood Scrubs is that when nurses attend a Code 1 call, they should take all the emergency medical equipment with them. This is in three parts: a large bag of equipment, an oxygen cylinder and a defibrillator. Sets of this equipment are in the healthcare centre and in the treatment room on each of the wings. The primary care general nurses (ie, not mental health nurses) take turns in being the emergency response nurse and they receive annual training in Intermediate Life Support, which includes how to use a defibrillator.

99. The defibrillator is an essential piece of equipment as it assesses the patient and, where possible, delivers a shock to restart the heart. In a previous death of a prisoner at the prison, our investigation highlighted problems with the use of a defibrillator. On that occasion, nurses took a defibrillator to the cell but they did not use it.

100. In this instance, when the nurses and HCA responded to the Code 1, they did not take a defibrillator with them. The nurse could have asked the HCA or any of the officers in the cell to bring it. It would have taken around a minute to

bring the one in the ground floor treatment room to the cell. The emergency response nurse should have asked for it to be brought. Oscar 1 could have called for it. Nobody appeared to notice the lack of a defibrillator or asked for it.

101. When the paramedics arrived and used their defibrillator, it shocked the man a number of times. The sooner a defibrillator can be used, the better it is for the patient. It would seem reasonable to assume that, if a defibrillator had been used earlier, it would have shocked him earlier, thus delivering vital treatment more promptly. Code 1 was called at 3.55pm and the ambulance staff arrived at the cell at 4.07pm. Therefore, for approximately ten minutes he was denied the opportunity of potentially life saving treatment.

102. When the investigator discussed her findings with the Governor, she drew to his attention to the fact that nursing staff did not take a defibrillator to the cell. The Governor told her that, since the man's death, he had ordered two additional defibrillators, one each for the gymnasium and visits hall, and was arranging for the staff who act as Oscar 1 to be trained how to use them. At the time of writing this report, the Head of Safer Custody told the investigator that training of staff in the Oscar team was about to start. Currently, over 80 prison and healthcare staff are trained in how to use the machines and training is an ongoing process. We consider that the Oscar team, as managers of emergency incidents, should check that a defibrillator is present in or on its way to the scene of a Code 1.

103. We welcome the provision of defibrillators and training. However, unless defibrillators are taken to Code 1 emergency calls, the investment in machines and training is in vain. The investigator raised this issue with the Modern Matron during the investigation. She subsequently discussed it with her primary care team and reminded the staff that a defibrillator must always be taken to a Code 1 call.

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

The Governor and Head of Healthcare should ensure that staff always take a defibrillator to a Code 1 emergency and that the manager of the incident checks that this has been done. Staff should also be given sufficient training in the use of defibrillators to be confident using them without supervision.

Hot debrief

105. In addition to providing support, the debrief is an opportunity for the staff to describe what each of them did, reflect on those actions and learn any lessons. It should be multidisciplinary and have all the key staff present. As it was held before the man was taken to hospital, some staff were still at the cell and were not able to attend. The need to hold the meeting as soon as practicable must be balanced with ensuring that the relevant staff are free to attend. This was

even more pertinent in this case in view of the conflicting accounts subsequently given by healthcare and discipline staff.

The Governor should ensure that all relevant staff attend the hot debrief after an emergency incident.

Breaking the news to the man's family

105. Prison Rules state:

> **"Notification of illness or death**
> **22.**—(1) If a prisoner dies, becomes seriously ill, sustains any severe injury or is removed to hospital on account of mental disorder, the governor shall, if he knows his or her address, at once inform the prisoner's spouse or next of kin, and also any person who the prisoner may reasonably have asked should be informed."

106. The man left the prison in the ambulance at 5.14 pm, arriving at the hospital at 5.35 pm. However, it was 10.15 pm before PO C arrived at his sister's home to break the news to her. There are a number of reasons for the five hour delay in notification.

107. On his arrival at the prison, the man had not given staff details of a family member or friend to act as next-of-kin. We do not know if this was through choice. PO C had to cross-reference his PIN phone records with his list of visitors to identify a family member to contact. This obviously took some time.

108. Prisoners are asked for details of friends or family on their reception into prison. Those who choose not to provide them no doubt do so for many different reasons. However, this information is essential in an emergency and it would be advisable for prisoners to have an opportunity at a later date to provide or update the details.

The Governor should ensure that staff give prisoners regular opportunities to provide or update their family contact details.

109. PO C was the residential governor responsible for C wing. After the man was taken to hospital, he organised support for his cellmate, the other prisoners on the wing and members of staff. He attended the hot debrief and the further meeting in the boardroom, at which he was appointed family liaison officer. From his log, it appears that he then met with staff and continued to be involved in their care.

110. The role of the family liaison officer is an important and demanding one. Once a member of staff is given the role, their immediate focus should be on informing and supporting the family. We do not criticise PO C's actions in supporting staff and attending to other necessary tasks. However, managers should have considered passing other duties connected with the incident to other staff to allow the family liaison officer the freedom to concentrate on the family.

The Governor should ensure that, after a serious attempt of self-harm or the death of a prisoner, family liaison officers give priority to notifying and supporting the prisoner's family.

CONCLUSION

106. The man spent eight months in Wormwood Scrubs. Staff on his wing noted only that he attended English classes and was “quiet and compliant”. In late November, he became withdrawn, his personal hygiene deteriorated, he no longer attended religious services or went outside for exercise periods. These warning signs were not picked up. In addition, his Tamil speaking cellmate was moved to another cell and replaced by a Vietnamese prisoner with poor English.

107. Prison Service guidance lists factors that may put a prisoner at heightened risk of self-harm or suicide. Several of the categories were relevant to the man, including being in prison for the first time, being convicted of a crime of violence against a family member and being dependant on alcohol. When convicted he was given an indeterminate sentence. Staff did not recognise these factors and did not open an ACCT to support him or take any other action to mitigate the risks. .

108. His offender supervisor and offender manager had made it clear to the man that his attitude to his offence needed to improve significantly before he would be considered for release and they explained what would happen as he learned English, attended offending behaviour courses and moved through the prison system. They also told him he would probably never see his estranged wife again. He desperately wished for contact with his children and had begun the process by writing to request this.

109. It is difficult to say just how much of an impact the discussion about his future contact (or lack of) with his family had on the man. Whatever his thinking, he did not share it with anyone, not even his former cellmate, to whom he spoke in the hour before he hanged himself. The clinical reviewer points out that an accumulation of problems can have the same impact as a major issue. He exhibited a number of risk factors which should have caused prison staff more concern, but there was too little communication and knowledge of him for the extent of these risks to be fully identified and acted on.

RECOMMENDATIONS

The following recommendations were made in the draft report. The Service responses are included in italics following each recommendation:

1. The Governor should provide basic mental health awareness training to all staff at Wormwood Scrubs.

   Recommendation accepted:
   Mental Health awareness training is included in the monthly rota of staff training. This is open to all staff within the establishment. A Safer Custody Learning sheet will be published to remind staff to attend. Action completed.

2. The Head of Healthcare should ensure that healthcare staff fully complete patient records.

   Recommendation accepted:
   This will be monitored through audit reports to Clinical Governance.

   Ongoing- audit reports to the Prison Health partnership Board by the 31st March 2013.

3. The Head of Healthcare should ensure that staff obtain prisoners' GP records and that management checks are put in place to audit this.

   Recommendation accepted:
   Healthcare providers have adopted a medicines reconciliation policy that ensures that all staff performing a prisoner assessment requests GP records, where required following patient consent. The resident pharmacist is tasked with obtaining the records and requests are followed up daily from SystmOne. The medicines reconciliation policy is part of the audit plan and the CQUIN target with the NHS.

   Ongoing- audit report due to the Prison Health partnership Board by January 2013.

4. The Governor should ensure that all prisoners have a named officer who should be aware of their individual needs, whom they can approach for assistance and who will make regular checks on their well-being, backed up by good quality entries in their case notes.

   Recommendation not accepted:
   There is no mandate to operate a personal officer scheme. The management of at risk prisoners is the concern of all staff that come in to contact with prisoners. Where a risk has been identified, the prisoner concerned will be placed under the support of the ACCT process. The Case Review Team will then determine the level of support and who should provide it.

5. The Governor should ensure that all staff are aware of and take fully into account all the indicators that heighten a prisoner's risk of self- harm or suicide and actively consider how to mitigate them, including through the ACCT process.

Recommendation accepted:
The ACCT training and refresher training covers this and is offered to all staff across the establishment on the monthly training shut down with some groups being targeted to increase awareness in those areas. Work is ongoing.

6. The Governor and Head of Healthcare should ensure that staff who carry out emergency response duties are fully trained and conversant with all the relevant equipment.

Recommendation accepted:
The provider Trust has a Resuscitation Committee where prison health is represented. Healthcare has introduced ILS training to all using a training cell to ensure competency in the physical environments is fully met. Training is mandatory and is part of a rolling training programme with yearly updates to ensure sustainability of best practice. The course is designed to enable candidates to manage a medical emergency until the arrival of Advanced Life Support providers or emergency services. The training also ensures staff demonstrate the knowledge and ability in the safe use of emergency equipment. Scenario training has been introduced with all relevant partners to address challenges experienced in responding to a Code 1.

All relevant staff trained by end of December 2012 and training on-going.

7. The Governor and Head of Healthcare should ensure that staff always take a defibrillator to a Code 1 emergency and that the manager of the incident checks that this has been done. Staff should also be given sufficient training in the use of defibrillators to be confident using them without supervision.

Recommendation accepted:
See above

The use of defibrillators is covered during the ILS training as detailed above. A flowchart has been designed and distributed in plain sight to ensure all staff are aware of their responsibilities when responding to Code 1. A new set of competencies are being designed for the role of Hotel 1.

As above. Flow chart in place

8. The Governor should ensure that all relevant staff attend the hot debrief after an emergency incident.

Recommendation accepted:
The prison's contingency plans direct that all person's involved in the incident are invited to attend and participate in the hot debrief.

Healthcare Input
Healthcare was invited to a later death in custody (August 2012) which was managed very well and offered great assistance to all staff communication and support. Healthcare will ensure that this joint process is maintained with the incident manager in accordance with PSI 08/2010 on post incident care as outlined in PSI 64/2011. Action completed.

9. The Governor should ensure that staff give prisoners regular opportunities to provide or update their family contact details.

Recommendation accepted:
The average length of stay at HMP Wormwood Scrubs is between six to eight weeks, we believe that this process would be ineffective to the whole population. However, a notice to prisoners will be published to allow anyone to update the details if required. When an ACCT is opened NOK details are recorded and can be updated at any time.

Target for completion is January 2013

10. The Governor should ensure that after a serious attempt of self-harm or the death of a prisoner, family liaison officers give priority to notifying and supporting the prisoner's family.

Recommendation accepted:
The current FLO policy is that the person carrying out this role makes contact with the Family at the earliest opportunity. Consideration is given to ensure that the FLO is released from all other duties.

Target for completion is January 2013