

A Report by the  
Prisons and  
Probation  
Ombudsman  
Nigel Newcomen CBE

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**Investigation into the death of a man in January 2013  
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. He was charged with a serious offence against a family member and remanded to HMP Wormwood Scrubs in December 2012. He was found hanging in his cell in January 2013. He was 45 years old. I offer my condolences to his family and friends.

A clinical reviewer conducted a review of the clinical care the man received at Wormwood Scrubs. The prison cooperated fully with the investigation.

When he arrived at Wormwood Scrubs, the man was not identified as a risk of suicide or self-harm and this risk was not assessed again while he was at the prison. This was despite the fact he had a number of factors known to increase this risk which were either not known to reception staff or not fully considered. Subsequently, prison staff had very little contact with him. Because Wormwood Scrubs does not operate a personal officer scheme, no individual member of staff was responsible for getting to know him and checking on his welfare. He withdrew from the prison regime, did not associate with other prisoners and spent most of his time locked in his cell. No one noted his withdrawal or knew him well enough to assess his state of mind.

In a previous investigation at Wormwood Scrubs, the prison rejected a recommendation that named officers should be responsible for individual prisoners. The prison said that they were not required to do this and suggested that all prison officers were responsible for prisoners' welfare. Unfortunately, it is evident from cases such as the man's, particularly in busy local prisons, that when all officers are regarded as responsible for individual prisoners without any specific accountability, there is a risk that, in reality, none are.

The Governor of Wormwood Scrubs needs to introduce a system that ensures individual prisoners do not disappear from the sight. There is also a need to ensure that staff making assessments about the risk of suicide and self-harm have all the information they need to make a properly informed decision, and that they consider all the known risk factors rather than relying on a prisoner's personal presentation at the time.

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

**Nigel Newcomen CBE**  
**Prisons and Probation Ombudsman**

**July 2013**

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## SUMMARY

1. The man was remanded into custody at HMP Wormwood Scrubs on 14 December 2012, charged with rape. He had last been in prison between 1996 and 2004 during which time he had self-harmed and had mental health problems.
2. When the man arrived at the prison he said he had no current thoughts of self-harm and had no mental health, drug or alcohol problems. Prison officers in reception knew about the charges he faced, but the nurse who completed his reception health screen was not given this information.
3. There were only two brief written observations from wing staff in the man's record while he was at Wormwood Scrubs, neither of which demonstrated any individual knowledge about him, except that he was quiet and compliant. Staff did not record any concerns. It appears that he did not socialise with others and as he had no allocated activity, he was locked in his cell for most of the time. He told another prisoner that he was depressed, although the prisoner said that they also joked together when they talked.
4. His solicitor saw him on 15 January, a few days before his death. She thought his mood was low but was not surprised by that as she knew he understood the seriousness of his position and that he faced a long sentence, if convicted.
5. The day before the man's death, he telephoned a friend who was concerned that he had refused to have visits from his friends and family. He told her that he would find visits too difficult but that he was okay. His friend reassured him that he was well supported. Later that day he gave a friend he talked to on the wing, two bottles of soft drinks and a pack of biscuits which he had bought at the prison shop. His friend did not consider that he intended to harm himself.
6. At around 3.30pm on the day of the incident, the man's friend was returning to his cell and decided to speak to him as he went past his cell. When he looked through the cell observation hatch, he saw him apparently standing immobile at the end of the cell. He knew something was wrong and then realised that he appeared to have hanged himself. He alerted a prison officer on the landing who went straight to the cell and sounded a general alarm for assistance.
7. The officer went into the man's cell and found him hanging from a bed sheet attached to the window bar. She was quickly followed by other officers who cut the sheet from his neck and radioed an emergency code which automatically led to an ambulance being called. Two nurses arrived and began cardiopulmonary resuscitation (CPR<sup>1</sup>). They were quickly joined by other nurses and the prison doctor followed shortly afterwards by paramedics. They were unable to resuscitate him, who was declared dead at 4.37pm. An apparent suicide note was found in his cell.
8. This investigation has found that the man had a number of factors which increased his risk of suicide and self-harm which were not properly taken into account when he was assessed in reception when he first arrived at the prison. There was little further recorded staff interaction with him during his time in the

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<sup>1</sup> Cardiopulmonary resuscitation (CPR) is a technique where oxygen is pumped around the body using a combination of chest compressions and rescue breaths.

prison as Wormwood Scrubs does not operate a personal officer scheme. We make recommendations about the assessment of risk, sharing offence details with appropriate staff and contact with the family.

## THE INVESTIGATION PROCESS

9. The Ombudsman's office was informed of the man's death on 19 January 2013. The investigator issued notices to staff and prisoners at HMP Wormwood Scrubs to inform them of the investigation and asking anyone with relevant information to contact him. One prisoner responded and was interviewed.
10. HM Coroner for West London District was informed of the investigation. The Coroner provided a copy of the post-mortem report. A copy of this investigation report has been sent to the Coroner.
11. The local Primary Care (PCT) appointed a clinical reviewer to review the man's clinical care at Wormwood Scrubs. He was given a copy of the man's prison records.
12. The investigator reviewed the man's prison records. On 4 and 5 March 2013, he and the clinical reviewer interviewed eight members of prison and healthcare staff.
13. One of the Ombudsman's family liaison officers (FLO) contacted the man's brother and sister and explained the investigation process. His brother raised the following issues:
  - The level of contact his brother had with staff.
  - Whether previous medical and prison records retrieved, in particular about his previous suicide attempts and mental health treatment.
  - Should he have been identified as at risk of self-harm because of his previous suicide attempts?
14. The man's family received a copy of the draft report. They raised a number of issues/questions that do not impact on the factual accuracy of this report and have been addressed through separate correspondence.

## **HMP WORMWOOD SCRUBS**

15. HMP Wormwood Scrubs is a large local prison in West London which can hold more than 1,200 adult male prisoners. In addition to the five main residential units, there is an induction unit, an inpatient healthcare centre, a dedicated drug stabilisation unit and a segregation unit. Health services are commissioned by Hammersmith and Fulham PCT. Primary care services are provided by Central London Community Health NHS Trust and mental health services Central North West London NHS Foundation Trust.

### **Her Majesty's Inspectorate of Prisons (HMIP)**

16. The most recent inspection of Wormwood Scrubs was a full unannounced follow-up inspection in June 2011. While the Inspectorate noted a number of improvements, it also found that there was no personal officer or other named officer scheme to ensure that nominated officers had responsibility for overseeing the progress and welfare of individual prisoners. Case note entries did not provide a useful record of a prisoner's time at Wormwood Scrubs and most entries were observational or functional. HMIP recommended:

"A named officer should be aware of the individual needs of prisoners for whom they are responsible. They should provide input and advice on matters relating to their prisoners, encourage family contact and keep a regular record of contact in case notes identifying any significant events."

17. The Inspectorate noted some improvements in healthcare services but that there were problems with the healthcare appointments system, which led to a high rate of non-attendance.

### **Independent Monitoring Board**

18. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who monitor all aspects of prison life to help ensure that proper standards of care and decency are maintained. In its 2012 annual report the IMB was concerned that further cuts to the prison's budget would affect the welfare of prisoners. They commented that prisoners stayed at Wormwood Scrubs for an average of just 10 weeks and that several workshops had been closed, making rehabilitation unlikely to be achieved. The IMB considered that relationships between staff and prisoners were generally good but they were concerned that some prisoners had contacted the Board to say they did not feel safe on their wings and had reported negative behaviour by some individual prison officers.

### **Previous deaths at Wormwood Scrubs**

19. In the last two years, there has been one other self-inflicted death at Wormwood Scrubs. One of the issues identified in that investigation was that prison staff knew very little about the prisoner, who was a quiet and compliant man. Similar to the man, this prisoner was charged with serious offences against a family member yet this and other risk factors for suicide and self-harm were not identified.

## KEY EVENTS

### Previous custody

20. The man was from Northern Ireland, where he had spent two years in a Young Offenders' Institution (YOI). When he was released, at the age of 18, he moved to London.
21. In 1996, the man was sentenced to 12 years imprisonment for rape. Soon afterwards, he made a series of determined attempts to kill himself at HMP Brixton. These included slashing his wrist and abdomen, pouring boiling water and bleach over himself and jumping from a height onto his head and losing consciousness. He also stopped eating for a time and refused any medical intervention.
22. In December 1996, the man was admitted to a Regional Secure Unit because of his suicide attempts. He was provisionally diagnosed with reactive depression because of the length of his sentence. After an assessment period it was decided that he did not have an underlying mental illness and that his self-harm and suicide attempts were aimed at getting out of the prison system. In part this was because it was observed that, after his admission to the secure unit, he did not have any symptoms of depression or mental illness. He remained mentally stable without any medical treatment until he transferred back to prison. In February 1997 he moved from the Secure Unit to HMP Parkhurst. He was subsequently released from prison in April 2004.
23. The man was treated with anti-depressants for a short time in the late 1990s. No further incidents of self-harm were recorded and no other record of psychiatric treatment.

### December 2012

24. On 13 December 2012, the man was arrested and charged with raping his estranged wife in February 2009. He was taken to the police station. While in police custody, no concerns about his mental or physical health were identified. He said he had no thoughts of self-harm and he did not abuse drugs or alcohol. He had no problems reading or writing.
25. On Friday 14 December, the man appeared at Magistrates' Court and was remanded to HMP Wormwood Scrubs. He was to go back to Crown Court on 15 February 2013.
26. Prison reception staff noted it was not his first time in custody, and he had been released from a prison sentence some years previously. The Person Escort Record<sup>2</sup> (PER) recorded that he had been charged with rape and had no medical issues. No risk of self-harm or suicide was recorded. The court warrant noted "Previous conviction for rape, complainant ex-wife".
27. An officer completed the cell sharing risk assessment (CSRA). He considered that the man presented as a standard risk. He requested a quiet cell and/or a quiet cell mate. The officer recorded that if he "doesn't gain his sleep he can

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<sup>2</sup> PER, a document used when escorting a prisoner between prisons, court and police stations which includes risk pertinent information such as risk to others and self

become aggressive". His offence was recorded on the CSRA as rape. Prisoners convicted or charged with sexual offences are often at risk from other prisoners. The officer offered him the opportunity to be kept separate from the general prison population by being allocated to the vulnerable prisoners' wing, which he declined. There is no evidence that the officer considered whether the charges or other factors increased his risk of suicide and self-harm.

28. A nurse said that she had conducted the man's reception health screen at 9.18pm and at the time, was unaware of the nature of his charge. She recorded that he was well, not depressed, was mentally stable and interacted and talked appropriately. Her only recorded concern was his high blood pressure (155/110 mmHg), for which he said that he was taking ramipril<sup>3</sup> (2.5mg). He said he did not know who his GP was.
29. The nurse recorded that the man had told her that he had cut his wrists and throat while in prison in 1997 and had spent some time in a psychiatric hospital in 1997 for depression. He said he had not been prescribed any medication for his mental health at the time. He said his mental health had been fine since then and he had no drug or alcohol issues and no current thoughts of suicide or self-harm. She had no concerns about his mental health. Because of his high blood pressure and the medication he said he had been taking, she referred him to the prison doctor on the First Night Centre. She did not request medical records from the regional secure unit.
30. A doctor, who was based on the First Night Centre that evening, saw the man immediately after he had seen the nurse. He told the doctor that he had a history of high blood pressure but he had not taken his medication (ramipril) for about a week and that he also had high cholesterol. He said he did not know his GP details. The doctor's examination found his mood to be appropriate and that he had no thoughts of suicide or self-harm. He prescribed ramipril 2.5mg capsules (one to be taken daily – 28 capsules).
31. After the man saw the prison doctor, an officer interviewed him and completed a "First Night Urgent Needs Assessment" document. He noted that he had been released from a prison sentence in 2004 and that he did not abuse alcohol or drugs and had no current thoughts of self-harm or suicide. He raised no concerns with reception staff or to the officer.
32. No concerns were noted about the man's first night at the prison. The next morning, 15 December, he moved to B wing to complete his induction. He had a secondary health screen when more details of his medical history were taken. No other health related concerns were identified.
33. In the afternoon the man telephoned a friend and told her that he had had a 10 minute visit from his solicitor and they had discussed his application for bail. His friend had booked a visit for Thursday 17 January, but he told her that he was not in the mood for visits. He told her to cancel the visit and explained that he found it was just too hard at that time to see his friends.

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<sup>3</sup> Ramipril is used to treat high blood pressure and congestive heart failure.

34. On B wing, the man shared a cell with another prisoner. Both smoked, were the same age and got on well with each other. The prisoner told the investigator that the man did not socialise with other people on the wing. He chose to stay in their cell most of the time and slept, usually with a towel covering his head. A nurse had given him ear plugs to help reduce the noise of the wing. He usually only left their cell to collect meals (although he did not eat much), for showers and to make telephone calls.
35. As part of their induction to the prison all new prisoners are asked to complete a literacy and numeracy test. Although this is not compulsory for unconvicted prisoners they are not able to participate in work, education and other prison activities unless they complete it. The man's induction records show that he did not attend the education assessment but no explanation was recorded. The prisoner told the investigator that he was present when an officer asked the man to attend the education tests. He said that he refused and said he was depressed. The prisoner said the prison officer did not pursue this matter with the man or ask about his depression. There was no record of this in his case notes.
36. On 21 December, a doctor recorded that the man's blood pressure was "borderline", at 132/91<sup>4</sup>. He was to have his blood pressure checked weekly and needed a fasting blood test. He told the doctor that he had bought his ramipril from a 'pharmacist friend' in the community. The doctor completed a risk assessment to determine whether he should be allowed to keep his medication in his cell and self-administer. The doctor found no cause for concern. As part of the risk assessment he said he had no thoughts of self-harm.
37. No concerns were recorded about the man over the following days. On 23 December, an officer recorded in his case notes that he was very well mannered towards prison staff. That day, a nurse checked his blood pressure when it was 148/84 mmHg and on 24 December when it was 133/86, both of which were high.
38. On 31 December, the man did not attend an appointment on B wing for a nurse to take his clinical observations. No reason was entered in his medical record.

### **January 2013**

39. A doctor reviewed the man's blood test results on 4 January 2013. The blood tests demonstrated that he had high cholesterol, but the rest of the tests were within normal range. He was to be reviewed again on 11 January.
40. On 5 January, the man moved to D wing, which has mainly single cell accommodation. The man's cellmate also moved to D wing at the same time and both were on the same landing, D3. They maintained their friendship and the prisoner said the man still did not mix with any of the other prisoners. He said he often visited him for a chat in his cell. He had told the prisoner that he was depressed but the prisoner said that he had not been concerned about

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<sup>4</sup> A "normal" blood pressure reading is between 90/60 and 120/80.

his mood. He noted that he had mostly stopped collecting a meal at lunchtime.

41. After the man had moved from B wing on 5 January, an officer from B wing made a retrospective entry in his case notes on 6 January. This said that he was a polite prisoner and staff had no concerns about him.
42. On 15 January, the man's solicitor visited him. She told the clinical reviewer that at this visit he seemed to be the same as when she had seen him previously in that he was polite and softly spoken. She thought that his mood was low, but was not surprised by this as he understood the gravity of the charges he was facing and the possibility that he would get a long sentence if he was convicted. Most of their conversation related to his application for bail, but he understood that this was likely to be refused.
43. On 17 January, the man did not attend an appointment that had been arranged with the doctor on D wing. The reason for the appointment or why he did not attend was not recorded in his medical record.
44. The next day, 18 January, the man's former cellmate went to see him in the afternoon. He said that when he went to his cell he told him he had a present for him and gave him two bottles of soft drinks and a packet of biscuits, which he had bought from the prison shop. He said the man insisted he took them. He did not place any particular meaning on this as he said he was often generous. He did not notice any changes in his behaviour or mood and had no concerns about him. The man telephoned a friend that day, who was concerned that he was not having visits from his friends and family. He said that visits were too difficult for him but that he was okay. His friend reassured him that she and others were there to support him and that he should talk about how he was feeling. She told him that if he needed her she would visit him immediately. She said she was worried about him and told him not to get depressed or worry.

### **Events leading up to the incident**

45. A packed breakfast of cereal is given to prisoners at Wormwood Scrubs the evening before to eat the next morning, so prisoners are not unlocked at breakfast time. On D wing at the weekend, each landing takes turns to have an association period in the morning or afternoon, when prisoners are allowed out of their cells to shower, make telephone calls and socialise with each other. On 19 January, prisoners on the third landing had their association in the morning. An officer unlocked the man's landing and cell at around 10.00am for the morning association period. At the time he was lying in bed with a towel over his eyes. She thought he was asleep and had no concerns about him.
46. After an early lunch at about 11.00am, all prisoners were locked in their cells. At about 12.10pm, an officer carried out a roll check of the man's landing to ensure that all prisoners were present and where they should be. The officer did not specifically recall him, but said that he had had no concerns about any of the prisoners he checked on that landing.

47. The man's former cellmate returned from a visit shortly after other prisoners had been locked in their cells. He was escorted to his cell by an officer, who told him that as he had missed the morning association period he would be allowed to take association in the afternoon with prisoners from the first and second landings.
48. After lunch, prisoners on the third landing remained locked in their cells until 4.00pm unless they had visits, afternoon association or needed medical treatments. The man remained locked in his cell. Prisoners on the first and second landings were unlocked for association at approximately 2.00pm. The man's former cellmate was also unlocked and went to the first landing to see another prisoner.
49. In a statement to the police after the man's death, a prisoner said that he lived in the cell next door to him. He did not know him well but had spoken to him occasionally and had given him cigarettes. The prisoner, like the man's former cellmate, was also unlocked after lunch for association. He said he had returned to his cell around 3.00pm. He said he had looked into the man's cell through the observation panel as he went by. It was dark inside and he recalled seeing him standing at the back of the cell by the window, looking outward. He did not think he looked distressed nor had anything around his neck.
50. About 30 minutes later, the prisoner said he heard a banging noise on the large pipe which runs down the back of the cells. He said there were around five to seven bangs in a short period of time and he also heard banging on his cell wall and a sound he described as similar to a blackbird. As he was not sure what the noises were, he thought nothing of it.
51. At about 3.30pm, the man's former cellmate returned to the third landing. On his way back to his cell he went to speak to him. He looked through the cell observation panel and said that the cell was dark as there was a makeshift curtain at the window. The television was on and from the glow of the television he could see him standing at the window facing the cell door. He said that he tapped the door, but he did not move or respond and he knew that something was seriously wrong. He thought that he had hanged himself. He ran to an officer, who was talking to a prisoner on the other side of the landing, and asked her to check him.
52. The officer went immediately to the man's cell. She looked through the observation panel and saw him suspended. She pressed the emergency alarm button next to her on the landing and called for help. She unlocked his cell and she and another officer, who had arrived at the cell, went in. Three officers followed close behind. The prisoner was told to return to his cell. An officer radioed a Code One (life-threatening emergency) over the radio at 3.34pm and the control room immediately called an ambulance.
53. The man was suspended by a bed sheet around his neck, tied to the window bars. While the other officers supported his body, an officer used his anti-ligature knife to cut the sheet and laid him on the floor. Another officer described his body as cold and another officer said he showed no signs of life. Two nurses arrived while the officers were checking him,

54. Two nurses had been in the D wing treatment room when they heard the emergency alarm. An officer immediately told them that a prisoner had been found hanging. The nurses picked up the medical emergency equipment bag (which included oxygen and a defibrillator<sup>5</sup>) and went to the cell. They arrived just after he had been placed on the cell floor.
55. The nurses assessed the man as unresponsive. They started cardiopulmonary resuscitation (CPR), administered oxygen and attached the defibrillator. Other nurses and the prison doctor arrived at the cell at 3.36pm. Nurses continued to give cardiopulmonary resuscitation until paramedics arrived and took over at 3.56pm. Despite their efforts, there was no change in his condition and he was pronounced dead at 4.37pm.

### **Events after the man's death**

56. An undated letter was found in the man's cell after his death. The letter was addressed to his solicitor. In the letter he wrote:

"I am happy with that my life is over and I am happy to go. When I am gone I will at least be away from them all.... they are putting things in my food and the water. I have stopped eating and drinking since Monday the day before I seen you. I told you they were conspiring against me."
57. His solicitor said that he had made no mention of the prison food or people conspiring against him when she had visited him on 15 January.

### **Support for prisoners**

58. The man's former cellmate said one of the wing officers told him that the man had died and afterwards a number of staff, including the wing manager and a member of the chaplaincy team came to see him and offered him support. Notices were displayed in the prison to let prisoners know of his death and the support that was available to them. All prisoners subject to suicide and self-harm monitoring procedures were reviewed in case they had been adversely affected by his death. The next weekend, prayers were said for him during the prison church service.

### **Support for staff**

59. After the man's death an operational manager held a hot debrief to support all the staff who had been involved in the incident. They were offered the services of the staff care team if they needed further support. A further additional debriefing session was held for the nurses in the evening, chaired by the Service Manager.

### **Family liaison**

60. One of the prison's chaplaincy team acted as the prison's family liaison officer. The man had listed a friend in Colchester as his next of kin. The prison said that, because of the distance, they asked the family liaison officer

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<sup>5</sup> The defibrillator is of a type that indicates whether or not the activity of the heart might be restarted by administering an electric shock.

at HMP Wayland to visit his friend and break the news on behalf of Wormwood Scrubs. This was done at around 7.00pm. His friend was surprised that he had been listed as his next of kin and said that he had not seen or heard from him for some time. He gave the Wayland family liaison officer the man's sister's telephone number. This was passed on to the family liaison officer, who then telephoned her at 7.45pm, as she had no address for her, and explained what had happened. She telephoned the man's sister again later that evening and the next day, to offer support. She also spoke to the man's brother on the telephone. His family were still very shocked and she agreed to visit them the next day, when more of his family members would be present.

61. On Monday 21 February, the family liaison officer and deputy family liaison officer visited the man's family. They gave them an information leaflet about deaths in custody and explained about the post-mortem and inquest process. They answered his family's questions and passed on the details of the coroner.
62. The prison offered financial assistance towards the funeral costs, in line with national guidance. The funeral was held on 11 February.

### **Post-mortem report**

63. The preliminary post-mortem examination report dated 5 February 2013, gave the provisional cause of death as "Hanging". The additional comments were:  
  
"This man was found dead in his prison cell, having fashioned a torn bed sheet into a ligature. Autopsy shows features consistent with self-suspension. There is no evidence of third party assault or restraint. There are scars on both arms consistent with previous acts of self-harm. The results of the toxicological analysis were negative."

## ISSUES

### Clinical care

64. The clinical reviewer made four recommendations. He found that the clinical care the man received while he was at HMP Wormwood Scrubs was comparable with the care he could have expected to receive in the community.

### Reception health screen

65. The man did not provide details of his community GP when he arrived. He gave information about his history of self-harm and mental health problems during his previous prison sentence. This included a short stay at a Regional Secure Unit 15 years previously.
66. Prison Service Order (PSO) 3050 about continuity of healthcare for prisoners, states that when new prisoners arrive, “efforts should be made to retrieve any information required from the prisoner's GP or other relevant service he/she has recently been in contact with”. The man did not know his GP details so this could not be done.
67. The prison did not request the man's medical records and associated correspondence from the Regional Secure Unit from his stay in 1997, which was understandable as his hospitalisation could not be regarded as recent. Nonetheless, we did consider whether the prison ought to have sought them. The clinical reviewer obtained the relevant records but did not consider that they would have had any impact on the decisions of healthcare staff. As he had disclosed his previous self-harm and the time he had spent in hospital when he arrived at the prison, we are satisfied that it was reasonable not to obtain the hospital records.
68. When the man arrived he said he did not know his GP's details. However, because of his previous psychiatric history and self-harm in prison we consider that further efforts should have been made to obtain them, in case there had been more recent health concerns even if, at first, he was unwilling or unable to provide them. We make the following recommendation:

**The Head of Healthcare should ensure that community GP details are obtained and records sought as part of the reception health screening process, and that particular efforts are made when a prisoner has or had a pre-existing condition.**

### Missed healthcare appointments

69. The man missed two healthcare appointments and there were no recorded reasons to explain why they were missed. As a quiet prisoner who did not leave his cell often, the clinical reviewer notes that these were missed opportunities which could have led to an assessment of his state of mind and to explore any mental health concerns. His blood pressure was supposed to have been monitored weekly yet had not been checked since 24 December. We make the following recommendation:

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

### **Assessment of risk on arrival**

70. When the man arrived at Wormwood Scrubs reception staff were aware that he was charged with a serious offence of rape. If convicted, he could have received a life sentence. The warrant identified that the 'complainant' in the charges against him was his ex-wife (in fact we understand his estranged wife) but it is not clear that prison staff understood that alleged offence involved what could be regarded as a family member.
71. The man was not identified as at risk of self-harm and suicide on 14 December 2012 when he was arrested. Reception staff identified no concerns about how he presented but did not appear to consider whether the charges he was facing or other factors increased his risk. The reception nurse assessed his mental state and did not consider that he was at risk of self-harm. The nurse recorded that he had a history of mental health problems and self-harm in prison. He was also assessed by the prison doctor and first night officer on the First Night Centre. Neither raised any concerns about his wellbeing or risk of self-harm.
72. Prison Service Instruction 64/2011 – Safer Custody, lists a number of risk factors for suicide. These include a background history of deliberate self-harm, mental illness, relationship instability and early days in custody. The offence, particularly those charged with violence against another person, especially against family members or partners is also a factor. All of these factors were present with the man, but it is not clear that they were taken into account in assessing his risk of suicide and self-harm or what weight was given to them if they were. The records merely reflect that he said he had no thoughts of suicide or self-harm and that his presentation caused no concerns.
73. It is a particular concern that none of the staff involved in assessing the man's risk of suicide and self-harm seemed to have taken into account the charge that he was facing as a factor that would increase his risk and that there was a lack of awareness of the alleged victim and the implications for assessment of risk. The nurse said that she did not usually get information about the charges new arrivals were facing, which we consider would hamper effective risk assessment. The operational manager responsible for safer custody at Wormwood Scrubs told the investigator that information about victims is not usually available in reception, but should be included on the custody warrant, but often was not. However, in this case there was some information on the warrant which indicated his relationship to the victim of the alleged offence. Even if there had been no information in the warrant, there is no evidence that anyone spoke to him about the circumstances of his alleged offence and took this into account when assessing his risk.
74. Staff judgement is fundamental to assessing risk and relies on them using their experience and skills, as well as local and national assessment tools, to determine risk. All risk factors must be collated and considered to ensure that

a prisoner's level of risk is holistically judged. 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. Healthcare staff and officers accepted his assurances that he had no thoughts of suicide and self-harm. While it is possible that a full consideration of all the risk factors in reception would still have reached the conclusion that he was not at serious risk, it is a concern that insufficient weight was given to known risk factors when his risk was being assessed.

**The Governor and Head of Healthcare should ensure that staff take account of all known potential risks and triggers when assessing a prisoner's risk of self-harm or suicide.**

### **The man's contact with staff**

75. During his time at Wormwood Scrubs the man was not employed and did not take part in education. As he had no allocated activity he spent most of his time locked in his cell with little to do. It does not appear that he left his cell or the wing very often. Moreover, the investigator found no one at Wormwood Scrubs who knew him well, other than to say he was a quiet and polite man.
76. From his arrival at Wormwood Scrubs on 14 December 2012, until his death on 19 January 2013, only two observational entries were made by wing staff in the man's case history notes. An officer wrote on 23 December "Very well mannered towards staff. No issues at present time" and on 6 January, another officer wrote a retrospective entry "Very polite prisoner follows regime. No concerns". There were no written recorded contact entries made in his case notes from 5 January 2013, when he moved to D wing, until the time of his death on 19 January, and it does not appear that the wing staff knew much about him.
77. We are concerned at the apparent lack of staff interaction with the man. Wormwood Scrubs does not operate a personal officer or other named officer scheme to ensure that nominated officers have responsibility for overseeing the progress and welfare of individual prisoners. In the case of a prisoner like him, who spent most of his time in his cell this meant staff had no insight into his concerns and had little awareness of his apparent withdrawal, such as declining to have visits.
78. HMIP made a recommendation about the personal officer scheme at an inspection in 2008 and noted at the 2011 inspection report that the recommendation had not been achieved. HMIP made a main recommendation in their 2011 report that "A named officer should be aware of the individual needs of prisoners for whom they are responsible. They should provide input and advice on matters relating to their prisoners, encourage family contact and keep a regular record of contact in P-Nomis case notes identifying any significant events".
79. After the death of a prisoner at Wormwood Scrubs in January 2012, we made a recommendation about the need for specified officers on a wing to have some responsibility for the welfare of individual prisoners. The recommendation was rejected. For the issue to be highlighted once again in

the man's case suggests a significant corporate failure. While we do not consider that such a system would be a panacea, its omission means that officers will continue to have little knowledge of prisoners like him who isolate themselves on the wings and thus make it harder to identify any concerns and signs of risk. We therefore repeat the previous recommendation:

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

### **Breaking the news of the man's death to his family**

80. The man was pronounced dead at 4.37pm. The prison family liaison officer was appointed shortly after that. HMP Wayland was asked to provide staff to break the news of his death to his identified next of kin in Colchester, as Wayland was closer than Wormwood Scrubs. (Although in fact, only by ten miles.) The Wayland family liaison officers informed his friend, his nominated next of kin at around 7.00pm, nearly two and a half hours after his death. His friend, who had not been in touch with him for a while, gave the staff the man's sister's telephone number. The family liaison officer telephoned the man's sister at around 7.45pm and discovered she lived in Edgware about ten miles from the prison. No one from Wormwood Scrubs visited the family until Monday 21 January.
81. PSI 64/2011 requires that wherever possible the prison's family liaison officer and another member of staff should visit in person the next of kin to break the news of the death. It notes that "time is of the essence" to ensure that the next of kin does not learn the news from another source and suggests that where the distance is too far prisons should consider asking for the help of staff from the nearest prison to the next of kin. Staff from the prison where the prisoner died are likely to have more accurate and detailed information and we consider that staff from Wormwood Scrubs should have delivered the news in person. The distance is just over 70 miles with an estimated journey time of just over one and half hours, a similar journey time from Wayland.
82. In the event, the man's nominated next of kin was not a close contact but directed the prison staff to his sister. It was then a further two days before staff from Wormwood Scrubs visited his family in person. We accept that this was agreed with his family so that as many of them as possible could be together.

**The Governor should ensure that, except in exceptional circumstances, where the next of kin of a prisoner who dies lives within a reasonable distance of the prison, they are informed promptly in person by a member of Wormwood Scrubs staff.**

### **RECOMMENDATIONS**

1. The Head of Healthcare should ensure that community GP details are obtained and records sought as part of the reception health screening process, and that particular efforts are made when a prisoner has or had a pre-existing condition.

2. The Head of Healthcare should ensure that reasons for missed appointments are recorded and where they are not rebooked, the reasons for this decision are entered on the clinical record.
3. The Governor and Head of Healthcare should ensure that staff take account of all known potential risks and triggers when assessing a prisoner's risk of self-harm or suicide.
4. The Governor should ensure that all prisoners have a named officer who should be aware of their individual needs, whom they can approach for assistance and who will make regular checks on their well-being, backed up by good quality entries in their case notes.
5. The Governor should ensure that, except in exceptional circumstances, where the next of kin of a prisoner who dies lives within a reasonable distance of the prison, they are informed promptly in person by a member of Wormwood Scrubs staff.

**Annex 11**

**ACTION PLAN: The Man – HMP Wormwood Scrubs**

No	Recommendation	Accepted/Not accepted	Response	Target date for completion	Progress (to be updated after 6 months)
1	The Head of Healthcare should ensure that community GP details are obtained and records sought as part of the reception health screening process, and that particular efforts are made when a prisoner has or had a pre-existing condition.	Accepted	<p>GP details are sought and records requested for prisoners who have pre-existing physical or mental health condition(s). Inpatient/Community Mental Health records are also sought, if relevant.</p> <p>Consent is obtained from the patient at reception health screening and records are usually received within 72 hours.</p> <p>If a prisoner presents with no physical or mental health conditions at reception health screening, GP records are not requested.</p>	30 <sup>th</sup> September 2013	

2	The Head of Healthcare should ensure that reasons for missed appointments are recorded and where they are not rebooked, the reasons for this decision are entered on the clinical record.	Accepted	A Primary Care Appointments Protocol is being developed which gives staff clear guidelines on what action to take when a prisoners does not attend for an appointment.	31 <sup>st</sup> December 2013	

3	<p>The Governor and Head of Healthcare should ensure that staff take account of all known potential risks and triggers when assessing a prisoner's risk of self-harm or suicide.</p>	Accepted	<p>All staff attend ACCT training on a yearly basis.</p> <p>Healthcare is exploring the use of a suicide risk assessment tool for use in Reception.</p> <p>Mental Health training for Healthcare and Prison staff is currently under review to ensure suicide risk factors and triggers are adequately addressed.</p>	31 <sup>st</sup> December 2013	
4	<p>The Governor should ensure that all prisoners have a named officer who should be aware of their individual needs, whom they can approach for assistance and who will make regular checks on their well-being, backed up by</p>	Accepted	<p>Whilst reinforcing to prisoners that all staff are available to assist them when needed, Wormwood Scrubs will explore the best way of introducing a named officer scheme as part of the 3 month review (due in January 2014) of the new Benchmarking arrangements which have reduced officer numbers by 20% resulting in them now regularly working across a range of residential units.</p>	31st-January-2014	

	good quality entries in their case notes.				
5	The Governor should ensure that, except in exceptional circumstances, where the next of kin of a prisoner who dies lives within a reasonable distance of the prison, they are informed promptly in person by a member of Wormwood Scrubs staff.	Accepted	The allocated FLO will be despatched to assist and inform family members when a death in custody happens.	Completed	