

**Investigation into the circumstances surrounding the
death of a prisoner at HMP Wormwood Scrubs
in March 2010**

**Report by the Prisons and Probation Ombudsman
for England and Wales**

April 2011

This is the report of an investigation into the death of a 31 year old man in March 2010 at Charing Cross Hospital, whilst in the custody of HMP Wormwood Scrubs. Another prisoner found the man hanging in his cell early that morning. Prison staff attempted to resuscitate him before he was taken to hospital by emergency ambulance. However, despite the efforts of medical staff, he died at 9.13am. He had been in prison for less than two months.

I offer my sincere condolences to the man's family and everyone touched by his death. I would also like to apologise for the delay in publishing my report, and for any additional stress that this may have caused.

A senior investigator conducted the investigation on my behalf. Hammersmith and Fulham Primary Care Trust commissioned a review of the man's medical care. A panel undertook the review, and I am grateful to the panel for their contribution.

I would also like to thank the Governor of Wormwood Scrubs, and his staff for their cooperation. I am particularly grateful to the appointed prison liaison, who provided a high standard of support and ensured that the documentation was in good order.

The man had been remanded to prison charged with murder. He had never been in custody before. He harmed himself soon after coming into prison and the suicide monitoring procedures were put in place. He was still being monitored in March when he took his life. On that morning, a fellow prisoner and friend was unlocked at around 7.00am, to attend court. He went to the man's cell before leaving and, when he looked through the observation panel on the cell door, he saw him hanging at the back of the cell.

Staff responded to the prisoner's shouts for help and went into the cell. They released the ligature from around the man's neck and carried out cardio pulmonary resuscitation (CPR) until the arrival of paramedics at around 7.25am. Efforts to revive him continued and a pulse was established before he was taken by emergency ambulance to Charing Cross Hospital, where he later died.

The investigation highlights concerns about managing the man's medical care at Wormwood Scrubs and some of the healthcare processes. It also reveals inadequacies in the procedures for looking after prisoners subject to the suicide and self-harm monitoring procedures. However, I am pleased to learn that, since this death, new processes and procedures have been implemented, particularly within the healthcare centre.

Unfortunately, information from the man's sister about the ability of her brother to speak and understand English was gained after the draft report had been circulated. The information given is in contrast to that gathered by the investigator from prison staff. In view of this, I would ask the Governor to remind staff of the importance of using translation services such as Language Line or The Big Word that are available to them.

The report makes five recommendations relating to self-harm monitoring procedures and the recording of interventions such as the use of alternative (anti-tear) clothing. In addition, the clinical review panel makes a number of additional recommendations

and I endorse those that fall within the remit of my office. Following sight of my draft report the Prison Service accepted all recommendations made by my office. A record of their response to each recommendation can be found on page 32. Additionally, the response from the man's family can also be found on page 30 of the report.

Prisons and Probation Ombudsman

April 2011

CONTENTS

Summary	5
The investigation process	8
HMP Wormwood Scrubs	10
Key events	11
Issues	22
Conclusion	29
Family response to draft report	30
Recommendations including Prison Service response	32

SUMMARY

The man had been remanded into custody, following his arrest for murder on 18 January 2010, and taken to HMP Wormwood Scrubs. He was 31 years old, a Sri Lankan national who had never been in prison custody before. On reception, he was seen by nursing staff who completed a health screen. The screening highlighted no immediate concerns with either his physical or mental health. Reception staff also completed additional documentation and risk assessments. Due to the nature of his alleged offence, The man was considered unsuitable to share a cell and was therefore allocated to a single cell. Although not his first language, he was able to communicate with staff in English, but the extent of his ability was questioned during the investigation.

On 22 January, he refused his evening meal and a short while later he pressed the call bell in his cell. When staff went to see him, he showed them that he had made deep cuts to his wrist. Although initially treated by healthcare staff at the prison, it became apparent that his cuts required hospital attention. Before leaving the prison, staff put in place the suicide and self-harm prevention measures by opening an Assessment, Care, Custody and Teamwork (ACCT) document which went with him to Hammersmith Hospital. (The ACCT process supports prisoners who are suicidal or at risk of self-harm. It allows for varying levels of monitoring depending on the perceived risk to the individual. All persons working in prisons who have direct contact with prisoners should be trained in ACCT procedures.)

The man was treated first at Hammersmith Hospital where he was seen by a psychiatrist who prescribed anti-psychotic medication. He was then taken to Chelsea and Westminster Hospital for further treatment to his arm. He returned to the prison two days later on 24 January, where he was admitted to the healthcare centre under constant supervision. In addition, staff decided that he should wear alternative clothing. (Alternative clothing, previously known as protective or anti-tear clothing, is made from a strong material that makes it difficult to tear. It is used to prevent a prisoner using his clothing to harm himself or others.) The removal of a prisoner's own clothes and replacement by alternative clothing is described within Prison Service Order 2700, Suicide Prevention and Self-Harm Management as a "measure of last resort to prevent someone from harming themselves". It should be used for the shortest time possible. It should trigger an enhanced case review within four hours of the decision being taken or within four hours of the prisoner being unlocked in the morning if the decision is made at night.

Constant supervision continued until 28 January, when the man's level of observation was reduced following an improvement in his demeanour. He remained in the healthcare centre, where he was described as coping well and his medication was reduced. There were no further attempts by the man to harm himself while in healthcare, and he moved to D wing on 5 February. He settled in well on the wing and mixed well with other Sri Lankan prisoners giving staff no cause for concern. However, on 8 February, he cut his arm again. On this occasion it was not as severe as the earlier injury and he was treated in the prison by nursing staff. He was still subject to ACCT monitoring, but no review took place following this instance of self-harm. It is a requirement that a review should be held following any further episodes of self-harm by a prisoner on ACCT monitoring, within two hours, unless at

night. In addition to the ACCT review, a F213SH form should also be completed. The F213SH details the circumstances of the self-harm, and is then passed to the person providing medical treatment for them to complete the details on the treatment given. This was not completed when he harmed himself on 8 February.

The guidance provided to prison staff says that, ACCT case reviews conducted during the day Monday to Friday should be attended by a minimum of three staff, including a mental health or nursing professional and residential staff. However, in the event that a member of nursing staff is unable to attend, the case manager should seek any relevant information from the healthcare department and record this prior to the review. Subsequent ACCT case reviews that take place at weekends or during evening duty and at night should be attended by a minimum of two staff and include a member of the healthcare team. Again if not possible, advice should be sought by residential staff.

When spoken to by wing staff, the man would say that he was all right. However, on 24 February, he approached a nurse from the Case Management Protocol (CMP) team who support wing staff to manage the behaviour of difficult prisoners. (The CMP is a dedicated multi-disciplinary team comprising discipline staff, mental health nurses and a psychologist, who help wing staff to manage the behaviour of the most difficult to manage prisoners. Referrals can be made from any residential unit, the healthcare centre, mental health professionals and the segregation unit. Information regarding prisoners who may benefit from the protocol is also received from the security department and violence reduction co-ordinator.) The man told the nurse that his head was “spinning”.

Following this, the nurse attended an ACCT review with the man and the wing senior officer (SO). During the review, the nurse said that she considered The man was potentially in a frame of mind to take his own life or seriously harm himself and his risk level was increased from ‘low’ to ‘high’. Afterwards, the nurse arranged for him to be assessed by a doctor from the mental health in-reach team (MHIRT). The doctor stopped the anti-psychotic medication and prescribed citalopram (an anti-depressant) and a seven day course of zopiclone to help him sleep.

Over the next two weeks no concerns were raised about him. He continued to speak with CMP and chaplaincy staff. ACCT reviews were conducted and the level of observation was again reduced.

In early March, a fellow prisoner and friend of the man was unlocked at around 7.10am, to attend court. Before leaving the wing, he went to the man’s cell to speak to him. When he opened the observation panel he saw him at the back of the cell and he appeared to be looking out of the window. His friend called to him but got no response. He then realised that he was hanging and immediately called to staff on the wing.

Officers were called by the man’s friend, who said “he’s dying”. Officer’s saw the man suspended from the bar on the window, and used their radio to call for assistance before going into the cell. They then supported the man’s body and, as they did so, the ligature came away from the window bars without being cut. Staff placed him on the cell floor and started cardio pulmonary resuscitation (CPR).

Nurses arrived at the cell at 7.20am, with emergency equipment. The staff continued in their attempts to resuscitate until the emergency paramedics arrived at around 7.25am.

The paramedics took over resuscitation, administering drugs intravenously and eventually managed to get a pulse. They continued to treat The man en route to Charing Cross Hospital, later handing over to emergency staff at the hospital. However, he was pronounced dead at 9.13am, by a hospital doctor.

A hot debrief was held at the prison and staff contacted the man's next of kin. Prison staff and the man's friend were also offered support.

The investigation has found there is a need for improvement in the handling of the ACCT procedures and use of alternative clothing. I make five recommendations in regard to these matters. In addition, the panel review of the medical care afforded to The man makes a further 24 recommendations. The panel was unable to determine whether his death could have been prevented, but considered that improvements in clinical processes might have reduced his risk of harming himself.

THE INVESTIGATION PROCESS

1. The investigation was opened at HMP Wormwood Scrubs in March, where the investigator met the Safer Custody Manager. He collected documentation relating to the man and was shown both the healthcare wing and D wing where the man had lived. Notices were issued informing both staff and prisoners of the investigation. They asked anyone who had information pertinent to the investigation to contact the investigator, but no responses were received.
2. Hammersmith and Fulham Primary Care Trust (PCT) were asked to conduct a review of the medical care provided to the man while in custody. A review panel was formed and a meeting was held on 11 June. It was attended by various medical professionals who were to be involved in the review and the investigator. The team discussed the care the man had received and identified staff that would need to be interviewed during the course of the investigation.
3. One of the PPO family liaison officers (FLO), attempted to contact the man's sister who was named as his next of kin. However, this proved difficult. The FLO therefore wrote to a known family friend on 24 June, explained her difficulty making contact, and suggested that the family get in touch with her to discuss any concerns that they may have. The man's sister telephoned on 7 July, and explained that she did have concerns about her brother's care at Wormwood Scrubs, but her English was limited. It was arranged for the introductory letter to be translated into Tamil. It was agreed that the man's sister would await publication of the draft report, which was also translated, and then raise any concerns with the FLO.
4. The man's sister was visited by the FLO and investigator along with a Tamil speaking translator on 12 April to discuss the draft report. Comments and concerns raised by the his sister were added to the final report.
5. The investigator and various members of the clinical review panel attended Wormwood Scrubs on 12, 13 and 15 July, and 7 September in order to interview staff who were involved in the man's care. Following the interviews with those identified by the investigator, feedback was provided to the prison both verbally and in writing, highlighting the issues discussed in my report.
6. Much of this investigation has focused on the medical care given to the man. The clinical review completed by Hammersmith and Fulham PCT and their subsequent report details this and makes relevant recommendations on the areas of concern. The clinical review was eventually received by my office on 2 November, which has been the cause of my report being delayed.

7. The investigator also wrote to HM Coroner to inform him of the investigation and to request a copy of the post mortem report. A copy of this report, including the annexes, was made available to the Coroner to assist with the inquest process.

HMP WORMWOOD SCRUBS

8. HMP Wormwood Scrubs principally serves the courts of West London. It has a maximum capacity of 1,277 prisoners and holds remand and convicted adult males. The prison holds a high number of foreign nationals due to the proximity of Heathrow Airport. There are five main residential wings, together with an inpatient healthcare facility. The man had spent time in the healthcare unit, but was on D wing at the time of his death.
9. Healthcare services are commissioned through Hammersmith and Fulham Primary Care Trust (PCT). The inpatient healthcare unit that is staffed by qualified nurses, healthcare assistants and discipline officers. The nursing staff have a range of skills including mental health and a nurse qualified to prescribe medication. Medical cover is provided by two doctors on a daily sessional basis. An electronic records system has recently been introduced for patients' notes and replaces the previous paper system.
10. An unannounced inspection by HM Inspectorate of Prisons took place in June 2008. The Inspectorate's report commented that progress made at the prison since the previous inspection had halted and there had been "an appreciable drift" in all key areas namely safety, respect, purposeful activity and resettlement. However, the report acknowledged the difficulties the prison faced in coping with constant daily pressure.
11. The inspection highlighted problems with the reception, first night and induction procedures, which were found to be "not sufficiently supportive or consistent". The health centre was judged to have improved, but staffing was still an issue. In September 2007, the healthcare department was placed under special measures as part of the PCT's improvement plan. The investigation has learnt that changes have taken place within the healthcare at Wormwood Scrubs in both staffing and policies, and these improvements are ongoing.
12. Each prison in England and Wales is monitored by an Independent Monitoring Board (IMB). (Members of the IMB are drawn from the local community and monitor the day to day routines of the prison ensuring standards of decency and care are maintained.) In their last published report they noted similar concerns to those of the Inspectorate.
13. In the 12 months prior to The man's death, there were four other apparent self-inflicted deaths at Wormwood Scrubs that were investigated by my office. Issues arising in some of these investigations, such as the use of alternative clothing and quality of the suicide prevention and self-harm management procedures, also feature in this investigation. However, I am aware that the prison is addressing concerns from earlier investigations, and improvements are ongoing.

KEY EVENTS

14. The man was remanded into custody on 18 January 2010. On reception at Wormwood Scrubs, a nurse completed a health screen with him. The nurse recorded that he was taking medication for cholesterol but he raised no other problems. She recorded that he appeared healthy, calm and “appropriate.” The man said that it was his first time in custody and that he would learn to cope while in prison. He said that he had been unable to sleep for three weeks due to his charge. When asked about any thoughts of harming himself, he said that he had not tried to harm himself before, and had received no medication for any mental health conditions. The nurse referred him to the doctor due to the nature of his alleged offence (murder), and considered him fit for normal location (a cell on a regular wing).
15. Following the health screening, the man was assessed by the prison doctor. The man told the doctor that his community GP had prescribed sleeping tablets and advised him not to drink alcohol while taking them. However, on the night he allegedly committed his offence, he had drunk alcohol with them, and he had no recollection of what had happened. The doctor made a note to contact the GP to find out what had been prescribed. He also recorded that the man was mentally stable and quiet. When asked, he denied any thoughts of harming himself. The doctor prescribed 7.5mg of zopiclone (to aid sleep) to be taken at night for three days.
16. After the doctor’s assessment, reception staff completed the remainder of the reception process which included the completion of a Cell Sharing Risk Assessment (CSRA). (The CSRA assesses a prisoner’s suitability to share a cell, with regard to the risk he would pose to others. The prisoner is asked a series of questions relating to previous custody and any racist or violent behaviour.) However, due to the charges against him he was automatically considered ‘high risk’ and not considered to be suitable for sharing. The man was then allocated to a wing.
17. Little is recorded about the man’s first few days on the wing. On 22 January, it is documented that he refused his evening meal and, during the evening, he cut his wrist with a razor blade. An officer answered the man’s cell call bell and discovered that he had harmed himself. (Each cell has a bell to be used by prisoners in an emergency or if they require an officer’s attention.) The officer opened the Assessment, Custody, Care and Teamwork (ACCT) procedures. (The ACCT procedures support prisoners who are suicidal or at risk of self-harm. It allows for varying levels of monitoring to be prescribed depending on the perceived risk to the individual. All staff who work in prisons and have direct contact with prisoners should be trained in ACCT procedures.) The officer contacted a nurse who came to treat the man. The man is recorded as saying to the nurse “you don’t do this, just kill me”.
18. A prison doctor also examined the man due to the severity of the cut he had inflicted. The doctor recorded that he said that he was suicidal and depressed and unable to cope with being in prison. The man was uncooperative during

examination and there was reduced movement of his wrist and finger. The doctor was unsure as to the extent of the injury and recorded that the tendon could be seen to be intact. The wound was dressed and the doctor referred him to outside hospital for an opinion from an orthopaedic specialist. He also recorded that the man should be referred to the psychology department.

19. Prison staff escorted him to Hammersmith Hospital. Although the ACCT procedure was open, because The man was taken to outside hospital, no ACCT assessment was made until his return. However, the document went with him to hospital and staff completed it as required.
20. The man remained in hospital overnight and was assessed by the duty doctor. In the early hours of 23 January, he told the escort staff that he wished to return to the prison. He also told the doctor that he wanted to discharge himself, but was persuaded to stay. At 11.00am on 23 January, while being assessed by another doctor, he said that he would not kill himself, but then asked the doctor if he would kill him by giving him an injection. He was told that he would need to go to Chelsea and Westminster Hospital for surgery on his arm, and he transferred there later that day. While at Hammersmith Hospital, he was also assessed by a psychiatrist who began treatment with risperidone, an anti-psychotic drug.
21. The psychiatric team at Hammersmith Hospital concluded that the man was displaying some signs of acute psychosis, but their report was not forwarded to the prison. This may have been due to him going to the Chelsea and Westminster. This issue is raised within the clinical review. However, the notes of the assessment were faxed to the prison, giving the view of the psychiatrist at Hammersmith Hospital. The consultant also recorded that he should be continuously observed by staff and followed up by liaison psychiatry if he remained in hospital. If he returned to the prison, this should be followed up by the prison mental health team.
22. The operation on the man's arm took place around lunchtime on 24 January. After he had recovered, nursing staff at the hospital authorised his return to Wormwood Scrubs. On his return to the prison, he was taken straight to the healthcare centre (H3) in a cell where he could be under constant supervision. The cell is similar to others apart from having an additional gate fitted. When a prisoner is under constant supervision, the normal cell door is locked back and the gate used so that a member of staff can see the prisoner at all times.
23. A prison nurse spoke to the man when he returned from Chelsea and Westminster Hospital. She then had a discussion with the duty governor, about the man being 'high risk' due to the nature of his alleged offence. He was due to attend court again on 26 January. The next court date was not recorded on the ACCT document as a potential trigger for self-harm. It was agreed that he would remain on constant supervision and also as an added precaution be given alternative clothing instead of the usual prison uniform.
24. The ACCT document has a space on the inside of the front cover for staff to record any potential trigger points that may increase an individual's risk of

self-harm. They may include information from court staff or mentioned by a prisoner during an assessment. A potential risk may also be a forthcoming anniversary or court dates.

25. It is recorded in the ACCT document that he appeared to settle in well on his return from hospital, but he was quiet. The constant supervision was conducted by healthcare assistants (HCAs) who were employed via an agency. Staff carrying out constant supervision can be of any grade or professional background, as long as they are considered competent to deliver the level and quality of support set out within the CAREMAP. (The CAREMAP lists the actions necessary to keep the prisoner safe.) Prison Service Order (PSO) 2700 provides guidance on other desirable qualities that persons conducting these duties should possess. They should:
- Have completed the relevant training for observers and be deemed competent to carry out the observation.
 - Have good interpersonal and report writing skills and be able to convey to the person-at-risk that they are valued.
 - Be Control and Restraint (C&R) trained or able to access immediate support from staff who are.
 - Be able to speak English well enough to allow effective communication with the prisoner – there is also additional guidance about foreign national prisoners and communication.
26. During the next day, the man communicated well with the HCA who was conducting the constant supervision. He refused to take his prescribed medication as he said it made him dizzy. The clinical review team raised concerns about the levels of medication given on the man's return from hospital, and suggested that this may account for the feelings of dizziness. This issue is discussed in more detail as part of the clinical review.
27. Despite The man being subject to constant supervision and required to wear alternative clothing, no enhanced case review took place. However, the ACCT assessment was conducted by a trained officer at 11.30am, during which it was recorded that the man had cut himself because he was in prison. The officer added that his responses were slow, he spoke about being followed and there may have been some paranoia. The man does not appear to have provided much more information about his feelings and little is recorded that provides any great insight. A case review took place, but it appears that the time on the document was recorded incorrectly. If correct, it would mean that the review had taken place before the assessment.
28. The case review that followed the assessment was not an 'enhanced case review' as it should have been, and a governor did not attend. Instead, the assessing officer, a nurse, and a consultant psychiatrist who works part-time at Wormwood Scrubs attended it. The psychiatrist told the investigator that he attends twice a week to review patients in the healthcare centre. He said that the ACCT reviews he conducted were done as part of his normal ward round. He confirmed that a prisoner would not be taken to a separate room to facilitate the review. When the nurse was interviewed she told the

investigator that there would have been a separate room for conducting reviews. However, the psychiatrist said that although this was normal practice in January 2010, it had since changed. The first review recorded that constant supervision should continue until at least 28 January, and concluded that the man still posed a high risk of self-harm. No mention of alternative clothing was made.

29. The man's solicitor visited him during the afternoon. It is not recorded whether he was provided with normal clothing to attend the visit, but the prison policy is that he should have been. It is unclear how long he was required to remain in alternative clothing, and staff who were interviewed were unable to give a definitive answer as to when he was allowed to wear his own clothes. It is recorded in the ACCT document that during the evening of 25 January, he was lying in bed and pulled the "protective blanket" over him, which would suggest that he was still in alternative clothing at this time.
30. There were no further reviews of the ACCT, enhanced or otherwise, over the next couple of days. Also, no documentary evidence is available to indicate whether there was any change to the requirement for him to wear alternative clothing. During 26 and 27 January, he conversed well with the staff assigned to his constant supervision, mixed with his peers and spent time out of his cell. The Head of Mental Health In-Reach, telephoned the community mental health team on 27 January, to find out whether the man was known to them, but they had no record of any involvement.
31. An entry in the ACCT document on the morning of 28 January, says that he complained about the trousers and jumper he had been wearing for the last week and was told that they would be changed later that day. This is a possible indication that he was no longer in alternative clothing, but the same entry mentions him covering himself with a "protective blanket" which suggests that the alternative clothing was still in place. Without a documented history of the use of the alternative clothing, it is impossible to be able to say when this restriction was finally removed.
32. The next ACCT review took place later on the morning of 28 January, again during the psychiatrist's ward round. The review was attended by two nurses, and an officer. No representatives from outside of healthcare and no governors were there. The man said he was feeling better and more settled, no longer entertaining thoughts of self-harm or suicide. He said that he had not had any contact with his few relatives who lived in England, but did not appear concerned by this. The review panel decided to reduce monitoring him to every 30 minutes and his level of risk of self-harm was lowered from 'high' to 'low'. The reduction in risk and observation level meant that the man was no longer subject to constant supervision. In view of this, the use of alternative clothing would no longer be in accordance with prison policy. However, an entry at 12.30pm, the afternoon of the review, says "appears asleep, covered himself with protective clothing".
33. The psychiatrist also recorded on 28 January, that there was no evidence of any behavioural disturbance and the man appeared to be sleeping well.

When interviewed, the psychiatrist said that on the day he made that entry, he also halved the dose of Clonazepam (an anti-anxiety medication) and stopped the risperidone as he felt that the man showed no signs of mental illness.

34. Once the constant ACCT supervision came to an end, there was less evidence of meaningful interactions between The man and staff. Although staff may have been interacting with him, the entries do not indicate any meaningful contact. Instead, the entries are brief and describe visual observations rather than conversations. A further ACCT review was conducted on 1 February, again during a ward round by the psychiatrist. The man wished to move to A wing, and said that he did not want to harm himself. The man complained that it was noisy on H3 and he was not sleeping well, he also said that he was bored. The psychiatrist recorded that the ACCT observations should be reduced to every hour, and a plan to discharge the man would be discussed at next review.
35. Prison Service Order (PSO) 2700 gives instructions about managing prisoners considered to be at risk of harming themselves, describing how they should be kept active and provided with “purposeful activity.” (Purposeful activity, can take the form of paid employment, or attending offending behaviour courses.) Provision of unpaid work or crafts that can be completed in the prisoner’s cell, often provided by the education department and distractions such as television are also recommended. Apart from attending association, there is no evidence of any other forms of purposeful activity being considered or provided for the man while in the healthcare centre.
36. On 1 February, the man spoke to a member of the chaplaincy team, who had visited prisoners in the healthcare centre. The man is recorded as saying that he could not cope with coming to prison for the first time, but understood what was going on and felt safe. He also said that he would like to return to the wing, and did not feel like harming himself. He had a good visit from family members the previous day and seemed cheerful, positive and relaxed.
37. The next ACCT review took place on 3 February. A Senior Staff Nurse, together with two officers, led it. All those present were from healthcare and there is no evidence of input from a governor or doctor. The man was calm and composed, with no suicidal or self-harm intentions. Although a further review was scheduled for 8 February, the next one was actually held the following day and recorded as the “review prior to discharge from healthcare”. This was led by the psychiatrist and attended by two nurses, and an officer. The psychiatrist made a diagnosis of “severe adjustment disorder”. A summary of the review recorded:

“... Denied any current thoughts of suicide, advised to talk to staff if feeling low and suicidal. Observation level, 3 entries during the day and 5 at night in the ACCT document. (This would require an entry to be made in the ACCT document, morning, afternoon and evening during the core day, and five entries during the night.) Continue with present treatment. Discharge to the wing. In-Reach to follow up in a week. Single cell ...”

38. The responsibility for following up the man's care once he moved to the residential wing appears not to have been clear to those involved. The psychiatrist believed that staff from the Case Management Protocol (CMP) team would be involved, despite his entry stating that the in-reach team should follow up. When asked about this, he clarified that he meant that if CMP were not going to assist in his management, then in-reach would need to review him. When asked how CMP would know of the referral, he said that they were present during the ward round. By this, the psychiatrist was referring to the nurse who is a dual diagnosis nurse and a member of the CMP team. (Dual diagnosis describes people who have mental health and substance abuse problems.)
39. When interviewed, the nurse said that her first contact with the man was on 28 January, during the H3 ward round. She explained that she was not there specifically for him, but a member of the CMP team would attend the ward rounds each week to collect referrals. The nurse confirmed that the man was still wearing alternative clothing on 28 January when she saw him. The nurse went to H3 for the case review on 4 February as the plan was to discharge the man to the wing. When asked who would be responsible for following up the man on the wing, the nurse said that he did not meet the criteria for the CMP. However, when she went to the meeting on 4 February, she was doing a favour for D wing staff who could not attend because they were short staffed. She told both wing staff and nurses based on D wing about the man, so that they would be aware of him once he moved. A Senior Nurse in the CMP team who accompanied the nurse at interview, described their role with the man as "distant monitoring" as a favour to the mental health services. The clinical review addresses the problems regarding clear follow up care.
40. On 5 February, a nurse made an entry on the man's medical notes referring to a "contract of trust" with staff not to harm himself. At interview, the nurse said that she completed a template on the electronic medical notes as she had noticed one had not been completed for him. She confirmed that the care plan was retrospective for use on H3, and was not envisaged to be transferred to the residential unit.
41. The man moved to D wing later the same day and was given a single cell. His wing history file only contains five entries from 18 January to 8 February, and does not describe much of his time on the wing. There was no review of his ACCT monitoring when he moved to D wing. Also, apart from an entry in the ACCT document that says that he had said he was 'fine', there is no evidence of any other interaction with him by staff on the day that he moved. The following day, he was said to have been out on the landing and mixing with other prisoners. He asked a member of the chaplaincy team for a Bible and was given one in Tamil. During the afternoon on 6 February, prisoners on D wing were locked in their cells. When unlocked later to collect his evening meal, an officer asked him how he was feeling and recorded in the ACCT that he replied "not bad, but not good". The officer then asked whether he was going to be alright and he replied "yes".

42. While collecting his medication on 7 February, The man told the nurse that his throat was sore and his tonsils were swollen. The nurse gave him some more medication. In his interactions with staff, the man continued to say that he was alright. However, on 8 February, he made cut his left arm. The cuts were not as serious as those he made in January but he was taken to the treatment room. While there, he told the nurse that he wanted to share a cell with someone. A nurse from CMP spoke to him after he had cut himself.
43. The nurse said that the wing staff had contacted her as the CMP office is located on D wing. She also remembered speaking to the Senior Officer (SO) on that wing. An entry in the ACCT document by the SO says that she had spoken to the man about the trigger points for his self-harm, and he was tearful and reluctant to talk. The SO also wrote that "CMP are writing up a report". When the nurse was asked about this report, she said that it would have referred to her entry on the man's medical record. However, there is no entry relating to this on his SystemOne record. (SystemOne is a computer record system now used widely within prison healthcare settings. It is similar to the one which is used by GP surgeries in the community.) There was no ACCT case review following the self-harm or F213SH completed and no change or discussion about the level of observations, which the man required.
44. There were no other reported concerns with the man for the remainder of the day, but entries in the ACCT document are few despite his self-harm, with none between 11.30am and 5.30pm. Over the next week, the entries in the ACCT document say that he associated with fellow Sri Lankan prisoners and said he was alright when asked by staff. An ACCT review was held on 11 February, attended by just two members of staff and the man. No healthcare staff or anyone from CMP were present. The review concluded that the ACCT should remain open. A further review on 17 February was again only attended by two members of D wing staff, the man was very vague during the review, but was clear about having no thought of harming himself.
45. A nurse wrote in the man's medical notes on 17 February that he had applied to work on the wing, but this had not been granted. He wanted some sort of activity as he was bored being in his cell. He had complained of pain in his head, throat and legs and arrangements were made for him to be seen by the GP. The education department were also contacted to provide the man with some form of activity. He was assessed the following day by a prison doctor who diagnosed tonsillitis and prescribed a course of antibiotics.
46. The man continued to mix with his peers on the wing. On 22 February, a chaplaincy assistant spoke to him. It was recorded in his ACCT that he said he found talking to fellow Sri Lankan prisoners very helpful. He told the chaplaincy assistant that he was worried about his sentence, and could not remember the details of his offence. He said that he felt confused and sometimes thought about harming himself. The same day, he approached the nurse in the CMP office and said that he did not know why he was in prison. The nurse looked his details up on the computer and told him the date of his next court appearance and that a referral had been made for him to attend the Seacole Centre. (The Seacole Centre is a day centre within the

healthcare centre at Wormwood Scrubs which provides activities such as drama classes and counselling.)

47. As mentioned previously, purposeful activity is considered a key component in managing prisoners who are at-risk. While referrals were made to both the education department and Seacole Centre, The man was never given any activities and, apart from association periods, he remained alone in his cell.
48. The man spoke to the nurse again in the CMP office on 24 February and told her that he was not feeling well. He said that his head was “racing and spinning” and he had not been sleeping very well. The nurse contacted the nurse in the treatment room and was told that they were going to speak to her themselves as the man had also told them that he was not feeling well “in his head.” Following this, the nurse went to an ACCT review with him and the wing senior officer. The SO recorded that the nurse had referred the man to the Mental Health In Reach Team (MHIRT) as a matter of urgency, as she believed that he was in a state of mind to either harm himself or commit suicide. He was to be seen by a doctor later that day. The SO raised his risk level to ‘high’ and said that his ACCT observations should be increased to hourly.
49. On the front cover of the ACCT document is an area for recording the level of ‘observations’ and ‘conversations’ and this guides staff working with the prisoner as to what is required. Following the man’s ACCT review, the front cover of the document was updated. However, the recorded frequency of observations from 24 February are not recorded hourly, and in some cases there are up to three hours between entries. While the frequency of observations and the recording can differ, the requirement for observations was not noted on the front cover, after the case review on 24 February.
50. The nurse asked a prison doctor, who works as part of the Mental Health In-Reach Team (MHIRT), to assess the man later in the morning on 24 February. The doctor recorded his assessment and referred to the man feeling low for a few weeks. The man said that he felt worse during the daytime, and stressed at being in prison. The doctor recorded that the man had not been sleeping well and having bad dreams about people trying to kill him. The medication that he was currently on was recorded. The nurse who was also present said that the man would approach her, and had not expressed any thought of harming himself. During the review the man was tearful, but had good eye contact and responded well to the questions that were asked. The doctor recorded that the Risperidone would be stopped and the man would be started on 20mg Citalopram daily and 7.5mg Zopiclone at night for 7 days.
51. The doctor, mentions the first self-harm in January, but does not mention the most recent one, despite the nurse being present, and having been involved with the man following the second incident. When interviewed, the doctor was asked whether he was told about the most recent self-harm and whether he had read the medical notes or ACCT. He said that he did not have the ACCT document with him during the assessment and the nurse had not mentioned

the recent self-harm. In relation to the medical notes, the doctor said that he looked briefly on SystmOne before seeing the man, but had not noted the recent self-harm. He said that, if he had been aware of the self-harm, this would not have made any difference to his assessment or prescribing of Citalopram. (Citalopram is used to treat depression and can in some cases increase the risk of suicide in some patients. It is important that the person prescribing is aware of any suicidal thoughts the patient may have.)

52. Over the next week staff reported no significant concerns about the man. On 1 March, the chaplaincy assistant, again spoke to him on the wing. He told her that he got confused easily and his memory was not good. He also said that he was concerned about the outcome of his trial. The chaplaincy assistant spoke to him about the Seacole Centre and agreed to refer him as he appeared interested.
53. The man continued to tell wing staff that he was alright when they asked. He interacted well with his friends on the wing and no concerns were raised. On 3 March, another ACCT review took place. The man said that he had no thoughts of self-harm or suicide. The man said that he had a few friends on the wing who he spoke to and he went to the Hindu service. The SO again recorded that he would refer him to the Seacole Centre to provide some occupation and time out of his cell. The review concluded that the ACCT should remain open but with a reduction in the frequency of observations (although this is not clearly detailed on the front cover of the ACCT document.) The ACCT states "5 daily and 5 nightly" it is unclear whether this refers to observations or the frequency of recording them.
54. At 5.08am on 4 March, the man pressed his cell call bell, and told a member of staff who answered that he was unable to sleep. He was advised to speak to the nursing staff when he was unlocked later that morning. He was seen associating that evening with his friends on D wing and raised no concerns. At 9.30pm, he told a member of staff carrying out a routine ACCT check that he could not sleep, but was otherwise alright. He said that he had seen the nurse during the day but had not been given any medication.
55. The man was checked four times during the night at 11.40pm, 2.00am, 4.00am and 6.00am by Operational Support Grade (OSG). On each occasion it was recorded that he appeared asleep. When checked at 6.00am, he was recorded as waving to the OSG when she looked through the observation panel on the cell door. The OSG said that while she was getting prisoners ready to attend court, she returned to the man's cell at around 6.40am, and he was standing by the window. The man did not respond to her when she looked into the cell.
56. At around 7.10am on 5 March, another prisoner and a friend of the man, was unlocked to go to court. He went to the man's cell to speak to him before leaving the wing. When he opened the observation panel, he said that he could see his friend who seemed to be standing at the back of the cell, looking out of the window. He called to him but got no response and then realised that the man was actually hanging. He immediately called to wing staff.

57. Two officers were on the wing and had begun their duty at 7.00am, and were unlocking other prisoners for court when the prisoner called that “he’s dying”. One officer went up to D3 landing and on looking into the cell, saw the man suspended from the window bar. He used his radio to call a ‘code 1’ and called to the other officer before going into the cell. (Code 1 refers to the emergency coding system used at Wormwood Scrubs to indicate to staff that a prisoner requires urgent medical assistance and is not breathing.)
58. The officer supported the man’s body. In his statement, he says that, as he did so, the ligature came away from the window bars without being cut. As the ligature came away, the man fell forward on to the officer who laid him on the floor. By this time, other staff had responded to the radio call and a Principal Officer (PO) had joined him in the cell. Another officer helped to move the man on to his back. The PO and one of the officer’s started cardio pulmonary resuscitation (CPR).
59. A nurse arrived at 7.20am and brought the emergency equipment, including a defibrillator and oxygen. (A defibrillator can be attached to a patient who may be in cardiac arrest, and delivers a controlled electrical shock to get the heart back into a correct rhythm. It cannot restart a heart that has no output.) The nurse immediately attached the defibrillator to the man’s chest and began giving him oxygen. The defibrillator advised that there was no shockable rhythm to his heart and the staff continued their attempts to resuscitate until the emergency paramedics arrived at around 7.25am.
60. Staff gave the paramedics a full explanation of what had happened and the treatment that had been given. The paramedics continued resuscitation, administering drugs directly into the vein and eventually managed to get a pulse. The man was taken by ambulance to Charing Cross Hospital. Two members of staff went with him as an escort but no restraints were used due to the severity of his condition.
61. On the way to the hospital the paramedics continued to treat him and attempted to stabilise his heartbeat. Staff at the hospital continued to treat him. Despite the efforts of staff, paramedics and emergency staff at Charing Cross Hospital, The man was pronounced dead at 9.13am, by a hospital doctor.

Following the man’s death

62. The prison attempted to notify the man’s sister who was his appointed next of kin of his death during the morning of 5 March. However, the prison were unable to make contact via the two telephone numbers that they had recorded. The prison made enquiries to ascertain other numbers that the man had contacted while in custody and identified the contact number for a regular visitor.
63. A message was left on an answering machine and the prison received a call back from the best friend of the man’s sister. The prison explained what had

happened and the friend agreed to pass on the information. Further contact was made and the prisons nominated family liaison officer, along with a member of staff who was fluent in Tamil visited the family on 8 March.

64. The staff involved were supported and a hot debrief was co-ordinated by the chaplaincy team at the prison. The man's friend who had discovered him and raised the alarm was also offered support and the prison arranged to postpone his court appearance that day.

ISSUES

Prevention of suicide and self-harm procedures

65. When the man harmed himself on 22 January, the prevention of suicide and self-harm procedures were correctly put in place. The ACCT document went with the man to hospital as is the correct process and staff completed the observations and made the necessary entries. Due to going straight to hospital for treatment, an assessment which should take place within 24 hours was not completed until he returned to prison. This was in line with the guidelines set out in Prison Service Order (PSO) 2700.
66. The assessment conducted on his return to Wormwood Scrubs records little information that would provide any more insight into how the man was feeling, but this may have been due to the man's reluctance to share his feelings.
67. The decision to place the man on constant supervision when he returned from outside hospital should have triggered enhanced reviews of his ACCT plan. This did not happen. PSO 2700 sets out instructions on every aspect of the procedures that should be followed and included within the prison's own suicide and self-harm policy. In relation to constant supervision, the PSO states that when a prisoner is placed on constant supervision during the day, an ACCT review chaired by either the duty governor or head of healthcare must take place as soon as is practical, but at least within four hours. When constant supervision begins during the evening or night, the review must take place within four hours of the prisoner being unlocked the following morning. The reviews should be chaired by the duty governor or head of healthcare and take place daily for the first 72 hours. Constant supervision should only continue beyond this period in extreme cases.
68. The first review of the man's ACCT monitoring followed the assessment and was attended by nursing staff and the consultant psychiatrist. Neither a governor, nor the head of healthcare attended nor were they notified. It was conducted as part of the psychiatrist's normal ward rounds and the man was not taken to a separate office or private area for the review. During this first review, it was recorded that constant supervision should continue until at least 28 January. No further reviews took place on the man's ACCT between 25 January and 28 January, despite him remaining on constant supervision.
69. While on constant supervision, the entries made in the ACCT document of interactions with the man were of a good standard. The constant supervision was conducted by agency nurses who were brought in specifically to fulfil this task. As mentioned earlier in this report, the requirements for conducting such levels of monitoring are set out in PSO 2700. The PSO says that constant supervision can be carried out by anyone, but they should be competent to carry out such observations. The PSO does not exclude agency nursing staff from conducting these observations, but they are expected to have some understanding of ACCT procedures and the recording requirements. During the investigation, Mr Williamson was told that the prison

was working with the agency that supplied the staff to provide some ACCT training, but this was still ongoing.

70. When the man returned to the residential unit, his ACCT monitoring continued, but subsequent reviews were poorly attended, usually only by two residential staff and the man. No involvement from healthcare or mental health staff was requested. There was no review following the second episode of self-harm on 8 February. The PSO dictates that a review of an ACCT must take place following any act of self-harm.
71. While living on both healthcare and the residential unit, the man was given nothing to keep him occupied. Referrals were made to both the Seacole Centre and the education department when he returned to the residential unit, but there is no evidence of anything actually being provided. PSO 2700 links purposeful activity with a reduction in self-harm, and the provision of such interventions is seen as good practice.
72. The investigation found that the procedures in place at Wormwood Scrubs at the time of the man's death were not in line with those set out in PSO 2700. Equally, the prison was in the process of making changes not only to the way ACCT is managed and delivered, but also to other internal healthcare processes. However, they do not appear to have been in place at that time. Since The man's death the prison has made a number of changes which were communicated to the investigator by the Head of Safer Custody. They include:
 - The provision of guidance books for healthcare assistants who are assigned to conduct constant supervision. These books provide advice on the levels of interaction required, and reinforce the requirement for interaction and not just supervision. Governor Emmett has told the investigator that the prison hopes to deliver ACCT training to agency staff in the future.
 - All ACCT documents are now kept inside individual folders. The inside cover of these folders provides advice to staff on procedures such as how an ACCT should be opened, who should attend case reviews, roles of case managers and other individuals involved with the ACCT process, in addition to advice on recording information within the ACCT.
 - The Safer Custody team at Wormwood Scrubs also issues Safer Custody Learning Bulletins, to remind staff of the importance of the ACCT and explain any changes to the safer custody policy.
 - The prison published a new policy for 'Constant Supervision, Gated Observation Cells and Alternative Clothing' in April 2010. This new policy provides information on 'enhanced' case reviews, including when and by whom they should be conducted. The policy defines the use of both a 'gated cell' and the rules around placing a prisoner in alternative clothing.

- In addition to the policy, the prison has also introduced a separate document for recording all prisoners who are placed on either constant supervision, in a gated cell or subject to alternative clothing.

73. During the investigation, the prison demonstrated that there had been changes to the way ACCT is managed with a view to improving safer custody measures within the prison and the changes are ongoing. I welcome those that have already been implemented, but make the following additional recommendations about ACCT procedures.

The Governor should satisfy himself that the new arrangements for managing prisoners subject to constant supervision are stringent and working effectively.

The Governor should ensure that all staff who carry out the role of Case managers in the ACCT process have completed the necessary element of the ACCT training course, regardless of whether they are clinical or discipline staff.

In relation to ACCT case reviews the Governor should ensure that the requirements of PSO 2700 are being followed, especially in relation to conducting reviews during healthcare ward rounds, a practice which should be stopped.

The Governor should ensure that the provision of purposeful activity becomes an integral part of the Suicide and Self-Harm Prevention Policy, in line with the guidance in PSO 2700.

Alternative clothing

74. As with constant supervision, PSO 2700 describes the use of alternative clothing as “a last resort” to be used for the shortest time possible. There are also requirements for recording when such interventions are used and the reasons for doing so. In the man’s case neither was recorded. The investigation was unable to clearly identify exactly when the man was required to wear alternative clothing, and staff were unable to explain the requirements for this intervention. Documentation considered during the investigation indicates that the man was subject to these restrictions for over 48 hours, but the absence of the records means that it could not be confirmed.

75. Issues arising from enhanced case reviews, and alternative clothing have been explored in previous investigations into deaths at Wormwood Scrubs. As previously mentioned, the new policy should give staff a better understanding of these interventions, and will record all prisoners who are subject to them. Nevertheless, I make the following recommendation in relation the use of gated cells, constant supervision and alternative clothing:

The Governor should ensure that a record is kept when a prisoner is placed in a gated cell, on constant supervision or alternative clothing, and also the date that these interventions come to an end.

Clinical care

76. Following the man's death, Hammersmith and Fulham Primary Care Trust commissioned a full review of the medical care afforded to him while in custody. The report produced is attached in full as annex 1 of my report.
77. The PCT have highlighted six issues relating to the delivery of care and service delivery, some of which fall outside the remit of my office.
- Clinical care whilst in hospital -
Prescription of benzodiazepines
Communication between prison and hospital psychiatrists
 - Clinical care on the prison healthcare unit
 - Clinical care on the residential wing
 - Prescribing issues
 - Management of self-harm
 - Record keeping
78. In identifying the contributory factors, the PCT record the following in their report:
- Failure to use a Care Plan resulted in poor coordination of care on the healthcare centre and inadequate discharge and aftercare planning.
 - Absence of a medicines reconciliation policy resulted in drug errors being made and possible side effects.
 - Confusion over the roles and responsibilities of different professionals within the healthcare team resulted in poorly coordinated and delivered care.
79. The issues raised by the PCT in relation to the management of self-harm have already been addressed by my investigation, and recommendations made accordingly.
80. In addition to the clinical review being annexed to this report, NHS Hammersmith & Fulham, Prison Partnership Board, Prison Transformation Project Board, Director of Services, Central London Community Healthcare (CLCH), and the PCT Clinical Governance & Risk Management Committee will receive copies of the report to monitor the progress towards

implementation of the recommendations made. The prison-based clinical governance forum and service managers will receive a copy for local review and implementation.

81. The managing directors of NHS Hammersmith & Fulham, CLCH & Central and North West London (CNWL) NHS Foundation Trust will also receive copies for information.
82. The clinical review panel has made 24 recommendations in total, arising from the six headings mentioned earlier these are:
 - We recommend that clinical staff at HMP Wormwood Scrubs should liaise with hospital teams to clarify the rationale for prescription recommendations if it is not clear from the discharge summaries received.
 - Recommend that enquiries are made of Hammersmith & Chelsea & Westminster hospitals regarding protocols or policies in relation to benzodiazepine prescriptions.
 - Recommend that staff providing out of hours psychiatric care at Hammersmith Hospital should be made aware that their ongoing duty of care to a patient requires them to communicate promptly and adequately with colleagues outside the hospital to whom they are transferring care.
 - Recommend that NMC guidelines are followed for completion of nursing plans and that these are regularly audited.
 - Recommend that the prison GP visits the healthcare centre daily and reviews all patients with the nurse in charge for physical health problems.
 - Recommend that clarity is given to doctors about who has day to day clinical responsibility for patients on healthcare centre and responsibility for clinical leadership.
 - Recommend that the mental health team should adopt the care programme approach to improve co ordination of care for mentally disordered prisoners.
 - Recommend that patients requiring mental health follow up should not be discharged from the healthcare centre unless a member of the in-reach nursing team has attended a clinical discharge meeting and received an adequate handover.
 - Recommend that there continues to be clarity about which prisoners are being managed by CMP and that 'informal' arrangements do not recur.

- Recommend that there is improved clarity of the roles of CMP, how its remit differs from other prison mental health services and how it interfaces with the prison mental health team.
- Recommend that the process for liaison with GPs in the community is reviewed to ensure that requests for information from GPs (& other healthcare professionals) are processed effectively & efficiently.
- Recommend that a medicines reconciliation policy is introduced to ensure that medication recommended in discharge letters is accurately prescribed.
- Recommend that the prison introduces a policy regarding the prescription of benzodiazepines.
- Recommend that when psychiatric medication is commenced by a psychiatrist, psychiatric staff are responsible for its continuation and for review of the patient unless agreed with GP in advance.
- Recommend that all patients are seen face to face when re-prescribing.
- Recommend that pharmacy and nursing staff are responsible for ensuring medicines reconciliation and that there is close monitoring to ensure stock does not run out.
- Recommend that the new medicines reconciliation policy also requires checking for drug allergies/sensitivities to ensure relevant information is passed on to prison healthcare team.
- Recommend that the new system whereby medication is not dispensed unless it is recorded on both electronic and paper based prescribing systems continues.
- Recommend that CBT and structured therapeutic activity should be made available in a timely manner to all offenders identified as having ongoing mental health problems in line with NSF guidelines for mental health and NICE depression guidance.
- Recommend that paperwork is completed for all prisoners placed in protective clothing/bedding detailing reasons for these decisions and clearly documenting reasons for its continuation or date and time of its discontinuation.
- Recommend that anyone doing continuous observations must be trained to level 1 ACCT standards.
- Recommend that case managers must have completed ACCT training to an appropriate level.

- Recommend that the Head of Offender Healthcare, a nominated prison service governor and the Head of Information Governance develop and implement an information sharing protocol to address communication issues. Head of Healthcare is also asked to ensure that all healthcare staff are aware of the importance of sharing risk and care information and that this does not contradict professional guidelines.
- Recommend that there is a single integrated record for clinical notes and no separate paper records are kept.
- Recommend that the prison partnership board, commissioning PCT, mental health trust and primary healthcare provider are asked to prioritise a review of current governance arrangements to ensure that all stakeholders are working to the same coordinated practices, protocols and procedures with common goals and with service delivery clearly integrated into all aspects of those teams responsible for providing care to offenders.

CONCLUSION

83. The evidence considered during the investigation by the investigator and the clinical review panel identified the man as a troubled individual with complex mental health needs who was struggling to cope with his situation. He had been identified as being a high risk of deliberate self-harm, having harmed himself by cutting his wrists and the severity of this indicated that he was actively attempting to end his life.
84. The clinical review panel felt that the prison's local team working and information sharing practices are fragmented between prison and healthcare staff. This was exacerbated by lack of use of care plans, absence of a medicines reconciliation policy and confusion over roles and responsibilities within the healthcare team.
85. It is not possible to determine whether the man's death could have been prevented. However, the view of the clinical review panel is that his risk may have been reduced had there been improved planning of his care pathway, monitoring of his medication and understanding of the different roles and responsibilities of team members within healthcare overseen by robust multi-agency governance arrangements.
86. While my report identifies that at the time the man was being held within the healthcare centre, the policies and processes being followed were not in line with Prison Service instructions, or medical guidelines, I also recognize the steps that have been taken by the prison to address these areas of concern and that it is an ongoing process.

Family response to draft report

87. Having read my draft report the man's sister felt there were numerous failings in the care her brother received at Wormwood Scrubs, which she feels ultimately led to his death. It is very important to her and her family that lessons be learned for the benefit of other prisoners.
88. In relation to her brother's mental health, she said her brother suffered with mental health problems. She said he had difficulty retaining information and would easily forget what was said to him, sometimes just minutes before. The man's sister said her brother had been very anxious about his forthcoming court hearing on 26 April.
89. The man's sister said that they were very concerned about the apparent failure of healthcare staff to take responsibility for her brother's mental health care. She believed the confusion over roles and responsibilities within the healthcare team were instrumental in the man, "a vulnerable prisoner", not receiving the necessary care and support.
90. She was also very concerned by the lack of information sharing between medical professionals, which led to the inappropriate prescribing of Citalopram, a drug that in some cases can increase the risk of suicide.
91. The man's sister said her brother had told her he felt very alone and depressed and that he had asked to share a cell as he did not want to be alone. She questioned the prison's failure to assess his suitability to share a cell following his request. She felt this should have been acted on given his obvious distress at being in a cell alone and the fact he was a remand prisoner. She feels that he had made the prison aware that he was not fit to be on his own and believe that the prison's failure to act on this information was a contributing factor in his death.
92. The investigator explained to the family when he met with them on 12 April to discuss the draft report, that the man was considered 'high' risk due to the nature of the charges for which he had been remanded and the prison service had to follow certain procedures. As he had been charged with a violent offence, the prison had to consider the safety of other prisoners. The prison did also move him to another cell that had better natural light, on the opposite side of the residential wing.
93. The man had previously self-harmed while in Wormwood Scrubs and his family questioned the quality and appropriateness of the self-harm monitoring, given that he was able to take his own life, despite preventative measures being in place at this time. The investigator explained that issues with the self-harm monitoring procedures at the prison had been raised within the report. He also explained that while the ACCT procedures do highlight those considered at risk and provide extra monitoring, prisoners who are on ACCT unfortunately do still manage at times to self-harm.

94. The man's sister described her brother's understanding and spoken English at around 40%. She explained, however, that during mental health episodes his ability to understand and speak, even in his first language (Tamil) was drastically reduced. She is concerned that translation services were not used at any time during her brother's time at Wormwood Scrubs, particularly when translation services were available for staff to use.
95. The description given by the man's sister as to his level of English is in contrast to the description provided by prison staff during my investigation. Those staff that were interviewed and asked how well the man was able to communicate told my investigator that he communicated his needs well.
96. The man's sister is concerned that prisoners are provided with bed sheets that can so easily be torn into ligatures. The investigator explained that this is normal bedding provided to prisoners, and is standard across the prison estate.
97. Concerns were also raised that the OSG did not notice any change in the man's demeanour when she looked in the cell at 6:40am. His sister believes it must have been possible to tell that he was hanging at this time. The investigator explained that in the statements provided by staff including the OSG there is no indication that her brother was hanging when checked at 6:40am. The OSG said that he was "standing by the window." The information provided by the man's friend, when he looked into the cell at 7.10am, was that he could see the man was hanging
98. The man's sister said her family found out about her brother's death from another prisoner, who had contacted his parents, who in turn had contacted their uncle. The man's uncle contacted the police for confirmation but the police were unable to confirm his death at that time. His sister said she did not recall being officially informed by the prison until much later that afternoon or possibly the following day, this was despite the prison having contact numbers for both her and their Uncle.
99. The investigator contacted the prison to clarify how the family were notified of The man's death. He was told that the member of staff who had been appointed as the prison family liaison attempted to contact the family on two separate numbers on 5 March, as no address was recorded. However, he did not manage to get a response and the prison then looked at other numbers that the man had contacted while in custody, and identified a number of someone who had been a regular visitor. The prison left a message on this number and then received a call back from the best friend of the man's sister. The prison explained what had happened and the friend agreed to pass on the information.
100. The prison liaison made further contact in the following days, and both he and a Tamil speaking member of staff visited the family on 8 March at their home.

RECOMMENDATIONS

1. The Governor should satisfy himself that the new arrangements for managing prisoners subject to constant supervision are stringent and working effectively.

In response to this recommendation the Prison service said:

A manager from HMP Latchmere House will be asked to review the current policy and practices in line with the PSO and local operating instructions. Target for this to be completed is 31 July 2011

2. The Governor should ensure that all staff who carry out the role of Case Managers in the ACCT process have completed the necessary element of the ACCT training course, regardless of whether they are clinical or discipline staff.

In response to this recommendation the Prison Service said:

An enhanced training schedule is to be launched in January 2011 this will ensure all staff receive the necessary level of training and the refresher dates are recorded on the Safer Custody database. Target for this to be completed is 31 December 2011.

3. In relation to ACCT case reviews the Governor should ensure that the requirements of PSO 2700 are being followed, especially in relation to conducting reviews during healthcare ward rounds, a practice which should be stopped.

In response to this recommendation the Prison Service said:

ACCT case reviews are now not carried out as part of the ward round and are seen on a one to one basis in a separate case review. This has been completed.

4. The Governor should ensure that the provision of purposeful activity becomes an integral part of the Suicide and Self-Harm Prevention Policy, in line with the guidance in PSO 2700.

In response to this recommendation the Prison Service said:

All newly opened ACCT's are now interviewed and any possible intervention is recorded on the care plan, this is then e-mailed to all residential managers for follow up action. All relevant referrals are firstly initiated by safer custody team. This is followed up once a week and progress e-mailed to SMT members. Those located in healthcare and segregation units have access to education and other activities built into the regime of the units. Target for this to be completed is 31 July 2011.

5. The Governor should ensure that a record is kept when a prisoner is placed in a gated cell, on constant supervision or alternative clothing, and also the date that these interventions come to an end.

In response to this recommendation the Prison Service said:

This has already been completed as part of a recommendation following an earlier PPO investigation.