

**Prisons &
Probation**

Ombudsman
Independent Investigations

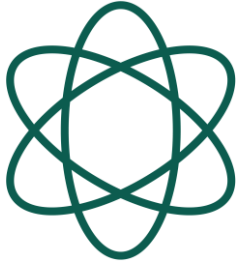
Independent investigation into the death of Mr Khader Saleh, a prisoner at HMP Wormwood Scrubs, on 31 January 2018

A report by the Prisons and Probation Ombudsman



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

OGL

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

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 Khader Saleh died on 31 January 2018, having been found with stab wounds in a cell at HMP Wormwood Scrubs. Mr Saleh was 25 years old. I offer my condolences to Mr Saleh's family and friends.

Three prisoners who had gone into the cell with Mr Saleh were arrested and charged with his murder. They were all subsequently acquitted. Our investigation was suspended until the trial was completed.

I commend those involved for the prompt emergency response by prison and healthcare staff.

We do not know what led to the incident in which Mr Saleh died. I am satisfied that there was no intelligence that Mr Saleh was at any specific risk of harm prior to his death.

I am very concerned that prisoners were able to access the service areas between cells and were thereby able to pass between locked cells. Prisoners were also able to store illicit items in these areas. This had been known about since 2016 and should have been dealt with effectively long before Mr Saleh's death.

I am also concerned that there is no evidence that any accommodation cell checks had been carried out in January 2018. As a result, prisoners had access to broken furniture from which to make weapons.

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

April 2020

Contents

Summary	1
The Investigation Process.....	3
Background Information.....	4
Key Events.....	5
Findings	9

Summary

Events

1. Mr Khader Saleh was remanded to HMP Wormwood Scrubs on 10 May 2017. He was awaiting sentencing for drugs offences. He had been in prison before and had a history of substance misuse. He had no health concerns when he arrived at the prison.
2. Later that month, Mr Saleh told a prison GP that he felt stressed. The doctor referred him for a mental health assessment which indicated that Mr Saleh did not need any input from the mental health team. He was referred to a drug rehabilitation organisation for a course of psychological sessions focused on learning and coping skills. On completing this course in July, he was referred for further sessions to help him address his substance misuse. When given an appointment, however, Mr Saleh did not attend.
3. In July, Mr Saleh was involved in a fight with another prisoner, and their brother. The fight was broken up by staff.
4. On 17 January 2018, Mr Saleh's next of kin was arrested after trying to pass a quantity of cannabis to Mr Saleh during a visit.
5. On 30 January, Mr Saleh and his cellmate were involved in a fight with another prisoner.
6. On the afternoon of 31 January, Mr Saleh, his cellmate and another prisoner went into a cell on C wing. Shortly afterwards, the three other prisoners emerged from the neighbouring cell. An officer went into the first cell and found Mr Saleh lying on the floor, bleeding and unresponsive. He called a medical emergency code immediately.
7. Prison healthcare staff attended very quickly and found that Mr Saleh had been stabbed. They attempted to resuscitate him and were joined by ambulance paramedics and a helicopter medical team, but at 3.45pm Mr Saleh was pronounced dead.
8. The three prisoners who had entered the cell with Mr Saleh were charged with his murder. They were all subsequently acquitted in November 2018. Prisoner A admitted stabbing Mr Saleh but said he had done so in self-defence.

Findings

9. There was no intelligence available to suggest that Mr Saleh was at specific risk of harm by other prisoners before his death.
10. It is possible that the interception of the drugs during a visit on 17 January had left Mr Saleh in debt. This is, however, only speculation.

11. No security report was submitted about the fight Mr Saleh was involved in the day before he died. As a result, the security department did not have the opportunity to make any assessment of this information.
12. When Mr Saleh was found bleeding in his cell, the emergency response was prompt and efficient.
13. There was a power failure in the prison on the morning of 31 January. This might have led prisoners to believe, incorrectly, that the security cameras were not working.
14. We are extremely concerned that it was possible for prisoners to access the service areas between cells to hide illicit items and to move between locked cells. Although Carillion, the estates management company at the time, were aware of this, adequate steps had not been taken to resolve the problem. Since Mr Saleh's death, metal bars have been fitted to prevent access to the service areas.
15. We are also concerned that there is no evidence that any cell accommodation checks had been made on C wing during January 2018. Subsequent checks found damaged furniture in many cells, including Prisoner A, which could be used to make weapons (although we cannot say if this played a part in Mr Saleh's death).
16. It is very unfortunate that Mr Saleh's family heard of his death from other prisoners and social media before they were formally informed. Because the police were investigating Mr Saleh's death as a possible murder, it fell to them to inform Mr Saleh's family and we make no criticism of the prison. We note that, given the prevalence of illicit mobile phones in prisons, it can be difficult to prevent news leaking out before families can be informed.

Recommendations

- The Governor should ensure that incidents of violence are reported to the security department promptly.
- The Governor should ensure that prisoners do not have access to the service areas between cells.
- The Head of Healthcare should ensure that, when necessary, timely appointments are made for prisoners with Forward Trust, and that referrals are properly documented on their medical records
- The Governor should ensure that accommodation fabric checks are made sufficiently regularly and frequently to detect damage that could potentially be used to make weapons.

The Investigation Process

17. 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.
18. The investigator visited Wormwood Scrubs. He obtained copies of relevant extracts from Mr Saleh's prison and medical records. He had ongoing contact with police investigating Mr Saleh's death.
19. The investigator interviewed three members of staff at Wormwood Scrubs. He also had access to police interview and witness statements.
20. NHS England commissioned an independent clinical reviewer to review Mr Saleh's clinical care at the prison. The clinical reviewer joined Mr Lusted in interviewing staff.
21. The investigator remained in ongoing contact with police involved in investigating Mr Saleh's death. We had to wait until the outcome of the trial before we could complete our investigation.
22. We informed HM Coroner for Western London district of the investigation. She gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
23. One of the Ombudsman's family liaison officers contacted solicitors representing Mr Saleh's next of kin to explain the investigation and to ask whether she had any matters the family wanted the investigation to consider. Mr Saleh's next of kin did not raise any specific issues. We provided her solicitors with a copy of this report.

Background Information

HMP Wormwood Scrubs

24. HMP Wormwood Scrubs is a local prison in west London, holding nearly 1,300 men. The prison holds men on remand from west London courts and London prisoners serving short sentences or coming to the end of long sentences. Care UK is contracted to provide primary care and several other health services at Wormwood Scrubs.
25. In August 2018, Wormwood Scrubs was selected to be part of the “10 Prisons Project”, which seeks to improve safety, security and decency in the prisons involved. The project is focusing on reducing violence, improving living conditions, preventing drugs from entering the establishment and enhancing the leadership and training available to staff.

HM Inspectorate of Prisons

26. 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 of staff. Inspectors criticised the high levels of violence in the prison and graded the prison ‘1’, the lowest level, for safety. They also noted that some key contracted providers were not delivering services effectively, and highlighted specifically that there were long delays in Carillion carrying out maintenance tasks.

Independent Monitoring Board

27. 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 2018, the IMB reported its concerns at staffing levels. There were also concerns over prisoners’ access to weapons and drugs. The Board said that prisoners told them that C wing had a tense and troubled atmosphere, and felt that it was dangerous.
28. The Board was also concerned about the backlog of physical maintenance issues in the prison. They said they had expressed very serious concerns about Carillion’s ability to maintain the fabric of the prison in their previous annual report, and that this situation had continued without improvement until Carillion eventually entered liquidation in January 2018. When maintenance was transferred to GFSL, there was a backlog of over 2,000 tasks to complete. Although the additional funding provided in the latter half of the year had helped with some large-scale projects to improve the physical environment, GFSL still struggled with the day-to-day minor repairs and smaller maintenance tasks.

Previous deaths at HMP Wormwood Scrubs

29. Mr Saleh was the twelfth prisoner to die at Wormwood Scrubs since February 2015. There have been seven further deaths since that of Mr Saleh. The circumstances of his death are not comparable to those of the other deaths.

Key Events

30. On 10 May 2017, Mr Khader Saleh, a Somali national, was remanded to HMP Wormwood Scrubs, awaiting sentence for supplying Class A drugs. He had been in prison before. A reception health screening showed no evidence of physical or mental health concerns, and Mr Saleh was relaxed and seemed to be in a stable mood. He admitted a history of using cannabis, and a drug test showed the presence of cannabis in his system.
31. On 19 May, Mr Saleh asked to see a doctor and, on 23 May, he told a prison GP that he felt stressed, with no motivation and poor sleep. Mr Saleh told the doctor that he had previously suffered a head injury. He admitted the previous use of heroin and crack cocaine but said that withdrawal symptoms had settled. He denied any drug use in the prison. The doctor referred Mr Saleh to the mental health team. He was assessed by the mental health team but was not considered to need any mental health input. He was referred to a drug rehabilitation organisation for a course of psychological sessions focused on learning and coping skills.
32. On 2 June, Mr Saleh was assaulted by other (unknown) prisoners after Muslim prayers. This resulted in some bruising and a small cut to his forehead.
33. In July, an improvised weapon and illicit prescription medication was found in Mr Saleh's cell and he was placed on the basic regime, the lowest level of the Incentives and Earned Privileges (IEP) scheme. (In total Mr Saleh spent five periods on the basic regime for reasons including fighting, assault on another prisoner and possession of an improvised weapon.)
34. In the same month, Mr Saleh completed a course of cognitive behavioural therapy, with which he engaged well. He was subsequently referred for a course run by the Forward Trust (a charity that works with prisoners to provide psychosocial solutions) to address issues around his substance misuse.
35. A prison intelligence report stated that Mr Saleh was involved in a fight with another prisoner, Prisoner A, and Prisoner A's brother on 31 July. The fight was broken up by staff.
36. In August, a prison officer recorded that five prisoners had tried to hide in the toilet in Mr Saleh's cell at the end of association. This happened again for four days in a row in October, and again on three occasions in November. An intelligence report was submitted.
37. In November, Mr Saleh was given an appointment with the Forward Trust. He did not attend.
38. Later that month, an improvised weapon (a tin can in a sock) was found in Mr Saleh's cell. There is no further information about who might have made, owned or hidden this weapon, nor any indication that it had been used.
39. On 17 January 2018, Mr Saleh's next of kin was caught trying to pass a quantity of cannabis to Mr Saleh during a visit.

40. On 30 January, Mr Saleh and his cellmate were involved in a fight with another prisoner. He was a friend of Prisoner A.

Events of 31 January 2018

41. On the morning of 31 January, there was a power cut. Although the prison's generator cut in very quickly and most services were reinstated almost immediately, the prison's IT went down and was not reinstated until the following morning.
42. On the afternoon of 31 January, CCTV shows that Prisoner A and another prisoner went into cell C2-85, which was Prisoner A's cell, at 2.39pm during association. One minute later, the cellmate and Mr Saleh also went into the cell. Mr Saleh appeared to enter the cell freely and not under any duress. Prisoners are able to close and lock their cell doors to prevent other prisoners accessing them (although prison officers are still able to unlock them from outside). When the cellmate and Mr Saleh went into the cell, the door was pushed shut, automatically locking it.
43. Cell C2-83 is the neighbouring cell to C2-85. At 2.44pm, the call bells in both cells were activated within seconds of each other.
44. A prisoner said in a police interview that as he walked past cell C2-85, someone inside the cell called out for him to fetch a prison officer. He assumed that staff had forgotten to unlock the cell so spoke to an officer and told her that the cell needed unlocking. She told him to ask another officer, who was nearby.
45. As the prisoner and the officer passed cell C2-83, the officer saw that the cell bell had been pressed, so he unlocked the cell door. Prisoner A, the cellmate and a prisoner came out of the cell and walked away.
46. The officer then opened cell C2-85, and saw Mr Saleh lying on the floor, surrounded by blood. The officer used his radio to call a code red (an emergency medical code indicating that a prisoner is bleeding heavily). The call was made at 2.53pm. This prompted the control room to call an ambulance. London Ambulance Service records show that the request was received at 2.54pm.
47. A prison GP and a nurse were already on C wing and responded very quickly to the emergency call. When they assessed Mr Saleh, he was not breathing and the prison GP could not detect a pulse. Two other nurses arrived and joined their colleagues in providing medical aid. A nurse put out a call for all healthcare staff to attend.
48. When they removed Mr Saleh's upper clothing, they found a stab wound to his chest. They attempted to resuscitate Mr Saleh, assisted by two further medical staff, who had also responded to the emergency call. They applied a defibrillator (a machine which, in some instances, restarts the heart) but the machine advised them to continue with cardiopulmonary resuscitation (CPR). They did so until paramedics and a helicopter medical team arrived and joined them in attempting to resuscitate Mr Saleh. Staff moved Mr Saleh from the cell onto the landing to provide more space to work but he was pronounced dead at 3.45pm.

Post-mortem report

49. The post-mortem examination showed that Mr Saleh has suffered two stab wounds, one to his back (which was not life threatening) and one to the front of his chest which had penetrated the lung and the pulmonary artery. The pathologist concluded that Mr Saleh died of shock and haemorrhage as a result of the stab wound to his chest.
50. The pathologist said that following the fatal wound, Mr Saleh would not have collapsed immediately and may have remained capable of some purposeful activity for up to a minute.
51. Toxicology tests showed that Mr Saleh may have been under the influence of cannabis at the time of his death.

Contact with Mr Saleh's family

52. Police visited Mr Saleh's family to inform them of his death. The family were upset that they had already heard the news from other prisoners and social media.
53. The prison's Head of Safer Custody visited Mr Saleh's family that evening with two police family liaison officers and a member of staff from the prison's chaplaincy team. She remained in touch with the family. In line with Prison Service guidance, Wormwood Scrubs offered a contribution to the cost of Mr Saleh's funeral.

Support for prisoners and staff

54. After Mr Saleh's death, the Duty Governor debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.
55. The prison posted notices informing other prisoners of Mr Saleh'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 Saleh's death.

After Mr Saleh's death

56. A homemade knife was discovered on the exercise yard outside C wing. It is thought this was used to stab Mr Saleh.
57. On 2 February 2018, the Executive Director for Public Sector Prisons South, commissioned the Prison Group Director for Surrey and Sussex, to carry out an internal investigation into the circumstances of Mr Saleh's death. The Prison Group Director for Surrey and Sussex liaised with the police to ensure that his investigation did not compromise the police investigation. He interviewed three members of staff – the Duty Governor, the Head of Safer Custody and a Custodial Manager (CM) who took on the role of Bronze Incident Commander. - and produced a report on 2 March making a number of recommendations.
58. On 6 January, cells on C wing were searched in the light of Mr Saleh's death. The internal investigation team were present when this happened and the Prison Group

Director for Surrey and Sussex commented in his report that the amount of broken furniture found in cells suggested that staff did not have a grip on what prisoners had in their cell.

59. Prisoner A, another prisoner and the cellmate were charged with Mr Saleh's murder. Prisoner A admitted killing Mr Saleh but said that he had acted in self-defence. During the trial, the judge acquitted the cellmate. At the conclusion of the trial the jury found Prisoner A and the other prisoner not guilty of murder.

Findings

Assessment of the risk to Mr Saleh

60. There was no intelligence to suggest that Mr Saleh was at specific risk of harm from Prisoner A or anyone else on 31 January.
61. We note that staff intercepted Mr Saleh's next of kin passing a quantity of cannabis to Mr Saleh during a visit on 17 January 2018. It is possible that the loss of these drugs caused Mr Saleh to fall into debt, but this can only be speculation.
62. For obvious reasons, prisoners try to conduct illicit activities, such as drug trafficking, without the knowledge of staff. We cannot say why Mr Saleh and the other three prisoners entered Prisoner A's cell on 31 January or whether illicit activities played any part in Mr Saleh's death.
63. Mr Saleh and his cellmate were involved in a fight with another prisoner on 30 January, the day before Mr Saleh died, but there are no records to indicate what this fight was about or whether it was connected in any way to what happened on 31 January. We are concerned that the fight was not logged and brought to the attention of the security department. We cannot say whether this might have made any difference to what happened the following day.

The Governor should ensure that incidents of violence are reported to the security department promptly.

64. On the morning of 31 January, there was a power failure in the prison. The emergency generator cut in within minutes but prisoners may have heard staff mention that the IT system was not working. They may have thought, incorrectly, that this meant the CCTV system was not working and was therefore an opportunity to undertake any activity they might usually be deterred from by the security cameras.

Emergency response

65. An officer, who found Mr Saleh bleeding on the floor of his cell, called a medical emergency code almost immediately. He had only been a prison officer for a few months at the time and we commend him for his effective response. As a result, an ambulance was called and prison and healthcare staff arrived very promptly.

Access to service areas between cells

66. Wormwood Scrubs is an old prison and its cells were built without internal sanitation. When toilets were introduced to the cells on C wing, this was done by turning three cells into two, extending the outer two cells towards each other into the third, middle, cell. New toilets and sinks were then installed back to back in what had been the middle cell. A small service area, the size of a small room, was left between the outer cells to contain the plumbing for the toilets and sinks. (The cells were not renumbered when this was done, so cells C2-83 and C2-85 were adjacent cells.)

67. In 2016, staff became aware that prisoners could remove mesh window panels above their toilets and access the service area. If this was done in both cells, prisoners could move between cells even though they were supposed to be locked into their own. The rooms also provided space where prisoners could hide illicit items, as prison officers did not carry door keys to these middle cells. The prison reported this to Carillion, the estates management company at the time, which covered the mesh panels with hardboard panels. These, however, remained relatively easy for prisoners to remove.
68. On 27 January 2017 it was reported that the mesh windows between cells C2-83 and C2-85 were missing. They were boarded up on 30 January. They were reported to be missing again on 2 February 2017, and records do not indicate when they were replaced. An intelligence report created in January 2017 stated that the window behind the toilet in the cellmates cell had been loosened, allowing access to the store cupboard between that cell and the next.
69. We are extremely concerned that prisoners were able to move between locked cells without being seen by staff. We are also very concerned that they could store illicit items in the service areas which prison officers did not have access to. Although Carillion were aware of the issue, it remained unresolved at the time of Mr Saleh's death.
70. Since Mr Saleh's death, the Prison Service's National Estates team have fixed large sets of metal bars in each of the window panels between cells in C wing. Wormwood Scrubs' Head of Safety assured the investigator that the bars are extremely robust and it would be impossible for a prisoner to gain access to the storage areas now. A recent inspection by the Head of Safety and the Security Manager found all the bars correctly in place with no signs of tampering. However, we consider that the Governor should ensure that regular checks are made to ensure the integrity of these bars. We recommend:

The Governor should ensure that prisoners do not have access to the service areas between cells.

Accommodation checks

71. Guidance on cell accommodation checks (known as accommodation fabric checks, AFCs) is contained in Prison Service Instruction (PSI) 09/2016, *Cell, Area and Vehicle Searching*. The guidance states that if any furniture is found to be broken, full consideration must be given to whether any of its parts could be used as a weapon. The PSI does not specify the frequency by which checks should be made, as the need will vary between prisons and wings.
72. Mr Saleh was stabbed with an improvised weapon. Prisoner A said in court that he had made weapons from chair legs from a chair in his cell about a month earlier. (He did not specify whether these were the weapons used to stab Mr Saleh.) The damaged chair was found in his cell. Staff had not noted in the intervening period that the chair had been damaged.
73. We are concerned that there is no evidence that any fabric checks had been made on cells in C wing during January 2018. We make the following recommendation;

The Governor should ensure that accommodation checks are made sufficiently regularly and frequently to detect damage that could potentially be used to make weapons.

Mr Saleh's healthcare

74. The clinical reviewer noted that Mr Saleh had no significant issues recorded in his medical history. He had previously suffered a stab wound in his left arm. On reception into Wormwood Scrubs there were no concerns over either his physical or mental health.
75. The clinical reviewer noted that Mr Saleh had no physical or mental health issues that were relevant to his death.
76. Post-mortem tests showed that Mr Saleh may have been under the influence of cannabis at the time of his death. There was no intelligence about Mr Saleh using drugs during his time in the prison. He had been referred to the Forward Trust to help him address his substance misuse but his medical record does not contain information about this referral. When the referral was made, there was a delay before he received an appointment. In the event, Mr Saleh did not attend the appointment. We make the following recommendation;

The Head of Healthcare should ensure that, when necessary, timely appointments are made for prisoners with Forward Trust, and that referrals are properly documented on their medical records.

77. The clinical reviewer noted that the medical emergency response was appropriate and well led. Some staff said that the suction equipment used during the resuscitation attempt was not of good quality. The clinical reviewer believes that this was unlikely to have affected the outcome for Mr Saleh, and the healthcare department have since replaced the equipment. We do not, therefore, make a recommendation.
78. The clinical reviewer concluded that the healthcare provided to Mr Saleh was equivalent to that which he could have expected in the community.

Contact with Mr Saleh's family

79. Mr Saleh's family were, understandably, upset that they learned of his death from other prisoners and social media before they were formally informed by the police.
80. Following a death in custody, prison staff should normally inform the prisoner's family in person as promptly as possible to avoid the family hearing from other sources. However, in Mr Saleh's case the police were investigating his death as a possible murder and their investigation, rightly, took precedence. This meant that it fell to the police, not the prison, to inform Mr Saleh's family and we make no criticisms of the prison.
81. We note that Mr Saleh's death took place during an association period when prisoners were out of their cells on the wing. We are satisfied that staff cleared the area and returned other prisoners to their cells promptly and effectively. However, some prisoners would have been able to see and hear aspects of the emergency

response and, given the prevalence of illicit mobile phones in the prison, it was virtually inevitable that the news of Mr Saleh's death would get out before the police had an opportunity to inform Mr Saleh's family.

Inquest

82. The inquest into Mr Saleh's death was held in May 2023. In light of the prisoner who stabbed Mr Saleh being acquitted of murder, the inquest concluded that Mr Saleh's death was a lawful killing.

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