Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Winston Augustine a prisoner at HMP Wormwood Scrubs on 30 August 2018

A report by the Prisons and Probation Ombudsman

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Our Vision

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

Our Values

We are:

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

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

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

Mr Winston Augustine died on 30 August 2018, having been found hanged in his cell in the segregation unit at HMP Wormwood Scrubs. He was 43 years old. I offer my condolences to Mr Augustine's family and friends.

Mr Augustine had been taken to the segregation unit under restraint 48 hours earlier to await a disciplinary hearing on a charge of assaulting prison staff. I have some serious concerns about the care Mr Augustine received in the unit.

Mr Augustine was verbally aggressive and threatening to staff in the unit. Prison officers said that they did not, therefore, feel it was safe to open his door or allow him to leave his cell. As a result, he received no food or exercise, was not able to shower or make a phone call and received only a very low dose of his pain relief medication for the entire time he was in the unit. I am very concerned that this was not properly recorded by staff or monitored by managers.

I am also concerned that officers did not carry out good quality hourly checks on Mr Augustine as they should have done. He was not checked for nearly four hours on the day he died and, although he was checked twice in the two hours before he was found dead, staff could not see him properly and we cannot rule out the possibility that he was already dead when they checked him.

On the day of Mr Augustine's death, the segregation unit was almost entirely staffed by officers who did not normally work there and I am concerned that there was insufficient management oversight or leadership.

I am also concerned that some healthcare staff did not see or speak to Mr Augustine themselves. A doctor did not assess Mr Augustine in person but relied on the prison officers' assurance that Mr Augustine had no health concerns, and a nurse was told by officers that Mr Augustine had refused his medication without speaking to him herself to confirm this. In addition, there was no system for recording the fact that Mr Augustine had not received his medication or for escalating it to senior managers.

We have been told that changes have now been made to improve the management of the segregation unit. The Governor of Wormwood Scrubs must ensure that these changes are effective and that the circumstances of Mr Augustine's death cannot be repeated.

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

Sue McAllister, CB
Prisons and Probation Ombudsman

December 2019

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Summary

Events

1. Mr Winston Augustine was remanded to HMP Wormwood Scrubs in December 2017. He had been in Wormwood Scrubs before. A reception health screening noted previous treatment for cancer (which was in remission) and a history of depression. He was prescribed pain relief medication but said that he did not want to take anti-depressants as they made him feel suicidal.

2. Mr Augustine had a history of drug misuse. In January 2018, he was suspected of being under the influence of illicit drugs and was referred to the prison's drug and alcohol rehabilitation service.

3. In May, he told his substance misuse worker that he suffered from depression and had a history of self-harm, although he denied having any such thoughts at the time. He said that he was using illicit drugs as he was in constant pain. He was referred for a medication review and in July his pain relief medication was increased.

4. Later in July, Mr Augustine said he was suffering increased pain and, in August, a prison doctor altered his medication. Some prisoners who knew Mr Augustine said that he was depressed at the likelihood of a lengthy prison sentence after attending court in July, but that they were not concerned that he would harm himself.

5. In mid-August, Mr Augustine told his substance misuse worker that he was still in constant pain and using illicit drugs to cope, and that he was concerned that he was facing a long prison sentence. She noted that he was low in mood but did not consider opening Prison Service suicide and self-harm prevention procedures (known as ACCT).

6. On 28 August, Mr Augustine became angry and upset during a visit from a probation worker. When he returned to the wing he became aggressive to staff. He was restrained after allegedly assaulting two prison officers and was taken to the prison's segregation unit. Mr Augustine was aggressive and threatening to staff in the unit, and healthcare staff were not able to assess him in person.

7. The following day, Mr Augustine continued to threaten staff and they considered it was unsafe to allow him out of his cell. He was said to have refused food and medication. In the evening, he told a nurse he was in pain and she passed some pain relief medication, lower than his prescribed dosage, under his cell door.

8. On 30 August, Mr Augustine continued to be threatening and abusive in the morning. Later that day, he covered the observation panel in his cell door and did not respond to questions. Segregation unit staff said it was unsafe to open the door because he was non-compliant and healthcare staff were again unable to give him his medication. He was not given any meals and did not leave his cell.

9. An officer checked him just after 3.00pm and said Mr Augustine swore at him. He said he could partially see Mr Augustine lying on the floor and had no concerns for his wellbeing.

10. Other officers checked Mr Augustine again just before 4.00pm. As they were unable to see through the observation panel, an officer looked through the cell's inundation point (a small opening in the cell door) and said he heard movement and saw Mr Augustine crouched on the floor. He said he had no concerns for Mr Augustine's wellbeing.

11. When officers went to Mr Augustine's cell to offer his evening meal at 4.47pm, they found him with a ligature around his neck. He was very cold and rigor mortis was present. Attempts were made to resuscitate him but, after assessment by nurses and a doctor, it was agreed that Mr Augustine had died.

Findings

12. Mr Augustine died as a result of hanging.

13. Some prisoners have suggested to his family that Mr Augustine was killed by prison officers, but the police investigation and our own investigation have not found any evidence that his death was anything other than self-inflicted.

Risk assessment

14. On a previous stay in Wormwood Scrubs, Mr Augustine had been managed under ACCT procedures. This was because he had threatened to harm himself over what he felt were deficiencies in his cancer treatment. Since he had returned to prison, there had been no indication that he posed a threat to himself.

15. In mid-August 2018, however, his substance abuse worker noted that he was low in mood. He had some risk factors for suicide and self-harm and we consider that she should have considered whether to open an ACCT.

16. Staff said that from his arrival in the segregation unit, Mr Augustine was shouting threats and abuse. They were focussed on his challenging behaviour and did not consider whether he might be at risk of suicide or self-harm.

Mr Augustine's segregation

17. We are very concerned about the care Mr Augustine received during the 48 hours he spent in the segregation unit. He did not leave his cell during that time, did not receive any food or exercise, was not able to have a shower or make a phone call, and received only one low dose of his pain relief medication. This was not properly recorded and was not immediately obvious to managers. Management oversight of his care was poor.

18. Staff said that Mr Augustine's aggressive behaviour made it unsafe to open his cell door. Although staff said, both in interview and in statements, that they continually tested Mr Augustine's compliance to assess whether it would be safe to unlock him, this was not documented and there is no evidence that they attempted to engage with him. Mr Augustine's electronic record contains only one entry relating to his behaviour or wellbeing in the segregation unit.

19. We are also concerned about the frequency and quality of the wellbeing checks made by staff. He should have been checked once an hour. However, on 30 August, he was not checked for nearly four hours after 11.12am. During this period Mr Augustine had his observation panel covered and did not respond to staff.

20. Officers checked him at 3.07pm and 3.53pm. They could not see his upper body because he had covered his observation panel, but they said they had no concerns about his wellbeing. When Mr Augustine was found at about 4.47pm, he was extremely cold and rigor mortis was present. As rigor mortis normally starts to set in within two to six hours of death, this suggests that he had been dead for some time. We cannot therefore rule out the possibility that Mr Augustine was already dead when officers checked him during the afternoon. We note that there is in fact no hard evidence that Mr Augustine was alive after 8.10am.

Segregation unit staffing

21. We are concerned that segregation unit staff lacked the necessary training and experience and that there was insufficient management oversight.

22. On the afternoon that Mr Augustine died, the Supervising Officer was the only permanent member of segregation unit staff on duty and she was very new to the role. The other officers normally worked elsewhere in the prison and were occasionally drafted in to work in the segregation unit. The nurse who tried to administer Mr Augustine's medication was also unused to working in the unit.

Healthcare

23. The clinical reviewer is satisfied that the prison's management of Mr Augustine's various medical conditions was good before his transfer to the segregation unit.

24. When Mr Augustine was in the segregation unit, medical staff were told by prison staff that they could not have face to face access to him for security reasons. Prison officers effectively controlled Mr Augustine's access to healthcare. Healthcare staff were not clear what they should do in these circumstances.

25. There was no system for recording or escalating the fact that Mr Augustine had not received his pain relief medication.

Recommendations

- The Governor should ensure that the segregation unit is adequately staffed by officers with the necessary skills and training.
- The Governor should ensure that segregation unit staff follow national and local policies in relation to segregated prisoners and, in particular:
    - all prisoners are checked hourly;
    - a record is kept of whether prisoners have (i) been offered and (ii) had their regime entitlements (meals, showers, telephone calls, exercise and medication), and if they have missed any of these entitlements the

reasons should be recorded (eg refused, unresponsive, non-compliant, etc);

- staff attempt to engage with prisoners and make three ‘quality’ entries a day on the prisoner’s record; and
- senior managers exercise meaningful oversight of the segregation unit and record their actions.

- The Head of Healthcare should ensure that procedures and safeguards are in place so that if a member of staff decides to refer a prisoner to the mental health team, the referral is taken forward.
- The Governor, the Head of Healthcare and the lead GP should develop a joint specification which sets out exactly what a healthcare review in the segregation unit should be, including:
  - advice on what to do if access to a prisoner is denied due to staffing constraints;
  - what the expectations are if a prisoner presents a physical threat to staff preventing them from undertaking a review or administering medication;
  - escalation procedures.
- The Head of Healthcare should:
  - ensure that the Local Operating Procedure on missed medication is fit for purpose;
  - clarify the need to escalate to senior nurses and GPs when a prisoner has not received critical and/or important drugs; and
  - ensure that all healthcare staff are aware of the procedures.
- The Prison Group Director for London should provide the Ombudsman with details of the action she has taken to ensure that that national policies are followed in the segregation unit at Wormwood Scrubs.

The Investigation Process

26. 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. Some prisoners responded, and he interviewed them.

27. The investigator visited Wormwood Scrubs in September and November 2018. He obtained copies of relevant extracts from Mr Augustine's prison and medical records. He interviewed seven prisoners and thirteen members of staff at Wormwood Scrubs, and one former prisoner of Wormwood Scrubs.

28. NHS England commissioned a clinical reviewer to review Mr Augustine's clinical care at the prison. The clinical reviewer joined the investigator for some interviews.

29. We informed HM Coroner for West London of the investigation. He gave us the results of the post-mortem examination and we have sent the coroner a copy of this report.

30. The investigator wrote to the solicitors representing Mr Augustine's mother to explain the investigation and to ask whether there were any matters the family wanted the investigation to consider. Mr Augustine's family had a number of concerns about Mr Augustine's care in the prison and raised a number of issues with us. In particular, they asked for details of Mr Augustine's time in the segregation unit and for details of the emergency response. We have provided this information in this report.

31. Mr Augustine's family also asked that we interview prisoners who were in the segregation unit at the time of Mr Augustine's death. They said that other prisoners had told them they believed Mr Augustine had been killed by prison officers who had tried to make his death look like suicide. The investigator had already interviewed one of the three prisoners the family identified and was able to find and interview a second. The third man had been released from prison and could not be traced.

Background Information

HMP Wormwood Scrubs

32. HMP Wormwood Scrubs is a local prison in West London. It holds nearly 1,300 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.

33. In August 2018, the prisons minister announced that Wormwood Scrubs would be one of the prisons participating in the '10 Prisons Project'. The project seeks to improve safety, security and decency at the prisons by focusing on reducing violence, improving living conditions, preventing drugs entering the establishments and enhancing leadership training available to Governors and their staff.

HM Inspectorate of Prisons

34. The most recent inspection of HMP Wormwood Scrubs was conducted in July and August 2017. Inspectors reported that staff shortages were pervasive and that this resulted in significant redeployment (that is, staff doing shifts in areas of the prison where they did not normally work).

35. The number of prisoners segregated was similar to that at other local prisons. The segregation unit was generally clean and in reasonably good order, and segregation staff worked hard to deal with the incessant, often offensive, graffiti in the cells. However, almost a third of all cells were damaged, as a result of some destructive behaviour from prisoners in the unit. Prisoners reported good treatment by segregation staff and inspectors observed skilful management of some challenging behaviour. Managerial oversight had begun to improve but there had been only one segregation monitoring and review group meeting in the previous year. There were no formal reintegration plans but records showed that most prisoners returned to the main population.

Independent Monitoring Board

36. 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 to May 2017, the IMB reported that the prison was improving but still had some serious problems. The prison remained a dangerous environment for staff and prisoners. The supply of drugs was a major problem. Segregation unit staff did a good job of managing some very challenging prisoners and, overall, the atmosphere was supportive.

Previous deaths at HMP Wormwood Scrubs

37. Mr Augustine was the fourteenth prisoner to die at Wormwood Scrubs since February 2015. Of the previous deaths, five were self-inflicted, six were due to natural causes, one prisoner died from a drugs overdose and one death is awaiting classification. None of these deaths took place in the segregation unit and there were no similarities with Mr Augustine's death. There have been four further deaths since Mr Augustine's.

Assessment, Care in Custody and Teamwork (ACCT)

38. 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. After an initial assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. Checks should be irregular to prevent the prisoner anticipating when they will occur. There should be regular multi-disciplinary review meetings involving the prisoner.

39. As part of the process, a caremap (a plan of care, support and intervention) is put in place. The ACCT plan should not be closed until all the actions of the caremap have been completed. 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, *Management of prisons at risk of harm to self, to others and from others (Safer Custody)*.

Segregation Units

40. Policy on the segregation of prisoners is set out in Prison Service Order (PSO) 1700, *Segregation*. Segregation units are used to keep prisoners apart from other prisoners. This can be because they feel vulnerable or under threat from other prisoners or because they behave in a way that prison staff think would put people in danger or cause problems for the rest of the prison. Segregation units also hold prisoners serving punishments of cellular confinement after disciplinary hearings.

41. Segregation is authorised by an operational manager at the prison who has to be satisfied that the prisoner is fit for segregation after an assessment by a member of healthcare staff. Segregation unit regimes are usually restricted and prisoners are permitted to leave their cells only to collect meals, wash, make phone calls and have a daily period in the open air.

42. One or more cells in a segregation unit may be designated 'Special Accommodation'. Special Accommodation is a cell with any one (or more than one) of the following items removed in the interests of safety: furniture, bedding, sanitation. PSO 1700 says that Special Accommodation must only be used to hold a violent or refractory prisoner for the shortest necessary time to prevent that prisoner injuring themselves or others, damaging property or creating a disturbance. It specifies that "every effort must be made to keep the time a prisoner is held in Special Accommodation to a minimum, i.e. minutes rather than hours or days". Special Accommodation must not be used as a punishment and must only be used to manage prisoners who cannot be located safely in normal accommodation.

Psychoactive Substances (PS)

43. Psychoactive substances, previously known as 'legal highs' are a problem across the prison estate. They are difficult to detect and can affect people in a number

of ways including increasing heart rate, raising blood pressure, reducing blood supply to the heart and vomiting. Prisoners under the influence of PS can present with marked levels of disinhibition, heightened energy levels, a high tolerance of pain and a potential for violence. Besides emerging evidence of such dangers to physical health, there is potential for precipitating or exacerbating the deterioration of mental health with links to suicide or self-harm.

Key Events

44. Mr Augustine was remanded to HMP Wormwood Scrubs on 13 December 2017, charged with six counts of robbery. He had been in prison before, including at Wormwood Scrubs.

45. He had previously been diagnosed with cancer and had received treatment during his previous sentence at Wormwood Scrubs, although he was in remission at the time of his death.

46. During his previous sentence he had been monitored under Prison Service measures to support those at risk of harming themselves (known as ACCT). His records indicate that this was not because he had harmed himself but because he had threatened to do so in protest at what he believed were deficiencies in his cancer treatment. He said at the time that he had no wish to take his own life.

47. Mr Augustine had been assessed as presenting a serious risk of harm to others and had assaulted police and prison staff in the past. He was noted to have a history of drug misuse.

48. A reception health screening noted Mr Augustine said that he had asthma and pre-diabetes (a condition where blood sugar levels are raised and which could develop into diabetes). His previous cancer was also noted, as was his history of depression, although he reported no current depression or suicidal thoughts. He said he was worried about his mother as she had said she would have nothing to do with him if he went back to prison. He was referred to the mental health team for assessment. He saw a mental health nurse and, at his request, was referred for counselling.

49. A GP reviewed his medication and he was prescribed tramadol (opiate-based pain relief for moderate to severe pain). Mr Augustine said he had been prescribed sertraline (an anti-depressant) in the community but had stopped taking it as it made him feel suicidal. An appointment was later made for him to discuss this further. This took place with an Advanced Nurse Practitioner on 16 January 2018. As his mood appeared to be settled, they agreed he would stop the sertraline and return if his mood dropped.

26 January to 27 August 2018

50. In late January 2018, Mr Augustine was suspected of being under the influence of illicit drugs. He had often asked for paracetamol to relieve headaches and he had said that he was not happy with his pain-relief medication, and staff considered whether he was using illicit drugs to help with pain.

51. On 30 January, Mr Augustine needed stitches to his jaw and ear after a fight with another prisoner. He needed further stitches to a cut above his eyebrow on 23 February but told the doctor that he could not remember what had happened.

52. In March, Mr Augustine decided to stop attending counselling but, because of his history of drug misuse, he was referred to FORWARD, a drug and alcohol rehabilitation service, on 27 March. His file noted that he had been a daily heroin, crack and cannabis user and had used psychoactive substances (PS).

53. From March, Mr Augustine worked as a wing cleaner and was recorded to be hard-working. In April, Mr Augustine was placed on report for threatening an officer in the visits hall.

54. Also, in April, Mr Augustine saw a prison GP. Mr Augustine said that he felt tired all the time and he ordered blood tests. The results were essentially normal, apart from low levels of Vitamin D, for which he was prescribed a supplement. His blood sugar was below the level at which diabetes or pre-diabetes is diagnosed.

55. On 8 May, Mr Augustine saw his FORWARD case manager for the first time. There is nothing in the records to explain why there had been a delay. He told She that he had a number of health issues, including diabetes, kidney problems and asthma, as well as being in remission from cancer. He said that he suffered from depression and had a history of self-harm, although he denied having any such thoughts currently.

56. On 17 and 18 May, Mr Augustine was unfit to attend court as he was suspected of being under the influence of an illicit substance. On 21 May, he was found guilty of possessing an offensive weapon in a public place.

57. On 25 May, the FORWARD case manager saw Mr Augustine again. She recorded in his medical notes that he was "very low in mood" but had no current thoughts of self-harming and did not need to be on an ACCT. She also recorded that he said he was using PS because he was in constant pain. She made a note in the complex care ledger that Mr Augustine should have a medication review and be assessed for further support. There is no evidence that a discussion took place with a clinician about Mr Augustine's pain.

58. On 15 June, a nurse asked for a doctor to review Mr Augustine's tramadol as it was no longer providing effective pain relief.

59. On 18 June, the FORWARD case manager went to see Mr Augustine to tell him that she had put him forward for education classes. However, she recorded that she ended the conversation because he appeared to be under the influence of PS. She went to see him again four days later on 22 June, but she noted that once again he appeared to be under the influence of PS. She recorded this in Mr Augustine's medical records but did not discuss it with healthcare staff or report it to prison staff.

60. A blood test result on 25 June showed that Mr Augustine did not have diabetes and his blood sugar level was below the level where he appeared to be at clear risk of developing it.

61. Also, in June, Mr Augustine asked to speak to his offender manager (probation officer) as he was facing a long sentence. He was given three warnings for poor behaviour towards prison and education staff during the month and was removed from education as a result.

62. On 3 July, Mr Augustine saw a prison GP to review his pain relief medication. His prescription of tramadol was increased.

63. On 6 July Mr Augustine was due to attend court. He refused to do so.

64. On 31 July, Mr Augustine told a nurse that he was suffering from increased pain from kidney stones. She referred him to a doctor. On 4 August, Mr Augustine saw a GP who scheduled further tests. He increased Mr Augustine's tramadol prescription.

65. On 17 August, Mr Augustine spoke to his FORWARD case manager. He told her that he was in constant pain and not receiving the right medication. He said that he had been smoking PS to enable him to cope. She noted that he was low in mood and that he was concerned that he was likely to get a lengthy prison sentence when he appeared in court the following month. She referred him to the GP for a review of his medication. She also made a note to refer him to the mental health team for assessment but did not in fact do so. At interview she said she could not remember why she had not done so, but she had been very busy at the time. She did not consider opening an ACCT.

66. In July and August, Mr Augustine was given further warnings for abusive behaviour to staff. On 27 August, he was charged with a disciplinary offence after being found in possession of a mobile telephone.

28 August

67. On the afternoon of 28 August, Mr Augustine had a visit from a probation worker. Staff outside the room could hear that he was shouting and upset during the visit. When he came out, he asked a prison officer for a book. When this was refused, Mr Augustine became aggressive, spitting at the officer (although there was a window between them) and threatening him.

68. Mr Augustine returned to the wing and took his medication. A prisoner who was a friend of Mr Augustine's, told the investigator that Mr Augustine seemed rather down that afternoon at the prospect of a long sentence but that, overall, he seemed to be okay. Another prisoner said that there had been some tension between Mr Augustine and two prison officers on the wing. When officers asked prisoners to go back to their cells, Mr Augustine refused to do so, saying that he wanted to see a nurse about his blood pressure. When he was told this was not possible, he became aggressive, and a few minutes later, he allegedly assaulted two prison officers. As a result, he was restrained by staff.

69. A nurse was on the wing and, once the officers had Mr Augustine under control, she was concerned that he was hyperventilating. Both prisoners both said that they heard Mr Augustine shouting that he was unable to breathe properly. A nurse asked the officers to let Mr Augustine stand up so she could check him. She said he was "very, very angry" and shouting threats against the officers, but that she tried to calm him and regulate his breathing.

70. Because he had assaulted staff, Mr Augustine was walked under restraint to the segregation unit by officers, and the nurse accompanied them to check on his wellbeing. Other prisoners in the segregation unit told the investigator that they saw Mr Augustine arrive. They said that, although staff were holding his arms, Mr Augustine was not resisting and was walking of his own volition. He arrived in the unit at approximately 5.00pm.

71. A segregation unit officer carried out Mr Augustine's induction to the unit. He said that he knew Mr Augustine from his previous periods at Wormwood Scrubs. He told the investigator that Mr Augustine was "very angry" when he arrived and that, although he did all he could to get him to calm down, Mr Augustine refused to comply with instructions and remained "generally explosive". He said that Mr Augustine had never been that way with him before and that, because of his behaviour, he thought he might be under the influence of some illicit substance.

72. Staff put Mr Augustine into a Special Accommodation cell to be searched and a nurse said she wanted to assess him. (A medical assessment is a requirement after prisoners have been restrained.) The nurse spoke to him through the observation panel of the door. Mr Augustine said that he had a cut to his finger but, as he was angry and abusive, the nurse told him she would return when he was calmer. She returned after about 40 minutes but Mr Augustine remained very angry, showing a side of him she said she had never seen before, so she was unable to assess him. As her shift was about to end, she contacted healthcare and asked if someone could see him later to assess if he was fit for segregation.

73. At 7.12pm, a nurse manager, noted in Mr Augustine's medical record that he had gone to the segregation unit to confirm that Mr Augustine was fit for segregation. He noted that Mr Augustine was agitated and refused to be examined but that, on the basis of what he could see, Mr Augustine appeared well and there was no obvious medical reason why he could not be held in segregation. The nurse manager told the investigator that Mr Augustine was still in the Special Accommodation cell when he saw him and that he spoke to him through the observation panel. He said Mr Augustine was sitting on the floor at the back of the cell and would not get up.

74. At 7.40pm, Mr Augustine was moved to a standard cell in the segregation unit. Two other prisoners in the unit, said that they could hear Mr Augustine shouting and banging for a long time, first in the Special Accommodation cell downstairs and then in his cell on their landing. He was asking for clothes and for his medication. They said he calmed down after five or six hours.

29 August

75. There are no records to show whether Mr Augustine was offered or refused breakfast on Wednesday 29 August.

76. An officer said that Mr Augustine continued to be very aggressive and threatening to staff during the morning and refused to comply with instructions. He said he was surprised as Mr Augustine had always been respectful to him before and it therefore came as a shock when Mr Augustine threatened to bite his face off and similar threats. An officer, who was also working in the unit, said that whenever anyone went near his door, Mr Augustine was very aggressive and made threats to kill anyone who entered the cell, as well as wishing cancer on the staff and their families.

77. A nurse went to the segregation unit to dispense medication to the prisoners who needed it. Staff on the unit told her that Mr Augustine would not be able to come out of his cell to collect his medication because of his behaviour. She said that

she could hear him shouting, banging on his door, and making threats. She returned to the Segregation Unit twice later in the morning to try again but Mr Augustine was still creating a disturbance. She did not see him but she said she could hear him "screaming and shouting and kicking off at the door" and "very, very angry". Prison staff told her they did not consider it safe to unlock him for his medication.

78. A prisoner, who had a cell on the opposite side of the landing from Mr Augustine, said that he could hear Mr Augustine kicking his door and shouting all day that he had not had his medication, saying, "I'm sick, I'm ill, I'm dying, I need my medication." Another prisoner said healthcare staff tried several times to give Mr Augustine his medication but the prison officers would not open his door while he was making threats.

79. A prisoner, who was in a cell on the opposite side of the landing from Mr Augustine, said he could hear Mr Augustine shouting that he needed his medication. He said he did not remember Mr Augustine trying to communicate with other prisoners during his time in the unit.

80. One of the prison's managers went to the unit to conduct Mr Augustine's disciplinary hearing. The note of the hearing showed that Mr Augustine was too aggressive to attend the hearing at that time, so it was adjourned to the following day.

81. He also made a statutory visit to the segregation unit on 29 August to check on all prisoners. CCTV shows that he went to Mr Augustine's cell. However, he did not make an entry in Mr Augustine's electronic record. He told the internal investigation that he had not recorded the statutory visit because Mr Augustine's prison number was incorrect on the paperwork he had. He did complete entries for other prisoners, but he said he forgot to go back and complete Mr Augustine's.

82. A prison GP also went to the segregation unit to carry out a routine check on the prisoners there. He told the investigator that the duty doctor visited the segregation unit three days a week and that he was duty doctor that day. He said he was not required to see every prisoner in the unit, but he did his very best to do so. On 29 August, the prison officers said that they would not open Mr Augustine's cell door because of his aggressive behaviour. They told the prison GP that there were no specific concerns about his health or wellbeing and that Mr Augustine had not requested any medical input. The prison did not see Mr Augustine in person, even through the observation panel of his cell door. He said he was not told that Mr Augustine had not received his medication.

83. A nurse returned to the unit that afternoon to try again to give Mr Augustine his medication. She told the investigator she did not see him, but she could hear him banging and shouting and prison staff said he was still judged to be behaving too aggressively to unlock his door.

84. At approximately 5.50pm she went back to try again. She told the investigator that she went to Mr Augustine's cell door and spoke to him for about five minutes and asked him to be calm so she could give him his medication. He said that he was in pain and no-one cared, and she told him that she did. She did not think it would be safe to give him his normal 24-hour dose of 200mgs of modified-

release (slow release) tramadol as she did not know when he would get the next dose. Instead she passed a 50mg capsule of immediate release tramadol under his door. She said that she saw Mr Augustine pick it up and swallow it with water. She gave a verbal handover to the night shift healthcare staff.

85. Two prisoners told the investigator that after a nurse's visit, Mr Augustine was shouting that he had not had the right medication.

86. When he was interviewed during the prison's internal investigation into Mr Augustine's death, a Supervising Officer (SO), the most senior officer in the segregation unit on 29 August, said that he had made the decision not to give Mr Augustine meals or a 'regime' (time out of his cell for a shower, exercise or a phone call) that day because of his threats to staff. He said he had no real concern about Mr Augustine missing these entitlements as it was only his first full day in the unit.

30 August

87. On the morning of 30 August, an SO came on duty in the segregation unit. She told the investigator that she had an email from another SO containing "a few lines" of handover notes, but that she did not have time to read this. She then chaired a briefing meeting with the staff who would be working on the segregation unit that day, including an officer who had been on duty the previous day.

88. In an undated statement written after Mr Augustine's death, an SO said that staff reported at the briefing that a number of prisoners, including Mr Augustine, had been behaving badly the previous day and had not been out of their cells as a result. At interview the SO told the investigator that she was told that Mr Augustine was being aggressive and threatening and that he had been in the Special Accommodation cell for a while, but that she was not aware that he had not been out of his cell at all and had not had his medication or any food the previous day.

89. After the briefing, prisoners were released from their cells one at a time to collect their breakfasts. Staff then took breakfast to those prisoners who had not been allowed out of their cells. An SO and an officer said that when they arrived at Mr Augustine's cell, one of the officers asked him if he wanted breakfast and told him to stand at the back of his cell. (This was so he would be as far as possible from the door so that, if he attempted to assault staff, they would have time to close the door.) The SO told the investigator that Mr Augustine had partly covered his observation panel but that she could see him standing very close to the door, holding something – she did not know what – in his hand. She said Mr Augustine replied with abuse and threats, saying that he did not want his breakfast, and he did not go to the back of his cell. The SO said they asked him several times but he replied in the same way. She said she told him that his disciplinary hearing was due that morning but Mr Augustine continued to be abusive and said he was not going to attend.

90. The SO said that after breakfast she told a CM (the orderly officer who was in charge of the day-to-day running of the prison) that Mr Augustine had not complied with attempts to give him food and medication, and also raised her

concerns about the prisoner in the cell next to Mr Augustine's who was on a dirty protest. She said that the CM said that he would speak to both prisoners. However, when he spoke to the other prisoner, he threw urine over him. As a result, the CM had to go and clean himself up and did not speak to Mr Augustine, although he told the SO that he would get back to her.

91. The SO said that after this, she was almost entirely occupied with adjudications from 11.00am until about 4.00pm and had little interaction with staff on the unit. She said she mentioned her concerns about Mr Augustine to the governor who was conducting the adjudications, but that he was content that she had spoken to the orderly officer.

92. During the morning, an officer made a round of the segregation unit checking on prisoners. He could not remember the time. He told the investigator that knew Mr Augustine from his previous sentence at Wormwood Scrubs and remembered talking to him about his cancer treatment at that time. He said that as he passed Mr Augustine's cell, Mr Augustine asked about his medication. He said that he was diabetic and needed his medication. The officer said that he told Mr Augustine he would contact the healthcare department and did so.

93. Staff said that throughout the morning, Mr Augustine was banging on his cell door and being abusive to them every time they passed his cell. He made threats to assault anyone who opened the door. He was also obscuring his observation panel at times.

94. A prisoner said that Mr Augustine was much quieter on 30 August.

95. CCTV footage shows that at 11.12am, three officers and a nurse went to Mr Augustine's cell to deliver his lunch. Mr Augustine had obscured the observation panel so they could not see him. An officer spoke to him through the door and told him to go to the back of the cell so they could open the door and give him his lunch. The officer told the investigator that he could not remember if Mr Augustine replied or not. An officer later recorded in Mr Augustine's notes that he refused to engage (meaning that he did not speak to them). He told the investigator that he could not hear if Mr Augustine spoke. Mr Augustine was not given his lunch.

96. The nurse said that she was standing behind the three officers and could not see Mr Augustine. She heard an officer asking whether Mr Augustine wanted his medication but did not hear Mr Augustine's response. One of the officers said that he had refused. They left the cell but an officer told the investigator that he went back and told Mr Augustine that they had the medication he had been requesting. He said he could not see Mr Augustine as the observation panel was blocked. He said he could hear Mr Augustine moving in the cell but got no response from him.

97. The nurse did not tell anyone in healthcare that Mr Augustine had not had his medication, but she recorded it in his medical notes.

98. At 12.08pm, an officer signed to say that he had completed the routine hourly welfare check on prisoners in the unit. An officer did the same at 1.00pm, and another officer at 2.00pm. However, a screen had been put up next to Mr

Augustine's cell because the prisoner in the next cell was on a dirty protest and had been throwing urine and excrement out through the observation panel in his door (which he had broken), and CCTV shows that both officers did not go beyond the screen to check on Mr Augustine, although they did check all the other cells. CCTV also shows that no one completed any checks on any of the cells at 2.00pm.

99. At 3.07pm, an officer went to Mr Augustine's cell door to carry out the routine hourly check. The officer told the investigator that the screen next to the cell meant he could not get as close to Mr Augustine's door as he would normally have done. He said that as he approached the cell door, he heard Mr Augustine say, "Fuck off." CCTV footage shows the officer at the door for several seconds looking at the observation panel. He did not speak to Mr Augustine. He told the investigator that Mr Augustine had put some paper over the observation panel but that it was not totally covered at the bottom and he could see through this gap. He said he could see Mr Augustine lying on the floor with his head towards the door and his feet towards the window. He could not see Mr Augustine's upper body. He said that it was not possible that Mr Augustine had already hanged himself because Mr Augustine was lying closer to the bed than when he was found hanged.

100. At 3.24pm, Mr Augustine's partner telephoned the prison, saying that she was concerned that neither she nor his family had heard from him for a few days. A member of staff in the Safer Custody Department recorded that she spoke to the manager of the segregation unit - in fact she spoke to an officer. She then told Mr Augustine's partner that he was in segregation, that he was okay, and that he was allowed to make telephone calls if he wanted to.

101. At 3.53pm, an officer went to Mr Augustine's cell to conduct the hourly check. He could not see through the observation panel as it was covered. He called to Mr Augustine and kicked the door but did not receive a response. An SO joined him at the cell and also called to Mr Augustine.

102. The officer went to fetch the key to the cell's inundation point. (This is a small opening in the cell door which staff can direct a hose through in the event of a cell fire.) He returned and opened the inundation point. He said that as he did so, he heard movement in the cell. He looked in and told the investigator that he saw Mr Augustine crouched on the right-hand side of the cell door, with his head bent forward towards his knees as if he was trying to hide from sight. He said that he spoke to Mr Augustine, but he did not reply. He told the investigator that, although he did not see Mr Augustine move, he did not see anything that gave him concerns about his welfare and that he was satisfied that Mr Augustine was alright at that point. The SO asked the officer if he could see whether Mr Augustine was okay, and the officer said that he was fine. The officers then moved away from the door.

103. The officer told the investigator that when he looked through the inundation point, Mr Augustine was not in the same position as he was when he was later found hanged. He said that he could not see Mr Augustine's neck, but he could see the sink unit and the taps which Mr Augustine used to secure the ligature, and that there was nothing tied to the taps at that point.

104. CCTV shows that at 4.47pm, five officers went to Mr Augustine's cell to offer Mr Augustine his evening meal. The cell observation panel was covered from inside. An officer tapped on the door and called to Mr Augustine but received no reply. There was a small gap to the right of the panel that was not covered. This allowed the officer to look through the gap and to see part of Mr Augustine, together with a strip of torn bed sheet tied to the washbasin tap and stretching down towards where Mr Augustine was sitting. The officer told the other officers that he could see a ligature and asked them to open the door.

105. An officer opened the cell door. He said Mr Augustine was sitting on the floor with his back against the sink unit and with the end of the ligature tied around his neck. The officer said that he used his anti-ligature knife to cut one end of the sheet from the tap while another officer used his to cut the other end of the sheet from Mr Augustine's neck. The officer began to perform cardiopulmonary resuscitation (CPR).

106. An officer shouted, "Code blue", which is an emergency code used to indicate that a prisoner is not breathing or is having difficulty doing so. An officer used his radio to transmit the code blue emergency across the radio network. This prompted the control room to call an ambulance. The control room log shows that the code blue call was made at 4.49pm and the ambulance was called immediately. London Ambulance Service records confirm this.

107. A nurse was in the segregation unit at the time and she ran to Mr Augustine's cell when she heard the code blue call. CCTV shows that the nurse arrived at 4.49pm, followed shortly by a second nurse. The nurse said that Mr Augustine was extremely cold to the touch and that rigor mortis was present. With the prison officers, the nurses continued to attempt to revive Mr Augustine. Having heard the emergency call, a prison GP had also made his way to the cell. He assessed Mr Augustine but could detect no signs of life. Healthcare staff agreed that Mr Augustine had died. The ambulance crew arrived at the cell at 4.57pm.

Accounts by prisoners

108. The investigator interviewed five prisoners who were in the segregation unit at the time of Mr Augustine's death.

109. The first prisoner, who was in the cell opposite Mr Augustine's, told the investigator that on 30 August he heard staff telling Mr Augustine to stand at the back of his cell so they could deliver his evening meal. He said that he then saw Mr Augustine running towards the door, "they had communication or a scuffle" and then they went behind the door and he could not see anything further. He said he then heard screams and he and the other prisoners in the unit started shouting and kicking their doors in solidarity with Mr Augustine, and then it went quiet and he heard a call for all medical staff to attend.

110. The second prisoner was also on the opposite side of the landing. He said he could not see what was happening but he heard staff tell Mr Augustine to get to the back of his cell so they could deliver his evening meal and then he heard a lot of banging and heard Mr Augustine say, "Help me" two or three times. He also said that the first prisoner had told him he could see everything through the gap between his door and the door frame and that Mr Augustine had run at staff.

111. The third prisoner whose cell was also on the opposite side of the landing from Mr Augustine's, said he could not see what happened because the flap on his observation panel was closed. He said he heard staff tell Mr Augustine to stand at the back of his cell for his meal and shortly afterwards he heard the alarm being called and staff saying that Mr Augustine had hanged himself. He said he looked through the gap under his door – about half an inch – and saw three staff run out of Mr Augustine's cell.

112. The fourth prisoner was on the same side of the landing as Mr Augustine, next door but one. He said he could not see anything but heard staff tell Mr Augustine get to the back of his cell for his meal and then heard "a little amount of scuffling". He said the first prisoner had told him he had been able to see everything.

113. The fifth prisoner was on the opposite side of the landing to Mr Augustine, two doors along. He said staff frequently went to Mr Augustine cell to offer him food while he was in the unit and told him to stand at the back of his cell but would not open the door. This had happened at lunchtime on the day of Mr Augustine's death. Later that afternoon, he heard an officer call a code blue and through the gap between his door and the door frame he saw officers running into Mr Augustine's cell and nurses arriving shortly after that.

Post-mortem report

114. The post-mortem report showed that Mr Augustine died from asphyxia due to hanging.

115. Toxicology tests found levels of tramadol in his system consistent with therapeutic use. There was nothing in the toxicology results to indicate that Mr Augustine had taken any illicit drugs before his death, although the pathologist noted that in cases of rapid death (such as hanging) death may occur before any drugs can be completely absorbed into the blood and they may, therefore, not show up in toxicology tests.

116. The post-mortem showed an indicator of ketoacidosis (which occurs when some-one has been fasting). Diabetic ketoacidosis leads to hyperglycaemia (very high blood sugars) which can lead to coma and death. However, the post-mortem established that Mr Augustine did not die from ketoacidosis and was not suffering from hyperglycaemia at the time of his death.

117. The post-mortem also found the following minor injuries:

- an abrasion above the right eyebrow
- an abrasion on the right side of the chin
- a scratch at the top of the right arm
- discolouration at the right lower abdomen
- a healing wound on the left calf
- a bruise over the left knee
- an abrasion at the tip of the third index finger.

Contact with Mr Augustine's family

118. A prison manager was appointed family liaison officer (FLO). She informed Mr Augustine's family of his death. In line with Prison Service policy, Wormwood Scrubs offered a contribution towards the costs of Mr Augustine's funeral.

Support for prisoners and staff

119. After Mr Augustine's death, one of the prison's managers, held a debrief for 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.

120. Prisoners were notified of Mr Augustine's death by notices posted on the wings, which indicated where they could access support if they felt it necessary. All prisoners subject to ACCT monitoring had their circumstances reviewed in case they had been affected by Mr Augustine's death.

Internal investigation

121. The Prison Service held an internal investigation into the circumstances of Mr Augustine's care in the segregation unit. The lead investigator was the Deputy Governor of HMP Huntercombe. He found that the management of the segregation unit was deficient and recommended formal advice and guidance be given to some staff, and disciplinary action be taken against others.

Findings

Risk assessment

122. Prison Service Instruction (PSI) 64/2011, *Management of prisoners at risk of harm to self, to others and from others* (Safer Custody), and PSI 7/2015, *Early Days in Custody – Reception in, first night in custody, and induction to custody*, both list a number of risk factors and potential triggers for suicide and self-harm. All staff who come into contact with prisoners are expected to be aware of these risk factors.

123. On a previous stay in Wormwood Scrubs, Mr Augustine had been managed under procedures for those thought to be at risk of self-harm (known as ACCT). This was because he threatened to harm himself over what he felt were deficiencies in his cancer treatment, and not because he self-harmed.

124. We are satisfied that when Mr Augustine returned to prison in December 2017, there was no indication that he posed a threat to himself and that there was no need for staff to monitor him under ACCT.

125. Over the next eight months Mr Augustine was located on a standard wing. Although he used drugs at times, his friends said that, so far as they were aware, he was not under pressure from drug debts and did not have problems with other prisoners. They knew that he was feeling down from July onwards as he was expecting a long prison sentence, but they did not have any concerns that he might kill himself. We are satisfied that staff had no reason to consider that Mr Augustine was at risk of suicide or self-harm during this period.

126. However, we consider that his FORWARD case manager, who knew that Mr Augustine had a history of depression, should have considered whether it would be appropriate to open an ACCT after her meeting with Mr Augustine on 17 August when he told her that he was in constant pain, was using PS to enable him to cope, was concerned that he was likely to get a lengthy prison sentence, and was low in mood. These were all risk factors for suicide and self-harm.

127. We also consider that things changed when Mr Augustine was taken to the segregation unit on 28 August. Segregation is an extreme and isolating form of custody which inherently reduces protective factors against suicide and self-harm, such as activity and interaction with others. A prisoner's mental health may deteriorate quickly under the stress of segregation.

128. When Mr Augustine arrived in the segregation unit, he was upset and angry after a visit; was concerned about facing a lengthy prison sentence; and had just been restrained. He was then held in Special Accommodation for almost two hours. It is clear from the way he behaved that he was in a state of emotional distress and at least one officer thought that Mr Augustine might be under the influence of an illicit substance. While it is understandable that staff focussed on Mr Augustine's challenging behaviour, staff in a segregation unit must always be aware that such behaviour may mask vulnerabilities. In addition, any prisoner who is thought to have taken drugs must be considered at risk of health problems, if nothing else.

129. In Mr Augustine's case any potential vulnerabilities were likely to be exacerbated by the fact that he did not leave his cell for 48 hours and during that time he did not receive any food, exercise, fresh air, a shower or his normal dose of pain relief medication, was not able to contact his family and did not have a radio, reading material or a distraction pack.

130. We are very concerned that no one considered whether this, together with his highly emotional state, might place Mr Augustine at risk of suicide or self-harm, especially when he blocked his observation panel and stopped speaking to staff on 30 August.

The management of Mr Augustine's segregation

131. Prison Service Orders and Instructions recognise the potentially damaging effects of segregation and include mandatory procedures designed to ensure that segregation units are run effectively and that prisoners are kept safe. It is essential that managers and staff working in segregation units fully understand their special responsibilities and are aware of and follow the required mandatory procedures. Managers need to ensure that all staff working in segregation units are competent, qualified and trained to carry out their duties. When prison staff do not know the rules, or do not put them into practice appropriately, prisoner safety can be compromised with potentially fatal consequences.

132. We have a number of serious concerns about the care Mr Augustine received in the segregation unit. These are discussed below.

Special accommodation

133. Special Accommodation is a particularly extreme form of segregation. PSO 1700 says that that "every effort must be made to keep the time a prisoner is held in Special Accommodation to a minimum, i.e. minutes rather than hours or days". The Chair of the prison's Independent Monitoring Board told us that the Board received an email informing them that Mr Augustine was in Special Accommodation from 5.50pm to 7.40pm. However, we are concerned that the prison was unable to provide us with any record that Mr Augustine was held in Special Accommodation on the evening of 28 August, how long he was held there or who authorised this.

Record keeping

134. Mr Augustine was in the segregation unit for approximately 48 hours. Staff accept that he did not leave his cell during this time, that his cell door was not opened and that he did not receive food, exercise, a shower, the opportunity to make a phone call, or his pain relief medication (apart from a small dose passed under the door by a nurse on the evening of 29 August). However, no information was recorded about this at the time, meaning that it was not apparent to managers that Mr Augustine had not received these entitlements over such a long period.

135. We are particularly concerned that there is no record of whether Mr Augustine was given meals, or of when he was offered food and why he was not given it (for example, if he was making threats to staff, or refused food, or just did not reply when asked). We have seen no evidence that anyone expressed any

concerns that he had not eaten or that they mentioned it to the healthcare staff who visited the unit. There is also no evidence that anyone considered a planned intervention to open Mr Augustine's cell to give him food.

136. Staff said that they were only required to start a food refusal log if a prisoner refused food for more than 72 hours. However, given the lack of staff continuity in the unit and in the absence of any record of when Mr Augustine last ate, it is difficult to see how staff would have known when the 72-hour period started if Mr Augustine had continued to go without meals.

137. Staff told us that, in the absence of written records, they relied on verbal handovers and briefings. However, we are concerned that these were also very poor. On the morning of 30 August, an SO was mainly reliant on an email handover note from the previous day's SO for information on prisoners in the unit. She described this as "very limited", just a few general lines that said nothing about Mr Augustine. She also said that she did not have time to read it. She said that at the time, the unit's observation book was not well maintained, and that those working there relied heavily on the staff briefing. She said that when she came on duty on the morning of 30 August, she did not have a good notion of what management arrangements were in place for Mr Augustine. She did not know that Mr Augustine had not had his proper medication, or that he had not been out of his cell since 28 August. She did not know whether he had been offered fresh clothing or a distraction pack.

Hourly checks

138. At the time of Mr Augustine's death, the local policy at Wormwood Scrubs was for all prisoners in the segregation unit to be observed and checked hourly. Staff told the internal investigation that there was no set process for conducting these checks: they were completed by whoever had the time and opportunity to do them.

139. We are concerned that these hourly checks were not always carried out. On 30 August, CCTV shows that staff checked Mr Augustine at 11.12am, then did not do so again until 3.07pm, nearly four hours later. Officers signed the cell check log to confirm that they had conducted cell checks at 12.08pm, 1.00pm and 2.00pm. However, CCTV footage shows that the officers who made the checks at 11.12am and 1.00pm did not check Mr Augustine's cell, although they did check other cells. CCTV footage also shows that an officer did not check any cells at 2.00pm although he signed the log to say he had.

140. We are also concerned that the checks that were made were not good quality. Mr Augustine blocked his observation panel on the day of his death, although an SO said she could partially see him when she tried to give him breakfast at about 8.10am. Mr Augustine blocked his panel more completely after this and there is no hard evidence that anyone heard or saw him alive during the rest of the day.

141. Staff told us that Mr Augustine had continued to shout threats during the morning whenever anyone passed his cell, although this was not recorded at the time. An officer said he spoke to Mr Augustine about his medication some time during the morning, but he did not record this conversation at the time.

142. An officer said he could not remember if Mr Augustine replied or not when he was offered lunch at 11.12am. The others present said they could not hear if Mr Augustine said anything and it was recorded that Mr Augustine had not "engaged" (that is, did not speak to staff). An officer said he heard movement when he spoke to Mr Augustine about his medication after this, although again he did not record it.

143. An officer said that he heard Mr Augustine swear when he checked on him at 3.07pm and that he could see the lower part of his body through a gap and had no concerns about him. An officer said that he heard movement and could see the lower part of Mr Augustine's body and was satisfied that Mr Augustine was well when he looked through the inundation point at 3.53pm.

144. When Mr Augustine was found hanged at about 4.47pm, he was extremely cold, even though it was a hot day, and rigor mortis was present. This suggests he had been dead for between two to six hours, perhaps longer. This means that, although two officers were adamant at interview that they had no concerns about Mr Augustine when they saw the lower part of his body at 3.07pm and 3.53pm, we cannot rule out the possibility that he was already dead by then.

145. This illustrates the importance of making good quality welfare checks on prisoners in a segregation unit. We do not think it is acceptable that no one got a response from Mr Augustine or saw him properly for around eight hours. The fact that he had not eaten for 48 hours makes the failure to check his welfare properly even more unacceptable.

Staff engagement with prisoners

146. PSO 1700 says that prisoners in segregation must have a designated officer who records three "quality entries" daily on a segregation history sheet. This does not need to be the same person every day. Prisoners should be encouraged to change their behaviour, and this should be recorded.

147. At the time of Mr Augustine's death, the local policy at Wormwood Scrubs was for all prisoners in the segregation unit to have a care plan and to have their behaviour updated on their electronic record.

148. Mr Augustine's records do not show that he had a designated officer, nor do they contain a segregation history sheet with three quality entries per day or a care plan. His electronic record contains only one entry about his behaviour or wellbeing after he was taken to the segregation unit on 28 August. There is no record that any member of staff attempted to engage with Mr Augustine.

149. As we have said, no information was recorded during Mr Augustine's time in the segregation unit about whether he left his cell, or about how much food he was either offered or accepted, or whether he received his medication. Although staff said in interview and in statements that they continually tested Mr Augustine's compliance in order to assess whether it was safe to unlock him, this was not documented.

150. A number of staff said in statements and interviews that Mr Augustine was behaving noisily and aggressively throughout his time in the segregation unit, although a prisoner said that Mr Augustine was quiet on the day of his death.

Very little information was recorded about this and there is no evidence to say when Mr Augustine stopped behaving in this way.

151. We are concerned that there is no evidence that staff made any attempt to engage with Mr Augustine or to encourage him to change his behaviour.

Management of the segregation unit

152. Although prisoners in segregation units may be very challenging to manage, they are isolated from the outside world, rely largely on support from and management by staff, and are particularly vulnerable. They are also difficult places for staff to work in. For these reasons, PSO 1700 requires that staff are assessed as suitable to work in a segregation unit and are properly trained for their special role. Wormwood Scrubs' local segregation unit policy in force in August 2018 reflected this. Segregation units also require good quality management to ensure that staff treat the prisoners in their care properly and do not engage in inappropriate punitive practices.

153. We were told that there was no Custodial Manager (CM) responsible for the segregation unit at the time of Mr Augustine's death: the previous CM had been suspended from duty and, although a new CM had been identified, they had not yet taken up post. This meant that the SO was the most senior person on duty in the unit each day.

154. In these circumstances it was particularly important that the unit was staffed by a stable and experienced staff group. However, on the day that Mr Augustine died, there were only two permanent members of segregation unit staff on duty: an officer (who only worked the morning shift) and an SO who had only undertaken five shifts in the unit. She said that she considered that she had received insufficient training and that she felt isolated in her role as there had been no segregation unit manager in post for some time. The other members of staff in the unit that day normally worked elsewhere in the prison and were occasionally drafted in to work in the segregation unit. They told us they had not received any segregation-specific training.

155. On the day of Mr Augustine's death, the SO was occupied with adjudications for most of the day, and the governor who should have carried out a round of the unit was busy first with a promotion interview and then with adjudications and therefore intended to carry out his round of the unit later that day. This meant that the officers were effectively left to run the unit without adequate supervision.

156. We do not consider that there were sufficient properly trained and experienced staff working in the unit that afternoon or that they had appropriate management and leadership. It appears that this was not a unique situation around this time. We are not satisfied that senior managers ensured that the unit was operating in line with the requirements of PSO 1700.

157. As a result of insufficient management and leadership, some unofficial practices appear to have been operating in the unit. For example, we were told by staff that Mr Augustine was not officially on a multi-officer unlock protocol but that he was unofficially treated as if he were. We consider that such decisions should be made by managers and properly documented and reviewed.

158. We were also told that staff operated a kind of unofficial 'incentives and reward scheme' in the segregation unit and that prisoners who were regarded as non-compliant might be denied exercise, showers or phone calls as an incentive to improve their behaviour. These are legal entitlements and should only be denied in exceptional circumstances and only when properly recorded and monitored.

159. The existence of such unofficial practices in a segregation unit is a cause for considerable concern as they can easily become informal punishments awarded by staff without due process or monitoring.

160. The Head of Safer Custody had overall responsibility for the segregation unit. Given the absence of a CM to manage the unit, we would have expected her to have played a key role in overseeing the management of the unit. However, the internal investigation found that she performed poorly in this respect, although it accepted in mitigation that she had had multiple responsibilities and a heavily loaded role. The internal investigation recommended that she receive formal advice and guidance.

161. Since Mr Augustine's death, a permanent segregation unit CM has been appointed. We were told that he has redrafted the segregation unit policy, introduced monitoring sheets for prisoners' meals and participation in the regime, and given the unit staff a better sense of direction. The Governor will need to ensure that the changes in the unit have provided the proper stability, experience and leadership.

The internal investigation

162. The Prison Service held an internal investigation into the circumstances of Mr Augustine's care in the segregation unit. This recommended that some staff should be given formal advice and guidance and that two officers and should face disciplinary charges. We therefore make no recommendations of our own about staff.

163. We do, however, make the following recommendations about the operation of the segregation unit:

The Governor should ensure that the segregation unit is adequately staffed by officers with the necessary skills and training.

The Governor should ensure that segregation unit staff follow national and local policies in relation to segregated prisoners and, in particular:

- **all prisoners are checked hourly;**
- **a record is kept of whether prisoners have been (i) offered and (ii) had their regime entitlements (meals, showers, telephone calls, exercise and medication), and if they have missed any of these entitlements the reasons should be recorded (eg refused, unresponsive, non-compliant, etc);**
- **staff attempt to engage with prisoners and make three 'quality' entries a day on the prisoner's record; and**

- **senior managers exercise meaningful oversight of the segregation unit and record their actions.**

164. Given the significant failings we found in the operation of the segregation unit at Wormwood Scrubs, we are escalating our concerns to the Prison Group Director for London and make the following recommendation:

The Prison Group Director for London should provide the Ombudsman with details of the action she has taken to ensure that national policies are followed in the segregation unit at Wormwood Scrubs.

Healthcare

165. The clinical reviewer concluded that, overall, the management of Mr Augustine's various medical conditions before he was taken to the segregation unit was good and was equivalent to that he could have expected in the community. Arrangements were made for him to attend outpatients' appointments and there was a clear approach to pain control which took account of Mr Augustine's history of opiate misuse

166. The clinical reviewer was, however, concerned that when his FORWARD case manager saw Mr Augustine on 17 August, she noted that she would refer him to the mental health team, but did not subsequently do so. The clinical reviewer noted that it did not appear that this referral was necessary. Nevertheless, the Head of Healthcare should safeguard against such oversights.

The Head of Healthcare should ensure that procedures and safeguards are in place so that if a member of staff decides to refer a prisoner to the mental health team, the referral is taken forward.

167. Although Mr Augustine received good quality care up to 28 August 2018, we share the clinical reviewer's view that there were deficiencies in the oversight of healthcare and management of medication while Mr Augustine was in the segregation unit. These are discussed below.

Role of the duty doctor

168. When a prison GP made his round of the segregation unit on the morning of 29 August, the officers told him that Mr Augustine was behaving aggressively and could not be unlocked. They said that there were no specific concerns about his health. He was not aware that Mr Augustine had had nothing to eat and had not received his pain relief medication. He did not see Mr Augustine and did not attempt to speak to him through the observation panel in his door. He could therefore only say that Mr Augustine was fit to remain in segregation on the basis of what he had been told by prison staff and not from personal observation.

169. We do not consider that this was acceptable. It was the doctor's responsibility to assess Mr Augustine's wellbeing and he should have insisted on seeing him himself, even if this was only through the observation panel. The fact that a prisoner is in an extremely agitated state may mean that he is particularly vulnerable and should not be a reason for not seeing him.

170. The duty doctor's listed responsibilities for segregation unit rounds include a handover from the unit manager about any issues or concerns and conducting a door-to-door assessment of the mental and physical wellbeing of each of the prisoners in the unit and their fitness to remain there. We agree with the clinical reviewer that there should be a detailed operating procedure in place setting out how the duty doctor should carry out their assessment.

Medication

171. We share the clinical reviewer's concerns that healthcare staff were not clear about their role in the unit, including what to do if they were unable to administer medication. We are concerned that none of the nurses who carried out reviews in the unit observed Mr Augustine directly after a nurse spoke to him through the cell hatch at 5.50pm on 29 August.

172. The nurse responsible for administering medication in the segregation unit on the day of Mr Augustine's death was a member of the substance misuse team. Dispensing medication in the segregation unit was not a normal part of her duties and she had only done it once before. When it became apparent that there was difficulty in getting Mr Augustine's medication to him, she did not know what to do or whether she could insist on seeing him.

173. We are concerned that she did not see or speak to Mr Augustine herself when she attempted to give him his medication on the morning of his death. We do not consider it is acceptable for prison officers to ask a prisoner if he wants his medication and effectively control his access to healthcare, as happened in Mr Augustine's case. The nurse may be able to establish a completely different relationship with a prisoner and should be able to see him first hand, even if this is only through the observation panel.

174. We are also concerned that there is no guidance for healthcare staff about what to do if they cannot administer medication for any reason. Prison staff do not know what prisoners' medication needs are or whether it is important that they receive their medication. It is the responsibility of healthcare staff to ensure that prisoners receive the medication they require.

175. The clinical reviewer found that there were no clear plans to manage Mr Augustine's medication needs in the segregation unit, and nurses did not escalate the problem to senior staff when they were unable to give him his medication on 29 and 30 August. Healthcare staff were not aware of the local operating procedures on missed medication, although the reviewer noted that the policy itself is not clear on what staff should do when they cannot access prisoners. The clinical reviewer recommended that the procedures should be clarified. We agree.

176. We recommend:

The Governor, the Head of Healthcare and the lead GP should develop a joint specification which sets out exactly what a healthcare review in the segregation unit should be, including:

- **advice on what to do if access to a prisoner is denied due to staffing constraints;**
- **what the expectations are if a prisoner presents a physical threat to staff preventing them from undertaking a review or administering medication;**
- **escalation procedures.**

The Head of Healthcare should:

- **ensure that the Local Operating Procedure on missed medication is fit for purpose;**
- **clarify the need to escalate to senior nurses and GPs when a prisoner has not received critical and/or important drugs; and**
- **ensure that all healthcare staff are aware of the procedures.**

Emergency response

177. We are satisfied that staff called a medical emergency code promptly when Mr Augustine was discovered hanged, and that the control room immediately called an ambulance.

178. The clinical reviewer considered that the medical response to the emergency call was appropriate.

Allegations about staff involvement in Mr Augustine's death

179. Mr Augustine's family have told us that other prisoners have suggested to them that Mr Augustine had been killed by prison officers who had tried to make his death look like suicide.

180. In support of this:

- Four prisoners who were in the segregation unit at the time, told us that they heard staff tell Mr Augustine to go to the back of his cell when they went to deliver his evening meal just before 5.00pm on 30 August. They said staff would not have needed to do this if Mr Augustine was already dead.
- A prisoner told us that he saw Mr Augustine run at staff when they opened his door to give him his evening meal. He said there was then a scuffle, staff went behind the door and he heard screams.
- A prisoner said he heard a lot of banging and Mr Augustine saying, "Help me."
- Prisoners said it was not possible for Mr Augustine to have hanged himself from the taps on his basin as described by staff.
- Prisoners who knew Mr Augustine said that he was "not the type to kill himself".

181. We have considered these points very carefully. The investigator viewed the CCTV footage. Mr Augustine's door was not opened that day until just before 5.00pm. There is no sound on the CCTV footage but it does not appear to show staff telling Mr Augustine to stand back from the door. It is possible that they did, but it is also possible that the prisoners who said they heard this had confused the time and heard staff say this earlier in the day. We note that another prisoner said that staff told Mr Augustine to stand back when they took his lunch to him, but not when they went to deliver his evening meal.

182. We are satisfied that the CCTV does not show Mr Augustine running at staff when the door was opened. We are also satisfied that the medical evidence suggests that Mr Augustine had been dead for two to six hours before he was found hanged. He could not, therefore, have run at staff, screamed or called for help.

183. The prisoners in the segregation unit were in their cells with the flaps on their observation panels closed. They could, therefore, only look under their doors or through the very small gap between the door and the door frame. This would have allowed only a very restricted and partial view, and we are satisfied that a prisoner was mistaken in what he thought he saw.

184. It is entirely possible that other prisoners did hear banging, scuffling, shouting/screaming or calls for help as staff entered the cell, cut the ligature and called for medical assistance, but we are satisfied that Mr Augustine was already dead before staff opened his door.

185. With regard to the method of death, if a ligature is placed around the neck, full suspension is not necessary to cause death: pressure on the carotid arteries in the neck can cause unconsciousness within seconds, with death following after that. It is not uncommon for prisoners who kill themselves to do so in similar ways to Mr Augustine.

186. We cannot know why Mr Augustine took his own life but, as we have said, he had some risk factors - including a history of depression, constant pain and the fact that he was facing a long sentence - before he entered the segregation unit. He was then restrained, and isolated for 48 hours without food, exercise or pain relief medication. People do not always share their distress before a suicide.

187. We recognise that Mr Augustine's death must have been extremely distressing for the other prisoners in the segregation unit. They were isolated and may have felt vulnerable themselves and they had to try to make sense of what had happened based on the fragments they could see and hear.

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