



A Report by the
Prisons and
Probation
Ombudsman
Nigel Newcomen CBE

**Investigation into the death of a man
at HMP Wormwood Scrubs in December 2013**

Our Vision

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

This is the investigation report into the death of a prisoner at HMP Wormwood Scrubs who was found hanged in his cell in December 2013. He was 39 years old. I offer my condolences to the man's family and friends.

The investigator was appointed. A clinical reviewer reviewed the clinical care the man received in prison. HMP Wormwood Scrubs co-operated fully with the investigation.

The man arrived at Wormwood Scrubs on 19 December 2013. He had been released from a prison sentence in June 2013 but was recalled to prison just before his licence was about to expire. He had previously harmed himself in prison and this was noted on his escort record which was seen by reception staff at the prison. The man was very anxious that other prisoners might discover the nature of his offence and immediately asked to be treated as a vulnerable prisoner and kept separate from the general population. Wormwood Scrubs does not have a discrete unit for vulnerable prisoners and a reception officer told the man that he would be moved to the segregation unit the next day to wait for a move to a suitable prison. He did not go to the prison's first night centre but was held on another wing before being moved to the segregation unit on the afternoon of Friday 20 December. The man spent the weekend in the segregation unit and, at lunchtime on Monday 23 December, an officer found him hanged in his cell.

I am concerned that, despite evident indicators of risk, no one assessed the man as at risk of suicide and self-harm during his short time at the prison and a number of opportunities to identify his vulnerability were missed. The early days in custody are a critical time for any prisoner and the man had a poor introduction to the prison which can only have exacerbated his risk. I am not satisfied that his risk was appropriately assessed or that he received the support he evidently needed. The investigation identified a number of issues which we have raised with the prison before and a recent inspection of Wormwood Scrubs found that there had been very little progress in implementing recommendations arising from previous deaths at the prison. Prison Service senior managers need to ensure that the prison provides a suitable and safe environment for vulnerable new arrivals.

This version of my report, published on my website, has been amended to remove the names of the man who died and those of staff and prisoners involved in my investigation.

Nigel Newcomen CBE
Prisons and Probation Ombudsman

September 2014

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1. SUMMARY

1. In June 2013, the man was released from prison on licence until 20 December 2013. Just before his licence was due to expire, he was recalled to prison for an alleged breach of the terms of his licence. He was arrested and taken to Hounslow Police Station on 18 December. He told the police that he had previously suffered from depression and had self-harmed by cutting his wrists when he was last in prison in March 2012. He said that he had no medical or mental problems and no thoughts of suicide or self-harm.
2. The next day, 19 December, the man was taken to HMP Wormwood Scrubs. Because of the nature of his offence, he asked to be held separately from other prisoners, as he had been during his previous period in custody. The prison does not have a vulnerable prisoner unit and he was told that he would move to the segregation unit the next day. No one in reception identified him as at risk of suicide and self-harm and it is not clear that his risk factors, including recall, history of depression and previous self-harm in prison, were fully considered. A nurse in reception referred him to the doctor because of his previously diagnosed depression. The man did not spend his first night on the prison's first night centre, as new prisoners usually do. It is not clear why he was allocated a cell on another wing, but this appears to be why he missed his doctor's appointment the next day.
3. On the afternoon of 20 December, a prison probation officer spoke to the man who said he was anxious and feared for his safety on the wing he was on. He said he thought that other prisoners were aware of his offence and would harm him. He asked the probation officer to pass messages to his family which she believed sounded like farewell messages but she did not open an ACCT (Prison Service suicide and self-harm prevention procedures) as she believed a move to the segregation unit would resolve his immediate concerns. When the man moved to the segregation unit later that day, a nurse noted that he had self-harmed by making a superficial cut or scratch to his left arm but did not regard him as at further risk and did not open an ACCT.
4. Over the next two days in the segregation unit, the man had a very restricted regime. He had little interaction with staff and did not go outside to spend time in the open air when offered the opportunity. He had been unable to telephone his family as his prison telephone account had not been activated but, on Sunday 22 December, the deputy governor, who was visiting the segregation unit, arranged for him to have a call. An officer noted that he did not eat anything after lunch on Sunday. .
5. At midday on Monday 23 December, an officer found that the man had tied a ligature made of a radio power lead around his neck and attached it to the bed frame. An emergency alarm was raised immediately. Prison staff, healthcare staff and paramedics when they arrived, attempted to resuscitate the man but, at 1.10pm, paramedics pronounced him dead.

6. The investigation found that the man had a number of factors which increased his risk of suicide and self-harm which were not properly taken into account when he first arrived at Wormwood Scrubs and further opportunities to identify his risk and give him appropriate support were missed. Procedures to support new arrivals were poor. We make seven recommendations about suicide and self-harm prevention procedures, mental health referrals, attending GP appointments and induction arrangements.

THE INVESTIGATION PROCESS

7. We issued notices to staff and prisoners at HMP Wormwood Scrubs about the investigation asking anyone with relevant information to contact the investigator. No one responded.
8. The investigator obtained the man's clinical and prison records but there is no evidence that a first night needs assessment was ever completed and this was not among the documents provided.
9. NHS England, London region, commissioned Nina Murphy Associates to review the man's clinical care in custody.
10. On 19 and 20 February 2014, the investigator and clinical reviewer (acting for Nina Murphy Associates) interviewed staff at Wormwood Scrubs. The investigator informed the Governor of his initial findings and followed this up in writing. The investigator interviewed the man's Offender Manager on 3 March and further staff at the prison on 17 March.
11. We have sent the local coroner a copy of this report.
12. One of our family liaison officers spoke to and wrote to the man's father to explain our investigation process. His father said he would like to know how his son was able to take his own life while in prison.
13. The man's father received a copy of the draft report. He did not make any comments.

HMP WORMWOOD SCRUBS

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

Her Majesty's Inspectorate of Prisons

15. The most recent inspection of Wormwood Scrubs was in May 2014. Inspectors noted that five prisoners had committed suicide during 2013, yet not all the Prison and Probation Ombudsman's recommendations had been implemented. Many prisoners in crisis were held in very poor conditions with not enough support or activities to occupy them. Assessment, care in custody and teamwork (ACCT) processes were poor. Inspectors found that the safer custody team was poorly resourced, that the manager of the team had several other functions in his remit and officers were frequently redeployed to other tasks.

Independent Monitoring Board

16. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community to help ensure that prisoners are treated fairly and decently. In its most recent annual report for the year to 31 May 2013, the IMB reported that it had become increasingly concerned about the safety of both staff and prisoners during the year. The IMB noted that initiatives were needed to make time spent in the segregation unit more useful.

Assessment, Care in Custody and Teamwork (ACCT)

17. Assessment, Care in Custody and Teamwork (ACCT) is the Prison Service process for supporting and monitoring prisoners at risk of harming themselves. The purpose of the ACCT is to determine the level of risk posed, the steps that might be taken to reduce this and the extent to which staff need to monitor and supervise the prisoner. Checks should not be at predictable intervals to prevent the prisoner anticipating them. Part of the ACCT process involves assessing immediate needs and drawing up a caremap to identify the prisoner's most urgent issues and how they will be met. Regular multi-disciplinary reviews should be held. The ACCT plan should not be closed until all the actions of the caremap have been completed.

Previous deaths at Wormwood Scrubs

18. We have investigated a number of deaths at Wormwood Scrubs. The man was the sixth self-inflicted death since 2012. All of these prisoners died in the early days of their custody. In three of these cases, we identified concerns about ACCT procedures and we make another recommendation in this report about ACCT procedures. We make a similar recommendation to one made in the investigation report into the death of a prisoner in January 2013 about missed healthcare appointments. We also make a similar recommendation to one previously made about mental health referrals.

KEY EVENTS

Events leading up to the man's recall

19. On 15 March 2012, the man was arrested and remanded to HMP Forest Bank charged with sexual offences against a close family member committed over twenty years earlier when he was 17. He was allocated to a standard residential wing. In his first few days in custody, the man became increasingly anxious. He believed that other prisoners were talking about him and making death threats and he was convinced that other prisoners would attack him.
20. The man harmed himself by cutting both his wrists with a razor blade on 19 March. He was admitted to the prison's healthcare centre for observation and his wounds were dressed. He said that he had harmed himself to get off the wing.
21. Staff opened an ACCT (assessment, care in custody and teamwork) document and the man was constantly observed as he was regarded as a very high risk of suicide. He said that if he did not get bail he would kill himself. The man was granted bail on 21 March.
22. On 29 June 2012, the man was sentenced to two years' imprisonment and taken to HMP Manchester. During his reception screening, he requested vulnerable prisoner (VP) status due to the nature of his offences. He was initially managed under ACCT procedures because of his previous self-harm in prison. The ACCT was closed after three weeks as prison staff considered that he had settled and did not have any thoughts of self-harm.
23. On 7 September, the man transferred to the vulnerable prisoner side of HMP Wymott and settled well there. Staff frequently recorded positive comments about his behaviour and he caused no concerns.
24. The man was released from prison on 20 June 2013 and was subject to supervision under his licence conditions until 20 December 2013. His offender manager met him frequently to monitor his progress. The offender manager told the investigator that the man engaged and complied well with the conditions of his licence and she had no concerns that he might harm himself. She met the man on 11 December for his last appointment with her before his licence supervision period ended and discussed his future.
25. As part of his supervision arrangements, the police conducted a routine unannounced visit to the man's home on 11 December. They found children's toys at his home which the man was trading online. The officers were concerned that the man might have breached the terms of his licence so contacted the offender manager. The offender manager met the man on 16 December to discuss the situation. She said that the man had been fully aware that his actions could be viewed as a breach of his licence conditions, one of which was only to undertake work approved by his supervising officer. The offender manager told the investigator that she discussed the man with her managers and they decided to revoke his licence and recall him to prison.

26. The offender manager told the investigator that she explained the reasons for the recall to the man. She told him that he would serve a fixed period of 28 days in prison, although the offender manager did not know which prison he would go to. (At the end of a fixed recall a prisoner is released unless they are assessed as a risk of serious harm) The man was concerned about his safety as he thought that other prisoners would know about his offence. The offender manager told the man that the prison would be aware of his concerns. She completed a Recall and Review Report which was sent to the National Offender Management Service (NOMS) recall section. She gave details of the circumstances of the man's recall and noted that he was considered as vulnerable in custody and had previously attempted suicide in prison.
27. The man was arrested on Wednesday 18 December and taken to Hounslow Police Station. He told the police that he had previously cut his wrists in prison in March 2012 but he had no current thoughts of suicide or self-harm. No concerns about the man's physical or mental health were noted.

The man's arrival at Wormwood Scrubs

28. The next day, Thursday 19 December, the man was transferred to HMP Wormwood Scrubs, and arrived at 6.15pm. The Person Escort Record (PER) that accompanied him on his journey recorded that he had previously self-harmed in prison by cutting his wrists. The police assessment record and the man's licence recall order was attached to the PER.
29. The officer who was working in the reception unit, recorded the man's personal and offence details. He noted that the man had been recalled to prison and that his next of kin was his father. The man told the officer that, when he was last in prison, he had lived in a VP (vulnerable prisoner) unit and wanted to do so again under Prison Rule 45 because of the nature of his offence. The officer did not make a formal record of this. The officer explained to the man that Wormwood Scrubs did not have a VP unit and that he would be located in a single cell in the first night centre initially and would be moved to the segregation unit the next day. The officer said the man appeared content with this.
30. The officer completed a cell sharing risk assessment (CSRA, which is designed to assess the risk of violence that a prisoner poses). He assessed the man as a standard risk but noted he should be located in a single cell overnight (to be reviewed on 20 December) due to the nature of his offence. He ticked the box on the form to indicate that the man's offence was against a person of the same sex. He told the investigator that he knew this was factually incorrect but it would ensure that the man had a single cell. The officer had no other concerns about the man. He did not ask him about the circumstances of his previous self-harm in prison.
31. After the reception procedures, the man was taken to the first night centre where a nurse began a healthcare assessment at 11.48pm. The nurse told

the investigator that the man arrived with no current active suicide or self-harm warnings. He examined the man and recorded some basic clinical observations. The man said he had no significant physical illness, had no outstanding healthcare appointments and was not taking any prescribed medication. The nurse noted that the man appeared mentally stable. He said that he had cut his wrists in 2012, suffered from depression and had previously seen a psychiatrist but had no current thoughts of self-harm.

32. The nurse referred the man to the prison's mental health in-reach team and to the prison doctor because of his history of depression. He did not see a doctor that evening as the doctors usually leave the prison at about 10.00pm.

Friday 20 December 2013

33. An officer saw the man on Friday 20 December, at 12.23am. He endorsed the cell sharing risk assessment to say that the man was a standard risk and gave him some tobacco and cigarette papers. The prison was unable to find any record of a first night interview or an urgent needs assessment on which officers should record any issues or concerns the prisoner might have, including whether they have a history or current thoughts of suicide or self-harm. The officer told the investigator that he would have completed these documents and did not know why they were not with the man's records. The man was allocated a single cell on E wing rather than the first night centre. The officer could not recall why the man was located on E wing and no reasons for this were recorded. As it was after 10.00pm, the man would not have been able to make a telephone call on his first night. It is not clear why the reception and first night procedures for the man took over six hours
34. At 9.00am, the man had an appointment in the first night centre with the prison doctor but a note in his medical record indicates that he did not attend. The reasons are not recorded but it appears likely that he was not escorted from E Wing. There is no record that the man was ever offered a general health assessment, which is a requirement for all prisoners within a week of arrival and which is usually conducted the next day.
35. At 10.40am, a registered mental health nurse and other members of the mental health inreach team, reviewed the nurse's referral. The referral was very brief and just stated "history of depression". It did not refer to other factors such as his previous self-harm. The mental health nurse concluded that because the man did not have any severe and enduring mental health problems, the primary care mental health service should review him within the next seven days. (The mental health inreach team usually assess prisoners with severe depression, psychotic conditions and those with active suicidal ideation).
36. That day, details of the man's fixed term recall were emailed to the prison's custody office. The email noted that he had been recalled for 28 days, that he was considered vulnerable in prison custody and that he had previously attempted suicide when on remand. The custody department did not pass the information on to anyone.

37. A chaplain visited the man that day. He recorded that the man had requested to be registered as Church of England and there were no concerns.
38. Around 3.00pm, a prison probation officer visited E wing to speak to the man about his licence recall. When the probation officer arrived on the wing, it was association time (when prisoners are allowed out of their cells to socialise with each other). She found the man in his cell, looking anxious. The probation officer told the investigator that he was terrified, felt unsafe and was scared to leave his cell. He believed that other prisoners were aware of his offence, that he would be killed and that he would probably leave the prison in "a box". The probation officer said that he clarified this and said that he meant he would probably be killed rather than he would kill himself.
39. The man told the probation officer that he had requested to be kept apart from other prisoners under Prison Rule 45 when he arrived, but the reception officer had told him that he would be okay. He had not been given a phone call in reception or on his first night and he was concerned that his parents did not know where he was. He asked the probation officer to tell his parents and his son that he loved them and was sorry for what had happened. She told the investigator that she was unable to discuss the man's recall with him in any detail as all he could focus on was his safety on the wing. After speaking to the man, the probation officer alerted the wing manager, a Senior Officer (SO) to the man's concerns about his safety. She also emailed details of her contact with the man to the offender manager in which she described the man's messages to his family as appearing to be some form of a farewell.
40. The probation officer told the investigator that she had not received ACCT training, although she had opened ACCTs before. She knew about the man's history of self-harm in prison but, despite her view about the messages to his family, she did not specifically ask him if he had any intention to harm himself. As it was planned that he would move to the segregation unit that day, she thought that would resolve his main concerns.
41. The SO spoke to the man in the wing office sometime between 4.00pm and 5.00pm. The man said he had not been threatened by any other prisoners but felt unsafe on the wing. He said he had expected to be in a prison with a VP unit and wanted to apply for Rule 45. The SO explained that Wormwood Scrubs did not have a VP unit but used the segregation unit for Rule 45 prisoners until they could be transferred elsewhere. She explained that the segregation unit regime was limited compared to standard residential wings but the man accepted this and said he still wanted to move there. The SO said that the man showed no signs of wanting to harm himself and, although he was anxious, he did not appear distressed. She immediately contacted the segregation unit to arrange for the man to be moved, and arranged for him to speak to his mother on the telephone.
42. The SO took the man to the segregation unit around 5.30pm and two officers explained the regime of the unit. The man said he was okay and had no thoughts of suicide or self-harm. They said he appeared relieved to have

moved off E wing. As a matter of routine, when a prisoner is moved to the segregation unit, a "Report of Injury to Prisoner" form is completed. During a strip search, the officer discovered a scratch on the man's left forearm, which he described as very superficial. He did not ask the man about this. No concerns were raised about the man. (It is not clear why the man, who had been moved to the segregation unit for his own protection, was subject to a strip search.)

43. At 5.40pm, a mental health nurse assessed the man's fitness to be located on the segregation unit. He recorded that the man had a superficial cut on left forearm which he said he had made that afternoon. The nurse told the investigator that the cut was a scratch and that the man said he had harmed himself to instigate a move to the segregation unit. The man said he had no current thoughts of self-harm. The nurse did not discuss the man's self-harm with him further and assessed him as fit to be located in the segregation unit.
44. The man was taken to cell S2-86 and observed hourly as is routine in the segregation unit. He was given a kettle and a radio and told that while he was in the segregation unit he would be able to attend religious services and the library and would have some access to education. (A teacher visits the segregation unit twice a week.)
45. At 5.45pm, an operational manager formally authorised the man's segregation under Prison Rule 45 and signed the relevant documentation.

Saturday 21 December 2013

46. On the morning of 21 December, the records indicate that the man had a shower but declined to go outside for a period in the open air in the exercise yard or to make a telephone call. (Although his prison telephone account had not been activated so he would have been unable to make one.) Around 11.26am, a nurse saw the man during a routine segregation healthcare round. She had a short conversation with him and said his mood appeared bright. She recorded in his medical record that there were no concerns about his physical or mental health. Prison staff recorded no other concerns about the man for the remainder of the day.

Sunday 22 December 2013

47. When the man was unlocked on the morning of 22 December, he declined a shower and exercise. At 9.00am, the deputy governor spoke to the man during a routine segregation visit. The man said that he did not want to be "here". The deputy governor asked him what he meant and the man explained that things had gone wrong for him and he felt that as a sex offender he had no chance. He felt that he was receiving an inadequate regime because he was in the segregation unit and had not been able to speak to his parents because he was not yet on the prison telephone system.
48. The deputy governor told the man that a number of cells in the segregation unit were being updated at the time to allow televisions and the man would be

moved to one of them as soon as this was completed. He said he would contact the phone clerk to get his phone account activated and would ensure that he was given a telephone call that day so that he could speak to his parents. They discussed a transfer to another prison with a VP unit and the deputy governor said that the prison's offender management unit would deal with this. He suggested that the man should keep himself occupied by reading and using the educational activity packs in the cells (which contain crosswords, quizzes and general reading material). The deputy governor told the investigator that the man maintained good eye contact throughout their conversation and did not indicate that he had any intentions of harming or killing himself. The deputy governor told the man that he would speak to the segregation unit manager and update her about their conversation.

49. The segregation unit manager then spoke to the man. She told the investigator that the man was angry and frustrated with himself at being recalled to prison. He asked to be moved to a VP prison. The segregation unit manager said that she would contact the offender management unit the next day (Monday 23 December) and would let him know the outcome. The man said he had not received written details of his recall yet, although his offender manager had informed him of the reasons. The segregation unit manager allowed the man to telephone his parents. She recalled that his telephone conversation was short and it gave her no cause for concern.
50. At 10.33am, a GP (who was unavailable to be interviewed) saw the man on a routine visit to the segregation unit and noted that he was 'feeling down about his return to prison' and that 'he had self-harmed a few days ago'. The man told the GP that he had no current thoughts of suicide or self-harm. He said that he had spoken to his parents earlier that morning and they were supportive and he did not want to let them down. The GP advised the man to try and remain as occupied as much as possible. The segregation unit manager spoke to the GP after he had assessed the man. He said he felt that being in prison contributed to the man's feelings of frustration.
51. An officer later recorded that the man had eaten only his lunch that day. No other concerns were raised.

Monday 23 December 2013

52. An officer and the segregation unit manager unlocked the man's cell at around 8.00am on Monday 23 December. They said he did not want a shower, to go out to the exercise yard or to make a telephone call. (Again he was not able to use the telephone as he was not yet on the system.) The officer later noted in the segregation review book that this was normal for the man and in the short time he had been there he had rarely interacted with staff or left his cell when he had the opportunity.

53. The segregation unit manager emailed the offender management unit at 9.10am about transferring the man to a prison with a VP unit. A member of staff in the offender management unit identified HMP Littlehey as a suitable prison and emailed Littlehey later that day asking if the man could transfer there the next day, 24 December. The segregation unit manager emailed the PIN clerk to re-activate the man's prison telephone account.
54. At 9.30am, a member of the Independent Monitoring Board and, at 10.22am, a member of the chaplaincy team saw the man during their daily rounds. Neither raised any concerns about him.
55. Around 10.26am, a doctor and nurse saw the man during the routine segregation unit healthcare round. The doctor said that the segregation staff did not raise any concerns about the man. The man was lying on his bed when officers unlocked his cell. He told the doctor that he was okay and felt fine. He did not say he had any thoughts of suicide or self-harm and the doctor assessed his mood as "reasonably good". Just before leaving the cell, the doctor said that he gave the man one more opportunity to mention any problems and the man said "I will probably see you later". The doctor told him that he would not be around later that day and if the man needed to raise any urgent issues he should alert the duty nurse. He said that the man had smiled and repeated that he might see him later. The doctor said that he was not concerned about the man's comments or his presentation.
56. Records indicate that an officer checked the man at 11.00am. The officer told the investigator that at the time he observed him through the observation panel in his cell door, he was lying on his bed and had waved at him.
57. Around 11.45am, three officers began taking prisoners their lunch. They arrived at the man's cell around 12.00pm. The officer looked through the cell observation panel and said he saw the man half underneath his bed, with a ligature tied around his neck and attached to the bed frame. He shouted for assistance and immediately opened the cell door. One officer cut the ligature, which was made from a radio power lead, and the officers pulled the man from under the bed. The officer said the man was warm but was unresponsive and showed no signs of life.
58. Two officers heard the shout for assistance and arrived at the man's cell within ten seconds. The officer immediately radioed a code one emergency to indicate a life-threatening situation and requested an ambulance. The control room log showed that the ambulance was requested at 12.01pm. The nurse arrived at the man's cell around ten seconds after the officer with the medical emergency bag. Two officers began cardiopulmonary resuscitation (CPR). Two doctors and two nurses arrived very soon after and helped. A nurse attached a defibrillator which found no shockable heart rhythm.
59. At 12.17pm, paramedics arrived at the man's cell and examined the man who showed no signs of life. The paramedics continued CPR and administered oxygen and adrenalin but, at 1.10pm, they pronounced the man's death.

Support for prisoners

60. Prisoners were informed of the man's death by notices which outlined the support that was available to them. All prisoners subject to suicide and self-harm prevention procedures were reviewed in case they had been adversely affected by the man's death.

Support for staff

61. Around 2.00pm, the deputy governor held a hot debrief to support the staff who had been involved in the incident. The staff care team visited the wing and offered their services.

Family Liaison

62. A custodial manager was appointed as the prison's family liaison officer. The man's parents, his nominated next of kin, lived in Manchester so the prison asked a family liaison officer from HMP Manchester to visit them and break the news on their behalf. This was done at 5.45pm. The family liaison officer then contacted the man's parents, explained what had happened to the man and offered support. He arranged to meet the man's parents on 2 January 2014.
63. The family liaison officer remained in frequent contact with the man's parents and gave them information including about the post-mortem and inquest process. The prison offered financial assistance towards funeral costs in line with Prison Service guidance. The man's funeral was held on 17 January 2014.

Post-mortem report

64. The post-mortem examination found that the cause of the man's death was hanging.

ISSUES

Assessing the risk of suicide and self-harm

65. Prison Service Instruction (PSI) 64/2011 (Safer Custody), and PSI 74/2011 (Early Days In Custody), both list a number of risk factors and potential triggers for suicide and self-harm. These include factors such as early days in custody, impulsiveness, previous self-harm, young age, being charged with a violent offence, licence recall and a history of mental health problems. All staff who come into contact with prisoners are expected to be aware of these risk factors. PSI 74/2011 requires new prisoners to be interviewed in reception to assess the risk of self-harm and states that all staff should be alert to the increased risk of suicide and self-harm posed by prisoners in those categories and act appropriately to address any concerns, including opening an ACCT if necessary.
66. Staff judgement is fundamental to the ACCT system. The system relies on staff using their experience and skills, as well as local and national assessment tools, to determine risk. It is not an exact science.
67. We have considered whether staff at Wormwood Scrubs should have identified the man as being at risk of suicide and self-harm and opened an ACCT to ensure that he was appropriately supported. The man consistently said he had no thoughts of suicide or self-harm when asked directly. However, he suffered from depression and had been recalled to prison just days before his licence was due to expire, which had caused him a lot of frustration and distress. He had harmed himself in prison previously in 2012 and this was recorded on the PER. Because he had requested to be treated as a vulnerable prisoner, he was located in the segregation unit where he had a very limited regime. All these factors were significant indicators of an increased risk of suicide and self-harm. However, it is not clear that they were taken into account by members of staff who assessed the man's risk of suicide and self-harm when he arrived or what weight was given to them if they were.
68. None of the members of staff who saw the man in reception thought that ACCT monitoring was necessary. The reception officer did not record that he had asked the man about his history of self-harm and we do not know whether he took this into account when he assessed the man's risk. There was no evidence of a first night interview or urgent needs assessment and it does not appear that the man had a comprehensive initial reception and induction assessment to appropriately consider all of his risk factors.
69. We are concerned that staff relied so heavily on the man's presentation, when he had a number of known risk factors when he arrived at Wormwood Scrubs. Greater weight should have been given to the fact that he had been recalled and had harmed himself the last time he had been in prison. The man had also requested vulnerable prisoner status which is a clear indication that he was concerned from the outset about his safety. This request was not appropriately documented. A prisoner's presentation is obviously important

and reveals something of their level of risk. However, it is only a reflection of their state of mind at the time they are seen by the member of staff and should be considered as a single piece of evidence used when assessing risk. We have previously identified similar issues in the reception process at Wormwood Scrubs. We make the following recommendation:

The Governor should produce clear local guidance about procedures for identifying prisoners at risk of self-harm and for managing and supporting them. In particular this should ensure that reception and first night staff:

- **Have a clear understanding of responsibilities and the need to share all relevant information about risk.**
- **Consider and record all the known risk factors of a newly-arrived prisoner when determining their risk of suicide or self-harm, including information from suicide and self-harm warning forms and PERs.**
- **Complete all relevant first night interviews and prisoner needs assessments.**
- **Open an ACCT whenever a prisoner has recently self-harmed or expressed suicidal intent.**

70. There were at least two further occasions when members of staff should have considered opening an ACCT. On 20 December, the probation officer saw the man and said he was so anxious and scared about his safety that they did not spend much time discussing his recall. The man asked the probation officer to tell his parents and his son that he loved them and that he was sorry for what had happened. The probation officer said that this appeared to be meant as some form of farewell, but she did not discuss this with him further or open an ACCT.

71. The probation officer had not received ACCT training, but told the investigator that she had opened ACCT documents in the past. Probation officers in prisons often discuss a range of issues with prisoners including licence recall and sentencing, which are factors which affect the risk of suicide and self-harm. It is important that anyone in such a role should be properly trained in assessing risk and in suicide and self harm prevention procedures. We make the following recommendation:

The Governor should ensure that all staff who have contact with prisoners receive ACCT training.

72. Also on 20 December, the man told a nurse during his segregation health check that he had harmed himself shortly before he moved to the segregation unit. The nurse did not ask any in-depth questions about the nature of the self-harm, or why the man had harmed himself and did not carry out a full suicide or mental health risk assessment.

73. The clinical reviewer believed that the nurse should have opened an ACCT document after seeing the man. We cannot know whether managing the man

under ACCT procedures would have affected the outcome for him, but it would have led to additional support being provided. It is particularly concerning that this was not explored further with the man as the confined environment and the restricted regime of segregation units are known to exacerbate the risk for vulnerable prisoners. We make the following recommendation:

The Governor and Head of Healthcare should ensure that all the known risk factors of a newly-arrived prisoner in the segregation unit are fully considered to determine their risk of suicide and self-harm and that an ACCT is opened when there is any indication that the prisoner is at risk.

Healthcare assessments

74. The clinical reviewer concluded that the clinical care provided to the man while he was in HMP Wormwood Scrubs was not comparable with the clinical care one would expect to receive in the community.
75. At his reception health screen, a nurse identified that the man had a history of self-harm and that he suffered from depression. He said that the man presented as being mentally stable, but he made a general referral for the man to see the mental health team and the prison doctor because he suffered from depression. The clinical reviewer noted that the referral was extremely brief, gave no background information about the man such as his history of self-harm. Such information helps mental health teams prioritise referrals appropriately. We make the following recommendation:

The Head of Healthcare should ensure that referrals to the mental health team contain all relevant information.

76. The man missed an appointment with the prison doctor on his second day in prison after being referred by the nurse at his reception health screen because of his history of depression. There was no recorded reason to explain why the man did not attend. It is possible that it was because he did not have a cell on the first night centre and officers on E wing were unaware of the appointment. As a new prisoner with a number of risk factors of self-harm, this was a missed opportunity which could have led to an assessment of his state of mind and an exploration of any mental health concerns. After the death of a prisoner at Wormwood Scrubs in January 2013, we made a recommendation about missed GP appointments. We note that HM Inspectorate of Prisons has recently found that insufficient action was taken against this recommendation. We therefore repeat the recommendation:

The Head of Healthcare should ensure that reasons for missed appointments are recorded and, when they are not rebooked, the reasons for this decision are entered on the clinical record.

Managing the man's request for vulnerable prisoner status

77. Prisoners can request to be held separately from the general population which has to be authorised under Prison Rule 45. This can be for a number of reasons, such as the nature of their offence or indebtedness to other prisoners. In many prisons, vulnerable prisoner units allow these prisoners to mix with other vulnerable prisoners and have a full regime, but Wormwood Scrubs does not have such a unit. Instead, such prisoners are held in the segregation unit until they can be transferred to a suitable prison.
78. The man told staff in reception that he wanted to apply for Prison Rule 45 because he was concerned about his safety from other prisoners. We have not found any evidence that this request was properly recorded by the reception officer. The officer simply noted that the man should be located in a single cell overnight due to the nature of his offence and this would be reviewed the following day with a view to him being located in the segregation unit. The man was then held on a standard residential wing for his first night in custody.
79. The man's request for vulnerable prisoner status was then not followed up until 3.00pm the next day, when he raised it with the probation officer, who found him too scared to leave his cell on E wing. There is nothing to explain why the man, who feared for his safety, was not located on the first night centre but was allocated to a wing with very little support. Vulnerable prisoners who feel under threat from other prisoners because they are not appropriately protected are at heightened risk of suicide and self-harm, yet staff did little to ensure that the man was appropriately supported when he arrived at Wormwood Scrubs. The man was not supported or protected on E wing. When he went to the segregation unit, he was strip searched when he arrived there and there seemed little to differentiate his regime from that of other prisoners held in the segregation for punishment. This left him isolated and with little to do, factors that would have increased his risk of suicide and self-harm. We make the following recommendation:

The Governor should ensure that vulnerable prisoners who need to be kept separately from other prisoners for their own protection are effectively supported and have an appropriate regime until they transfer to other suitable prisons.

Reception, first night and induction

80. Prison Service Instruction, PSI 74/2011 (Early Days In Custody), requires prisoners to have an appropriate reception to custody. It notes that reception procedure can be stressful and should be for the minimum time possible before prisoners move to their first night location. We note that the man arrived at the prison at 6.15pm, but did not have a reception healthcare screen until 11.48 pm and a cell sharing risk assessment was completed in the first night centre at 12.23am. This means that his reception process took over six hours which is unacceptably long. Because of the time, he was unable to make a telephone call, and there is no record of a first night interview or immediate needs assessment.

81. The PSI requires new prisoners to be allocated to dedicated first night accommodation if available. There are no prison records setting out the reasons why the man did not spend his first night on the first night centre or why he was then subsequently located on E wing. Staff on E wing appeared to have had little contact with him. A chaplain saw him in the morning, but he was not taken to his appointment with the prison doctor and did not have a secondary health screen. At 3.00pm, a probation officer saw him and noted his distress.
82. The PSI includes a mandatory requirement that governors must ensure that all prisoners are given the guidance and information they need on the issues that are important to them. The instruction outlines that all new prisoners should be provided with key information relevant to their first few days in the establishment, and notes that prisoners can find the first few days in custody overwhelming and emphasises the importance of safer custody.
83. We are not satisfied that the man's reception, first night and induction arrangements were in line with those expected under PSI 74/2011. We make the following recommendation:

The Governor should ensure that reception, first night and induction arrangements are delivered to prisoners in line with the requirements of PSI 74/2011.

RECOMMENDATIONS

1. The Governor should produce clear local guidance about procedures for identifying prisoners at risk of self-harm and for managing and supporting them. In particular this should ensure that reception and first night staff:
 - Have a clear understanding of responsibilities and the need to share all relevant information about risk.
 - Consider and record all the known risk factors of a newly-arrived prisoner when determining their risk of suicide or self-harm, including information from suicide and self-harm warning forms and PERs.
 - Complete all relevant first night interviews and prisoner needs assessments.
 - Open an ACCT whenever a prisoner has recently self-harmed or expressed suicidal intent.
2. The Governor should ensure that all staff who have contact with prisoners receive ACCT training.
3. The Governor and Head of Healthcare should ensure that all the known risk factors of a newly-arrived prisoner in the segregation unit are fully considered to determine their risk of suicide and self-harm and that an ACCT is opened when there is any indication that the prisoner is at risk.
4. The Head of Healthcare should ensure that referrals to the mental health team contain all relevant information.
5. The Head of Healthcare should ensure that reasons for missed appointments are recorded and, when they are not rebooked, the reasons for this decision are entered on the clinical record.
6. The Governor should ensure that vulnerable prisoners who need to be kept separately from other prisoners for their own protection are effectively supported and have an appropriate regime until they transfer to other suitable prisons.
7. The Governor should ensure that reception, first night and induction arrangements are delivered to prisoners in line with the requirements of PSI 74/2011.

ACTION PLAN

| No | Recommendation | Accepted/Not accepted | Response | Target date for completion | Progress (to be updated after 6 months) |
|----|--|-----------------------|--|----------------------------|---|
| 1 | <p>The Governor should produce clear local guidance about procedures for identifying prisoners at risk of self-harm and for managing and supporting them. In particular this should ensure that reception and first night staff:</p> <ul style="list-style-type: none"> • Have a clear understanding of responsibilities and the need to share all relevant information about risk. • Consider and record all the known risk factors of a newly-arrived prisoner when determining their risk of suicide or self-harm, including information from suicide and self-harm warning forms and PERs. | Accepted | <p>The Governors have produced and published an order instructing all staff, including staff of all providers of services to the establishment, as to when an ACCT document should be opened and of the responsibilities placed on an individual to do so. Staff have separately been reminded of the need to share relevant risk information and consider all recorded risk factors when assessing whether someone is at-risk of suicide and/or self-harm.</p> <p>Efforts are being made to ensure that first night interviews are completed. Any missed appointments are called back to Healthcare within 24 hours.</p> <p>In addition, all Heads of Functions have been instructed to ensure that prisoners subject to ACCT monitoring reside in suitable accommodation, are engaged in activities and that staff and managers responsible for these individuals safekeeping, are compliant with the aforesaid order.</p> | 31 December 2014 | |

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| | <ul style="list-style-type: none"> • Complete all relevant first night interviews and prisoner needs assessments. • Open an ACCT whenever a prisoner has recently self-harmed or expressed suicidal intent | | | | |
| 2 | The Governor should ensure that all staff who have contact with prisoners receive ACCT training. | Accepted | All staff working within the establishment are required to have undertaken ACCT training and be conversant in the use of the system to enable them to; open and contribute to a prisoners ACCT document and their care. A review will be conducted of all staff currently trained in ACCT, with a view to identifying those personnel who require either initial or refresher training. Thereafter a targeted training programme will be raised to address the reviews findings and training requirements. | 31 st December 2014 | |
| 3 | The Governor and Head of Healthcare should ensure that all the known risk factors of a newly-arrived prisoner in the segregation unit are fully considered to determine their risk of suicide and self-harm and that an ACCT is opened when there is any indication that the prisoner is at risk. | Accepted | <p>A process for information sharing and formal handover between the Officers and Healthcare staff on the Segregation unit has been implemented.</p> <p>A comprehensive mental health assessment template (in addition to the Segregation Algorithm) is in development to ensure all risk information is reviewed and taken into consideration when assessing the mental state and risk factors of prisoners subject to Rule 45.</p> <p>Guidance has been issued to inform all staff that an ACCT document is to be opened if anyone expresses a desire to harm themselves or have self harmed regardless of the severity</p> | 31 December 2014 | |

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| | | | of the injury. Healthcare staff attend ACCT training yearly. | | |
| 4 | The Head of Healthcare should ensure that referrals to the mental health team contain all relevant information. | Accepted | <p>A detailed mental health referral form has been developed and is in use on the clinical records system.</p> <p>The quality of referrals to mental health are currently being audited monthly to ensure all staff are using the new referral form and that the forms are completed fully with all relevant information.</p> <p>Staff who do not use the form or do not complete referrals correctly are contacted by the mental health team to provide further details.</p> | 31 December 2014 | |
| 5 | The Head of Healthcare should ensure that reasons for missed appointments are recorded and, when they are not rebooked, the reasons for this decision are entered on the clinical record. | Accepted | <p>A protocol for missed appointments has been developed and sent to all staff.</p> <p>A Did Not Attend (DNA) template has also been added to the clinical records system. This prompts staff to give a reason the prisoner did not attend and detail their follow up actions such as rebooking the appointment. DNA templates are currently being audited monthly to ensure these are being completed by all staff.</p> <p>A Reception process mapping exercise is being carried out with prison colleagues to ensure that there are robust procedures in place to follow up prisoners who do not follow the usual pathway (of reception, to first night centre, to normal location) so the second part of the healthcare assessment and GP appointments are not missed.</p> | 31 December 2014 | |
| 6 | The Governor should | Accepted | A Governors Order will be drafted directing | 31 December | |

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| | ensure that vulnerable prisoners who need to be kept separately from other prisoners for their own protection are effectively supported and have an appropriate regime until they transfer to other suitable prisons. | | <p>Managers and staff on the procedures to be adopted when a prisoner requests Rule 45 status and of the initial support / monitoring which should be considered to assist the prisoner during this initial period in custody.</p> <p>In addition, the Functional Head with responsibility for the Segregation Unit will review the support and regime currently available to prisoners housed within the Segregation Unit, at own request, making recommendations as to possible improvements that may be possible under current staffing levels.</p> | 2014 | |
| 7 | The Governor should ensure that reception, first night and induction arrangements are delivered to prisoners in line with the requirements of PSI 74/2011. | Accepted | The Functional Head for Reception and Head of Healthcare will review the processes currently in place for managing prisoners through their reception procedures with a view to reducing the time taken to complete the procedure and ensure that all new prisoners are provided with key information relevant to their first few days in the establishment | 31 December 2014 | |