A Report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

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

Our Vision

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

This is the investigation report into the death of a man in July 2013, at HMP Wormwood Scrubs. He was found hanged in his cell. He was 40 years old. I offer my condolences to his family and friends.

One of my investigators had conduct of this case. A clinical reviewer reviewed the clinical care and treatment the man received at Wormwood Scrubs. The prison cooperated fully with the investigation.

The man was a citizen of Sierra Leone and had lived in the UK for 37 years years. On 20 June 2013, he was given a ten week sentence for breaching a community order. He suffered from paranoid schizophrenia and, although he had been in hospital in January 2013, had been stable for some time before his imprisonment. This was not his first time in prison.

At a meeting with an immigration officer at the prison on 18 July, the possibility of eventual deportation was discussed. The man was worried about his situation and when a decision would be made, but the immigration officer did not have any concerns about the man's state of mind. Wing staff were unaware that he might be deported. The next morning, an officer found the man suspended from his upturned bed by a ligature made of bed sheets. Staff responded immediately and called an emergency code which ensured an ambulance was called automatically. They carried out cardiopulmonary resuscitation but unfortunately they were unable to revive him. Paramedics arrived and pronounced him dead at 8.15am.

The investigation found that the man had appropriate mental heath care at Wormwood Scrubs and his psychiatric nurse from the community was involved. Even if wing staff had been aware that he was concerned about facing deportation, it would have been difficult to have predicted his actions. Nevertheless, I consider that all such information should be shared with wing staff so that they can monitor whether concerns about immigration status impact on a prisoner's risk.

The man's family was unhappy about their dealings with the prison's family liaison officer. I believe that the officer acted appropriately. However, it is important that families have confidence in the information and support they are given and alternative arrangements should have been made for liaison when it became evident that the relationship was not working.

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 **August 2014**

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SUMMARY

1. The man was a citizen of Sierra Leone who had indefinite leave to remain in the United Kingdom. He was 40 years old and suffered from paranoid schizophrenia. He was serving a ten week sentence at Wormwood Scrubs for breaching a community order. He was also on police bail for another violent offence.

2. When he arrived at Wormwood Scrubs, the man continued to be prescribed medication for schizophrenia which he received by monthly injection. (Although he was not given the expected dose the clinical reviewer is satisfied that this had no impact on the outcome.) He was appropriately referred to the mental health team. He did not report any other health concerns and, according to his community psychiatric nurse, had been stable for some time. He lived in a single cell on D wing. He had been in custody in Wormwood Scrubs before and some of the staff knew him.

3. The man was concerned that the offences might affect his immigration status and discussed this twice with an immigration officer at the prison. He was worried that he might remain in prison after his sentence had expired and then be deported. On 18 July, the immigration officer told the man that he would ask the relevant Home Office caseworker to deal with his case quickly, but he could not say what the outcome would be. He did not think that the man appeared particularly stressed by his situation.

4. On a morning in July at 7.50am an officer found the man hanging by a bed sheet tied to his upended bed and radioed an emergency code. A nurse arrived and, although he thought that the man was dead, began to attempt resuscitation. A senior nurse said he should continue. Paramedics arrived and pronounced the man dead at 8.15pm.

5. We are satisfied that the man was cared for appropriately at Wormwood Scrubs and it would have been difficult to predict or prevent his death. We make three recommendations about sharing information, advising staff when it is appropriate not to resuscitate a prisoner and the appointment of family liaison officers.

THE INVESTIGATION PROCESS

6. Notices were issued to staff and prisoners at Wormwood Scrubs inviting anyone with information to contact the investigator. No one responded.

7. The investigator visited Wormwood Scrubs on 31 July, and obtained the man's prison and clinical records. She met the head of safer custody, saw where the man had lived and spoke to the prisoners who had been in the cells either side of him. They said that they had not heard anything unusual during the night when the man died and that he generally kept himself to himself.

8. NHS Fulham and Hammersmith appointed a clinical reviewer to review the man's clinical care and treatment at the prison. The investigator and the clinical reviewer interviewed a number of staff from Wormwood Scrubs.

9. The investigator informed the Coroner for West London about the investigation. We have sent the Coroner a copy of this report.

10. One of the Ombudsman's family liaison officers contacted the man's family to explain the investigation and allow them to identify any relevant matters which they wished the investigation to consider. His family raised the following issues:

    - His parents were very upset that the news of their son's death was broken over the telephone.

    - The man's sister said that they had had little faith in the prison family liaison officer who she considered had been unable to answer questions about her brother's death comprehensively and gave them incorrect information about the circumstances in which he had been found. His sister was concerned that an alternative liaison officer had not been appointed even when the family had indicated they did not want further communication with the original officer.

11. The man's family received a copy of the draft report. The solicitor representing them wrote to us pointing out some factual inaccuracies and/or omissions. The report has been amended accordingly. They also raised a number of questions that do not impact on the factual accuracy of this report. We have provided clarification by way of separate correspondence to the solicitor.

HMP WORMWOOD SCRUBS

12. 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, and a dedicated drug stabilisation unit.

Her Majesty's Inspectorate of Prisons

13. The most recent inspection of Wormwood Scrubs was an unannounced full follow-up inspection in June 2011. Reception and induction were described as generally appropriate, with good arrangements to ensure drug and alcohol dependent prisoners received quick treatment. Inspectors judged that suicide and self-harm prevention procedures were satisfactory, with through initial assessments, but identified risk factors were often not translated into actions in care plans and followed up at reviews.

14. Primary health care had improved as a result of effective leadership, and there was less reliance on agency staff. Inspectors found that most prisoners were able to see a doctor reasonably quickly, that prison staff had access to mental health training, and that prisoners referred for a psychiatric assessment were seen within a week. Inspectors described the medication regime on D wing, where the man lived, as "slightly chaotic".

15. Inspectors also noted that United Kingdom Border Agency (UKBA) staff held surgeries on the wing, which they described as useful.

Independent Monitoring Board

16. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who oversee all aspects of prison life to help ensure that prisoners are treated fairly and decently. In its most recent annual report (to 31 May 2013), the IMB reported that their concerns about the safety of both staff and prisoners had increased during the year. They also reported that there were many mentally ill prisoners on D wing, where the man lived.

Previous deaths at Wormwood Scrubs

17. There were four deaths at Wormwood Scrubs in 2010 and a further three in 2012. Three of these deaths were self-inflicted. There were no significant similarities with the circumstances of this man's death. However, as a result of one of these investigations, we made a recommendation about advising staff about the circumstances when resuscitation is not appropriate. We make a similar recommendation in this report. We have also recently made a recommendation that family liaison officers should inform next of kin in person after a death in custody.

KEY EVENTS

18. The man was sentenced to ten weeks imprisonment on 20 June 2013, for breaching a community order (a sentence which requires the offender to undertake certain activities such as offender behaviour programmes, unpaid work or drug rehabilitation). He was also on bail for an alleged offence of violence. He had been to Wormwood Scrubs and other London prisons a number of times after being convicted of begging. He was a citizen of Sierra Leone who, according to his parents came to England on 4 June 1977. He had lived in the UK since his arrival. He suffered from paranoid schizophrenia, frequently used crack cocaine and was being treated by community health services.

19. At a reception health screen, the man told staff that he did not have physical health problems, but that he had spent some time in hospital in January 2013 for mental illness. He said that he was being treated with a monthly injection of pipotiazine palmitate (medication to reduce the symptoms of schizophrenia). He told the nurse that he had previously tried to harm himself in 1999, by jumping in front of a bus, but had not harmed himself since and had no current thoughts of suicide. The nurse referred him to the mental health team. He gave his mother as his next of kin but could not remember her address or contact details.

20. The man subsequently lived on D wing. An officer told the investigator that D wing was a difficult wing to manage. He said that there were a lot of high-risk prisoners who had committed violent offences or had behavioural or mental health problems. D wing only had single cells.

21. A prison doctor assessed the man on 21 June. The man said that he was settled on his current medication. The doctor noted that the man interacted appropriately and had good eye contact. He found no evidence of psychosis and he said that he did not have any thoughts of self-harm. A psychiatrist prescribed pipotiazine palmitate 50 mg/1ml, by deep intramuscular injection every four weeks, starting on 28 June.

22. Later that day, a mental health nurse assessed the man. He told her about his personal history and said that his mood was low because he felt that he had let everyone down. However, she reported that he was calm and good humoured with no evidence of psychosis or mood disorder. She concluded that he should be discussed at the mental health team meeting and be allocated a caseworker. She completed a care plan for staff to assess the man's health and social care needs, complete a full risk assessment, obtain information from the community health providers. His case was to be reviewed on 25 June. He signed a consent form to allow information to be shared.

23. Healthcare staff received information about the man's medical history from his community GP on 24 June. The same day, a pharmacist reviewed the man's prescription and noted that the correct dose should be 50mg/0.5ml. On 25 June, mental health practitioners at Wormwood Scrubs, including the

psychiatrist, met to discuss the man's care and treatment. They agreed to allocate a mental health in-reach worker to work with him and for him to continue with his current medication.

24. The mental health nurse administered an injection of pipotiazine palmitate 50 mg/1ml on 28 June. A doctor checked the man's medication on 2 July and noted in the clinical record that the man had been administered 50mg/1ml pipotiazine palmitate which was the wrong dose because of a conversion error between millilitres and milligrams on the SystmOne clinical system. He subsequently changed the records to correct the dosage for the next injection.

25. An immigration enforcement officer based at Wormwood Scrubs told the investigator that his job was to interview all foreign national prisoners when they had been sentenced. He first interviewed him on 4 July, when the man told him that he was concerned that he was likely to be deported after his sentence. The immigration enforcement officer told the investigator that the man had first come to the notice of the immigration authorities in 2009 and had been considered for deportation. He successfully appealed this decision and was granted indefinite leave to remain in UK on 27 November 2009. The immigration enforcement officer said that, although the man had been given indefinite leave to remain in the UK, he had since been convicted of a number of offences and was facing further charges for which he was on bail at the time. These circumstances could have affected his immigration status and deportation was again a possibility.

26. On 12 July, his community psychiatric nurse briefed a multi-disciplinary health team at Wormwood Scrubs about the man's mental health problems. He reported that the man's mental health had been stable for some time and that he had been taking his medication. He was very worried about how the offence for which he was on bail might impact on his immigration status. He had told his community psychiatric nurse that he had seen an immigration enforcement officer and he was worried that the Home Office would not have made a decision before his release date. The community psychiatric nurse said that he would inform the man's mother that he was in prison.

27. On 18 July, at about 9.30am, the immigration enforcement officer saw the man in his cell. The man was worried that he would not have a decision about his possible deportation before his sentence expired and would have to remain in prison under immigration detention. The immigration enforcement officer discussed this with him and said that he would contact the man's Home Office immigration caseworker to get a decision quickly. He said that he had contacted the man's caseworker the same day and was told that his case would be considered urgently.

28. The immigration enforcement officer told the investigator that he knew that the man had been diagnosed with mental health problems but he did not have any concerns about him when he interviewed him. He said that the man did not show any symptoms of distress. He had completed ACCT (the Prison Service's suicide and self-harm monitoring process) awareness training during his induction to the prison and said that he would have alerted staff and

opened the suicide and self-harm prevention procedures if he had had any concerns about the man's mental health or state of mind.

29. There was nothing in the man's case notes on his prison record about his immigration status. Wormwood Scrubs does not operate a personal officer system or allocate specific officers to take particular responsibility for overseeing the wellbeing of individual prisoners and the case notes contained little information about the man, a matter about which we have previously been critical at Wormwood Scrubs.

30. At 7.50am on a morning in July, an officer was unlocking prisoners on D wing. When he arrived at the man's cell, he opened the observation hatch and found that it had been covered from the inside. He then looked through a gap at the side of the door and saw that the bed had been turned on its end. As he could not see the man, he went into the cell and found him suspended by a bed sheet from the top of the upended bed. He then radioed a code 1 medical emergency. (A code 1 emergency code is used when a prisoner is not breathing or unconscious.) When the control room received the code 1 call, they immediately called an emergency ambulance.

31. An officer was working on the landing above the man's cell and went to help his colleague as soon as he heard the emergency call. He said it took him just seconds to get to the cell. Both officers supported the man, while one officer tried to cut the ligature from around his neck with his anti-ligature knife. The officer found it difficult, so his colleague took the knife and managed to cut it. They moved the man to the floor and put him in the recovery position. The officer said that, although it was a very hot day, the man felt very cold and his limbs were very stiff. He saw spittle coming from the man's mouth and noticed a smell of faeces from the floor. Both officers were not first aid trained but one tried to find a pulse in the man's neck and could not find one. He said that he considered that the man had been dead for some time. A nurse and a further officer arrived at the cell very quickly afterwards with emergency equipment, including a defibrillator. (A life-saving device which can administer a shock to restart the heart when the machine indicates.) The two officers moved outside the cell to allow them to treat the man. The officer who had found the man said that he was also not first aid trained.

32. The nurse and officer went into the cell. The nurse checked for signs of life, and noted that he could not find a pulse or signs of breathing, and that the man's pupils were fixed, dilated and cloudy. He was also very cold to the touch. He then started cardiopulmonary resuscitation by administering chest compressions. He asked a senior officer (SO) to apply the defibrillator pads to the man's chest. There was no pulse and he was very stiff and cold. The nurse then asked the officer to continue with the chest compressions while he checked the defibrillator, which advised not to administer a shock. Another nurse then arrived and took over the chest compressions while her colleague tried to administer oxygen. The nurse said that he was unable to do so as the man's jaw was locked tight.

33. The nurse told the investigator that he knew that the man was dead but, because he was not sure if there was any written guidance, he thought he had to continue. He said that a senior nurse had told him that he did not have the right to stop resuscitation. Paramedics arrived and pronounced the man dead at 8.15am.

34. That afternoon, the deputy governor held a debrief for the staff involved to review what had happened. All the staff felt that they had done everything that they could and could not have done anything differently to change the outcome. The duty care team was on hand to help anyone who needed support. The two officers were very shaken and were allowed to go home after they had made statements to the police. The officers were away from work for three weeks after that and were shocked to find that when they returned the man's cell was untouched, with the bed still upright and had not been cleaned. We have brought this to managers' attention. Other prisoners on D wing were informed of the man's death by staff on the wing. Prisoners who were being monitored under suicide and self-harm prevention measures were reviewed in case they had been affected by the man's death.

35. At 8.30am, a prison family liaison officer was appointed. He checked the man's records and noted that an address had been written next to it. At 9.55am, the Head of Performance and the family liaison officer went to the address given in the records. When they arrived, a neighbour told them that no one was there, the previous occupant was in prison and that the man's parents had moved away. They returned to the prison to make further enquiries.

36. The healthcare team referred the family liaison officer to the man's community psychiatric nurse, who gave him the man's mother's telephone number, although he did not have an address for her. At 10.55am, the family liaison officer telephoned the man's mother and informed her and his father of his death. The man's parents said that they had spoken to the community psychiatric nurse the previous Friday and he had told them that their son's mental health was good. They were therefore very shocked to hear the news that he had taken his own life. The man's mother was extremely upset that she was given the news by telephone.

37. At approximately 2.00pm on the afternoon of 19 July, the man's brother and sister went to Wormwood Scrubs to ask about their brother's death. The family liaison officer met them and explained what he knew of the man's death. His family wanted to see their relative's body. It appears that his body was still in the prison at this stage but the family liaison officer said that they would need to make arrangements through the coroner's officer. He does not seem to have done anything to assist with this and the man's family were unhappy about the replies they received to their questions. According to the family liaison officer's log, the man's sister told the family liaison officer that she did not want to deal with him any further after this. The safer custody manager told her that another family liaison officer would be appointed and that he was only standing in for someone else. No other liaison officer was appointed and the family liaison officer continued to contact the man's family

against the wishes of his sister. The prison later made a financial contribution to the funeral, in line with national guidance.

38. After the man's death, three pages of writing were found in his cell. One was dated 18 July and said "NO MORE PAIN! Love you mum xxxx Goodbye, [name]". The other two pages were written to the man's community psychiatric nurse and they indicated that he had been scared and worried about his immigration status and that he might have to stay in prison after his sentence ended. There seemed to be some pages missing and on the second page he wrote that he was depressed, had had a breakdown and was suicidal. There was no date on these two pieces of paper and the prison staff told us that they had not found any other pages.

ISSUES

Clinical treatment

39. The clinical reviewer concluded that, overall, the man was given care and treatment at Wormwood Scrubs which was comparable to that which he could have expected to receive in the community. He was assessed appropriately for both his physical and mental health and information was obtained from healthcare professionals who worked with him in the community. He was prescribed the same medication that he had been receiving in the community and his case was referred to and discussed by the mental health team. He was examined by a doctor and psychiatrist when he arrived at Wormwood Scrubs and was allocated a mental health caseworker. The man's psychiatric nurse in the community also attended a meeting at Wormwood Scrubs to discuss him.

40. The clinical reviewer noted that the man was given the wrong dose of medication on 28 June. However, he concluded that this mistake did not have any bearing on subsequent events. He has made a recommendation in the clinical review that the Head of Healthcare should investigate this event further and take remedial action to prevent further occurrences.

Management of risk of self-harm

41. People with schizophrenia are up to 12 times more likely to kill themselves than people who do not. However, according to the man's community psychiatric nurse, he had been stable for some time and was regularly taking his medication regularly, which would have reduced his risk. He had previously attempted suicide, but this had been 14 years before.

42. The man was clearly concerned about his immigration status. When interviewed, the immigration officer said that he was aware that the man had a mental illness, but that he had no concerns about him when they had spoken on 18 July. He therefore did not speak to wing officers about the interview and there is nothing to suggest that they were aware of the man's concerns about his status.

43. The immigration officer said that he would have opened an ACCT if he had had any concerns. There is no evidence that the man was in evident distress after his interview with the immigration officer and there was therefore no reason for wing staff to consider that he was planning to kill himself. However, we believe that it is important that staff who are responsible for prisoners are fully aware of their circumstances and any changes that might affect their wellbeing or risk of self-harm. Concern about immigration status is such a circumstance. Wing staff should be informed about such matters so that they can provide support when necessary.

44. Prison Service Instruction 64/2011 - Safer Custody - notes that changes in status and foreign national prisoners who are, or about to be held under immigration detention powers and those close to deportation can be triggers

for suicide or self-harm. The man's diagnosed mental illness also increased his risk. Although the man was not yet at the stage where he was being held as an immigration detainee, and no decision about possible deportation had been made, he was clearly concerned about these issues. There does not appear to have been a system to ensure that wing staff were informed about such matters and there was nothing noted on the man's case notes to indicate anything about his immigration status. We make the following recommendation:

The Governor should implement a system to ensure that wing staff are informed of any potential changes to the immigration status of foreign national prisoners and that wing staff consider whether this might affect their risk of suicide and self-harm.

Emergency response

45. When the emergency call was made, control room staff immediately called an emergency ambulance in line with local and national procedures. Healthcare staff attended swiftly with the correct emergency equipment. The nurse who responded considered that the man had been dead for some time because his joints were stiff, his pupils fixed and dilated and he did not have a pulse. However, he began to attempt resuscitation because he understood that was what he was required to do as he was not qualified to pronounce death and because a senior nurse instructed him to continue.

46. The European Council Guidelines for Resuscitation 2010, states that "Resuscitation is inappropriate and should not be provided when there is clear evidence that it will be futile." The guidelines define futility as cases of mortal injury, rigor mortis and the presence of post mortem staining (livor mortis). It is apparent that the man had rigor mortis and other signs of death which were apparent to the nurse who attended. In these circumstances staff should not be required to attempt or continue resuscitation. We make the following recommendation:

The Governor and Head of Healthcare should ensure that staff are given guidance about the circumstances in which resuscitation is inappropriate.

Family liaison

47. The prison's family liaison officer went to the man's address but there was no one living there. His parents had lived at that address previously, but the neighbour did not know their current address. His community psychiatric nurse subsequently provided a telephone number for the man's parents. While it is unfortunate that the family liaison officer was not able to break the news of the man's death in person, we are satisfied that he took appropriate steps in his attempts to do so.

48. The man's brother and sister attended the prison on the afternoon of his death and met the family liaison officer. He said that he answered their questions

but could not allow them to see their brother's body. He told them that they needed to make arrangements with the coroner's officer but he did not offer to speak to the coroner's officer on their behalf. The man's family told us that they were unhappy with the answers that the family liaison officer gave them and this caused them to lose confidence in him. We have examined the log that he kept while acting as the family liaison officer and consider that, overall, he made a comprehensive and appropriate account of his contacts, but could have acted more proactively on their behalf.

49. However, it is clearly important that a bereaved family have confidence and trust in their main contact at a prison after a death in custody. According to the family liaison log, the head of safer custody told the man's sister that another liaison officer would be appointed, although he subsequently told our investigator that there were no other trained family liaison officers available. We consider that alternative arrangements should have been made for liaison when it became evident that the relationship was not working. We make the following recommendation:

    The Governor should ensure that there are sufficient trained family liaison officers and that when possible, family requests for a new liaison officer to be appointed are accommodated.

RECOMMENDATIONS

1. The Governor should implement a system to ensure that wing staff are informed of any potential changes to the immigration status of foreign national prisoners and that wing staff consider whether this might affect their risk of suicide and self-harm.

2. The Governor and Head of Healthcare should ensure that staff are given guidance about the circumstances in which resuscitation is inappropriate.

3. The Governor should ensure that there are sufficient trained family liaison officers and that when possible, family requests for a new liaison officer to be appointed are accommodated.

ACTION PLAN: [man's name] HMP Wormwood Scrubs July 2013

No	Recommendation	Accepted/Not accepted	Response	Target date for completion	Progres updated months)
1	The Governor should implement a system to ensure that wing staff are informed of any potential changes to the immigration status of foreign national prisoners and that wing staff consider whether this might affect their risk of suicide and self-harm.	Accepted	A memorandum of understanding will be drawn up to outline the requirements for sharing of information directly affecting the immigration status of those in our care.	Completed	
2	The Governor and Head of Healthcare should ensure that staff are given guidance about the circumstances in which resuscitation is inappropriate.	Accepted	In response to a similar recommendation in an earlier report, NOMS undertook to work with NHS England to produce improved guidance for implementation nationally. NOMS undertook to issue this guidance by December 2014 and it will immediately be implemented at HMP Wormwood Scrubs.	December 2014	
3	The Governor should ensure that there are sufficient trained family liaison officers and that when possible, family requests for a new liaison officer to be appointed are accommodated.	Accepted	The role of the FLO is a voluntary position, we are at this time advertising to recruit and train more FLO's. When a request is made by the family of the deceased to change FLO consideration will be given to appointing a new FLO.	Completed	