

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr James Doherty, a prisoner at HMP Wormwood Scrubs, on 18 November 2021

A report by the Prisons and Probation Ombudsman

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



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

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 James Doherty died of asphyxia (suffocation caused by insufficient oxygen in the body) after he was found hanged in his cell at HMP Wormwood Scrubs on 18 November 2021. He was 25 years old. I offer my condolences to his family and friends.

Mr Doherty reported being threatened by prisoners on several occasions in the weeks leading to his death and spent most of his time alone in his cell. Although I am satisfied that there were no indications that Mr Doherty was at imminent risk of suicide or self-harm and that staff could not have reasonably foreseen his actions, I am concerned that they missed multiple opportunities to escalate their concerns, to explore fully the underlying reason for his behaviour and to arrange a wing move. I am also concerned that despite numerous requests, the prison did not provide the investigator with a document that would have been significant in understanding as fully as possible Mr Doherty's isolation in his cell and any potential consideration that staff gave to moving him to another wing.

Mr Doherty had a history of mental health difficulties and healthcare staff generally responded in a timely and appropriate way. However, we found that they failed to arrange two GP reviews and escalate his self-reported multiple NHS identities.

I am concerned that when Mr Doherty was found hanged, staff did not immediately consider entering his cell. This caused an unnecessary delay in Mr Doherty receiving emergency medical treatment.

I am also concerned that the prison did not allocate Mr Doherty a keyworker or notify his next of kin of his death, in line with national policy.

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

August 2022

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Summary

Events

1. On 9 August 2021, Mr James Doherty was remanded to HMP Wormwood Scrubs, charged with several offences, including harassment and criminal damage. (He was subsequently sentenced to 16 months in prison).
2. At reception, Mr Doherty told a prison GP who reviewed him that he had been admitted to a mental health hospital in the past and attempted suicide in 2020. The GP referred him to the mental health team and prescribed several medications, including an antidepressant.
3. Over the next 4 weeks, a prison GP reviewed Mr Doherty on two occasions but had difficulty obtaining his medical history which Mr Doherty said was due to him having multiple NHS identity numbers. A mental health nurse conducted an initial assessment and concluded that he did not display any psychotic symptoms.
4. On 13 October, a consultant psychiatrist attended an in-reach team meeting and recorded that the plan was to discharge Mr Doherty to primary care. Later that day, Mr Doherty asked an officer if he could move wing as he felt under threat from other prisoners. However, there no evidence that staff took any action.
5. On 30 October, Mr Doherty told an officer that he had received death threats. On 31 October, another officer conducted a welfare check, recorded that Mr Doherty felt under threat from prisoners and that he informed a supervising officer (SO). However, there is no evidence that staff considered a wing move.
6. On 14 November, a prison manager saw Mr Doherty's name on a whiteboard in an office under the heading 'do not unlock'. She checked his case notes, found that he was under threat from other prisoners and asked a supervising officer (SO) to do a welfare check. The SO subsequently enquired about a wing move but it did not take place.
7. At 5.23am on 18 November, an Operational Support Grade (OSG) found Mr Doherty hanging from a ligature and radioed a medical emergency code blue. An OSG and an officer arrived at 5.24am but remained outside the cell. At 5.25am, an officer arrived, and unlocked the cell. Officers removed the ligature but did not start cardiopulmonary resuscitation (CPR). At 5.29am, healthcare staff arrived and confirmed that it was inappropriate to start CPR as Mr Doherty had died.

Findings

8. Mr Doherty had several risk factors but gave no indication to staff that he was at imminent risk of suicide and self-harm. While we are satisfied that staff could not reasonably have predicted his actions, we are concerned that they missed multiple opportunities to address his self-isolation and to arrange a wing move.
9. The prison was unable to provide the PPO with a copy of a wing observation book, which would have helped to clarify what action staff took to address Mr Doherty's self-isolation and to facilitate a wing move.

10. Staff did not immediately enter the cell when they found Mr Doherty hanging, and this caused a delay of two minutes. While we are satisfied that this did not affect the outcome for Mr Doherty, in other emergencies, it could be critical.
11. We are concerned that the prison did not allocate Mr Doherty a keyworker and that staff had very little meaningful contact with him.
12. We are also concerned that the prison did not inform Mr Doherty's next of kin of his death in line with Prison Service instructions.
13. The clinical reviewer considered that the care that Mr Doherty received at HMP Wormwood Scrubs was equivalent to that which he could have expected to receive in the community. However, there were some failings: Healthcare staff failed to arrange two GP reviews and to escalate his self-reported multiple NHS identities.

Recommendations

- The Governor should ensure that all operational staff:
 - consider a CSIP referral when there is evidence to indicate that a prisoner may be at risk of violence; and
 - refer self-isolating prisoners to the safer custody department for discussion at the weekly safety intervention meeting, in line with local policy.
- The Governor should review the process for sharing safety information to ensure that all prisoners identified as a risk of harm to themselves or from others are brought to the attention of the safer custody team.
- The Governor should ensure that:
 - operational staff promptly consider a cell move when a credible risk to a prisoner's safety has been identified and record the reason if it is not considered appropriate; and
 - all evidence relevant to a death in custody is retained and that evidence is made available to the PPO, in line with PSI 58/2010.
- The Governor should ensure that the keyworker scheme provides meaningful and ongoing support to all prisoners in line with national policy.
- The Governor should ensure that all prison staff are made aware of and understand their responsibilities during medical emergencies, including that staff enter cells as quickly as possible in life-threatening situations.
- The Governor should ensure that Prison Service staff conduct an evidence-based risk assessment when deciding whether to visit a prisoner's next of kin.
- The Head of Healthcare should ensure that healthcare staff:
 - are aware of their responsibilities for escalating concerns about prisoners who refuse to collect their prescribed medication; and

- promptly report a disclosure of multiple NHS identities using formal reporting mechanisms.
- The Governor and Head of Healthcare should ensure that a copy of this report is shared with the staff named in this report and that a senior manager discusses the Ombudsman's findings with them.

The Investigation Process

14. The investigator issued notices to staff and prisoners at HMP Wormwood Scrubs informing them of the investigation and asking anyone with relevant information to contact him. No one responded.
15. The investigator obtained copies of relevant extracts from Mr Doherty's prison and medical records.
16. The investigator interviewed eleven members of staff at Wormwood Scrubs remotely using Microsoft Teams between 20 January and 1 February 2022.
17. NHS England commissioned a clinical reviewer to review Mr Doherty's clinical care at the prison. The investigator and clinical reviewer jointly interviewed healthcare staff and eight members of prison staff.
18. We informed HM Coroner for London West of the investigation who 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 Doherty's family to explain the investigation and to ask if they had any matters they wanted us to consider. His family wanted to know if he was being bullied by officers. We have addressed this concern in this report.
20. Mr Doherty's family received a copy of the initial report. They did not raise any further issues or comment on the factual accuracy of the report.
21. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies and their action plan is annexed to this report.

Background Information

HMP Wormwood Scrubs

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

HM Inspectorate of Prisons

23. The most recent inspection of HMP Wormwood Scrubs was in June 2021. Inspectors found that the prison was safer than it had been in the past but that the reduction in violence was at least partly due to most prisoners being locked in their cells for 23 hours a day. Challenge, support and intervention plans (CSIPs) were not used to full effect and only 11 plans had been started within 12 months. They also found that although leaders had been working to improve the quality and range of keywork, much more needed to be done to make sure that every prisoner had meaningful access to keywork.
24. Inspectors found that levels of self-harm had reduced substantially. They noted that the prison held regular safety meetings and a safety action plan included learning from Prisons and Probation Ombudsman (PPO) investigations. However, they found that not all PPO recommendations had been implemented effectively.

Independent Monitoring Board

25. 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 2021, the IMB reported that the CSIP process was re-launched following a period of suspension during the COVID-19 pandemic and that a weekly multidisciplinary safety meeting took place to discuss the most challenging and vulnerable prisoners. The board found that there had been a reduction in violence and attributed this to the limited time that prisoners spent mixing with each other.

Previous deaths at HMP Wormwood Scrubs

26. Mr Doherty was the eighth prisoner to die at Wormwood Scrubs since November 2019, and the fifth to take his own life. There has been one self-inflicted and two natural cause deaths since then. There were no similarities with the circumstances of the previous deaths.

Key Events

27. On 9 August 2021, Mr James Doherty was remanded to HMP Wormwood Scrubs charged with several offences, including harassment and criminal damage. He had been in prison before and although mental health staff reviewed him several times, they did not give him a formal diagnosis of mental illness.
28. When he arrived, a nurse conducted an initial health screen. She noted that he had a history of anxiety but strongly denied thoughts of suicide or self-harm. At 9.24pm, A prison GP reviewed Mr Doherty who told him that he had previously been admitted to hospital for paranoia and had been managed under suicide and self-harm prevention procedures, known as ACCT, at HMP Bedford in July. He also said that he had found a cellmate hanging in 2020, tried to hang himself the same year and wanted to re-start antidepressants. The prison GP referred him to the mental health team and prescribed several medications, including citalopram (an antidepressant).
29. At 12.37pm on 10 August, a mental health nurse, triaged Mr Doherty's mental health referral and recommended an in-reach mental health assessment. At 1.08pm, a nurse conducted a secondary health screen and noted that Mr Doherty had reported a history of anxiety, depression, paranoia and hearing voices. She also noted that he had not reported any substance misuse problems or thoughts of suicide or self-harm. At 2.33pm, a pharmacy technician checked Mr Doherty's prescribed medications and recorded that he did not have a summary care record (SCR, an electronic record of important information created from community GP records).
30. On 23 August, a prison GP reviewed Mr Doherty. He told her that he had stopped taking citalopram after one week as it did not help him. He said that he found it difficult to sleep, felt anxious and heard voices telling him off but not to self-harm. He said that he had found mirtazapine (an antidepressant) helpful in the past but the prison GP found no SCR to confirm this. Mr Doherty told her that he had more than one NHS number and that this had caused problems in the past. The prison GP changed his antidepressant to mirtazapine and booked a follow-up review. However, there is no record that she reported the possibility of multiple NHS identities to the appropriate governance team.
31. At 11.35am on 2 September, a prison GP reviewed Mr Doherty through his cell door because he did not want to attend her clinic as he did not want to wait outside the consultation room with other prisoners. She recorded that although he felt that mirtazapine had helped and did not report any thoughts of suicide or self-harm, he continued to feel anxiety and have difficulty sleeping. She increased his mirtazapine dose, recorded that he was still waiting for an in-reach mental health assessment and that she had booked an appointment to review him in three weeks. However, there is no record that this took place.
32. At 4.37pm, an officer recorded that Mr Doherty had been given an Incentives and Earned Privileges (IEP) warning for fighting with a prisoner on B Wing. (IEP is a scheme which encourages and rewards responsible behaviour.) He noted that Mr Doherty told him that they were "just play fighting" and "having a laugh".

33. On 6 September, prison staff moved Mr Doherty to a cell on D Wing. Location records show that the reason given was 'general move'.
34. On 9 September, a Community Psychiatric Nurse (CPN) conducted a mental health assessment. He recorded that Mr Doherty said that he had anxiety and paranoia and that he had been admitted to a mental health unit in 2020. He noted that Mr Doherty said he had attempted suicide by hanging in the past but did not report any current thoughts of suicide or self-harm. The CPN concluded that Mr Doherty did not show any psychotic symptoms but appeared to display drug-seeking behaviour as he kept asking for medication to relax. He noted that his case would be discussed at the in-reach team meeting.
35. On 15 September, the CPN chaired the in-reach team's new referrals meeting and reported that Mr Doherty's presentation was not indicative of severe mental illness. Attendees decided to obtain his discharge summary from the mental health unit before making an allocation decision.
36. On 17 September, a pharmacy technician asked Mr Doherty why he had not been collecting his medication. He told her that he was mostly sleeping in the evening and was therefore unable to get to the medication hatch. However, he said that he would attend in future.
37. On 30 September, Mr Doherty was sentenced to 16 months in prison. At 12.49pm, an officer spoke to Mr Doherty about his sentence and recorded that Mr Doherty had expected a shorter sentence but had no issue with it. At 3.33pm, a CPN recorded that he had reviewed Mr Doherty who had not reported any thoughts of suicide or self-harm.
38. On 13 October, a consultant psychiatrist attended an in-reach team meeting and recorded that staff were still waiting for a discharge summary from the mental health unit. However, she noted that a CPN had contacted them and they had confirmed that Mr Doherty had not been diagnosed with a severe mental illness. She added that the plan was to discharge him to primary care.
39. Later that day, an officer made an electronic case note (NOMIS) entry and submitted an intelligence report stating that Mr Doherty had asked to move to another wing as he felt under threat from other prisoners. However, there is no evidence that staff took any further action.
40. On 30 October, an officer recorded on NOMIS that Mr Doherty had told him that someone had slipped a death threat under his cell door. He said he that he gave the note to an officer, whose name he could not remember, and the officer said that he would deal with it. The officer submitted an intelligence report stating that he would put a note in the wing observation book and added Mr Doherty's name to the threat board in the wing office. However, there is no record that staff considered a challenge support intervention plan (CSIP) referral. (CSIP is a national case management model for managing those who are violent or pose a heightened risk of being violent. It can also be used to support victims or potential victims of violence.)
41. On 31 October, an officer recorded that he conducted a welfare check to find out why Mr Doherty did not want to leave his cell for exercise and to mix with other

prisoners. He said that he felt unsafe on the wing, that some people were after him and that he would like to be moved. The officer recorded that he had escalated this to the duty senior officer but there is no evidence that staff took any further action, such as referring Mr Doherty to the weekly safety intervention meeting (SIM, a multidisciplinary risk management meeting, chaired by a member of the prison's senior management team to provide additional support and guidance to staff).

42. The Head of Safety told the investigator that on 14 November, she went into the D Wing office during her rounds as duty manager and noticed a board with Mr Doherty's name on it under the heading 'Do not unlock'. She subsequently looked at NOMIS, found several entries about Mr Doherty about which she and the safety department had not been aware and asked a Supervising Officer (SO) to conduct a welfare check.
43. A short while later, the SO made a NOMIS entry under the name. He told us that he had just returned from annual leave and could not remember his login details, so he used a colleague's login details to avoid a delay. He recorded that Mr Doherty said that he was fearful for his life on D Wing and that prisoners had threatened to "get him" when he "gets out". He subsequently updated the Head of Safety and suggested that he should ask to move to A wing. She agreed. He noted that he 'opened up communication with A Wing' but was unable formally to ask the wing SO for a move. The Head of Safety told us that she also informed a Custodial Manager (CM) that Mr Doherty required a move but he remained on D Wing.

Events from 17 to 18 November

44. At 9.24pm on 17 November, an OSG looked through Mr Doherty's cell door observation panel to conduct roll check. In his prison statement, The OSG said that he saw Mr Doherty standing in the cell and that that he did not have any concerns about him.
45. At 5.23am on 18 November, another OSG looked through the cell door observation panel to conduct a roll count. She saw him hanging from a ligature made from a bedsheet, attached to a light fitting. She radioed a medical emergency code blue (indicating that a prisoner is unconscious or has breathing difficulties). At 5.24am, an OSG and an officer arrived. They looked through the observation panel but did not enter the cell.
46. At 5.25am, an officer arrived and looked through the observation panel. About 20 seconds later, he entered the cell with another officer. He took Mr Doherty's weight while she cut the ligature and they laid him on the bed. He checked Mr Doherty's vital signs but did not start cardiopulmonary resuscitation (CPR) as he was cold to touch and did not have a pulse. At 5.29am, two nurses arrived, conducted an assessment and found that rigor mortis was present. They concluded that it was inappropriate to start CPR as it was clear that Mr Doherty had died.
47. At 5.29am, an ambulance arrived at the prison and at 5.32am, paramedics arrived at Mr Doherty's cell. At 5.33am, a paramedic pronounced that Mr Doherty had died.
48. Mr Doherty left eight notes in his cell, six for his family and two for prison staff. In the first letter to staff, he appeared to talk about events leading to his offence. In the second letter, he said that a prison officer asked him if there was anything in his

cell and he said, “I got two guns, a criminal record and a load of problems. I think you’re going to need a bigger box”.

Contact with Mr Doherty’s family

49. A short while later, the Governor telephoned Mr Doherty’s brother, his named next of kin, to break the news of Mr Doherty’s death. At 6.30pm, the prison’s appointed family liaison officer (FLO), a safety hub manager phoned Mr Doherty’s brother and offered support.
50. At 2.15pm on 19 November, Mr Doherty’s sister contacted the FLO and said that she was taking over as the next of kin as his brother was finding it upsetting. The FLO explained the role of a prison family liaison officer and arranged for her to visit the prison and to collect Mr Doherty’s belongings.
51. The FLO provided ongoing support to Mr Doherty’s family until his funeral, which took place on 1 December. The prison contributed towards its cost, in line with national policy.

Support for prisoners and staff

52. After Mr Doherty’s death, a prison manger debriefed the staff involved in the emergency response to ensure that they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.
53. The prison posted notices informing other prisoners of Mr Doherty’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 Doherty’s death.

Post-mortem report

54. The post-mortem report established that the cause of Mr Doherty’s death was asphyxia caused by hanging/strangulation. No illicit substances were identified in routine post-mortem toxicology tests.

Findings

Assessment of risk

55. Prison Service Instruction (PSI) 64/2011 on safer custody requires all staff who have contact with prisoners to be aware of the risk factors and triggers that might increase prisoners' risk of suicide and self-harm, and to take appropriate action. Any prisoner identified as at risk of suicide and self-harm must be managed under ACCT procedures.
56. Mr Doherty was not subject to ACCT monitoring at Wormwood Scrubs. Prison records show that he did not have any difficulties with staff, which includes any bullying, and never reported any thoughts of suicide or self-harm. While we are satisfied that staff could not reasonably have predicted that Mr Doherty intended to take his life based on his presentation and the information available to them, we consider that they missed several opportunities to explore the underlying cause of his isolating behaviour, which may have led to formal monitoring and extra support.
57. Mr Doherty first reported feeling under threat from other prisoners on 13 October but there is no record that staff considered a CSIP referral. A SO told us that it was difficult to get a prisoner on a CSIP as safer custody did not always reach the same conclusion as the referring wing staff. The Head of Safety said that the prison had only been using CSIP to support violent offenders at the time of Mr Doherty's death, but they planned to start using CSIP to support victims as part of the national CSIP re-launch that was taking place at the time of interview (February 2022). She also said that custodial managers (CMs) for each wing would be leading on CSIP. While we are encouraged to hear that the prison plans to address the issue, we are concerned that HMIP found CSIP to be inadequate during their inspection in June 2021 and that five months later, there appeared to be little improvement.
58. The prisons safety policy (2021) states that self-isolating prisoners should be referred to the SIM. Despite self-isolating for several weeks, staff did not make a SIM referral for Mr Doherty. The Head of Safety told us that she would expect officers to discuss any concerns about a prisoner during daily briefings and, if required, refer them to the safer custody team for discussion at the SIM. We are concerned that staff did not notify safer custody in line with local policy, which meant that they missed a number of opportunities to discuss Mr Doherty in a multi-disciplinary setting and to devise a plan to monitor and support him.
59. Prison staff submitted two intelligence reports highlighting the risk posed to Mr Doherty by other prisoners. The Head of Safety told us that security analysts normally send safety intelligence to the safer custody team for them to follow-up but there was no evidence that they shared Mr Doherty's information. This meant that the safer custody team was not aware of him until Ms Perham checked his NOMIS record on 14 November. We therefore consider that staff missed a further two opportunities to review Mr Doherty and to refer him to the SIM.
60. We make the following recommendations:

The Governor should ensure that all operational staff::

- **consider a CSIP referral when there is evidence to indicate that a prisoner may be at risk of violence; and**
- **refer self-isolating prisoners to the safer custody department for discussion at the weekly safety intervention meeting, in line with the local safety policy**

The Governor should review the process for sharing safety information to ensure that all prisoners identified as a risk of harm to themselves or from others are brought to the attention of the safer custody team.

Re-location to A wing

61. Although we are satisfied that a SO promptly saw Mr Doherty for a welfare check on 14 November and enquired about a wing move, we are concerned that staff did not move him, or record the reason for not moving him. The Head of Safety told us that her instruction to a SO and a CM was to move Mr Doherty at the earliest opportunity, which she expected would be the following day, as it was a Sunday and the prison was operating at around maximum capacity. The CM said that A Wing was at capacity daily and that Mr Doherty was not subject to ACCT monitoring. He added that the wing observation book, which staff read during briefings, was updated to indicate that Mr Doherty required a move. We are, however, concerned that the prison was unable to send us a copy of the observation book.
62. PSI 58/2010, The Prisons and Probation Ombudsman (PPO), states that as a basic principle, the PPO must have unfettered access to documents during their investigation. The prison told us that a CM searched for the observation book on multiple occasions but was unable to find it. This meant that we were unable to confirm the information given to us by an officer and the CM. Observation book records frequently provide crucial evidence for investigations, and we would expect the prison to ensure that these are easy to obtain after a death in custody to enable appropriate scrutiny and accountability.
63. We cannot know whether the outcome would have been different if Mr Doherty moved wings but the immediate threat is likely to have been reduced. We make the following recommendation:

The Governor should ensure that:

- **operational staff promptly consider a cell move when a credible risk to a prisoner's safety has been identified and record the reason if it is not considered appropriate; and**
- **all evidence relevant to a death in custody is retained and that evidence is made available to the PPO, in line with PSI 58/2010.**

Key worker support

64. The Prison Service's Manage the Custodial Sentence Policy Framework 2018 states that all prisoners within the male closed estate must be allocated to a prison officer who will have a keyworker role. It also says that Governors must ensure that

time is made available for an average of 45 minutes per prisoner per week for the delivery of keywork, which should include time with each prisoner.

65. During the three months between being remanded to prison and taking his own life, prison staff do not appear to have had many meaningful conversations with Mr Doherty. He did not have an allocated keyworker and the contact he had with staff was brief. The prison told us that the keywork scheme was suspended nationally in March 2020 as a result of the COVID 19 Pandemic and that in the with the Prison service's exceptional delivery model, keywork was only being delivered to vulnerable prisoners or those assessed at risk of suicide or self-harm. We consider that Mr Doherty's self-isolation and reported threats from other prisoners made him vulnerable and that he should have had a keyworker. The lack of regular contact meant that it would have been more difficult for staff to pick up on signs that his mood might be deteriorating as a result of his circumstances and to help facilitate a wing move. We make the following recommendation:

The Governor should ensure that the keyworker scheme provides meaningful and ongoing support to all prisoners in line with national policy.

Emergency response

66. Prison Service Instruction (PSI) 03/2013 on medical response codes requires prisons to have a two-code medical emergency response system. Wormwood Scrubs' local policy instructs staff to use a medical code blue to indicate an emergency when a prisoner is unconscious, or having breathing difficulties, and a code red when a prisoner is bleeding. Calling an emergency medical code should automatically trigger the control room to call an ambulance, and for a member of healthcare staff to attend.
67. PSI 24/2011 on the management and security of nights states that staff have a duty of care to prisoners, to themselves, and to other staff, and that the preservation of life must take precedence over usual arrangements for opening cells. It says that where there is or appears to be an immediate danger to life, a single member of staff can enter the cell alone, after performing a rapid dynamic risk assessment.
68. An OSG responded quickly when she found Mr Doherty hanging in his cell. She used an appropriate emergency medical code and control room staff called an ambulance immediately, in line with prison service instructions. At interview, an OSG told the investigator that she was unable to unlock the cell as she was shadowing and did not have a key pouch. (At night, OSGs carry a cell key in a secure pouch for use in emergencies.) A CM told us that OSGs shadowing nights are expected to learn how to conduct roll checks and to feel confident doing them alone. He said that the OSG was on her seventh night of shadowing and that another OSG, who was experienced, was on the wing. We are satisfied that the OSG acted appropriately.
69. An OSG and an officer responded promptly to the code blue but waited outside Mr Doherty's cell for another officer to arrive. The officer told us that she did not enter the cell as she had been trained not to enter cells on her own at night. As two OSGs were present, we consider that staff should have entered the cell. Although we appreciate the distress of seeing a prisoner in such circumstances and that staff

must have regard for their own safety, we are concerned that they did not enter Mr Doherty's cell earlier given the risk to life.

70. While we accept that the delay entering the cell is unlikely to have affected the outcome for Mr Doherty, in future cases, it could be critical. We therefore make the following recommendation:

The Governor should ensure that all prison staff are made aware of and understand their responsibilities during medical emergencies, including that staff enter cells as quickly as possible in life-threatening situations and where it is safe to do so.

71. Two nurses took six minutes to arrive at Mr Doherty's cell. A nurse told us that they were in the healthcare unit when they received the code blue and went to the office to collect the medical emergency bags. He said that they began making their way to the cell but that their progress was slowed by multiple locked gates. We are satisfied that their actions were appropriate.
72. The clinical reviewer was satisfied that the decision not to start CPR was appropriate as it was evident that Mr Doherty had died.

Contact with Mr Doherty's family

73. Prison Rule 22 requires that the Governor should inform families at once when a prisoner dies. PSI 64/2011 requires that wherever possible, the family liaison officer and another member of staff visit the next of kin or nominated person to break the news of the death. It notes that time is of the essence to try to ensure that the family does not find out about the death from another source. If the next of kin lives a long distance away, consideration must be given to asking a family liaison officer from the nearest prison for help.
74. We are concerned that Mr Doherty's brother was notified of his death by phone and that there is no evidence that this decision was based on a risk assessment. Ms Harrison told the investigator that staff did not conduct a home visit as his family were from the travelling community and that staff did not always visit in person. While we appreciate that it will not always be appropriate to conduct a home visit and that staff safety is a priority, an evidence-based risk assessment must underpin the decision. We make the following recommendation:

The Governor should ensure that Prison Service staff conduct an evidence-based risk assessment when deciding to visit a prisoner's next of kin.

Clinical care

75. The clinical reviewer concluded that the clinical care that Mr Doherty received at Wormwood Scrubs was equivalent to that which he could have expected in the community. Mental health staff completed appropriate assessments, obtained information from community health services and frequently asked him about his emotional wellbeing. She did, however, identify some areas for improvement.
76. The clinical reviewer considered that healthcare staff failed to arrange a follow-up review with a prison GP and missed a further opportunity to arrange a GP review when Mr Doherty stopped collecting his medication. She also considered that

healthcare staff did not escalate the potential concern about Mr Doherty having multiple NHS identities in line with local policy.

77. While we cannot be certain whether additional GP reviews and the amalgamation of Mr Doherty's NHS records would have changed the outcome for Mr Doherty, in other circumstances, it could be critical. We therefore make the following recommendation:

The Head of Healthcare should ensure that healthcare staff:

- **are aware of their responsibilities for escalating concerns about prisoners who fail to take their prescribed medication; and**
- **promptly report a disclosure of multiple NHS identities using formal reporting mechanisms.**

Learning lessons

78. We have identified a number of concerns in this report. We consider it is important that staff learn from our findings. We recommend that:

The Governor and Head of Healthcare should ensure that a copy of this report is shared with the staff named in this report and that a senior manager discusses the Ombudsman's findings with them.

Inquest

79. At the inquest, which took place on 18 March 2024, the Coroner concluded that Mr Doherty died of suicide.

**Prisons &
Probation**

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