

A Report by the
Prisons and
Probation
Ombudsman
Nigel Newcomen CBE

**Investigation into the death of a man
on 15 June 2013 while in the custody of
HMP Wormwood Scrubs**

Our Vision

*'To be a leading, independent investigatory body,
a model to others, that makes a significant contribution to
safer, fairer custody and offender supervision'*

This is the investigation report into the death on 15 June 2013 of a prisoner at HMP Wormwood Scrubs who was found hanging in his cell. The man was 40 years old. I offer my condolences to his family and friends.

An investigator was appointed and a doctor reviewed the clinical care the man received in prison.

The man was arrested for harassment on 12 June. While he was in police custody, he was closely supervised because of his evident vulnerability. The man was sentenced to eight weeks imprisonment the next day, 13 June. After sentencing, he was taken from court to hospital because he appeared to have had a seizure. He was discharged from hospital later that afternoon, with no apparent physical problems, and sent to Wormwood Scrubs. Prison staff began suicide prevention procedures and the man was monitored hourly. He spent the night in a dormitory cell in the prison's first night centre.

The next morning, 14 June, the man appeared withdrawn and later began to make distressed noises and behave erratically. The wing manager, who was unaware that a doctor had said that the man should have a shared cell, moved him to a cell on his own, as he was disturbing the other prisoners. Despite the man's apparent distress, the manager did not consider increasing the frequency of monitoring checks or ask a mental health nurse to assess him. The man hanged himself just over an hour later. Cardiopulmonary resuscitation did not begin until healthcare staff arrived and paramedics subsequently established a pulse. The man was taken to hospital, but he died from his injuries the next morning.

I am concerned that staff in the first night centre were not fully aware of the man's risk of suicide and did not recognise that the changes in his mood and erratic actions that morning could have been signs of mental distress. I am also concerned that Wormwood Scrubs has a rigid practice of placing all prisoners at risk on hourly observations for the first 24 hours of self-harm monitoring, without taking into account individual needs or responding to any apparent change in risk. Finally, there remains some confusion as to the nature and adequacy of the emergency response in the man's case, from which lessons need to be learned.

Nigel Newcomen CBE
Prisons and Probation Ombudsman

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SUMMARY

1. The man committed an offence of harassment against a former partner and was arrested by the police on 12 June. He was taken to the police station, where he was initially kept under constant observation because of his vulnerability. He said that he had recently tried to take his own life. The man then appeared to collapse so he was taken to hospital. He was discharged and returned to the police station and kept under observation in a camera cell for the rest of the night and checked by staff every 30 minutes.
2. The next day, 13 June, the man was sentenced to eight weeks in prison. He seemed to collapse again in the cells, so he was taken to hospital again, where the emergency doctor did not think that an apparent seizure was genuine. The man was discharged and taken to HMP Wormwood Scrubs, where staff began suicide and self-harm monitoring and he was checked once every hour. He spent his first night in the prison in a shared dormitory. He was seen by a nurse and then a doctor, who prescribed antidepressant medication and a sedative.
3. Early the next morning, a nurse checked the man after he appeared to have another seizure in the dormitory cell. Again, the nurse suspected that this was not a genuine seizure. The man attended an assessment interview to identify the issues which were causing him distress, but did not cooperate. At lunchtime, he started wailing and making other sounds of distress. As he was disturbing the other prisoners, he was moved to a single cell. Staff did not increase the frequency of observations or arrange for a mental health nurse to see him.
4. An hour and 15 minutes after the man moved to the single cell, he was found hanging by the wing manager. He was initially revived and taken to hospital, but died the next day.
5. The investigation has identified that prison staff did not sufficiently consider the man's safety when he was moved to a single cell. They did not recognise his signs of mental distress, which they regarded as a behavioural issue rather than one of mental health. We were concerned to learn that there is no differentiation in the frequency of monitoring on the first night centre at Wormwood Scrubs. Prisoners regarded as at risk of suicide have hourly checks as a matter of course for their first 24 hours. Monitoring is not tailored to a prisoner's individual needs. We make seven recommendations as a result of the investigation.

THE INVESTIGATION PROCESS

6. The investigator visited HMP Wormwood Scrubs on 25 June and met the deputy governor and the investigation liaison officer. He visited the first night centre where the man died and interviewed the four prisoners who had shared a dormitory with the man. The investigator collected relevant records.
7. NHS England (London region) commissioned a doctor to review the man's clinical care in custody.
8. On 9 July, the investigator and the clinical reviewer interviewed seven staff at Wormwood Scrubs. The investigator informed the Governor of his initial findings and later followed this up in writing. He interviewed six more staff at the prison on 26 July.
9. A copy of our report has been sent to the local Coroner.
10. The man did not appear to have any family in the UK but eventually the prison's family liaison officer and the Coroner's officer established that his mother lived in India. The man's body was cremated and his ashes returned to India. Our family liaison officer emailed the man's mother about the investigation, asking if she wished to see our draft report, but received no reply. Our family liaison officer will also contact the man's mother to ask her if she wishes to see this final version of the report.

HMP WORMWOOD SCRUBS

11. HMP Wormwood Scrubs is a large local prison in West London which can hold more than 1,200 adult male prisoners. In addition to the five main residential units, there is an induction unit, an inpatient healthcare centre, and a dedicated drug stabilisation unit.

Independent Monitoring Board

12. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who oversee all aspects of prison life to help ensure that prisoners are treated fairly and decently. In its most recent annual report (to 31 May 2013), the IMB reported that their concerns about the safety of both staff and prisoners had increased during the year. The Board noted that interpreting services were often not used when needed, especially in ACCT reviews and that there was a lack of available ACCT assessors.

Her Majesty's Inspectorate of Prisons

13. The most recent inspection of Wormwood Scrubs was an unannounced full follow-up inspection in June 2011. Inspectors found significant improvements in the identification of prisoners' substance misuse needs and co-ordinating their care. Reception and induction were described as generally appropriate, with good arrangements to ensure drug and alcohol dependent prisoners received quick treatment. Inspectors judged that ACCT procedures were satisfactory, with thorough initial assessments, but identified risk factors were often too vague and not translated into actions in care plans and followed up at reviews. No named or key officers were identified and there was often no continuity of case management, which meant that concerns identified at reviews were not always followed up at subsequent reviews.
14. Primary health care had improved and there was less reliance on agency staff. Inspectors found that most prisoners were able to see a doctor reasonably quickly. Inspectors found that over 40% of prisoners were foreign nationals, many of whom did not speak English and some key policies did not take account of their specific circumstances. There was no nominated foreign nationals officer to coordinate work and services. Telephone interpreting services were little used including when confidentiality was required. Prison staff relied heavily on other prisoners to interpret and some language groups felt isolated.

Previous deaths at Wormwood Scrubs

15. There were three deaths at Wormwood Scrubs in 2012, one of which was self-inflicted. There were two further self-inflicted deaths at Wormwood Scrubs this year prior to the man's death.

Assessment, Care in Custody and Teamwork (ACCT)

16. Assessment, Care in Custody and Teamwork (ACCT) is the Prison Service process for supporting and monitoring prisoners at risk of harming themselves. The purpose of the ACCT is to try to determine the level of risk posed, the steps that might be taken to reduce this and the extent to which

staff need to monitor and supervise the prisoner. Checks should not be at predictable intervals to prevent the prisoner anticipating when they will occur. Part of the ACCT process involves assessing immediate needs and drawing up a caremap to identify the prisoner's most urgent issues and how they will be met. Regular multi-disciplinary reviews should be held. The ACCT plan should not be closed until all the actions of the caremap have been completed.

KEY EVENTS

17. The man pleaded guilty to a charge of harassment against his ex-partner on 1 June 2013.
18. On 6 June, a probation officer, using an interpreter, interviewed the man to complete a pre-sentence report. The man was originally from India and told the probation officer that he had been living in the UK for 14 years. He said that he was appealing a recent decision to refuse him permission to stay in the UK, as a result of which he was not allowed to work or claim benefits. He said that he had no family in the UK and few friends. The man failed to attend court for sentencing later that day.

12 June

19. On 12 June, the man was arrested and taken to Harrow Police Station. He was tearful and told the police doctor that he had wanted to take his own life at Southall railway station, two weeks earlier, but a friend had talked him out of it. The doctor assessed the man as fit to be detained but placed him under constant observation to keep him safe until he had 'calmed sufficiently'. This meant that an officer watched the man at all times and his cell door was kept open.
20. At 4.40pm, the man slumped to the floor of his cell. He seemed to be unconscious but was breathing and was taken to hospital. He returned to the police station at about 7.30pm, when the doctor saw him again. The man was placed in a cell equipped with CCTV and visited by an officer about every 30 minutes. During the night, he was reported to have screamed and shouted and to have rung his cell bell a lot.

13 June

21. The next morning, 13 June, the man appeared at Hendon Magistrates' Court. Police noted his recent suicidal thoughts at the railway station (referring erroneously to an actual attempt) on the Person Escort Record (PER) which accompanied him to court. The PER also indicated that the victim of the man's offence was his former partner, that the man had not engaged with the police doctor and that he might have undiagnosed depression.
22. At about 10.00am, the man was sentenced to eight weeks imprisonment for harassment. The court also imposed a restraining order forbidding the man from contacting his ex-partner.
23. After sentencing, the man was found lying on the floor of his court cell. He had a pulse and was breathing but was totally unresponsive. Court custody staff thought he was having a seizure and called a doctor and then an ambulance. Paramedics arrived and took the man to hospital as a precaution. Two Serco escort officers went with him in the ambulance.
24. The man arrived at the Central Middlesex Hospital Emergency Department at 12.26pm. An examination suggested that he had not had a fit and he was discharged later that afternoon. The emergency doctor noted on the man's discharge letter that he would benefit from a mental health assessment.

25. The man was taken from the hospital to HMP Wormwood Scrubs in a Serco escort vehicle. He arrived with copies of his PER, self-harm warning form, medical assessment from the police station and the discharge letter from the emergency department.
26. At 4.30pm in the prison's reception area, a Supervising Officer (SO) opened an Assessment, Care in Custody and Teamwork (ACCT) self-harm monitoring document for the man. On the ACCT 'Concern and Keep Safe' form the Supervising Officer wrote, 'PER states [self-harm] risk'. During his reception interview The man said that he felt stressed but would not harm himself.
27. At 5.35pm, the man moved to the first night centre, where prisoners spend their first 24 hours before moving to the induction wing. He was given a two minute free telephone call. There is no record of who he called because at that stage prisoners do not have individual telephone accounts. A Senior Officer spoke to the man, who was quiet and withdrawn. She told the investigator that he listened and nodded and seemed to understand what she said to him.
28. The Senior Officer completed an ACCT 'Immediate action plan', which required prison staff to check the man at least once an hour until his first ACCT case review which would be held the next day. The investigator was told that all newly arrived prisoners at Wormwood Scrubs who are subject to ACCT monitoring have hourly observations, unless their risk of suicide and self-harm is regarded as so high that they need constant supervision, in which case they are moved to the prison's healthcare centre.
29. At about 6.00pm, a Nurse completed a reception health screen. He told the investigator that the man was low in mood, tearful and finding it difficult to accept his imprisonment. The Nurse said that, although the man's understanding of English appeared reasonable, he tried to put him at ease by speaking Punjabi, the man's first language.
30. The man told the Nurse that he had seen his GP the week before and had been prescribed citalopram for depression and zopiclone to help him sleep. He said that he suffered from anxiety and insomnia. The Nurse did not think that the man was paranoid or hearing voices. The man told the nurse about his recent thoughts of suicide at Southall railway station and repeatedly said that life was not worth living anymore. He said that he did not have imminent thoughts of suicide but was unsure whether or not he would kill himself.
31. The Nurse wrote in the man's clinical record that he had not been in prison before and noted his admission to the emergency department earlier in the day. The police station medical assessment and emergency department discharge summary were scanned into the man's clinical record. The Nurse noted that the man had been under constant supervision at the police station, but did not record this in the ACCT document.
32. On the cell sharing risk assessment, the Nurse noted a possible diagnosis of epilepsy and recommended that the man be located in a flat location (where he would not need to use stairs) in a lower bunk bed. He recommended that the man attend the weekly Sikh service and contact the Sikh chaplain for

support. The man's mood had improved by the end of the interview and he was no longer crying.

33. At about 8.00pm, a doctor saw the man, whom he described as calm and coherent. The doctor read the emergency department discharge summary and knew that staff had begun ACCT monitoring. The man asked to share a cell and said that he was scared to be alone. The doctor wrote in the clinical record that hourly ACCT observations should continue until the man's case review or unless the risk escalated and that he should be held in a shared cell. He did not consider that the man required constant observation. The doctor wrote in the ACCT ongoing record that The man wanted to share a cell.
34. The doctor referred the man to the mental health in-reach team as recommended by the doctor in the hospital's emergency department. He prescribed a 28 day supply of citalopram and a three night supply of zopiclone.
35. The man spent the night in a dormitory cell with four other prisoners. The investigator spoke to the other four prisoners, who said that the man had been distressed and agitated and they had become increasingly worried about him. Five newly-arrived prisoners on the first night centre that night were subject to ACCT monitoring, three of whom, including the man, were in the same dormitory.
36. At about 9.00pm, the man spoke to a Nurse through the observation panel. He asked for his medication and the nurse reassured him he would get it. The man came out of his cell to collect the medication from the Nurse shortly afterwards.
37. When an Officer was carrying out an ACCT check at 10.00pm, the man asked him for medication. The man was lying in bed and the Officer asked him to come to the observation panel, but he would not get up. The Officer told the man that he would be able to see a nurse in the morning.
38. During the night, the Officer checked the man and the other two prisoners in the dormitory who were subject to ACCT monitoring at exactly hourly intervals at the same time each hour. The officer told the investigator that the man was mostly sleeping during the checks and there was no sign that he was agitated, distressed or crying. The officer said that it was a quiet night on the unit.

14 June

39. At 6.20am, one of the other prisoners in the dormitory shouted to the officer that there was something wrong with the man. The officer looked through the observation panel and saw that the man's arms were gently shaking but he was not violently fitting. He did not speak. The officer telephoned the nurse and said that a prisoner was lying on the cell floor and might have had a fit. The nurse and the night orderly officers came to the first night centre and The nurse checked the man. He was now lying on top of his bed covers and only his head was twitching. The man was conscious and there was no movement in his arms and legs. He was not rolling his eyes, he had not bitten his tongue and he had not wet himself.

40. The nurse was not convinced that these were the symptoms of a genuine seizure. He thought that the man had had a pseudo-fit (when a person is seemingly aware of what he is doing and his symptoms are not completely consistent with a fit). The nurse spent about two or three minutes with the man and did not give him any medication. The man then went to the toilet but did not speak. The nurse was satisfied that the man was not having a seizure. He asked the officers to monitor the man until the doctor saw him. The nurse booked an appointment for the man to see a GP later that morning. A Senior Officer began his day shift in charge of the first night centre at about 6.30am, as the nurse was checking the man.
41. At about 9.00am, healthcare staff faxed the man's GP surgery asking for his previous medical history. At about the same time, the man's mental health referral was discussed by the mental health in-reach team. They decided that he should initially be referred to the primary care mental health team because there was no indication that he had previously been under the care of a community mental health team or any evidence that he had a psychotic illness.
42. Meanwhile, the man attended a routine second day induction session. An Officer helped him complete an application for a telephone account so he could make telephone calls. His English seemed very basic. They spent about five or ten minutes doing this and the man gave her seven telephone numbers to add to his account. Two of these were for numbers outside the UK, three were friends in London and he said the other two belonged to his mother and uncle, although enquiries by the prison after his death indicated that the people on these numbers were not his relatives.
43. At 9.30am, an Officer interviewed the man for an initial ACCT assessment. As he began to explain the process, the Officer told the investigator that the man deliberately lowered his head to the desk and pretended to be asleep. The Officer spent a minute or two saying the man's name to rouse him but he did not answer. He checked that the man was breathing normally and then alerted two nurses in the treatment room on the other side of the corridor. A Nurse and a colleague came to check the man and when the nurse talked to him, he sat up, opened his eyes and responded.
44. The nurse then took the man to the treatment room to complete his routine second day health screening, which she had planned to do after his ACCT assessment interview. The man answered all of the nurse's questions. He said that he had been feeling depressed and hopeless for several days. The nurse completed a depression assessment tool and scored the man 6/30, a score which the nurse told the investigator indicated that he was depressed but did not suggest that he was likely to take his own life. The man seemed calm and made eye contact with her. He was not distressed or crying. The man was pleasant and cooperative and said nothing to indicate that he intended to take his own life. The nurse confirmed that the duty doctor would check him and dispensed citalopram.
45. After the curtailed assessment interview, the Officer wrote in each section of the man's ACCT assessment interview form, 'Unwilling to communicate'. He agreed with the Senior Officer that the duty ACCT assessor could interview

the man and a custodial manager then review him after he had been seen by healthcare staff and had moved to B wing at 2.00pm. They did not discuss whether the frequency of ACCT observations should be amended in the meantime and the man remained subject to hourly checks.

46. One of the Church of England chaplains, talked to the man through the cell door observation panel at 9.50am. He told her that he needed a solicitor, claimed that he was innocent and thought that he might be released because there had been a mistake. The chaplain gently tried to tell him that this was unlikely. She told the investigator that the man became tearful when he talked about his mother but she found it difficult to understand him because his English was limited. The man told her that he had mental health problems. He did not mention any suicidal thoughts and the chaplain did not think that he might take his own life.
47. The chaplain advised the man to speak to the Sikh chaplain and he agreed. The Sikh chaplain arrived at the prison at midday and the chaplain asked him to visit the man. He planned to do this at approximately 3.00pm after he had held a prearranged group session. At 10.50am, the Officer completed a routine ACCT check. The man was sitting on his bed and remained uncommunicative.
48. The duty doctor that morning, saw the man at about 11.00am. The duty doctor asked the man about his fits but he did not provide much information. The duty doctor told the investigator that the man's English was sufficiently good not to require an interpreting service. The man said he was not having any suicidal thoughts and the doctor did not think he appeared distressed. The duty doctor checked the information about the man and gave a probable diagnosis of pseudo-fitting. He recommended that the man should be located on the ground floor to minimise the risks associated with fitting and advised that staff should monitor any further seizures.
49. The Senior Officer told the investigator that he spoke to the man when he came out of his cell to collect his lunch at 11.15am, but he did not reply. Prisoners were then locked back in their cells by 11.30am. The prison staff lunch period was from 11.45am until 12.45pm. During the lunch hour an Officer responded to the man pressing his cell bell. She opened the cell door observation panel and told the investigator that the man appeared agitated and said, 'Please, please!' but did not articulate what was wrong, so she left him. The man pressed his cell bell again but this time he did not say anything to the officer. She told him to lie down.
50. At 12.40pm, the officer told the investigator that the man started moaning and wailing loudly but without voicing what was distressing him. The officer said that he was lying on his bed and making a crying sound but there were no tears. She called the man's name through the observation panel, but he did not respond. The officer went to the office where the Senior Officer and two Officers were taking their lunch break. She explained the situation and they all went to the man's cell. The other prisoners in the cell said that they had tried unsuccessfully to calm the man down.
51. The Senior Officer and another Officer went into the dormitory because the man was disturbing the other prisoners. They asked the man to be quiet, but

he continued to make a lot of noise and wave his arms. He did not threaten anyone but the staff believed that the man risked being assaulted by one of his cellmates if he did not quieten down. The officers told the investigator that they had viewed the incident as a discipline problem that needed resolving.

52. The Senior Officer was unaware of the doctor's advice that the man should share a cell and decided to move the man out of the dormitory because he was disturbing the other prisoners. The man did not move and continued to shout when the Senior Officer asked him to move. Although he did not cooperate, he did not actively resist. The Senior Officer took the man's left shoulder and the Officer took his right shoulder and supported and guided him to nearby cell 16. The Officer said that the man would have just sunk to the floor if they had let go of his arms. The man continued to make noises but started walking more independently once he was out in the corridor.
53. The man was on his own in cell 16. He was still moaning and wailing. The Senior Officer told the investigator that the man then became unruly and spat at him through the door observation panel and stuck his arm out. The Senior Officer said he pushed the man's arm back into the cell to shut the observation panel and the man repeatedly kicked the cell door.
54. The Senior Officer did not consider whether there was a need to increase the frequency of the man's ACCT observations. He did not hold a further ACCT case review or ask a mental health nurse to examine the man and did not discuss these options with the other officers. The SO told the investigator that he considered the incident to have been a discipline issue rather than indicative of mental distress which might affect his risk of suicide and self-harm. He said that he decided to move the man because his disruptive behaviour was disturbing the other prisoners rather than a manifestation of distress.
55. After the man was locked in cell 16, the staff returned to the wing office. At 1.15pm, the man calmed down and stopped banging and shouting. He knocked on his cell door. The Senior Officer and the officer spoke to him through the observation panel and he apologised for his behaviour. The Senior Officer made an entry in the ACCT document about this.
56. The man knocked on his cell door again a few minutes later and asked the officer for a drink and for his belongings which had been left in the dormitory. Another Officer took the man's property to the wing office and at about 1.25 pm, The officer and the Senior Officer told the investigator that they took his belongings, which included his turban, to the cell. The Senior Officer unlocked the door to give the man his property and told him that he would be moving to B wing at 2.00pm. He said that the man was polite and accepted a drink. This visit to the cell is not recorded in the ACCT document and CCTV footage is not available.
57. At about 1.58pm, the Senior Officer went to move the man to B wing. When he opened the cell door, he found the man had used his turban to hang himself from the hinge on the toilet door. The Senior Officer cut through the turban with his cut-down tool and radioed the control room to report a code 1 emergency (a life threatening situation) and ask for healthcare staff to attend

the first night centre. The man was not breathing. Control room staff immediately requested an emergency ambulance.

58. The Officer arrived in the cell when the Senior Officer was cutting through the man's turban and helped the Senior Officer to lay the man on the floor. The Officer told the investigator that he thought that the man did not look unconscious at this point and that there were signs of life and even that the man was breathing. However, the Officer was only in the cell for a few seconds and did not observe any rise and fall in his chest and did not check for a pulse.
59. The Officer was up to date with cardiopulmonary resuscitation (CPR) training, but told the investigator that he did not stay to try to resuscitate the man because he had seen what he thought were signs of life and because the Senior Officer did not ask him to do so. The Officer said he was worried about the number of prisoners out on the wing so left the cell to move them away. He said that when he returned to the cell, healthcare staff had arrived.
60. A Nurse heard the code 1 call on her radio in the inpatient unit, which is directly below the first night centre. On her way upstairs, she met the duty doctor and her manager and told them that an emergency had just been called. The duty doctor followed the Nurse a short distance behind and the Nurse went to alert the duty manager.
61. The Senior Officer told the investigator that he waited with the man until the healthcare staff arrived. However, the Nurse told the investigator that, when she reached the first night centre, she saw officers congregating at the far end of the corridor away from the man's cell. She did not know where the emergency was and assumed that the officers were near the scene. She headed towards them before they stopped her and directed her back in the direction of cell 16. She told the investigator that the Senior Officer was one of the staff who directed her.
62. The Nurse is quite certain that, when she reached the cell, the door was wide open and the man was alone and lying on the floor on his back. The turban was no longer around his neck. The Nurse is sure of this because she reported her concerns to her manager later that day. After finding the man in the cell, she immediately went to fetch three emergency response bags from the first night centre treatment room, a few yards away. (She had not brought these bags with her because she was not the designated emergency response nurse that day.) The bags included oxygen and a defibrillator.
63. The duty doctor was following slightly behind the Nurse. He told the investigator that he remembered the nurse and the Senior Officer both being in the cell when he arrived. When the duty doctor arrived, he began chest compressions and checked that an ambulance had been ordered. The nurse brought the emergency equipment and helped the duty doctor perform cardiopulmonary resuscitation (CPR). Another Nurse also brought a defibrillator, oxygen and an emergency bag. They were joined by five other healthcare staff.
64. Healthcare staff took it in turns to perform chest compressions and used a plastic airway to give the man oxygen. They attached a defibrillator, which

advised them repeatedly not to shock him because a shockable heart rhythm could not be found. A first response paramedic arrived by car at the prison gate at 2.08pm and reached the cell two minutes later. An ambulance followed at 2.10pm and was allowed into the grounds, parking by the first night centre. Another paramedic car arrived at 2.14pm and was also allowed to drive into the prison.

65. The man eventually regained a pulse after the paramedics gave him adrenaline. They continued to treat him and moved him by ambulance to St Mary's Hospital, Paddington at 3.07pm. He was escorted by two officers but was not handcuffed.
66. After the man was taken to hospital, prison managers held a hot debrief for all of the staff who responded to the emergency to discuss the incident and check their welfare. At about 6.30pm, the escort officers were told by hospital staff that the man no longer had any brain activity. Meanwhile, staff back at the prison had been trying to contact his next of kin. The numbers the man had given either were not answered or the person who answered said that they did not know him. The staff then showed the man's photo to other prisoners who they thought might be able to identify him from the Sikh community, but they did not. Staff also tried the numbers found on the man's mobile telephone in his property but were unable to locate any family members.

15 June

67. The man died at 5.45am the next morning, 15 June. The Sikh chaplain continued to try to contact his next of kin but had no success. It took two months for the Coroner's officer to establish that the man's closest relative and therefore his next of kin was his elderly mother who lived in India. She was unable to travel, so the prison agreed to pay for a Sikh funeral service and cremation. The prison's Sikh chaplain conducted the service and his ashes were returned to his mother.

ISSUES

Managing the risk of suicide and self-harm

Frequency of ACCT observations

68. We are concerned that staff did not set the frequency of the man's ACCT observations to take into account his individual risk factors. There were a number of predictors which made it more likely that he would take his own life, including his offence, his recent suicidal thoughts and the fact that it was his first time in prison.
69. Prison staff are expected to complete an Immediate Action Plan as soon as ACCT monitoring begins. An assessment interview and a first case review should then be held within 24 hours. The immediate action plan reminds the wing manager to consider the most appropriate regime to support the individual needs of the person at risk, after consulting them.
70. We found that the guidance in the immediate action plan is not being followed at Wormwood Scrubs. When staff open an ACCT document for a prisoner in reception, as a matter of course they set the frequency of observations as hourly until the first case review. The only exception is if a prisoner is considered to be at such high risk that constant supervision is needed. The safer custody department has instructed reception and first night staff to do this. These staff told the investigator that they have no discretion to set a different frequency of observations to reflect the needs of the individual prisoner. The rationale is apparently that a prisoner's risk to himself and therefore the correct frequency of observations cannot be determined until a full assessment interview and case review.
71. We were critical of this practice when we investigated deaths at Wormwood Scrubs in October 2012 and January 2013. We have previously recommended that staff should record the rationale for their decision making in the ACCT document. They did not do so in the man's case. We make the following recommendation:

The Governor should ensure that staff take account of a prisoner's individual risk factors and set the frequency of a prisoner's ACCT observations accordingly.

Sharing risk information

72. An officer tried to hold an assessment interview where risk factors could have been discussed, but the man did not cooperate. However, some risk factors were self evident and information about others was contained in the documents which arrived with The man in reception, in particular the following:
 - The police station medical assessment
 - The emergency department discharge letter
 - The Person Escort Record
 - The self-harm warning form

73. The first two documents were taken out of the core record in the reception area and given to healthcare staff to protect the man's confidential medical information. They were scanned into the clinical record the next day and then shredded. While this was standard procedure, the result was that some important information was not shared between healthcare and prison staff.
74. The Nurse saw a copy of the medical assessment conducted at the police station and wrote in the clinical record that the man had been subject to constant observation. However, he did not record this information in his ACCT entry. Consequently, the first night centre staff were unaware that the man had very recently caused a high level of concern at the police station. The doctor did not make it clear in his ACCT entry, his view that the man should share a cell. It is important that advice about safeguarding prisoners is communicated effectively. We make the following recommendation:

The Head of Healthcare should ensure that healthcare staff record all important information about a prisoner's risk of self-harm in the ACCT ongoing record.

75. The Clinical Reviewer reviewed the man's clinical care. He found that the doctor prescribed an antidepressant appropriately but that this drug had not been prescribed for long enough to have any effect on the man's mood. The clinical reviewer concluded that the clinical care the man received during his brief time in custody was comparable to that he could have expected to receive in the community. However, the clinical reviewer was concerned that the doctor's referral to the mental health in-reach team, did not mention his recent suicidal thoughts. This risk information might have prompted the team to review the man more urgently and without it they did not have a full picture of the man on which to base an assessment. We make the following recommendation based on the clinical reviewer's findings:

The Head of Healthcare should ensure that mental health referrals contain all relevant risk information to allow comprehensive and appropriately prioritised assessments.

Conducting ACCT checks

76. During the man's first night in custody, the Officer completed ACCT checks on the man and two other prisoners in his dormitory at 35 minutes past every hour. ACCT checks are supposed to be conducted at random intervals within the specified frequency, otherwise prisoners can all too easily predict a window of opportunity if they are planning to take their own life. We make the following recommendation:

The Governor should ensure that ACCT observations are conducted at random intervals within the specified frequency.

Responding to changes in risk

77. The day after he arrived, the man's behaviour and mood fluctuated considerably. He was completely uncooperative and withdrawn during an ACCT assessment interview. He behaved strangely, placing his head on the desk and pretending to be asleep. Later on, he started moaning and wailing

incessantly and then became aggressive to staff. His actions were becoming unpredictable and he was moved from a shared to a single cell in a state of distress.

78. The first night centre manager and his staff did not recognise the man's extreme and altering moods as a sign of mental distress or an indication that he might be at greater risk of suicide or self-harm. The Senior Officer viewed the man's behaviour solely as a discipline problem, even though he had not threatened anybody. He saw the risk to the man coming from the other prisoners in his dormitory, who he believed were so irritated by the man's behaviour that they might assault him.
79. The Senior Officer did not consider the increased risk the man would present to himself in a distressed state in a single cell. He did not take any action in response to the man's change in circumstances. We agree with the clinical reviewer that the Senior Officer should have asked for a member of healthcare staff to come and talk to the man as he was clearly exhibiting signs of distress. The investigator discussed these issues with the Senior Officer during interview. He maintained that, on the basis of the evidence available at the time, he would still not have called for a mental health nurse or that there was any reason to consider increasing the frequency of ACCT observations after the man was moved to a cell on his own.
80. The failure to increase the frequency of observations or bring forward the case review stemmed partly from the inflexible approach to ACCT monitoring we have already discussed. Staff did not think that the man warranted constant observation, so the best option which they felt was available to them on the first night centre was hourly checks. Measures routinely used at other prisons, such as up to five checks an hour or even half hourly checks, were not considered.
81. It became evident during interviews with first night centre staff that they were unwilling to re-evaluate a prisoner's risk before his assessment interview and case review. They viewed these stages of the ACCT process as the only appropriate forum for gathering information about risk and reviewing the frequency of observations. An adherence to rigid processes stopped officers and managers from thinking proactively to keep the man safe in the meantime.
82. Following this and other recent investigations, we are concerned that the ACCT process is not being implemented properly at Wormwood Scrubs. We are also concerned that staff on the first night centre lack understanding of how to identify distressed prisoners and when to call the mental health team. We make the following recommendation:

The Governor should ensure that all first night centre staff receive refresher ACCT training focusing on identifying risk factors for suicide and self-harm and identifying prisoners with mental health problems.

CCTV footage

83. The investigator requested CCTV footage of the first night centre to watch the man's move from the dormitory to the single cell and the emergency response

when he was found hanging. However, it is a concern that the footage could not be recovered. The safer custody manager wanted to satisfy himself that the footage had not been tampered with and had the equipment examined by an independent engineer, who confirmed that this had not been done. The system is now being updated. The effective operation of CCTV is an important aspect of safety in prisons and cameras should be checked regularly. We make the following recommendation:

The Governor should ensure that all CCTV systems are fully functional and regularly checked.

Emergency response

84. The nurse claims that the Senior Officer was not waiting with the man in cell 16 when she arrived on the first night centre. She is quite certain that the Senior Officer was standing in the corridor with his staff and that he had left the man alone in his cell after he had cut him down. We are concerned that prison officers did not begin CPR as soon as he was cut down. The nurse claims that she ran past cell 16 towards the officers at the far end of the corridor because nobody was in the cell to call to her. The investigator has confirmed that the nurse complained to her manager immediately after the emergency because she was so upset about this. She repeated her assertion during her interview some weeks later with the investigator.
85. The Senior Officer told the investigator that he did not leave the man until the healthcare staff entered the cell. The duty doctor supports this viewpoint, and says that the Senior Officer and the nurse were both in the cell when he arrived just a few seconds behind the nurse. It is regrettable that CCTV footage cannot allow us to say definitively what happened.
86. The Senior Officer did not perform cardiopulmonary resuscitation (CPR). The Officer had current training in CPR but also did not consider performing CPR because he thought that he had observed possible signs of life. However, he did not actually perform any checks to ensure that the man was breathing, such as looking for a rise and fall in his chest. As a CPR-trained member of staff, the Officer was best placed to stay with the man until the nurse arrived. The man had just been found hanging, and should have been monitored at the very least, but first aid advice is that better to do something rather than nothing in such situations and that even untrained staff can attempt chest compressions until trained personnel arrive. We make the following recommendation:

The Governor should ensure that all prison staff are briefed about the importance of beginning cardiopulmonary resuscitation as quickly as possible when a prisoner is unresponsive and not breathing normally and that they should carry out chest compressions until medically trained staff arrive.

RECOMMENDATIONS

1. The Governor should ensure that staff take account of a prisoner's individual risk factors and set the frequency of a prisoner's ACCT observations accordingly.
2. The Head of Healthcare should ensure that healthcare staff record all information about a prisoner's risk of self-harm in the ACCT ongoing record.
3. The Head of Healthcare should ensure that mental health referrals contain all relevant risk information to allow comprehensive and appropriately prioritised assessments.
4. The Governor should ensure that ACCT observations are conducted at random intervals within the specified frequency.
5. The Governor should ensure that all first night centre staff receive refresher ACCT training focusing on identifying risk factors for suicide and self-harm and identifying prisoners with mental health problems.
6. The Governor should ensure that all CCTV systems are fully functional and regularly checked.
7. The Governor should ensure that all prison staff are briefed about the importance of beginning cardiopulmonary resuscitation as quickly as possible when a prisoner is unresponsive and not breathing normally and that they should carry out chest compressions until medically trained staff arrive.

ACTION PLAN

No	Recommendation	Accepted/Not accepted	Response	Target date for completion	Progress (to be updated after 6 months)
1	The Governor should ensure that staff take account of a prisoner's individual risk factors and set the frequency of a prisoner's ACCT observations accordingly.	Accepted	Guidance will be issued to all staff outlining the risk factors that may be present and information that will allow the setting of observations according to the need of the individual.	30-05-2014	
2	The Head of Healthcare should ensure that healthcare staff record all information about a prisoner's risk of self-harm in the ACCT ongoing record.	Accepted	All healthcare staff attend yearly ACCT training and a focused piece of work is being done to ensure healthcare staff understand the importance of sharing information with prison colleagues using the ACCT document. GPs working in the Prison have received bespoke training from the Head of Safer Custody. A similar training	30-05-2014	

			<p>programme is planned for the nursing staff.</p> <p>The Prison and Healthcare are working together to ensure a multidisciplinary approach to ACCT reviews which reflects the new ways of working. This includes reviewing the timings of ACCT reviews and improving communication between prison staff and healthcare staff on the wings.</p>		
3	The Head of Healthcare should ensure that mental health referrals contain all relevant risk information to allow comprehensive and appropriately prioritised assessments.	Accepted	A change in how mental health referrals are reviewed was implemented immediately following this incident. The Mental Health Inreach team (MHIT) now review all information available about the prisoner when making decisions at referral meetings. Referrers have also been reminded to include all pertinent information on the MHIT	30-05-2014	

			<p>referral form. A revised MHIT referral form is in development which will make it easier to identify previous and current self-harm risks and triggers. The MHIT are able to upgrade routine referrals (5 day) to an urgent referral (24 hour) if following triage they feel there is an urgent risk.</p> <p>A full review of the mental health provision has been carried out with particular focus on providing mental health nursing sessions in Reception and First Night Centre. The proposal will be presented to the Prison Partnership Board in January 2014.</p>		
4	The Governor should ensure that ACCT observations are conducted at random intervals within the specified frequency.	Accepted	Guidance will be issued reminding staff of the frequency of observations. The need to make them frequent but irregular within the prescribed ACCT observations required.	30-05-2014	

5	The Governor should ensure that all first night centre staff receive refresher ACCT training focusing on identifying risk factors for suicide and self-harm and identifying prisoners with mental health problems.	Accepted	All staff will be provided the opportunity to attend annual refresher training. Staff within the FNC will be prioritised to attend the ACCT and mental health awareness training.	30-05-2014	
6	The Governor should ensure that all CCTV systems are fully functional and regularly checked.	Accepted	The FNC CCTV system has been replaced.	27-11-2013	Completed
7	The Governor should ensure that all prison staff are briefed about the importance of beginning	Accepted	All staff will be reminded of the importance of commencing CPR at the earliest opportunity and the reasons for this.	30-05-2014	

cardiopulmonary resuscitation as quickly as possible when a prisoner is unresponsive and not breathing normally and that they should carry out chest compressions until medically trained staff arrive.				
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