Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Nicholas Landau a prisoner at HMP Wormwood Scrubs on 29 April 2016

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.

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 Nicholas Landau was found hanged in his dormitory at HMP Wormwood Scrubs, on 29 April 2016. He was 62 years old. I offer my condolences to Mr Landau's family and friends.

Mr Landau had a complex mental health history and had been at Wormwood Scrubs for two weeks. Throughout that time, he was well supported by healthcare staff and the mental health team, who liaised effectively with community specialists who had previously been involved in his care.

Although Mr Landau persistently expressed suicidal thoughts and intent, the prison psychiatrist considered it was a coping mechanism to gain support and it would therefore have been difficult for staff to identify that he was at immediate and imminent risk of suicide. Staff managed his risk under the Prison Service suicide and self-harm prevention process, but the investigation found some weaknesses in its application.

I am concerned that some staff were not familiar with the prison's emergency response procedures. This suggests that the prison has not effectively disseminated its local instructions.

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

Richard Pickering
Deputy Prisons and Probation Ombudsman **February 2017**

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Summary

Events

1. On 14 April 2016, Mr Nicholas Landau was remanded to HMP Wormwood Scrubs, charged with attempted robbery and possession of an offensive weapon. He had longstanding complex mental health problems, including a history of suicide attempts and he had been an inpatient in secure psychiatric hospitals for several months from May 2015. After completing the reception procedures, staff began ACCT suicide and self-harm prevention procedures and admitted Mr Landau to the prison's high dependency inpatient unit.

2. A multidisciplinary team led by a psychiatrist managed Mr Landau. They conducted mental health assessments and created care plans, with frequent reviews. They also encouraged him to attend psychology and activity groups. The psychiatrist concluded that Mr Landau's persistent thoughts of suicide were a coping mechanism and it would have been difficult for staff to identify when his risk had increased.

3. Just after 6.00am on 29 April, Mr Landau's cellmate found him hanged in the bathroom of their dormitory. He alerted night staff, who called for assistance, but did not use an emergency code. Additional staff responded quickly and started cardiopulmonary resuscitation (CPR). Paramedics arrived at the dormitory at 6.32am and took over, but the resuscitation attempts were unsuccessful and at 7.31am they recorded that Mr Landau had died

Findings

4. In spite of some shortcomings in the management of the ACCT procedures, we consider that overall Mr Landau received a very high standard of care, including consistent input and support from the mental health team.

5. We are concerned that although the prison had reissued its instructions about the medical emergency procedures two days before Mr Landau's death, the healthcare staff who first discovered Mr Landau were unfamiliar with the procedures and the need to use an emergency code. It is also a concern that they did not try to cut down Mr Landau or assist in the resuscitation attempts.

6. We are satisfied that, with the exception of the emergency response, Mr Landau's clinical care was equivalent to that he could have expected in the community and that staff could not have prevented his death.

Recommendations

- The Governor should ensure that prison staff manage prisoners at risk of suicide or self-harm in line with national guidelines, including:
  - Ensuring consistent case management;
  - Holding case reviews as scheduled;
  - Completing caremaps in every case which set realistic goals aimed at reducing prisoners' risks that are reviewed and updated at each ACCT review;

- Setting appropriate levels of observations directly related to risk, which take place at irregular and unpredictable intervals;
- Consulting healthcare staff in decision-making about the location of prisoners.

- The Governor and Head of Healthcare should ensure that staff who find a prisoner hanging cut the ligature, check for signs of life as soon as possible and start resuscitation, if appropriate.

- 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 Investigation Process

7. 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.

8. The investigator visited Wormwood Scrubs on 5 May. She obtained copies of relevant extracts from Mr Landau's prison and medical records.

9. NHS England commissioned a clinical reviewer to review Mr Landau's clinical care at the prison.

10. The investigator interviewed 13 members of staff at Wormwood Scrubs in April and June. The clinical reviewer joined her for those with healthcare staff and an officer involved in the emergency response. She also interviewed another member of staff by telephone.

11. We informed HM Coroner for Western London District of the investigation who gave us the cause of death. We have sent the coroner a copy of this report.

12. One of the Ombudsman's family liaison officers and the investigator met Mr Landau's sister, brother-in-law and their solicitor, to explain the investigation. Mr Landau's family asked several questions about Mr Landau's management and clinical care, including:

    - Did prison healthcare staff have full information about his mental and physical healthcare needs, and his previous suicide attempts?
    - Was he in a suitable cell, was it appropriate for him to share a cell and did his cellmate (who had learning difficulties) adversely affect him?
    - Could the prison have arranged a transfer to a mental health unit and, if not, could they have requested additional community psychiatric care?
    - Had he self-harmed in prison? If so, what physical and psychiatric help did he receive and did staff complete a further ACCT assessment?

13. Mr Landau's family received a copy of the initial report. They pointed out a factual inaccuracy and the report has been amended accordingly. Mr Landau's family also raised a number of issues/questions that do not impact on the factual accuracy of this report and have been addressed through separate correspondence.

Background Information

HMP Wormwood Scrubs

14. 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.

15. On 1 April 2016, Care UK took over the healthcare contract for primary care and several other health services and mental health services are subcontracted to Barnet, Enfield and Haringey Mental Health Trust. There is 24-hour healthcare cover and an inpatient unit with 17 beds. The Seacole Centre offers a range of therapeutic interventions, such as clinical psychological provision for supporting prisoners' long term coping ability and mental wellbeing.

HM Inspectorate of Prisons

16. The most recent inspection of Wormwood Scrubs was in December 2015. Inspectors had a number of concerns about the prison. They found the reception process to be exceptionally busy and prisoners' experience was often poor. There had been a focus on improving self-harm and suicide prevention arrangements but they were still not effective. The quality of assessment, care in custody and teamwork (ACCT) case management documents for prisoners at risk of suicide or self-harm had improved slightly from a low base but the process still had frailties, including inconsistent case management, poor reviews, inadequate care maps and case note entries that lacked meaningful engagement. Despite seeing some good care, most prisoners spoken to said they did not feel supported by staff. Inspectors found that an appropriate range of individual and group support was provided for prisoners with severe and enduring mental illness and for some with mild-to-moderate needs, including self-harm.

Independent Monitoring Board

17. 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 recent annual report, for the year to 31 May 2016, the IMB reported a high number of prisoners with mental health issues. They were also concerned about delays in carrying out health assessments for prisoners who arrived late in the evening. These often took place in the early hours of the morning, or were postponed until the next day and, in some instances, prisoners were woken from their sleep for their assessments. The interview rooms were not private.

Previous deaths at HMP Wormwood Scrubs

18. Since the beginning of 2013, there have been 15 deaths at Wormwood Scrubs, including that of Mr Landau. Nine were apparently self-inflicted. We have made previous recommendations about the management of the ACCT procedures and the use of medical emergency codes.

Assessment, Care in Custody and Teamwork

19. 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

20. On 13 March 2016, Mr Nicholas Landau allegedly attempted a robbery. The police detained him under section 136 of the Mental Health Act (taken by the police from a public place to a place of safety) and a hospital admitted him as a voluntary patient. Mr Landau had a history of complex mental health problems and, between August 2015 and January 2016, he had been an inpatient at the hospital. On 13 April, Mr Landau was charged with attempted robbery and possession of an offensive weapon.

21. The next day, Mr Landau appeared at Magistrates' Court. The Person Escort Record (PER), which accompanied him to court noted that he had cut his wrists six weeks before and had felt suicidal in custody. In view of this and his previous mental health history, a forensic mental health practitioner offered Mr Landau a mental health assessment. During their discussion, she was concerned about Mr Landau's presentation and risk of suicide or self-harm. She therefore referred him for a Mental Health Act assessment, to determine whether he should be referred to hospital.

22. A consultant forensic psychiatrist at HMP Wormwood Scrubs assessed Mr Landau (in her capacity as a consultant with the Court Liaison and Diversion Service). She noted a history of suicide attempts and that he had been diagnosed with several mental health problems, including bipolar affective disorder, depression, a dependent personality disorder and generalised anxiety disorder. She spoke to Mr Landau's consultant psychiatrist at the hospital, who said that Mr Landau had chronic suicidal ideation, but did not need to be detained under the Mental Health Act. They discussed the possibility of an informal hospital admission, but there were no beds available and no one to escort him to hospital.

23. The psychiatrist concluded that Mr Landau had moderate to severe depression. She contacted Wormwood Scrubs to advise that if the court remanded Mr Landau to prison custody, he should be admitted to the inpatient unit to monitor his mental state. At interview, she said that her intention was to arrange a Mental Health Act assessment and a referral to hospital at a subsequent court date if the prison could not manage his risk.

24. The court remanded Mr Landau to prison. The psychiatrist then faxed a referral to the mental health team at Wormwood Scrubs, recommending that the prison manage him under the ACCT procedures. Mr Landau arrived at Wormwood Scrubs late evening on 14 April. It was his first time in prison. (His trial was due to begin on 12 May.)

25. An officer interviewed Mr Landau during the reception procedures. She noted Mr Landau's mental health and self-harm history and that he presented as vulnerable, confused and low. In view of his risk factors and presentation, she began the ACCT procedures (which continued until Mr Landau's death). She also conducted a cell sharing risk assessment (CSRA), which is used to determine whether someone would present a risk of violence to another prisoner in a shared cell. She assessed Mr Landau as a standard risk and therefore suitable to share a cell. Mr Landau was allocated to a single cell in H3, the high

dependency inpatient unit. Staff checked him hourly under the ACCT procedures, pending a full assessment.

26. Later that evening, a nurse created a mental health care plan. Key actions were to assess changes in Mr Landau's behaviour; observe him for signs of self-neglect; dispense medication; and spend time with him to enable him to express any anxieties and frustration. She scheduled a mental health review for 21 April. Mr Landau said he was too tired for his reception health assessments, so she deferred them to the next day.

27. As Mr Landau had gone straight to the healthcare unit, he did not go through the standard induction process. The prison said that induction documents were explained to him when he arrived and there was an unsigned custody compact with his name on it.

28. At Mr Landau's initial health assessment on 15 April, a nurse recorded his diagnoses of bipolar and depression and that he had received psychiatric treatment in the community. She also noted that he had difficulty sleeping, a lack of concentration and thoughts of suicide and self-harm, and he was already under ACCT monitoring.

29. The psychiatrist went to see Mr Landau in H3 that morning, but he was still in the first night centre having his health screens. She noted in the medical record that Mr Landau should continue his current medication once staff had obtained the details. She also instructed healthcare staff to obtain background information from the community team; complete a risk assessment; continue to manage Mr Landau's risk under the ACCT procedures; and arrange implementation of the Care Programme Approach (CPA - a formal system to plan specialist mental health care and support for those with severe mental illness). Healthcare staff faxed Mr Landau's GP and the hospital to request his previous medical records.

30. At an ACCT assessment in the afternoon, Mr Landau told an officer from the safer custody team that he felt suicidal. He said he had been particularly bad in the past two months and intended to kill himself that day, but did not know how and he would not tell staff beforehand. She noted that Mr Landau made very limited eye contact, he was nervous, slow, withdrawn and struggled to answer questions. She explained the process for access to the Samaritans and Listeners.

31. Shortly after the assessment, a custodial manager chaired the initial case review. A nurse, the healthcare manager, a prison chaplain and Mr Landau attended. A mental health nurse was also present, although this was not recorded on the case review form. Mr Landau said he had longstanding thoughts of killing himself, but it had become worse and he "could not face things". He added that he had committed the offence so that the police would arrest him and that he 'played' with staff by lying to them.

32. The custodial manager briefly noted Mr Landau's mental history and assessed him as a low risk of self-harm, with the likelihood of future risk behaviours noted as 'raised'. No caremap was completed. The case review form and the front of the ACCT document clearly noted that the next review was scheduled for 20 April.

Mr Landau's observations remained hourly and the ACCT ongoing record showed that most were conducted at regular intervals, on the hour.

33. At around 3.45pm, Mr Landau's sister telephoned the prison's safer custody office, as she was concerned that Mr Landau had not telephoned her. The officer noted in the prison record that she explained the process for a reception visit, the prisoner telephone system and how to send money into the prison. She made a note of her address and advised her to telephone the safer custody office if she had any concerns about her brother after the reception visit. Shortly afterwards, an officer allowed Mr Landau to make a telephone call to his sister, using an office telephone. The officer noted that during the conversation, he spoke confidently and clearly, without mumbling and stuttering as he had during his ACCT review.

34. Later that afternoon, a nurse had a conversation with Mr Landau. She noted that, although he appeared settled, he spoke about killing himself. He said he had no clear intention to do so, but he had handed over his belt as a precaution. Mr Landau received daily visits from members of the chaplaincy team, including the Rabbi.

35. On 16 April, a nurse carried out detailed health assessments. She noted Mr Landau's mental health disorders, previous acts of deliberate self-harm and enduring thoughts of suicide and created a self-harm care plan. At Mr Landau's request, she saw him again in the evening. Mr Landau said he felt hopeless, as he did not think his mental state would improve. He had been using the library and watching television, which he had found helpful and wanted to attend a relaxation and music group. She noted that Mr Landau had appeared restless and anxious, with intermittent eye contact.

36. The same day, a locum GP re-prescribed Mr Landau's medication, in line with the information on his community records. Healthcare staff subsequently completed twice-daily entries (morning and evening) in his medical record, noting their observations of his demeanour, mood and interactions. Mr Landau attended activity groups four or five times during his time in prison and accepted in-cell activities at other times and when there were insufficient prisoners to hold a group session.

37. Mr Landau's sister visited on 17 April. She telephoned the prison again on 19 April to discuss facilities for a forthcoming Jewish Festival and said she would visit her brother again soon.

38. On 18 April, prison staff moved Mr Landau to a dormitory so that he would have someone to talk to, as he had continued to express suicidal thoughts.

39. The psychiatrist conducted a weekly multidisciplinary ward round to review patients. On 19 April, the ward round included a prison psychiatrist, the acting ward manager and an officer. Mr Landau said he had constant suicidal thoughts and ideas, but no plans to carry them out. He had no problems with his cellmate and attended activity groups. The prison psychiatrist noted that Mr Landau's presentation during ward rounds was inconsistent with his behaviour to discipline staff, as he smiled and spoke fluently with prison officers. They found no acute change in his mental state and planned to refer him to the prison's Seacole

Centre, for structured psychological support and therapy, psychological groups and education. (An education assessment took place the following day.) In the meantime, staff would continue to manage his risks under the ACCT process in H3, as they thought he might have difficulty on a normal residential wing.

40. At interview, the prison psychiatrist said that a primary concern was to stabilise Mr Landau sufficiently to allow him to move to a normal wing, as the inpatient unit was not a suitable location long-term. However, it would be difficult to move him while he continued to have suicidal thoughts. They aimed to structure his day and monitor his mental state for signs of any psychotic or mental illness. They did not believe a transfer to hospital was clinically justified, as Mr Landau showed no signs of psychosis, or severe depression and interacted with others.

41. The ACCT case review due on 20 April did not take place and no reason was recorded.

42. At 10.45am on 23 April, a prison manager carried out a management check of Mr Landau's ACCT document. He noted that a caremap had not been completed and the ACCT review scheduled for 20 April had not taken place. There is no record of what action he took in relation to these omissions but, at 2.15pm, a custodial manager held a case review with a nurse and an officer. He noted that Mr Landau was very withdrawn, with poor eye contact. He was reluctant to participate and still felt suicidal. During the review, he said that he had cut his left wrist with a plastic knife and showed the scars. The panel assessed his level of risk as 'raised' and increased his observations to half hourly during the day, but hourly during the night. The next review was scheduled for 25 April.

43. A nurse wrote a more detailed account of the review in the medical record. Contrary to the custodial manager's note in the ACCT document, the nurse considered Mr Landau had maintained good eye contact and engaged well. She noted that he had been moved from a dormitory to a single cell so that staff could monitor him more closely. She recorded a list of actions, including staff searching Mr Landau to remove items he could use to harm himself; support to reassure him and manage his anxieties; and encouraging him to engage in education, unit and group activities to minimise his boredom. At interview, she said that Mr Landau was open about his feelings to staff and other prisoners and had told her that he had no problems with being in prison.

44. The nurse told the investigator that she had noticed there was no caremap, so she completed one on 23 April. The two actions identified in the caremap were - suicidal thoughts/intent, which should be addressed by staff allowing Mr Landau time every day to express his anxieties - noted as ongoing. The second was mental health issues, with an action for the psychiatrist to review him weekly - noted as completed and ongoing.

45. Later that afternoon, Mr Landau told an officer supervising prisoners in the exercise yard that he wanted to kill himself, but had no plan of how he would do it. They discussed how staff could help him.

46. On 24 April, a supervising officer (SO) conducted an ACCT review with Mr Landau, to check that he had not been affected by the death of another prisoner that day. Mr Landau said he still had thoughts of suicide, but also wanted to

'hold on'. The SO considered Mr Landau's level of risk to be high and noted he should remain on 30-minute observations.

47. The same day, a nurse made an entry in Mr Landau's medical record, stating that although he was a bit anxious in the morning his mental state appeared to be clinically stable. He had socialised and used the exercise yard with other prisoners, ate his meals and taken all his medication.

48. The SO and a nurse held an ACCT review on the morning of 25 April. The meeting notes show that Mr Landau presented as anxious, but said he found prison okay. The SO did not consider Mr Landau's continuing thoughts of suicide to be credible. He reviewed Mr Landau's caremap and although he could not think of anything to add to it, he believed that Mr Landau still needed to remain on ACCT monitoring. Mr Landau's level of risk was 'raised' and his observations were reduced to hourly. The panel scheduled the next review for 2 May.

49. Later that afternoon, a healthcare entry in the medical record by a nurse indicated that Mr Landau still had constant thoughts of suicide. He had attended morning and afternoon groups and accepted in-cell activities.

50. The same day, prison staff moved Mr Landau back to the dormitory without consulting healthcare staff or recording the reason for the move.

51. The same day, the psychiatrist conducted the weekly ward round with the prison psychiatrist, a clinical psychologist and a nurse. They reviewed Mr Landau and discussed the CPA meeting due to be held the next day. Mr Landau said he did not feel good in the dormitory, as he had to look out for other prisoners and this had made it difficult to carry out his plan to cut his wrists with the plastic knife. (It is unclear whether he had moved back to the dormitory before or after the ward round.) The team found Mr Landau's mood was low, with intense suicidal thoughts, but no signs of neglect. They considered that he possibly exaggerated his symptoms so that his needs were taken seriously and to prevent fatal consequences. They noted that the staff monitoring his ACCT reviews should be informed that his thoughts of self-harm and suicide continued and concluded that his risk should be managed through that process. They also thought he might benefit from long-term one to one psychotherapy, as he was insightful about his issues.

52. On 27 April, Mr Landau's community care coordinator, the psychiatrist, a nurse and Mr Landau attended the CPA meeting. They believed Mr Landau's attempts and thoughts of suicide were to get support, rather than serious attempts to die. The care coordinator thought that Mr Landau should be in hospital and he would have supported detention under the Mental Health Act. However, they acknowledged that one of the consultant psychiatrists at the hospital firmly considered that he was not detainable and would not approve this.

53. The team identified Mr Landau's risks and created a care plan, again noting he would probably remain suicidal. They considered his risk was likely to reduce if he felt well supported, but could increase if he moved to a normal residential wing, as he might seriously harm himself accidentally.

54. Given Mr Landau's chronic suicidal thoughts, the team felt it would be challenging for staff to detect any genuine increase in his risk. They planned to refer him to the prison's psychological groups and continue to manage his risks through the ACCT process. They would consider his long-term accommodation and ensure he was in full-time education before any move to a normal wing. The team concluded there had been no acute change in Mr Landau's mental state and he was unlikely to benefit from an increase in medication. They would consider referring him to hospital if his risk increased and they could not manage him appropriately in custody.

55. The psychiatrist told the investigator that Mr Landau had seemed less distressed and more relaxed than usual, with greater participation in the meeting. She did not consider him to be clinically depressed and repeated the possibility that his action might not have been an intention to end his life, but to seek help and support. During the last CPA meeting, Mr Landau had talked about renting or selling his flat and living independently, which she considered to be strong and reassuring plans for the future. The care coordinator had told her that his presentation was the same as in the community and she considered that there had been no recent change in presentation to warrant an increase in his level of observation or risk management.

56. In the daily entry during the evening of 28 April, a nurse noted that it had been easier to converse with Mr Landau. He had attended a support group in the afternoon, ate well, took his medication and seemed less preoccupied with thoughts of self-harm.

57. In addition to ACCT checks, night staff completed hourly checks on all prisoners in H3. At 5.00am on 29 April, an agency healthcare worker recorded in the ACCT document that Mr Landau was asleep on his back and breathing. At 5.56am, an entry in the medical record by a mental health nurse noted that Mr Landau was relaxing in his cell, he had slept through the night and appeared calm and settled.

58. At interview, a healthcare assistant said that during a routine check at 6.00am, Mr Landau was not in his bed or elsewhere in the dormitory. He assumed Mr Landau was in the toilet, but there was no response when he called out to him. He then went to check another prisoner with a nurse. On his way back, a prisoner (who was the only other prisoner living in the dormitory at that time) had shouted for help and told him that he had found Mr Landau hanged in the bathroom.

59. The healthcare assistant did not have a radio, so he went to the unit office and told the nurse what had happened. At 6.13am, the nurse radioed for the emergency response team and telephoned the control room to ensure that staff had received his message. The incident log noted that the nurse had repeatedly stated, "Assistance needed H3", and twice activated his personal alarm, but gave no details of the nature of the emergency. Officer A had overheard the two healthcare staff. He went to the cell and unlocked the door.

60. The night manager and Officer B immediately went to the unit. When they arrived, around one to two minutes later, Officer A and one of the healthcare staff were standing outside the cell. Two other officers arrived shortly afterwards.

The nurse pointed to the dormitory bathroom, where the night manager and the officers saw Mr Landau suspended by a ligature made from a towel and attached to the shower screen. Three of the officers held Mr Landau's body, while the night manager cut him down. Staff took Mr Landau's cellmate to another cell.

61. At 6.15am, an officer called a code blue emergency (used in circumstances such as when a prisoner is unconscious or has breathing difficulties) and requested an ambulance. The control room telephoned for an ambulance immediately.

62. Another nurse also responded to the initial call for assistance. She noted in the medical record that when she arrived, she saw Mr Landau hanging by a ligature and asked an officer to cut him down. On examination, she found no pulse and Mr Landau was not breathing. She began CPR and asked the other staff to request an ambulance and to call a colleague to assist. She continued CPR (chest compressions and air management) on her own until her colleague arrived at around 6.20am. The nurses used a defibrillator, which advised no shock. Her colleague said wing staff appeared panicky and had led her to the dormitory without explaining what had happened.

63. The ambulance arrived at 6.26am, followed by a paramedic car. The crews reached the dormitory at 6.32am and took over the resuscitation attempts, administering three cardiac shocks. Two additional emergency vehicles arrived at 6.52am and 7.16am. An advanced paramedic recorded Mr Landau's death at 7.31am.

Contact with Mr Landau's family

64. Prison manager and the deputy governor went to see Mr Landau's sister at around 11.00am, to break the news of his death. No one was at home and they received no response when they telephoned her landline and mobile numbers. They then telephoned the solicitors listed in Mr Landau's records, but were told that he was not registered with them. The deputy governor eventually made contact with Mr Landau's sister at 1.12pm and both managers returned to her home at 4.15pm. They offered condolences and support and explained what they knew of the circumstances of Mr Landau's death.

65. Mr Landau's funeral was held on 4 May. In line with national policy, the prison offered to contribute to the funeral expenses.

Support for prisoners and staff

66. Shortly after Mr Landau's death, prison managers and the deputy governor debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

67. The prison posted notices informing other prisoners of Mr Landau's death, and offering support. Staff reviewed all prisoners subject to suicide and self-harm prevention procedures in case they had been adversely affected by Mr Landau's death.

Post-mortem report

68. The Coroner confirmed that the cause of death was hanging.

Findings

Assessment and management of Mr Landau's risk of suicide

69. A psychiatrist had alerted staff at Wormwood Scrubs to Mr Landau's mental health and self-harm history and his clinical needs before he arrived at the prison. Immediately after his reception interview, staff appropriately began ACCT monitoring, which continued until his death.

70. In a thematic report on self-inflicted deaths of prisoners on ACCT, issued in April 2014, we listed a number of lessons from previous investigations and the need for improvement in the application of the ACCT process. We have some concerns about the management of Mr Landau, which was not fully in line with national policy.

Case management and case reviews

71. Prison Service Instruction 64/2011, about safer custody, sets out a number of requirements in the management of the ACCT procedures. This includes the appointment of a case manager. Although a custodial manager chaired two of Mr Landau's four ACCT case reviews, there was no designated case manager. He told the investigator that there should be a nominated case manager who would arrange case reviews at convenient times. However, he was the only trained case manager on both the detoxification and healthcare units and, due to the high number of prisoners in those units subject to ACCT monitoring, it was not feasible for him to be the case manager for all of them. If there had been a specific case manager, the case review scheduled for 20 April might not have been overlooked.

72. Another mandatory requirement is the completion of a caremap tailored to meet the individual needs of the prisoner by addressing their risk and issues identified in the assessment interview and case reviews. Staff should consider a range of factors including health interventions, peer support, family contact and access to diversionary activities. They should update the caremap at case reviews to take account of any additional needs. We are concerned that staff did not complete a caremap until nine days after Mr Landau's ACCT monitoring began – just six days before his death.

ACCT observations

73. At the ACCT review on 23 April, a prison manager assessed that Mr Landau's risk had increased from 'low' to 'raised'. He increased the frequency of observations to twice an hour during the day, but they remained hourly at night. The rationale for this was not recorded. The investigator discussed the checks with him, who agreed that the level of observations were inconsistent as a prisoner would be more at risk during the night, when they cannot leave their cell at all, than in the daytime. Therefore, he did not understand the reason for fewer checks in the night.

74. The PSI specifies that ACCT observations should be at unpredictable times. Contrary to this instruction, most of the checks on Mr Landau were conducted

and recorded at regular hourly intervals, on the hour. This would have allowed Mr Landau to predict when the next check would take place.

Mr Landau's location

75. PSI 64/2011 states that "ACCT case managers and case review teams must base their decision on where to locate an at-risk prisoner against the risk they present and the benefits the location may afford them". Our thematic report about prisoner mental health, published in January 2016 and based on our investigations into self-inflicted deaths in prisons, highlighted that mental health staff and the ACCT case review team should be involved in all decisions about a prisoner's risk, including their location.

76. On 18 May, Mr Landau moved from a single cell to a dormitory so that he would have company. After deliberately cutting himself on 23 May, his risk increased and staff moved him back to a single cell where it was easier to observe him. He returned to the dormitory on 26 May. It is unclear who took this decision. No one recorded the reason and healthcare staff had no input.

77. Mr Landau's family questioned the suitability of Mr Landau's accommodation and whether he should have been sharing with another prisoner. A prison manager explained that there was no particular risk in Mr Landau and the prisoner being in the dormitory together, as their cell sharing risk assessments indicated that neither of them was at risk of hurting another prisoner in their cell. He said that it was difficult to check on prisoners in the dormitory where the bathroom was in a closed-off area, so a prisoner could be out of sight for some time. There was also an unwritten rule that anyone needing checks more frequently than once an hour would be placed in a single cell (though not specifically a safer cell - a cell with minimal ligature points)). However, he regarded placement in the dormitory as positive because prisoners would have more interaction with others. A nurse thought that Mr Landau had been placed in a safer cell, but the investigator established that the prison had no cells which met the criteria for safer cells.

78. The Healthcare Manager acknowledged that the decision- making on Mr Landau's move back to the dormitory was not documented. She has since recommended that staff conduct a risk assessment before prisoners are moved into the dormitory and that it is discussed with the multidisciplinary team.

79. Mr Landau's mental health problems and history of suicide attempts and chronic suicidal thoughts suggested that he was always a long-term risk. A psychiatrist and his community coordinator agreed that his suicidal thoughts were a coping mechanism and a way of seeking support. In view of this, we do not consider that prison staff could have identified that Mr Landau was at high or imminent risk of suicide immediately before his death, or been expected to foresee or prevent his actions. However, there is a need for staff at Wormwood Scrubs to improve their management of the ACCT procedures and managing prisoners' risk. We make the following recommendation:

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

- **Ensuring consistent case management;**
- **Holding case reviews as scheduled;**
- **Completing caremaps in every case which set realistic goals aimed at reducing prisoners' risks, that are reviewed and updated at each ACCT review;**
- **Setting appropriate levels of observations directly related to risk, which take place at irregular and unpredictable intervals;**
- **Consulting healthcare staff in decision-making about the location of prisoners.**

Clinical care

Mental health care

80. Mr Landau had longstanding complex mental health problems which were well documented. Due to his history of self-harm and chronic suicidal thoughts, he had received long-term inpatient and outpatient psychiatric treatment in the community. Before he arrived at Wormwood Scrubs, the prison's psychiatrist had arranged for him to be admitted to the inpatient unit.

81. Healthcare staff conducted appropriate mental health and risk assessments, created care plans and obtained Mr Landau's community records. They continued his previously prescribed medication and implemented the multidisciplinary Care Programme Approach, involving his community care coordinator and seeking advice from the consultant psychiatrist at the hospital where he had been an inpatient. They also actively contributed to Mr Landau's ACCT case reviews.

82. During his two weeks in prison, Mr Landau attended a psychology group and completed an education assessment so that staff could refer him for more structured support. The prison's consultant psychiatrist considered that he was not clinically depressed and that his mental health had not deteriorated in prison.

83. The clinical reviewer considered that it would have been challenging to manage Mr Landau's complex mental health problems in any environment. We agree with his conclusion that Mr Landau's clinical care before he was found unresponsive was of a high standard, equivalent to that he could have expected to receive in the community.

Emergency response

84. Prison Service Instruction 03/2013, Medical Emergency Response Codes, issued in February 2013, sets out the actions staff should take in a medical emergency. It contains mandatory instructions for governors to have a protocol to provide guidance on efficiently communicating the nature of a medical emergency, ensuring staff take the relevant equipment to the incident and that there are no delays in calling an ambulance. It stipulates that if an emergency code is called over the radio, an ambulance must be called immediately and that it should not

be a requirement for a member of the healthcare team or a manager to attend the scene to authorise this. It also explicitly states that all prison staff must be made aware of and understand this instruction and their responsibilities during medical emergencies. Wormwood Scrubs updated and reissued their local instructions on 27 April 2016, reiterating the requirements of the PSI.

85. Code blue is used in medical emergencies where a prisoner is having trouble breathing or is unconscious. A nurse radioed for assistance, but did not use a medical emergency code. Additional staff responded quickly, but they did not initially know the nature of the incident. Two minutes later, Officer A radioed a code blue.

86. After Officer A unlocked the dormitory door, neither he nor the two healthcare staff who first saw Mr Landau attempted to cut down him down or assist in the subsequent resuscitation attempts. Both the healthcare assistant and the nurse said it was the first time they had been involved in an emergency response. The nurse said that no one at Wormwood Scrubs had told him about the emergency response codes, so he did not know that he should have used a code blue. He also said that although he had a key to the dormitory, he had been told previously that he was not allowed to open cells at night and he thought only one person at a time could perform CPR.

87. The nurse who began CPR no longer works at the prison. She did not respond to the investigator's request for an interview.

88. We do not know whether there would have been a different outcome if staff had started CPR sooner, but in situations where a prisoner is unresponsive, a quick response is vital in increasing the chances of successful resuscitation. Although the prison had reissued its local instructions just two days before Mr Landau's death, it is clear from the response to this emergency that it had not been effectively disseminated and there was still uncertainty among some staff about what should happen in a medical emergency. The clinical reviewer considered that this aspect of Mr Landau's care fell below the standard he could have expected in the community. We make the following recommendations:

The Governor and Head of Healthcare should ensure that staff who find a prisoner hanging cut the ligature, check for signs of life as soon as possible and start resuscitation, if appropriate.

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.

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