Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Ranique Edwards a prisoner at HMP Wormwood Scrubs on 15 June 2015

A report by the Prisons and Probation Ombudsman
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Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

Our Values

We are:

Impartial: *we do not take sides*
Respectful: *we are considerate and courteous*
Inclusive: *we value diversity*
Dedicated: *we are determined and focused*
Fair: *we are honest and act with integrity*

The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out **independent** investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

My office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Ranique Edwards was found hanged in his cell at HMP Wormwood Scrubs on 15 June 2015. He was 24 years old. I offer my condolences to Mr Edwards' family and friends.

I am concerned that staff consistently underestimated Mr Edwards' risk during his time at the prison and this was compounded by the lack of structured officer support which made it difficult for wing staff to spot any changes in risk. Mr Edwards was managed for three brief periods, using suicide and self-harm prevention procedures, but these had a number of deficiencies. There was also confusion about a referral for a mental health assessment and he was never fully assessed, despite some bizarre behaviour. Nevertheless, I recognise that it would have been difficult for staff to have identified that Mr Edwards was at imminent and high risk of suicide at the time of his death.

The investigation also found deficiencies in searching procedures when Mr Edwards went to court and in the thoroughness of security checks on the night he died. Finally, although there was a quick emergency response, I am concerned that healthcare staff felt compelled to attempt resuscitation, when it was evident that this would be futile.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman **February 2016**

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Summary

Events

1. On 3 November 2014, Mr Ranique Edwards was remanded to HMP Wormwood Scrubs. He arrived with a suicide and self-harm warning form and said that he had tried to hang himself in police custody. Prison staff began Prison Service suicide and self-harm prevention procedures, known as ACCT. The next day, a psychiatrist assessed him. He found no severe mental illness but considered that he was anxious and depressed because of his situation. A nurse referred him to the primary mental health team for further assessment but no one from the team ever saw Mr Edwards.

2. On 11 November, staff ended ACCT monitoring but began ACCT procedures again between 21 December until 6 January 2015, as Mr Edwards was anxious about his trial and was missing his daughter. On 19 January, a podiatrist found that Mr Edwards had bands of ripped sheets, pierced with drawing pins pointing outwards, around his ankles. A prison officer said Mr Edwards could continue to wear them.

3. On 10 March, staff began ACCT procedures again, when he said he was low in mood and had thoughts of self-harm. At an ACCT case review, Mr Edwards said he wore bands with drawing pins around his wrists and ankles to remind him of his grief at the loss of his partner and child. Staff asked him to remove them. A doctor prescribed sleeping tablets and ACCT monitoring ended after six days. On 16 March, Mr Edwards said he had no thoughts of suicide but was anxious about his forthcoming trial. Staff ended ACCT monitoring.

4. On 20 April, when Mr Edwards' trial started, court staff searching Mr Edwards found he had bands of drawing pins around his wrists and ankles. They noted that he seemed very depressed and completed a suicide and self-harm warning form. A court custody officer rang the prison and believed that staff had begun ACCT procedures. A supervising officer spoke briefly to Mr Edwards when he got back to the prison but did not begin ACCT monitoring.

5. On 27 April, Mr Edwards was convicted and his case was adjourned for sentencing until June. On 29 April, a GP referred Mr Edwards to the mental health team again, as he was anxious about his potential sentence. The mental health team did not formally assess him. Mr Edwards phoned his family and said he was finding it increasingly difficult to cope in prison. On 12 June, Mr Edwards appeared in court for sentencing but the judge adjourned the case for a psychiatric report. Prisoners who knew Mr Edwards said that his mood changed after this court appearance. On 13 June, an official visitor told an officer he was concerned about him. The officer did not realise that the visitor thought Mr Edwards might be at risk of suicide and took no further action.

6. On 14 June, Mr Edwards telephoned his aunt and his partner's brother and said he was going to hang himself that evening. Prison staff were not aware of this. A night patrol officer said he had checked all the prisoners on the landing at 9.00pm and 5.00am as required for a security check. He did not identify any

concerns but said it was difficult to see prisoners in their cells. Two prisoners in nearby cells told us that no one did the checks that night.

7. Around 8.00am on 15 June, an officer discovered Mr Edwards hanged in his cell. The officer immediately went in, cut the ligature from around Mr Edwards' neck, and radioed a code blue emergency. The control room called an ambulance. Other prison staff and nurses arrived. They tried to resuscitate Mr Edwards but all the staff said his body was completely rigid and they believed he was dead. Paramedics arrived at 8.17am and, very shortly afterwards, recorded that Mr Edwards had died.

Findings

8. Mr Edwards was assessed as at risk of suicide and self-harm when he arrived at Wormwood Scrubs, and on another two occasions. However, ACCT procedures did not operate effectively to protect him. Case reviews were not multidisciplinary and there was very little healthcare staff involvement in the management of his risk. Caremap actions were not all completed before ACCT monitoring ended. Staff did not identify and address in the caremaps all the issues that were causing Mr Edwards anxiety, such as contact with his daughter.

9. There were a number of times when staff did not assess Mr Edwards' risk properly, particularly when he got back from court on 20 April, after court staff had alerted the prison to his risk. On 13 June, an official visitor thought that Mr Edwards was at raised risk of suicide, but the officer he told did not realise that this was what was meant.

10. Mr Edwards wore bands of material with drawing pins around his wrists and ankles, which staff treated as a security issue rather than an indicator of potential poor mental health or self-harm. No one noted that Mr Edwards was wearing these bands when he left the prison. There was little evidence of any effective staff engagement with Mr Edwards on his wing. Doctors referred Mr Edwards to the mental health team twice but no one from the team fully assessed him.

11. It was evident that Mr Edwards had been dead for some time when he was found hanged and we are not satisfied that the night patrol officer checked him properly at the 5.00am security check. It was inappropriate for staff to try to resuscitate him.

Recommendations

- The Governor and Head of Healthcare should ensure that all staff working with prisoners have an understanding of risk factors for suicide and self-harm and are vigilant about changes that might indicate an increased risk, particularly when prisoners have previously been managed under ACCT procedures.
- The Governor and Head of Healthcare should ensure that prisoners returning from court appearances are properly assessed for risk of suicide and self-harm and staff take into account and record warnings received from court staff, including the reasons when warnings have been discounted.

- The Governor and Head of Healthcare should ensure that staff manage prisoners at risk of suicide or self-harm in line with national guidelines, including in particular that:
    - All known risk factors are considered when determining the level of risk of suicide and self-harm and taken into account whenever there is further information that a prisoner is at risk.
    - All case reviews are multidisciplinary with continuity of case management.
    - A member of healthcare staff should attend all first case reviews and subsequent reviews where relevant.
    - Triggers for suicide and self-harm are identified and recorded.
    - ACCT caremap actions are specific and meaningful, aimed at reducing a prisoner's risk and identify who is responsible for them.
    - ACCT documents accompany prisoners when they move around the prison.
- The Governor should ensure that prisoners are appropriately and effectively searched when they leave or return to the prison.
- The Governor should ensure that all prisoners have meaningful contact with a named officer who regularly checks their wellbeing and records contact in their case notes.
- The Governor should ensure that staff completing roll checks, satisfy themselves that the prisoner is alive and breathing at the time.
- The Head of Healthcare should ensure that there is an effective single point of referral system for mental health assessments, that assessments take place promptly, are documented in the clinical record, and ongoing treatment is provided as required.
- The Governor and Head of Healthcare should ensure that staff are given clear guidance about the circumstances in which resuscitation is inappropriate.

The Investigation Process

12. The investigator issued notices to staff and prisoners at HMP Wormwood Scrubs informing them of the investigation and asking anyone with relevant information to contact her. No one responded.

13. The investigator visited Wormwood Scrubs on 30 June. She obtained copies of relevant extracts from Mr Edwards' prison and medical records.

14. NHS England commissioned a clinical reviewer to review Mr Edwards' clinical care at the prison.

15. The investigator interviewed 14 members of staff, one official visitor and two prisoners at Wormwood Scrubs in July and August. The clinical reviewer joined the investigator for some of the interviews. The investigator subsequently interviewed two members of staff by telephone.

16. We informed HM Coroner for West London of the investigation. We have sent the coroner a copy of this report.

17. One of the Ombudsman's family liaison officers contacted Mr Edwards' mother and partner, to explain the investigation and to ask if they had any matters they wanted the investigation to consider. Mr Edwards' partner did not have any questions. The Ombudsman's family liaison officer and the investigator met Mr Edwards' mother and her solicitor on 9 September and answered some of their questions. Mr Edwards' mother said that she had been given several different versions of events by Wormwood Scrubs and she wanted answers to the following points, which we have covered in the report:

    - The position Mr Edwards was in when he was found hanged and whether his feet were touching the floor.
    - The level of monitoring Mr Edwards was subject to and the reasons.
    - The length of time Mr Edwards had been on E Wing.
    - Whether there was any evidence that Mr Edwards had been bullied by prisoners or staff at Wormwood Scrubs.

18. Mr Edwards' mother received a copy of the draft report. She raised a number of questions that do not impact on the factual accuracy of this report and have been addressed through separate correspondence.

Background Information

HMP Wormwood Scrubs

19. HMP Wormwood Scrubs is a local prison in West London for nearly 1,300 men. The prison holds men on remand from West London courts and London prisoners serving short sentences or coming to the end of long sentences.

HM Inspectorate of Prisons

20. The most recent inspection of Wormwood Scrubs was in May 2014. Inspectors noted that five prisoners had committed suicide during 2013, yet not all the Prison and Probation Ombudsman's recommendations had been implemented. Many prisoners in crisis were held in very poor conditions with not enough support or activities to occupy them. ACCT processes were poor. The safer custody team was poorly resourced and the team manager had several other responsibilities. Officers from the team were frequently redeployed to other tasks. The personal officer scheme was inconsistent and ineffective.

Independent Monitoring Board

21. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its most recently published annual report for the year to May 2014, the IMB said that the prison had had a 'very dismal and highly regrettable year.' Restructuring had led to major staffing problems and many weeks of chaos and dysfunction. The IMB was concerned about low staff morale and poor safety, and said that officers had little time for meaningful conversations with prisoners.

Previous deaths at HMP Wormwood Scrubs

22. Since 2012, we have investigated the deaths of 11 prisoners at Wormwood Scrubs, including that of Mr Edwards. Eight were apparently self-inflicted. We have previously made recommendations about ACCT procedures, including the need for multidisciplinary case reviews, better caremaps, training for officers and checks on prisoners. We identified similar problems during this investigation. We have also previously identified problems with the mental health referral process and that staff attempted resuscitation when this would be futile.

Assessment, Care in Custody and Teamwork

23. ACCT is the care planning system the Prison Service uses to support prisoners at risk of suicide or self-harm. Once a prisoner has been identified as at risk, the purpose of the ACCT process is to try to determine the level of risk, the steps that might be taken to reduce this and the extent to which staff need to monitor and supervise the prisoner. Part of the ACCT process involves assessing immediate needs and drawing up a caremap to identify the prisoner's most urgent issues and how they will be met. Regular multi-disciplinary reviews should be held. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

Key Events

24. On 1 November 2014, Mr Ranique Edwards was arrested and charged with two offences of rape and two of assault against his partner. On 3 November, he appeared at Hendon Magistrates' Court and was remanded to prison. A court custody officer completed a suicide and self-harm warning form to alert prison staff to Mr Edwards' risk. The custody officer noted that Mr Edwards had said that he wanted to kill himself because of the charges. The officer also recorded that he had possible mental health issues, seemed very depressed and had a history of self-harm.

25. Mr Edwards was taken to HMP Wormwood Scrubs. This was his first time in prison. At an initial health assessment, Mr Edwards told Nurse A that he felt low in mood, wanted to kill himself, and had tried to hang himself in police custody the day before. He said he used to hear voices. The nurse began Assessment Care in Custody and Teamwork (ACCT) suicide and self-harm prevention procedures. She referred him to a doctor and the mental health team.

26. The next morning, when he was being assessed as part of ACCT procedures, Mr Edwards said that he had felt overwhelmed at court but now felt more relaxed. He said he had no history or current thoughts of suicide or self-harm. A supervising officer and an officer held his first ACCT case review that afternoon. No healthcare staff were present. Mr Edwards said that he had felt suicidal after his court appearance, as he had found out his partner was having an affair, but no longer had thoughts of suicide. The review decided to continue ACCT monitoring for a week, as it was Mr Edwards' first time in prison. Staff set the level of observations at three during the day and five at night. Caremap actions were for Mr Edwards to be referred to the mental health team, for him to keep occupied by attending an activity and to interact with others by moving to a residential wing. (Mr Edwards was in the prison's first night centre at the time.)

27. That evening, a psychiatrist, Dr A, and a mental health nurse, Nurse B, reviewed Mr Edwards. He said he had felt suicidal because he had been remanded to prison for an alleged offence of rape. Mr Edwards said it was an impulsive thought but he had come to terms with his situation and now had no plans to end his life. Mr Edwards said he intended to separate from his partner, as he thought she was having an affair. He said he had not attempted suicide before.

28. Mr Edwards told Dr A that he was sleeping and eating well. The doctor noted that Mr Edwards had no anxieties, obsessions or delusions and concluded that he had formal thought disorder (disorganised thinking evidenced by disorganised speech). Mr Edwards said he had auditory hallucinations but the doctor recorded that these were more likely to be Mr Edwards' thoughts. The doctor concluded that Mr Edwards was in a dysphoric state (an emotional state characterised by anxiety, depression or unease) due to being in prison and his thoughts of suicide were impulsive. The doctor referred Mr Edwards to the primary mental health team.

29. On 6 November, Nurse C, a mental health nurse from the primary mental health team, noted that Mr Edwards was waiting for an assessment. She told the investigator that she thought it would have been more appropriate for Mr

Edwards to stay under the care of the secondary mental health team, due to his dysphoric state and suicidal thoughts. (The secondary mental health team is for those with more severe and enduring mental health problems.) The nurse she sent a message on the medical record system, asking the secondary mental health team what work they wanted her to do with Mr Edwards. There is no evidence record of this message. The nurse did not assess Mr Edwards herself.

30. Mr Edwards began full-time education classes. He told his literacy tutor, that he was subject to ACCT monitoring, but the literacy tutor never saw the ACCT document and therefore made no entry in it. She was, never invited to ACCT case reviews. The literacy tutor said Mr Edwards was initially very timid, shy and withdrawn but he worked very hard to improve his literacy to the extent that he became more positive and a help to other in the class. Eventually, he became a peer mentor. She never had any concerns that Mr Edwards might be at risk of suicide.

31. On 10 November, member of staff from the safer custody team, noted in Mr Edwards' prison record, "This prisoner is on trial / has been convicted for a serious domestic offence. This may act as a trigger for self-harm. Please be aware of this and act on any noticeable changes to his mood / demeanour."

32. On 11 November, Supervising Officer (SO) A, Officer A and Officer B held an ACCT review and ended ACCT monitoring. There was no member of healthcare staff present. The review noted that Mr Edwards was happier, believed things would settle and was focussed on his five-year-old daughter. Two of his caremap actions had already been marked as complete, as he had been assessed by a psychiatrist and had moved to a residential wing on 5 November. The action for him to keep occupied was not marked as complete, although he was attending full time education classes.

33. Also on 11 November, a prison GP saw Mr Edwards, who appeared to have a chest complaint. The doctor concluded that it was an anxiety related symptom and noted that Mr Edwards had already been referred to the primary mental health team. On 12 November, the prison received information from Mr Edwards' community GP practice, which said that he had not attended for years and he had no relevant medical history.

34. On 21 December, Officer C began ACCT procedures again and noted that Mr Edwards was having difficulty coping in prison, was facing serious charges that had resulted in him losing contact with his partner and daughter, and was having difficulty sleeping. Mr Edwards said he had mental health problems and had been schizophrenic since he was eight years old. (There is no evidence of this.) He said he had a child who had died along with his partner in a car crash in 2009.

35. A supervising officer and two officers held a case review later that day. Again, there was no member of healthcare staff present and no one from any other prison department who knew Mr Edwards. Mr Edwards said he suffered from depression because of neglect he had experienced as a child and because of his current relationship breakdown. He said he had spoken to the wing nurse about making an appointment with the doctor. Mr Edwards was anxious about his court case. The caremap identified his issues as wanting to change his religion to

Buddhist, to speak to a doctor about his depression and to occupy his time by continuing with education classes. The last of these was marked as complete.

36. On 29 December, custodial manager, A, held a case review with Mr Edwards. No other member of staff was present. Mr Edwards said he was still depressed and the officer noted he would speak to healthcare staff to make sure that Mr Edwards got an appointment with the doctor as soon as possible. He marked the caremap action for Mr Edwards to change his religion to Buddhist as complete.

37. On 1 January 2015, a doctor assessed Mr Edwards and prescribed him antibiotics for an infected cyst. They did not discuss his mental health and it does not appear the doctor knew that Mr Edwards was being managed under ACCT procedures. On 6 January, at an ACCT review, Mr Edwards said that he still felt low and had found it difficult to cope over Christmas. However, he was back in full-time education and had no thoughts of suicide. The staff at the review ended ACCT monitoring but did not review Mr Edwards' caremap. The action about his seeing a doctor was not marked as complete.

38. On 19 January, Mr Edwards saw a podiatrist as he had complained of some pain in his feet. She treated this, but noticed that he was wearing bands of material made out of ripped sheets around his ankles with drawing pins sticking outwards. The podiatrist had never seen anything, similar, before and was concerned that they might be a security issue. She asked an officer to look at them. The officer said that they were not a security issue and Mr Edwards could continue to wear them. The podiatrist said that Mr Edwards did not seem distressed when she saw him. He told her that he wore the bands as a symbol of the loss of his children. She said they did not seem to be causing Mr Edwards any injury.

39. On 30 January, Mr Edwards moved from A Wing to E Wing. Most of the prisoners in full-time education live on E Wing.

40. On 20 February, Mr Edwards pleaded guilty at court to one charge of assault and not guilty to two charges of rape and one of assault. His trial on the remaining charges was to take place later. A nurse did not assess him when he came back to the prison from court.

41. On 10 March, Mr Edwards told an officer he felt low in mood because he had not had any contact with his daughter since being in prison and had thoughts of harming himself. The officer began ACCT procedures. The next day, he told the officer who assessed him that he was worried that he might be facing a ten-year prison sentence. He said he had no thoughts of suicide, which would be selfish, as he had a young daughter. He said he was having difficulty sleeping. The officer noted that Mr Edwards needed to get his partner's telephone number so he could contact her and his child. She said she would try to get the number for him and referred him to a doctor. Although assessing his risk of suicide and self-harm as part of the ACCT process, the officer was apparently unaware of Mr Edwards' charges.

42. The next morning, Mr Edwards told Dr B that he was having difficulty sleeping, as he was worried about the possible length of his sentence and the lack of contact with his daughter. He told the doctor he had no suicidal thoughts. The doctor prescribed Mr Edwards herbal sleeping tablets for two weeks and recorded the

consultation in Mr Edwards' ACCT record. (This was the only evidence we found of a member of healthcare staff contributing to Mr Edwards' ACCT management.)

43. Two custodial managers, custodial manager, B and custodial manager, C, held an ACCT case review with Mr Edwards that evening. There was again no healthcare representation. Custodial manager, B entered one action in the caremap, for Mr Edwards to receive medication for his sleep problems and noted that he was waiting for this medication. At the review, Mr Edwards said that he had drawing pins attached to torn sheets tied around his wrists, which reminded him of his grief for his "lost wife and child". Both custodial managers told him to remove them and find "alternative therapies". They assessed Mr Edwards as a low risk of harm to himself and set the level of observations at three during the day and five at night. They noted that healthcare staff should be invited to the next ACCT review on 16 March.

44. On 16 March, Supervising Officer (SO) B and another supervising officer held the next case review. There was no member of healthcare staff present and no evidence that anyone had been invited as the previous case review had noted should be done. The SO noted that Mr Edwards was in a good mood. Mr Edwards said he did not need to be managed under ACCT procedures. He said that his mood had improved and he thought the officer who had opened the ACCT had misunderstood him. He said that he was worried about his trial at the end of the month.

45. Mr Edwards said he was not getting any visitors. (His last visitor had been his mother on 1 February.) SO B told Mr Edwards about the official prisoner visitor scheme and Mr Edwards said he would like to see a visitor. (Official prison visitors are independent volunteers appointed by Governors of prisons, who visit prisoners to offer friendship and support. Any prisoner can ask for an official visitor, but they are often used by prisoners who do not receive visits from family or friends.) The SO contacted the chaplaincy to arrange a visitor, added this action to Mr Edwards' caremap, and marked it as complete. He also marked the other caremap action, for Mr Edwards to get medication for sleeping problems, as complete.

46. SO B told the investigator that Mr Edwards was forthcoming during the review and he did not have concerns about his risk of suicide and self-harm. As both caremap actions had been completed, the review closed the ACCT.

47. On 23 March, SO B held a post-closure ACCT review with Mr Edwards. Mr Edwards said he was keeping his mind busy with education. He said that he had no outside support but had friends in prison.

48. Prisoner, A, moved to E Wing in April and became friends with Mr Edwards. He said they spent a lot of time talking and joking and Mr Edwards seemed fine. He said that they discussed religion and Mr Edwards talked about his daughter.

49. In April an official prison visitor, began visiting Mr Edwards every Saturday. They discussed a number of different topics including religion, sport and Mr Edwards' hopes for the future. Mr Edwards talked about missing his daughter, his frustration about his legal case and his lack of contact with his family.

50. On 20 April, Mr Edwards' trial started at Harrow Crown Court. A court custody officer found that Mr Edwards had bands of torn sheets with drawing pins wrapped around his wrists and ankles, with dried blood on them. The officer removed them from him. Mr Edwards said that these were to protect him from life and all that he was going through. The officer noted that Mr Edwards seemed very depressed and had taken an overdose in the last six months. At 11.10am, the officer completed a suicide and self-harm warning form.

51. The custody officer rang Wormwood Scrubs and spoke to SO C. Afterwards, the officer noted on the suicide and self-harm warning form that prison staff had opened an ACCT and had completed a security report. At 3.45pm, when Mr Edwards left the court cells to appear in court again, he had put more bands made of torn sheets and drawing pins around his wrists. Court staff searched Mr Edwards and found more scraps of torn sheets, drawing pins and a white tablet in his shoes.

52. When Mr Edwards arrived back at Wormwood Scrubs that evening, SO C checked his wrists. He told the investigator there were no bands of material around Mr Edwards' wrists and he had no injuries. He did not check his ankles. Mr Edwards told him that wearing the bands was part of his religion to ward off evil. The SO said that he did not really remember Mr Edwards and did not recall that he seemed low. He filled in a security form and put it into the security in-tray, and did not record their discussion anywhere else. The SO said that he did not usually spend more than a couple of minutes with a prisoner in reception. The SO did not begin ACCT procedures and had not opened one earlier, after he had spoken to the court custody officer.

53. On 22 April, a security intelligence collator, entered the information about the bands of drawing pins, in Mr Edwards' security record. She emailed Officer D, a member of the safer custody team, and the Head of Security and Intelligence, to let them know what had happened. On 25 April, the officer sent the email to the Head of Safer Custody, and SO B. She asked SO B to speak to Mr Edwards to check his welfare.

54. SO, B asked Officer D to speak to Mr Edwards. Mr Edwards told the officer that he had only been "messing around" and would not wear the bands again. The SO replied to Officer D and noted that he was concerned about the standard of searching procedures at the prison.

55. Mr Edwards' trial continued until 27 April. He attended court each weekday. Nurses spoke to him when he got back to the prison and noted in his medical record that they had no concerns about him. On 27 April, Mr Edwards was convicted of two charges of rape and one of assault. This information was noted in his escort record and on his remand warrant. The court adjourned the case until 12 June for a pre-sentence report. When he got back from court, a nurse noted only "no concerns". She did not record anything about his conviction or his reaction to it.

56. For security reasons all prisoners' phone calls, apart from legally privileged calls, are recorded. Staff listen to a random sample, unless there are particular security concerns. Prison staff were not monitoring Mr Edwards' calls and had not listened to them. The investigator listened to Mr Edwards' calls. In calls to

his family after he was convicted, Mr Edwards said he was worried about the length of sentence he would receive. He also talked about how much he missed his partner and his daughter. He said he was finding it increasingly difficult to cope with being in prison.

57. On 29 April, Mr Edwards saw Dr C, a prison GP and said that he expected to get a long prison sentence and was having difficulties sleeping. He told the doctor that he thought he was schizophrenic, as his mood could change very quickly from being calm to upset. The doctor reviewed Mr Edwards' medical record and found he had no history of mental illness and did not have any current symptoms. The doctor told Mr Edwards that they no longer prescribed sleeping tablets at Wormwood Scrubs, and referred him to the primary mental health team. The doctor considered that Mr Edwards was having an adjustment reaction. (This is when someone is unable to adjust to or cope with a particular stress or a major life event.)

58. The same day, Nurse C from the primary mental health team made an appointment to see Mr Edwards on 5 May. He did not attend the appointment and no reason was recorded. Mr Edwards attended the next appointment on 13 May, which was a yoga session. Afterwards, he told the nurse that he was not interested in yoga. Since this was the only treatment she had for sleeping difficulties, the nurse discharged him from her caseload. She wrote in his medical record that she would add the notes of the session, but did not do this. The nurse did not have any further contact with Mr Edwards.

59. In May, prisoner, B, moved into the cell between Mr Edwards and prisoner, A. They became friends, and spent time together each day, talking, and playing cards. Prisoner B said Mr Edwards talked to him about his court case. He said he was not guilty and missed his daughter.

60. On 16 May, Mr Edwards telephoned his aunt and said he wanted a going away present of a coffin in six or seven weeks. He said he needed to see his daughter one last time. On 23 May, he left a voicemail for his partner's brother saying he was getting sicker in prison and as long as he saw his daughter and his partner, he did not care if he died. At the beginning of June, Mr Edwards spoke to his brother several times, about how he could get in contact with his daughter.

61. On 12 June, when Mr Edwards appeared at court for sentencing, his case was adjourned until 24 July for a psychiatric report. No one assessed Mr Edwards' risk when he came back from court. Mr Edwards told prisoner B and prisoner A that the judge had told him to expect a sentence of eight to 12 years and he was anxious about that. Prison B said he encouraged him to wait and see what happened. Prisoner A said Mr Edwards seemed more reserved and stressed and he smoked more than usual. However, he did not think that Mr Edwards intended to kill himself.

62. On Saturday 13 June, the official prison visitor visited Mr Edwards for about 40 minutes in a private room on the wing. He said Mr Edwards was very angry and he had never seen him like that before. Mr Edwards was upset by the pre-sentence report, which he said had assessed him as a risk to society. He told the official prison visitor that his barrister had told him that he might receive a long sentence, which had shocked him. He was concerned about not seeing his

daughter and angry with his partner for pressing charges. He continued to maintain that he was innocent.

63. Mr Edwards told the official prison visitor that he had three options: he could be a monster, he could use his enlightenment or he could kill himself. The official prison visitor tried to give Mr Edwards hope and emphasised that he had not been sentenced yet.

64. Officer E was in the movements' office when the official prison visitor came in to sign out as he was leaving the wing. The officer asked if everything was okay and the official prison visitor said that Mr Edwards was a little bit angry. The officer said he had asked if Mr Edwards was all right and the official prison visitor had said that Mr Edwards was not angry with staff but frustrated about the delay in his sentencing. The officer said that the official prison visitor had said it was nothing to worry about. He estimated that they did not speak for more than 15 seconds.

65. The official prison visitor said that he had told Officer E that Mr Edwards was angry and he was concerned about his demeanour. The official prison visitor said he did not tell Officer Fiddimore specifically that he thought Mr Edwards was a risk of suicide or self-harm but he thought that the officer had understood that this was what he meant. The prison visitor said that the officer had said he would keep an eye on him. The officer did not accept that the official prison visitor had voiced any concerns or that he had said he would keep an eye on Mr Edwards.

66. The prison visitor saw Mr Edwards after this, as he was leaving the wing. They had a brief conversation and Mr Edwards had said that he might be able to better himself but not in this country. They shared a joke and the official prison visitor left the wing. The prison visitor signed out of the prison in the chaplaincy office, as is routine for all official visitors. He wrote in the chaplaincy logbook, "Reported R Edwards rage at delay in sentencing and perceived injustices."

67. Officer E said he saw Mr Edwards a few minutes later and asked if he was okay. Mr Edwards said he was fine and the officer said Mr Edwards did not appear to be angry or upset. He did not see Mr Edwards again. Prison A said that he did not see Mr Edwards much over that weekend as the regime was much more restricted and prisoners were locked in their cells for most of the time.

68. On Sunday 14 June, prisoner A saw Mr Edwards during the morning association period. He said that he seemed his normal self and was making jokes. That afternoon, Mr Edwards asked an officer if he could make a telephone call. The officer was only on E Wing temporarily, so passed the message to Officer F. The officer locked other prisoners in their cells before unlocking Mr Edwards to make the call. The officer said he would watch him from the landing below. He said that Mr Edwards did not seem upset.

69. At 2.44pm, Mr Edwards phoned his aunt. She did not answer, so he left a voicemail. In the message, Mr Edwards sounded very distressed and said he was going to hang himself that day. He said he missed his daughter and could not face spending twelve years in prison for something he did not do. He said he did not want to kill anyone else.

70. Mr Edwards then knocked on prisoner A's cell door and opened the observation flap. He said Mr Edwards had been crying and had tears running down his cheeks and his eyes were red. Mr Edwards said he had spoken to his mother on the telephone and said, "Darkness is consuming me. I can't take this." Prisoner A asked Mr Edwards what the matter was and told him to pray. At that point, prison A thought that an officer called Mr Edwards back to his cell and he did not see him again. He said he had never seen Mr Edwards upset in this way before.

71. Officer F said he had asked Mr Edwards why he had not gone back to his cell. Mr Edwards told him that the call had not been connected and he needed to wait to make another. (Prisoners have to wait five minutes between calls to make another one.) The officer asked Mr Edwards to make the call and then go back to his cell.

72. At 2.50pm, Mr Edwards phoned his partner's brother. He left a voicemail and again sounded distressed. He said he missed his partner and daughter and could not wait twelve years to see them. Mr Edwards said he was becoming someone he did not want to become and did not want to hurt anyone else, so he had decided to kill himself that day.

73. Mr Edwards then thanked Officer F, went back to his cell, and closed the door. The officer said he did not hear what Mr Edwards had said on the phone and he did not seem upset. He did not see Mr Edwards again. Mr Edwards was then locked in his cell until the next morning. (On Sundays, a cold evening meal is delivered to prisoners in their cells in the afternoon.)

74. Around 3.30pm, prisoner B came back from a gym session and spoke to prisoner A who was locked in his cell. Prisoner A said that Mr Edwards had made a telephone call and had been crying afterwards. Prisoner B was then, locked back in his cell. He called to Mr Edwards through his window and asked what had happened. Mr Edwards told him not to worry, he should keep cool and they would talk the next day. After that, they spoke for about 45 minutes about everyday things such as the television programme they were going to watch. Prisoner B then said he was going to rest, as he was tired after the gym.

75. Around 6.30pm, Mr Edwards shouted thank you through his window to prisoner A. Prisoner A asked if he was okay and Mr Edwards said he was. He told prisoner A to take care and that was the end of their conversation.

76. Around 8.00pm to 8.15pm, prisoner B woke up. Prisoner A told him through the windows that he had not heard anything from Mr Edwards. Prisoner B banged on the wall separating his cell from Mr Edwards' cell and shouted to him but Mr Edwards did not reply. Prisoner B said this was very unusual, as Mr Edwards always answered him. He thought that Mr Edwards might have been sleeping, so stopped trying to get his attention. A few minutes later, Mr Edwards asked prisoner B to call to prisoner A to get his attention. Mr Edwards then said, "Take care and keep it safe". Prisoner B said Mr Edwards had never said anything like that before and normally said, "See you tomorrow." This was the last thing he heard Mr Edwards say.

77. Night patrol officer A started work around 8.15pm that evening. He received a handover from the day staff and was then locked on the wing on his own.

Around 9.00pm, he started a roll check. He told the investigator that the purpose of the check is to make sure that each prisoner is their cell and is well. When carrying out the checks, he opens the observation flap of each cell, checks the prisoner is inside, that they are breathing and not in any difficulty. He could not specifically remember checking Mr Edwards' cell that night but said he knew that he must have done and that Mr Edwards must have been well at the time.

78. Around 5.00am on 15 June, the night patrol officer A began the morning roll count. Again, he could not specifically remember checking Mr Edwards' cell, but he had completed this in the same way as the evening roll check. He signed to say he had done both checks. He said that in the morning it is often more difficult to see prisoners, as they are usually in bed and have covered their windows, so it is dark in their cells. A number of staff and prisoners told the investigator that Mr Edwards had covered his window with black bin liners that he never took down, which made the cell very dark. Staff can turn on a cell night light to check prisoners if they cannot see prisoners when making checks. The night patrol officer did not use the cell light. He said that he normally used a torch for the checks, but had forgotten it that night.

79. Prisoner B said he had had difficulty sleeping that night and said he was sure that no one had done roll checks at 9.00pm or 5.00am. He said he was awake at both times and, at 5.00am, was making coffee. He said that he normally hears staff walking around and sees them when they open the observation panel, so he would not have missed an officer doing the checks. Prisoner A also said he did not hear or see anyone doing the 9.00pm roll check.

80. At 8.00am, Officer G began to unlock the cells on the wing. When he got to Mr Edwards' cell, he opened the observation flap, turned on the night light and saw Mr Edwards at the back of the cell by the window. He thought he was standing still and banged on the door and called his name. Mr Edwards did not respond, so the officer unlocked his cell. He went inside and called Mr Edwards' again. When he did not respond, he turned on the main light and saw that Mr Edwards was standing still, with his feet on the floor, slightly crouched with his head bowed forward. The officer then noticed that Mr Edwards had a ligature made from cloth tied around his neck and attached to the window.

81. Officer G immediately cut the ligature from the window but not from around Mr Edwards' neck. He said that Mr Edwards remained in an upright position, without any support. At 8.04am, the officer radioed an emergency code blue. (A code blue is medical emergency call used in circumstances such as when a prisoner is unresponsive, unconscious or has breathing difficulties.) The control room immediately telephoned an emergency ambulance. The officer ran to the cell door and shouted for help.

82. Officer H was working on the same landing. He did not hear the code blue over the radio but heard another officer on the wing shouting into her radio that they needed help at Mr Edwards' cell. The officer went to the cell immediately and saw Officer G at the door. Officer H also thought Mr Edwards was standing still and did not initially see the ligature around his neck. The officers moved Mr Edwards to the bed and Officer G cut the ligature from around Mr Edwards' neck. Officer H said this had been loose after he had cut the ligature from the window.

Both officers said that Mr Edwards was very cold, his body was completely stiff, and Officer H thought it was clear that Mr Edwards was dead. At this point, nurses arrived at the cell.

83. Nurse D and Nurse E were working on E Wing when they heard the code blue. They collected an emergency bag and went to Mr Edwards' cell. Nurse D said Mr Edwards was not breathing, was cold, stiff and did not respond when they shouted his name. They did not check for a pulse or check his airway but immediately started cardiopulmonary resuscitation, although Nurse D said she thought Mr Edwards was dead. She continued with chest compressions while Nurse E got the emergency equipment out of the bag

84. Nurse F, the designated emergency response nurse that day had also responded to the code blue and went to Mr Edwards' cell with Nurse G. When they got there, the other nurses were already attempting resuscitation. They moved Mr Edwards to the floor and attached a defibrillator, which found no shockable heart rhythm. Nurse F said she believed that Mr Edwards was already dead as he was cold, had no signs of life and had a deep ligature mark round his neck. Nurse G said they were unable to insert an airway since Mr Edwards' jaw was so stiff. She also thought Mr Edwards was dead.

85. Although the nurses considered that Mr Edwards was dead, they continued cardiopulmonary resuscitation until paramedics arrived at 8.17am. The paramedics also attached a defibrillator and at 8.20am, recorded that Mr Edwards had died. They noted that cardiopulmonary resuscitation had been futile and Mr Edwards was obviously dead. They had been unable to open his jaw and rigor mortis had set in.

86. Staff found a letter in Mr Edwards' cell, addressed to his partner and his daughter. He said goodbye to them and wrote that he did not want to live if he could not see them.

Contact with Mr Edwards' family

87. At 8.45am, deputy governor, A, asked the head of operations, to act as the family liaison officer. Mr Edwards had named both his partner and mother as next of kin at different points during his time in prison. As Mr Edwards' partner was the victim of the offence, the prison decided to treat his mother as his primary next of kin. They contacted the police who advised that they would accompany prison staff to his mother's home. Deputy governor, A and the head of Operations left the prison at 11.10am. Mr Edwards' mother was not at home at the time, so they telephoned her, collected her and took her home. The deputy governor told her that her son had died and offered condolences and support.

88. The police told Mr Edwards' partner of his death, as their family liaison officer had been in frequent contact with her during the court case.

89. The prison contributed to the costs of Mr Edwards' funeral, in line with Prison Service instructions.

Support for prisoners and staff

90. A manager debriefed the staff involved in the emergency response and offered his support and that of the staff care team.

91. The prison posted notices informing other prisoners of Mr Edwards' death, and offering support. Staff reviewed all prisoners assessed as at risk of suicide and self-harm, in case they had been adversely affected by Mr Edwards' death.

Post-mortem report

92. A post-mortem examination established that Mr Edwards died as a result of hanging.

Findings

Identifying and managing risk

93. Mr Edwards had a number of risk factors for suicide and self-harm. He was a young man, this was his first time in prison, he was charged with a serious violent offence against his partner, he had relationship difficulties, he had recently attempted suicide, had a lack of external social support and mental health problems. Throughout his time at Wormwood Scrubs, he consistently said he was worried about his trial, the length of sentence he might get, missing his partner and daughter and his possible mental health issues.

94. Mr Edwards' offence and background were significant factors that increased his risk of suicide and self-harm. While staff managed him under ACCT procedures when he arrived at the prison, and for two short periods afterwards, it is apparent that staff responsible for ACCT assessments and reviews were not always aware of the severity of his offence (once referred to as "minor charges") or the significance of the victim issues. One ACCT assessor offered to get his partner's telephone number for him. We consider that it is difficult for staff to address issues of suicide and self-harm unless they properly understand the underlying risk factors.

95. In a thematic report about risk factors in self-inflicted deaths published in April 2014, we noted that assessments of risk too often placed insufficient weight on known risk factors and too much on staff perceptions of the prisoner's behaviour and demeanour. Mr Edwards said, during an ACCT review on 16 March (when the ACCT was closed), that he was concerned about his forthcoming trial. The staff did not note this as an ongoing risk factor that would need to be monitored.

96. On the first day of his trial, on 20 April, court custody officers were concerned about Mr Edwards. He had wrapped bands of material around his wrists and ankles with drawing pins in them and there was dried blood on the material. He seemed depressed and a court custody officer completed a suicide and self-harm warning form. The officer phoned SO C at Wormwood Scrubs to alert the prison to their concerns about him. The court custody officer believed that the SO had agreed to open an ACCT. When Mr Edwards got back from court, the SO seemed more concerned about the security implications of Mr Edwards having strips of material, rather than any wider exploration of how Mr Edwards was feeling or his risk of suicide or self-harm. There is no evidence that the SO considered Mr Edwards' risk factors alongside the suicide warning from the court and he did not begin ACCT procedures.

97. Prison Service Order 3050, Continuity of Healthcare, states, "Events that require a prisoner to leave the prison and pass back through prison reception can have significant impact on the health of a prisoner." The PSO includes events such as attending court and sentencing at court and requires prisons to have protocols for screening such prisoners for any potential healthcare, or suicide and self- harm issues. On 27 April, Mr Edwards was convicted of two charges of rape and one of assault. A nurse spoke to Mr Edwards when he returned to the prison and recorded only "no concerns". There is no record that the nurse knew about his conviction or spoke to him about how he felt about this. This was particularly

important as Mr Edwards' was very anxious about the length of sentence he could expect to receive after his conviction.

98. On 12 June, when Mr Edwards returned from a court appearance for sentencing (which had been postponed), the judge had warned him to expect a long sentence. No member of healthcare staff assessed his risk of suicide and self-harm when he got back to the prison. Evidence from other prisoners, the official visitor, and Mr Edwards' telephone calls, shows that his mood worsened after this court appearance. He was anxious that he had been told to expect a prison sentence of up to twelve years and said that he could not cope without seeing his daughter for that long.

99. On 13 June, when the official visitor, saw Mr Edwards he said the thought he had conveyed to Officer E that he thought Mr Edwards was at risk of suicide and self-harm. However, he did not explicitly state this and did not make this clear in his entry in the chaplaincy logbook. Officer E said that official visitor had said that Mr Edwards was angry and frustrated about his delayed sentencing. Officer E spoke to Mr Edwards shortly afterwards and was satisfied with his demeanour. There is no record that he considered whether the change in mood represented a trigger for self-harm, which a member of the safer custody team had asked staff to be aware of, in November.

100. It is evident from the telephone calls that Mr Edwards made on 14 June, that he had intended to kill himself. However, staff were not aware of those calls and we recognise that it would have been difficult for staff to identify that he was at imminent and high risk of suicide on the weekend of 13 and 14 June.

101. The prison assessed Mr Edwards as at risk of suicide and self-harm and managed him under ACCT procedures three times. (We discuss the operation of the ACCT procedures below.) However, we are concerned that staff did not fully identify the extent and depth of his risk and too often relied on his demeanour rather than his known risk factors. In addition to the times when he was managed under ACCT procedures, there were a number of occasions when there were signs that Mr Edwards was at raised risk of suicide and self-harm which staff missed.

102. In our April 2014 review of risk factors, we noted that the level of risk is not fixed and stressful events can have a sudden and critical impact. The fact that Mr Edwards was no longer managed under ACCT procedures did not mean that his underlying risk factors had gone away. Staff need to be vigilant for any changes that might indicate increased risk. We make the following recommendations:

The Governor and Head of Healthcare should ensure that all staff working with prisoners have an understanding of risk factors for suicide and self-harm and are vigilant about changes that might indicate an increased risk, particularly when prisoners have previously been managed under ACCT procedures.

The Governor and Head of Healthcare should ensure that prisoners returning from court appearances are properly assessed for risk of suicide and self-harm and staff take into account and record warnings received

from court staff, including the reasons when warnings have been discounted.

Management of ACCT procedures

103. Mr Edwards was managed under ACCT procedures for three separate relatively short periods at Wormwood Scrubs: when he first arrived on 3 November until 11 November; between 21 December 2014 and 6 January 2015; and between 10 March and 16 March. We are concerned that ACCT procedures were not always managed in line with the requirements set out in Prison Service Instruction (PSI) 64/2011, Safer Custody. We recognise that following procedures correctly might not necessarily prevent a prisoner from suicide, but PSI 64/2011 notes that the ACCT process is necessarily prescriptive; it should be prisoner-centred and, when used effectively, can reduce risk.

104. PSI 64/2011 has a mandatory action that healthcare staff must be informed when an ACCT is opened and invited to the first case review. There is no record that this was done. Healthcare staff did not attend any case reviews. On 11 March, a doctor wrote in Mr Edwards' ACCT record, but apart from this, there was no healthcare input into the ACCT process or any evidence that healthcare staff were aware that Mr Edwards was subject to ACCT monitoring.

105. The PSI noted that the most effective way to assess and manage risk is through a multidisciplinary process and there is a mandatory requirement that case reviews should be multidisciplinary where possible. It notes that the process will operate more effectively if there is continuity in attendance of staff from relevant departments such as education. Mr Edwards had seven ACCT case reviews and none of them had multidisciplinary attendance. There is no record that anyone other than wing staff were invited to reviews, even though Mr Edwards attended education classes full time. On 29 December, custodial manager A was the only member of staff at the case review, which was inappropriate. Even when multidisciplinary attendance is not possible, it is implicit that ACCT reviews, which are based on teamwork, involve more than one member of staff. There was little consistency of case management, with five different managers for seven reviews.

106. Caremaps should reflect the prisoner's needs, level of risk and the triggers of their distress. The PSI says that they should address issues identified in the ACCT assessment interview and consider a range of factors including health interventions, peer support, location, provision of diversionary activities, including occupations in cell and access to gym and other activities. Each action on the caremap should be tailored to meet the individual needs of the prisoner, be aimed at reducing risk, and be time bound.

107. Although caremap actions for Mr Edwards addressed some of his identified issues, they were not comprehensive and did not always include the issues which were most important to him and which increased his risk. We accept it would have been difficult to address all of Mr Edwards' concerns, such as his contact with his daughter, but there was no goal to help him come to terms with this. Nothing was identified as a trigger for suicide and self-harm, even though Mr Edwards had consistently voiced anxieties about his forthcoming trial and the

likelihood that he would get a long sentence. We consider that staff ended ACCT procedures prematurely on 16 March, as Mr Edwards had said at the review that he was still worried about his trial at the end of the month and said he had no external support.

108. Although it is a requirement that ACCT documents travel around the prison with the prisoner when they take part in activities, the literacy tutor, told the investigator that she rarely sees ACCT documents for prisoners she teaches. She did not see any ACCT record for Mr Edwards and was only aware that he was on an ACCT when he first arrived at the prison, and then only because Mr Edwards had told her. We are also concerned that a number of staff said they had had no training in ACCT procedures.

109. We are not satisfied that the prison managed ACCT procedures fully effectively to support Mr Edwards. We make the following recommendation:

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

- **All known risk factors are considered when determining the level of risk of suicide and self-harm and taken into account whenever there is further information that a prisoner is at risk.**
- **All case reviews are multidisciplinary with continuity of case management.**
- **A member of healthcare staff should attend all first case reviews and subsequent reviews where relevant.**
- **Triggers for suicide and self-harm are identified and recorded.**
- **ACCT caremap actions are specific and meaningful, aimed at reducing a prisoner's risk and identify who is responsible for them.**
- **ACCT documents accompany prisoners when they move around the prison.**

Search Procedures

110. Prison staff searched Mr Edwards before he left for court on 20 April. When he arrived at court, staff there searched him and found he had bands of torn sheets with drawing pins sticking out wrapped around his wrists and ankles. Court staff removed them. Later in the day, Mr Edwards had again tied sheets with drawing pins around his wrists and ankles. Officers removed them, and a further search revealed more sheets, drawing pins and a tablet in his shoes.

111. The Head of Security and Intelligence at Wormwood Scrubs, told us that officers should have found these items when they searched Mr Edwards. We are concerned that Mr Edwards concealed these items round his wrists and ankles but also hid other items in his shoes. We make the following recommendation:

The Governor should ensure that prisoners are appropriately and effectively searched when they leave or return to the prison.

Officer support

112. From the time of his arrival at Wormwood Scrubs on 3 November 2014, until his death on 16 June 2015, wing staff made no entries in Mr Edwards' case notes in his prison record indicating any personal interaction with him.

113. In 2011, HM Inspectorate of Prisons (HMIP) made a main recommendation 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". At the 2014 inspection, HMIP described the personal office scheme as inconsistent and ineffective, and noted that the lack of an effective personal officer scheme compounded the poor care for prisoners at risk of self-harm.

114. After the death of a prisoner at Wormwood Scrubs in January 2012, we made a recommendation about the need for wing officers to have some specific responsibility for the welfare of individual prisoners. The prison rejected the recommendation. We repeated the recommendation after a death in 2013. This time, the recommendation was accepted and the prison said that they would explore the best way of introducing a named officer scheme by the end of January 2014. There is little evidence that this has happened. We make the following recommendation:

The Governor should ensure that all prisoners have meaningful contact with a named officer who regularly checks their wellbeing and records contact in their case notes.

Roll checks

115. The primary purpose of a roll check is for security, to check that all prisoners are present. Staff should also satisfy themselves of each prisoner's safety, but do not need to get a response from them. The Head of Safety and Equality, said staff should do whatever they needed to in order to satisfy themselves that prisoners are fit and alive, including contacting the manager on duty and unlocking a cell if necessary.

116. The night patrol officer, A, was responsible for completing the roll check at 9.00pm on 15 June and 5.00am on 16 June. He told us that he would have done the checks although he could not specifically remember doing so. He signed to say he had done them. He said that it was possible, particularly at the 5.00am check, that he had not been able to see Mr Edwards and had assumed that he was in bed. Mr Edwards covered his windows, so it would have been dark in his cell. He said he usually used a torch, but had forgotten it that night, and that night lights in cells often did not work. (However when Officer G went to Mr Edwards' cell, he used the night light to see inside the cell.)

117. Two prisoners in nearby cells said that they did not think that any roll checks happened that night. They said officers often do not complete checks properly and open and close the observation panel very quickly. They said officers never use a torch and do not attempt to get a response.

118. When officers discovered Mr Edwards hanged at 8.04am, he was completely stiff, indicating that he had been dead for some hours. The extent to which rigor mortis was present would usually take over four hours. There is no CCTV on the wing, so we cannot know for certain whether the night patrol officer, A, completed the 5.00am check. However, as Mr Edwards had clearly been dead for some time when Officer G went into the cell, we do not consider that the night patrol officer could have assured himself of Mr Edwards' wellbeing at the 5.00am check. We make the following recommendation:

The Governor should ensure that staff completing roll checks, satisfy themselves that the prisoner is alive and breathing at the time.

Clinical Care

119. The clinical reviewer concluded that the general standard of care that Mr Edwards received was not comparable to the care he would have received in the community. She noted that assessments were often incomplete and communication between healthcare staff and prison staff was ineffective. The clinical reviewer also concluded that the clinical records were not of an acceptable standard.

120. A psychiatrist referred Mr Edwards to the primary mental health team the day after he arrived at the prison. Nurse C was the only nurse attached to that team, and she told the investigator she asked the psychiatrist what work he wanted her to do with Mr Edwards. There is no evidence of this request and the nurse did not assess Mr Edwards. We are surprised that when Mr Edwards was found at court with torn sheets with drawing pins sticking out wrapped around his wrists and ankles, there was no review of his mental health.

121. On 29 April, a GP referred Mr Edwards to the primary mental health team. He attended an appointment in mid-May but the primary mental health team did not formally assess him. Although a psychiatrist had seen Mr Edwards, the clinical reviewer considered the primary mental health team should have assessed him when the GP referred him. Mr Edwards said he did not want to attend yoga, the service Nurse C offered him. She said she had forgotten to record the details of this appointment on the medical record, as she was overworked. The clinical reviewer concluded that the system to assess and support Mr Edwards' mental health did not deliver the service as intended.

122. A root cause analysis commissioned by Central London Community Healthcare after Mr Edwards' death concluded that a single point of referral for mental health services was needed with better integrated working between primary and secondary mental health services. We make the following recommendation:

The Head of Healthcare should ensure that there is an effective single point of referral system for mental health assessments, that assessments take place promptly, are documented in the clinical record, and ongoing treatment is provided as required.

Attempting Resuscitation

123. The officers and nurses who responded to the code blue said that there were no signs of life and Mr Edwards was stiff when they found him. All healthcare staff thought they had to start and continue chest compressions until a doctor or paramedic arrived to confirm death. Head of Healthcare, confirmed that this was the case.

124. The European Resuscitation Council Guidelines 2010 state, "Resuscitation is inappropriate and should not be provided when there is clear evidence that it will be futile …" The guidelines define examples of futility as including the presence of rigor mortis. More recently, the British Medical Association (BMA), the Resuscitation Council (UK) and the Royal College of Nursing (RCN) issued guidance in October 2014 about making appropriate decisions about resuscitation. The guidance says that every decision should be based on a careful assessment of each individual's situation. These decisions should never be dictated by 'blanket' policies.

125. We accept that the staff acted in what they considered to be Mr Edwards' best interests and do not criticise them for their actions. However, attempting resuscitation when someone is clearly dead is distressing for staff and undignified for the deceased. We have previously made a recommendation to Wormwood Scrubs about this issue following deaths in 2013. The prison said that they would introduce guidance in December 2014. We consider it was inappropriate to try to resuscitate Mr Edwards. We repeat our previous recommendation:

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

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