Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Jack Zarrop, a prisoner at HMP Wormwood Scrubs, on 20 March 2021

A report by the Prisons and Probation Ombudsman

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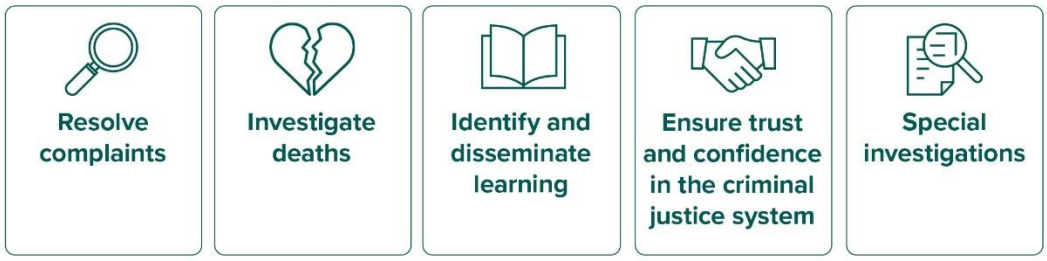
OUR VISION

To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.

WHAT WE DO



WHAT WE VALUE

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.

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 Jack Zarrop died on 20 March 2021 having been found hanging in his cell at HMP Wormwood Scrubs. Mr Zarrop was 23 years old. I offer my condolences to Mr Zarrop's family and friends.

Mr Zarrop had been at Wormwood Scrubs for less than 48 hours when he hanged himself. He had a history of attempted suicide, alcohol and substance misuse and mental health issues, and had told court staff that he would hang himself if he was remanded to prison. 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.

In addition, I am concerned that healthcare staff did not refer Mr Zarrop to the mental health team as soon as he arrived at Wormwood Scrubs.

Mr Zarrop was the third prisoner in 12 months to kill himself within a few days of arriving at Wormwood Scrubs. In each case we have concluded that staff failed to identify that the prisoner had significant risk factors for suicide. The Governor and the Health of Healthcare must now take urgent steps to address these shortcomings.

I am also copying this report to the Prison Group Director for London as I consider these deaths extremely worrying.

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 **November 2021**

Contents

Summary

Events

1. On 17 March, Mr Jack Zarrop was arrested for breaching the conditions of his bail. The next day he was taken to court. Court staff completed a suicide and self-harm warning (SASH) form recording that Mr Zarrop had said he would kill himself if he was taken to prison. He appeared in court, was remanded to custody and was taken to HMP Wormwood Scrubs.

2. On arrival, prison and healthcare staff assessed Mr Zarrop and he was prescribed medication to lessen his withdrawal symptoms from alcohol, along with medication for anxiety and depression. Staff did not assess he was a risk to himself.

3. On 19 March, several healthcare staff assessed Mr Zarrop. He told them that he had recently taken an overdose of prescribed medication in the community. A nurse referred him to the mental health team. Again, staff had no concerns that Mr Zarrop was a risk to himself.

4. At 9.46pm, CCTV shows Mr Zarrop threading a bedsheet through the top of his cell door and back into his cell through his observation panel. No movement can be seen in his cell after 9.57pm.

5. On 20 March, at 12.03am, an operational support grade (OSG) went to check on Mr Zarrop as he could see his head near his observation panel from the landing below. The OSG found Mr Zarrop hanging from his door. He radioed a medical emergency code and tried to cut the ligature. Other staff responded, went into the cell and tried to resuscitate Mr Zarrop. At 12.53am, paramedics pronounced he had died at 12.53am.

6. After Mr Zarrop had died, staff found letters in his cell which recorded his intention to take his own life.

Findings

7. Mr Zarrop had several 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 Zarrop's risk to himself and that he was not managed and supported under suicide and self-harm procedures (known as ACCT).

8. We are also concerned that crucial information about his risk was not shared and that not all staff have received ACCT training.

9. This is the third investigation in 12 months in which we have found significant failings in risk assessment when prisoners arrive at Wormwood Scrubs.

10. The clinical reviewer concluded that Mr Zarrop's mental healthcare was not of the required standard and not equivalent to that which he could have expected in the community. Staff did not routinely review information available to them and Mr Zarrop was not referred to the mental health team from reception as he should have been. In addition, staff were not clear about the correct process for referring a prisoner to the mental health team.

Recommendations

- The Governor and Head of Healthcare should ensure that all staff have a clear understanding of their responsibilities to manage prisoners at risk of suicide and self-harm in line with national guidelines, including that:
    - staff understand that they need to take a prisoner's risk factors for suicide and self-harm into account, and not just what they say or how they present;
    - reception staff consider and record the known risk factors of all newly arrived prisoners;
    - staff start ACCT monitoring procedures when a prisoner has significant risk factors, or record their reasons for not doing so;
    - staff share all information that affects risk; and
    - staff receive appropriate ACCT training.
- The Governor should share this report with SO A and Officer B and arrange for a senior manager to discuss the Ombudsman's findings with them.
- The Head of Healthcare should share this report with Nurse A, Nurse B, Nurse C and Nurse D and discuss the Ombudsman's findings with them.
- The Head of Healthcare should ensure that all healthcare staff make appropriate and timely mental health referrals having reviewed all relevant records available to them.
- The Prison Group Director for London should write to the Ombudsman setting out what steps they are taking to address the PPO's concerns in this report and the two previous reports on self-inflicted deaths at Wormwood Scrubs in 2020/21.

The Investigation Process

11. The investigator issued notices to staff and prisoners at HMP Wormwood Scrubs informing them of the investigation and asking anyone with relevant information to contact her.

12. Due to the COVID-19 pandemic, the investigator was unable to visit the prison. She obtained copies of relevant extracts from Mr Zarrop's prison and medical records via post and email.

13. The investigator interviewed 12 members of staff in June 2021. NHS England commissioned a clinical reviewer to review Mr Zarrop's clinical care at the prison. They jointly interviewed staff. All the interviews were conducted by video or telephone because of the COVID-19 restrictions.

14. 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.

15. One of the Ombudsman's family liaison officers contacted Mr Zarrop's mother and friend to explain the investigation and to ask if they had any matters they wanted the investigation to consider. Mr Zarrop's mother had no questions. Mr Zarrop's friend asked whether the prison had been aware of Mr Zarrop's mental health issues. This question is addressed in this report.

16. Mr Zarrop's mother and friend received copies of the initial report. They did not make any comments.

17. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed one factual inaccuracy and this report has been amended accordingly. The action plan has been annexed to this report.

Background Information

HMP Wormwood Scrubs

18. 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

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

20. 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.

21. 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

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 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

23. Mr Zarrop was the fourth prisoner to die at Wormwood Scrubs since March 2019, and the third to take his own life.

24. The two previous self-inflicted deaths occurred in April 2020 (where the prisoner took his life within 24 hours of arriving at Wormwood Scrubs) and in November 2020 (where the prisoner took his life within four days of arriving). In both cases our investigations found that prison and healthcare staff had failed to adequately

identify and assess the prisoners' risks to themselves. In this case and in one or the previous cases, we found no evidence that the new safer custody questionnaire was used.

Assessment, Care in Custody and Teamwork (ACCT)

25. ACCT is the care planning system the Prison Service uses to support prisoners at risk of suicide or self-harm. The purpose of the ACCT is to try to determine the level of risk posed, the steps that staff might take to reduce this and the extent to which staff need to monitor and supervise the prisoner. Checks should be made at irregular intervals to prevent the prisoner anticipating when they will occur.

26. 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. Staff should hold regular multidisciplinary reviews and should not close the ACCT plan until all the actions of the caremap are completed. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011, *Management of prisoners at risk of harm to self, to others and from others (Safer Custody)*.

Key Events

27. Mr Jack Zarrop's community medical record noted that in 2015, he had attempted to hang himself and had subsequently been hospitalised for two weeks. He had a history of anxiety and depression and had also taken overdoses in the past.

28. Mr Zarrop had been in prison on several occasions, most recently in HMP Wormwood Scrubs between December 2020 and February 2021 when he had been subject to Prison Service suicide and self-harm support, known as ACCT. At that time, he had told staff that he had recently tried to take his own life and wanted to kill himself. On 5 March 2021, Mr Zarrop told a GP in the community that he felt low all the time and had thoughts of suicide. The GP increased his prescription of mirtazapine (used to treat anxiety and depression).

17 March

29. On 17 March, police arrested Mr Zarrop for breaching his conditions of bail. A nurse assessed him while he was in police custody and noted Mr Zarrop was experiencing withdrawal symptoms from alcohol. Mr Zarrop also told the nurse that he used cannabis three times per week. He said he suffered from anxiety and depression and had taken an overdose of tablets two to three days ago but had not been admitted to hospital. Mr Zarrop said he had no current thoughts of self-harm or suicide.

18 March

30. On 18 March, a GP assessed Mr Zarrop in police custody and prescribed him mirtazapine. At 3.15pm, Mr Zarrop was taken to court. Staff there filled in a suicide and self-harm (SASH) warning form noting that Mr Zarrop had said he would hang himself if he was remanded to prison.

31. Mr Zarrop appeared at court and was remanded to custody, with his next court appearance due on 1 April. Mr Zarrop's Person Escort Record (PER) noted that he said that he would hang himself if he was sent to prison. (It also said in brackets after this '2017'.)

32. Mr Zarrop was taken to HMP Wormwood Scrubs where he arrived at 5.45pm.

33. Supervising Officer (SO) A met Mr Zarrop at the reception desk. SO A had Mr Zarrop's PER and the SASH warning form. He told the investigator that he asked Mr Zarrop whether he still wanted to hang himself. The SO said that Mr Zarrop replied that he had not said that. SO A said he had no concerns about Mr Zarrop and put the warning form and PER into Mr Zarrop's folder and handed it to Officer B. He said that if he had been concerned about Mr Zarrop, he would have made sure Officer B knew about the suicide and self-harm warning form by telling him or putting it on the front of Mr Zarrop's file.

34. Officer B then met Mr Zarrop in a private room. Officer B said that he did not see the suicide and self-harm warning form or Mr Zarrop's PER although they may have been in his folder. He said that if the SO had been concerned about Mr Zarrop, he

would have left the PER on the front of the folder for him to be aware of, but otherwise he did not need to look in the folder.

35. Officer B told the investigator that he filled in a form (presumably the safer custody questionnaire), as he does for all new arrivals, which included questions about the prisoner's risk to themselves. Despite requests, the investigator has seen no evidence of this document.

36. Officer B told the investigator that Mr Zarrop seemed "quite upbeat". He said Mr Zarrop was adamant that he would be out of prison in a couple of weeks. He said he vaguely remembered asking Mr Zarrop if he had previously self-harmed and that Mr Zarrop said 'no', and that when asked about any current thoughts, Mr Zarrop replied that he was going home soon so he was "quite happy". Officer B told the investigator that he had no concerns that Mr Zarrop was a risk to himself.

37. At 8.30pm, Nurse A assessed Mr Zarrop. She remembered Mr Zarrop from his previous time at Wormwood Scrubs but did not review his medical record before seeing him. She also had access to his PER and suicide and self-harm warning form. She used the Clinical Institute Withdrawal Assessment for Alcohol (CIWA) on which Mr Zarrop scored 18 indicting that he had severe withdrawal symptoms. Mr Zarrop told the nurse that he had last used opiates and crack cocaine three days ago but he tested negative for these drugs. He also said he smoked £70 of cannabis a week, and he tested positive for cannabis. He told the nurse that he suffered from depression and anxiety and had been prescribed mirtazapine in the community.

38. Advanced Nurse B was undertaking the role of duty clinician in Reception that evening. Because she needed to assess Mr Zarrop before she finished her shift, Nurse A then temporarily stopped her assessment so that Nurse B could see him.

39. Nurse B told the investigator that she did not have any paperwork in relation to Mr Zarrop, nor did she review his previous medical record. She said she did not see his PER or suicide and self-harm warning form. Mr Zarrop told Nurse B that he was prescribed mirtazapine but did not think that it helped him. He said he had taken eight tablets of mirtazapine one week ago to try to end his life. He denied any current thoughts of suicide or self-harm.

40. Mr Zarrop also told Nurse B that he used cocaine and cannabis in the community, and that he drank five bottles of wine a day and had last drunk alcohol three days ago. He said that he had alcohol related seizures and had had one in the police station before he was given diazepam to lessen his withdrawal symptoms. Nurse B also assessed Mr Zarrop's alcohol withdrawal symptoms using the CIWA on which he scored 9. (It is unclear why there was such a difference in Nurse A and Nurse B's CIWA scores.)

41. Nurse B assessed Mr Zarrop had mild alcohol withdrawal symptoms and prescribed him chlordiazepoxide (to lessen his withdrawal symptoms), mirtazapine and thiamine (vitamin B1). She referred him to the alcohol intervention service. She said that she spoke to Mr Zarrop about healthcare staff reviewing his mirtazapine prescription the next day to find another medication that might work better for him.

42. Nurse B told the investigator that Mr Zarrop had initially seemed quite "jovial" but towards the end of her assessment, he seemed more nervous, asking what would happen next. She said that she thought that his anxiety was related to him withdrawing from alcohol. Nurse B told the investigator she did not know why she had not referred Mr Zarrop to the mental health team.

43. Nurse A then resumed her assessment. She asked Mr Zarrop about the statement he had made that he would kill himself if he was remanded to prison. Mr Zarrop said that he had been frustrated at court but that he was "fine" now. He told Nurse A that he had previously overdosed on 10 mirtazapine tablets but had not gone to hospital. The nurse told the investigator that she did not realise this had happened recently. Mr Zarrop said he wanted to see the mental health team. Nurse A said she did not consider this was urgent and, because it was an exceptionally busy shift, she left the referral to be done by the nurse doing his secondary screening the next day.

44. Nurse A recorded that Mr Zarrop could have his medication in his possession. She told the investigator that this was a mistake: she had accidentally clicked the wrong button and she did not consider Mr Zarrop suitable for medication in his possession due to his previous overdose. Mr Zarrop was not given any medication in his possession. Nurse A said she had no concerns that Mr Zarrop was a risk to himself.

45. Mr Zarrop then moved from the first night centre to the Conibeere Unit which is the unit for prisoners detoxing from drugs or alcohol. A nurse told the investigator that she checked Mr Zarrop throughout the night but that he was asleep on every occasion.

19 March

46. On 19 March around 9.00am, Nurse C, a non-medical prescriber from the substance misuse team, assessed Mr Zarrop. He told the investigator that he had briefly reviewed Mr Zarrop's medical record before meeting him and noted that he had recently been in Wormwood Scrubs and had been referred to the mental health team but had not been seen by them. Mr Zarrop told Nurse C that he suffered from depression and anxiety and used alcohol to suppress his thoughts of self-harm and paranoia. He said that mirtazapine was not helping him. Nurse C told the investigator that he asked Mr Zarrop about the overdose he had taken the previous week and that Mr Zarrop replied that he had been drunk at the time. Mr Zarrop said he had no current thoughts of suicide or self-harm. The nurse said he had no concerns that Mr Zarrop was a risk to himself.

47. Nurse C noted that Mr Zarrop had symptoms of alcohol withdrawal. He referred him to the mental health team using a template. He marked the referral as 'urgent' because Mr Zarrop had been waiting to see the team when he was last in prison.

48. At 9.36am, Nurse D, a mental health nurse, took Mr Zarrop's clinical observations. She had not reviewed Mr Zarrop's medical record nor was she aware that he had come into prison with a SASH warning form. Nurse D asked Mr Zarrop if he would like to engage with Forward Trust (who provide psychosocial support for alcohol issues) but he declined and said he was more interested in engaging with the mental health team at present. She noted his previous suicide attempt by hanging five years ago.

49. Mr Zarrop told Nurse D that he had a "monologue in my head that tells me I am not good enough and also instructs me to harm myself". He said he had taken a deliberate overdose of 12 mirtazapine tablets a week ago. Nurse D referred Mr Zarrop to the mental health team using a template. She told the investigator that she asked Mr Zarrop whether he felt suicidal at the moment and he said no, although she did not record this in his clinical record and she said that she could not specifically remember meeting Mr Zarrop. She said she did not have any concerns he was a risk to himself.

50. At 12.46pm, a substance misuse worker, went to see Mr Zarrop on the wing and he confirmed he would like to engage and get support in the community for his alcohol use. Mr Zarrop said he was unable to complete the substance misuse assessment at that time, so she booked him an appointment for the following week. She said that Mr Zarrop seemed "fine" although a little distracted, but she said this was not unusual for prisoners during association. She said she had no concerns about Mr Zarrop.

51. At 4.15pm, Nurse D assessed Mr Zarrop's alcohol withdrawal symptoms, which she recorded were mild.

52. At 9.00pm, an OSG did a roll check of all the prisoners on the third and fourth landing. CCTV shows that there was a piece of fabric covering Mr Zarrop's observation panel. At 9.02pm, the OSG moved the piece of material aside and looked through the observation panel of Mr Zarrop's cell. He said Mr Zarrop was lying on his bed awake. The OSG noted that Mr Zarrop saw him but did not react to him when he said, "Goodnight."

53. At 9.46pm, CCTV shows Mr Zarrop threading a bedsheet through the gap in the top of the cell door and back through the observation panel. It is possible to see a shadow moving in the cell until 9.57pm, after which no further movement can be seen.

20 March

54. At 12.03am, the OSG was on the third landing when he looked up to the fourth landing and saw Mr Zarrop's head leaning against the door through the observation panel. He thought that Mr Zarrop was trying to look out of the panel or speak to him. The OSG went upstairs to Mr Zarrop's landing and noticed a prisoner on the other side had pressed their cell bell. He initially went to speak to them but then changed his mind and went straight to Mr Zarrop's cell.

55. When he reached the cell, the OSG saw the bedsheet over the cell door and tied around Mr Zarrop's neck. The OSG touched Mr Zarrop's head which he noted was not moving and was stiff. He radioed a code blue (a medical emergency code indicating a life-threatening situation) and shouted to a nurse, who was downstairs. The control room immediately requested an ambulance. The OSG tried to cut the ligature using his anti-ligature knife through Mr Zarrop's observation panel but it was too thick. He also tried to relieve the pressure from Mr Zarrop's neck but the ligature was too tight.

56. A Custodial Manager (CM), two officers got to Mr Zarrop's cell around 90 seconds after the OSG had first looked in. On their way to the cell, they had passed the

nurse who was struggling with emergency equipment, so the CM asked an officer to assist her. The CM looked into the cell and immediately unlocked the door causing Mr Zarrop to fall to the floor face down. Staff moved Mr Zarrop onto his back, an officer cut the ligature from his neck and the other officer checked for any signs of life. Staff started chest compressions.

57. The nurse got to the cell 20 seconds after the other staff. She assessed Mr Zarrop, inserted an airway and assisted with chest compressions. Further healthcare staff arrived and administered oxygen and attached the defibrillator. Paramedics arrived 12 minutes after the OSG had first found Mr Zarrop and took over his treatment. At 12.53am, they pronounced Mr Zarrop had died.

58. After Mr Zarrop's death, letters were found on his bed addressed to three people indicating his plans to take his own life and giving instructions for his funeral.

Contact with Zarrop's next of kin

59. A SO was appointed as family liaison officer (FLO). COVID restrictions at the time instructed that family liaison should be done via the telephone. However, the police informed the prison that Mr Zarrop's mother lived alone and was potentially vulnerable. Given the relatively short distance involved, the Governor and the FLO went to Mr Zarrop's mother's home address to break the news of her son's death in person and offer their condolences. The FLO remained in contact with Mr Zarrop's mother and offered a contribution to funeral expenses in line with Prison Service policy.

60. Mr Zarrop had nominated a friend as his next of kin. Due to the distance to his home and COVID travel restrictions, the police (rather than prison staff) informed him of Mr Zarrop's death. Once they had, the FLO telephoned Mr Zarrop's friend twice but he did not answer. Mr Zarrop's friend's mother returned her call the next day and spoke to the FLO who offered her condolences and support. The FLO remained in contact with Mr Zarrop's friend.

Support for prisoners and staff

61. After Mr Zarrop's death, the CM 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.

62. A Nurse and Nurse A, who had been involved in the emergency response, both told the investigator that they had to complete the rest of their shift after Mr Zarrop had died. They found this upsetting but also recognised that it would have been very difficult to arrange immediate nursing cover for their night shift.

63. The prison posted notices informing other prisoners of Mr Zarrop'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 Zarrop's death.

Post-mortem report

64. The pathologist concluded that the cause of Mr Zarrop's death was asphyxia due to hanging.

Findings

Identifying Mr Zarrop's risk of suicide and self-harm

65. Mr Zarrop hanged himself less than 48 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.

66. Prison Service Instruction (PSI) 64/2011, *Safer Custody*, lists 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. Any prisoner identified as at risk of suicide and self-harm must be managed under ACCT procedures. PSI 64/2011 also states that any information that becomes available which may affect a prisoner's risk of harm to self must be recorded and shared, to inform proper decision making.

67. We have considered whether staff at Wormwood Scrubs should have recognised Mr Zarrop was at risk and begun ACCT procedures to support him.

68. Mr Zarrop had several significant risk factors for suicide and self-harm as identified by PSI 64/2011. These included mental health issues, previous suicide attempts, alcohol and substance misuse, early days in custody, his recent overdose and his stated intent to hang himself if he was remanded to custody. Given these factors, it is very difficult to understand why staff did not recognise that Mr Zarrop was at risk of suicide and why they did not monitor him under ACCT procedures.

69. SO A said that prisoners often made statements about an intent to kill themselves in police or court custody so that they could get to prison quicker. He said he had to rely on what a prisoner told him and their presentation. He said he did not consider a prisoner's risk factors and this would be done later.

70. SO A put the PER and suicide and self-harm warning form in Mr Zarrop's folder and passed it to Officer B. He said that if he had been concerned about Mr Zarrop's risk to himself, he would have flagged this to Officer B or put the PER and the SASH warning form on the front of the file, instead of inside it.

71. We recognise that reception is a busy, fast-paced environment and that SO A was not aware of all Mr Zarrop's risk factors. However, we are concerned that SO A did not consider or attempt to explore Mr Zarrop's risk factors but simply asked him if was intending to kill himself and took his denial at face value. We consider that SO A should have, at the very least, documented his decision not to open an ACCT and should have ensured that Officer B, who saw Mr Zarrop next, was aware of Mr Zarrop's statement that he would hang himself in prison and why he had not opened an ACCT.

72. Officer B said that he did not see the PER or the SASH warning form, although he accepted that they may have been in the folder. He said SO A would have put them on the front of the folder if he had been concerned about Mr Zarrop and that he did not need to look in the folder.

73. Officer B said that he would have completed a safer custody risk interview with Mr Zarrop, but we have seen no evidence that he did so. The prison has not been able to produce the completed form. This form was also missing in in the case of the previous death in custody in November 2020. This suggests that the form is not always completed.

74. We are also concerned that Officer B said that he completed this form, which asked questions about substance misuse and mental ill health, "for the benefit of healthcare staff". Although he told the investigator that he knew how to open an ACCT and had sometimes done so, we are concerned that he gave the impression that he thought it was the responsibility of the SO and healthcare staff to identify if a prisoner was at risk of suicide, and that his role was purely functional.

75. Although both SO A and Officer B told the investigator that they knew how to identify signs that a prisoner might be at risk of suicide, neither gave any indication that they would a consider prisoner's risk factors or that they would do anything more than rely on what he said and how he presented.

76. SO A's actions were subject to an internal disciplinary investigation which was ongoing at the time of issuing this report.

77. Several healthcare staff also assessed Mr Zarrop that evening and the following day.

78. Nurse A, the reception nurse, recorded that Mr Zarrop told her that he had said he would hang himself in prison in frustration at court but was "fine" now. She had not reviewed his medical record which included information about his risk to himself during his time in Wormwood Scrubs a month earlier. We share the clinical reviewer's view that she should have done so.

79. We are also concerned that Nurse B, the prescribing nurse who assessed Mr Zarrop, had not seen his PER or suicide and self-harm warning form. She said that she and the prison GP had now introduced a template to act as a prompt for them to use when assessing new prisoners to ensure they had considered all the available information and done the relevant referrals.

80. Healthcare staff were aware that Mr Zarrop was detoxing from alcohol and suffering withdrawal symptoms. He told several staff that he did not think his mirtazapine was helping him and that he had recently taken an overdose of this medication. He also told Nurse D that he had a voice in his head which told him to harm himself. Given these significant risk factors, we consider that staff should have opened an ACCT.

81. The Head of Healthcare, said that she was concerned that there was no record of why staff did not open an ACCT. She said that the new version of ACCT (version six) was soon to be introduced and that after this she planned to carry out some refresher training on risk assessment and when to open an ACCT. She said that they were planning to have a dedicated healthcare team for prisoners' first days at Wormwood Scrubs with a much more robust induction process with prison and healthcare staff working in better partnership.

82. We have said repeatedly in our reports over many years that staff should consider an individual's risk factors for suicide and self-harm, rather than relying solely on what they say or their presentation. We share the clinical reviewer's concern that

staff were too easily reassured by Mr Zarrop saying that he had no plans to harm himself and did not give enough weight to his many other risk factors. In addition, there was poor communication of these risk factors between staff.

83. We are also concerned that Nurse A said she had never had any ACCT training, and that Officer B described his ACCT training as "only a vague, well, a very vague outlook from an ACCT … probably very limited" during his initial officer training three years earlier.

84. This is now the third investigation into a self-inflicted death in which we have identified inadequate risk assessment and management when the prisoners arrived at Wormwood Scrubs. There appears to be a lack of understanding among both prison and healthcare staff about how to identify and assess risk, as well as a lack of clarity about whose responsibility it is to do so and about the procedures to be followed. We understand that reception staff in busy local prisons like Wormwood Scrubs are having to work at pace and deal with many challenges, but we consider that such basic failings are unacceptable.

85. We recognise that the prison has not had a chance to embed learning from our most recent investigations, but the Governor must now address these shortcomings urgently.

86. We make the following recommendations:

The Governor and Head of Healthcare should ensure that all staff have a clear understanding of their responsibilities to manage prisoners at risk of suicide and self-harm in line with national guidelines, including that:

- **staff understand that they need to take a prisoner's risk factors for suicide and self-harm into account, and not just what they say or how they present;**
- **reception staff consider and record the known risk factors of all newly arrived prisoners;**
- **staff start ACCT monitoring procedures when a prisoner has significant risk factors, or record their reasons for not doing so;**
- **staff share all information that affects risk; and**
- **staff receive appropriate ACCT training.**

The Governor should share this report with SO A and Officer B and arrange for a senior manager to discuss the Ombudsman's findings with them.

The Head of Healthcare should share this report with Nurse A, Nurse B, Nurse C and Nurse D and discuss the Ombudsman's findings with them.

The Prison Group Director for London should write to the Ombudsman setting out what steps they are taking to address the PPO's concerns in this report and the two previous reports on self-inflicted deaths at Wormwood Scrubs in 2020/21.

Clinical care

Mental health

87. The clinical reviewer concluded that Mr Zarrop's mental healthcare was not of the required standard and not equivalent to that which he could have expected in the community.

88. The clinical reviewer concluded that staff did not routinely review available clinical records as part of their assessments of mental health and risk. She considered that although staff may not have had time to review Mr Zarrop's whole medical record, they should have reviewed information from his stay at Wormwood Scrubs a month earlier.

89. The Head of Healthcare said that she would have expected Mr Zarrop to have been referred to the mental health team from reception, and that, if this had happened, Mr Zarrop would have been seen and triaged the next day. Nurse B could not explain why she had not referred him and Nurse A said she thought that it could wait until the following day.

90. The clinical reviewer also noted that healthcare staff were not clear about how to refer prisoners to the mental health team. The Head of Healthcare said that submitting an electronic task on a prisoner's medical record was the correct method. No task was submitted for Mr Zarrop; instead nurses used a template to refer him to the mental health team the day after he arrived. We make the following recommendation:

    The Head of Healthcare should ensure that all healthcare staff make appropriate and timely mental health referrals having reviewed all relevant records available to them.

Substance misuse

91. The clinical reviewer concluded that Mr Zarrop's substance misuse care was of a good quality and met the required national guidance.

92. The clinical reviewer has also made several recommendations which did not directly impact on Mr Zarrop's death but which the Head of Healthcare will need to consider.

Inquest

93. The inquest concluded that the cause of Mr Zarrop's death was asphyxia due to hanging. The inquest also found that inadequacies in assessing Mr Zarrop's risk to himself both in police custody and prison probably contributed to his death.

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