PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent investigations

A Report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

Investigation into the death of a man at HMP Swaleside in July 2012

Our Vision

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

This is the report of the investigation into the death of a man who was found hanging in his cell at HMP Swaleside in July 2012. He was 24 years old. I offer my condolences to his family and friends.

A clinical review was conducted of the man's care in custody. HMP Wormwood Scrubs and HMP Swaleside cooperated with this investigation.

The man transferred to Swaleside from Wormwood Scrubs on 2 July 2012. During his time at Wormwood Scrubs, he had attempted suicide and was subject to suicide prevention measures. He also experienced mental health problems at Wormwood Scrubs and was prescribed antipsychotic medication which was not continued at Swaleside. The possibility of his appeal against his sentence being rejected was identified as a likely trigger to self-harm by officers at Wormwood Scrubs, who passed their concerns on to Swaleside when he transferred. After the news that his appeal had been rejected, Wormwood Scrubs again alerted Swaleside that this was a risky time for him. Despite the warning, officers from the Offender Management Unit at Swaleside, who did not know him, concluded from his presentation that he was coping well. Four days later, he was found hanging. The post-mortem report found that he had alcohol in his blood, but the source of that is unknown.

Some aspects of the man's care were not well managed at Wormwood Scrubs, but the prison ensured his risk factors were communicated when he transferred and they followed this up after the outcome of his appeal was known. I consider that Swaleside did not attach sufficient weight to the information they received from Wormwood Scrubs and should have put in place suicide prevention measures when he lost his appeal. I am also concerned that his mental health care and medication stopped when he transferred because of a series of administrative mistakes. Although it would not have affected the outcome for him, emergency response procedures at Swaleside need to improve. Finally, it is disappointing that his family were not informed of his death in person.

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 **December 2013**

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SUMMARY

1. On 27 June 2011, the man was remanded to HMP Wormwood Scrubs for attempted murder. Between 30 July and 14 September, he had four adjudications (disciplinary charges) and was segregated for fighting and refusing officers' orders. On 2 November, a mental health nurse referred him to a psychiatrist because she thought he might be psychotic.

2. On 16 November, the man started a fire in his cell. He was taken to the segregation unit, and a doctor recorded he was probably suffering from psychosis, but was not suicidal. The next day, he refused to leave his cell to see the psychiatrist but told him he felt safe there. He spent most of the next month in the segregation unit.

3. On 13 December, the man was convicted of attempted murder and monitored under suicide and self-harm prevention procedures after telling court staff that he would not be around much longer. He was assessed as unpredictable and at high risk of suicide and transferred to the healthcare centre for observation, where suicide prevention measures were closed.

4. The psychiatrist suggested that the man was suffering from stress related to his court appearance rather than an underlying psychotic illness, but prescribed antipsychotic medication. He remained in the healthcare centre until 13 January 2012 when he was returned to a standard prison wing. On 20 January, he set fire to the bed in his cell, suicide prevention measures were started and he was taken to the segregation unit. He received ongoing support from a nurse from the mental health in-reach team.

5. The man was assessed for court by a psychiatrist who concluded he was not suffering from any mental illness. On 12 March 2012, he was sentenced to an indeterminate sentence with a minimum period to serve of eight years. Four days later, he jumped from the wing landing with a ligature tied round his neck and attached to the landing rail. His fall was broken by the netting and he sustained minor injuries. Suicide prevention monitoring was started again and he was constantly supervised in the healthcare centre until 26 March, when the level of his observations was reduced. He said he had been shocked at the length of the sentence. He returned to the wing on 10 April, and suicide prevention measures were stopped on 21 April.

6. The man was due to transfer to Swaleside and, on 25 June, a safer custody officer at Wormwood Scrubs emailed Swaleside in advance about his history of self-harm. The officer was particularly concerned that the likely negative outcome of an appeal could trigger him to harm himself. This email was copied to reception and the induction officers at Swaleside. He transferred to Swaleside on 2 July.

7. The nurse carrying out the reception health screen at Swaleside was unfamiliar with the computerised medical records system and failed to access the man's medical notes from Wormwood Scrubs. At the time of his transfer, he was taking antipsychotic medication, but there is no evidence that he

arrived with his prescription chart or any medication from Wormwood Scrubs, or that he received any medication at Swaleside. The reception nurse made a mental health referral but this was never received or actioned by the mental health team.

8. After Wormwood Scrubs' mental health team had called the prison, a member of Swaleside's mental health team saw the man and intended to discuss his case at a multidisciplinary meeting a few days later. This meeting was cancelled and he had no further contact with the mental health in-reach team.

9. Wormwood Scrubs informed Swaleside on 16 July that the man's appeal had been refused and reminded them that this could be a trigger for him to harm himself. Two officers spoke to him but were reassured by his calm presentation and concluded that he was not at risk of self-harm.

10. A few days later, during an early morning roll check, an operational support grade (OSG) saw the man hanging in his cell. Rather than radio for help, the OSG telephoned the night manager to explain that he thought the man was dead. He did not enter his cell until other staff arrived about eight minutes later. An ambulance was not called until that stage. Staff decided not to attempt resuscitation, as there were signs of rigor mortis. He was pronounced dead at 6.18am by paramedics. The man's mother was told of her son's death by telephone later that morning.

11. The investigation found that the man's risk was poorly managed by Wormwood Scrubs, but information about his risk factors was communicated to Swaleside when he transferred. Swaleside did not take sufficient account of the information they received from Wormwood Scrubs and incorrectly concluded that he was not at risk of self-harm. His mental health support and treatment stopped when he transferred. Emergency response procedures were poor and we repeat a previous recommendation about the need to call an ambulance whenever there are grave concerns about a prisoner's immediate health. His family should have been told of his death in person by a prison representative, rather than by telephone.

THE INVESTIGATION PROCESS

12. The Ombudsman's office was informed of the man's death on 20 July 2012. The investigator issued notices to staff and prisoners at Swaleside and Wormwood Scrubs informing them of the investigation and inviting anyone with relevant information to contact her. No one came forward.

13. NHS Kent and Swaleside appointed a clinical reviewer to conduct a review of the clinical care that the man received in prison. The clinical reviewer received copies of all the relevant medical and prison documents.

14. The investigator interviewed staff at Swaleside on 27 August and 26 September. She was joined by the clinical reviewer for four interviews with clinical staff. She conducted two interviews at Wormwood Scrubs on 4 October and fed back to the Governors throughout the investigation.

15. The investigator contacted the IT company responsible for SystmOne, the computerised medical record system used in prisons, which provided a report about the use of SystmOne during the reception process at HMP Swaleside.

16. One of the Ombudsman's family liaison officers contacted the man's family to tell them about the investigation. They had no specific issues they wished the investigation to consider.

17. A copy of the draft report was sent to the National Offender Management Service (NOMS). They reported that there were no factual errors and accepted all the recommendations. The responses to the recommendations are repeated verbatim in the relevant section.

HMP SWALESIDE

18. HMP Swaleside is a category B prison that is part of the Isle of Sheppey group of prisons which also includes Elmley and Standford Hill prisons. Swaleside's main function is for life sentenced prisoners but it also holds prisoners serving shorter sentences.

Her Majesty's Inspectorate of Prisons (HMIP)

19. HMIP carried out an unannounced inspection of Swaleside in July 2011. HMIP concluded that Swaleside was a fundamentally safe prison, with well developed work in safe custody issues. Prisoners told HMIP that relationships with staff were respectful, and they found that the personal officer scheme was effective.

20. HMIP repeated a recommendation about a need for the reception area to be refurbished, in particular to allow for initial health screens to be conducted in private. A recommendation made in 2008 about ensuring all prescriptions, had been legally written and authorised by a GP had apparently been implemented.

Previous deaths

21. There were three deaths at Swaleside in 2011, one of which was self-inflicted. The man's death was the second self-inflicted death at Swaleside in 2012. Following a death in March 2012, we recommended that the Governor remind staff to call an ambulance as soon as possible in a life-threatening situation. That report was issued in August 2012, after his death, but we drew this issue to their attention in April. We repeat the recommendation.

HMP Wormwood Scrubs

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

KEY EVENTS

HMP Wormwood Scrubs

23. The man was remanded for attempted murder on 27 June 2011. It was his first time in prison. He said that he drank alcohol regularly but was not an alcoholic and did not need treatment. He was not assessed as at risk of suicide or self-harm.

24. On 22 July, a prisoner told an officer that the man had been talking about killing himself. Officers spoke to him, who said he was fed up, but not suicidal. He was reminded of the help available from the Samaritans and Listeners (prisoners who are trained by the Samaritans to support other prisoners) but said he did not need to speak to anyone. At the time he was described as a "polite prisoner who is always behind the door when he should be. No other concerns at this time".

25. Between the 30 July and 14 September, the man had four disciplinary hearings and was segregated for fighting and refusing officers' orders. On 26 October, officers refused his request to move cells and he barricaded himself in. He told a nurse that "the devil was in his cell". The nurse noted that he appeared to be responding to auditory hallucinations and referred him to the mental health in-reach team. He was taken to the segregation unit on 30 0ctober, and a GP assessed that he was fit to be segregated.

26. A community psychiatric nurse from the mental health in-reach team assessed the man on 2 November, when he had returned to his wing. He said his cell was bugged by the government and he was unable to sleep. He said he could tell whether or not other prisoners were bugged by looking at them. The nurse decided to discuss his mental health in a referral meeting the next day.

27. At the referral meeting, it was recorded that the man might have symptoms of psychosis and it was agreed that a psychiatrist would review him, with a view to prescribing medication. The in-reach team agreed that he should be added to their caseload. There is no evidence of an assessment by a psychiatrist or any contact with the in-reach team during the next two weeks.

28. On 16 November, the man started a fire in his cell and the fire service attended. He was taken to the segregation unit and seen by a mental health nurse. A GP locum saw him that evening, and he told the doctor that his cell was bugged. The GP recorded that he was possibly suffering from psychosis, but was not suicidal and referred him urgently to the in-reach team. The GP considered that he was fit to be segregated. No ACCT was opened (Assessment, Care in Custody and Teamwork or ACCT is the Prison Service process for supporting and monitoring prisoners at risk of harming themselves).

29. A psychiatrist tried to assess the man on 17 November, but he refused to leave his cell and would not explain why he had started the fire. He told the

psychiatrist that he felt safe in the segregation unit. He returned to the wing the next day but was still confrontational with staff. On 21 November, he was returned to the segregation unit.

30. Over the next week, the man remained in the segregation unit and was assessed daily by nurses or the doctor. On 28 November, he was allocated to the caseload of the community psychiatric nurse from the in-reach team, who saw him the next day. She described him as stable, but recorded that he had persecutory beliefs and felt he was not being listened to. She planned to review him again in two weeks. He remained in the segregation unit until 5 December, with daily healthcare checks.

31. The community psychiatric nurse saw the man again on 9 December. He told the nurse he believed the doctors were trying to programme him. He said that he was not sleeping well, that he thought about his life a lot but was not willing to explain what he meant. She planned to see him in a week.

32. The man was convicted of attempted murder on 13 December. Court officers completed a self-harm warning form as he had indicated he might harm himself if he was found guilty. The nurse at reception opened an ACCT and asked for an urgent review by the in-reach team. The community psychiatric nurse saw him that afternoon, but he refused to come out of his cell because he said he did not trust her. He said he did not have suicidal thoughts but would be happy if he was dead. She concluded that he was unpredictable and might be a high risk of suicide, and arranged for him to be transferred to the healthcare centre that day. On the ACCT caremap, it was recorded that he should be referred to in-reach and located in the healthcare centre. Both of these actions were completed that day on 13 December, and the caremap was updated. No further support measures were added.

33. The psychiatrist assessed the man on 14 December. The psychiatrist recorded that he had no insight into his illness. He told the psychiatrist that he was feeling suicidal but had no active plans to kill himself. At an ACCT case review, he told the case manager and senior officer that he had no more thoughts of self-harm and the ACCT was closed.

34. On 16 December, the psychiatrist prescribed risperidone (an antipsychotic medication). Another consultant psychiatrist chaired a multidisciplinary review on 20 December. The man said that he had suicidal thoughts at times, but ignored them. The psychiatrist concluded that these thoughts were triggered by a court appearance rather than an underlying psychotic illness. It was agreed that his medication should continue, but that he should remain in the healthcare centre for further assessment.

35. The consultant psychiatrist saw the man again on 23 December, and recorded that the risk of self-harm was markedly reduced and thought his mental health problems might have been caused by stress. He remained on antipsychotic medication, but complained that it made him drowsy. On 30 December, it was agreed that he should remain in the healthcare centre for another week for observation so that his medication could be reviewed. The

psychiatrist queried whether he had a psychotic disorder, or whether his symptoms were in fact behavioural problems linked to the stress of prison.

36. On 13 January, the psychiatrist discussed the man at a case review and it was agreed that he should be discharged to the wing, with continued support from the in-reach team.

37. The community psychiatric nurse went to see the man on 18 January, but he did not want to come out of his cell. He said he was worried about his court case and was not sure if he could cope with being sentenced, because he was not guilty. He said he had no thoughts of suicide or self-harm and the nurse concluded that he was stable. She planned to see him again two weeks later.

38. On 20 January, the man set fire to the bed in his cell. When the cell was opened he was sitting with a t-shirt over his mouth and nose. He was taken to the segregation unit, found guilty of a disciplinary offence and punished by three days cellular confinement. Healthcare staff reviewed him daily. Although it was recorded in the medical record that an ACCT was opened, neither prison could find this document. He said he wanted to go back to the healthcare centre, but accepted that he was not ill enough. On 23 January, the psychiatric nurse reviewed him and concluded that he was not acutely psychotic and did not have any current thoughts of self-harm. She continued to monitor him over the next month, as he settled onto the wing.

39. On 5 March, the man was interviewed by a psychiatrist for the court before sentencing. The psychiatrist assessed him as not suffering from a mental illness or disorder of any kind. The psychiatrist noted that he appeared to have had a brief psychotic episode at the prison, because of the stress of his court case, but this was now resolved.

40. On 12 March, the man received an indeterminate sentence for public protection, with a minimum of 8 years to serve before he would be considered for parole. Four days later, on 16 March, he jumped from the wing landing with a ligature around his neck that was tied to the landing rail, which snapped and he fell onto the safety netting below. He suffered some minor bruising. An ACCT was opened and he was moved to a gated cell in the healthcare centre on constant supervision. He said he was shocked at the length of his sentence. At an enhanced case review on 20 March, his risk was still assessed as high and he remained constantly supervised. On 26 March, his observations were reduced to hourly.

41. A “near-miss report” was completed after the man’s attempted suicide, which found that staff on the wing acted professionally and correctly. However, the report concluded that officers should have been alert to his increased risk around the time of his sentence.

42. On 28 March, the man told the psychiatrist that he had stopped taking his medication and agreed to try another antipsychotic drug, olanzapine. At a multidisciplinary care planning meeting on 30 March, it was agreed that his

psychotic symptoms were resolved. He was discharged from the healthcare centre to the wing on 10 April.

43. Senior Officer (SO) A chaired an ACCT case review on 21 April, when the man said he was happy on the wing and had no thoughts of self-harm or depression. A nurse was present and confirmed that he was taking his medication as prescribed. All present agreed to close the ACCT.

44. The man saw his offender supervisor a number of times between 1 and 23 May to discuss his sentence plan. The offender supervisor described him as unmotivated. He told the offender supervisor that he often misled the in-reach nurse, such as by telling her he slept well when he did not. The offender supervisor passed this onto the in-reach team.

45. On 25 June, SO B from the safer custody team recorded in his case history record that the man's appeal result might trigger self-harm. The senior officer described his concerted suicide attempt after he had been sentenced (when he jumped from the landing on 16 March) and alerted officers that the outcome of his appeal was coming up. (This entry was eventually printed out and stapled into the wing observation book at Swaleside.)

46. On 26 June, the man gained enhanced status under the prison's incentives and earned privileges scheme. The next day he got a job as a wing cleaner. The psychiatric nurse reviewed him on 28 June and described him as stable, very happy, and interacting appropriately with other prisoners. She planned to review him again in three weeks.

47. SO B emailed the Safer Custody department at Swaleside on 28 June, when he learned that the man was to be transferred there. He explained that he had previously made a concerted suicide attempt and been on an ACCT, which had been closed. The SO wrote that his appeal process was ongoing, and depending on the outcome, might trigger a further episode of self-harm. A SO from Swaleside's safer custody team, forwarded the information to reception and the induction wing.

Transfer to HMP Swaleside

48. On 2 July, the man transferred to Swaleside. A nurse at Wormwood Scrubs had assessed him as fit for transfer and noted his mental health issues on the escort record. (The nurse said that she attached a document to the escort record, which had details of his medication. This document has never been found.)

49. Nurse A, who had recently retired from Swaleside and worked some shifts as an agency nurse, completed the man's initial health screen at Swaleside. At interview, the nurse said that he was not familiar with SystmOne (the electronic medical records, which had been introduced since his retirement). He asked the Head of Healthcare to help him record the health screen information on the computer. However, the nurse unwittingly registered him incorrectly, which meant that his medical records from Wormwood Scrubs

were not accessible. Therefore, the nurse had to rely on his account of his medical history in custody.

50. The nurse described the man as forthcoming during the health screen, and he told him that he had self-harmed because he had received a long sentence. The nurse thought he was happy to be at Swaleside and progressing with his sentence.

51. The nurse recorded that the man had previously seen the mental health team and received medication for mental health problems. The nurse referred him to the primary care mental health team because of his history of self-harm and adjustment problems, but noted that he was settled, and taking olanzapine. (There is no record of the referral.) At the end of the entry, the nurse wrote "Olanzapine 5mg tablet". He could not accurately recall whether he made that entry because he had given him the medication, or whether he was just recording the details of his prescription.

52. There was no evidence to confirm that the man's medication or prescription chart transferred with him, or that he received his medication after the transfer. The prescription chart was not updated after he left Wormwood Scrubs. If he arrived without a prescription or medication, he should have been referred to the doctor, but he was not.

53. An induction officer spoke to the man on 2 July, and had seen the SO's message about his risk factors. She recorded that he was happy to be at Swaleside and keen to settle and progress with his sentence. He talked about his recent suicide attempt, but said he was keen to forget the incident and move on.

54. On 10 July, the psychiatric nurse from Wormwood Scrubs spoke to Nurse B from Swaleside's in-reach team, because she had discovered the man had been transferred. She told Nurse B that he had a history of self-harm, and described him as a very impulsive person. She explained that he had been more stable since his suicide attempt in March, but his presentation could be misleading. Nurse B tried to access the previous medical notes on SystmOne but was unable to do so. (This was because of the mistake in entering his details on SystmOne when he arrived at Swaleside.) He added him to the list of mental health in-reach referrals for consideration at the next meeting.

55. On 12 July, a mental health practitioner in the in-reach team went to see the man to complete a triage assessment in preparation for the in-reach referral meeting. In the absence of the previous medical records, she relied on his recollection of his treatment. He told her that he had been prescribed medication at Wormwood Scrubs but he did not know why and said that he was not currently prescribed anything. He said that he previously been diagnosed with paranoid schizophrenia, although there is no other evidence of this diagnosis. He said that he did not need support from the mental health team.

56. The man told the mental health practitioner that he had no history of self-harm or suicide, and no thoughts of doing so. She knew of his previous attempt, but did not want to challenge him. She recorded that it was difficult to determine any underlying mental health issues, because of his closed body language and his reluctance to speak to her. She intended to discuss her assessment at the next in-reach multidisciplinary meeting due to take place on Wednesday 18 July. The meeting was later cancelled because a local counselling agency could not attend. She said that she did not think that he was at risk of self-harm. She did not chase up his mental health records, or check that they were being sought.

57. On 13 July, the man moved to C wing at Swaleside. On Saturday 14 July, acting SO C received a phone call from the prison's offender management unit (OMU) which had received a message from his community probation officer (offender manager). The probation officer wanted to make sure that the prison was aware of his self-harm at Wormwood Scrubs and that a change in routine might trigger a deterioration in his mental health. After the phone call, the SO called him up to the wing office, recorded the conversation in the wing observation book and in his case history:

> "Had a chat with him with regard his previous self-harming in custody. He states that it was due to the environment that he was in at the time and that he is happy at Swaleside thus far. I reminded him of the Listeners and told him that the officers here have far more time to talk to him if he felt he wasn't coping well. At the moment in time, I do not feel that the ACCT document is warranted in his case."

58. On 15 July, the SO spoke to the man again to complete the C wing compact, and he asked about getting a job. He told the senior officer that he was not optimistic about his appeal.

59. One of the man's personal officers on C wing (personal officers should provide a first point of contact and support) remembered speaking to him about his outstanding appeal, and he asked her how to put in an application for prison issue clothing. She could not remember when she had this conversation with him, and made no record of it.

Appeal result

60. On 16 July, the man's offender supervisor at Wormwood Scrubs emailed Swaleside because his application for leave to appeal against his conviction had been refused. This was also discussed on the telephone by two operational managers from each prison and it was agreed that someone from the OMU would see him that day. His allocated offender supervisor was away so at about 2.30pm, SO D and an officer from OMU went to see him, to let him know that his appeal had been unsuccessful. In preparation, the SO looked at his OASys (a probation assessment) and quickly checked some details about his offending history.

61. The SO described the man as totally unfazed by the news. He told her that it was his first offence and initially he had reacted very badly in custody but he had now been in prison for a year, was engaged with his sentence plan and planned to do all his courses. The officer recalled that his colleague spoke to the man about his previous conduct in prison and that he would need to control this if he was going to progress through the system.

62. When the SO said that officers were worried because of his previous suicide attempt, the man said he had no intention of killing himself and looked around the cell and asked “how would I”. The officer recalled that he asked "how can I do it here, I’m being watched all the time”. An Acting SO was briefed by the SO both before and after seeing the man and updated the wing observation book:

> “He has been informed that his appeal has been turned down. He has a history of self-harm and previously stated that he’d kill himself if he failed in his appeal. However, when given the news by OMU he states that he had no feelings of self-harm.”

63. The Acting SO said that he spoke to the man during his time on the wing but not in any depth. He said he had no concerns about him and he was mixing with other prisoners.

64. On 19 July, the man reassured his personal officer that he was okay. She said that he came out for association and wandered around a bit at about 6.10pm. The wing was locked up at 7.45pm and the officer locked his cell door. She recalled that they spoke about clothing. He said he had forgotten to make an application for prison clothes and she told him to give it to her in the morning. She had no concerns about him at this time. This was the last time any member of prison staff spoke to him.

Events leading up to the incident

65. On the night of the incident an OSG was working on the wing. He was aware that the man had a history of self-harm but had had no contact with him. At about 5.30am, the OSG started the roll check. The man’s cell was the last one he checked that morning and the roll check took about 20 minutes. He said he opened the observation flap, thought that he was sleeping in a strange position, closed the flap and moved away from the door. Very quickly, he realised something was not right and returned to the cell. He said the man was leaning against the wall with his arm resting on the bed and it looked like he was sitting on a chair. He opened the flap again and saw a piece of torn sheeting tied to the window. He knocked a few times on the door without getting a response. The OSG then left the landing to telephone the senior officer.

66. The nearest telephone was on the next floor up in the wing office and the OSG said it took him about a minute to get there. At interview, he said that if he had thought the man was alive he would radioed for help, but thought he was dead so wanted to explain the situation over the telephone. At 5.50am,

the told an officer that a prisoner had died and then said he waited outside the cell. The OSG had worked nights for 20 years and had never used his cell key kept in a sealed pouch for quick entry to a cell in an emergency. He said he had always been trained to wait for back up, even in a life-threatening situation.

67. The officer was second in charge of the prison that night and was based in the operations room. Once he had spoken to the OSG at 5.50am, he contacted the night manager and healthcare by telephone. On his way to the wing, the officer collected a nurse from the healthcare centre. He estimated this took five minutes. The night manager was in the gate preparing to open the prison for day staff arriving when the officer phoned. He went to the wing and arrived at the same time as the others.

68. The officer opened the cell and immediately used his anti-ligature knife to cut the bed sheet, which was around the man's neck, and then supported his weight. He said that the indentation in his neck was very deep and there were signs of rigor mortis. The nurse was unable to find a pulse. She and the night manager decided not to carry out cardiopulmonary resuscitation (CPR). The officer radioed to request an ambulance at 5.58am. The man was pronounced dead at 6.18am by paramedics when they arrived.

Contact with the man's family

69. An operational manger (and the prison's family liaison officer) was informed of the man's death, and arrived at the prison at about 8.00am. After discussion with the deputy governor and the Imam, it was agreed that he should contact the man's mother by telephone, as they decided that it would take too long to drive to her home in West London.

70. The operational manager telephoned the man's mother at 9.15am, who was so shocked she dropped the telephone. He called back and tried to call the man's brother and sister, but no one answered. At 10.15am, a London police officer rang the prison to check that the man was dead. (A neighbour had called the police after hearing her distress.) At 10.30am, the man's sister telephoned the prison. Arrangements were made to meet his family later that afternoon, at the hospital where he had been taken. The prison paid the funeral expenses.

The post-mortem report

71. The post-mortem examination concluded that the man's death was caused by hanging. A toxicology analysis of his blood found that he had a blood alcohol level of 54mg/100 mls when he died (the limit for those driving is 80mgs/100 mls). No olanzapine was detected in his blood.

ISSUES

Management of self-harm at Wormwood Scrubs

72. While at Wormwood Scrubs, the man set fire to his cell on two occasions, 16 November 2011 and 20 January 2012. Before the first cell fire, he had been described as suffering from a psychotic illness and behaving in a disturbed manner. Both times he was taken to the segregation unit found guilty of an offence under Prison Rules after adjudications. It is recorded in his medical record that an ACCT was opened after the second incident, but a copy of this has never been found by Swaleside or Wormwood Scrubs. There is no other evidence that prison staff considered whether he had started the fires as acts of self-harm.

73. Prison Service Instruction 47-2011 which sets out prison discipline procedures states that:

> "…If a prisoner's actions involved an act of self-harm, or preparation for such an act, it would not normally be appropriate to lay a charge for an alleged disciplinary offence, but this may be done exceptionally if others were endangered (for example, by starting a fire.) In such a case the adjudicator should take account of the accused prisoner's state of mind at the time of the incident…"

There is no evidence that in laying the charge or at the adjudication that full consideration was given to his state of mind at the time and whether his actions amounted to acts of self-harm.

The Governor of Wormwood Scrubs should ensure that full consideration is given as to whether a prisoner's action in setting a fire amounts to an act of self-harm before laying a disciplinary charge and at adjudication if a disciplinary charge is brought.

74. Prison Service Instruction (PSI) 64/2011 Safer Custody requires that prisoners subject to ACCT are segregated only in exceptional circumstances and the reasons should be clearly documented in the ACCT plan. No ACCT was opened after the man's first fire, and the ACCT following the second fire is missing. Important information about whether the prison complied with the requirements of the PSI is therefore missing. In the absence of this evidence, we make the following recommendation:

The Governor of Wormwood Scrubs should ensure that prisoners on open ACCTs are segregated only in exceptional circumstances, and the reasons are fully documented in the ACCT plan.

Assessment of the man's risk at Swaleside

75. After the man's attempted hanging on 16 March 2012, a report was completed which concluded that officers should have been aware of his increased risk

when he was sentenced. The report was sent to Swaleside before he was transferred.

76. Before the man's transfer, SO B from Wormwood Scrubs' safer custody department, emailed his counterpart at Swaleside about his self-harm history and risks, noting in particular that a rejection of his appeal might be a trigger for self-harm. A SO forwarded copies of his email to reception and induction officers at Swaleside. Further exchanges took place between the man's offender supervisor, outside probation officer and staff at Swaleside. Information about his risk was therefore passed to Swaleside both in advance of his transfer and once he had been transferred.

77. After Wormwood Scrubs had contacted Swaleside to remind them of the associated risk, SO D and an officer told him personally that his appeal had been rejected. Although she looked at his OASys, the SO told the investigator that she focussed on the details of his offence, rather than his previous self-harm. She thought he reacted well to the news that his appeal had been unsuccessful. Both she and the officer were reassured when he said that he was not thinking of killing himself because he had no means to do so. Neither the SO nor the officer had met him until that day.

78. We have considered whether staff should have opened an ACCT plan after the man's appeal was rejected, particularly as we have been critical in the past when prison staff place too much reliance on what the prisoner tells them and ignore the weight of other risk related information. Staff judgement is fundamental to the ACCT system. At its core, the system relies on staff using their experience and skills, as well as local and national assessment tools, to determine risk. It is not an exact science. However, we are concerned that staff relied so heavily on the man's presentation, in the face of so much information from officers that knew and had supported him at Wormwood Scrubs. Staff at Wormwood Scrubs were so concerned about his possible reaction to a rejected appeal that they rang Swaleside to remind them when his appeal was coming up.

79. 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 to make a judgement of risk. All risk factors must be collated and considered to ensure that a prisoner's level of risk is holistically judged. We consider that more weight should have been given to the known risk factors in comparison to the man's presentation.

The Governor of Swaleside should ensure that, when assessing a prisoner's risk of suicide and self-harm, staff attach sufficient weight to known risk factors, particularly triggers identified by those who know the prisoner well.

Initial health screen at Swaleside

80. Nurse A said he was not familiar with the computerised medical records system in use across the prison estate (known as SystmOne) when he completed the initial health screen. He asked the Head of Healthcare to help him. He entered the man's details into the computer, but inadvertently used a shortcut which meant that the medical records from Wormwood Scrubs did not merge with his new entry and the previous records were not accessible.

81. The investigator asked the IT company responsible for the system to review the man's files to determine why his previous medical records were not available to staff at Swaleside and whether this was a problem with the system rather than user error.

> "Our understanding to date is that Swaleside prison used the Incoming Arrivals screen to add a patient to their prison. This screen is not designed for this purpose, but rather to allow a prison to list expected admissions. Registration of the record, with the linked transfer of information from previous prisons, is performed via the LIDS upload process or via the normal registration screen.
>
> The creation of a record that does not contain the full historical data from the previous prison has occurred by a use of the system that was not foreseen, nor is part of our training material which instructs users to use the registration process to register a new patient. However, the fact that it can occur is not ideal and this functionality has been suspended (as of today)."

82. SystmOne, used properly, should ensure inter-prison access to clinical records to promote continuity of care. The man had had an extensive history of medical intervention at Wormwood Scrubs including a diagnosis of a possible psychotic illness and prescription of antipsychotic medication. Although he told Nurse A some of these details, it is dangerous to rely on an individual prisoner's account of his medical history. While the IT company has removed the possibility of the error which occurred being repeated, it is important that all those using SystmOne are trained and confident in its use to ensure appropriate continuity of care.

The Head of Healthcare at Swaleside should ensure that all healthcare staff are trained in the use of SystmOne and are about to retrieve records to ensure appropriate continuity of care.

83. Nurse A, the Head of Healthcare and the mental health in-reach team were all aware that the man's previous medical records could not be accessed from SystmOne. Despite the initial mental health screen on 12 July, there is no evidence that anyone contacted Wormwood Scrubs at any point to retrieve his medical record, or check his immediate clinical needs.

The Head of Healthcare at Swaleside should ensure missing medical records are obtained from other prisons as soon as possible after transfer.

Medication and prescription charts

84. Before he was transferred from Wormwood Scrubs, a nurse indicated on the escort record that the man was prescribed medication, but gave no further details. The nurse said that she had attached a document with details of his medication, but this has never been found.

85. The man told Nurse A at Swaleside that he was prescribed olanzapine. At interview, the nurse could not recall clearly whether he had medication with him, or if he gave him some. Swaleside's Head of Healthcare explained that if he had arrived with antipsychotic medication he would not need to see the doctor, but would be referred to the in-reach team via the primary mental health team. If there was no medication then he would be booked to see the GP the next day. He was not referred to the GP.

86. The man's prescription chart was not updated by anyone at Swaleside. The Head of Healthcare said that healthcare staff would speak to a prisoner if he failed to collect his medication for three consecutive days. His prescription chart confirms that he was prescribed 5mg olanzapine at Wormwood Scrubs and there is no evidence that he collected his medication in the 17 days he was at Swaleside, or that anyone spoke to him about missing his medication.

87. The clinical reviewer suggests that the man responded well to the antipsychotic medication and it might have helped him to cope with the news of the appeal. Whatever the impact of his medication, he had been prescribed it and it was the prisons' responsibility to ensure he received it.

The Heads of Healthcare at Wormwood Scrubs and Swaleside should ensure that full information relating to prescriptions and medication are clearly recorded in a prisoner's medical record and transferred with a prisoner.

Mental health referral

88. At the initial health screen on 2 July, Nurse A recorded that he referred the man to the primary care mental health team (which acts as a gateway assessment to the in-reach team). That same day, the management of the mental health team transferred to a new provider. The Head of Healthcare believed that this could have contributed to the loss of that referral. There is no other record of Nurse A's referral.

89. It was not until the community psychiatric nurse from Wormwood Scrubs called Swaleside on 10 July to discuss the man, that the mental health team at Swaleside became aware of him. A mental health practitioner carried out an initial assessment of him on 12 July, and although she said that she did not

have any concerns about his risk, she decided to discuss him at the next weekly in-reach referral meeting with the consultant psychiatrist on 18 July.

90. The meeting was cancelled with little notice, because an external counselling service could not attend. The mental health practitioner therefore did not get the opportunity to discuss the man. We agree with the clinical reviewer that:

> ”multi-disciplinary meetings should not be cancelled if certain members are not able to attend, unless it is considered their presence is vital to making a clinical judgement”.

91. The man was supported by the mental health in-reach team at the time he transferred from Wormwood Scrubs. We agree with the clinical reviewer that his mental health support should have continued at Swaleside.

The Head of Healthcare at Swaleside should ensure that prisoners requiring mental health assessment receive these in a timely manner.

Emergency Response

92. An OSG found the man during his morning roll check at about 5.50am. He did not enter the cell or summon help by using his radio, but went upstairs to the office to use the telephone. Although he had long experience, he said that he did not consider entering the cell because he had been trained to wait for other staff, even in a life-threatening situation. We are surprised at this response as Swaleside’s night instructions outline that any member of staff can enter a cell if a situation is assessed as life-threatening without the duty governor’s approval. Night staff carry a sealed cell key for this purpose.

The Governor of Swaleside should ensure that all staff are familiar with the night time protocols for opening a cell and, subject to a personal risk assessment, should enter a cell in a life-threatening situation.

93. The OSG did not request an ambulance and one was not called until an officer reached the cell at least eight minutes after the man had been found. A letter written jointly to all prison governors and Primary Care Trusts by the Chief Executive of National Offender Management Services (NOMS) and the Director of Offender Health on 17 February 2011, made it clear that where there are concerns about the immediate health of a prisoner an ambulance should be called.

94. In March 2012, the Governor of Swaleside issued the following instruction to staff:

> “If the injury/health matter is serious enough: Heart attack / Suicide attempt / Assault and it looks like hospital treatment will be required, staff should contact communications and request they call an ambulance for you. You do not need to wait for Hotel 1 [emergency medical response] to arrive for an ambulance to be called.”

95. That instruction does not appear to have been followed. Although in this case it is apparent that the man could not have been saved it is essential that ambulances are called immediately in an emergency. Any delay has a significant impact on a person's chances of survival. After the death of a prisoner at Swaleside in March 2012, we recommended that an ambulance should be called as soon as possible in an emergency. Although the report was not issued until August, we drew the Governor's attention to this in feedback written in April. We repeat the recommendation:

The Governor of Swaleside should ensure that all staff call an ambulance at the earliest opportunity in the event of an emergency.

96. Although the OSG did not go into the cell, he concluded that the man had died. He decided to communicate the situation over the telephone, which meant that the control room was not immediately aware of the emergency. The OSG explained that if he had considered that he might was still alive, he would have used the radio. Because he thought he was dead, he wanted to explain the situation fully over the telephone. The OSG's decision was compounded by the assistant night manager and the night manager, who also did not use their radios until they arrived at the scene, about eight minutes later. Radios and code systems should be used to communicate an emergency to all staff on duty at night to ensure a prompt and appropriate response.

The Governor of Swaleside should ensure that all staff use their radio and the code system in an event of a medical emergency.

Hooch (prisoner brewed alcohol)

97. The man was found to have a blood alcohol level of 54mg/100ml at the post-mortem. (The prescribed limit for those driving is 80mg/100mls.) Hooch is a common problem within the prison estate. The investigator reviewed intelligence and security reports from his time at Swaleside, but found no concerns about hooch (the most recent report was submitted a month before he arrived at the prison). As hooch is made from the fermenting of everyday foods, it is difficult for prisons to eliminate its production. Since his death, Swaleside have conducted its own investigation into the use of hooch on his wing at that time.

Family contact

98. Prison Service Instruction (PSI) 64/2011 instructs that "wherever possible, the FLO and another member of staff must visit in person the next of kin or nominated person to break the news of the death". The prison FLO agreed with a governor that due to the time of day and the distance involved (about 60 miles), the news of the man's death should be broken over the telephone to avoid delay.

99. Because of the shock she received the man's mother's phone was disconnected when she was first told the news of her son's death. The prison

FLO could not re-establish contact for some time after that. This reinforces the importance of promptly breaking the news to families after a prisoner has died in person, to avoid confusion and to ensure that families' have appropriate support. As her home was a relatively short distance from the prison, we believe someone from the prison should have travelled to see her. We do not consider that it was reasonable to break the news by telephone and, in line with Prison Service guidance, at the very least the prison should have considered contacting a nearer prison to send a representative on their behalf to ensure that she was not left alone and unsupported when told of her son's death.

The Governor of Swaleside should ensure that, wherever possible, the family liaison officer and another member of staff visit a deceased prisoner's next of kin in person to break the news of the death.

RECOMMENDATIONS

1. The Governor of Wormwood Scrubs should ensure that full consideration is given as to whether a prisoner's action in setting a fire amounts to an act of self-harm before laying a disciplinary charge and at adjudication if a disciplinary charge is brought.

2. The Governor of Wormwood Scrubs should ensure that prisoners on open ACCTs are segregated only in exceptional circumstances, and the reasons are fully documented in the ACCT plan.

3. The Governor of Swaleside should ensure that, when assessing a prisoner's risk of suicide and self-harm, staff attach sufficient weight to known risk factors, particularly triggers identified by those who know the prisoner well.

4. The Head of Healthcare at Swaleside should ensure that all healthcare staff are trained in the use of SystmOne and are about to retrieve records to ensure appropriate continuity of care.

5. The Head of Healthcare at Swaleside should ensure missing medical records are obtained from other prisons as soon as possible after transfer.

6. The Heads of Healthcare at Wormwood Scrubs and Swaleside should ensure that full information relating to prescriptions and medication are clearly recorded in a prisoner's medical record and transferred with a prisoner.

7. The Head of Healthcare at Swaleside should ensure that prisoners requiring mental health assessment receive these in a timely manner.

8. The Governor of Swaleside should ensure that all staff are familiar with the night time protocols for opening a cell and, subject to a personal risk assessment, should enter a cell in a life-threatening situation.

9. The Governor of Swaleside should ensure that all staff call an ambulance at the earliest opportunity in the event of an emergency.

10. The Governor of Swaleside should ensure that all staff use their radio and the code system in an event of a medical emergency.

11. The Governor of Swaleside should ensure that, wherever possible, the family liaison officer and another member of staff visit a deceased prisoner's next of kin in person to break the news of the death.

ACTION PLAN: The Man at HMP Swaleside

No	Recommendation	Accepted/Partially accepted/Not accepted	Response	Target date for completion	Progress (to be updated after 6 months)
1	The Governor of Wormwood Scrubs should ensure that full consideration is given as to whether a prisoner's action in setting a fire amounts to an act of self-harm before laying a disciplinary charge and at adjudication if a disciplinary charge is brought.	Accepted	PSI47/2011 states "…If a prisoner's actions involved an act of self-harm, or preparation for such an act, it would not normally be appropriate to lay a charge for an alleged disciplinary offence, but this may be done exceptionally if others were endangered (for example, by starting a fire.) In such a case the adjudicator should take account of the accused prisoner's state of mind at the time of the incident…" Adjudicating Governors and the segregation staff will be instructed to take the above statement into account before laying or hearing a charge were self harm is in question. A Governors Order will be published to outline the responsibilities.	30-08-2013	
2	The Governor of Wormwood Scrubs should ensure that prisoners on open ACCTs are segregated only in exceptional circumstances, and the reasons are fully documented in the ACCT plan.	Accepted	PSI 64/2011 Safer Custody requires that prisoners subject to ACCT are segregated only in exceptional circumstances and the reasons should be clearly documented in the ACCT plan. We routinely located R45 own protection into the segregation unit some of these are on open ACCT documents. A new system of managing ACCT's located into the segregation unit as been published. There is now a requirement for an enhanced review to take place chaired by a manger F or above. All reviews on open ACCT documents will fall within the same guidance.	Completed	
3	The Governor of Swaleside	Accepted	Governor to issue a Notice to Staff to ensure the	31st January 2013	

	should ensure that, when assessing a prisoner's risk of suicide and self-harm, staff attach sufficient weight to known risk factors, particularly triggers identified by those who know the prisoner well.		views of those who know the prisoner well are taken into account when assessing self harm cases		
4	The Head of Healthcare at Swaleside should ensure that all healthcare staff are trained in the use of SystmOne and are about to retrieve records to ensure appropriate continuity of care.	Accepted	Head of Healthcare to ensure all staff are trained in SystmOne	31st January 2013	
5	The Head of Healthcare at Swaleside should ensure missing medical records are obtained from other prisons as soon as possible after transfer.	Accepted	Head of Healthcare to implement	31st January 2013	
6	The Heads of Healthcare at Wormwood Scrubs and Swaleside should ensure that full information relating to prescriptions and medication are clearly recorded in a prisoner's medical record and transferred with a prisoner.	Accepted	In September 2012, Healthcare at HMP Wormwood Scrubs moved over to a fully electronic patient records system, which includes the prescribing of medication and recording of medicines administered. The system used is SystmOne which is used across all Prisons in England. This allows the healthcare record to follow the prisoner from one prison to another to ensure all clinical information about the prisoner is instantly accessible on arrival.	Completed	Accepted
7	The Head of Healthcare at Swaleside should ensure that prisoners requiring mental health assessment receive these in a timely manner.	Accepted	Head of Healthcare to implement	31st January 2013	
8	The Governor of Swaleside should ensure that all staff are familiar with the night time	Accepted	Governor to issue a Notice to Staff to remind staff of their responsibilities when dealing with a life threatening situation	31st January 2013	

	protocols for opening a cell and, subject to a personal risk assessment, should enter a cell in a life-threatening situation.				
9	The Governor of Swaleside should ensure that all staff call an ambulance at the earliest opportunity in the event of an emergency.	Accepted	Governor to issue a Notice to Staff to remind staff of their responsibilities when dealing with a life threatening situation	31st January 2013	
10	The Governor of Swaleside should ensure that all staff use their radio and the code system in an event of a medical emergency.	Accepted	Governor to issue a Notice to Staff to remind staff of their responsibilities when dealing with a life threatening situation	31st January 2012	
11	The Governor of Swaleside should ensure that, wherever possible, the family liaison officer and another member of staff visit a deceased prisoner's next of kin in person to break the news of the death.	Accepted	Wherever possible Next of Kin will be informed in person when news of a deceased prisoner is broken	31st January 2013	