PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent investigations

A Report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

Investigation into the death of a man at HMP Wormwood Scrubs in April 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, who was found hanging in his cell in April 2013, at HMP Wormwood Scrubs. He was 45 years old. I offer my condolences to his family and friends.

A clinical reviewer reviewed the clinical care and treatment that the man received at Wormwood Scrubs. Regrettably some members of prison staff did not attend for interviews, which impeded the investigation and hampered the search for learning to avoid future tragedies in cases such as this. This matter will be raised formally with the National Offender Management Service.

The man was remanded into custody on 19 March 2013. He was Albanian and could not speak English. Healthcare staff at the prison used a telephone interpretation service to interview the man when he arrived but officers did not do so during the reception process. At reception, he was described as being low in mood, tearful, depressed and very anxious about being in prison. He was assessed as being at risk of suicide and self-harm and was monitored under suicide and self-harm prevention procedures. However, monitoring ended less than a week later on 25 March. He was found in his cell one morning in April, suspended by a ligature made from a leather belt. Healthcare staff attended promptly and attempted to resuscitate him, but were unsuccessful.

The investigation identified a number of serious shortcomings in the management of the suicide and self-harm prevention procedures and related care and support offered to the man at Wormwood Scrubs. In particular, staff did not use professional interpretation services when assessing his risk or reviewing his progress and monitoring ended with little evidence to support the decision.

I am concerned that a number of other of our recent investigations into deaths at Wormwood Scrubs have also identified weaknesses in suicide and self-harm prevention procedures. The governor needs to ensure that improvements are made to the management of this fundamental aspect of safer custody.

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 **February 2014**

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SUMMARY

1. The man was a 45 year old Albanian national who was in the United Kingdom illegally. He was remanded to Wormwood Scrubs for drug related offences. This was his first time in prison in the United Kingdom. He did not speak English. Apart from one sister who lived in London, his family were all in Albania

2. When the man arrived at Wormwood Scrubs on 19 March 2013, he was tearful, anxious and in a low mood. Prison Service suicide and self-harm prevention procedures (known as ACCT) were begun.

3. Staff completed the ACCT documents without using official interpreting services and the ACCT was closed on 25 March, after the man had been able to contact his family. A post- closure review, completed on 5 April, did not contain any information about the risk that he posed to himself at that time.

4. A few days later an officer found the man in his cell, suspended from the top bunk of his bed by a leather belt. The emergency response was swift. Healthcare staff arrived at the cell quickly and tried to resuscitate him. Paramedics arrived shortly afterwards. Sadly it was not possible to resuscitate him and he was pronounced dead at 6.55pm.

5. We make five recommendations relating to healthcare, ACCT procedures and using official interpreting services.

THE INVESTIGATION PROCESS

6. Notices were issued to staff and prisoners at HMP Wormwood Scrubs inviting anyone with information about the man's death to contact the investigator. One prisoner wrote to her but the matters were not related to the man's death.

7. The investigator visited the prison on 16 April, and obtained the man's prison and clinical records. She visited the wing and saw the cell where he had lived and spoke to staff and prisoners on the wing. She spoke to the Metropolitan Police about a letter that he had given to another prisoner before he died. The prisoner declined to be interviewed by the investigator or the police without a solicitor present and no solicitor would provide this service as he was not being interviewed under caution. Further attempts to interview the prisoner when he transferred to another prison were also unsuccessful.

8. An Assistant Ombudsman interviewed a member of staff on 13 June 2013. The investigator carried out further interviews with four members of staff on 27 June. Three other members of staff were not available for interview as planned. The investigator returned to Wormwood Scrubs on 28 June and 31 July to interview the remaining staff. Some staff were still not available for interview. She made arrangements to complete the outstanding interviews on 23 August, but the members of staff were again said to be unavailable. One member of staff refused to be interviewed.

9. NHS Hammersmith and Fulham commissioned a clinical reviewer to conduct a clinical review of the man's care. The clinical reviewer and the investigator conducted some joint interviews.

10. HM Coroner for Western London District was informed of this investigation and has provided a copy of the post-mortem report. A copy of this report has been sent to the Coroner.

11. One of our family liaison officers contacted the man's sister to outline the purpose of the investigation and ask if she had any specific issues she wanted the investigation to consider. She did not believe that her brother had taken his own life and she thought that he had been killed in prison. She asked about the letter he had left with another prisoner and asked if he had named people he thought might harm him. She also asked about the belt he had used to hang himself, as he did not normally wear one. His property card indicated that he had a belt with him when he arrived at the prison.

12. The man's family received a copy of the draft report as part of the consultation process. They did not raise any comments within the feedback period.

HMP WORMWOOD SCRUBS

13. 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.

Independent Monitoring Board

14. 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 noted that interpreting services were not used as often as they should be, especially in ACCT reviews. They also noted that there was a lack of available ACCT assessors. Overall, the IMB reported that their concerns about the safety of both staff and prisoners had increased over the past year. The IMB noted that many prisoners did not attend medical appointments often due to staff shortages or uncoordinated movements when officers did not check lists and sent prisoners to other activities instead.

Her Majesty's Inspectorate of Prisons

15. The most recent inspection of Wormwood Scrubs was an unannounced full follow-up inspection in June 2011. Inspectors found significant improvements in the identification of prisoners' substance misuse needs and co-ordinating their care. Reception and induction were described as generally appropriate, with good arrangements to ensure drug and alcohol dependent prisoners received quick treatment. Inspectors judged that ACCT procedures were satisfactory, with thorough initial assessments, but identified risk factors were often too vague and not translated into actions in care plans and followed up at reviews. No named or key officers were identified and there was often no continuity of case management, which meant that concerns identified at reviews were not always followed up at subsequent reviews.

16. Primary health care had improved and there was less reliance on agency staff. Inspectors found that most prisoners were able to see a doctor reasonably quickly. Inspectors found that over 40% of prisoners were foreign nationals, many of whom did not speak English and some key policies did not take account of their specific circumstances. There was no nominated foreign nationals officer to coordinate work and services. Telephone interpreting services were little used including for those that required confidentiality. Staff relied heavily on other prisoners to interpret and some language groups felt isolated.

Previous deaths at Wormwood Scrubs

17. There were four deaths at Wormwood Scrubs in 2012, one of which was self-inflicted. Issues about the completion of ACCT documents were raised in that case. At the time of the man's death, in 2013 there had been one other self-inflicted death, following which we raised concerns about ACCT procedures.

There have been two further self-inflicted deaths at Wormwood Scrubs since his death this year. We have identified further concerns about ACCT procedures in one of the investigations into these deaths.

Assessment Care in Custody and Teamwork

18. Assessment, Care in Custody and Teamwork (ACCT) is the Prison Service process for supporting and monitoring prisoners at risk of harming themselves. The purpose of the ACCT is to try to determine the level of risk posed, the steps that might be taken to reduce this and the extent to which staff need to monitor and supervise the prisoner. Checks should not be at predictable intervals to prevent the prisoner anticipating when they will occur. 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. The ACCT plan should not be closed until all the actions of the caremap have been completed.

KEY EVENTS

19. The man was an Albanian national and was remanded into custody for drug offences at Wormwood Scrubs on 19 March 2013. He was in the UK illegally and was known to the immigration authorities. Police records noted that he spoke very little, if any English. They had used interpreters when they interviewed him.

20. The man arrived at Wormwood Scrubs at 6.05pm. He was then interviewed by a number of staff. It is not clear from who completed the first night induction record as the form was only initialled. The officer recorded that this was his first time in prison, that he had very little English and that he had answered 'no' to the following questions:

- Does someone important to you know where you are?
- Do you have worries or concerns about being in prison?
- Do you have any worries or concerns about your home or family members?
- Do you have any urgent problems outside which you were not able to solve before you came in?
- Have you ever harmed yourself in the past?
- Do you feel like harming yourself now?
- Are you dependent on drugs or alcohol?
- Do you have any immediate health concerns or disabilities which are affecting you?

21. At 6.25pm, an officer completed a 'concern and keep safe' form, which starts the ACCT monitoring process for prisoners considered to be at risk of suicide or self-harm. The officer wrote that the man was very low in mood and tearful during his initial interview. He also wrote that he spoke very little English. A Senior Officer (SO) completed an immediate action plan. When interviewed, the SO said that he could not remember him. As part of the immediate action plan, the SO wrote that he should be in a shared cell and should be observed hourly until he had been assessed. He also allowed him an international telephone call and explained about Listeners (prisoners who have been trained by the Samaritans to offer support.) The SO also wrote that he did not speak English. At interview, he said that he had thought that the best place for him to live would be in a dormitory with five other prisoners. He said that the other prisoners were from mixed nationalities, including one Albanian who was a wing cleaner and a Listener.

22. The SO told the investigator that he had probably asked another Albanian prisoner to interpret for him rather than use the interpreting service. The investigator asked if he thought this was good practice, bearing in mind that the man was upset and might have wanted to speak confidentially. The SO said that he thought it was best for one prisoner to interpret for another but he was aware of the interpreting service and had used it previously.

23. The SO said he could not remember if there was anyone else present at the interview. At the bottom of the immediate action plan, there is a place for

names and signatures of others present. There is one illegible signature which he said he did not recognise.

24. At 8.05pm, an officer carried out an assessment interview with the man. It is not clear from the records who carried out this interview and prison staff were unable to clarify this. The information in the assessment merely states that he spoke very little English and had said that he was Italian, but when someone spoke to him in Italian he could not understand them. The officer noted that he was not engaging with the questions and that another prisoner had said that he was Albanian. Without an interpreter none of the expected areas were covered in the assessment. It was decided that he should be observed five times a day and five times at night at irregular intervals, and should see a nurse or doctor on the first night centre.

25. At 8.15pm, an ACCT case review was held by a SO and an officer. They wrote in the ACCT document that the man's risk to himself was low. According to the ACCT document, there was no healthcare input at the review and there is no indication that an interpreting service was used. There is an indication that another prisoner helped interpret. One caremap action was agreed for him to contact his sister. We have been unable to establish more of what happened at the review and how the assessment of low risk was reached as we were not able to interview either member of staff.

26. At 9.23pm, a nurse used a telephone interpretation service to carry out an initial health screen. She noted that the man was not registered with a doctor in the community. He told her that he suffered from high blood pressure, had previously had jaundice and was allergic to a number of substances. She noted that he told her that he was otherwise fit and well but that he was in a low mood and was very anxious about being in prison. He said that he did not misuse drugs or alcohol. She made an appointment for him to see the doctor on 26 March. He does not seem to have been taken to this arranged appointment. Staff said that they believed this was because he moved wings that day.

27. The man stayed in the first night centre in a dormitory with five other prisoners on 19 March. On 20 March, a nurse completed a second healthscreen with him, using a telephone interpretation service. She noted that he seemed vague, gave long, erratic answers to her questions and was anxious. She also noted that his blood pressure was high at 148/94 and that it should be monitored. She noted that he had asked to see the doctor before he agreed to a course of hepatitis B injections and that another nurse had already booked an appointment for him on 26 March. She was not aware that he had been identified as at risk of suicide and self-harm and did not make an entry in his ACCT document.

28. According to the ACCT ongoing record, an officer helped the man to complete a PIN phone application at 9.00am on 21 March. The officer was helped by another prisoner. (PIN numbers are given to prisoners to allow them to phone agreed telephone numbers.)

29. On 25 March, at 9.07am, a nurse examined the man who was complaining of a headache. The nurse used the telephone interpreting service during the interview and completed a full assessment, including asking him about his mental state. He said the assessment took about an hour.

30. After the assessment, the nurse concluded that the man was not at risk of suicide or self-harm. He told the investigator that he believed his anxieties were about his feelings of isolation (he was now in a single cell), his lack of understanding of the prison procedures and his language difficulties. He said that the man did not know why he was in prison or what was likely to happen, so he explained to him why he thought he had been remanded into custody. When asked whether he felt suicidal, he said that he had lots of reasons not to harm himself, the most important being his family, and had never planned to do so. The nurse said that if he had had any reason to think he would harm himself he would have raised the risk on his ACCT and passed the information to wing staff. He passed on his concerns about the man's feelings of isolation to the safer custody team and reminded him of his appointment with the GP the next day. The nurse said that he thought that staff would move him to a cell with an Albanian speaking prisoner.

31. At 2.05pm on 25 March, a SO carried out an ACCT case review which had originally been scheduled for 24 March. It is not clear why it did not take place then but she had noticed that it had not been done when she arrived for work that day. Another prisoner interpreted. She said that the man and the prisoner were friends and she had no reason to be concerned about bullying. She said that if a prisoner had not been available to interpret she would have used the official interpreting services. No other members of staff were present but she had contacted a nurse, who said that he thought that the ACCT could be closed. She wrote that he had no thoughts of self-harm but he was upset that he could not speak to his family. He also wanted to share a cell with other Albanian prisoners, so that he could talk with them. She said that she helped him to complete an application to have his family's telephone number on his PIN phone list and closed the ACCT document. She scheduled a post- closure review for 1 April.

32. On 26 March, the man moved to a double cell on A wing where he stayed for the remainder of his time in prison. The other prisoner was English and was not able to communicate with him. He had not started a prison job or any education courses, so he spent most of the time locked in his cell. On the morning of 8 April, his cell mate was moved to a different wing leaving him alone in the cell.

33. The ACCT post-closure review is dated 5 April. There is no explanation recorded why it did not take place on 1 April as planned, and we have not been able to establish who conducted the review. The only information on the form is the man's name and the date. None of the questions on the form have been answered and there is a line scored through each part of the form that requires a response so it is difficult to conclude that one actually took place.

34. A few days later an officer looked through the observation panel in the man's cell door when she was doing a roll check. She saw him suspended by a ligature from the top bunk of his bed and immediately shouted for help. Another officer, who was on the landing below, responded immediately. They both went into the cell and found him suspended by a leather belt attached to the top bunk.

35. The officer called an emergency code over the radio and then used her anti-ligature knife to cut the belt from the man's neck and laid him on the floor. The control room called an ambulance as soon as the emergency call was made. Healthcare staff responded rapidly and a nurse started chest compressions when she arrived at the cell. The nurse said that he had no pulse, his pupils were dilated and his teeth were clenched. Other healthcare staff arrived quickly and brought emergency equipment, including an automated external defibrillator which analyses whether a heart rhythm can be re-established by an electric shock. The defibrillator advised to continue with compressions and not to administer a shock.

36. A prison doctor arrived at the man's cell shortly afterwards. She noted that cardio-pulmonary resuscitation (CPR) had been taking place for approximately five minutes when she arrived and the defibrillator was advising not to shock. She observed CPR taking place for another two minutes then asked staff to stop. She examined him and found no pulse, no heart beat or any breathing sounds and no signs of life. She pronounced him dead at 6.55pm. Paramedics arrived shortly afterwards and also confirmed that he had died.

Support for prisoners and staff

37. Staff informed prisoners on the wing about the man's death and offered support. Prisoners who were at risk of suicide or self-harm were reviewed and support was offered to them. A member of staff spoke individually to the prisoner who had shared a cell with him until that morning. He said they had been unable to communicate but had not seen anything which led him to be concerned that he might take his life.

38. After the man had died an operational manager held a debrief for staff involved. He allowed the officer who had found him to go home because she had been deeply affected by his death. The staff who attended the hot debrief were offered the support of the duty care team.

39. Later that day, another Albanian prisoner handed in a letter, which was addressed to the man's wife at an address in Albania. It was written in Albanian and he gave it to him before his death. It was given to police and translated. In the letter, he said he was anxious about being in prison, did not feel safe there and thought he might be killed. He did not name anyone who he thought was a risk to him or indicate that anyone had threatened him. Prison staff said that he had never told them that he was worried about being harmed by other prisoners and there are no security information reports about this. His sister said that when she had spoken to him he had expressed

similar concerns. As noted in the investigation section the prisoner who received the letter declined to be interviewed by the investigator.

40. The investigator contacted a Detective Sergeant to ask if the police had found any evidence that the man had been harmed or threatened by other prisoners. The Detective Sergeant said that they had not found any suspicious circumstances surrounding his death. The prisoner who gave the letter to prison staff also refused to be interviewed by the police.

Family liaison

41. A prison family liaison officer (FLO) was appointed. She arrived at the prison at 8.00pm and gathered information about the man's death. He had not nominated a next of kin, so she checked his prison phone records and found that he had called someone else with his surname. She called the number and established that this was the man's sister and explained what had happened to him. She was on holiday abroad when she received the call. She was extremely distressed at the news. She was the only member of his family who lived in United Kingdom and told the FLO that his wife and family all lived in Albania and she would contact them to give the news of his death. She cut short her holiday and returned on 9 April. The FLO contacted her that day and arranged to meet her at the prison.

42. On 15 April, the man's sister visited the prison and the cell where her brother had lived. She had arranged for his body to be flown back to Albania on 17 April. The FLO visited her when she returned from Albania after his funeral. The prison made an appropriate financial contribution towards the costs of the repatriation of the body and the funeral.

ISSUES

Clinical care

43. Healthcare staff assessed the man when he arrived at Wormwood Scrubs, appropriately using a telephone interpreting service. He indicated that he suffered with high blood pressure and some allergies. A nurse requested that his blood pressure should be monitored. However, apart from the two readings at the initial health screens and one on 25 March, when a nurse examined him, there is no record of any further monitoring taking place. This omission did not have a direct bearing on his death, but we refer the Head of Healthcare to the recommendation in the clinical review.

44. The man did not see a doctor during his health screen but an appointment was made for him to visit the GP on 26 March. However, the clinical reviewer notes that he did not see a GP at his reception, which he considers he should have done because of the concerns over his mental health. While the clinical reviewer concluded that, overall, the care and treatment offered to him was equivalent to that which he would have received in the community and of a good standard, we are concerned that a GP did not examine him when he arrived. This might have led to other action, such as a referral to the mental health team, or prescription of medication which could have helped him. We make the following recommendation:

The Head of Healthcare should ensure that a GP examines prisoners assessed as being at risk of self-harm and suicide during the reception procedure.

45. A further possible chance to assist the man was missed when he did not attend the GP appointment on 26 March. Prison staff said that this was likely to have been because he moved wings that day, and that staff on his new wing were not aware of the appointment. While there will always be occasions where prisoners have to move at short notice, it is important that any GP appointments that are not missed or rebooked quickly if this is not possible. We note that the Inspectorate of Prisons and the Independent Monitoring Board were both critical about the number of missed healthcare appointments in their recent reports. The IMB were critical about uncoordinated movements and officers not checking movement lists properly which led to missed appointments. We make the following recommendation:

The Governor and Head of Healthcare should introduce an appropriate system to ensure that staff are aware of and ensure prisoners are taken to GP and other booked healthcare appointments.

Assessment and Care in Custody and Teamwork (ACCT)

Language issues

46. The man was Albanian with a very limited understanding of English. He was identified as a risk of suicide and self-harm shortly after he arrived in reception. The reception senior officer could not recall exactly, but believes that he would have used another prisoner to interpret when speaking to him to complete the immediate action plan. At the ACCT assessment interview which followed it is again apparent that no professional interpretation service was used and it does not appear that a prisoner was used either. It is a mandatory requirement of PSI64/2011 that 'where prisoners do not speak English, ACCT assessment must be undertaken with the assistance or involvement of an interpreter, or appropriate translation service'. The purpose of the ACCT assessment is to identify the main issues causing the prisoner distress and what might be done to support him. It is difficult to understand how the assessment could have proceeded without proper communication with him. In reality this means that no meaningful assessment could have been done.

47. The first ACCT review was held shortly afterwards. The purpose of the first review is to identify the prisoner's most pressing needs, using the information from the ACCT assessment and identify appropriate activities to address these needs, agree the level of risk posed by the prisoner and how he will be supported, and to identify whether a mental healthcare referral or a referral to drug or alcohol services is needed. It appears that another prisoner might have been used to interpret at this review which we would consider inappropriate for such a task. We have been unable to discover more as the records are poor and the SO and officer who attended the reviews have not cooperated with this investigation.

48. The ACCT was closed at the second review when the only member of staff present was a SO. The SO used another prisoner to interpret, who she said was a friend of the man's; therefore she had no concerns about bullying. She does not appear to have considered that the presence of another prisoner might inhibit another prisoner from talking about issues that were causing him distress or other personal matters. None of the staff involved in the ACCT process appear to have followed the requirement in PSI 64/2011 to consider the use of interpretation and translation services when dealing with prisoners whose first language is not English and in particular when conducting assessments of risk and during the risk management process. He managed to go through the entire ACCT process from the initial concern stage to closure and post-closure without the support of any professional interpretation, despite a further reminder in the PSI that 'Prisoners who do not speak English must be given access to an interpreter or appropriate translation service in order to participate in the ACCT process'.

49. A SO told the investigator that staff were expected to use the interpretation service with prisoners who do not speak English. However, staff told the investigator that it was common practice to use other prisoners. Had the

official interpretation service been used, we consider the staff would have been able to assess the man's problems more effectively and taken appropriate action to support him. We note that the IMB, in their most recent report, also commented that official interpreters are not used as required in ACCT reviews. We make the following recommendation:

The Governor should ensure that, when prisoners do not speak or understand English well, professional interpreting services for prisoners at risk of suicide and self-harm are used as required by PSI 64/2011.

ACCT procedures

50. The quality of the ACCT documents was very poor. It has not been possible to establish who completed parts of the procedures, including the assessment and post-closure interviews, because the signatures are illegible and prison staff were unable to tell us who completed them. It should always be clear who has conducted interviews. We also found a number of deficiencies in the ACCT procedures. PSI 64/2011 notes that the "ACCT process is necessarily prescriptive and it is vital that all stages are followed within the timescales prescribed".

51. Within an hour of being opened the appropriate manager is, among other tasks, supposed to inform healthcare staff so that the opening of the ACCT plan can be noted in the clinical record. He or she should also request any relevant information from healthcare staff which will contribute to the assessment and subsequent risk management of the prisoner. There is no evidence that this was done and the nurse who completed a secondary health screen on 20 March, the day after his arrival, was unaware that he was on an ACCT even though she might have had useful information to provide. This is all the more surprising as the ACCT document is expected to travel with the prisoner and it should have been available to her when she assessed him.

52. It is difficult to regard the ACCT assessment interview as having been completed at all. Where the prisoner is unable to take part in the interview the PSI requires the ACCT assessor to undertake the assessment based on all other available information including from healthcare. As the man had just arrived we accept that little information would have been available, but as the assessor chose not to use an interpreter, this placed more onus on him or her to find information from other sources.

53. Even with the difficulties in communication, there were certain risk factors that should have been obvious but were not noted on the ACCT documentation. It was the man's first time in prison, he was a foreign national prisoner, an illegal immigrant whose status in the United Kingdom was made more uncertain by his arrest, was on remand and could not speak English. All of these factors could have been noted as part of the assessment whether or not he co-operated or communicated. We are concerned that there is no evidence that any weight was given to these and other risk factors outlined in PSI64/2011 when assessing his risk of suicide or self-harm. The assessor did not attend

the first case review as assessors are expected to do and no explanation is given.

54. The quality of the first review was poor and it is not clear how the assessment that the man was low risk was reached. Again we have not been able to discuss this further as the staff involved did not cooperate with the investigation. There was no healthcare involvement or any representation from other disciplines at this review.

55. The ACCT was closed by a SO on 25 March, less than a week after the man had arrived at the prison, although the staff still knew very little about him or his concerns. Little weight was attached to his known risk factors. Only the SO was present at this review so she took the decision to close the ACCT on her own, which is poor practice and not in line with what is expected in ACCT guidance. The SO took into account the nurse's view from his assessment that morning. However, although the nurse considered that he was not at risk of suicide he had identified that he felt very isolated and it is apparent from the nurse's assessment that he had little idea what was happening to him which must have increased his feelings of vulnerability. He had still not been seen by the GP, yet the SO closed the ACCT on her own.

56. The only identified caremap action from the first review was that the man should establish contact with his sister. It is not clear from the ACCT review that this had been done at the time, as the SO noted that she helped him complete an application to have his family's telephone number added to his agreed phone list. (It was also noted on the ACCT ongoing log that an officer helped him make an application on 21 March in the wing office when another prisoner helped to interpret.) The ACCT guidance emphasises that ACCTs should not be closed until all caremap actions have been completed.

57. An ACCT post-closure review should take place within seven days of closure and should review the caremap and the progress made by the prisoner since the ACCT was closed. The man's review was scheduled to take place on 1 April exactly seven days after the ACCT was closed. The document is dated 5 April, ten days after. No explanation was given. As there is no information on the post-closure review form other than his name and the date, it is not clear that a review was actually done. It certainly cannot be regarded as an effective check on his progress and provides no assurance that any attempt was made to find out whether he had any ongoing or new concerns and how he was feeling at that time.

58. The lack of adherence to mandatory procedures means we cannot conclude that the man was given a sufficient level of support through the ACCT process. We have identified weaknesses in ACCT procedures in previous investigations at Wormwood Scrubs, and it is a concern that there are so many in this case over such a short period. There is also little evidence of any senior management oversight of ACCT procedures. We make the following recommendation:

The Governor should ensure that ACCT procedures are followed correctly in line with the requirements of Prison Service Instruction 64/2011, and in particular that assessment interviews identify areas of concern, that ACCT reviews are multi-disciplinary, appropriate caremap targets are set and checked at each review and that ACCTs are not closed until all the caremap actions are complete.

The man's location at Wormwood Scrubs

59. After the man's first night at Wormwood Scrubs, when he was in a dormitory with another Albanian–speaking prisoner, he appears to have been very isolated. The IMB noted in their report that staff try to "pair up" prisoners who speak the same language. However, he was moved to a cell with an English-speaking prisoner. We understand that in a busy local prison, there will inevitably be occasions where it will be very difficult to locate prisoners in cells with others who speak their language. However, particularly for those who are identified as at risk of suicide and self-harm and who need of extra support, this should be considered and recorded in the ACCT document. We have not seen any evidence that such cell-sharing was considered and make the following recommendation:

The Governor should ensure that, so far as possible and appropriate, prisoners at risk of suicide or self-harm are located with prisoners who speak the same language.

Emergency response

60. Staff made a code 1 emergency call when they found the man hanging in his cell. Healthcare staff arrived promptly, started cardiopulmonary resuscitation and attached a defibrillator. Staff in the control room called for an emergency ambulance, as soon as the emergency was called, in line with national guidance. Sadly, the resuscitation attempts were unsuccessful and he was pronounced dead by paramedics at 6.55pm.

61. The clinical reviewer commented that the evidence from clinical records and interviews with staff indicate that procedures were followed properly. We agree with this conclusion.

RECOMMENDATIONS

1. The Head of Healthcare should ensure that a GP examines prisoners assessed as being at risk of self-harm and suicide during the reception procedure.

2. The Governor and Head of Healthcare should introduce an appropriate system to ensure that staff are aware of and ensure prisoners are taken to GP and other booked healthcare appointments.

3. The Governor should ensure that, when prisoners do not speak or understand English well, professional interpreting services for prisoners at risk of suicide and self-harm are used as required by PSI 64/2011.

4. The Governor should ensure that ACCT procedures are followed correctly in line with the requirements of Prison Service Instruction 64/2011, and in particular that assessment interviews identify areas of concern, that ACCT reviews are multi-disciplinary, appropriate caremap targets are set and checked at each review and that ACCTs are not closed until all the caremap actions are complete.

5. The Governor should ensure that, so far as possible and appropriate, prisoners at risk of suicide or self-harm are located with prisoners who speak the same language.