Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Priyank Vassantlal, a prisoner at HMP Wormwood Scrubs, on 17 November 2020

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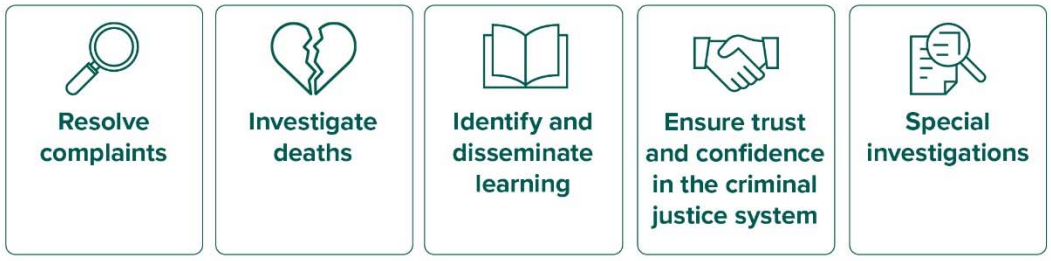
OUR VISION

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.

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 Vassantlal was found hanged in his cell at HMP Wormwood Scrubs on 17 November 2020. He was 27 years old. I offer my condolences to Mr Vassantlal's family and friends.

This is a very troubling case of a man who, just hours before his arrest and subsequent remand to prison, had been judged by community specialists as requiring admission to a psychiatric hospital. Although the community team made efforts to share this information with the mental health team at Wormwood Scrubs, the latter's hours of work meant that it was not acknowledged until nearly three days after Mr Vassantlal arrived in prison.

During this time, Mr Vassantlal's behaviour in prison had been repeatedly described as "strange" and four separate referrals were made to the mental health team. I am concerned that no one considered that he might be at risk of suicide and self-harm either in Reception – when an important risk interview was not completed – or at any other time. Even when the extent of his psychiatric history was revealed, no one considered the potential impact on Mr Vassantlal's risk or prioritised his mental health assessment.

Mr Vassantlal subsequently died after four days in prison, before he had been properly assessed and without full consideration of the range and magnitude of his risk factors for suicide and self-harm.

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 **January 2022**

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Summary

Events

1. On Friday 13 November 2020, Mr Priyank Vassantlal was remanded in custody to HMP Wormwood Scrubs. It was his first time in prison.

2. Mr Vassantlal had a diagnosis of paranoid schizophrenia and a long history of contact with community mental health services, including several admissions to secure psychiatric hospitals. Two days before he was sent to prison, his community mental health team had recommended that he be assessed for another admission following a deterioration in his mental health.

3. On the afternoon of Friday 13 November, a community mental health worker telephoned and then emailed the mental health team at Wormwood Scrubs to warn them of Mr Vassantlal's impending arrival and to summarise his history. No one made a record of the telephone call, and the email was received after the mental health team had finished work for the weekend.

4. As a result, and as no information was contained in his Person Escort Record, Reception staff did not know of Mr Vassantlal's mental health history when he arrived at Wormwood Scrubs later that evening. A Reception interview, which should include questions about the risk of suicide and self-harm, did not take place.

5. On the morning of 14 November, Mr Vassantlal was segregated after assaulting another prisoner. Staff who saw Mr Vassantlal in the segregation unit were concerned by his behaviour and presentation. They made three separate referrals to the mental health team, one of which (from a prison GP) was marked as 'urgent'. A fourth referral was made the following day.

6. On Monday 16 November, the mental health team discussed Mr Vassantlal's referrals and recorded that he should be assessed by a member of the team. Later that afternoon, Mr Vassantlal left the segregation unit when his disciplinary hearing was remanded, in part to assess whether he was 'fit' for the hearing.

7. On 17 November, wing staff were concerned about Mr Vassantlal's "odd" behaviour, and a supervising officer instructed that he should be locked in his cell for the day. A safer custody officer made a fifth referral to the mental health team. At around 3.30pm that afternoon, wing staff found Mr Vassantlal hanged in his cell. Paramedics attended and confirmed that he had died.

Findings

8. Hours before his arrest, community mental health specialists had concluded that Mr Vassantlal required admission to hospital under the Mental Health Act and he was awaiting formal assessment at the time of his arrest. Although this is outside the remit of the PPO, we question whether it was appropriate for Mr Vassantlal to have been remanded to prison.

Identifying the risk of suicide and self-harm

9. Mr Vassantlal had several risk factors for suicide and self-harm when he arrived at Wormwood Scrubs. While we appreciate that Reception staff did not know the extent of his history of mental ill health at the time, it is concerning that no safer custody risk interview was completed, and we are not satisfied that Reception staff appropriately considered Mr Vassantlal's risk of suicide and self-harm.

10. Over the following days, staff frequently recorded that Mr Vassantlal's behaviour was "strange" or "odd", to the extent that five separate referrals were made to the mental health team. By 16 November, the full extent of his history of mental ill health should have been known, including that he had very recently been recommended for assessment for admission to a psychiatric hospital. We are very concerned that the range and magnitude of his risk factors did not prompt anyone to consider that Mr Vassantlal might be at risk of suicide and self-harm or to start Prison Service suicide and self-harm prevention procedures.

Mental health care

11. No action was taken when Mr Vassantlal's mental health history was received at the prison on Friday evening because the mental health team do not work over the weekend.

12. We are concerned that the information provided by the community mental health team, particularly when combined with the number of referrals received from prison and healthcare staff, did not prompt escalation or a priority mental health assessment.

Segregation

13. Mr Vassantlal was segregated under an inappropriate Prison Rule. Despite his "strange" behaviour and four separate mental health referrals, no one reviewed or reassessed whether there were healthcare reasons not to segregate him.

Emergency response

14. It is likely that Mr Vassantlal was already dead when an officer checked his welfare around 40 minutes before he was found hanged.

15. Prison and healthcare staff later tried inappropriately to resuscitate Mr Vassantlal when rigor mortis was clearly present.

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:
    - Reception staff consider and record the known risk factors of all newly arrived prisoners.
    - Staff record, share and consider all relevant information about risk, and start ACCT procedures when indicated.

- The Head of Healthcare should ensure that prisoners with mental health needs are managed in line with expectations, including that:
    - Information received from community mental health teams, including urgent patient information, can be accessed in a timely manner, is recorded in the SystmOne record, and is shared with and considered by appropriate members of staff.
    - All staff know the pathway for the out-of-hours and weekend assessment of patients who present with an acute mental health need.
    - Newly arrived prisoners who have been recommended for assessment for admission to a psychiatric hospital under the Mental Health Act are prioritised and assessed at the first opportunity.
- The Governor and Head of Healthcare should ensure that staff manage prisoners held in segregation in line with national guidelines, including that:
    - Prisoners are segregated under the most appropriate Prison Rule.
    - Prisoners whose presentation warrants a referral to the mental health team should have a review of their segregation health screen.
- The Governor should ensure that staff completing welfare checks satisfy themselves that the prisoner is alive and well.
- The Governor and Head of Healthcare should ensure that staff are given clear guidance about the circumstances in which resuscitation is inappropriate in line with European Resuscitation Council Guidelines.

The Investigation Process

16. The investigator, Mr Mark Judd, issued notices to staff and prisoners at HMP Wormwood Scrubs informing them of the investigation and asking anyone with relevant information to contact him. Mr Judd obtained copies of relevant extracts from Mr Vassantlal's prison and medical records.

17. Mr Judd interviewed 13 members of staff at Wormwood Scrubs in January 2021. NHS England commissioned a clinical reviewer to review Mr Vassantlal's clinical care at the prison. The investigator and clinical reviewer jointly interviewed healthcare staff. All the interviews were conducted by telephone because of the restrictions in place in response to the COVID-19 pandemic.

18. 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.

19. The Ombudsman's family liaison officer contacted Mr Vassantlal's parents to explain the investigation and to ask if they had any matters they wanted the investigation to consider. They asked the following questions:

    - Was Mr Vassantlal's mental ill health properly assessed and treated in prison?
    - Were there any indications that he was at risk of suicide?
    - Why was Mr Vassantlal in a cell by himself given his mental ill health?

    We have addressed these questions in this report.

20. We shared the initial report with HM Prison and Probation Service (HMPPS). They did not find any factual inaccuracies.

21. We also shared the initial report with Mr Vassantlal's family. The solicitor representing them identified some factual inaccuracies, which we have amended. They also asked several additional questions, which we have answered by way of separate correspondence.

Background Information

HMP Wormwood Scrubs

22. 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

23. The most recent inspection of HMP Wormwood Scrubs was in September 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 prison staff conducted interviews in Reception that explored the risk of self-harm, but these were often insufficient in detail.

24. Inspectors found that the use of segregation was similar to other local prisons, although they considered that it was excessive that over half of prisoners were segregated pending disciplinary hearings.

25. 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

26. 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. 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

27. Mr Vassantlal was the seventh prisoner to die at Wormwood Scrubs since November 2018, and the fourth to take his own life.

28. Our report into the death of a man in November 2018 found that he received a timely mental health assessment but poor care thereafter. Our report into the death of a prisoner in March 2019 found that staff initiated cardiopulmonary resuscitation when rigor mortis was seemingly present. Our report into the death of a prisoner in April 2020 found that he did not receive the usual Reception procedures (because

he had tested positive for COVID-19), his risk of suicide and self-harm was not properly assessed, and he did not receive appropriate mental health care.

Assessment, Care in Custody and Teamwork

29. ACCT is the Prison Service care-planning system used to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk, how to reduce the risk and how best to monitor and supervise the prisoner. After an initial assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. Checks should be irregular to prevent the prisoner anticipating when they will occur. There should be regular multi-disciplinary review meetings involving the prisoner.

30. As part of the process, a caremap (plan of care, support and intervention) is put in place. The ACCT plan should not be closed until all the actions of the caremap have been completed. All decisions made as part of the ACCT process and any relevant observations about the prisoner should be written in the ACCT booklet, which accompanies the prisoner as they move around the prison. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

Key Events

31. Mr Priyank Vassantlal had significant contact with community mental health services throughout his adult life. In 2013, aged 20, he was first admitted to a secure psychiatric hospital under the Mental Health Act. Mr Vassantlal was diagnosed with paranoid schizophrenia and was subject to six further hospital admissions in the following years.

32. In the community, Mr Vassantlal was prescribed a depot injection of antipsychotic medication. (A depot injection provides slow-release medication that can be administered relatively infrequently, usually monthly.) This was maintained by a Community Treatment Order (CTO, a means of allowing a patient to leave a psychiatric hospital and be treated in the community). In January 2020, the CTO and depot injection were discontinued, and Mr Vassantlal was prescribed aripiprazole (antipsychotic medication) to take in tablet form instead.

33. On 11 November, a caseworker at Mr Vassantlal's local Recovery Team (which provides support for adults in the community with severe and enduring mental ill health) and other specialist staff visited Mr Vassantlal at his family home. They concluded that he should be detained under the Mental Health Act and they completed a referral for assessment that day.

34. That evening, Mr Vassantlal was arrested after assaulting his mother. In her email to Wormwood Scrubs, the caseworker recorded that a Police Liaison Nurse assessed Mr Vassantlal in police custody and concluded that he was "non-detainable under the Mental Health Act."

Friday 13 November

35. On 13 November, Mr Vassantlal was remanded in custody to Wormwood Scrubs.

36. The Recovery Team caseworker told us that she telephoned the mental health team at the prison that afternoon to provide background information about Mr Vassantlal and his risks. She said that she spoke to a member of staff who asked her to send an email with the information. She did not know who she spoke to, and no one made a record of the conversation.

37. The Recovery Team caseworker sent her follow up email at 5.34pm. The email provided information about Mr Vassantlal's history, including that he had been referred for admission to a psychiatric hospital under the Mental Health Act. She said that Mr Vassantlal had chosen to stop taking aripiprazole in August 2020, and that this had led to a deterioration in his mental state and to him becoming verbally and physically aggressive, particularly to his family. The caseworker highlighted that Mr Vassantlal was at high risk to himself due to the deterioration in his mental state, and that he posed a risk to and from others. She also said, "Due to his current presentation [Mr Vassantlal's] mental state would need to be assessed urgently at HMP Wormwood Scrubs".

38. There is no one on duty in the mental health team at Wormwood Scrubs from 5.00pm on a Friday until Monday morning. The mental health team manager told us that, at the time, their emails were checked three times a day, lastly at 4.00pm.

As a result, the caseworker's email was not available until staff from the mental health team returned to work on the morning of Monday 16 November.

39. At around 7.00pm, Mr Vassantlal arrived at Wormwood Scrubs. The Person Escort Record (PER, a form that accompanies prisoners from court to prison to provide a timeline of events and identify any risk issues) identified that he had a scar on his left wrist dating from 2019. It did not contain any information about Mr Vassantlal's mental ill health. No information about Mr Vassantlal's time in police custody travelled with him.

40. A Supervising Officer (SO) met Mr Vassantlal in Reception. She told us that she asked standard questions about Mr Vassantlal's demographic information and custodial history. The SO said that Mr Vassantlal answered the questions articulately and that she had no concerns at the time. She told us that she would only ask in-depth questions about a prisoner's risk of suicide and self-harm if they arrived with a warning form from the escort contractor. (Mr Vassantlal did not arrive with one of these forms.)

41. An Early Days in Custody Manager told us that an officer should complete a safer custody form in Reception, which includes questions about the prisoner's history of self-harm and current thoughts, plus information about other risk factors such as substance misuse. No one completed this form for Mr Vassantlal.

42. At around 9.00pm, Mr Vassantlal tried to push past officers who had escorted him to a cell. The officers restrained Mr Vassantlal and returned him to the cell.

43. A reception nurse then assessed Mr Vassantlal. As this was Mr Vassantlal's first time in prison, a new medical record was created and there was therefore no information available about his history. The nurse recorded that Mr Vassantlal was upset and did not initially talk to him, but after much persuasion, began to engage and said that he was "fine". Mr Vassantlal said he believed he was not supposed to be in prison. The nurse recorded that Mr Vassantlal told him that he had no history of mental ill health, had never been prescribed medication for this, and had never seen a psychiatrist. Mr Vassantlal said that he had no thoughts of suicide or self-harm. The nurse recorded that the only medication Mr Vassantlal brought into prison with him was lymecyline (for acne). He told us that he had no immediate concerns about Mr Vassantlal's mental health or risk of suicide and self-harm.

Saturday 14 November

44. The next morning, Mr Vassantlal returned to Reception to complete various processes including the recording of his property. While in a holding room, he assaulted another prisoner and was subsequently restrained by staff. The duty SO (the same SO who had seen him the previous evening) recorded that Mr Vassantlal was "extremely non-compliant" and continued to be physically and verbally abusive during the restraint. She charged him with offences of committing an assault and fighting with another person.

45. A nurse tried to assess Mr Vassantlal for injuries but recorded that he refused treatment. He completed a referral to the mental health team.

46. As a result of this incident, Mr Vassantlal was assessed as a high risk for cell sharing, meaning he would be allocated a single cell.

47. The Head of Early Days in Custody authorised Mr Vassantlal's segregation under Prison Rule 53, which allows prisoners to be segregated while they are awaiting a disciplinary hearing. She recorded that Mr Vassantlal was very aggressive and non-compliant when he arrived in segregation but calmed down after staff had spoken to him. She told us that Mr Vassantlal began crying and said that he should not have assaulted the other prisoner. The Head of Early Days in Custody asked segregation unit staff to complete a referral to the mental health team. She said that she had no concerns about Mr Vassantlal's risk of suicide and self-harm, and that his behaviour indicated that the significant risk was to others.

48. A segregation nurse assessed whether there were healthcare reasons not to segregate Mr Vassantlal. She concluded that there was no evidence to indicate that Mr Vassantlal's mental health would deteriorate significantly if he were to be segregated, or that he would not be able to "cope" with segregation. The nurse told us that Mr Vassantlal was calm when she saw him, and he engaged with her. She said that there was no indication that he was experiencing a deterioration in his mental health. The nurse said that she did not know about Mr Vassantlal's history of mental ill health and that she might not have 'fitted' him for segregation had she been aware of this.

49. In the late afternoon, a prison GP saw Mr Vassantlal in the segregation unit as part of a general round of prisoners who had arrived late the night before. He recorded that Mr Vassantlal told him that he was in prison because he had "slapped his parents for performing Satanic rituals". The GP also recorded that Mr Vassantlal believed he had cancerous spots on his back (although they were actually acne scars). Mr Vassantlal initially told the GP that he had no mental health diagnosis, but later explained that he had previously been admitted to a psychiatric hospital, had a community mental health worker, and had taken antipsychotic medication. Mr Vassantlal said that he had no thoughts of suicide or self-harm.

50. The prison GP prescribed a short course of zopiclone (a sleeping tablet) and told us that this was because Mr Vassantlal had appeared agitated, and he thought this would help him settle in his first days in prison. The GP completed a referral to the mental health team, which he marked as 'URGENT' [his capitals] and told us that he thought Mr Vassantlal should be seen very soon when the mental health team returned on the Monday morning.

Sunday 15 November

51. In the morning, the segregation nurse completed a healthcare segregation round. (A member of healthcare staff – a doctor or a nurse - is required to visit all prisoners in the segregation unit every day.) She recorded that Mr Vassantlal had "no issues."

52. The Head of Reducing Reoffending completed a manager's segregation round. She recorded that Mr Vassantlal was "acting strangely" and punching his mattress to "get rid of his demons". She completed a referral to the mental health team.

Monday 16 November

53. The Head of Early Days in Custody told us that that at around 9.00am, she spoke to the mental health team manager about her 14 November referral and asked for Mr Vassantlal to be seen that day.

54. At around 9.30am, a mental health nurse visited the segregation unit, alongside a prison GP, to complete the healthcare segregation round.

55. The prison GP recorded that there were "no current concerns" about Mr Vassantlal's physical or mental health. He prescribed paracetamol as Mr Vassantlal complained of a slight pain to the side of his forehead.

56. The mental health nurse recorded that Mr Vassantlal's thoughts appeared disordered and he spoke of "higher powers" that were telling him to "gouge [his] eye out". Mr Vassantlal told him that he had received input from community mental health services in the past due to anxiety and depression, and that he was not currently on any medication and did not "feel he needed any". The mental health nurse recorded that Mr Vassantlal was fit for segregation from a mental health perspective. He told us that Mr Vassantlal denied any thoughts or history of self-harm and that he was satisfied that Mr Vassantlal posed no risk of harm to himself at the time.

57. At 10.49am, an operational manager chaired Mr Vassantlal's disciplinary hearing (relating to the events of 14 November). Mr Vassantlal pleaded not guilty to the charge. The operational manager adjourned the hearing for one week as Mr Vassantlal had requested legal advice. He also noted that a medical assessment was required to ensure that Mr Vassantlal was fit for the hearing. The operational manager told us that he was concerned about the way Mr Vassantlal answered his questions, describing the answers as "a little bit bizarre" and not as coherent as he expected.

58. Shortly before 1.00pm, the mental health multidisciplinary team met to discuss the weekend referrals. The mental health nurse who had seen Mr Vassantlal that morning recorded that he should be assessed by a member of the mental health team. No further details of the discussion were recorded. The nurse told us that he spoke about his consultation with Mr Vassantlal that morning.

59. At around 2.20pm, the mental health nurse telephoned the community Recovery Team to discuss Mr Vassantlal's history. He recorded that a community psychiatric nurse told him that Mr Vassantlal was due for a mental health assessment but was arrested before this took place. The mental health nurse also recorded that he was told that Mr Vassantlal had been non-compliant with his medication for around three months. He recorded a plan to await further information and discharge summaries from the community team.

60. At around 3.30pm, Mr Vassantlal left the segregation unit and moved into a single cell on B wing (the prison's induction wing). The mental health nurse told us that the mental health team were not aware that Mr Vassantlal had left segregation until the following day.

Tuesday 17 November

61. At around 9.00am, Officer A recorded that Mr Vassantlal had displayed "odd behaviour" that morning. She noted that he had pressed his cell call bell several times with "no idea" he had done so. Officer A also noted that when Mr Vassantlal was unlocked for morning medication, he came out of his cell with no shoes on before going back into the cell, where he "stood and stared at the wall." She told us that she asked Mr Vassantlal several times whether he wanted to collect his medication and he said "no". Officer A said that Mr Vassantlal's "strange" behaviour that morning meant that the wing's supervising officer later authorised that he should be locked in his cell for the day and asked staff to "document his behaviour".

62. During the morning, a safer custody officer visited Mr Vassantlal to speak about the incident on 14 November. She recorded that Mr Vassantlal did not engage with her and said that he was going to sleep. The safer custody officer told us that she reported this to the wing supervising officer, who asked her to speak to Officer A. She then returned to try to speak to Mr Vassantlal and told us that he continued to "ignore" her. The safer custody officer made a referral to the mental health team and told us that she received email confirmation that Mr Vassantlal was on their waiting list.

63. At 12.12pm, the mental health nurse made an entry in the medical record in which he noted that he had reviewed the email received from the community caseworker four days earlier and discharge summaries subsequently submitted by the community mental health team. (He uploaded the documents to the medical record after making this entry.) He recorded that before his arrest, Mr Vassantlal was due to have a mental health assessment "with the hope for hospital admission due to his current deterioration in mental state". The mental health nurse told us that Mr Vassantlal was due to be discussed at the mental health team's weekly meeting the next day (Wednesday 18 November) at which he would be allocated a nurse and psychiatrist.

64. At 2.53pm, CCTV shows that Officer A looked through Mr Vassantlal's observation panel for a fraction of a second. She told us that she did this because she wanted to check Mr Vassantlal due to his behaviour earlier. She told us that Mr Vassantlal was sitting cross legged on his bed and looked at her but did not speak. She said that she could not see a ligature.

65. At 3.34pm, Officer A went to Mr Vassantlal's cell to unlock it so he could collect his medication. She found him sitting on his bed, with his legs on a cabinet, hanging from a ligature which he had made from a prison jumper and tied to the bed frame.

66. Officer A called the wing SO and other officers. The SO removed the ligature with assistance from colleagues and radioed a medical emergency code blue, indicating a life-threatening situation. The control room operator telephoned for an ambulance. An officer began cardiopulmonary resuscitation. In his statement, the officer wrote that Mr Vassantlal's body temperature was cold and that he suspected he might have died "some time ago".

67. At 3.37pm, a member of healthcare staff arrived at the cell. A prison doctor also responded and took over the chest compressions with two nurses. He recorded that

Mr Vassantlal's legs were stiff and that his jaw was too stiff to allow an airway to be inserted. A nurse recorded that rigor mortis appeared to be established.

68. At 3.54pm, paramedics arrived and confirmed that Mr Vassantlal had died. They recorded that rigor mortis was established.

Contact with Mr Vassantlal's family

69. The Deputy Governor and a prison family liaison officer visited Mr Vassantlal's family on the evening of 17 November and told them of his death.

70. Wormwood Scrubs contributed to the costs of Mr Vassantlal's funeral in line with Prison Service instructions.

Support for prisoners and staff

71. After Mr Vassantlal's death, an operational manager 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.

72. The prison posted notices informing other prisoners of Mr Vassantlal's death and offering support.

Post-mortem report

73. A post-mortem examination identified the cause of death as compression of the neck by way of suspension (hanging).

Findings

Identifying the risk of suicide and self-harm

74. Prison Service Instruction (PSI) 64/2011, which governs ACCT suicide and self-harm prevention procedures, requires all staff who have contact with prisoners to be aware of the risk factors and triggers that might increase the risk of suicide and self-harm and take appropriate action. 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 himself must be recorded and shared to inform proper decision making.

75. We have considered whether staff at Wormwood Scrubs should have recognised Mr Vassantlal as at risk and begun ACCT procedures to support him.

Reception

76. When he arrived at Wormwood Scrubs, Mr Vassantlal had some risk factors for suicide and self-harm that Reception staff should have known. It was his first time in prison, and he had been remanded in custody having committed a violent act against a close family member. The PER identified a scar on Mr Vassantlal's wrist, which might have indicated that he had previously harmed himself. PSI 64/2011 also recognises that prisoners are at increased risk of suicide and self-harm in their first days in custody.

77. Mr Vassantlal also had a very significant history of mental ill health. Just two days earlier, he had been recommended for assessment for admission to a psychiatric hospital following a deterioration in his mental health. We appreciate that Reception staff did not know this at the time (and discuss this later in this report).

78. The Early Days in Custody Manager told us that an officer should complete a safer custody risk interview in Reception. This did not happen for Mr Vassantlal and represents a significant missed opportunity to identify any risk of suicide and self-harm. We would also expect all staff who see a newly arrived prisoner in Reception to consider their risk of suicide and self-harm and are very concerned that the Reception SO told us that she would only ask risk questions if a prisoner arrived with a warning form.

79. The Early Days in Custody Manager told us that since Mr Vassantlal's death, Wormwood Scrubs have amended their Reception process. If a prisoner arrives with a known risk of self-harm, the supervising officer will discuss and document this, including explaining any consideration for starting ACCT procedures.

80. While this is a positive step, PSI 64/2011 is clear that there is a range of risk factors that influence an individual's risk of suicide and self-harm, not just recorded history. Our view is that this discussion and recording should occur for all new arrivals into prison custody.

Saturday 14 November to Tuesday 17 November

81. Over the following days, further significant risk factors were revealed:

- On Saturday 14 November, prison and healthcare staff were so concerned by Mr Vassantlal's behaviour and for his wellbeing that they made three separate referrals to the mental health team. Mr Vassantlal also described some details of his medical history, including that he had previously been admitted to a psychiatric hospital.

- On Sunday 15 November, Mr Vassantlal's "strange" behaviour prompted a fourth referral to the mental health team.

- On Monday 16 November, information about Mr Vassantlal's medical history was confirmed through discussion with his community team. The email from the Recovery Team caseworker was also now available to the mental health team. Both of these sources included the information that Mr Vassantlal had been recommended for assessment for admission to a psychiatric hospital on the day of his arrest, and the Recovery Team caseworker's email also said he would need to be assessed "urgently". The mental health nurse also visited Mr Vassantlal that day and described him as "thought disordered".

- On Tuesday 17 November, staff described Mr Vassantlal's behaviour as "odd" and "strange", to the extent that a supervising officer authorised that he should be locked in his cell for the day. A safer custody officer completed a fifth referral to the mental health team.

82. PSI 64/2011 highlights that a mental illness diagnosis and recent contact with psychiatric services are risk factors for suicide and self-harm. Despite his behaviour, history and other contextual risk factors, no one at Wormwood Scrubs at any time considered that Mr Vassantlal might be at risk of suicide and self-harm or considered starting ACCT procedures. Several staff told us that they did not think that Mr Vassantlal was at risk because he said that he had no intention of harming himself.

83. We have said repeatedly in our reports that staff should consider an individual's range of risk factors, rather than just what they say or how they present. It is astonishing that the range and magnitude of Mr Vassantlal's risk factors, presentation and behaviour did not prompt anyone to consider that he might be at risk of suicide and self-harm or to start ACCT procedures until that risk could be mitigated. We make the following recommendation:

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:

- **Reception staff consider and record the known risk factors of all newly arrived prisoners.**

- **Staff record, share and consider all relevant information about risk, and start ACCT procedures when indicated.**

Mental health care

Friday 13 November

84. On the afternoon of 13 November, the caseworker from the community Recovery Team telephoned the mental health team at Wormwood Scrubs to advise them of Mr Vassantlal's impending arrival and of his history. We do not know who she spoke to and no one made a record of the call or informed the Reception team.

85. At 5.34pm, the Recovery Team caseworker sent a follow-up email to the mental health team inbox, including significant information about Mr Vassantlal's history. As the inbox is last checked at 4.00pm each weekday, and the mental health team is not contracted to work over the weekend, this meant that the content of the email was not available until the morning of 16 November. This meant that no one knew of Mr Vassantlal's significant medical history from his arrival on Friday evening until the following Monday.

86. The clinical reviewer concluded that there is a worrying gap in information sharing protocols and the ability to carry out an assessment if a prisoner with significant mental health needs arrives after 5.00pm on a Friday.

Monday 16 November to Tuesday 17 November

87. When the mental health team returned to work on the morning of 16 November, there were four referrals for Mr Vassantlal awaiting them, one of which had been marked as 'URGENT' by a prison GP. The Recovery Team caseworker's email was also now available to them. It is unclear when this email was first identified and by whom.

88. There is no evidence that Mr Vassantlal's history was discussed at the multidisciplinary team meeting on 16 November, or that consideration was given to escalating Mr Vassantlal's assessment then, later in the afternoon when the mental health nurse spoke to the community team, or at any other time. We are very concerned that the information provided by the Recovery Team caseworker did not prompt a priority assessment, especially when considered alongside the referrals by a prison GP and others. When he died, Mr Vassantlal was still awaiting assessment.

89. The clinical reviewer noted that there was no escalation to or discussion with senior managers or clinicians when it was identified that Mr Vassantlal had a pre-existing need for urgent assessment. She concluded that the clinical care that Mr Vassantlal received was not equivalent to that which he could have expected to receive in the community. We make the following recommendation:

The Head of Healthcare should ensure that prisoners with mental health needs are managed in line with expectations, including that:

- **Information received from community mental health teams, including urgent patient information, can be accessed in a timely manner, is recorded in the SystmOne record, and is shared with and considered by appropriate members of staff.**

- **All staff know the pathway for out-of-hours and weekend assessment of patients who present with an acute mental health need.**
- **Newly arrived prisoners who have been recommended for assessment for admission to a psychiatric hospital under the Mental Health Act are prioritised and assessed at the first opportunity.**

Segregation

90. Mr Vassantlal was segregated under Prison Rule 53, which allows prisoners to be segregated while they are awaiting a disciplinary hearing. Prison Service Order 1700, which governs segregation, states that Rule 53 can only be used during the period between the alleged offence and the initial hearing. It states that segregation should not be an automatic measure when a prisoner is charged with a disciplinary offence but should only be used when there is real need, such as when there is a risk of collusion or intimidation relating to the alleged offence.

91. We are not satisfied that these criteria applied to Mr Vassantlal and that his segregation under Rule 53 was justified. We note that, following their inspection of September 2019, HM Inspectorate of Prisons found that too many prisoners were segregated under Rule 53.

92. Prison Rule 45 allows prisoners to be segregated where there are reasonable grounds to believe that their behaviour is likely to be so disruptive that keeping them in a standard location is unsafe, such as when there is a risk to the safety of staff or other prisoners or a risk of damage to prison property. Given that Mr Vassantlal had allegedly assaulted another prisoner, seemingly unprovoked, it would have been more appropriate to segregate him under Rule 45. Significantly, this would have prompted additional safeguards to Rule 53, including a Segregation Review Board within 72 hours. The Segregation Review Board must consider whether segregation should continue and must include a healthcare representative and consideration of emerging mental health concerns.

93. Mr Vassantlal spent around 52 hours in the segregation unit. During this time, several different healthcare and operational staff made entries about his “strange” behaviour and four separate referrals were made to the mental health team. Although a nurse concluded there were no healthcare reasons not to segregate Mr Vassantlal when he arrived in the unit, we consider that Mr Vassantlal’s behaviour following this should have prompted a review of this assessment. We make the following recommendation:

The Governor and Head of Healthcare should ensure that staff manage prisoners held in segregation in line with national guidelines, including that:

- **Prisoners are segregated under the most appropriate Prison Rule.**
- **Prisoners whose presentation warrants a referral to the mental health team should have a review of their segregation health screen.**

Emergency response

Welfare check

94. We are concerned that, although the wing supervising officer decided that Mr Vassantlal should be locked behind his door because of his "strange" behaviour, they did not consider opening an ACCT and asking staff to conduct checks on him.

95. From prison and healthcare staff's descriptions of Mr Vassantlal when he was found hanged at around 3.34pm, it is apparent that rigor mortis had begun to occur. Rigor mortis can occur from within two to six hours of death. It is therefore likely that Mr Vassantlal was already dead when Officer A checked him at 2.53pm.

96. Officer A told us that Mr Vassantlal was sitting on his bed, looked at her, and that she could not see a ligature. CCTV shows that she looked through the observation panel for a fraction of a second and it is therefore possible that she did not clearly see what was happening in the cell. While a more thorough check on Mr Vassantlal's welfare is unlikely to have affected the eventual outcome, in other circumstances it might have made a difference.

Resuscitation

97. In September 2016, Professor Sir Bruce Keogh, the National Medical Director at NHS England, wrote to Heads of Healthcare for prisons introducing new guidance to support staff on when not to perform cardiopulmonary resuscitation. This guidance was designed to address the issue of inappropriate resuscitation following a sudden death in a prison and was in line with the European Resuscitation Council Guidelines 2015 which state, "Resuscitation is inappropriate and should not be provided when there is clear evidence that it will be futile".

98. The officer who began chest compressions recorded that he thought Mr Vassantlal had died "some time ago". A prison GP continued cardiopulmonary resuscitation when he arrived, supported by prison nurses. He described signs of rigor mortis and a nurse recorded that rigor mortis appeared to be established. Paramedics confirmed this when they arrived.

99. The clinical reviewer concluded that the management of the resuscitation attempt was not in line with the Resuscitation Council guidelines. We understand the commendable wish to attempt and continue resuscitation until death has been formally recognised. However, staff should understand that they are not required to carry out resuscitation in these circumstances. Trying to resuscitate someone who is clearly dead is distressing for staff and undignified for the deceased. We make the following recommendations:

The Governor should ensure that staff completing welfare checks satisfy themselves that the prisoner is alive and well.

The Governor and Head of Healthcare should ensure that staff are given clear guidance about the circumstances in which resuscitation is inappropriate in line with European Resuscitation Council Guidelines.

Inquest

100. The inquest into Mr Vassantlal's death concluded on 26 January 2024. The jury returned a narrative verdict. They concluded that the following omissions and agencies contributed "more than minimally and negligibly towards his death":

- Lack of precise medical information and its communication.
- The absence of an adequate medical health assessment.
- Inadequate information provided on the PER form.
- The failure to compete an ACCT.

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