

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Kanusikan Sriskantharajah a prisoner at HMP Wormwood Scrubs on 1 June 2017

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*



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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.

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

Mr Sriskantharajah was found hanged in his cell at HMP Wormwood Scrubs on 1 June 2017. He was 19 years old. We offer our condolences to his family and friends.

We are satisfied that there were no indications that Mr Sriskantharajah was at risk of suicide at Wormwood Scrubs, including in the days leading up to his death. We do not therefore consider that staff could reasonably have predicted his actions or prevented his death.

However, there were procedural failings during the roll check and at unlock and a number of deficiencies in the emergency response. We are concerned that it is not the first time that that we have identified such shortcomings at Wormwood Scrubs. Even though it is highly unlikely that the delay in finding Mr Sriskantharajah affected the outcome for him, it is critical that prison staff carry out a full roll check and are aware of their responsibility when unlocking cells as early intervention can save lives.

We are also concerned that nursing staff at Wormwood Scrubs tried to resuscitate Mr Sriskantharajah inappropriately when there were clear signs that he was dead. Wormwood Scrubs has twice accepted our previous recommendations to address failures in knowing when resuscitation is appropriate, and the Governor and Head of Healthcare must now address this issue robustly.

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

Elizabeth Moody
Acting Prisons and Probation Ombudsman

April 2018

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Summary

Events

1. On 12 July 2016, Mr Kanusikan Sriskantharajah was remanded to HMP Wormwood Scrubs, charged with grievous bodily harm and possession of drugs. It was his first time in prison.
2. At his initial health screen, the nurse noted that Mr Sriskantharajah had no mental health diagnosis or concerns and that he denied thoughts of self-harm and suicide. Over the following months Mr Sriskantharajah worked, and for the most part interacted with staff appropriately.
3. In late January, Mr Sriskantharajah told a probation officer that he had had suicidal thoughts in the past and during his time in prison. On 20 February, having been sentenced to 10 years in prison, Mr Sriskantharajah told a prison doctor that he had no thoughts of suicide or self-harm. Staff were made aware of his sentence and told to act on any change in his behaviour.
4. At around 8.12am on 1 June, a prisoner found Mr Sriskantharajah hanged in his cell. Staff responded promptly and, although there were no signs of life, healthcare staff tried to resuscitate him. The prison doctor pronounced him dead shortly afterwards.

Findings

5. We found nothing to indicate to staff that Mr Sriskantharajah was at risk of suicide and we do not consider that staff could reasonably have predicted his actions or prevented his death.
6. On two occasions, during the roll check and at unlock, staff failed to identify that Mr Sriskantharajah had taken his life. When his friend found him, the responding officer sounded the general alarm but failed to call the required emergency code.
7. Despite Mr Sriskantharajah showing no signs of life, healthcare staff tried to resuscitate him, contrary to national guidelines. This is the third time in recent years that we have commented on inappropriate attempts at resuscitation at Wormwood Scrubs.

Recommendations

- The Governor should ensure that staff completing roll checks satisfy themselves that prisoners are alive and well, and should take action as appropriate to address any underlying causes if this is not happening.
- The Governor should commission a disciplinary investigation into Night Support Officer's failure to conduct the roll check properly on 1 June 2017.
- The Governor should ensure that when a cell door is unlocked, staff satisfy themselves of the prisoner's safety and welfare and that there are no immediate issues that need attention.

- The Governor should ensure that all prison staff are made aware of and understand the need to use the appropriate code to communicate a medical emergency, in line with national and local instructions.
- The Governor and Head of Healthcare should ensure that staff are aware of the circumstances in which resuscitation is inappropriate.

The Investigation Process

8. 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 him. No one responded.
9. The investigator obtained copies of relevant extracts from Mr Sriskantharajah's prison and medical records.
10. NHS England commissioned a clinical reviewer to review Mr Sriskantharajah's clinical care at the prison.
11. The investigator interviewed eight members of staff and three prisoners, some jointly with the clinical reviewer.
12. We informed HM Coroner for Western London District of the investigation and have sent him a copy of this report.
13. One of the Ombudsman's family liaison officers contacted Mr Kanusikan Sriskantharajah's family to explain the investigation. They did not have any specific questions.

Background Information

HMP Wormwood Scrubs

14. HMP Wormwood Scrubs is a local prison in west London, holding 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. Care UK is contracted to provide primary care and several other health services at Wormwood Scrubs.

HM Inspectorate of Prisons

15. The most recent inspection of Wormwood Scrubs was in July to August 2017. Inspectors raised very serious concerns and commented on the lack of progress in improving outcomes for prisoners, since their last inspection. Inspectors reported that staff shortages were pervasive which resulted in the failure to deliver even basic services.

Independent Monitoring Board

16. 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 latest annual report for the year ending May 2016, the IMB said that although the first part of the reporting year had been chaotic, the prison had demonstrated a strong determination to improve standards in the second half of the year. The IMB reported that there were continuing staff shortages which affected the general management of wings and activities.

Previous deaths at HMP Wormwood Scrubs

17. Mr Sriskantharajah was the eleventh prisoner to die at Wormwood Scrubs since January 2015, and the third to take his life. In one investigation, we made recommendations about completing roll checks and in another, about using the medical emergency code blue call appropriately. In a further two investigations, we made recommendations about the need for staff to be aware of the circumstances in which resuscitation is inappropriate. Wormwood Scrubs accepted these recommendations but we repeat our concerns in this report.

Assessment, Care in Custody and Teamwork (ACCT)

18. ACCT is the Prison Service care-planning system used to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk, how to reduce the risk and how best to monitor and supervise the prisoner. All decisions made as part of the ACCT process and any relevant observations about the prisoner should be written in the ACCT booklet, which accompanies the prisoner as they move around the prison. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

Key Events

Background

19. Mr Kanusikan Sriskantharajah had several previous convictions for robbery and possession of controlled drugs. On 12 July 2016, he was charged with grievous bodily harm, possession of drugs and assaulting a police officer. He was remanded to HMP Wormwood Scrubs. It was his first time in prison.
20. At an initial health screen, a nurse assessed Mr Sriskantharajah. The nurse noted that he had no mental health diagnosis or concerns and that he denied thoughts of suicide and self-harm.
21. Over the following weeks, Mr Sriskantharajah, for the most part, caused few concerns and was compliant with the prison's regime. Although he occasionally failed to attend education classes, he later worked as a wing cleaner. In October, Mr Sriskantharajah was involved in an assault on other prisoners and, in December, he assaulted another prisoner.
22. On 10 October, a health and wellbeing practitioner with the prison substance misuse team, assessed Mr Sriskantharajah's needs. Mr Sriskantharajah told her that at the age of eight he had tried to kill himself. Mr Sriskantharajah also admitted to smoking Spice (a synthetic cannabinoid) in prison.
23. On 6 December, Mr Sriskantharajah was convicted of the offences for which he was charged and was told that he would remain in prison until he was sentenced.
24. In January 2017, Mr Sriskantharajah completed an anger management course.
25. On around 23 January, a probation officer at the Crown Court interviewed Mr Sriskantharajah by video link at Wormwood Scrubs to complete a pre-sentence report. She assessed his emotional wellbeing. Her report of 25 January noted that he appeared to struggle to cope with the isolation of custody. Mr Sriskantharajah told her that he had had suicidal thoughts as a child. And, more recently, when he had been remanded in custody, he had considered trying to overdose on antibiotics but decided not to when he realised that this was not possible. She told the investigator that she did not believe Mr Sriskantharajah was at imminent risk of self-harm and had not therefore reported his comments to prison staff. She had however noted them in the joint probation and prison service risk assessment tool, known as the Offender Assessment System (OASys).
26. On 20 February 2017, Mr Sriskantharajah was sentenced to ten years in prison. A prison GP assessed him when he returned to the prison. Mr Sriskantharajah told him that he had been expecting ten years but had been hopeful that he would receive a lighter sentence. The GP noted that Mr Sriskantharajah engaged well, described his mood as stable and denied thoughts of suicide and self-harm. He reminded Mr Sriskantharajah of the support services available in the prison, including the Samaritans and Listeners (prisoners who are trained by the Samaritans), if he ever felt low in mood or had thoughts of suicide or self-harm.

27. On 21 February, an officer noted in Mr Sriskantharajah's prison record that he had recently been sentenced to ten years in prison and that his change in circumstances might increase his risk of suicide or self-harm and give rise to a change in his behaviour.
28. While little is recorded about Mr Sriskantharajah in the first half of 2017, he worked as a wing cleaner and, later, doing laundry. He was occasionally warned about failing to attend work.
29. On 3 April, staff found a mobile phone in his cell during a regular check. Mr Sriskantharajah later admitted, at a disciplinary hearing, that the phone was his and that he used it to keep in contact with his family. On 28 May, another mobile phone was found, which Mr Sriskantharajah again admitted belonged to him. At a disciplinary hearing two days later, he was found guilty of having it in his possession and received a suspended punishment of 16 days to be added to his sentence.
30. Mr Sriskantharajah regularly telephoned his girlfriend during his time in custody. His last call to her was on 29 May. The call lasted ten minutes and during the call he did not refer to thoughts of suicide or self-harm or indicate that he planned to take his life several days later. Their final telephone call ended in an argument. Prisoner A, a friend of Mr Sriskantharajah, later told the investigator that Mr Sriskantharajah often argued with his girlfriend.
31. Prisoner B, another friend of Mr Sriskantharajah, told the investigator that on 31 May, he had felt Mr Sriskantharajah had something on his mind. He said that Mr Sriskantharajah was talking but not listening to what he said, and he added that he had seen Mr Sriskantharajah like this before. The prisoner said he was concerned and told an officer that something was "not right" and asked her to "keep an eye" on Mr Sriskantharajah. (The officer told the investigator that she could not recall this conversation.)
32. At around 6.00pm on 31 May, as prisoners were being locked in their cells, Prisoner A said good night to Mr Sriskantharajah. He told the investigator that Mr Sriskantharajah appeared happy, that his behaviour was normal and he had not indicated that he would take his life. He said that when he said good night at around 6.30pm, Mr Sriskantharajah had joked with him.
33. At around 9.30pm, Prisoner A said he spoke to Mr Sriskantharajah, who had asked him what the segregation unit was like. He and another prisoner both said that at around this time they had also heard Mr Sriskantharajah talking to officers about a prisoner who had not returned from court. Both prisoners, who occupied the cells next door to him, said they heard nothing more that night.

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34. The night support officer had no contact with Mr Sriskantharajah during the night. He told the investigator that at around 5.00am / 5.30am, he started the morning roll check of all prisoners, but as he was tired, he did not count the prisoners on the top landings of the wing, including Mr Sriskantharajah, as he should have. When the time came to complete the roll, he confirmed the roll numbers from the previous evening's count.

35. At around 8.10am, Officer A unlocked Mr Sriskantharajah's cell so he could go to work. As he opened the cell door, he was distracted by another prisoner who was demanding a shower. He said that as he tried to reason with the prisoner who had asked for a shower, he walked away from Mr Sriskantharajah's cell towards the landing office. The officer did not look into Mr Sriskantharajah's cell and see him hanging.
36. At around 8.12am, Prisoner A was unlocked and made his way to Mr Sriskantharajah's cell to say good morning, as he did every day. He said Mr Sriskantharajah appeared to be standing next to his bed, which was upturned. He said he thought that Mr Sriskantharajah was messing about, and approached him and pushed him on his arm. He said he then realised that his friend was hanging. He said Mr Sriskantharajah was cold and stiff and believed he had been dead sometime. He shouted to Officer B, who was nearby, to come to Mr Sriskantharajah's cell. When the officer saw Mr Sriskantharajah hanging, he pressed the general emergency alarm nearby.
37. Officer A heard Prisoner A shout and the subsequent general alarm, and went to see what was happening. Officer B was standing at the cell door when Officer A arrived soon after the alarm was raised. Officer A went into the cell and with the help of Officer B, who supported Mr Sriskantharajah's body, cut the ligature from around his neck. The ligature was made of bed sheets. Officer C, who had also responded to the shouts for assistance, helped Officer A lay Mr Sriskantharajah on the cell floor. The officers said that Mr Sriskantharajah was cold and that rigor mortis was present.
38. The Deputy Head of Residence for D and E wings responded and arrived at the cell within around 30 seconds of the alarm being raised, just behind Officer C. She immediately called a medical emergency code blue (indicating that a prisoner is unconscious or having difficulties breathing) and asked Officer A if there were any signs of life. He confirmed that there were none.
39. A nurse arrived as Officer C had finished checking for signs of life, and said that when she arrived Mr Sriskantharajah's body was cold. The nurse started cardiopulmonary resuscitation. A healthcare assistant arrived several minutes later, bringing with her the emergency response bag. She helped the nurse with the resuscitation efforts. She said that rigor mortis was present. Another nurse and other healthcare staff also attended and helped try to resuscitate Mr Sriskantharajah.
40. At about 8.20am, a prison GP arrived and told the nurses to stop trying to resuscitate Mr Sriskantharajah. He declared that Mr Sriskantharajah had died. Paramedics arrived and at 8.26am, noted that Mr Sriskantharajah was dead.

Reaction to Mr Sriskantharajah's death

41. Prisoner A told the investigator that Mr Sriskantharajah was popular with other prisoners, that there was no change in his behaviour in the days leading to his death and that he would often talk about his girlfriend and how he loved her. He said that when Mr Sriskantharajah was upset, it was because he had rowed with his girlfriend, but that he would make up with her the next day. Prisoner B said Mr Sriskantharajah was often laughing and joking and got on well with other

prisoners. He said that he did not think the length of his sentence had anything to do with his death. Another prisoner said that there was no change in Mr Sriskantharajah's behaviour in the weeks and days leading to his death. All three prisoners said that Mr Sriskantharajah had never talked to them about suicide or self-harm.

Contact with Mr Sriskantharajah's family

42. Mr Sriskantharajah named his partner as his next of kin. The Head of Business Assurance and the Hindu chaplain were appointed as family liaison officers. They broke the news of his death later that morning. The prison offered to contribute to the cost of Mr Sriskantharajah's funeral in line with national policy.

Support for prisoners and staff

43. The Deputy Head of Residence debriefed the staff involved in the emergency response and offered support. She also spoke to prisoners who had been close to Mr Sriskantharajah and notified other prisoners of his death, offering them support. Officers checked on prisoners assessed as at risk of suicide and self-harm in case they had been affected by the news of Mr Sriskantharajah's death.

Cause of death

44. The post-mortem examination established the cause of Mr Sriskantharajah's death as hanging. Toxicology tests detected low levels of tetrahydrocannabinol, the active ingredient of cannabis, suggesting fairly small but recent use of the drug.

Findings

Identifying risk of suicide and self-harm

45. Prison Service Instruction (PSI) 64/2011, which governs ACCT suicide and self-harm prevention procedures, requires all staff who have contact with prisoners to be aware of the risk factors and triggers that might increase prisoners' risk of suicide and self-harm, and take appropriate action. Any prisoner identified as at risk of suicide or self-harm must be managed under ACCT procedures. Staff judgement is fundamental to the ACCT system. The system relies on staff using their experience and skills, as well as local and national assessment tools, to determine risk.
46. Mr Sriskantharajah had no recorded history of attempted suicide or self-harm in prison or, in recent history, in the community, although he told a support worker he had tried to take his life at the age of eight. None of the prison staff we interviewed said they had ever considered he was at risk of suicide or self-harm. Mr Sriskantharajah's friends agreed that they had never thought that he would harm himself.
47. Six months before his death, Mr Sriskantharajah told a probation officer that he had had thoughts of suicide and self-harm. Although she recorded his thoughts in the prison and probation risk assessment records, she considered that Mr Sriskantharajah was not at risk of self-harm at that time. She said that if she had considered him at risk, she would have reported it to prison staff. Although we accept her assessment and judgement about the risk that Mr Sriskantharajah posed at that time, we would expect as a minimum that staff tell a safer custody manager when a prisoner has expressed thoughts of self-harm so that the prisoner's risk can be fully considered and appropriately managed.
48. We are satisfied that while Mr Sriskantharajah was at Wormwood Scrubs, including in the days leading up to his death, there were no indications that he was at risk of suicide. We do not therefore consider that staff could reasonably have predicted his actions or prevented his death.

Morning roll check and unlock procedures

49. The officer on duty during the night of 31 May to 1 June, did not check Mr Sriskantharajah during the early morning roll check, as he should have. We recognise that a roll check is primarily a security check to count prisoners to ensure that they are present in their cells but it is also an opportunity for any concerns about prisoners' safety to be identified and managed. In our report into the death of a prisoner at Wormwood Scrubs in June 2015, we identified similar concerns about the need for officers to complete roll checks appropriately. We repeat our recommendation which the prison accepted in 2015:

The Governor should ensure that staff completing roll checks satisfy themselves that prisoners are alive and well, and should take action as appropriate to address any underlying causes if this is not happening.

The Governor should commission a disciplinary investigation into Night Support Officer's failure to conduct the roll check properly on 1 June 2017.

50. The Prison Officer Entry Level Training (POELT) manual says that before unlocking a cell, staff should physically check that the prisoner is present. It says that staff must ensure that they receive a positive response from the prisoner by knocking on the door and waiting for a sign of acknowledgment. The manual says that if staff do not get a response, they may need to open the cell to check that the prisoner has not escaped, is not ill or dead.

51. Prison Service Instruction 75/2011 on Residential Services says that:

“Reports from the Prisons and Probation Ombudsman on deaths in custody have identified cases in which a prisoner has died overnight ... but staff unlocking them have not noticed that the prisoner had died. This is not acceptable... “

“[Differing] arrangements will depend on the local regime, but there needs to be clearly understood systems in place for staff to assure themselves of the wellbeing of prisoners during or shortly after unlock ...Where prisoners are not necessarily expected to leave their cell, staff will need to check on their wellbeing, for example, by obtaining a response during the unlock process.”

52. While we recognise that Officer A was distracted by another prisoner, he failed to check Mr Sriskantharajah’s cell when he unlocked him, as he should have done. We make the following recommendation:

The Governor should ensure that when a cell door is unlocked, staff satisfy themselves of the prisoner’s safety and welfare and that there are no immediate issues that need attention.

53. Staff missed two opportunities to intervene earlier. It is unlikely that that outcome would have been different, had the officers carried out their duties fully. Nevertheless, officers should always check a prisoner’s welfare when carrying out roll checks and at unlock as early intervention in emergencies where prisoners are found unconscious or in a critical situation might save lives.

Emergency response

54. A local instruction from the Governor (Order 015/15) on medical emergency response codes, based on the requirements of PSI 03/2013, requires staff to call a code blue in medical emergencies. Despite carrying a radio, Officer B did not call a code blue when he saw Mr Sriskantharajah hanging. The officer said that although he was aware that he should have called a code blue, he pressed the general alarm instead as it was the first thing that came into his head. The Deputy Head of Residence called a code blue when she arrived at the cell approximately 40 seconds after the general alarm was activated.

55. Although there was no delay in healthcare staff attending or in an ambulance being called and the outcome for Mr Sriskantharajah was not affected by the delay in calling a code blue, in other emergencies, this might not be the case. We are concerned that this is not the first time that we have identified this issue at Wormwood Scrubs and that we must repeat the same recommendation the prison agreed to implement after our investigation in to the death of a prisoner in

April 2016:

The Governor should ensure that all prison staff are made aware of and understand the need to use the appropriate code to communicate a medical emergency, in line with national and local instructions.

Resuscitation

56. European Resuscitation Council Guidelines for Resuscitation 2015 which were shared with prison managers in September 2016 say that, “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. The British Medical Association (BMA), the Royal College of Nursing (RCN) and the Resuscitation Council (UK) issued guidance in October 2014 on making appropriate decisions about resuscitation. The guidance says that every decision should be made on the basis of a careful assessment of an individual’s situation. These decisions should never be dictated by ‘blanket’ policies. Trying to resuscitate someone who is clearly dead is distressing for staff and undignified for the deceased.
57. The officers who found Mr Sriskantharajah could find no sign of life and said that Mr Sriskantharajah felt cold. They believed that he had been dead for some time as rigor mortis was present. We agree with the clinical reviewer, who concluded that healthcare staff should not have started cardiopulmonary resuscitation as Mr Sriskantharajah was clearly dead: there were no signs of life and rigor mortis was present. We repeat another recommendation we made to Wormwood Scrubs in 2015 and 2016, another recommendation which the prison agreed to implement at the time:

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

Clinical care

58. The clinical reviewer concluded that Mr Sriskantharajah’s clinical care was equivalent to the care that he could have expected to receive in the community.

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