Prisons & Probation Ombudsman
Independent Investigations

# Independent investigation into the death of Mr Luke Clarke, a prisoner at HMP Wormwood Scrubs, on 7 April 2020

**A report by the Prisons and Probation Ombudsman**

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T l 020 7633 4100

# 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.

If my office is to best assist His Majesty's Prison and Probation Service (HMPPS) in ensuring the standard of care received by those within service remit is appropriate, our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.

Mr Luke Clarke was found hanged in his cell at HMP Wormwood Scrubs on 7 April 2020. He was 38 years old. I offer my condolences to Mr Clarke's family and friends.

This is a shocking case. Although it is outside the PPO's remit, we question whether Mr Clarke should have been in prison at all.

Mr Clarke had been at Wormwood Scrubs for less than 24 hours when he hanged himself. He had a history of self-harm and attempted suicide, substance misuse and significant mental health issues. He had been arrested behaving bizarrely in the street and had arrived at the prison via assessment in a psychiatric crisis unit. He was also thought to have COVID-19. I am very concerned that, despite this, he was not assessed as being at risk of suicide or self-harm and I consider that more should have been done to support and manage his risks.

Part of the problem seems to have been that, because staff believed Mr Clarke had COVID-19, he was taken directly to the prison's isolation unit without going through the normal reception procedures, without receiving the normal entitlements of a newly arrived prisoner and without being subject to the usual first night wellbeing checks. I am also concerned that at this early stage in the pandemic, there was a lack of clarity about where management responsibility for the isolation unit lay.

We recognise that it was a very frightening time for all staff at Wormwood Scrubs and the general public in the early days of the COVID-19 pandemic, but it was equally frightening for prisoners, and Mr Clarke had the additional vulnerabilities associated with a personality disorder which made him overly suspicious and impulsive.

The clinical reviewer also found that Mr Clarke did not receive an acceptable level of care for his physical or mental health needs.

I consider that Mr Clarke's treatment at Wormwood Scrubs amounted to neglect. Although the prison told us that they have made changes since, we have made a number of recommendations, and I am also copying this report to the Prison Group Director for London.

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

**Adrian Usher**
**Prisons and Probation Ombudsman** **September 2023**

# Contents

# Summary

## Events

1. On 6 March 2020, Mr Luke Clarke was recalled to prison after his licence was revoked for failing to attend probation appointments and comply with the conditions of his licence. He remained unlawfully at large.

2. Mr Clarke had a long history of illicit drug misuse and mental health issues.

3. On 5 April, Mr Clarke was arrested by the police and taken to A&E after he was found behaving strangely in the street. He was seen by a consultant psychiatrist who concluded that he did not need to be detained under the Mental Health Act and that his mental health needs could be met in prison. On the morning of 6 April, he was taken to HMP Wormwood Scrubs by the police.

4. Before he arrived at the prison, prison staff were told that Mr Clarke was COVID-19 positive (although it is not clear whether this was in fact the case, and no tests to confirm this were available outside hospitals at that time). He was the first such prisoner to arrive at Wormwood Scrubs since the pandemic started. Prison staff agreed that on his arrival he would not enter the prison's reception area and that he would be taken directly to a cell on the designated COVID-19 isolation wing to reduce his contact with staff and prisoners. He did not, therefore, go through the normal reception process.

5. At about 3.00pm, a prison nurse went to Mr Clarke's cell to carry out his initial healthcare screening. Mr Clarke asked the nurse to open his cell door so he could speak to her, but she refused because he was reported to be COVID-19 positive, and she thought she did not have adequate Personal Protection Equipment (PPE). The nurse attempted to speak to him through his door, but he refused to engage.

6. Later that afternoon, an officer opened Mr Clarke's cell door to give him a meal, but he attempted to run out of the cell. The officer pushed him back in the cell and closed the door.

7. At about 9.30pm, an officer carrying out a routine roll check of all prisoners, said he looked through the observation panel of Mr Clarke's cell door and saw him standing in the centre of the cell. He said he asked Mr Clarke if he was 'ok' and that Mr Clarke responded by giving a thumbs up gesture.

8. The following morning, an officer should have completed a roll check on all prisoners at 7.00am but did not do so.

9. At about 9.00am, a prison doctor carried out welfare checks in the isolation unit on prisoners with COVID-19. She did not check on Mr Clarke because there was no name card outside his door, so she did not know his cell was occupied.

10. At 10.57am, healthcare staff went to Mr Clarke's cell to give him his medication and to conduct a mental health assessment. When they looked into the cell, they could not see him. Staff called to him, but he did not respond. Prison staff opened the cell door and found Mr Clarke hanging in the toilet area.

11. Staff radioed an emergency medical code. They cut Mr Clarke down and laid him onto the floor. Staff did not start cardiopulmonary resuscitation (CPR) because it was clear that Mr Clarke had been dead for some time. Shortly afterwards, a prison GP confirmed that Mr Clarke had died.

## Findings

12. Although it is outside the PPO's remit, we question whether Mr Clarke should have been in prison at all given the circumstances of his arrest and his poor mental health.

13. Mr Clarke had a number of significant risk factors for suicide and self-harm when he arrived at Wormwood Scrubs. We are very concerned that both prison and healthcare staff failed to identify and assess Mr Clarke's risk to himself and that he was not managed and supported under suicide and self-harm procedures (known as ACCT).

14. Because staff had been told that Mr Clarke had tested positive for COVID-19, and at the time had no way of testing for COVID-19 themselves to confirm the diagnosis, he was not subject to the normal reception procedures and the focus was more on the risk Mr Clarke might pose of infecting others, rather than on his risk to himself.

15. There was no clarity about where responsibility for managing the A4 isolation unit lay, and we are concerned that, as a result, there was inadequate oversight of Mr Clarke's care. For example, Mr Clarke did not receive the normal entitlements of a newly arrived prisoner. He was not given the opportunity to take a bath or shower. Staff gave him little information about the support that was available and there is no evidence that he was offered the opportunity to make a telephone call.

16. Prison staff assumed that Mr Clarke understood why he was placed in isolation. There is no evidence that he was given any verbal or written explanation or information about COVID-19 or had his temperature checked as part of the COVID-19 reception process, as it should have been.

17. Mr Clarke spent the afternoon and night of 5 April in A&E and the early hours of 6 April in a psychiatric unit. We do not know if he was given any food during this time. There is no evidence that Mr Clarke received lunch when he arrived at Wormwood Scrubs on 6 April, and we know he did not receive an evening meal or a breakfast pack.

18. The failure to put a name card outside Mr Clarke's cell meant that his cell appeared to be unoccupied. Although this was recognised as a problem on the evening of 6 April, nothing was done to correct it.

19. No first night welfare monitoring checks were carried out on Mr Clarke on the night of 6/7 April as they should have been.

20. An officer failed to carry out a routine roll check of prisoners at 7.00am on the morning of 7 April. This was a missed opportunity to check on Mr Clarke's wellbeing.

21. Prison staff did not carry out any welfare checks on the morning of 7 April.

## Clinical care

22. The clinical reviewer concluded that Mr Clarke did not receive an acceptable level of care at Wormwood Scrubs.

23. There was no adequate care plan to oversee his immediate care needs and there was a lack of structured partnership working and limited effective healthcare leadership.

24. A nurse did not enter the cell to conduct an initial health screen with Mr Clarke because she considered that the PPE available was not adequate, although the clinical reviewer considered that the PPE met Public Health England guidelines for the type of interaction she should have had with Mr Clarke.

25. Healthcare staff did not monitor Mr Clarke overnight as they should have done.

26. The decision not to resuscitate Mr Clarke was appropriate as resuscitation would have been futile and would have been undignified for Mr Clarke and distressing for staff.

27. The clinical reviewer commended the willingness of Nurse B and the principal pharmacist to provide face to face care beyond their usual roles of what was expected of clinicians.

## Breach of Information Assurance

28. Our investigation found that staff often used each other's personal computer accounts to make entries in prisoners' records on NOMIS (the electronic records system) and that it appeared to be accepted as normal practice. This is contrary to the Prison Service's Information Assurance Guidance.

## Recommendations

- The Governor and the Head of Healthcare should ensure that staff manage prisoners at risk of suicide and self-harm in line with PSI 64/2011, including that prison and healthcare staff:
    - share all information that affects risk;
    - start ACCT monitoring procedures when a prisoner has significant risk factors, or record their reasons for not doing so; and
    - review the prisoner's level of risk whenever there is an event or change of circumstances that could impact on risk.
- The Governor should ensure that first night procedures are in place for all prisoners entering the prison in line with PSI 07/2015, including that:
    - prisoners are offered the opportunity to take a bath or shower before being located into a cell overnight;

    - staff ask newly arrived prisoners if they need to telephone their legal advisor or to address urgent domestic issues; and
    - first night information is provided to all newly arrived prisoners.
- The Governor should ensure that first night monitoring procedures are in place for all newly arrived prisoners, wherever they are located.
- The Governor should ensure that all roll checks and welfare checks are conducted in line with local policy.
- The Governor should ensure that this report is shared with Officer B and Officer D and that a senior manager discusses the Ombudsman's findings with them.
- The Head of Healthcare should ensure that:
    - there is a system in place to obtain direct information from the appropriate provider when trying to establish a diagnosis; and
    - a copy of the A&E discharge summary is obtained if a prisoner has attended A&E while in police custody.
- The Head of Healthcare should ensure that healthcare staff are aware of current advice on PPE and that it is discussed with them.
- The Head of Healthcare should share this report with Nurse A and discuss the Ombudsman's findings with her.
- A senior manager from Practice Plus Group (from outside Wormwood Scrubs) should offer healthcare staff named in this report an opportunity to discuss and reflect on it and identify and address any outstanding training and support needs.
- The Head of Healthcare and the Governor should jointly use this report as a basis for considering what systems and processes are now in place ensure that similar issues do not recur.
- The Head of Healthcare should share this report with the principal pharmacist and Nurse B so that they are aware of the Ombudsman's findings.
- The Governor should ensure all staff complete and comply with Information Assurance Training.
- The Governor should share this report with the duty governor and CM A.
- The Prison Group Director for London should write to the Ombudsman setting out what he has done to satisfy herself that the culture at Wormwood Scrubs is one that fosters good and appropriate care for all prisoners.

# The Investigation Process

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

30. Due to restrictions in response to the COVID-19 pandemic, the investigator was unable to visit Wormwood Scrubs. She obtained copies of relevant extracts from Mr Clarke's prison and medical records electronically and by post.

31. NHS England commissioned a clinical reviewer to review Mr Clarke's clinical care at the prison. The investigator and clinical reviewer jointly interviewed 18 members of staff by telephone on 18 and 21 September and 1, 7 and 9 October 2020. The investigator also interviewed two members of staff by telephone on 13 and 16 November.

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

33. The Ombudsman's family liaison officer contacted Mr Clarke's next of kin to explain the investigation and to ask if they had any matters, they wanted the investigation to consider. They asked the following questions:

    - Given his diagnosed, long-term mental health disorder, why was he not taken to a psychiatric hospital instead of a prison on 6 April?
    - Why was he taken to prison with COVID-19, putting inmates, staff, and their families at risk?
    - Did he receive a physical and mental health assessment on entry to prison?
    - Given his history of psychosis and suicide attempts, why was he not managed under ACCT procedures and was a risk assessment carried out?
    - Why was he put onto A wing?
    - Did he ask to contact anyone or request anything?
    - Was he given the opportunity to make a telephone call?
    - Were prison staff aware of the phone call Mr Clarke's sister made to both 101 and to the prison in the days prior to his death, expressing her concern for her brother and his vulnerable state?
    - What personal items did Mr Clarke have when he was taken into custody?

34. We have answered the family questions that are within remit of our investigation in this report and in the clinical review.

35. Mr Clarke's family received a copy of the initial report. The solicitor representing the family wrote to us raising a number of questions that do not impact on the

factual accuracy of this report. Where relevant we have provided clarification by way of separate correspondence to the solicitor.

36. HMPPS responded to the initial draft and as a result this was re-issued. They have since provided final feedback, including an action plan detailing steps taken to address those recommendations made.

# Background Information

## HMP Wormwood Scrubs

37. HMP Wormwood Scrubs is a local prison in West London holding almost 1,300 men. The prison holds men on remand from West London courts or prisoners serving short sentences or coming to the end of long sentences. Practice Plus Group provide physical health services, and Barnet, Enfield and Haringey Mental Health Trust provide mental health services.

## HM Inspectorate of Prisons

38. The most recent inspection of HMP Wormwood Scrubs was in June 2021, but the report had not been published at the time of writing.

39. The most recent published inspection was in October 2019. Inspectors reported that the number of self-harm incidents was high, although similar to other local prisons. They found that the prison had taken too long to address significant weaknesses in self-harm prevention, but there had been some good work since the beginning of the year. Inspectors reported that reception and induction procedures were reasonable. Prison staff conducted interviews in reception that explored the risk of self-harm, although these were often insufficient in detail. Inspectors found that first night support for prisoners withdrawing from drugs or alcohol was thorough.

40. Inspectors reported that the mental health team delivered effective mental health services and urgent cases were seen within 24 hours despite the extremely high demand for the team's services. However, many prison staff said they had not received training in helping prisoners with mental ill health.

## Independent Monitoring Board

41. 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 2020, the IMB reported that there had been a reduction in incidents of self-harm in the reporting year. They reported that the introduction of a safer custody questionnaire in reception had helped to identify risk issues, although they were concerned that it did not fully explore health risks. The IMB also reported that the Mental Health Team had met most of their assessment targets for new referrals.

## Previous deaths at HMP Wormwood Scrubs

42. Mr Clarke was the eighth prisoner to die at Wormwood Scrubs since April 2018, and the fourth self-inflicted death. Since Mr Clarke's death, there have been two further self-inflicted deaths in November 2020 and March 2021.

43. In a previous investigation into a death at Wormwood Scrubs in November 2018, we found that some key information about risk for newly arrived prisoners was not properly considered and shared between healthcare staff and prison staff. The

prison undertook to ensure that staff received training on risk management and that all prisoners with a history of self-harm would be seen by a prison GP on reception to the prison.

## Assessment, Care in Custody and Teamwork

44. ACCT is the Prison Service procedure used to support prisoners at risk of self-harm or suicide. 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.

45. Part of the ACCT process involves assessing immediate needs and drawing up a caremap to identify the prisoner's most urgent issues and how they will be met. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

## COVID-19 restrictions

46. On 11 March, the World Health Organisation declared COVID-19 a worldwide pandemic. To reduce the spread of the virus, the Government introduced voluntary and mandatory actions, such as 'social distancing' and 'lockdown' (on 16 and 23 March respectively).

47. On 13 March, Public Health England (PHE)'s National Health and Justice team issued an interim notice providing advice on preventing and controlling outbreaks of COVID-19 in prisons. HMPPS issued further instructions over the following weeks with guidance on the appropriate use of personal protective equipment (PPE), hygiene, cleaning schedules and stock checks

48. On 24 March 2020, in response to the COVID-19 pandemic and in line with Government advice, HM Prison and Probation Service (HMPPS) issued an instruction to all prisons to introduce social distancing and a restricted regime for staff and prisoners, wherever possible. On 27 March, HMPPS issued operational guidance to prisons on exceptional regime and service delivery, which reflected Government restrictions following the national lockdown of 23 March. This guidance resulted in significantly restricted prisoner activities. Prison visits were suspended, education and non-essential work was cancelled, and healthcare delivery was also affected. This meant that prisoners spent much of their day locked behind their cell doors.

49. On 31 March, HMPPS, in consultation with PHE, issued an order to significantly reduce transfers between prisons. Other measures, known as 'compartmentalisation', were also announced. These measures were designed to be implemented at local level, depending on the needs of each individual establishment, and included protective isolation units to accommodate known COVID-19 cases and shielding units to protect the most clinically vulnerable prisoners.

# Key Events

50. Mr Luke Clarke had a long history of drug misuse, poor mental health and suicide attempts in the community. He was under the care of West London Mental Health Trust Services. His major diagnoses were paranoid schizophrenia, anti-social personality disorder and a history of alcohol dependence and substance misuse, mainly cannabis and cocaine. He was prescribed anti-psychotic medication which was administered by depot injection (which releases the medication slowly over an extended period).

51. He was also supported by various community drug and mental health services, although at times he chose to not to engage and failed to attend appointments and refused support and interventions offered to him. Mr Clarke said that he used drugs as a coping mechanism due to the pressures of his mental health issues and things that had happened to him in the past.

52. On 30 January 2020, Mr Clarke was released from HMP Wormwood Scrubs after serving a sentence of 20 weeks for battery and criminal damage offences.

53. On 6 March, Mr Clarke was recalled to prison after his licence was revoked for failing to attend his probation supervision appointments and comply with the conditions of his licence. He remained unlawfully at large.

## Events of 5 and 6 April 2020

54. The actions of agencies prior to Mr Clarke's arrival at Wormwood Scrubs is outside the remit of the PPO. The information below has not been investigated or checked for accuracy and is provided for context only.

55. On 5 April, the police arrested Mr Clarke and took him to Ealing Hospital A&E after he was found in the street without trousers and behaving in a sexually disinhibited manner. Mr Clarke is said to have told police that he had used illicit drugs and that he had not been taking his medication for his mental health. Mr Clarke was shouting, making no sense, and was physically aggressive.

56. When he arrived at hospital, Mr Clarke had a raised temperature. He refused to wear a face mask and was aggressive and had to be sedated so that staff could examine him. He had blood tests and a chest x-ray. The blood test results were normal but his chest x-ray showed changes which were described as "indeterminate" for COVID-19. He was not tested for COVID-19 in hospital, but at some point, his records start to describe him as being COVID-19 positive. (Mr Clarke's treatment in hospital is outside the PPO's remit and we have not therefore attempted to establish whether Mr Clarke did in fact have COVID-19.) He was not considered to require hospital admission for his physical health, and he was therefore transferred to another hospital to be seen by the Ealing Liaison Psychiatry Service (ELPS).

57. Mr Clarke was seen by a psychiatrist at about 3.00am on 6 April. He was hostile and verbally abusive, and she noted that he was paranoid and could not retain information. After considering his mental health history, she concluded that he

should be admitted for assessment under the Mental Health Act and began the process for doing so, which requires authorisation by two approved doctors.

58. Later that morning, Mr Clarke was seen by a consultant psychiatrist who assessed that "his behaviour appears to be in keeping with his anti-social personality disorder and substance abuse rather than a clear relapse in mental illness". She noted that he reported feeling stressed by the social constraints imposed by the pandemic, and that that he told her he had been smoking cannabis. She identified that he had auditory hallucinations but did not appear to be responding to them. He denied any thoughts of harming himself or others. She also noted that he had tested positive for COVID-19 but that he did not believe this. She concluded that there was "no indication to proceed further with the Mental Health Act assessment" as his symptoms did not warrant an in-patient mental health admission and "his mental health needs can be met by the mental health services in prison".

## Wormwood Scrubs: 6 April

59. The police then took Mr Clarke to Wormwood Scrubs in line with his recall notice. Before doing so, they telephoned the prison and spoke to a Senior Officer (SO) in Reception to tell her that they were taking Mr Clarke to the prison following his discharge from hospital and that he was COVID-19 positive.

60. This was the start of the pandemic and Mr Clarke was the first prisoner to be admitted to Wormwood Scrubs who was said to be COVID-19 positive. New prisoners would normally be admitted to the prison via Reception, where they would go through a number of established introductory procedures, including an interview with a prison officer and a health screen with a nurse. However, the SO told the investigator that after she spoke to the police, she contacted the prison's Head of Early Days in Custody and suggested that to minimise potential spreading of COVID-19 to others, Mr Clarke should be taken straight to A4 landing (the designated COVID-19 isolation unit) on his arrival, where his initial reception screening could be completed. The Head spoke to the duty governor, who agreed the plan. The SO said that she knew Mr Clarke well having released him from prison in January 2020 and considered he did not need his photograph taken on arrival as his records had a recent photograph.

61. Staff told us that, at this early stage in the pandemic, procedures on A4 were still being developed as they went along and were not set in stone. Custodial Manager (CM) A (one of the two CMs responsible for A Wing) said that the other three landings on A Wing continued to operate as normal, while A4 operated as a separate unit. Many of the staff were working there on overtime and there was not a consistent staffing team at the time. The CM said that it was not clear initially who was responsible for A4. He and another CM went up there from time to time to make sure that the staff were alright, but they had no contact with the prisoners in order to avoid spreading the virus and he did not know what the reception arrangements were for new prisoners. He said that prisoners on A4 stayed behind their doors to self-isolate and their food was delivered to their cells. They were offered a shower every two days or so, and each cell contained all the necessary furnishings and equipment (such as a television and a kettle), as well as an in-cell telephone. As the landing had just been refurbished, all the furnishings were brand new.

62. A SO, who worked on A Wing, also told us that A4 was being run as a separate unit at this time. She said that the A4 staff did not receive routine briefings with the other A Wing staff, although she made it her responsibility to go up to A4 during her shift and "sort of support the staff there". She also said that, at the time of Mr Clarke's death, there was no clear regime, agreed with healthcare, for her and the other prison officers on A4 to follow. She said a lot of things were still being developed on A4 at the time.

63. At 11.43am, Mr Clarke arrived at Wormwood Scrubs. He was escorted to A4 by the police, Officer A and a colleague who were working in Reception. The officer said that Mr Clarke was calm and compliant with staff instructions. Mr Clarke can be seen on CCTV wearing a face mask and standing quietly outside his cell door waiting for it to be opened to allow him to enter. The officer told the investigator that the police helped to escort Mr Clarke onto the wing because he needed them to sign some paperwork. He said there was no verbal handover by the police.

64. At 11.49am, Officer B, who was working on A4, unlocked the cell door and Mr Clarke went into the cell followed by the police officers and the two officers from Reception. Officer A completed Mr Clarke's reception screening with him in the cell. He told us he was dressed in a full PPE body suit of the "Hazmat" type, including a hood, and with the addition of a face mask and eye protection.

65. Officer B said that he tried to speak to Mr Clarke in his cell. He said he explained how to use the emergency cell bell to call for assistance and that staff would be carrying out welfare checks every hour on him. He said that he did not give Mr Clarke any information about the wing regime or COVID-19 but told him that his evening meal would be served soon. He said that Mr Clarke was calm but did not engage with him.

66. Officer A said he could not remember if he had explained to Mr Clarke why he was required to isolate. He said he believed that Mr Clarke understood that the reason was because he had tested positive for COVID-19. He told the investigator that Mr Clarke's demeanour was calm and compliant, that he answered questions appropriately and that he displayed no signs of any intention to harm himself or that he had thoughts of suicide.

67. At 11.55am, the police officers and prison staff can be seen on CCTV footage leaving Mr Clarke's cell and closing the door. Officer B did not put a name card with Mr Clarke's name on it outside his door.

68. Later that day, at 2.52pm, Nurse A, a mental health nurse, went to Mr Clarke's cell to conduct his initial healthcare screening. She told the investigator that the personal protection equipment (PPE) provided by the prison for her to wear was not adequate to protect her from COVID-19, and she therefore decided not to open Mr Clarke's door and speak to him face to face. She spoke to Mr Clarke through his cell door. She said he asked her to open the door so he could speak to her 'like a human being', and that he said she was not going to do his assessment through the hatch and that she should either open the cell or take him to an office. She said that she was unable to explain to Mr Clarke why she could not open the door because he was agitated, had walked away from the cell door, sat on his bed and refused to engage with her. She did not complete an initial health reception screen.

69. Nurse A noted in Mr Clarke's records that she had not seen him because there was no PPE available. She recorded that Mr Clarke did not appear unwell and was orientated and she noted "no overt psychosis". She did not attempt to take Mr Clarke's vital signs observations and there is no record that she asked him if he had any symptoms of COVID-19.

70. Nurse A spoke to a worker at the Mental Health Trust and recorded that Mr Clarke had been arrested by the police "after he was found in the community trying to spread COVID-19 to others since he knew he was positive". She asked for the hospital discharge information, and a copy of the consultant psychiatrist's assessment was emailed to the prison and entered into Mr Clarke's medical record shortly after 6.00pm.

71. Prison healthcare staff received a letter from West London Forensic Services (WLFS) at 5.11pm on 6 April, which gave background information about Mr Clarke's known psychiatric, substance misuse and medication history. It said he had been diagnosed with paranoid schizophrenia and anti-social personality disorder, that he had had his last depot injection on 1 April, and that there were no concerns about his mental state. It also said he had recently smoked cannabis but had no other substance abuse issues and he was denying any thoughts of harming himself or others.

72. In normal circumstances, prisoners arriving into custody would be seen by a GP. However, the investigator was told that the process to be followed for a prisoner who was indicated to be COVID-19 positive was unclear at the prison at that time. (There were no tests to confirm a COVID-19 diagnosis available outside of hospitals at the time.) A prison GP had a conversation about Mr Clarke with Nurse A at around 6.58pm but did not see him in person. He re-prescribed Mr Clarke's anti-psychotic medication based on what had been recorded and uploaded onto his medical record. Due to restrictions in response to the COVID-19 pandemic, prisoners who were isolating were not allowed out of their cells to collect meals.

73. At 5.00pm, Officer B and Officer C went to Mr Clarke's cell to serve him a prepacked evening meal and a breakfast pack for the next day. This was the first time Mr Clarke had been seen since Nurse A had visited the cell at 2.52pm. Officer B said he looked though the observation panel of Mr Clarke's cell door and saw him sitting on his bed. He said that when he opened the door, Mr Clarke jumped up and attempted to run out of the cell. He stopped Mr Clarke getting past him by blocking his way and took hold of his upper arms. He then pushed Mr Clarke back into his cell and closed the door.

74. Officer C said that Mr Clarke looked "really disorientated, all of a sudden if someone wakes from a sleep and they're not sure where they are, kind of look". He was not aggressive and just seemed to be coming out of the door and bumped into Officer B. She said that, although it was an odd incident and they reported it to the SO, it did not seem like a significant event at the time and they did not think any more about it.

75. Officer B said he looked through the observation panel to check that Mr Clarke had no injuries and saw him standing in the centre of the cell. Mr Clarke shouted at him to open his door. The officer said that the door would not be opened again. He made no further attempts to provide Mr Clarke with an evening meal.

76. Officer B said that he was shocked to see the change in Mr Clarke's demeanour since his arrival and that he went to the office to report what had happened to the SO and Custodial Manager (CM). He said he did consider informing healthcare staff of Mr Clarke's change in behaviour but recorded the event in Mr Clarke's records. However, due to a mistake, he entered the record using another officer's personal computer account and not his own.

77. At 6.08pm, Officer B went to carry out a routine welfare check on Mr Clarke. He said he looked through the observation panel of his cell door and saw him standing in the centre of his cell. He said he attempted to speak to him, but Mr Clarke refused to engage. He then went off duty.

78. Later that evening at around 9.08pm, Officer D carried out a routine roll check and welfare check on all prisoners on the isolation wing. CCTV footage shows that he did not look into Mr Clarke's cell. He said that this was because he did not know that Mr Clarke was in the cell because there was no name card outside the cell door. When he returned to the office and realised that the numbers did not tally, he returned to the landing and can be seen on CCTV checking Mr Clarke at 9.29pm.

79. Officer D said he looked through the observation panel, but he could not initially see Mr Clarke. He switched the night observation light on and he saw Mr Clarke standing in the centre of his cell. He said Mr Clarke turned to look at him and he asked him if he was 'ok'. He said Mr Clarke appeared calm and responded by giving a thumbs up gesture. He did not recall Mr Clarke raising any issues or concerns. This was the last time Mr Clarke was seen alive.

## Events of 7 April

80. At 7.00am on 7 April, Officer D was tasked with completing the early morning roll check of all prisoners. He told an OSG that he had completed the roll check and that it was correct. CCTV shows that he did not complete the early morning roll check.

81. At 8.52am, a prison GP carried out wellbeing checks on all prisoners on A4 who were isolating due to COVID-19. She said that she took it upon herself to do these checks because she wanted to support the nurses as no formal checking procedure was in place at the prison at the time.

82. The GP said that when she arrived on the isolation unit, she expected to find a nurse there, but there were none. She asked the prison staff on the wing if they knew where the nurses were, and they said they did not. He did not have a list of prisoners who were isolating as she had come straight to the wing after arriving at the prison that morning and she was expecting to find a nurse there who would have one. She said that prison staff appeared busy and so she did not ask them to accompany her but asked if each prisoner had an identifying name card outside their cell and was told these were in place.

83. The GP can be seen on CCTV looking through the observation panel of each cell with a name card displayed outside the door. She spoke to each prisoner to check on their wellbeing, but she did not check on Mr Clarke because she did not know that he was in the cell as there was no name card outside his cell door.

84. A SO said she had not been on duty on A Wing when Mr Clarke arrived, but she was on duty on 7 April. She said that she had had a handover in the morning from a CM, who had told them that Mr Clarke had been taken directly to A4 because he had tested positive for COVID-19 and that he had tried to push his way out of the cell the day before. She said the CM had therefore advised them to be very careful opening Mr Clarke's door.

85. At 10.57am, Nurse B (the manager of the mental health in-reach team) and the principal pharmacist went to Mr Clarke's cell, accompanied by the SO and three prison officers, to administer his medication and to conduct a mental health assessment. An officer looked through Mr Clarke's observation panel and saw bedding on the bed, but she could not see Mr Clarke. She said that the cell appeared to be empty and unlike the other cells there was no name card outside the cell to indicate Mr Clarke was inside.

86. The SO knocked on the door and called out to Mr Clarke but received no response. The officers told her the prison GP had carried out welfare checks on all prisoners earlier that morning and had raised no concerns about Mr Clarke.

87. Nurse B said that the cell appeared to be empty and at 10.57am, she asked staff go and check the records to confirm that they had the right cell for Mr Clarke. She and the pharmacist continued to knock on the door and call out to Mr Clarke in an attempt to gain a response from him.

88. Staff checked the records and confirmed they had the correct cell for Mr Clarke and at 11.01am, the SO opened the door and she and the officer went into the cell but could not see Mr Clarke. The officer then opened the toilet door and saw him hanging from the window frame.

89. Staff immediately cut Mr Clarke down and laid him onto the floor. Nurse B instructed staff not to start CPR (cardiopulmonary resuscitation) as it was clear that Mr Clarke had been dead for some time as there were signs of rigor mortis. At 11.05am, a prison GP confirmed that Mr Clarke had died.

## Contact with Mr Clarke's family

90. On 7 July, a prison Family Liaison Officer (FLO) contacted Mr Clarke's next of kin, his mother, to inform her of her son's death. Due to restrictions in response to the COVID-19 pandemic, the FLO contacted Mr Clarke's mother by telephone instead of visiting her home in person.

91. The FLO remained the point of contact for Mr Clarke's next of kin, providing support. The prison contributed to the cost of Mr Clarke's funeral in line with national policy.

## Support for prisoners and staff

92. The Governor conducted a debrief with the staff closely involved in the emergency response. The staff care team offered support.

93. The prison posted notices informing other prisoners of Mr Clarke'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 Clarke's death.

## Post-mortem report

94. The pathologist gave Mr Clarke's cause of death as asphyxia by hanging.

95. The pathologist noted that although the post-mortem toxicology tests did not detect any drugs or alcohol in Mr Clarke's system, the blood samples received for testing were very small and therefore the use of cannabis, barbiturates or opioids such as heroin could not be ruled out.

# Findings

## Management of Mr Clarke's risk of suicide and self-harm

96. Mr Clarke hanged himself less than 24 hours after he arrived at Wormwood Scrubs and we have, therefore, considered, whether his risk of suicide or self-harm was appropriately assessed and managed.

97. PSI 64/2011 lists a number of risk factors and potential triggers for suicide and self-harm. It says all staff should be alert to the increased risk of self-harm or suicide posed by prisoners with these risk factors and should act appropriately to address any concerns.

98. Mr Clarke had a number of significant risk factors, including a history of suicide and self-harm in the community, significant mental health diagnoses, and drug misuse. In addition, he had arrived at Wormwood Scrubs via a psychiatric hospital assessment after being found behaving in an inappropriate and agitated way in the community. Given these factors, it is very difficult to understand why staff did not recognise that Mr Clarke was a vulnerable man who might be at risk of suicide and why they did not monitor him under ACCT procedures.

99. A partial explanation might be that Mr Clarke arrived at Wormwood Scrubs very early in the pandemic when the prison was experiencing severe staff shortages and when appropriate processes for managing the risks posed by the virus were still being developed and put in place. We cannot say if Mr Clarke did have COVID-19. What we can say is that both prison staff and healthcare staff at Wormwood Scrubs believed that he had tested positive for COVID-19 and this affected his care. He was the first prisoner to enter the establishment with such a diagnosis and, as a result, the normal reception processes were by-passed.

100. We are concerned that, at this early stage of the pandemic, there was no clear management oversight of the staff and prisoners in the A4 isolation unit and as a result there were some shortcomings. For example, there is no record that Mr Clarke received the entitlements for newly arrived prisoners set out in PSI 07/2015, such as access to a bath or shower and the opportunity to make a telephone call to his legal adviser or to address urgent domestic issues.

101. Nor was he given a written explanation to help him understand why the prison system with which he was familiar had changed, why he was in isolation and what to expect in terms of any prison procedures. Staff assumed that Mr Clarke understood the reason why he was in isolation because they assumed he knew he had tested positive for COVID-19 but, irrespective of whether this was in fact the case, there is plenty of evidence that Mr Clarke did not accept that he had COVID-19. We cannot, therefore, be sure whether he understood what was happening.

102. We recognise that this was a very frightening time for all staff in Wormwood Scrubs. But it was equally frightening for prisoners and Mr Clarke had the additional vulnerabilities associated with a personality disorder which made him overly suspicious and impulsive. We are very concerned that this was not taken into account in the assessment of Mr Clarke's risk to himself. All the emphasis seems

to have been on the risk Mr Clarke might pose of infecting others and his risk to himself seems to have been overlooked.

103. We are particularly concerned that Mr Clarke did not have an initial health screen. This was a key missed opportunity to assess his wellbeing and mental health and to identify immediate risk concerns.

104. We consider that Nurse A should have started ACCT monitoring on 6 April, given the detailed background information she had already received from secondary care providers. Although she recorded that Mr Clarke was showing no signs of psychosis, the clinical reviewer said it was difficult to know how she reached this conclusion on the basis of her very brief contact with him from outside his cell door. We share the clinical reviewer's concern that her brief assessment of Mr Clarke's risk was heavily weighted to consideration of his previous behaviour towards healthcare staff in the community before he was sedated and that there was little assessment of the risk, he posed to himself. The potential impulsivity, which was a feature of Mr Clarke's personality disorder was not considered as a risk and no steps such as increased levels of observation were put in place to mitigate this.

105. We are also concerned that prison staff did not start ACCT monitoring, given Mr Clarke's obvious risk factors. His potential risk should also have been reconsidered after he demonstrated his impulsivity and unpredictability by trying to get out of his cell when Officer B delivered his evening meal, but again there is no evidence that the officer or the SO or CM he spoke to considered whether Mr Clarke posed a risk to himself.

106. In addition, we have seen no evidence that Mr Clarke was given any food during his time at Wormwood Scrubs. He had spent the previous afternoon and evening in A&E and the early hours of 6 April in the psychiatric unit and we do not know if he had anything to eat there. He arrived at Wormwood Scrubs too late for breakfast or lunch, and he was not given an evening meal or a breakfast pack after he tried to leave his cell when his meal was delivered.

107. Apart from Nurse A's brief and unsatisfactory contact with him, there is also no evidence that either healthcare or prison staff spoke to Mr Clarke after he had been locked in his cell at midday on 6 April.

108. We make the following recommendations:

- **The Governor and the Head of Healthcare should ensure that staff manage prisoners at risk of suicide and self-harm in line with PSI 64/2011, including that prison and healthcare staff:**
    - **share all information that affects risk;**
    - **start ACCT monitoring procedures when a prisoner has significant risk factors, or record their reasons for not doing so; and**
    - **review the prisoner's level of risk whenever there is an event or change of circumstances that could impact on risk.**

- **The Governor should ensure that first night procedures are in place for all prisoners entering the prison in line with PSI 07/2015, including that:**
    - **prisoners are offered the opportunity to take a bath or shower before being located into a cell overnight;**
    - **staff ask newly arrived prisoners if they need to telephone their legal advisor or to address urgent domestic issues; and**
    - **first night information is provided to all newly arrived prisoners.**

## Roll checks and welfare checks

## Overnight checks

109. At this stage of the pandemic, it is clear that procedures were still evolving in the A4 isolation unit. Under first night procedures, newly arrived prisoners should be checked hourly overnight. However, our investigation found that, as the A4 unit was not considered to be a first night centre, Mr Clarke was not checked overnight.

## Roll checks

110. Officer B forgot to put a name card outside Mr Clarke's cell. As a result, Officer D did not initially realise that Mr Clarke's cell was occupied when he conducted the 7.30pm roll check on 6 April. Despite this, Officer D did not correct Officer B's mistake and the absence of a name card continued to cause problems more than 12 hours later.

111. Our investigation also found that Officer D did not complete the 7.00am roll check as he should have done. At interview, he said that he had told the OSG that he had completed the roll check and that it was correct.

112. The primary purpose of a roll check is to confirm that all prisoners are present and correctly accounted for. Not completing a roll check is, therefore, a serious breach of security. However, roll checks are also an opportunity to check on prisoners' well-being and to identify any obvious signs that a prisoner may be ill or dead.

113. Mr Clarke was described as being 'rigid' and 'cold to touch' when he was found at about 11.00am, which suggests that rigor mortis was present. As this normally sets in within two to six hours after death, it is possible that Mr Clarke was already dead at 7.00am when the early morning roll check should have taken place. We cannot say whether the outcome might have been different for Mr Clarke if the roll check had been completed, but, at the very least, Mr Clarke might have been found earlier.

114. The prison conducted an internal investigation into Officer D's actions. The investigation recommended that he should be issued with a written warning.

## Welfare checks

115. With regard to welfare checks, Prison Service Instruction (PSI) 75/2011, *Residential Services,* says:

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

117. "The appropriate arrangements will depend on the local regime, but there need to be clearly understood systems in place for staff to assure themselves of the well-being of prisoners during or shortly after unlock. For example, if a prisoner is expected to leave their cell for an activity shortly after being unlocked, then it will be sufficient for there to be a check on any prisoner who does not do so. Where prisoners are not necessarily expected to leave their cell, staff will need to check on their well-being, for example by obtaining a response during the unlock process."

118. Prison staff did not conduct any welfare checks on the morning of 7 April.

119. A prison GP conducted an unofficial welfare check at about 9.00am on her own accord, but she did not check on Mr Clarke because she did not know that his cell was occupied as Officer B had forgotten to place a name card outside the cell. This was another missed opportunity to check on Mr Clark (although as we have said, he may have already been dead by this time).

120. The problems caused by the missing name card had been identified by Officer D more than 12 hours earlier, but nothing had been done to correct the mistake.

121. If Nurse B and the principal pharmacist had not gone to Mr Clarke's cell at 11.00am to give him his medication, there would have been a further delay before he was found dead.

122. The prison told us that, following Mr Clarke's death, they have now put measures in place to ensure that prisoners who are isolating due to COVID-19 receive regular formal welfare checks.

123. We make the following recommendations:

- **The Governor should ensure that first night monitoring procedures are in place for all newly arrived prisoners wherever they are located.**
- **The Governor should ensure that all roll checks and welfare checks are conducted in line with local policy.**
- **The Governor should ensure that this report is shared with Officer B and Officer D and that a senior manager discusses the Ombudsman's findings with them.**

## Clinical care

124. The clinical reviewer identified a number of concerns about the healthcare Mr Clarke received at Wormwood Scrubs.

## Initial health screen

125. The clinical reviewer was concerned that healthcare staff did not contact the Ealing Hospital A&E Department to obtain accurate information about Mr Clarke's physical health.

126. No healthcare staff saw Mr Clarke overnight and there was no plan to ensure that healthcare staff maintained any oversight of the isolation wing overnight. There is no evidence that Mr Clarke was given any verbal or written explanation or information about COVID-19, and his temperature was not checked as part of the COVID-19 reception process as it should have been.

127. The clinical reviewer was also concerned that Nurse A did not conduct an initial health screen with Mr Clarke. The nurse recorded at the time that she was not able to enter his cell to do this in person as there was no PPE available. However, our investigation established that PPE (in the form of disposable masks, aprons and gloves) was available for all staff on A4.

128. Nurse A told us at interview that she had serious concerns about seeing Mr Clarke without the same level of PPE as that worn by Officer A, who had escorted Mr Clarke to his cell. The clinical reviewer said that it was not clear why Officer A was kitted out in this manner and that the level of protection he was wearing was far in excess of the PHE recommendations. As prison reception staff were not carrying out any aerosol generating procedures (AGP), PHE's advice for ambulance staff and first responders would have been the most relevant to follow. This was to wear a disposable apron and gloves, single use fluid resistant masks and eye/face protection when dealing with confirmed cases of COVID-19.

129. We established that advice on appropriate PPE had been produced by Care UK and was available to healthcare staff on the intranet. The Deputy Head of Healthcare told us that various additional methods had been used to alert all staff to the PPE advice, including a newsletter and notices on walls and in staff rooms.

130. The clinical reviewer said that Nurse A's rationale for refusing to see Mr Clarke in person without the same level of PPE as Officer A appeared to relate to her personal view of risk, rather than consideration of the task she was to undertake, supported by advice. We found no evidence to suggest that additional support was provided to Nurse A to help her to deal with her concerns.

## Absence of a care plan

131. The clinical reviewer said that, although Mr Clarke's apparent diagnosis of COVID-19 was acknowledged, it did not translate into a clear plan of healthcare oversight to establish if he was developing symptoms which might have required intervention.

132. Although A4 was designated as the isolation unit, no specific regime had been established between healthcare and custodial staff by 6 April. There was no regular routine checking of prisoners or routine healthcare oversight of their condition. The prison GP took it upon herself to conduct welfare checks on the morning of 7 April, but this was not a formal arrangement and there was no nurse on the unit to assist her.

133. The clinical reviewer acknowledged that systems have been changed at Wormwood Scrubs since Mr Clarke's death and we have seen evidence that there is now a much more coherent approach to the management of prisoners with COVID-19 infection and those who require isolation. The isolation area has moved from the A4 landing. Much more is now known of the transmissibility of COVID-19 and there is less debate about the type of PPE required. PPE is largely accessible and available.

134. The clinical reviewer also recognised that Mr Clarke arrived at Wormwood Scrubs at a very challenging time, when there were severe staff shortages due to the pandemic and a lack of established operational systems. However, she said that the arrival of a patient with COVID-19 infection was a contingency which could have been anticipated and plans should have been developed and agreed in advance. Clear partnership working between healthcare and custodial staff at all levels was vital and we have not been given evidence that this was the case at an operational level in early April 2020. It is also unclear what escalation was made to more senior Care UK clinical managers about the specific challenges faced at Wormwood Scrubs.

135. The clinical reviewer said that the situation in April 2020 was extraordinary for prisons and the wider NHS. There are therefore no benchmarks to consider whether Mr Clarke received equivalent treatment to that he could have expected in the community at a time of extreme volatility within healthcare systems.

136. However, she concluded that it is possible to say that the reception assessment of Mr Clarke at Wormwood Scrubs did not lead to an adequate care plan to oversee his immediate care needs and that there was a lack of structured partnership working and limited effective healthcare leadership. She said that this does not represent acceptable care in any environment.

137. The clinical reviewer did, however, commend the willingness of the pharmacist and Nurse B to provide face to face care beyond their usual roles of what was expected of clinicians.

## Emergency response

138. The clinical reviewer considered that Nurse B acted decisively and appropriately when Mr Clarke was found hanged on 7 April. As Mr Clarke was showing signs unequivocally associated with death, she exerted her clinical authority to ensure that staff did not begin a resuscitation procedure, which would have been both futile and undignified. The clinical reviewer was satisfied that Mr Clarke's perceived COVID-19 status played no part in the decision not to begin resuscitation as he was clearly beyond such assistance.

139. The prison GP attended the code blue call and supported her colleagues, assessing Mr Clarke and identifying clear evidence of well-established rigor mortis. We recommend:

- **The Head of Healthcare should ensure that:**
    - **there is a system in place to obtain direct information from the appropriate provider when trying to establish a diagnosis; and**

    - **a copy of the A&E discharge summary is obtained if a prisoner has attended A&E while in police custody.**

- **The Head of Healthcare should ensure that healthcare staff are aware of current advice on PPE and that it is discussed with them.**

- **The Head of Healthcare should share this report with Nurse A and discuss the Ombudsman's findings with her.**

- **A senior manager from Practice Plus Group from outside Wormwood Scrubs should offer healthcare staff named in this report an opportunity to discuss and reflect on it and identify and address any outstanding training and support needs.**

- **The Head of Healthcare and the Governor should jointly use this report as a basis for considering what systems and processes are now in place ensure that similar issues do not recur.**

- **The Head of Healthcare should share this report with the principal pharmacist and Nurse B so that they are aware of the Ombudsman's findings.**

## Breach of information assurance

140. Information assurance is about understanding and managing the risks related to the safeguarding of data. It is a requirement for all prison staff to complete information assurance (IA) training each year.

141. We found that Officer B made an entry in Mr Clarke's prison record using another member of staff's computer log in details, meaning that the entry that appeared on the record was not attributed to him. This was a serious breach of data protection procedures, and we are concerned that staff considered this to be a common practice.

142. We recommend:

- **The Governor should ensure all staff complete and comply with Information Assurance Training.**

## Conclusion

143. We appreciate that COVID-19 procedures were still being developed at this time at Wormwood Scrubs and that Mr Clarke was the first suspected COVID-19 positive prisoner to arrive at the prison. However, we agree with the clinical reviewer that this was a contingency that could and should have been anticipated, and we are concerned about the lack of clear management responsibility for the A4 isolation unit. There seems to have been very little guidance to staff and very little leadership by managers to ensure that Mr Clarke's risk to himself was assessed and that he received all his entitlements and safeguards. As he was the first such prisoner to arrive, we consider that the Duty Governor should have made sure that

everything was done properly. As it was, it is difficult to avoid the conclusion that the treatment this vulnerable man received amounted to neglect.

144. We recommend:

- **The Governor should share this report with the duty governor and CM A.**

- **The Prison Group Director for London should write to the Ombudsman setting out what he has done to satisfy herself that the culture at Wormwood Scrubs fosters good and appropriate care for prisoners.**

Prisons & Probation Ombudsman
Independent Investigations

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T l 020 7633 4100