

**Investigation into the death in custody
of a man at**

HMP Wormwood Scrubs in August 2004

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

September 2005

CONTENTS

INTRODUCTION	3
SUMMARY	5
REPORT BY SENIOR INVESTIGATOR	8
INVESTIGATION PROCESS	8
HMP WORMWOOD SCRUBS	9
SUMMARY OF EVENTS FROM 9 JANUARY 2003 TO 8 AUGUST 2004	11
SUMMARY OF EVIDENCE FROM STAFF AND OTHERS INTERVIEWED	20
THE MAN'S DEATH.....	25
CHECK OF PRISONERS IN SEGREGATION AND CELLULAR CONFINEMENT.....	29
FINDINGS	31
CONCLUSIONS	34
LOCAL RECOMMENDATIONS.....	35
NATIONAL RECOMMENDATIONS.....	36
ANNEX A - INQUISITION	37

This is the report of an investigation into the circumstances surrounding a death at HMP Wormwood Scrubs in August 2004. The man who died was 29 years of age.

The investigation was conducted under the terms of the transitional arrangements agreed between my office and the Prison Service, which came into effect on 1 April 2004. The bulk of the investigative work has been conducted on my behalf by a Senior Investigator and an Assistant Investigator both from London Area Office. An independent clinical review was conducted by a doctor employed by Hammersmith and Fulham Primary Care Trust.

I have structured this report so that the Senior Investigator's report can be separately identified.

The Senior Investigator has asked me to offer through this report his sympathy and condolences to the man's mother, family and friends. I would like to take this opportunity to add my own condolences.

A colleague from my office liaised with the Senior Investigator throughout this investigation. My colleague also spoke with the man's mother and with her legal representatives.

I should like to record here my thanks to the prison Governor and his staff for the help the Investigators received during the investigation.

The man suffered from a depressive illness. His anxieties were doubtless further reinforced given the serious physical condition (acromegaly) with which he was diagnosed and for which he underwent surgery. This investigation and the clinical review have also revealed evidence of his suicidal ideation and probable instances of self-harm. However, little or nothing about the man's suicidal intent was known to the staff in closest contact with him.

I have thought carefully about the circumstances that led to the man being held in Wormwood Scrubs' segregation unit to serve a punishment of cellular confinement. Although undoubtedly severe, I cannot conclude that in the circumstances it was so unreasonable that had I considered it on appeal (as I do, as Ombudsman, in respect of many disciplinary punishments) I would have recommended it be mitigated. If there is a lesson here, it is that all decisions to impose cellular confinement, especially on those with some mental health problems, are inherently risky. I would like to see cellular confinement used much less frequently than is currently the case.

That said, among other matters that emerged at the inquest, was the fact that, contrary to the requirements of the Prison Discipline Manual, no medical practitioner carried out an assessment on 6 August of the man's physical, mental and emotional well-being. On that same day the man had refused all of his meals and had refused all of his medication.

The inquest into the man's death was held in February 2006. Further information emerged at inquest that had not been considered during my investigation. Accordingly, I have made changes to this report to take account of the new information. In addition, I have appended the form of inquisition to this report.

The man's death was the third self-inflicted death to have occurred at Wormwood Scrubs since I was entrusted with responsibility for these investigations and this is the first of the reports to be issued. To date, there would not appear to be any significant similarities in the circumstances surrounding the three deaths.

**STEPHEN SHAW CBE
PRISONS AND PROBATION OMBUDSMAN**

September 2005

Summary

On 24 February 2003, the man was convicted of armed robbery and more minor offences. He was sentenced to life imprisonment with a tariff of three years and seven months, but the sentence was not to commence until 11 December 2004, which was the expiry date of a previous sentence. On conviction, the man was first received into custody at HMP Norwich, before being transferred to HMP Wormwood Scrubs on 9 April 2003.

In July 2003, the man was diagnosed at outside hospital with a condition called acromegaly which, in the man's case, had been caused through the development of a pituitary adenoma (a non-cancerous tumour within the pituitary gland). As the tumour grows it may press on other structures within the brain, causing headaches and changes in vision. Acromegaly causes abnormal release of growth hormone resulting in growth of bone and soft tissue. Typically, an individual's hands, feet, jaw line and forehead will grow. The disease will also affect the individual's heart and lungs. Without treatment, patients with acromegaly are likely to die early. With treatment, a patient with acromegaly may be able to live a normal life span. The first step in treatment of acromegaly is surgical removal of all or part of the pituitary adenoma. The man had such surgery in March 2004. Following surgery, most patients with acromegaly will also require additional medication, and this was the case with this man.

It is clear that considerable efforts were made by medical staff within Wormwood Scrubs to support the man with his condition and need for pain relief. It is also clear that the man believed that not enough was being done to relieve his pain. There is some evidence that the man used class A and C drugs while in custody, although the frequency and amount used cannot be determined. However, any illicit drugs taken at the time he was also receiving prescribed medication may have had some effect on the efficiency of the prescribed analgesic drugs. The man's medical records and history sheets also show that on a number of occasions he refused treatment.

There was also an occasion when the man was referred for counselling, but then refused to see the counsellor. Instead, the man asked to see a psychiatrist, but there is no evidence that a psychiatric referral was ever made for him.

The man had access to a personal officer and a senior nurse at Wormwood Scrubs, both of whom built up a good relationship with him. Both members of staff were aware that the man was distressed both about his clinical condition and his treatment. However neither member of staff believed that the man was considering self-harm. The man was never subject to F2052SH procedures while at Wormwood Scrubs (the F2052SH procedure relates to handling of prisoners who might be at risk of self-harm or suicide).

Doctors assessing the man in relation to his potential for self-harm, on a number of occasions noted that there was such a risk, the last being on 11 May 2004 when a doctor made a note about this in the man's Lifer Sentence plan form. All entries in his medical record in relation to any noted or perceived risk were responded to by

some offer of support. This ranged from access to Samaritans to counselling. The man never mentioned to discipline staff that he ever thought of self-harm.

Many of the prison staff interviewed as part of this investigation described the man as a likeable person. However, he was involved in incidents of poor behaviour which led to him breaching prison rules on a number of occasions, for which he was subject to prison adjudication procedures. Entries in the man's medical record would not have been accessible to discipline staff managing him. Nevertheless, it is clear that many staff were aware that he was suffering from a serious clinical condition, even if they would not necessarily have known whether his condition could have an impact on his mood and behaviour.

On 31 July 2004, a charge was found proved at adjudication that the man had had in his possession a self-made grappling claw. Part of the adjudication penalty was 14 days' loss of his television. Despite that adjudication, on 3 August the man was found to be in possession of a television. This breach of behaviour was found proved at adjudication on 5 August, and the adjudication penalty this time was 14 days cellular confinement in the segregation unit.

Consistently, staff described the man as being annoyed or disgruntled with the adjudication penalty. However none of these staff thought that the man was distressed or depressed and none had any concern that the man might have been at risk of self-harm.

Although one officer said that the man was less upset on 6 August than he had been the day before, the man refused all of his meals and all of his medication that day. The Prison Discipline Manual requires that the man should have been seen by a health care professional on 6 August to assess his physical, mental and emotional well-being and fitness to remain in segregation. However, staff were unaware of this requirement, so no such assessment took place.

At some time around 7pm to 8pm on the evening of 6 August, the man had been chatting to three of the other prisoners in the segregation unit. None of the three thought of the man as the sort of person who would harm himself. The night officer carried out the final roll call of the day at about 9pm. At that time the man was sitting on his bed; he did not appear distressed.

The man was found hanging just after 8am the following morning. The man might have been discovered at 5am when the night officer carried out his morning roll call. However, when the night officer looked into the man's cell he did not identify anything amiss. He did not see the ligature around the man's neck and tied to the window frame and he simply assumed that the man was standing at his window.

Checks on prisoners in segregation were not routinely conducted between the final roll call at night – around 9pm – and the first roll call the following morning – which is at around 5am. This is endorsed by the prison's Local Security Document. Management and staff at Wormwood Scrubs were unaware of the provisions contained within the Prison Discipline Manual, which requires that prisoners in cellular confinement following an adjudication should be observed at least once

every hour. This omission has been brought to the attention of the Governor at Wormwood Scrubs.

This report makes 11 recommendations. The most significant is about the need to ensure that prisoners are checked with appropriate frequency. Several of the recommendations relate to the management of deaths in custody and preservation of evidence.

SENIOR INVESTIGATOR'S REPORT

Investigation Process

The Ombudsman appointed as Senior Investigator a serving operational governor grade at HMP Pentonville, subsequently transferred to London Area Office. The Senior Investigator's assistant was the Area Investigating Officer for London.

The Senior Investigator and the Ombudsman's representative initially met with the acting Governor of Wormwood Scrubs, a member of the Independent Monitoring Board and the prison liaison officer for this investigation.

The Senior Investigator carried out an initial sift of the evidence. From the initial sift the Senior Investigator identified staff to be interviewed and themes for questions. The Senior Investigator and the Ombudsman's representative agreed that, due to the complex nature of the man's clinical condition and its treatment, a clinical review would take place.

The Senior Investigator was assigned the investigation of the non-clinical elements of the man's death; the Ombudsman's representative assumed responsibility for organising the clinical review, inclusion of post mortem evidence and communication with the man's family. The man's mother raised a number of concerns. She was concerned that discipline staff were unaware of her son's clinical condition. She said that his clinical condition caused him to be depressed, both because of the condition itself and also because of insufficient and ineffective pain relief. She believed that her son's condition might have been responsible for some of his poor behaviour and staff did not take that into account. The man's mother was surprised to learn from the prison that her son had been left unchecked for several hours before he was found to be dead. She was also concerned about the delay in being informed of her son's death.

The Senior Investigator constructed the main body of the report and submitted it in the form of a draft report to the Ombudsman. The Ombudsman's office then drafted the final report based on the work both of the Senior Investigator and the Ombudsman's representative.

Due to the circumstances surrounding the man's death, the Senior Investigator examined documentation dating back to the man's initial reception into Wormwood Scrubs. These circumstances have also necessitated the inclusion and analysis of a large amount of documentary evidence.

Five of the interview tapes from the interviews with staff were later found to have been spoilt, so case notes were constructed. It is the Senior Investigator's view that this has not affected the analysis of the events.

HMP Wormwood Scrubs

HMP Wormwood Scrubs is a Victorian prison sited in west London. It holds a maximum population of 1,229 prisoners. The prison is staffed with 611 personnel of varying grades and roles. The prison predominantly serves West London courts and has very high reception and discharge rates for prisoners, averaging around 40 new prisoners each weekday. It holds a mixture of adult male convicted and unconvicted prisoners, the average ratio being nine to five respectively. Of the convicted prisoners in custody on 26 July 2004, 238 were serving life sentences.

The overall establishment rating is three (four being the highest overall standard and one the lowest). This rating is established from a number of factors, including performance against area prison targets, Prison Service National Standards and independent inspection by Her Majesty's Chief Inspector of Prisons (HMCIP).

In relation to Prison Service National standards, the establishment attained a rating of 'Good' for both non-security and security standards. At the last standards audit, suicide awareness and self-harm procedures were rated as 'Good', achieving a mark of 94%.

Following the last HMCIP inspection in November 2003, the Chief Inspector wrote in her report that:

'... nearly two years [on from the last inspection] we found a greatly improved prison, gradually implementing and consolidating fundamental changes – under a Governor who had stayed to see them through and senior managers who were actively managing staff and wings ... [in areas] such as the first night centre, the resettlement unit and drug strategy – there was evidence of real and sustained improvement ...'

HMCIP commented, with respect to preventing self-harm and suicide:

'3.17. Almost all of the concerns and recommendations arising from our last inspection had been fully addressed or were in the process of being responded to ...'

HMCIP's recommendations for further improvements were:

'3.26. There should be at least one appropriately decorated and furnished listener suite capable of accommodating a prisoner and two listeners overnight.'

'3.27. Work to create five safer cells should be completed.'

'3.28. The range of support mechanisms and specialist services available to those who are risk of self-harm or suicide should be expanded.'

'3.29. The rank and work load of the safer custody officer should be reviewed.'

'3.30. Staff should have sufficient personal contact with prisoners to enable them to assess and monitor changes in mood or behaviour and thereby anticipate and prevent incidents of self-harm ...'

In relation to the inspection recommendation points the following progress has been made:

'3.26. Completed.'

'3.27. [Work still not complete. No completion date at present].'

'3.28. Support mechanisms include SOS officers, day care, listener scheme, in-reach support and one-to-one counselling.'

'3.29. [No change in rank of safer custody officer but second officer appointed to lighten workload].'

'3.30. Existing practice.'

Prior to the man's death, there have been two apparently self-inflicted deaths in Wormwood Scrubs in July 2003.

Summary of events from 9 January 2003 to 8 August 2004

9 January 2003: The man was brought into custody at HMP Norwich in breach of his last sentence and on remand for his most recent offence. He was seen on reception. It was noted in his IMR (medical record) that he was assessed as having no self-harm issues.

10 February 2003: The man was assessed using the Offender Assessment System (OASys). He was assessed as at no risk of suicide or self-harm, and as not vulnerable. There were no previous concerns about him coping in custody, but there were current concerns as he said he was not sure how he would cope with a long sentence. It was noted that he had been prescribed anti-depressants in the past, that he stated he was abused as a child and had attempted suicide when in a young offenders unit. Also recorded was that he was under the influence of cannabis at time of his most recent crime, and was using heroin, cocaine and temazepam, and needed to commit crime to fund his habit.

24 February 2003: The man was seen on return from court by medical staff. Staff noted in his medical record that he had been sentenced to life imprisonment, that he was shocked and upset with the outcome but he had no thoughts of self-harm.

25 February 2003: Noted in IMR that the man asked to see Healthcare staff. He was given zopiclone (a drug used to treat insomnia) and advised to see the Governor about his life sentence.

25 February 2003: IMR noted that a message was passed by the court to HMP Norwich that the man might be suicidal. Staff talked to him and opened an F2052SH (a form raised when a prisoner might be at risk of self-harm).

12 March 2003: The man was prescribed zopiclone.

18 March 2003: Noted in IMR that the man stated that he felt that he could hurt someone when out of his cell ... this would give him a rush and a sense of power ... when he is bored gets a mild throbbing in his head. He can feel a vibration or a buzzy thing. This is sometimes accompanied by a mild headache. He asked for drugs to help him sleep and diazepam and zopiclone were prescribed. Need to chase up ENT (Ear, Nose and Throat) appointment.

28 March 2003: The man did not attend ENT clinic.

2 April 2003: Noted in IMR that the man refused to follow-up ENT appointment. He had waited many years and would re-arrange the appointment when settled in.

9 April 2003: The man received into Wormwood Scrubs. No medical complaints expressed. Not on medication. The man declined to see the Senior Medical Officer (SMO) and signed a disclaimer for his decision.

17 July 2003: The SMO, treating the man for a foot injury, noted unrelated symptoms that suggested acromegaly.

21 July 2003: SMO saw the man who was complaining of a headache, hyperactivity, and continued growth of facial bones, hands and feet etc.

1 August 2003: A referral letter was sent to a consultant endocrinologist for the man's symptoms of acromegaly to be investigated.

7 August 2003: SMO saw the man who recorded that he was anxious about acromegaly, wanting to know about it. SMO counselled him, drawing given, informed him that diagnosis not confirmed. Stress diagnosed.

13 August 2003: Noted on inmate intelligence card that the man and another prisoner had taken fabric out of the workshop.

7 September 2003: Noted on inmate intelligence card that the man's security file from previous custody had been received at Wormwood Scrubs. It contained notes on his previous convictions, drug habit, disorder, threatening and abusive behaviour, threats to staff, drug trafficking in custody, bullying and intimidation of other prisoners.

10 September 2003: The man sent to an outside hospital's Endocrinology department. The Lecturer in Endocrinology wrote to the SMO confirming diagnosis of acromegaly.

15 September 2003: The man complained of a headache for which he was given co-codemol.

16 September 2003: The man saw Healthcare complaining about headaches, especially at night. The man also complained about symptoms of vomiting, insomnia and nightmares. The man stated that he was feeling anxious and had relapsed into use of heroin. Medical staff counselled him to stop his use of heroin. The man stated that he did not like his current medication. Medical staff recorded his general condition as 'good'. Medical staff allowed the man to telephone his mother.

17 September 2003: The man spoke to his Personal Officer about his illness. The man said that he had not told his mother so the Personal Officer allowed him to telephone his mother in private by using the wing office, rather than using a pay phone on the landing.

19 September 2003: Healthcare staff wrote that the man was complaining of dizziness and headaches. Vital signs checked. He was encouraged to rest and a note was made that he was to be seen by a doctor on 22 September.

20 September 2003: The man's Personal Officer wrote up her report about the man. She described him as polite and courteous to staff and that he displayed generally good behaviour although he was stressed and confrontational that day. She also recorded that he appeared to be coping well with his clinical condition.

23 September 2003: Healthcare staff noted in the man's medical record that they had spoken to his mother. She was very worried and anxious about his condition.

The entry also said that the man's headache had improved, but not his insomnia. It was recorded that he did not like his prescribed medication.

27 September 2003: A member of the Healthcare staff noted in the man's medical record that his medication could not be found. Other staff were informed. At 1.40pm a nurse stated that she knew where the medication was and would administer it later.

2 October 2003: Healthcare staff wrote that the prescription of co-codemol had been stopped as it was not working and a new drug was prescribed. It was also noted that the man was still suffering sleep disturbance and that he was due for eye and visual field tests at outside hospital the following week (this appointment was later cancelled by the prison on operational grounds).

4 October 2003: Staff completed paperwork for the man's sentence plan review board. It was recorded that the man had a problem with drugs, but there were no concerns about his behaviour, indeed he was said to be polite and courteous to staff. The man was noted as seeming to be coping well with his clinical condition.

9 October 2003: For the purpose of the man's annual lifer review, his risk factors were identified. In compiling the list, staff would have considered factors including the man's social and medical history, his previous offences, and work he had done to address his offending behaviour. The risk factors listed included: poor coping when under threat, post traumatic stress disorder, depression, suicide risk, lack of consequential thinking, poor problem solving, anti social attitudes.

28 October 2003: Medical record noted that the man was upset about his symptoms of increased headache, diminishing vision in one eye and vomiting. He was transferred to outside hospital for MRI and CT scans. The man returned to Wormwood Scrubs on 31 October.

4 November 2003: The man completed a complaint form complaining that night staff would not provide adequate pain relief.

15 November to 16 December 2003: Various correspondence between outside hospital and doctor at Wormwood Scrubs discussing appointments, treatment and diagnosis.

6 December 2003: Healthcare staff recorded that the man had complained about a headache and pins and needles in legs. They also noted that he was awaiting neurosurgery.

9 December 2003: Healthcare staff noted that the man was still in pain, and that they had tried, unsuccessfully, to contact the outside hospital's Specialist Registrar in Endocrinology about a change of painkiller.

12 December 2003: Healthcare staff noted that the man had not taken one of his drugs for 4-5 days. He said the drug did not work and he claimed to be in pain. Staff noted that they had spoken to the outside hospital's Specialist Registrar in Endocrinology who stated that the man could get headaches due to his tumour and

that he could be allowed a change of medication. A change of medication was prescribed.

30 December 2003: Security records indicated that the man was found in possession of fermenting liquid and had misused electrical equipment.

31 December 2003: Noted in medical record that the GP for D wing had found the man to be fit and well and fit for adjudication and cellular confinement. He was not suicidal. In the segregation unit the man was noted as feeling sick and the medical officer changed him to being unfit for cellular confinement.

15 January 2004: Noted by Healthcare staff that the man was complaining of pain in his hands, occasional sweating, but he was not asthmatic. Drugs prescribed.

16 January 2004: Security records indicate that there was information that the man had retrieved a package thrown over the prison wall.

1 February 2004: Noted by Healthcare staff that the man was complaining of palpitations and a panic attack. He was complaining of heat and lack of ventilation in his cell. The note records that the man was not agitated, but was sitting reading a book. He declined advice to see a Samaritan or a Listener. He was given medication. He requested to see SMO on Tuesday. He was offered a cell move to 3s landing, but refused saying he could not manage the stairs. He requested a cell on 1s landing where windows were not welded. He was refused. He threatened to smash cell window if he did not get his own way.

3 February 2004: The first prison doctor wrote in the medical record that the man felt confused, had short-term memory loss, insomnia and worries. The man was expecting surgery, had prison and family problems, and felt despondent. He declined counselling. The first prison doctor added co-codemol to prescription.

4 February 2004: Note made in security report that the man was found in possession of a £5 note and had dangerously misused electrical equipment.

15 February 2004: Note made in security report that the man stated that another prisoner owed him £30.

16 February 2004: Note made in security report that the man was trying to find out the date of his next hospital appointment to prevent a clash with a legal visit. Information given to the prison indicated that the man allegedly had a mobile phone that he used to arrange for drugs to be left at outside hospital when he visited. He was also allegedly swapping his medication for heroin and allegedly dealing in drugs and that a lot of other prisoners were in debt to him.

17 February 2004: Noted by Healthcare staff that the man was awaiting surgery and wanted to change his prescribed painkillers.

26 February 2004: The first prison doctor noted in the man's medical record that he was complaining of insufficient pain relief and also of constipation. Extra medication prescribed.

2 March 2004: The man attended a clinic at outside hospital. He was found to be well and it was noted he was due to be admitted to hospital the following day in order to prepare for surgery on 5 March. The Consultant Endocrinologist noted that she would review him in May 2004. She asked the prison doctor to ensure that the man got his Hydrocortisone on time as this was very important.

3 March 2004: Noted in IMR that the man left prison for admission to outside hospital for surgery with possible stay of five to seven days.

3 March 2004: A security report referred to a lot of prisoner activity around three cells, one of which was the man's.

4 March 2004: The man underwent cranial surgery.

9 March 2004: The first prison doctor wrote in medical record that the man had returned from outside hospital. He was complaining of a headache, but was fully mobile. At 6.45pm the first prison doctor made a further entry noting that the man appeared to be stable. Medication given as prescribed.

9 March 2004: A note in a security report stated that a number of prisoners, including the man, were involved in drug distribution in prison.

10 March 2004: Noted in medical record that the man appeared to be stable. Baseline observations were completed. The man reported that he was feeling 'fairly fine' and was mainly concerned about being discharged to wing (D wing). Reviewed later by the first prison doctor who recorded that the man still had some discomfort and was finding his bed uncomfortable. The first prison doctor added – 'Allow [to go to] D wing'.

11 March 2004: The outside hospital wrote to the SMO informing him of appointment for the man in endocrine clinic on 30 March.

14 March 2004: Noted in security report that information had been received that the man had a mobile phone in his cell.

16 March 2004: Noted in security report that a mobile phone was found inside the man's in-cell television. Also found were a variety of screws, wires and blades.

16 March 2004: Noted in medical record that Healthcare had been called to see the man as he had a nose-bleed. Very minimal nose-bleed was observed on tissue. Medical staff instructed him not to blow his nose. He complained of dizziness and was advised to apply a cold compress to forehead. He declined Brufen for headache. He was advised to see a doctor the following day if still unwell.

17 March 2004: A letter from the outside hospital summarised the outcome of the man's operation.

19 March 2004: A letter from the outside hospital informed the man of an appointment for an Oral Glucose Tolerance Test on 6 April.

30 March 2004: Noted in medical record that the man had refused his prescription of Hydrocortisone. It was recorded that he was very upset about being placed on closed visits and about being accused of drug dealing on the wing. The risks of not taking his Hydrocortisone were explained, but he was adamant about refusing. The doctor was made aware of the situation.

31 March 2004: A lengthy note was made in the man's medical record by the first nurse that he was refusing his medication (Hydrocortisone), but was taking analgesia. The man was advised of the danger of not taking Hydrocortisone, but he said that he was aware of that.

1 April 2004: The second prison doctor made a note in the medical record that the man was still refusing Hydrocortisone, but wanted more of other drugs and painkillers, although he was already on analgesia.

6 April 2004: The man was unable to attend a pre-arranged Oral Glucose Tolerance Test as he had consumed food after midnight. A note was made by prison staff to say that the man had been informed that he should not eat after midnight. However, the man wrote an entry in his diary to say that he had not been so advised.

15 April 2004: The GP for D wing noted the man's medical record that he had complained of being unable to sleep, of headaches, of feeling tense and anxious. The man said he did not want to stop smoking, or to reduce his smoking. It was noted that the man was clinically okay with no obvious neurological signs. He was not suicidal.

27 April 2004: Medical record was noted by the GP for D wing that the man complained of pain all over his legs and ankles. Also noted clinically okay. He was taking Codeine Phosphate and he was trying to get more but there was no indication for that. Staff explained that Codeine was addictive and can cause constipation.

8 May 2004: Noted in medical record by the second nurse that at 3.00am Healthcare staff called to see the man who was complaining of a headache. Analgesia was given.

11 May 2004: Noted in Lifer Sentence Plan form by the first prison doctor that the man – '... still shows emotional immaturity and inadequacy and a propensity to self-harm behaviour in dealing with problems that he cannot cope with ... has recently suffered mixed reactive and depressive symptoms following ... surgery. ... He will require psychologically structured training to improve his coping skills ...'.

12 May 2004: The outside hospital wrote to the prison summarising the man's review there on 4 May.

25 May 2004: The GP for D wing noted in the man's medical record that he was seen at outside hospital (on 4 May) and a new drug treatment plan issued. If unwell, Hydrocortisone dose should be doubled.

25 May 2004: A letter from the outside hospital notified a rescheduled follow-up appointment for 13 July.

29 May 2004: At 3.40am the second nurse saw the man who was complaining of a severe headache. He refused Brufen and the nurse wrote a question in the medical record whether analgesia could be reviewed so that paracetamol could be given when necessary.

2 June 2004: Noted in security report that a petrol lighter was confiscated from the man.

23 June 2004: The man completed a prisoner application to request a compassionate transfer to a prison close to his family. On 2 July, prison staff started to take action on the man's application.

25 June 2004: The second Specialist Registrar in Endocrinology at the outside hospital wrote a detailed letter to the man, in response to a letter from him, outlining his treatment. She summarised her exchange with the man in a letter to the SMO.

3 July 2004: The man was seen on adjudication on a charge of taking cannabis. In his written statement, the man admitted the charge but stated that over the previous nine months he had been suffering pain and anxiety due to his medical problems. The man included with his statement a letter from his hospital doctor. The Acting Governor found the man guilty of the charge of taking cannabis and imposed penalties of: 14 days stoppage of earnings at 50 per cent (i.e. half pay for 14 days), 14 days no access to prison shop or own money, three days loss of association.

6 July 2004: An entry in the man's medical record by the GP for D wing discussed the options mentioned in the letter of 25 June from the second Specialist Registrar in Endocrinology to the SMO.

7 July 2004: Noted in unit observation book (D wing) that the man became demanding, pressing his cell bell for medication. He had been unlocked earlier for at least 45 minutes giving him ample time to collect treatments.

8 July 2004: Noted in medical record by an unidentified clinician that the man had insomnia.

12 July 2004: Noted in security report that the man was charged with having a grappling claw in his possession. The first prison doctor noted that the man was fit for adjudication. The adjudication was postponed, however, as the man had gone to outside hospital.

18 July 2004: Noted in security report that the man informed staff that prisoners on D wing were padding themselves with paper because they were afraid of being stabbed due to debts.

19 July 2004: Letter from the outside hospital to the SMO following a review of the man's condition. The option of a further operation had been discussed with him but he indicated he was not keen.

22 July 2004: Noted in medical record by the third prison doctor that the man was fit for adjudication for the case postponed on 12 July.

27 July 2004: The GP for D wing recorded a discussion about the contents of the letter of 19 July from the outside hospital.

27 July 2004: The man telephoned his mother and said he was unsure what he should do about his medical treatment. He said he was going to refuse further surgery, but had arranged to see a radiological specialist. He indicated that he was doing all he could to cope with his medical condition. He gave his mother details of his condition and said that, according to the book he was reading, further surgery for his condition had only a 20 per cent success rate and with an increased chance of serious complications. He also asked his mother to get him a tracksuit. During the conversation, his mother was very supportive. There was no indication that the man was considering self-harm.

27 July 2004: The Lifer Principal Officer confirmed that the man, at his request, would be moved to an establishment nearer his home after his 'lifer' review in September 2004. Two establishments were being considered for their suitability. The Lifer Principal Officer had already informed the man that he was to be moved.

30 July 2004: At 2.19pm, the man telephoned a friend but she was not there and he spoke instead to a friend of hers. The man asked why his friend had not turned up for a visit. The man was told that his friend had not been well but was now okay. The man passed on his regards for his friend. At 2.25pm, the man telephoned his mother and left a message on her answer-phone telling her the name of the author of the medical book he was reading on his illness.

31 July 2004: The man was seen on adjudication after first being found fit for adjudication and cellular confinement by the third prison doctor. This adjudication had been adjourned twice because the man was at outside hospital on each occasion. The acting Governor found the man guilty of the charge of being in possession of an unauthorised article (a grappling claw). The penalty was seven days stoppage of earnings at 50 per cent (i.e. half pay for seven days), seven days no access to prison shop or own money, 14 days loss of television. A further punishment of 14 days cellular confinement was suspended for three months. The man was returned to his normal unit.

3 August 2004: It was noted in the medical record by the GP for D wing that the man had complained of cramping pains in his hips and knees, sweating, clinically he was okay, not in agony, not asthmatic, no stomach ulcer. Medication was prescribed. In the evening of 3 August, the man was found to have a television in his cell contrary to the punishment imposed on 31 July.

4 August 2004: The man made a number of telephone calls. At 10.20am he telephoned another friend. He talked to her about another prisoner and told her that the other prisoner was okay. At 10.36am he telephoned the friend he had tried to contact on 30 July. She was not in. The man left a message that he was all right and that he noted that she was down for visit the following day.

4 August 2004: At 7.05pm and 7.08pm the man telephoned his friend and she said she would visit him on 5 August. He asked her to buy him a sandwich and a drink for the visit. He asked if she had sent in money for him and she said no as she had not yet been paid. A few minutes later, the man telephoned her again and asked her if she would put some money into his brother's bank account for him if he sent the money. She agreed to do so.

5 August 2004: The man was judged fit for adjudication and cellular confinement by the first prison doctor. The man was found guilty on adjudication of being in unauthorised possession of a television. He was punished with 14 days cellular confinement by the acting Governor. This punishment was that suspended from the adjudication on 31 July. The Governor's Journal shows that the man would have had access to the acting Governor, a chaplain and the first prison doctor.

6 August 2004: An entry in the unit observation book was made – '[the man] not very happy at all, refused medication yesterday and again this morning. Did not want to go in the shower. Appears to be feeling sorry for himself'. An entry in the unit's occurrence book recorded that – '[the man] has refused all meals and medication today'.

7 August 2004: At just after 8am, the man was found dead.

8 August 2004: A Security Information Report stated that an informant had reported that the man was taking heroin and was over £400 in debt. Also reported that the man aided or abetted the collection of parcels from the east side of D wing through windows, allegedly to pay off his debts.

13 August 2004: A maintenance check found that the closed circuit television (CCTV) monitoring system in the segregation unit had been inoperable since 26 July 2004.

Summary of evidence from staff and others interviewed

The Senior Nurse said that she began to have fairly regular contact with the man when it was first suspected that he might have a brain tumour and investigations were started. After the man had surgery, they then had daily contact when the man received his medication. He would come to have a chat and a cup of tea and they would talk about his condition. He was on several different lots of medication: hydrocortisone three times a day; injections twice a day; he was also on quite a high dose painkiller. The man continually fought to have higher doses of painkillers. The outside hospital did not offer an awful lot of advice about this, but said that, if his prescribed medication was not working, the prescription should cease. For that reason, the dose was being reduced. Prison Healthcare staff were under the guidance of the endocrinologist at the hospital, but the man felt that nobody was doing anything for him and he regularly asked to see the doctor because he felt his pain relief was inadequate. There was no easy answer to this because, although the man had a genuine medical need for analgesia, the doctors were reluctant to prescribe high dose opiates because they are addictive and in prison have a high currency value. The Senior Nurse confirmed that, if the man was illicitly taking heroin, it would have compromised the effectiveness of his prescribed analgesia as heroin was a far stronger and far more effective painkiller than any prescribed medication.

The Senior Nurse said that she and the man had long discussions about his treatment. Although his brain tumour was not a terminal condition, the Senior Nurse was not sure whether he accepted that was the case. He knew his condition affected other organs in his body so he was having to have his heart and lungs checked. The Senior Nurse was unsure how well the man, given his youth, could accept having to live with this condition. The man felt quite low about the situation and, around the beginning of the summer of 2004, the Senior Nurse referred him to day care with the thought that he could see a counsellor. The referral form was endorsed to say that the man had refused an assessment with the day care team as he wanted to see a psychiatrist. However there is no evidence to show that a referral was made for a psychiatric review.

The Senior Nurse said that it was common for the man not to take his medication. If he was annoyed about something or somebody, if something had been taken off him or something had not gone his way, he often used his medication as a weapon to hold staff to ransom. He used it to show them that he was unhappy about something. Staff would let the doctor know and would tell the man that their advice was to take the medication, but they could not force him. Sometimes it used to be just his hydrocortisone which he refused, because he knew how important that drug was, and he would take his painkillers. Very rarely did he refuse all his drugs.

The man's Personal Officer confirmed she had known the man from the time of his first arrival at Wormwood Scrubs on 9 April 2003. The Personal Officer believed that she came to know the man fairly well and he called her by her first name. They spoke on a daily basis when she was on duty, both professionally and about private and personal matters. He would tell her that he needed a chat, and she always made five minutes for him. Their chats could be about anything: about his family, about his mother, about being in prison. The Personal Officer said that the man

called her his second mum and she felt that he seemed to feel a bit better after they had talked. The man was not a stranger to prison life, but the Personal Officer thought that the man found it very frustrating that his sentence was not a determinate one so that he did not know how long he would have to serve. However, the man did not seem to be helping himself as a life sentence prisoner by applying for appropriate courses. The man, she said, had no problems on the wing. He conformed to the wing regime and was never violent. It was when his illness came that he seemed reluctant to return to his cell at lock-up time. Staff always seemed to have to chase him to return to his cell. Nor did the man always mix with the right kind of people. For instance, in July 2003 he was given a warning when containers were found in his cell that had contained illegally brewed alcohol.

The man told the Personal Officer about his condition when he walked into the landing office one day. He said that he had a brain tumour and he drew diagrams to illustrate his condition. At some later point in time, the man confided in her that he was frightened about the prospect of a second operation. He complained frequently to her about headaches and occasionally complained of blurred vision. He also complained that he was not getting the medication that he should. The Personal Officer would speak to Healthcare staff who assured her that the man was getting the appropriate medication and she would report this back to him. The Personal Officer said that she was shocked that the man killed himself. She continued by stating that she could have written a list of 50 names of prisoners who might self-harm and he would not have been on that list.

The Lifer Principal Officer (PO) said that the man asked him for a compassionate transfer to a prison close to his family. The Lifer PO arranged for the request to be considered at the next board in September 2004, thereby bringing forward a transfer by 12 months. The Lifer PO spoke to the man about the establishments he would approach.

The man's friend said that she visited him about once a fortnight and had last visited him on 5 August 2004. He always complained to her about his medication, saying that he was not getting the right medication and that he would not be given his pain-killing medication on time. The reason the man frequently damaged his cell and caused disruption was to try to get the drugs and medication that he wanted. At the visit on 5 August, the man said that he was going to kill himself and he would leave a note to say why he had done so. He also said that he had a rope and some tablets in his cell. She asked him what she could do to make him change his mind about killing himself and he asked her to write more often. She agreed to do this. She did not tell staff about what the man had said because she did not want to get him into trouble. However, the man was in any case fairly certain that his tumour was going to kill him in a month or so. The friend said that the man got on well with one of the prison nurses and she thought that he might have said something to her about his intent to take his life. The friend said that the man was not the sort of person who ordinarily would have harmed himself and she was certain that it was the prison that had failed him.

A prisoner at Wormwood Scrubs (the first prisoner) said that when the man was taken to the segregation unit he appeared all right. The man had, on occasion, discussed with him the possibility of suicide using a belt. The first prisoner said that

he spent some time dissuading the man from self-harm and he believed he had been successful and had not, therefore, said anything about it to staff. The first prisoner believed that the man should not have been put into the segregation unit. He explained that the man was anxious about the future treatment of his condition. He said that the man was not being bullied and that he was not the type of person who could be bullied. He added that the man's family seldom visited him and most of his visits were from his friend.

The acting Governor said that at the adjudication hearing on 5 August the man said that he did not know he could not have a television, the loss of which was part of the punishment given on 31 July, as his canteen had not been stopped which was also part of the punishment. The acting Governor thought the man felt the charge was unfair, he was not happy and he did not see why he should have lost his television in the first place.

The first Senior Officer (SO) said that he was involved in the man's adjudication on the morning of 5 August. At one stage, the first SO had asked the man to keep quiet as he was becoming agitated and talking while the acting Governor was trying to talk. The first SO thought that the man had collected his meal that lunchtime and had been very quiet.

Another officer present at the man's adjudication hearing believed that the only comment the man made was that he had had no knowledge of how the television got into his cell. The man appeared very unhappy with the punishment imposed by the acting Governor as he seemed to believe that it did not fit the offence. However, the man gave no indication that he was at all distressed, just annoyed at the adjudication outcome. After the adjudication, the man took his meal and went to his cell.

The first Officer said that he knew the man quite well and would always say hello to him. The man was an easy person to talk to. The first Officer said that, over the period he knew the man, he became more withdrawn and not as happy go lucky as he was at first. But this was consistent with lifers' moods. On 5 August, the man said that he had been given cellular confinement and the first Officer, referring to the fact that the adjudication had twice been adjourned, replied that the man had given the prison a good run for its money. The first Officer believed that the man refused his dinner that day, but that was not unusual for prisoners who had just received cellular confinement and there was nothing about the man's behaviour to give the first Officer any cause for concern. The first Officer thought it unlikely that the man would have been in debt, as he was keen to return to normal location whereas prisoners who are in debt are often afraid to be on normal location.

The second Officer was one of the officers at the man's adjudication on 5 August. After the adjudication the man seemed disgruntled, but was not overly upset. The second Officer did not think that the man was expecting to receive a stay in the segregation unit. He did not make any real complaint, but he seemed a bit disgruntled before shrugging his shoulders and saying: "alright, fair enough". On 6 August, the man did not seem as upset as he had been the day before.

Another of the Senior Officers from the segregation unit said that he had known the man for some time, predominantly from the man's previous visits to the unit. The

man was always quiet and polite to staff. The man appeared to be a little down on 5 August, however that was not an uncommon reaction with prisoners who had recently been segregated. He said that, from his perspective, the man would have been the last person he would expect to self-harm. He confirmed that segregation unit staff were aware of the man's medical condition and that they went out of their way to ensure that the man received his medication. On previous occasions, the man had pointed out his condition to the adjudicator. The man had told him that he had some of his tumour remaining but did not mention future treatment.

The third Officer was aware that the man had had an operation for a brain tumour and he made it clear that he was down about his health. The man had refused his medication on both 5 and 6 August, but it was recorded that it was quite common for the man to refuse medication. The man had also said that he was not going to eat on that day. He said: "I just don't fancy eating". This was not a matter of concern to staff as it often took a couple of days for prisoners to get used to being in segregation. Moreover, the man was unhappy about the penalty of cellular confinement thinking that he had been 'stitched up'. Although it was clear that the man was unhappy from his attitude and behaviour, there was nothing to indicate there was a need to worry about suicide or self-harm. When asked if he was alright, he replied he was fine and just wanted to be left alone. Nor were there any concerns following the visit that the man had from his friend while in segregation. The third Officer added that the man was chatting to prisoners through the window.

The second Senior Officer (SO) said that, on Friday 6 August, the man did not collect his meals, but he was offered hot water as cells in the segregation unit did not have kettles. The man offered no reason for refusing his meals, but he did not appear depressed in any way and it was not unusual for prisoners to be a little disgruntled when first arriving in segregation. The man refused to take his medication. The second SO noted this in the staff observation book.

The fourth Officer said that, from what he could remember, the man did not take any meals on 6 August. He also refused his medication from the nurse at around 8pm that evening when the fourth Officer, together with another officer, unlocked the man's door for the nurse. The man did not seem down or angry, he showed little emotion as was normal for him. The nurse administering had said that it was not unusual for the man to refuse his medication.

A second prisoner in the segregation unit said the man was 'pissed off' after his visit on 5 August, but the second prisoner did not know why this was. Later that evening, the man, himself and another prisoner and had a conversation through their cell windows about the out of tune nature of the prison band that they could hear playing. The man was laughing and joking about this. On 6 August, the second prisoner asked the man if he was going on exercise. The man said he was not but he gave no reason. Some time after 7pm on the evening of 6 August, the second prisoner chatted with the man, again through their cell windows, and the man seemed okay. Over all, the man seemed to be the same person in the segregation unit as he was on normal location and the second prisoner was shocked when he heard that the man was dead, as he did not seem the type of person to do such a thing.

A third prisoner in the segregation unit said that he had known the man for around 18 months. He described the man as someone who was generally 'happy go lucky' and not the sort of person who would commit self-harm. The man did not take exercise on 6 August, but again that was not unusual. That evening, the man had been talking to other prisoners through his cell window.

The fourth prisoner said that before the man had his operation, they used heroin together a couple of times. The fourth prisoner said they only met occasionally, but got on pretty well as once you got to know the man he would open up and was a laugh. After his operation the man was different, if anything he was more friendly. By this time, the fourth prisoner did not see so much of the man who then started to spend more time with the first prisoner and another prisoner whose surname he did not know. On the evening of 6 August, the fourth prisoner had spoken with the man at some time around 7.30pm, or possibly later. They had joked and had a giggle. The fourth prisoner said that he was 'gob smacked' when he heard that the man was dead.

Two of the prison chaplains visited the segregation unit while the man was there. Both said that they would have attended the man's cell as part of their rounds but neither could recall speaking with him and the chaplaincy records contained no application or note about contact with the man. One of the chaplain's said that the critical incident debrief to discuss the man's death had taken place on 14 September.

The Deputy Head of Residence confirmed the contents of her memo that on 6 August she conducted the governor's round and spoke to all prisoners and staff in the segregation unit, except the man. She had been distracted by an incident with another prisoner that required her attention and she forgot to return to see the man.

The man's death

The OSG said that he took over night duty for the segregation unit at 8.30pm on 6 August. He was told by the evening duty staff that the man had refused food and medication, but he was not on special watch. When the OSG checked the observation book later in the evening, he saw that the man had not taken food and medication because he was unhappy with the penalty of cellular confinement. Around 9pm, the OSG carried out a check of all prisoners. At the time of the check, the man was sitting on his bed. He did not look stressed or unhappy, but nor did he acknowledge the OSG. The OSG recorded that he patrolled the segregation unit landing at 11.15pm, 3.15am and 5am. He said that he would have carried out other patrols during the night, but there was no room on the form to record additional patrols. It had been very quiet that night. The OSG said at interview that he had not had any suicide awareness training for at least three years and had never had first aid training, even though he had asked for such training. Some of the OSG's comments indicated that he was unclear about how he would respond in an emergency situation at night and he acknowledged that he was uncomfortable with the thought of dealing with an emergency medical situation.

During the course of the night, two officer grade staff visited the segregation unit as part of the routine supervision of the night staff. One visit was made at 9.15pm on 6 August and the other visit at 0.45am on 7 August. The officer who visited at 0.45am said that she spoke with the OSG who advised her that there were no problems in the unit.

At about 5.05am on 7 August, the OSG carried out a roll check. The OSG said that his practice was to carry out the check at this time as the numbers had to be reported to the Night Orderly Officer by 6am (the local security document confirms this). All that was required of the morning roll check was to ensure that each prisoner was in his cell. The officer was not required to obtain a response from the prisoner. The OSG said that the daylight at that time was sufficient for him to see into the man's cell so he did not turn on the cell light. The man seemed to be standing with his back to the cell window looking towards the cell door. It was not unusual to see prisoners standing in that position. The OSG said good morning. The man did not reply, but the OSG thought he saw a slight flick of the man's right hand in acknowledgement. At 7.40am, the OSG was relieved by the fifth Officer. The OSG told the first Officer that the man was at his cell window.

The other day staff in the segregation unit came on duty from between about 7.30am to 8am to join the fifth Officer for an 8am start. In his interview, the second SO said that when all the day staff were present, they had a very quick briefing but nothing of any real note arose.

At around 8.10am to 8.15am the officers started to serve breakfast. The fifth Officer was waking the prisoners ready for breakfast in advance of other officers who would then unlock cells one at a time for them to collect breakfast. On reaching the man's cell, the fifth Officer opened the observation flap to wake him and saw the man at the back of his cell suspended by his neck. The fifth Officer raised the alarm by calling to his colleagues. One of the officers radioed the communications room where the

communications officer issued a code 1 alert over the radio net (a code 1 alert is recognised by staff as a 'hanging'). This alert was timed at 8.19am.

The fifth Officer entered the cell to render aid to the man. At virtually the same time, the second Officer entered followed by the fourth Officer and then the first SO. The second SO went to the segregation unit office to get the ligature scissors and returned to the cell. The second and fourth Officers supported the man's weight while the fifth Officer cut the man free from the ligature which had been attached to the window frame. Staff then placed the man on his bed. Staff did not administer first aid due to obvious signs of death.

Healthcare staff responded to the code 1 alert at 8.19am. An nurse and the Deputy Head of Healthcare came from the Healthcare centre and a HCSN came from B wing (which is adjacent to the segregation unit). There are no timings for their arrival, although the evidence indicates that they arrived just as the man was being placed on his bed by the landing staff. The nurse and the Deputy Head of Healthcare took with them resuscitation and other equipment, including a defibrillator and a fish knife (a special knife for cutting ligatures). The Deputy Head of Healthcare used the fish knife to remove the part of the ligature that was still around the man's neck. In their statements and interviews staff describe the man's condition and appearance in some detail. All staff said that there was no purpose in using the defibrillator and in attempting to resuscitate the man.

The Deputy Head of Healthcare instructed that an ambulance be called. The communications room incident log indicates that the call to the ambulance service was made at 8.27am. It was logged that the ambulance arrived at the prison gate at 8.35am. The Deputy Head of Healthcare said that the paramedics checked the man using a defibrillator, which confirmed that nothing more could be done. The third doctor then arrived. He examined the man and agreed that it was inappropriate to attempt resuscitation due to the obvious signs of death. In his report of the incident, the third doctor wrote: "*... No resuscitation attempted. [Patient] cool to touch, rigid. No spontaneous breathing, no pulse, pupils fixed and dilated. Pronounced dead at [8.50am]*".

Two Principal Officers (POs) arrived at the scene just after arrival of the Healthcare staff. The first PO took charge of the incident. He ordered non-medical staff to move away from the scene to allow room for the medical staff to do what they needed to do. The first PO said at interview that he designated the second PO to ensure nothing untoward occurred at the scene. However, the second PO said that he had no involvement in the incident.

The Security SO attended the scene on receiving a telephone call asking her to attend. She was not advised of the reason for the request. On arrival, the Security SO thought that there were too many people on scene, she estimated 15. She set about preserving any evidence and was concerned that part of the ligature was on the table in the segregation unit office, and part on the man's bed alongside his body. She sealed both parts of the ligature in an evidence bag, which she took to the command suite and surrendered it without signature. She was later told that someone in the command suite had given the evidence bag to the police, but she did not know who had done so.

The Security SO said that she sealed the man's cell in the segregation unit and passed the key to the first PO. When the Security SO later tried to trace the key, the first PO told her that he had passed the key to the Duty Governor who, in turn, said that he had passed the key to the first SO. The second SO maintained control of the key until the man's body was removed from the cell. No log of this key transference, nor of the key holder, was made. The Security SO added that to the best of her knowledge, no log of actions and movements was maintained at the scene.

Officers from Hammersmith Police arrived at the prison just after 9am and were taken to the man's cell by the second SO. The officers checked the scene, made notes and left. The officers returned at about 4pm in the afternoon with a photographer and second SO was again the escorting officer. Photographs were taken of the cell and of the extensive text written on the man's mattress cover. Among other things, the man wrote that he was in pain, that he was being given the wrong medication, that his illness was disfiguring and terminal, that he was being victimised by staff. The man also apologised to his mother. Prison officers assisted the police and photographer by moving the man's body slightly to allow for clearer photographs to be taken. The mattress cover was taken by the police as evidence. Undertakers removed the man's body at 4.40pm. Prison staff said that they were told by the police that, due to a heavy workload that day, there was a lack of availability of Scenes of Crime Officers. For that reason, it had taken a long time for the police to complete their work and therefore a long time before the man's body could be taken from the cell. Staff working in the segregation unit found it disturbing to have to continue with as normal a regime as possible, whilst showing due respect for the man's body.

The Head of Offender Management was acting in charge that weekend. With the third PO, she opened the command suite. The Head of Offender Management said that the Duty Governor was in charge of the prison regime and the first PO was on the scene in charge of the incident. The first PO was not advised he was incident Bronze Commander, but the Head of Offender Management assumed that he took it for granted that he was filling that role. While other people attended the command suite, only the Head of Offender Management and the third PO actually made up the command suite team to deal with the contingency tasks. The third PO said that he used the contingency plans as an aide memoire, but he did not fill in the plans. Nor was he aware if any notes were made and nor was a Bronze Commander role formally assigned. The acting Governor, who was not working that day, was contacted. She came into the prison, but allowed the Head of Offender Management to continue managing the incident. National Operations Unit were informed of the man's death. The Head of Offender Management did not make a log of Silver Commander's actions in the command suite. Nor did she write her report of the incident until it was solicited by the Senior Investigator.

It was established that the man's next-of-kin was his mother who lived in Lincolnshire. Due to the distance involved, the Head of Offender Management asked the police to contact the man's mother. The police, in turn, contacted the police force local to the mother's home to ask them to inform her. The command suite was closed at midday once everything needing to be done was completed. At 1.30pm, the Head of Offender Management led a hot debrief for staff involved.

As the Head of Offender Management had been closely involved in dealing with the man's death, she decided against appointing a family liaison officer and, instead, retained responsibility herself for contact with the family. She spoke by telephone with the man's mother on Monday 9 August and they spoke again the following day. The Head of Offender Management met the man's mother, her husband and the man's uncle when they visited the prison on 11 August. On the same day, the man's family were also able to meet the acting Governor, the man's personal officer, and the first prisoner. The Head of Offender Management said that she had a number of telephone conversations with the man's mother and wrote to her twice.

The Duty Governor attended the segregation unit but left it to the PO to continue managing the scene. The Duty Governor was also a member of the staff care team and in that capacity he visited staff involved in the incident. The first Officer was very upset by the incident, having discovered the man's body and had been instrumental in attempting to aid him. He was therefore allowed to finish his shift early at about 11am.

Check of Prisoners in Segregation and Cellular Confinement

The OSG said at interview that his practice was to carry out a roll check at 9pm and the next roll call at just after 5am. This was broadly in accordance with the evidence from other staff and broadly in accordance with the requirements set out in the local security document.

However, at paragraph 7.24 the Prison Discipline Manual states:

“A prisoner serving a punishment of cellular confinement, wherever the punishment is taking place, must be observed at least once an hour ... “

Paragraph 7.24 goes on to say:

“... The medical officer must visit each prisoner in cellular confinement as often as his/her individual health needs dictate. A daily visit must be made by a healthcare professional if the medical officer has not visited or is not visiting. At each visit the prisoner’s physical, mental and emotional well-being must be assessed to ascertain continuing fitness for punishment. A note of each visit must be made on the prisoner’s medical record. Any concerns about the health of a particular prisoner must be brought to the attention of the rest of the healthcare team. Where a medical officer considers that there are clinical reasons why the punishment should not continue, s/he must inform the governor, who must terminate the punishment.¹

Two nurses visited the segregation unit on 6 August to issue medication. Both made written statements. The first nurse visited the unit some time between 8am and 8.30am. She wrote that she entered the man’s cell accompanied by two officers. The man was lying on his bed facing the wall. The man had covered his head with a blanket. The first nurse asked the man several times whether he wanted his medication. He refused each time. The first nurse wrote that when she returned to healthcare she told the Senior Nurse that the man had refused his medication. The first nurse made a note of the man’s refusal in both his medical record and in the prescription chart.

The second nurse wrote that her first visit to the segregation unit was between about 4pm to 5pm. She saw from the man’s records that he had refused his morning medication. The second nurse was told that the man had refused his evening meal. She wrote that she went to the man’s cell and looked through the observation flap. The man was lying on his bed with a sheet covering his face. The second nurse called the man’s name and offered him his medication. The man did not respond, nor did he respond when she called him a second time. The second nurse knocked the door and called the man’s name once again. This time the man removed the sheet from his face, mouthed some words, and moved his arm to signal for her to go away. The second nurse left the unit.

¹ This check is now being carried out.

Between 7pm to 8pm the second nurse returned to the segregation unit to give the man his night time medication. The second nurse wrote that an officer told her that the man did not want his medication and so she left the unit.

The second nurse noted the man's prescription chart that he had refused both his afternoon and night time medication. She did not make a note in the man's medical record.

Neither of the two nurses carried out an assessment of the man as described in paragraph 7.24 of the Prison Discipline Manual.

Findings

From the clinical review, it is clear that before the man was diagnosed with acromegaly, he had a pre-existing condition of depression.

Many of the references in the man's medical record refer to his feelings of anxiety and depression, predating his final period in custody. However, during the man's final period in custody, commencing on 24 February 2004, the majority of references relate to feelings of anxiety about his clinical condition. Staff usually responded with offers of help and support.

The overall assessment of the man's clinical care as judged by the independent clinical reviewer was that he received an appropriate level of clinical support and treatment from Healthcare staff at Wormwood Scrubs and the medical staff at the local NHS hospitals. It is evident, however, that the man missed a number of hospital appointments due, it seems, to problems with escort arrangements. There was also an occasion when the man asked to be referred to a psychiatrist, but no such arrangements appear to have been made for him.

The man was examined by a Prison doctor (who would have been familiar with his medical record) on each occasion he was held in the segregation unit or adjudicated on.

The man had difficulty coping with his medical condition and its symptoms. This was illustrated by his continual lobbying of medical staff and conversations with family and staff he was close to. However, with the exception of his friend and the first prisoner, no one else thought that the man was considering self-harm or suicide. Neither the man's friend nor the first prisoner alerted either the man's family or prison staff. In none of the telephone calls mentioned in this report was there any indication that the man was considering self-harm.

There is evidence to indicate that the man used heroin within Wormwood Scrubs. Use of such a drug would have diminished the effect of prescribed pain relief medication.

Most of the discipline staff who dealt with the man were aware that he had a serious clinical condition, but their understanding of the condition and its effects was limited.

On a number of occasions, the man had refused part or all of his medication.

Despite allegations written by the man on his mattress cover, there is no evidence that he was ill treated by discipline staff at Wormwood Scrubs.

Prison staff who knew the man considered him to be polite and courteous. Some staff described him as very pleasant and very likeable.

The man's Personal Officer and the Senior Nurse established a close professional relationship with the man and provided him with good support and care.

None of the staff or prisoners in the segregation unit in the two days leading up to the man's death considered him to be at risk of self-harm.

While in the segregation unit on 6 August, the man refused all of his meals and all of his medication. It also seems that he refused to go to exercise.

Contrary to the requirements of the Prison Discipline Manual, no assessment was made by a healthcare professional on 6 August of the man's physical, mental and emotional well-being and his continuing fitness for punishment.

It would seem that the last contact with the man prior to his death was at around 9pm on 6 August, by the OSG.

The sunrise time for London on 7 August was 5.34am. The man's cell window was east facing, however when the OSG carried out his check at 5.05am there would probably have been sufficient light only to see the man in silhouette. This indicates that the check made by the OSG at 5.05am, when he stated that he believed the man to be alive, was fairly perfunctory. The OSG was unsure about how he would have responded had he recognised that it was an emergency situation.

Day staff in the segregation unit on the morning of 7 August carried out their duties in accordance with their orders. The man was found, hanging from a ligature, at 8.19am.

The entry made in the man's medical record by the Deputy Head of Healthcare, who is a trained nurse, described his body when found as cold with some rigor mortis.

Staff acted promptly and appropriately to the incident.

There was no automatic call for ambulance dispatch on discovering the man hanging. The ambulance service was not alerted until 8 minutes after the initial alarm was raised at 8.19am.

Staff managing the incident were generally effective in their duties, although insufficient attention was paid to the preservation of evidence. No log of the preservation of the scene was undertaken. The cell was sealed initially just after 9am, but was reopened on a number of occasions through the day to allow police and eventually the undertaker access to the scene and to the man's body. The key to the seal lock was not formerly tracked, but was passed from person to person without any log being kept. No log of passing the ligature to the police, and to which police officer it was given, was available.

The managers in overall control of the incident did not make appropriate and timely records of the incident.

The CCTV monitoring system was found not to have been working during the period that the man was in the segregation unit.

The security manager of the day had not been trained in the preservation of evidence and was not directed appropriately by the Principal Officer in charge of the incident.

It was not until about 4.45pm that the police completed their inspection of the scene and it was only then that the man's body could be taken away. Prison staff involved in the original incident were required to continue to manage the scene until around 4.45pm.

The method used to notify the man's mother – first asking Hammersmith Police to make contact and who, in turn, asked the police force local to her home to do so – was unsatisfactory as Wormwood Scrubs lost control of the process.

Despite some very good work by the establishment care team, insufficient attention was paid to the support of staff who had dealt with the man. Some staff felt they were neglected and had not received appropriate support. This occurred, in part, through the Duty Governor also attempting to cover the role of care team member. Staff being approached by him in Healthcare viewed his enquiry as one from the Duty Governor, not realising that he was approaching them as a care team member.

Of several staff who would have benefited from more structured support from the care team, the most notable care failure was with the OSG. He had not taken part in the critical incident de-brief and was not informed of the man's death until he returned to work to undertake another night duty. The OSG had still not been approached by the care team when interviewed on 30 September 2004 in connection with this investigation.

One of the chaplains conceded that there have been occasions when people involved in an incident are missed, due to there not always being a comprehensive list of staff and prisoners involved.

There is no duty care team member for nights.

There was a slight delay in holding the critical incident debrief. Ideally, this should have taken place within two to three weeks of the incident.

Wormwood Scrubs is failing to comply with the Prison Discipline Manual's requirement that prisoners in cellular confinement must be observed at least once an hour.

Conclusions

The clinical reviewer, in her closing comments, pointed out that the man's condition of acromegaly is a notoriously difficult one to treat in any circumstances. However, she said that she considered that the man's depression was properly identified and anti-depressant treatment prescribed. She also said that further referrals to outside hospital were made promptly and appropriately when attempts to treat the man's condition failed.

However, there were occasions when the man missed hospital appointments and it appears this was due to problems with escort arrangements. In addition, the man's diary contains many comments of him being in pain. It is possible that the missed hospital appointments might have delayed experimentation in adjustment of the man's pain relief medication and possible referral to a pain specialist.

Two of the man's friends suspected that he might have been at risk of self-harm or suicide. However, none of the staff who knew him well thought that he was at such risk.

The man was medically assessed prior to being placed in the segregation unit, and his segregation via cellular confinement was not objected to on medical grounds. Contrary to Prison Service requirements, no assessment was made by a healthcare professional on 6 August to ascertain whether the man was fit to remain in cellular confinement.

The man's family raised with me, the lack of information exchanged between clinical and discipline staff. I welcome the changes the Prison Service intends to introduce shortly with the replacement of the F2052SH (Self Harm at Risk Form) by the ACCT form. This will provide greater integration of mental health and suicide/self-harm assessments and should ensure greater safeguards surrounding the imposition of cellular confinement.

The early morning check undertaken by the OSG followed accepted standards, but nevertheless was fairly perfunctory. It delayed the discovery of the man's death.

Day staff in the segregation unit carried out their duties appropriately, including their response when the man was discovered hanging.

There was a delay in calling for an ambulance, although the man was already dead at this time.

Control and recording of events at the scene was not well managed.

Staff and managers who were directly involved in managing the scene were not sufficiently supported by the establishment after the man's death.

Local Recommendations

1. That the Governor of Wormwood Scrubs reminds staff of the arrangements for early morning roll checks of prisoners and of hand-over arrangements. The local security document should be amended as necessary to reflect this.
2. That the Governor reminds staff that, when an alarm is raised of a prisoner being found hanging, an ambulance is automatically called by the communications officer.
3. That the Governor reminds all orderly officers of their role in relation to managing a death in custody. The Governor might wish to consider implementation of memory aides for issue to orderly officers when a death in custody occurs.
4. That the Governor reminds all orderly officers and security managers of the prison's contingency plans for dealing with deaths in custody.
5. That the Governor reviews arrangements for notification to families of deaths in custody. If notification is to be via a third party, an appropriate officer must maintain close control of the process.
6. That the Governor reminds senior staff that appropriate records of an incident, including command suite log, hot de-brief minutes, family contact details are written in a timely manner.
7. That a system is introduced for the manager in charge of the incident to identify all staff and prisoners in need of care and support post incident and pass a list of the same to the Care team and Chaplaincy.
8. That an identified scheduled care team worker should be on call for staff 24 hours per day.
9. That notices be prominently displayed in the visits area encouraging visitors to report to staff any concerns they may have about the physical or emotional well-being of a prisoner.
10. That the Governor reviews arrangements for maintenance checks of the CCTV system.
11. That the Governor arranges for the OSG's training needs to be reviewed with the needs identified being reflected in his performance and development objectives.

National Recommendations

With regard to the requirement set out at paragraph 7.24 of the Prison Discipline Manual, that prisoners in cellular confinement must be observed at least once an hour, the Prison Service should consider whether to:

- a) amend the policy; or,
- b) ensure that all prisons comply with the policy requirement.

ANNEX A

An Inquisition taken for our Sovereign Lady the Queen at West London Coroners Court

The deceased was transferred to HMP Wormwood Scrubs on 9th April 2003 following a sentence of life imprisonment given that February. He commenced serving his sentence on D Wing.

In July 2003 a prison doctor suspected the deceased was suffering from the rare condition of acromegaly and referred him to Hammersmith Hospital's endocrinology department. The diagnosis was confirmed in September 2003. At the same time, the hospital requested a MRI scan to be made urgently, along with a glucose tolerance test. The first appointment for this was cancelled by the prison for unspecified operational reasons. The MRI scan took place on 28th October.

From the diagnosis in September 2003, the prison medical staff were directed by Hammersmith Hospital in administering medication. While active attempts were made to control the deceased's pain, there seems to have been no co-ordinated effort made to assess and address holistically the psychological risks.

On 3rd March 2004 the deceased underwent surgery to remove the adenoma in his pituitary gland. He returned to Wormwood Scrubs on 9th March. The immediate post-operative outpatient appointment on 30th March was missed, and an appointment for a glucose tolerance test was again missed on 6th April. He did not attend hospital until 4th May, after which treatment with Octreotide started. The operation was not successful. It became clear in June 2004 that either a repeat operation or radiotherapy would be required.

During this time, the deceased was despondent that the treatment was not effective and anxious to avoid further surgery. His physical discomfort and depression is evident from his letter to the hospital consultant of 9th June 2004. A prison healthcare nurse referred the deceased for a Day Care Assessment some time in June 2004. He declined the assessment and instead asked to see a psychiatrist. This request appears not to have been acted upon. On 3rd July, the deceased attended an adjudication for cannabis usage, at which he gave pain relief as the reason and stated his medication was not working. The options of further surgery and radiotherapy were discussed with the deceased at the hospital on 19th July.

At an adjudication on 5th August 2004, a sentence of 14 days' cellular confinement which had been given at an earlier adjudication on 31st July was activated. The deceased was declared fit for cellular confinement. That afternoon a previously arranged visit from a female friend occurred. The deceased indicated to his friend that he was considering suicide.

On 6th August the deceased did not eat, refused his medication and did not leave his cell for afternoon association. He communicated briefly with inmates of neighbouring cells in the evening. He was last seen alive in his cell by a support officer doing rounds at about 9.15 pm.

The deceased was found in his cell, suspended from the window frame by a ligature, at 8.05am on Sunday, 7th August 2004. At this point he was already cold to the touch and showing lividity and signs of rigor mortis. The exact time of his death is impossible to establish, although it seems likely that he was already dead when seen in an upright position in the window corner of his cell at 5.00am by the duty support officer. An ambulance was

called and arrived at 8.35am. Life was pronounced extinct at 8.50 am. The ligature was made from plaited strips of bedsheet. When the cell was searched, it was found that the deceased had written extensively all over his mattress cover. The writing betrayed his deep anxiety, anger and despair relating to both his current pain and his perceived bleak prospects, and was clearly written to be found after his death.

It is clear that the circumstances of the deceased's confinement in Wormwood Scrubs led to an inadequate level of overall care for the condition he was in. Appointments missed for logistical reasons, delays in adjusting his medication, and lack of information sharing and co-ordination between those involved in his care all contributed indirectly to his death. In addition, in the prison regime at that time, both medical staff visits and prison staff observations appear to have been superficial.

The overt signs that the deceased was not fit for segregation on 5th August were:

- a. his despondency about further treatment for acromegaly;
- b. his confession to use of cannabis for pain relief at the adjudication on 3rd July and repeat mention of his illness at the adjudication on 31st July;
- c. his correspondence with the hospital during June.

His withdrawal from association and refusal of medication and food on 6th August were further signs that cellular confinement should not have been continued.