

A Report by the
Prisons and
Probation
Ombudsman
Nigel Newcomen CBE

**Investigation into the death of a man in November
2014, while a prisoner at
HMP Wormwood Scrubs**

Our Vision

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

This is the investigation report into the death of a man, who was found hanged in his cell at HMP Wormwood Scrubs on 3 November 2014. He died in hospital on 13 November. The man was 35 years old. I offer my condolences to his family and friends.

An investigator was appointed. A clinical reviewer reviewed the man's clinical care in prison. The prison cooperated fully with the investigation.

The man was arrested at Heathrow Airport on 28 October 2014 for using a false passport. While he was in police custody, he was taken to hospital with chest pains. Hospital staff found no physical cause but advised a mental health assessment. The man was constantly supervised by the police and at court on 30 October, when he tried to hang himself. When he arrived at Wormwood Scrubs that evening, staff began Prison Service suicide and self-harm prevention procedures, with checks every hour. A nurse referred him for a mental health assessment, but not urgently, as should have happened.

On 31 October, at his first case review, a supervising officer, acting on his own, reduced the frequency of observations to three times during the day. Over the next three days, the man spent most of the time locked in his cell. On the morning of 3 November, the man's cellmate went to an education class, leaving him in the cell alone. At lunchtime, officers found the man hanging from the light fitting. Staff began resuscitation, but confusion about emergency response codes led to a four-minute delay in calling an ambulance. Afterwards, a manager asked an officer to make a retrospective and inaccurate entry in the man's suicide and self-harm support document. The man was taken to hospital, but died after ten days.

I am concerned that the man did not have an urgent mental health assessment when he arrived at Wormwood Scrubs, after he had tried to hang himself at court, earlier that day. I am also concerned that, for the third time in recent years, an investigation by this office has found that staff at Wormwood Scrubs made inappropriate alterations to the monitoring records of the prisoner who died. Finally, poor emergency response procedures delayed the calling of an ambulance and this may have affected the man's chances of survival.

In previous investigations into deaths at Wormwood Scrubs I have made a number of recommendations about the implementation of suicide and self-harm support procedures, which an inspection in May 2014 found had not been properly addressed. It is regrettable that, at the time of the man's death in November, similar problems remained. I recognise that Wormwood Scrubs has been operating under significant pressures, but senior managers need to examine the root causes of continuing failures in safeguarding arrangements at the prison and ensure that they are addressed.

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 2015

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SUMMARY

1. The man was arrested on 28 October 2014 for using a false passport. In police custody, officers took him to hospital with chest pains. The hospital found no physical cause but recommended a mental health assessment. The police constantly supervised the man because of his high risk of suicide. On 30 October, the man tried to hang himself at court. Court staff completed a suicide and self-harm warning form.
2. When the man arrived at Wormwood Scrubs, an officer began suicide and self-harm prevention procedures, known as ACCT. A nurse did not mark a mental health referral urgent, as should have happened. Staff checked the man once an hour in the first night centre.
3. On Friday 31 October, the day after the man had tried to hang himself, a supervising officer held an ACCT case review with no other staff present, and reduced the frequency of checks to just three times during the day and five at night. The man moved to a shared cell on C Wing. Over the weekend of 1 and 2 November, he was locked in the cell for 23 hours each day.
4. At 8.00am on Monday 3 November, an officer noted in the man's ACCT document that he had no new concerns. The man's cellmate went to an education class, leaving him alone in the cell. An officer said he saw the man in the landing office during his association period between 10.30am and 11.00am, but did not record this at the time. All prisoners were locked up at 11.00am. At 11.55am, an officer unlocked the man's cell and found him hanging by shoelaces attached to the light fitting. Officers cut the ligature and began cardiopulmonary resuscitation. The emergency response was disorganised and a confusion about emergency codes led to a delay of four minutes before the prison called an ambulance. While nurses and paramedics were trying to resuscitate the man, the wing manager asked an officer to make a retrospective and inaccurate entry in the ACCT document, which said that the officer had seen the man at 11.00am. The man was taken to hospital but died on 13 November.
5. The man should have had an urgent mental health assessment when he arrived at the prison, after his suicide attempt earlier that day. The operation of ACCT procedures and management of the man's risk was very poor. The level of risk and frequency of observations were inappropriate for a prisoner who had tried to hang himself so recently. Staff did not properly record the frequency of observations on his ACCT document. There was no multidisciplinary case review and his caremap did not include relevant issues. Several significant interactions with the man were not recorded in the man's ACCT document. Checks at night were not at random intervals. A manager pressed an officer to make an inaccurate entry in the ACCT record, after the man was found hanging. Very few of the staff had received recent ACCT training. We make four recommendations.

THE INVESTIGATION PROCESS

6. We issued notices to staff and prisoners at HMP Wormwood Scrubs informing them of the investigation and inviting anyone with relevant information to contact the investigator. No one responded. The investigator initially visited Wormwood Scrubs on 18 November 2014. He subsequently interviewed 16 members of staff and one prisoner and informed the Governor of his initial findings.
7. The clinical reviewer reviewed the man's clinical care at the prison. She and the investigator interviewed healthcare staff together.
8. We informed HM Coroner for West London of the investigation, who provided a copy of the post-mortem report. We have sent the coroner a copy of this report.
9. One of our family liaison officers contacted the man's wife to explain the investigation process. She wanted us to explain what had happened to her husband in prison. We provided her solicitors with a copy of the draft report and they responded with their comments. We have corrected two factual inaccuracies they identified and have replied to their other comments in separate correspondence.

HMP WORMWOOD SCRUBS

10. HMP Wormwood Scrubs is a large local prison in West London for nearly 1,300 men. The prison holds men on remand from West London courts and London prisoners serving short sentences or coming to the end of long sentences. The prison also holds young adult men on remand and is a 'hub' prison for foreign nationals subject to immigration enforcement.

Her Majesty's Inspectorate of Prisons

11. 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. Services for the large number of foreign nationals and immigration detainees were particularly poor.

Independent Monitoring Board

12. 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 May 2014, the IMB commented that the prison had had a 'very dismal and highly regrettable year.' Restructuring had led to major staffing problems and many weeks of chaos and dysfunction. A new Governor had come into post and the IMB had observed some improvements. However, the Board was concerned about ongoing low staff morale and staff and prisoner safety. Officers had little time for meaningful conversations with prisoners. The Board called for a more strategic approach to the management of foreign national prisoners, who made up about 40 percent of the prison population.

Assessment, Care in Custody and Teamwork (ACCT)

13. ACCT is the care planning system the Prison Service uses to support prisoners at risk of suicide or self-harm. Once a prisoner has been identified as at risk, the purpose of the ACCT process is to try to determine the level of risk, the steps that might be taken to reduce this and the extent to which staff need to monitor and supervise the prisoner. 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. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

Previous deaths at Wormwood Scrubs

14. Since 2012, we have investigated the deaths of ten prisoners at Wormwood Scrubs, including that of the man. Seven were apparently self-inflicted, two were from natural causes and in one case the cause of death was not determined.

15. In May 2014, inspectors found that the prison had accepted, but not implemented, many previous PPO recommendations - in particular, improvements to ACCT procedures, including the need for multidisciplinary case reviews, better caremaps, more training for officers and random checks on prisoners within the specified frequency. We have identified these problems again during this investigation.
16. In investigations of the deaths of prisoners in December 2010 and October 2012, we found that officers had deliberately falsified records of checks on prisoners. We have found this again during the investigation into the man's death.

KEY EVENTS

17. The man was a citizen of Nigeria and used an alias. The man had three previous criminal convictions in the United Kingdom and had served a short prison sentence in 2010. It is not clear how long he had been in the United Kingdom.
18. On the evening of Tuesday 28 October 2014, police arrested the man at Heathrow Airport, while he was trying to leave the country using a false passport, and took him to Heathrow Police Station. He told the police that he had tried to take his own life many times, most recently the day before, and said that he had many mental health problems. Just before midnight, the man complained of chest pains. The police called an ambulance and took him to Hillingdon Hospital.
19. Hospital staff could not find anything physically wrong with the man and discharged him at 9.00am on Wednesday 29 October. The hospital recommended a mental health assessment. When the man returned to the police station, officers constantly supervised him in a special cell with a glass-fronted door, as they were concerned about his risk of suicide and self-harm. At lunchtime, a police doctor saw the man, but did not think he needed a mental health assessment at the time, as he was being constantly supervised.
20. That evening, the man was charged with attempting to pervert the course of justice and possessing a false identity document. A police officer completed the man's Person Escort Record (PER) before his court appearance the next day. (The PER accompanies a prisoner when they transfer between police custody, courts and prisons, and should contain any relevant risk information.) The officer wrote that the man was an 'overstayer', meaning that his leave to remain in the United Kingdom had expired. He noted that the man claimed to have mental health problems but was fabricating his condition. The officer wrote that the man also claimed to self-harm. He had been uncooperative during his time in custody. The man stayed at the police station overnight and remained under constant supervision.
21. On Thursday 30 October, the man went to Uxbridge Magistrates' Court. At 12.20pm, the man tried to hang himself using a cable from a light fitting in the ceiling of the legal visits room. A court custody officer cut the cable from the man's neck and prevented him from harming himself. Court custody staff kept the man under constant supervision. That afternoon, the man was remanded to prison. His next court appearance was scheduled for 13 November.
22. At 5.05pm, the court custody officer, who had saved the man, completed a suicide and self-harm warning form to alert prison staff to his risk. He wrote that the man had tried to hang himself using a lighting cable at 12.20pm and that a constant watch was needed. He marked the PER to indicate that a suicide and self-harm warning form was attached. The man was taken to HMP Wormwood Scrubs.

HMP Wormwood Scrubs, Thursday 30 October

23. The man arrived at Wormwood Scrubs at 5.55pm. A Supervising Officer (SO) signed the suicide and self-harm warning form. The man gave his wife's contact details as his next of kin.
24. An officer interviewed the man in reception and noted the suicide and self-harm warning form. The SO asked the officer to begin ACCT procedures. The man told the officer that he had not intended to kill himself at court but had been trying to draw attention to the injustice of his arrest. He said that he had not tied or tightened the cord around his neck. The officer noted that the man spoke loudly, but clearly and reasonably, and was upset at how he had been treated by the immigration authorities and the police.
25. At 7.05pm, the officer wrote on an ACCT concern and keep safe form that the man had tried to hang himself using electrical cable from the ceiling. The man told the officer that he might be suicidal and that he was low in mood and depressed because of his family circumstances. The officer showed the man the ACCT document and explained that he was opening it to support him because of the information on the suicide and self-harm warning form. The officer did not think that the man needed constant supervision.
26. The officer completed a routine reception safer custody checklist. He recorded that the man had been having thoughts of suicide and self-harm during the previous two weeks because of family issues (he did not note what the issues were). The officer assessed the man as suitable to share a cell with a non-smoker.
27. The man was taken to the prison's first night centre and was allowed to telephone his wife. A SO, who was in charge of the first night centre that night, did not think that The man seemed upset after the telephone call. The SO read the suicide and self-harm warning form and the ACCT concern and keep safe form and spoke to the man in a private room. He talked openly, seemed comfortable and spoke English well. The SO explained the ACCT process and they looked at the suicide and self-harm warning form together. The man shook his head. The SO thought that this was because he did not agree with the information on the form. He said that he had not tied the cord tightly around his neck. The SO said she tried to obtain more information from him, but he just shrugged. The SO noted that there were no marks on his neck and was persuaded by the man that he had not made a serious suicide attempt.
28. The SO completed the ACCT immediate action plan and decided that staff should check the man once an hour until his ACCT assessment interview and first case review the next day. She thought that hourly observations were appropriate because, in her opinion, the man's risk of suicide and self-harm was raised. She did not think that constant supervision was necessary. The SO told the man that he would be referred to the immigration authorities. She recorded one trigger in the ACCT document - immigration circumstances - and noted that his next court appearance was on 13 November.
29. At about 8.15pm, a nurse completed a reception healthcare assessment and signed the suicide and self-harm warning form. The form clearly stated that

the man had tried to hang himself earlier that day, but the nurse did not read it correctly and thought that this incident had happened earlier in the week. He spent about 45 minutes with the man, who said that he did not have mental health problems and was not in contact with mental health services. The man said that he did not misuse drugs or alcohol.

30. The nurse thought that the man seemed depressed, withdrawn and unsettled. They discussed the suicide and self-harm warning form and the man said that he was not planning to hang himself in prison. The nurse referred the man to the duty GP. He sent information electronically to the primary care mental health team that the man was a new prisoner who appeared depressed and had tried to hang himself the day before in Heathrow Police Station (not Uxbridge Magistrates' Court, as was actually the case). The nurse did not send an accompanying electronic mental health referral form required to complete the referral process. (If the referral form is ticked as urgent, a prisoner should have a mental health assessment the next morning.) The nurse did not make an entry in the ACCT record about his assessment.
31. At about 8.50pm, a doctor assessed the man. The doctor asked the man about the information on the suicide and self-harm warning form and the man told him he had no current plans to harm himself. He did not elaborate on what had happened at court and just said that he was now okay. Afterwards, the doctor checked with the nurse, who said he had made a mental health referral. The doctor did not prescribe any medication and the man said he did not want any. The doctor noted the consultation in the man's ACCT record.
32. A Listener then spoke to the man as part of the first night centre routine for newly-arrived prisoners. (Listeners are prisoners trained by the Samaritans to provide confidential support other prisoners.) He was located in a six-bed dormitory, in the first night centre. During the night, a night patrol officer checked him at 56 minutes past every hour.

Friday 31 October

33. At about 11.45am on 31 October, a second nurse saw the man for a second day health screen. She did not look at the previous clinical entries before seeing him. He answered all of her questions and said that he was fit and well. He said that he missed his family and was very worried about them. The second nurse advised him to book a visit. He said that he had never been in prison before and was scared about being deported. The nurse told a first night centre officer that the man was very worried, but she could not recall who the officer was. The second nurse thought that the man's mood seemed stable and he was not likely to harm himself or take his own life. She recorded no additional concerns about him in his clinical record and did not make an entry in the ACCT record.
34. Staff took the man to C Wing but the SO who was in charge of C Wing, refused to accept him until first night centre staff had completed his ACCT assessment interview, case review and caremap. At 2.20pm, a first night centre officer, completed the man's ACCT assessment. Although she was a trained assessor, she said she did not usually complete ACCT assessments, but none of the usual assessors was available. A first night centre officer had very little information about the man. She had read the ACCT concern and

keep safe form completed by the officer, but this did not specify when the man had attempted to hang himself.

35. When the first night centre officer spoke to the man, he did not make much eye contact with her but talked freely. He thought that his family were being unfairly treated by immigration services. He was angry and said that, if he was not around, his family would not be deported and the immigration services would leave them alone. A first night centre officer told the man that his family might still be deported anyway. The man spoke about having tried to hang himself, but the officer did not realise that this had happened only 24 hours earlier. He said that he was very up and down in mood and did not think that he should be in prison. The man said that he had no current plan to kill himself but could not be certain that he would not do so at some point. He agreed to speak to staff if he felt low.
36. A first night centre officer had no major concerns about the man. She noted that he knew about the Listener scheme, might get bail at his next court appearance, would share a cell and was likely to get visits from his wife and children. After the assessment interview, she briefed the SO, who was due to hold the first ACCT case review. A first night centre officer advised him that she considered the frequency of observations could be reduced.
37. At about 3.00pm, the SO held the man's first ACCT case review, with no other staff present. The SO did not invite any healthcare staff and A first night centre officer told the investigator that she had been too busy to attend. The case review lasted about 15 minutes. The SO knew that the man had tried to tie a ligature before arriving at the prison. He thought that some of the man's behaviour was odd and bizarre, and possibly manipulative. However, he did not appear hopeless or tearful. The man talked about his immigration status. He thought that he was being persecuted by the authorities and did not deserve to be in prison. He was anxious about his possible deportation. He said he planned to apply for bail at court on 13 November. He talked about his family lovingly. The SO did not think that the man was at imminent risk of suicide or self-harm.
38. The SO decided that staff should continue to monitor the man under ACCT procedures, but assessed his risk of suicide and self-harm as low. He reduced the frequency of observations to three times during the day and five times at night. He scheduled the next ACCT case review for 6 November. The SO recorded family contact as an issue on the ACCT caremap, with an action for regular telephone calls and visits, for which staff and the man were responsible. The SO explained to the man how to arrange a visit from his wife. The SO spoke to A first night centre officer later and they agreed that the new frequency of observations was appropriate.
39. After the ACCT case review, the man moved to C Wing. At about 4.00pm, an officer located the man in a double cell on C Wing, C3-80, with a prisoner who also did not smoke. The association period (when prisoners have free time out of their cells) on C Wing was in the morning on Fridays, so the man had missed this. He was locked up for the night at about 4.00pm and given a cold meal.

Saturday 1 November - Sunday 2 November

40. Prisoners on the man's wing were unlocked for a kit change, shower and association period at about 9.00am on Saturday morning. They were locked in their cells again between 10.00am and 11.15am. They were then unlocked to collect a hot lunch to eat in their cells before being locked up again at midday until the next morning. On Sunday, the prisoners were unlocked at about 10.00am for an hour's association period. They were later unlocked to collect a hot lunch and were then locked up from midday until Monday morning.
41. The man's cellmate told the investigator that he and the man had talked a lot over the weekend. The man apparently told him that he had telephoned his wife on his first night in prison and said that he would not be coming out of prison alive. (The man's wife saw the draft investigation report and told us that her husband had not made this remark to her in their telephone calls.) The man's cellmate did not tell officers about this. Over the weekend, the man's cellmate said that the man did not seem especially distressed and was not tearful, but seemed unhappy and kept saying, 'This is not life.' He asked the man's cellmate when he would get his prison telephone account number, so he could make calls. The man's cellmate said that the man did not go to the chapel on Sunday.

Monday 3 November

42. At about 8.00am on 3 November, an officer checked the man. He was fully dressed, and did not have any new concerns. The officer told the man to let him know if he had any issues during the day. He then went to the office and made an entry in the man's ACCT record.
43. At about 8.30am, the man's cellmate went to an education class and the man was then locked in the cell alone. At 10.30am, cells on his landing were unlocked to allow prisoners the opportunity to shower, spend some time in the open air, make telephone calls and collect medication. As the man had not yet been allocated any activity, this would have been his only opportunity to spend time out of his cell that day.
44. At about 11.00am, there was an incident on the wing when a prisoner threatened to jump from an upper landing. As soon as the incident began, all prisoners were locked in their cells. Prison managers attended and staff talked the man down. The SO took him to the segregation unit. He estimated that the incident ended at about 11.40am.
45. The man's association period began at about 10.30am and was curtailed by the incident on the landing at 11.00am. The officer told us that he had seen the man when he had come to the C3 landing office to ask for his telephone PIN number, which he had not yet received. (Prisoners need a personal identification number (PIN) to use the prison telephone system. The man had completed a communications compact when he first arrived and had given staff a list of telephone numbers for family and friends he wanted to call.) the officer said that the man had not seemed particularly depressed and had seemed no different from any other new prisoner asking for advice. The

officer the PIN phone clerk, who said that the man's PIN phone details would be available later that day.

46. We do not know who locked the man in his cell that morning, because there is no CCTV footage of the wing and no one has said they remembered for certain doing so. At 11.55am, two officers unlocked prisoners on C3 landing for lunch. One officer looked through the observation panel in the man's cell door and saw him hanging from the strip light in the middle of the ceiling. He shouted to the other officer, who was on the opposite side of the landing, who arrived with a third officer, who had come down from the landing above. As the two officers joined him, the officer radioed the control room stating, 'code blue cell 3-80.' (Prisons are required to use radio codes in a medical emergency, which should prompt the control room to call an emergency immediately and alert other staff. Most prisons use code blue to indicate an emergency, such as when a prisoner is hanging or not breathing, but Wormwood Scrubs uses code 1.) The officer then unlocked the cell.
47. The three officers went into the cell and found that the man had hanged himself from the strip light in the ceiling using shoelaces tied around his neck. An officer supported the man's weight while the other officer cut the laces. The officers lowered the man to the floor of the cell and the officer then cut the rest of the lace from the man's neck.
48. The officer began to put the man in the recovery position then realised he was not breathing. He rolled him onto his back and began chest compressions, and then two other officers took over. The first two officers helped by tilting the man's head and using a plastic spoon to stop his swollen tongue obstructing his airway. The officers did not give rescue breaths.
49. Another officer and an operational support grade (OSG) received the officer's transmission in the control room. They were confused that the officer had not uses a recognised emergency code and had not said which wing he was calling from. They had also misheard cell 80 as cell 18. They radioed for clarification, but could not obtain a response. The officer said that he had replied to say that the emergency was on C Wing, but there were a lot of other conversations on the radio network and the officer did not hear this.
50. The officer said he had tried to work out who had transmitted the message, but this was difficult, as the first officer had not joined the radio network. (When officers draw a radio at the start of a shift, they should contact the control room and state their name. This allows control room staff to know who is using which radio and check that it is working.) However, he identified the radio as one normally assigned to C Wing, and asked the emergency response nurse to go to C Wing.
51. An unidentified member of staff on C Wing blew their whistle several times and someone else pressed the general alarm. At 11.56am, an unknown female member of staff (who had also not joined the radio network) radioed the control room to say that no more prison staff were needed because it was a medical emergency. At 11.57am, the orderly officer in charge of the prison overruled this and instructed the officer to send all available staff to C Wing. Because the situation on C Wing sounded so worrying, the officer activated a double alarm bell on the radio network.

52. An SO had left the segregation unit and was in the administration block when he heard the general alarm. He did not know the nature of incident. He went to C Wing and an officer told him that he thought there was a fight. The SO went to C3 landing and, initially, an officer told him that a prisoner had become unwell.
53. The SO reached the cell, saw that the man was in a critical condition and asked if anyone had requested an ambulance. At 11.59am, the SO radioed the control room and said that a prisoner had hanged himself and was not breathing. The OSG then called an ambulance service. This meant that there was at least a four-minute delay in calling an ambulance from the time that the officer had first radioed an emergency. By 12.01pm, an ambulance was on the way to the prison.
54. An nurse arrived on C Wing but did not bring any emergency equipment, as he was unaware of the nature of the incident. The SO told him that a prisoner had been found hanging and he urgently needed to bring the emergency response bag (containing oxygen and a defibrillator) from the treatment room on C1 landing. The nurse went to the treatment room, where a doctor was working, and collected the bag. The doctor and nurse went back to the man's cell together.
55. The response nurse was in the prison's reception area when he heard the request for the emergency response nurse. He took a grab bag and went to C Wing, which he estimated took him four or five minutes.
56. The lead GP and the duty doctor was in the segregation unit, when he heard the messages on a colleague's radio. He was uncertain whether he was needed, so he waited for clarification. When no clear announcement was made, he went to C Wing as a precaution. When he arrived at the wing, the lead GP said an officer had asked him to leave the wing for his own safety. However, the lead GP insisted that he was needed and went to the cell.
57. The doctor helped with chest compressions and the lead GP inserted a plastic airway, which allowed nurses to give the man oxygen. The nurse attached a defibrillator (a life-saving device that gives the heart an electric shock in some cases of cardiac arrest to re-establish a normal heart rhythm). The defibrillator found no shockable rhythm and the staff continued with cardiopulmonary resuscitation.
58. At 12.05pm, the first paramedic response car arrived at the prison and an ambulance arrived at 12.08pm. A second paramedic response car arrived at 12.12pm and a third at 12.17pm. All the vehicles were escorted to C Wing.
59. The paramedics took over the resuscitation attempt and re-established a pulse. While nurses and paramedics were still treating the man in the cell, the SO and the officers went to the wing office. An officer, who was temporarily working at Wormwood Scrubs, away from his usual prison, told the investigator that the SO looked through the man's ACCT document, threw it down on the desk and said that one of his staff needed to write something in the document before they all 'got in the shit'. The officer said he felt uneasy about this and excused himself from the room.

60. The SO and officer gave a slightly different account to the visiting officer. The SO said he looked through the ACCT document and asked if anyone had seen the man during the morning because there were no entries in the record after 8.00am. The officer said that he had seen the man in the landing office when he had asked how to make an application about his PIN telephone number. The SO had then asked him to make an entry in the ACCT document. The officer made an entry in the record, which said that he had locked the man in his cell at 11.00am. However, he later told the investigator that he could not be certain that he had locked up the man. He said he had made the entry after 12.00pm.
61. Once paramedics had stabilised the man, he was taken to St Mary's Hospital in West London and arrived at 1.40pm. He was in a critical condition and was admitted to the hospital's intensive care unit. Two officers accompanied him.
62. The family liaison officer, telephoned the man's wife on her mobile number to let her know what had happened. He told her which hospital her husband was in and checked that she had support.
63. Staff found that the man had left a note in his cell, addressed to his wife. He said that he could not 'take this anymore' and that he was sorry. He wrote that the immigration service and the police wanted him to do it.
64. Staff arranged for the man's cellmate to be located with Listeners for support. At 1.15pm, healthcare staff discussed the handling of the emergency at their usual daily handover. Later that day, the deputy governor debriefed the prison and healthcare staff to check on their welfare, offer support and discuss the emergency response. Staff on C Wing checked other prisoners who were being monitored under ACCT procedures, in case they had been adversely affected by the man's actions.

Tuesday 4 November - Thursday 13 November

65. Members of the man's family, including his wife and children, visited him over the next few days. On 8 November, the deputy governor decided to reduce the hospital escort to one officer. The man never regained consciousness. At 9.00pm on 13 November, hospital staff withdrew treatment and switched off his life support machine. He died at 10.15pm.
66. One of the prison chaplains visited the man's cellmate to check his welfare after the man died. Most staff said they were well supported after the emergency. However, officer said that support could have been better. The care team were not initially told that the three officers were involved as they had been on early shifts and had gone home before the debrief meeting. The officers attended a later critical incident debrief.
67. On 23 December, the man's wife and her brothers visited the prison and collected her husband's property. The man's funeral was held on 27 January 2015. The prison contributed towards the cost, in line with national guidance.

ISSUES

Clinical care

68. The nurse assessed the man when he arrived in reception. However, he did not read the suicide and self-harm warning form properly and did not realise that the man had attempted to hang himself at court, earlier the same day. He did not therefore understand the level of risk and the need for an urgent referral. The nurse did not complete the mental health referral process properly, which meant that there was no priority attached to the request sent to the mental health team. An urgent referral would have meant that someone from the mental health team would have assessed the man the next day. The nurse did not make an entry in the ACCT record to let other staff know that he had seen the man. The next day, the second nurse saw the man for a second health screen, and she did not make an entry in his ACCT record.
69. The man did not have a mental health assessment, despite a very recent suicide attempt, which was clearly outlined on the suicide and self-harm warning form. The clinical reviewer noted that the nurse did not properly assess the likelihood of the man attempting suicide again or establish whether he was depressed, and did not make the mental health referral properly. The doctor did not make an urgent referral either. The clinical reviewer considered that the standard of healthcare the man received at Wormwood Scrubs was not equivalent with that he could have expected to receive in the community. We make the following recommendation:

The Governor and Head of Healthcare should ensure that prisoners identified as at risk of suicide and self-harm are appropriately referred for an urgent mental assessment and that all referrals identify the priority.

Managing the risk of suicide and self-harm

70. The man had a number of risk factors which increased the likelihood that he might take his own life. Because of this, he had been constantly supervised in police and court custody. This was clearly stated on a suicide and self-harm warning form completed to alert the prison to his risk. He had tried to hang himself at court on the day he arrived at the prison. He was a foreign national prisoner facing deportation and separation from his wife and children and his immigration status was clearly a worry for him. We do not consider that the man's risk of suicide and self-harm was well managed at Wormwood Scrubs. The investigation identified the following problems:
- The level of checks when he arrived at Wormwood Scrubs was set at once an hour, which was not frequent enough to reflect the level of risk for someone who had tried to hang himself just eight hours earlier.
 - On the man's first night in prison, officers carried out ACCT checks at precise and predictable intervals.
 - The ACCT assessor had no recent experience, did not identify the man's risk factors and inappropriately advised the case manager to reduce the frequency of observations, even though the man had told her that his family would be better off if he was not around.

- Contrary to Prison Service Instruction 64/2011, the man's first case review was not multidisciplinary. The case manager held it on his own and did not invite any healthcare staff.
- The ACCT case manager assessed the man's risk of suicide and self-harm as low, when guidance in the ACCT document states that the risk should be assessed as raised if there has been a recent suicide attempt.
- The ACCT case manager inappropriately reduced the frequency of checks only 24 hours after the man had tried to hang himself at court and did not make it clear on the front cover of the ACCT document whether these were conversations or observations.
- The ACCT case manager was not trained to hold case reviews. Other staff said that they had not had any ACCT training for years.
- The man's caremap missed significant issues such as his mental health and immigration problems.
- There were no entries in the ACCT ongoing record about the man's reception health screen, his second day health assessment, ACCT assessment interview, his ACCT case review or his cell move on his second day at the prison.

71. As with previous investigations at Wormwood Scrubs, we found that the levels of observations, before and after the man's first ACCT case review, were set in line with standard practice. Although the prison has previously accepted recommendations that the frequency of checks should relate to the individual's risk of suicide and self-harm, there has been no change in practice and managers did not take fully into account the man's individual risk factors, including his very recent suicide attempt.

72. During an inspection of Wormwood Scrubs in 2014, inspectors found that few recommendations from previous investigations into deaths at the prison had been effectively implemented. It was apparent from the investigation into the man's death that many of the same problems remain. We make the following recommendation:

The Governor and the Head of Healthcare should ensure that staff manage prisoners at risk of suicide or self-harm in line with national guidelines, including:

- **Holding multidisciplinary case reviews, with healthcare representation at all first ACCT case reviews;**
- **Taking into account all known risk factors when determining the level of risk of suicide and self-harm;**
- **Setting appropriate levels of observations which are accurately recorded on the ACCT front cover;**
- **Setting ACCT caremap actions which are specific and meaningful, aimed at reducing prisoners' risks and which identify who is responsible for them;**
- **All staff, including healthcare staff, recording observations and interactions with prisoners as required;**
- **Staff checking prisoners at unpredictable intervals within the specified frequency of observations;**
- **Staff receiving up-to-date ACCT training.**

Incorrect entry in the ACCT record

73. The entry in the ACCT ongoing record timed at 11.00am on 3 November, apparently the final one before the man was found hanging, was misleading. During the investigation, after we received information from the visiting officer, who had been working temporarily at Wormwood Scrubs, the officer told us that he had agreed to make a retrospective entry at the SO's request. The officer said that he had agreed to do this because he had seen the man during the morning. He said that the man had asked him about access to the telephone system in the landing office during his association period. The officer made his entry during the emergency response at about 12.30pm, but timed it at 11.00am, almost an hour before the man had been found hanging. The record indicated that the officer had locked the man in his cell at 11.00am but, in fact, the officer could not say whether he had locked up the man.
74. The SO accepted that he had asked any officer who had interacted with the man that morning, but had not written it up in the ACCT document, to do so retrospectively. We are very concerned that a manager encouraged an officer to make such a misleading entry, after a prisoner had been found hanged - particularly when the entry was not an accurate reflection of events. The entry suggested that the officer was the last member of staff to see the man before he hanged himself, but we do not know whether this was the case.
75. If the officer spoke to the man in the landing office that morning (and we have no evidence otherwise), it is difficult to understand why he did not write this in the ACCT document. It is also difficult to understand the SO's motivation, except that, like the officer he was concerned that the ACCT document did not give an accurate impression of the work that staff were doing with prisoners. While staff should record any significant encounters with a prisoner in an ACCT document, the man had been locked in his cell for most of the morning and the formal requirement for ACCT checks at the time was only three during the day. A check had been done at 8.00am and without a further entry, there would have been no criticism that an additional check had not been made that morning.
76. We are concerned that neither the SO nor the officer seemed fully to accept that it was wholly inappropriate to make such a misleading retrospective ACCT entry in these circumstances. Neither of the staff volunteered that this had been done and it seems unlikely we would have known had another officer not given us this information. While we have no evidence that it was done deliberately to deceive the investigation, it is worrying that this is the third time in five years that one of our investigations at Wormwood Scrubs has found that an officer falsified records of checks on a prisoner.
77. After the visiting officer submitted his statement, the actions of the SO and the officer were subject to an internal disciplinary investigation at Wormwood Scrubs. We were told that the internal investigation found that neither officer 'deliberately set out to fabricate' so no disciplinary action would be taken, although both had been given advice and guidance. The Ombudsman's office is wholly independent of the Prison Service, which means we cannot direct operational or personnel matters. However, we are very concerned that managers would accept that an officer and a supervising officer would be unaware that this was a wholly inappropriate action. All staff need to know

that it is a serious matter to alter ACCT documents after a serious incident. It is all the more unacceptable that such inappropriate actions have been repeated over recent years at Wormwood Scrubs. We make the following recommendation:

The Deputy Director of Custody should ensure that all staff at Wormwood Scrubs fully understand that alteration of ACCT documents, including retrospective entries, after a death or act of self-harm, can amount to a criminal or serious disciplinary matter.

Emergency response

78. Officers went into the man's cell as soon as they saw him hanging and began basic life support immediately. However, there were a number of problems with the emergency response. Prison Service Instruction (PSI) 03/2013 requires every prison to have a two level code system that differentiates between a blood injury and all other injuries. It recommended that code red should be used for blood / burns and code blue for all other medical emergencies. Governors were given discretion to use code one instead of code blue and code two instead of code red, if this was already the local practice. The Governor of Wormwood Scrubs issued a local order in April 2014 requiring staff to use code 1 and code 2. When the officer found the man hanging, he incorrectly used code blue, which he had used when he previously worked in care homes.
79. The use of the correct medical emergency response code should prompt control room staff to call an ambulance immediately. The officer said that he was unfamiliar with code blue call and did not recognise it as a life-threatening emergency. He waited for more information before calling an ambulance. The situation was further complicated because the officer did not indicate which wing the emergency was on, and the officer misheard the cell number.
80. Because the officer had not joined the radio network control room staff did not know his location immediately. The officer told that investigator that he estimated that about 25 percent of staff do not join the network. This is a basic requirement that not only assists control room staff, but also contributes to the safety of staff and prisoners.
81. Once the emergency was underway, staff were confused by the use of a whistle and the pressing of the general alarm and were unaware that it was a medical emergency. One officer tried to prevent the lead GP going to the cell as he thought there was a general disturbance. Healthcare staff coming to the scene did not realise the nature of the emergency and did not bring emergency equipment with them.
82. As a result of all this confusion, there was an unacceptable four minute delay in calling an ambulance. It was only when the SO reached the scene, four minutes after the officer had first called an emergency, that he asked control room staff to call an ambulance.
83. We understand that prison managers are currently considering moving from a numeric emergency code system to a colour code system, which is widely used across the Prison Service. We think this would be sensible. Wormwood

Scrubs often uses staff from other prisons to cover vacancies, and they are more likely to be familiar with the colour code system. We make the following recommendation:

The Governor should ensure that all prison staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies, understand how to use their radios effectively, and that Wormwood Scrubs has a Medical Emergency Response Code protocol which:

- **Provides guidance to staff on efficiently communicating the nature of a medical emergency; and**
- **Ensures there are no delays in calling, directing or discharging ambulances.**

RECOMMENDATIONS

1. The Governor and Head of Healthcare should ensure that prisoners identified as at risk of suicide and self-harm are appropriately referred for an urgent mental assessment and that all referrals identify the priority.
2. The Governor and the Head of Healthcare should ensure that staff manage prisoners at risk of suicide or self-harm in line with national guidelines, including:
 - Holding multidisciplinary case reviews, with healthcare representation at all first ACCT case reviews;
 - Taking into account all known risk factors when determining the level of risk of suicide and self-harm;
 - Setting appropriate levels of observations which are accurately recorded on the ACCT front cover;
 - Setting ACCT caremap actions which are specific and meaningful, aimed at reducing prisoners' risks and which identify who is responsible for them;
 - All staff, including healthcare staff, recording observations and interactions with prisoners as required;
 - Staff checking prisoners at unpredictable intervals within the specified frequency of observations;
 - Staff receiving up-to-date ACCT training.
3. The Deputy Director of Custody should ensure that all staff at Wormwood Scrubs fully understand that alteration of ACCT documents, including retrospective entries, after a death or act of self-harm, can amount to a criminal or serious disciplinary matter.
4. The Governor should ensure that all prison staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies, understand how to use their radios effectively, and that Wormwood Scrubs has a Medical Emergency Response Code protocol which:
 - Provides guidance to staff on efficiently communicating the nature of a medical emergency; and
 - Ensures there are no delays in calling, directing or discharging ambulances.

Action Plan					
No	Recommendation	Accepted/Not Accepted	Response	Target date for completion and function responsible	Progress (to be updated after 6 months)
1	The Governor and Head of Healthcare should ensure that prisoners identified as at risk of suicide and self-harm are appropriately referred for an urgent mental assessment and that all referrals identify the priority.	Accepted	<p>The referral template has been amended so that tasks are sent to correct recipients and records the priority level. At present the referral form is divided into three sections, each with different priorities. Each section has its own quick action "Task" button. Depending on the section completed and the reason for the referral, the task sent will be received by the specific healthcare team with the required priority attached.</p> <p>A meeting will take place in June 2015 to implement a single point of referral and single point of triage for all mental health referrals. Once implemented, all referrals will go to a single healthcare team who will not only process the referral but will also review the referral and the decision made by the referrer, to ensure that any such referrals are assessed against all available information and not only on the individual referrer's impressions. The referrals will be reviewed every day and will be actioned</p>	<p>31/07/15.</p> <p>Healthcare centre manager</p>	

Action Plan					
No	Recommendation	Accepted/Not Accepted	Response	Target date for completion and function responsible	Progress (to be updated after 6 months)
			every day. The template referral will be updated to reflect this change in the process. It is expected that this system will be in place by 31 July 2015.		
2	<p>The Governor and the Head of Healthcare should ensure that staff manage prisoners at risk of suicide or self-harm in line with national guidelines, including:</p> <ul style="list-style-type: none"> • Holding multidisciplinary case reviews, with healthcare representation at all first ACCT case reviews; • Taking into account all known risk factors when determining the level of risk of suicide and self-harm; 	Accepted	<p>Bullet Point 1: The requirement for multidisciplinary attendance at ACCT case reviews will be addressed in a new Governor's Order, and this will be reinforced through the local ongoing ACCT training programme to be conducted to this effect. In addition, healthcare staff will arrange for specific times to be made available for attendance at ACCT reviews, which will be confirmed in due course.</p> <p>Bullet Point 2: This will be addressed as part of the 2015 local ACCT training programme (all Band 4 –Band 10 refreshed in Case Managers). A local Notice to Staff (NTS) will be updated and re-issued with examples of known risk factors for all staff (in line with national policy) which</p>	<p>31/07/15</p> <p>Safer Custody Department</p> <p>ACCT training is ongoing. NTS to be issued by 31/07/15.</p> <p>Safer</p>	

Action Plan					
No	Recommendation	Accepted/Not Accepted	Response	Target date for completion and function responsible	Progress (to be updated after 6 months)
	<ul style="list-style-type: none"> Setting appropriate levels of observations which are accurately recorded on the ACCT front cover; Setting ACCT caremap actions which are specific and meaningful, aimed at reducing prisoners' risks and which identify who is responsible for them; All staff, including healthcare staff, recording observations and interactions with prisoners as required; Staff checking prisoners at unpredictable intervals within the specified 		<p>staff need to be familiar with.</p> <p>Bullet Point 3 - 6: An earlier Governor's Order (21/14, issued in August 2014) will be reissued with additional guidance. The current Governor's Order contains advice about determining appropriate levels of observations and conversations based on the level of risk perceived. The updated Governor's Order will contain further guidance on this and how to appropriately record the observations set on the front cover. In addition, this new guidance will address the setting of specific and meaningful actions on the CAREMAP. These concerns will be addressed as part of 2015 local ACCT training programme for all Band 4 –Band 10 refreshed in Case Managers.</p> <p>Bullet Points 4 & 7: A Case Managers Training and Introduction to Safer Custody Training is in</p>	<p>Custody Department</p> <p>ACCT training is ongoing. New Governors Order to be issued by 31/07/2015.</p> <p>Safer Custody Department</p> <p>ACCT training is</p>	

Action Plan					
No	Recommendation	Accepted/Not Accepted	Response	Target date for completion and function responsible	Progress (to be updated after 6 months)
	<p>frequency of observations;</p> <ul style="list-style-type: none"> Staff receiving up-to-date ACCT training. 		the process of being implemented for all staff (part of the 2015 ACCT training programme).	ongoing Safer Custody Department	
3	The Deputy Director of Custody should ensure that all staff at Wormwood Scrubs fully understand that alteration of ACCT documents, including retrospective entries, after a death or act of self-harm, can amount to a criminal or serious disciplinary matter.	Accepted	A Governors Order will be issued to confirm that retrospective entries should not be made in the ACCT document following a death.	31/07/15 Safer Custody Department	
4	The Governor should ensure that all prison staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies, understand how to use	Accepted	Bullet Point 1: Local training has taken place to support the implementation of the change to the Emergency Response Codes (to Code Red and Code Blue, as of 1 June 2015). A Notice to Staff explaining process has been published and	complete	

Action Plan					
No	Recommendation	Accepted/Not Accepted	Response	Target date for completion and function responsible	Progress (to be updated after 6 months)
	<p>their radios effectively, and that Wormwood Scrubs has a Medical Emergency Response Code protocol which:</p> <ul style="list-style-type: none"> • Provides guidance to staff on efficiently communicating the nature of a medical emergency; and • Ensures there are no delays in calling, directing or discharging ambulances. 		<p>'quick-guide' business cards have been circulated to all staff</p> <p>Bullet Point 2: Wormwood Scrubs Local Medical Emergency Response Code local protocol will be published. This will set out the new Emergency Response Codes and set out the requirement for calling, directing or discharging ambulances.</p> <p>Governors Order 008/15 contains instructions regarding all operational staff on duty collecting the correct radio. Further guidance has been sent out to remind staff who are detailed a radio that they join the net to ensure they are contactable.</p>	<p>Training completed and guidance published.</p> <p>Protocol to be published by 31/07/15.</p> <p>Safer Custody Department & Healthcare Centre Manager</p>	