Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Matthew Lambert a prisoner at HMP Wormwood Scrubs on 13 November 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 Matthew Lambert was found hanged in his cell at HMP Wormwood Scrubs on 13 November 2018. He was 47 years old. I offer my condolences to his family and friends.

Mr Lambert had a history of self-harm, attempted suicide, mental health issues and alcohol misuse. He was prescribed antidepressants and alcohol detoxification medication. He was appropriately managed under suicide and self-harm prevention measures (known as ACCT) during the three weeks he spent at Wormwood Scrubs.

However, I am concerned that were deficiencies in the way that the ACCT procedures were managed. In particular, prison and healthcare staff did not share information as they should have done; there was no consistent attendance at ACCT reviews; and not all caremap actions were completed.

I am also concerned that although healthcare staff completed an initial mental health assessment promptly, they did not monitor Mr Lambert after he was accepted on to the mental health caseload.

As a result, I am not satisfied that staff fully identified Mr Lambert's needs, which meant that he did not receive all the support that he required.

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 **July 2019**

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Summary

Events

1. On 26 October 2018, Mr Matthew Lambert was remanded to HMP Wormwood Scrubs, charged with a violent offence against his ex-partner. He had longstanding mental health problems, including depression, and a history of attempted suicide, self-harm and substance misuse. He had been an inpatient in a psychiatric hospital in 2017.

2. After completing the reception procedures, staff began ACCT suicide and self-harm prevention procedures. Mr Lambert also started an alcohol detoxification programme.

3. Staff completed Mr Lambert's ACCT assessment on 28 October and his ACCT review on 29 October.

4. Mr Lambert made cuts to his arm on 29 and 30 October. On 31 October, a multidisciplinary team, led by a psychiatrist, reviewed Mr Lambert's care but appeared unaware that he had harmed himself in the preceding days. Although he was allocated a mental health nurse to review and support him, no one from the mental health team saw him subsequently. Mr Lambert said that his antidepressants were not working but no one reviewed this.

5. Mr Lambert self-harmed again on 2 November by swallowing nicotine products and 5 November by cutting his arm. At an ACCT review later on 5 November, staff reduced his assessed risk level and the frequency of observations.

6. At 8.16am on 13 November, staff found Mr Lambert hanged in his cell. They radioed a medical emergency code. Staff, including healthcare staff, responded quickly and started cardiopulmonary resuscitation (CPR). Paramedics arrived at Mr Lambert's cell at 8.29am and took over resuscitation efforts but at 9.15am, they recorded that he had died.

Findings

Management of risk of suicide and self-harm

7. When Mr Lambert arrived at Wormwood Scrubs, staff appropriately assessed that he was at risk of suicide and self-harm and monitored him under ACCT procedures. However, there were some deficiencies in the way they did so.

8. Staff did not complete Mr Lambert's ACCT assessment and first case review in line with the required timeframes.

9. Each of the seven ACCT reviews was chaired by a different manager and six of them were attended by a different member of the healthcare team. As a result, there was a lack of continuity which made it more difficult to understand and assess Mr Lambert's risk and provide him with the necessary support.

10. Information about Mr Lambert's risk was not always consistently recorded in his ACCT document and medical records and there is little evidence that prison and healthcare staff shared information about his risk.

11. The ACCT caremap included an action to review Mr Lambert's mental health medication but this did not happen before he died.

Clinical care

12. While Mr Lambert's initial mental health assessment was undertaken quickly as healthcare staff recognised that he was at risk, the care he was given after he was accepted onto the mental healthcare caseload was poor. Although he was allocated a mental health nurse to support his needs, no one saw him before he died. The healthcare team's input to the ACCT reviews and the action taken after them was largely ineffective.

Recommendations

- The Governor and Head of Healthcare should ensure that prison staff manage prisoners at risk of suicide or self-harm in line with national guidelines, including that:
  - Staff consider and record all the known risk factors of newly arrived prisoners when determining their risk of suicide or self-harm, including information from suicide and self-harm warning forms, person escort records and medical records.
  - Staff have a clear understanding of their responsibilities and the need to record and share relevant information about recognised risk.
  - Prison and healthcare staff, including the mental health team, work together to manage prisoners at risk of suicide and self-harm. Healthcare staff should be invited to and attend at least the first ACCT review, and subsequent reviews as necessary, and ensure they read a prisoner's SystmOne records in detail before attending ACCT and healthcare review meetings.
  - Staff hold multidisciplinary ACCT reviews, with the same case manager and involving staff who contribute to a prisoner's care.
  - Case managers complete caremaps, setting specific and meaningful caremap actions, identifying who is responsible for them and reviewing progress at each review.
- The Head of Healthcare and the clinical leads for the Barnet, Enfield and Haringey Mental Health Trust (BEHMHT) should ensure that the zoning guidance is reviewed so that there is a clear and explicit expectation that staff review records and contact new patients promptly.
- The Head of Healthcare should ensure that an effective system is in place to provide mental healthcare staff with appropriate oversight of prisoners' risks in line with the zoning guidance.

The Investigation Process

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

14. The investigator visited Wormwood Scrubs on November 2018. He obtained copies of relevant extracts from Mr Lambert's prison and medical records.

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

16. They interviewed 16 members of staff and two prisoners at Wormwood Scrubs on December 2018 and 11 February 2019, some jointly.

17. We informed HM Coroner for Western London District of the investigation. He gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

18. One of the Ombudsman's investigators contacted Mr Lambert's ex-partner, to explain the investigation and to ask if she had any matters she wanted the investigation to consider. She asked how Mr Lambert had taken his life, particularly as he was monitored under the prison's suicide and self-harm prevention procedures. She also wanted to know where he had obtained the belt which he had used as a ligature. We have addressed her concerns in this report.

19. Mr Lambert's ex-partner received a copy of the draft report. The solicitor representing her wrote to us but did not raise any questions that impacted on the factual accuracy of this report.

Background Information

HMP Wormwood Scrubs

20. HMP Wormwood Scrubs is a local prison in West London which can hold nearly 1,300 men. The prison holds men on remand from West London courts and London prisoners serving short sentences or coming to the end of long sentences. Care UK is contracted to provide primary care and several other health services at Wormwood Scrubs.

HM Inspectorate of Prisons

21. The most recent inspection of HMP Wormwood Scrubs was in July and August 2017. Inspectors reported that there had been three self-inflicted deaths in the previous 18 months. The prison had reviewed previous PPO recommendations but elements of its local action plan were not up to date and serious self-harm incidents had not been investigated. They found that strategic oversight of suicide and self-harm was superficial and cross-deployment of safer custody staff hindered the effectiveness of the team. They noted that the management of prisoners in crisis was poor and in too many cases, insufficient action was taken to promote prisoners' safety. Inspectors found that care for prisoners vulnerable to self-harm was inadequate. They noted that the quality of many ACCT documents was poor and did not provide assurance that men were being well cared for. Inspectors found that many prisoners on an ACCT did not feel well supported.

Independent Monitoring Board

22. 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 its concerns about the treatment of newly arrived prisoners who required detoxification. They noted that the supply of drugs continued to be a major problem for the prison and that tackling this had been hampered by a lack of resources. They said that Wormwood Scrubs had secured funding for more cameras, both CCTV and body-worn, as well as additional money for safety improvements.

Previous deaths at HMP Wormwood Scrubs

23. Mr Lambert was the fourteenth prisoner to die at Wormwood Scrubs since November 2015 and the sixth prisoner to take his own life. Since Mr Lambert's death, another prisoner took his life in March 2019. We have previously made recommendations to improve the management of suicide and self-harm prevention procedures at the prison.

Assessment, Care in Custody and Teamwork

24. ACCT is the Prison Service care-planning system used to support prisoners at risk of suicide and 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. There should be regular multidisciplinary review meetings involving the prisoner. 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.

Key Events

25. On 3 May 2018, Mr Matthew Lambert was remanded to HMP Bedford, charged with a domestic violence offence against his ex-partner. It was his first time in prison. He arrived at Bedford with a suicide and self-harm warning form which noted that he had been banging his head in police custody. Staff started ACCT procedures which were continued until 13 June.

26. During his reception health screening, a nurse recorded that Mr Lambert had anxiety and depression for which he was prescribed medication. The nurse noted that Mr Lambert misused alcohol and would be referred to the substance misuse and mental health team, that he had taken an overdose of his medication the previous year and had been hospitalised, and that he had tried to take his life in February 2018. Mr Lambert told the nurse that he had been admitted to a psychiatric hospital on four occasions in 2017 and had borderline personality disorder.

27. On 5 October 2018, Mr Lambert attended court, was found not guilty and released from prison. While in the community, Mr Lambert's GP prescribed him medication for depression, anxiety and pain relief.

HMP Wormwood Scrubs

28. On 24 October 2018, Mr Lambert was charged with a violent domestic offence. While in police custody, Mr Lambert said that he wanted to die and was seen banging his head on the wall. He said that he would not be able to serve five years in prison. The police medical officer prescribed him medication for anxiety.

29. On 26 October, Mr Lambert remanded to HMP Wormwood Scrubs. The person escort record (PER) that travelled with him from the police station, court and Wormwood Scrubs noted his behaviour in police custody, that he had taken an overdose on three occasions in the previous year, and that he had anxiety, depression and was an alcoholic. The PER also noted that Mr Lambert had torn clothing into strips on 2 October 2018 and tied it around his neck.

30. An officer completed Mr Lambert's initial reception screen at Wormwood Scrubs. He noted that Mr Lambert had arrived with a suicide and self-harm warning form and staff started ACCT procedures. Mr Lambert was initially monitored hourly. He said that he had mood swings and struggled to sleep. Staff noted that Mr Lambert had bruises on his head and that he was scheduled to return to court on 26 November. Mr Lambert named his ex-partner as his next of kin. Staff referred Mr Lambert to the secondary mental health team (the in-reach team).

31. A nurse completed an initial health screen for Mr Lambert. He noted that Mr Lambert had a history of alcohol and drug misuse and had depression and anxiety. The nurse noted that Mr Lambert had harmed himself in police custody and reception staff had started ACCT procedures. Mr Lambert said that he had no current thoughts of suicide or self-harm. The nurse completed an alcohol and drugs screen. Mr Lambert tested positive for cannabis and benzodiazepine a synthetic opioid) and displayed mild withdrawal symptoms – his hands trembled when outstretched. The nurse noted that Mr Lambert would be referred to the mental health team.

32. Afterwards, a prison GP examined Mr Lambert and noted that he engaged well and was calm. He recorded that Mr Lambert had been prescribed naproxen (a painkiller) for a past knee injury, omeprazole for acid reflux as well as mirtazapine (an antidepressant). Mr Lambert said that he had thoughts of suicide and self-harm and experienced "shakes" when he had not had alcohol. The prison GP started Mr Lambert on a seven-day benzodiazepine alcohol detoxification programme, and noted that he would be located on the wing for prisoners undergoing detoxification.

33. The prison GP prescribed Mr Lambert a seven-day course of standard detoxification medications.

34. Staff gave Mr Lambert a two-minute telephone call to speak to his family. Afterwards, he was moved to the detoxification wing. He shared a cell with another newly arrived prisoner.

27 October

35. A nurse told the investigator that he was concerned about Mr Lambert's mood at around 9.00am on 27 October. He said that Mr Lambert had refused to take his prescribed propranolol (a beta blocker for his anxiety). Mr Lambert's cellmate, had also attended the medication hatch a little earlier to express concerns about him saying that Mr Lambert had told him that he had suicidal thoughts. The nurse asked a community psychiatric nurse who worked as a dual diagnosis nurse (for the substance misuse and mental health teams), to speak to Mr Lambert.

36. The community psychiatric nurse did so later that day, and completed a secondary health screen for Mr Lambert. He told the investigator that Mr Lambert engaged well during his assessment. He said that Mr Lambert told him that he felt hopeless, had thoughts about dying and appeared depressed. However, he said that their conversation ended positively, and that Mr Lambert was happy to take his medication. He said that Mr Lambert also talked about his family and children and said that he wanted to be around for them in the future.

28 October 2018

37. An officer unlocked Mr Lambert at around 8.50am so that he could collect his medication from the medication hatch. A nurse dispensed the medication to Mr Lambert. He took some of his antidepressants but refused to take the chlordiazepoxide, paracetamol, naproxen and omeprazole prescribed to him. As the chlordiazepoxide was aimed at managing his withdrawal from alcohol safely, the nurse assessed him visually but recorded that he appeared okay.

38. At around 12.50pm, an officer recorded that when he checked Mr Lambert, he saw him kneeling next to the sink, with a razor blade in his hand. Mr Lambert had made a small cut to his wrist and although he initially refused to give the officer the razor blade, he eventually did. He said that Mr Lambert's mood was low and that he was worried about his offence because it was serious. Mr Lambert asked if he could make a telephone call. He also wanted to speak to someone from the mental health team. The officer arranged for a nurse to treat Mr Lambert's cut but he refused treatment.

39. The community psychiatric nurse saw Mr Lambert afterwards to check on his wellbeing. He decided to complete a mental health assessment for Mr Lambert although he was not working as a community psychiatric nurse that day. Mr Lambert said that he had had a bereavement in his family, and that he was taking medication for anxiety and depression. The community psychiatric nurse told the investigator that Mr Lambert's mood appeared a little better than the previous day and he did not show signs of acute psychotic illness. He said that he referred Mr Lambert to the mental health team for further assessment (as he did not think that a previous referral had been completed). He said that he intended to discuss Mr Lambert at the weekly mental health multidisciplinary referral meeting, following which he expected that Mr Lambert would be assigned a case worker and be offered support.

40. At 3.30pm, an officer facilitated a telephone call for Mr Lambert to speak to his ex-partner in the presence of the community psychiatric nurse. He said that Mr Lambert's ex-partner offered him support which appeared to encourage him.

41. At 4.40pm, an officer assessed Mr Lambert under ACCT procedures. Mr Lambert said that his mood was low when he was in his cell, he had lost his appetite and was not sleeping well. He said that he was dependent on alcohol and antidepressants and wanted to be dead. The officer recorded Mr Lambert's main concerns as his forthcoming attendance at court, that he wanted a prison job, that he wanted to maintain contact with his family and to be transferred to a prison closer to them. The officer did not refer to Mr Lambert's health concerns.

42. A Custodial Manager (CM) began her shift at 5.30pm. She told the investigator that she did not know why the ACCT assessment had not been completed on time. She was also conscious that Mr Lambert's first ACCT case review was also late. She said that she had not been able to gather the appropriate staff to conduct the first ACCT review when it should have taken place. The CM spoke to an officer and nurse before they finished their shifts. They updated her verbally about Mr Lambert. The nurse told her that Mr Lambert had complied with his medication regime and that he had no concerns.

43. The CM spoke to Mr Lambert at 6.30pm. She said she considered that their meeting was an "interim" ACCT case review so that any immediate risks or concerns could be dealt with before a formal ACCT case review was completed the next day. Mr Lambert said that he had no current thoughts of self-harm or immediate concerns. The CM noted that Mr Lambert's risk level was raised, his observations were to remain hourly and that his first ACCT review was to be held on 29 October.

29 October 2018

44. At 8.05am, Mr Lambert's cellmate pressed the emergency cell bell and told staff that Mr Lambert had made superficial cuts to his wrist. Staff noted that Mr Lambert's mood was low and that he would not talk to them. Mr Lambert was escorted to the healthcare department.

45. A nurse examined Mr Lambert, and noted that he had dried blood on his left wrist. She cleaned and dressed his wound. Mr Lambert told the nurse that he had no current thoughts of suicide or self-harm.

46. At around 11.00am, a member of staff from the Forward Trust Drug and Alcohol Service (which provides psychosocial interventions) assessed Mr Lambert. Mr Lambert said that he drank around 50-60 units of alcohol a day and was currently on an alcohol detoxification programme. He said that he felt unwell and did not like to mix with other people. She gave Mr Lambert some crosswords and workbooks about alcohol misuse to complete in his cell. She started a recovery and release plan to address his alcohol misuse and anger management problems. She noted that he was not talkative and scheduled an appointment to see him again on 5 November. (There is no evidence that this meeting took place.)

47. At 2.15pm, an officer from the Safer Custody Team recorded in the prison records that Mr Lambert had been remanded for a serious domestic offence which might trigger self-harm. She noted that staff should be aware of changes in Mr Lambert's mood.

48. A Supervising Officer (SO) completed Mr Lambert's first ACCT review at 4.30pm. A nurse was present. The SO noted that Mr Lambert's mood was low, that he had thoughts of suicide and was crying. Mr Lambert said that he had let his children down by returning to prison and they would be better off without a dad. However, he acknowledged that during detoxification, his feelings would be heightened. The nurse explained to Mr Lambert that he should engage with the Forward Trust service as they could support him with his housing and psychosocial interventions. Mr Lambert said that he was happy with his cellmate and hoped to take part in activities to occupy him after he had finished his detoxification programme. The SO and nurse noted that Mr Lambert's risk level was raised and agreed to monitor him at hourly, irregular intervals and that staff would have three conversations with him during the day (morning, afternoon and evening). The next ACCT review was scheduled for 2 November.

49. The SO noted in Mr Lambert's ACCT caremap that he had two issues to address. He noted that Mr Lambert would try to maintain family ties by writing to his children and would engage with the Forward Trust Service for support while completing his alcohol detoxification programme. The SO did not sign or date the caremap.

30 October 2018

50. At 6.30am on 30 October, the night operational support grade officer (OSG), recorded that Mr Lambert had made superficial cuts to his wrist with a razor blade. A CM and a nurse attended Mr Lambert's cell and removed the razor blades. The nurse treated and dressed his wound.

51. The CM completed an ad-hoc ACCT review immediately afterwards. An officer and nurse from the alcohol detoxification team were present. Mr Lambert was reluctant to engage fully with staff about the incident. The CM noted that a full ACCT review would be completed later that day and did not change Mr Lambert's risk or observation level.

52. A SO completed Mr Lambert's ACCT review at 11.20am. A nurse was present. The SO recorded that Mr Lambert's mood was still low but that his medication had been sorted out and he had spoken to his family. This account contrasted

with the nurse's version. She recorded in Mr Lambert's medical record that he was crying and had thoughts of suicide. They told Mr Lambert that prison and healthcare staff would support him and they reminded him that he could use a Listener (a prisoner trained by the Samaritans to offer confidential peer support). They reduced Mr Lambert's risk level to low, and reduced the level of his observations to hourly at night, three during the day and two daily conversations. The next ACCT review was scheduled for 2 November. The nurse had also noted that Mr Lambert had asked to be moved to E Wing and wanted to get a prison job. Despite this, no additions or changes were made to the ACCT caremap.

53. Staff recorded in Mr Lambert's prison records that, a member of the chaplaincy team, saw Mr Lambert at 11.15am, and had long conversation with him and offered him support. Mr Lambert was upset that he had been arrested again.

54. That afternoon, a healthcare assistant saw Mr Lambert for a smoking cessation advice session and gave him nicotine replacement patches.

31 October

55. At 10.00am, a lead consultant psychiatrist, chaired the in-reach mental health team's weekly multidisciplinary case referrals meeting attended by, a specialist in forensic psychiatry, an occupational therapist, and five community psychiatric nurses. A nurse updated the team about Mr Lambert's assessment and contact with him. (Neither the specialist in forensic psychiatry nor the nurse could recall if they had reviewed Mr Lambert's medical records before the meeting and the meeting notes do not refer to Mr Lambert's recent episodes of deliberate self-harm.)

56. The specialist in forensic psychiatry noted that Mr Lambert would be allocated a mental health case manager and that he would be referred for counselling and to an activity centre run by the secondary mental healthcare team and the occupational therapy team. A nurse completed these referrals immediately but there was a waiting list for both services. The nurse noted that Mr Lambert would only be able to attend after he left the detoxification wing. The nurse also noted that he would contact Mr Lambert's community GP for any additional information, much of which he discovered was contained in Mr Lambert's medical record.

57. The meeting allocated a nurse to manage Mr Lambert's ongoing care. Mr Lambert's medical record noted that his risk was assessed as "zone amber", and that the nurse should review his wellbeing weekly. They agreed to review Mr Lambert in a fortnight.

58. Wormwood Scrubs' mental health team use a zoning protocol (consisting of red and amber to reflect a prisoner's risk level) to set the timeframe for reviewing patients. The red zone indicates that a prisoner is considered to be in immediate danger and should be reviewed daily. The amber zone indicates a prisoner whose risk is not life-threatening but urgent, and the case manager would be expected to review the prisoner once or twice a week.

59. The investigator found no evidence to suggest that the nurse reviewed Mr Lambert's medical record, assessed him or offered support after the meeting.

The nurse told the investigator that he had overlooked the required weekly review in the management plan. His rationale was that as Mr Lambert was in the amber zone, fortnightly contact was sufficient.

60. A prison GP, a nurse and, a member of the Forward Trust Service, saw Mr Lambert at 10.26am, and reviewed him as part of his detoxification monitoring regime. The prison GP had no concerns about Mr Lambert's presentation and noted that Mr Lambert had completed six days of the seven-day programme. Mr Lambert said that he had no problems with the detoxification regime but still had some alcohol withdrawal symptoms, was not sleeping well and still had thoughts of self-harm. He said that that he expected to see a member of the mental health team later that day. The prison GP noted that he would wait for the mental health assessment and contribute to that, if required. He noted that Mr Lambert would be seen again if he felt unwell or had any concerns.

1 November 2018

61. The night operational support grade officer (OSG) was on duty. He recorded that Mr Lambert had been awake at 4.09am, vaping. Although Mr Lambert returned to bed shortly afterwards, he was again awake at 6.17am. The OSG noted that Mr Lambert was standing by the sink and asked to speak to a Listener. He then knelt on the ground while resting his head over the sink. The OSG immediately contacted the officer in charge to report Mr Lambert's low mood.

62. Within ten minutes, an officer from the Safer Custody Team visited Mr Lambert in his cell. He told her about his anxiety, his dependence on alcohol and that he believed that he had let his family down. He said that he had thoughts of hurting himself. The officer encouraged Mr Lambert to write to his children and reminded him of the support networks available to him. Mr Lambert said that he would ask to speak to a Forward Trust team member. He added that he got on well with his cellmate and did not want to have to change.

63. In the evening, Mr Lambert took the last dose of his alcohol detoxification medication. After completing this programme, prisoners are usually moved to a standard residential wing. However, staff told the investigator that they had intended to move Mr Lambert to E Wing (which provides additional support for prisoners) but they wanted to keep him with his cellmate as they got on well. They therefore waited for a double cell to become available for them on E Wing.

2 November 2018

64. Staff recorded that during the morning association period, Mr Lambert had been a little upset because someone had stolen his vape pipe. At lunchtime, Mr Lambert's cellmate told an officer that Mr Lambert had swallowed some of his nicotine products. A nurse attended the wing to see Mr Lambert and told staff that the products were not harmful. Mr Lambert had also said that his antidepressant was not working. The nurse told the investigator that he thought Mr Lambert's actions were a ploy between him and his cellmate to get more nicotine replacements and were not an act of self-harm. The nurse could not recall whether he had reported to the mental health team that Mr Lambert had said that his antidepressant was not working.

65. A CM chaired Mr Lambert's fourth ACCT review at 2.15pm, with a nurse and an officer present. He noted that Mr Lambert's mood was low, he was very reluctant to engage with the review or answer questions. Mr Lambert said that his antidepressant was not working. He said that his ex-partner supported him but he was worried about his children. The nurse recorded that Mr Lambert said that he felt suicidal and had taken an overdose of his nicotine replacement therapy products that day. He told Mr Lambert to speak to staff if he later felt unwell. The review panel noted that Mr Lambert's risk was raised and increased his ACCT observations to hourly at night, with staff required to have conversations with him every other hour in the afternoon and evening. The next ACCT review was scheduled for 5 November.

66. Mr Lambert collected his medication over the next two days. No concerns were recorded.

Events between 5 to 8 November 2018

67. At 7.50am on 5 November, an officer recorded that Mr Lambert's cellmate had pressed the cell bell and said that Mr Lambert had tried to kill himself by cutting his wrist. There is no record of this in Mr Lambert's medical record and there is no evidence that healthcare staff were told about this incident.

68. An officer spoke to Mr Lambert in his cell. Mr Lambert said he felt okay. The officer checked on Mr Lambert throughout the morning and raised no concerns.

69. At 11.02am, a CM completed an ACCT review, with a nurse present. On this occasion, it was noted that Mr Lambert engaged well, although he made little eye contact. Mr Lambert said that he had thoughts of taking his own life as he was struggling in prison. He disclosed that his main issues were to get a new solicitor and to move to E Wing. The CM noted that Mr Lambert would be given a phone call to help him to change his solicitor and that he would find out whether a move to E Wing could be accommodated. The nurse recorded in the medical record that Mr Lambert did not express thoughts of self-harm. There is no evidence that healthcare staff were told that Mr Lambert had earlier harmed himself.

70. The review panel reduced Mr Lambert's risk to low, set the observations at four conversations with staff during the day, one observation in the evening and hourly (irregular) observations at night. The next ACCT review was scheduled for 9 November.

71. A CM updated the ACCT caremap, and noted that Mr Lambert wanted a new solicitor. (Later that day, staff facilitated a phone call for Mr Lambert to start this process.) The caremap also noted that Mr Lambert's mental health medication should be reviewed. (This was signed off as completed by the healthcare team on 9 November although there was no corresponding entry in Mr Lambert's medical record and the nurse could not recall any discussion about medication.)

72. On 6 November, a member of the chaplaincy team saw Mr Lambert who was tearful and distressed, and said that he was upset that he had not managed to avoid getting into trouble.

73. Later that evening, an officer gave Mr Lambert a warning after he was involved in an altercation with another prisoner during the serving of the evening meal. Mr

Lambert said that he was not happy with the meal so had thrown it over the other prisoner.

74. On the afternoon of 7 November, an officer spoke to Mr Lambert after his cellmate raised concerns about him. Mr Lambert was again feeling low and had wanted to see the mental health team. There was no evidence that this information was passed to the mental health team and nothing was recorded in his medical record.

75. A nurse who had been allocated to manage Mr Lambert's care a week earlier, had not seen him. There was no evidence in Mr Lambert's medical record that the nurse had reviewed his record or that his case was discussed at the case referral meeting.

76. On the evening of 8 November, a nurse noted that Mr Lambert repeatedly refused his medications (paracetamol, naproxen, mirtazapine, thiamine and Vitamin B).

9 November 2018

77. At 3.15am, an officer recorded in the ACCT log that he responded to Mr Lambert's emergency cell bell. Mr Lambert asked him if his ACCT observation levels had been changed because he believed that he had not been checked since 1.30am. The officer said that he assured Mr Lambert that he had been checked. (CCTV is not in operation on the detoxification wing. However, the ACCT record noted that the officer had completed ACCT checks at 12.00am, 12.50am, 1.45am and 2.40am.)

78. That morning, staff noted that Mr Lambert had collected his medication, attended a legal visit and collected his lunch.

79. In the afternoon, Mr Lambert asked to see a GP. Staff told him to speak to the healthcare team who would make an appointment for him. There is no evidence in Mr Lambert's medical record that he did so.

80. That afternoon, Mr Lambert made three phone calls. First, he rang his brother and asked him to transfer £10 into his prison account. He then called his ex-partner. They talked about his offence and that he had "messed up". He said that he had had a visit from his solicitor earlier and they discussed the possibility that he would receive a prison sentence of six to nine years. Mr Lambert talked about his health, the detoxification wing, his medication and that he had been referred for bereavement counselling. He said that he was close to taking his life but wanted to stay positive for the children. Mr Lambert then made a second shorter call to his ex-partner. They talked about his possible transfer to a prison nearer home.

68. At around 5.00pm, a SO completed an ACCT review. A nurse was present. The SO told the investigator that it was the first time that he had met Mr Lambert. He noted that Mr Lambert engaged well, said that he felt better but made little eye contact. Mr Lambert said that he had had a few bad days recently, was struggling but had managed not to self-harm. He said that he was taking his medication but admitted that he sometimes intentionally missed doses. The review panel noted that the mental team would continue to support him. They

noted Mr Lambert's risk as low and agreed that staff should have five conversations with him during the day (two in the morning, two in the afternoon and one in the evening) and hourly observations at night. The next ACCT review was scheduled for 16 November. The SO reviewed and updated the ACCT caremap. He recorded that staff had referred Mr Lambert to the Forward Trust Service, and noted the mental health team had reviewed Mr Lambert's medication. There is no record of the ACCT review in Mr Lambert's medical record.

81. Mr Lambert's cellmate told the investigator that he believed Mr Lambert's mental health had deteriorated over time and became worse as his court hearing date (26 November) approached. He said that as a result, Mr Lambert sometimes did not take his medication and regularly spat it out.

10 and 11 November

82. On 10 November, an unknown officer recorded in the ACCT record that Mr Lambert asked to see a nurse and a doctor. However, there is no entry recorded in his medical record that he made an application to see the healthcare team. Aside from this, staff raised no concerns about Mr Lambert on this or the following day.

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83. In the afternoon, staff unlocked Mr Lambert for his medication. Staff recorded in the ACCT record that Mr Lambert said that he was trying to cope but was in a bad way and wanted to speak to a psychiatrist. There is no evidence in Mr Lambert's medical record that the healthcare team were told of his request. (A nurse had still not seen Mr Lambert, thirteen days after he was allocated to manage his care.)

84. An officer noted that Mr Lambert was not talkative when he attended the servery to collect his evening meal. Mr Lambert said he was fine.

85. His cellmate said that Mr Lambert's mood was low and that he was stressed that evening. He wanted to smoke something and a prisoner in an opposite cell threw a line (a long string) across the landing with a vape capsule attached to it for him.

86. Shortly after 7.30pm, during ACCT checks, an officer smelt cigarette smoke coming from Mr Lambert's cell and saw the line. Mr Lambert and his cellmate denied that they had been smoking. The officer closed their observation panel and gave them a warning.

87. A night operational support grade officer (OSG), started his duty at around 8.30pm and received a handover from an officer. He recorded that he completed hourly ACCT checks throughout the night but recorded no concerns about Mr Lambert.

88. The cellmate told the investigator that from his recollection, staff did not complete ACCT checks for Mr Lambert from about 7.30pm until around midnight. It is not possible to confirm this as there is no CCTV on the detoxification wing.

89. Mr Lambert's cellmate also told the investigator that Mr Lambert watched the TV news that night "about a young lad that was in a psychiatric unit that had hung himself...the programme stated that within six minutes of hanging at the most, there's no chance of bringing a person back". He said that Mr Lambert asked him if he thought that was true.

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90. The investigator was told that none of the staff present during the emergency response had worn body-worn cameras on 13 November because there had been a power cut in the local area and problems with charging camera units.

91. At 6.45am, Mr Ohemeng recorded that Mr Lambert was awake and using the toilet. He told the investigator that he had no concerns about Mr Lambert.

92. The night OSG gave a SO and an officer a handover at around 7.45am when they arrived for duty. They discussed a number of issues but no concerns were raised about Mr Lambert. Shortly afterwards, two other officers also started their shift on the unit.

93. At around 8.14am, an officer started unlocking the cleaners on the wing and those prisoners who needed to collect medication. The officer went to unlock and complete an ACCT check for Mr Lambert. When she arrived at his cell, she looked through the observation panel but did not see him. Mr Lambert's cellmate was sleeping on the opposite bed. The officer called Mr Lambert's name but there was no response. She thought that an officer might already have unlocked Mr Lambert and so went over to check with him. An officer said that he had not done so and quickly made his way to Mr Lambert's cell.

94. The officer looked through the cell door observation panel. He could not see Mr Lambert in the cell or on his bed on the left-hand side of the cell. Mr Lambert's cellmate was still asleep. The shower rail where the privacy curtain had once hung, had been replaced by a blanket and was drawn across the toilet and partially obstructed the view of Mr Lambert's bed. As the officer looked behind the cell door, he saw Mr Lambert hunched on his knees, suspended by a belt attached to a piece of bedsheet, wedged into an access panel over the toilet. (Mr Lambert's property card listed that he had a black belt when he arrived at Wormwood Scrubs.)

Emergency response

95. An officer immediately unlocked the cell door while the other officer radioed a medical emergency code blue (to indicate that a prisoner is unconscious or has difficulty breathing) at 8.16am. Staff in the control room immediately called an ambulance.

96. As Mr Lambert was behind the cell door, a prisoner helped staff to push it open. An officer supported Mr Lambert's body, and the prisoner assisted him. An officer passed her cut-down tool to the officer who cut the ligature. They then lowered Mr Lambert to the cell floor and placed him in the recovery position. An officer checked Mr Lambert for signs of life but found none. Healthcare staff arrived at the cell with emergency equipment at 8.18am, and took over. The

prisoner and Mr Lambert's cellmate, who was initially sleeping, left the cell, followed by the two officers'.

97. A nurse began CPR, assisted by another nurse, a HCA, a nurse and pharmacy a technician. They used a defibrillator, but it advised that a shock was not required.

98. Paramedics arrived at Mr Lambert's cell at 8.29am and took over resuscitation efforts. They stopped at 9.15am and confirmed that Mr Lambert had died.

99. Mr Lambert left a note in his cell, addressed to his ex-partner, in which he apologised and said that he had not meant to hurt anyone. He said that he loved his ex-partner and children.

Contact with Mr Lambert's family

100. At 1.45pm on 13 November, a lead manager in the Public Protection Team, and the hub manager of the Safer Custody Team, visited Mr Lambert's ex-partner to break the news of his death but she was not home. They did not manage to speak to her until later that evening. They visited her again the next day. They stayed in regular touch with her until Mr Lambert's funeral, which the prison arranged. The prison contributed to the funeral costs in line with national guidelines.

Support for prisoners and staff

101. After Mr Lambert's death, the Deputy Governor debriefed the staff involved in the emergency response to ensure that they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

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

Post-mortem report

103. The post-mortem examination established that Mr Lambert died of asphyxia caused by hanging. Post-mortem toxicology results confirmed the presence of Mr Lambert's prescribed medications, including mirtazapine, at levels consistent with therapeutic use. They also indicated that Mr Lambert had used cannabis before he died although the post-mortem report indicated that it was likely that the use had not been recent.

Findings

Management of risk of suicide and self-harm

104. Prison Service Instruction (PSI) 64/2011 on safer custody) and PSI 07/2015 on early days in custody list a number of risk factors and potential triggers for suicide and self-harm. Mr Lambert had a number of these risks when he arrived at Wormwood Scrubs. He had a history of attempted suicide and self-harm, had arrived with a suicide and self-harm warning form, had mental health issues, including depression, he was remanded for a serious violent domestic offence and was an alcoholic. Staff appropriately started ACCT procedures when Mr Lambert arrived at Wormwood Scrubs and he was then managed under ACCT procedures until his death.

ACCT procedures, assessment and reviews

105. The PSI requires a multidisciplinary approach for ACCT case reviews, with relevant people involved in the prisoner's care and a continuity of case manager. It states that where possible, healthcare staff should attend the first ACCT case review. It says that a case manager should hold a first ACCT case review within 24 hours of starting ACCT monitoring, ideally immediately after the assessment interview, with the assessor present.

106. This did not happen. An officer completed the first ACCT assessment on 28 October, two days after ACCT monitoring started. On the same day, a CM completed an "interim case review due to late ACCT assessment" alone. The CM did not know why the assessment was not completed in line with national instructions nor why a first ACCT case review had not been held. She told us that she had obtained a verbal update about Mr Lambert's wellbeing from an officer and a member of the mental health team in order to complete an interim ACCT review. While the CM actions were better than nothing, the meeting was not a formal ACCT review which would have fully assessed his risks.

107. Contrary to PSI 64/2011, Mr Lambert's first ACCT review was held on 29 October, three days after ACCT procedures started. Neither the CM nor the ACCT assessor was involved in this review.

108. On 1 November, Mr Lambert told an officer that he had thoughts of hurting himself. We consider that this should have prompted an ACCT review.

109. Including the initial interim ACCT review, staff completed seven ACCT reviews, each one chaired by a different manager and six of the seven attended by a different member of the healthcare team. This meant that there was no continuity of care in the way ACCT procedures were operated. The contribution of healthcare staff to ACCT reviews appears to have been unplanned and dependent on staff availability. As a result, there was poor communication and a lack of input between prison and healthcare staff and important information was not always consistent, shared, recorded or actioned.

110. For example, at the ACCT review held on 30 October, the nurse who attended noted in the medical record that Mr Lambert was crying and asked to be moved to E Wing to get a prison job. However, the case manager did not record this

detail. Although Mr Lambert was under the care of the mental health team, staff failed to share information about two incidents of self-harm on 29 and 30 October with the team which meant that the mental health referral panel were not fully updated about his risk.

111. There is no evidence that the healthcare team was aware when Mr Lambert harmed himself on the morning of 5 November. The nurse who attended the ACCT review later that morning also failed to record that it had been agreed that the mental health team would review Mr Lambert's medication. The review panel lowered Mr Lambert's risk and level of observations at this review and we consider that this was not appropriate after his recent act of self-harm. It is important that all incidents of self-harm and those which may increase a prisoner's risk are reported to relevant staff so that a prisoner can be appropriately assessed.

112. On 9 November, the nurse who attended the ACCT review failed to record Mr Lambert's attendance in his medical record.

113. PSI 64/2011 requires caremaps to reflect prisoners' needs, their level of risk and the triggers of their distress. They should aim to address issues identified in the ACCT assessment interview and be tailored to meet prisoners' individual needs and reduce risk. They must be time bound and say who is responsible for completing the action.

114. Mr Lambert's key concerns were to maintain contact with his family, to complete his alcohol detoxification, to have a review of his mental health medication and to change solicitors. Although staff recognised these concerns, they only addressed two of these issues. They kept no record of progress on completing a review of his mental health medication. Contrary to the caremap, this was not completed on 9 November and did not refer to the fact that the Forward Trust had not seen Mr Lambert for another appointment on 5 November, as recorded.

115. It was clear that Mr Lambert was finding it difficult to cope in prison and his mood was low. He told staff on more than one occasion that he wanted to take his life, and harmed himself more than once. Mr Lambert had a number of identified risks but staff missed opportunities to fully support, identify, monitor and address his needs using a multidisciplinary approach. We make the following recommendation

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

- **Staff consider and record all the known risk factors of newly arrived prisoners when determining their risk of suicide or self-harm, including information from suicide and self-harm warning forms, person escort records and medical records.**
- **Staff have a clear understanding of their responsibilities and the need to record and share relevant information about recognised risk.**
- **Prison and healthcare staff, including the mental health team, work together to manage prisoners at risk of suicide and self-harm.**

Healthcare staff should be invited to and attend at least the first review, and subsequent reviews as required, and ensure they read a prisoner's SystmOne records in detail before attending ACCT and healthcare review meetings.

- **Staff hold multidisciplinary ACCT reviews with the same case manager and involving staff who contribute to a prisoner's care.**
- **Case managers complete caremaps, setting specific and meaningful caremap actions, identifying who is responsible for them and reviewing progress at each review.**

Clinical care

116. The clinical reviewer noted that overall, the care that Mr Lambert received was equivalent to that which he could have expected to receive in the community. She noted that the healthcare team's approach to managing Mr Lambert's alcohol problem was clear and acceptable.

Mental health care

117. Mr Lambert was managed under ACCT procedures throughout his stay at Wormwood Scrubs. Healthcare staff attended the ACCT reviews but in general, they had little or no contact with Mr Lambert. He was assessed by the mental health team two days after arriving at Wormwood Scrubs but it is not clear if the team were aware that Mr Lambert had harmed himself on 29 and 30 October as it was not mentioned at the team's referrals meeting on 31 October.

118. The referrals meeting agreed that a nurse would manage Mr Lambert's ongoing mental health care. The meeting also assessed Mr Lambert's level of need as 'amber'. This meant that Mr Lambert should have had a minimum of fortnightly contact, although in fact the meeting agreed that the nurse should have weekly contact. Neither the nurse nor any other member of the member of the mental health team reviewed Mr Lambert before he died two weeks later and the nurse said he had overlooked the requirement for a weekly review. Under the mental health zoning protocol the nurse should also have attended Mr Lambert's ACCT reviews. If the nurse was unavailable, another member of the mental health team should have attended. This did not happen.

119. The zoning protocol does not set out how community psychiatric nurses should ensure that they are fully informed about the individuals allocated to them. There was no clear process in place for the mental health team manager to have oversight of overdue and missed visits. The mental health team used a white board in their office to record in which zone a prisoner had been categorised (red, amber or green). The community psychiatric nurse still had to check the individual prison records to establish when they were last seen and when they were due to be seen. This way of working makes it difficult for mental health staff to keep track of prisoners in their caseload and the level of support that the multidisciplinary case referrals meeting had agreed. It is clear that this system has some flaws and in this case, allowed Mr Lambert's care plan to go unnoticed. We make the following recommendations:

The Head of Healthcare and the clinical leads for the Barnet, Enfield and Haringey Mental Health Trust (BEHMHT) should ensure that the zoning

guidance is reviewed so that there is a clear and explicit expectation that staff review records and contact new patients promptly.

The Head of Healthcare should ensure that an effective system is in place to provide mental healthcare staff with appropriate oversight of prisoners' risks in line with the zoning guidance.

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