Investigation into the death of a man whilst in custody of HMP Wormwood Scrubs in October 2009

Report by the Prisons and Probation Ombudsman for England and Wales

May 2011

This is the report of an investigation into the death of a man. He was found hanging in his cell at HMP Wormwood Scrubs. At the time of his death he was a remand prisoner and recently been to court on trial. He was 50 years of age. It was his first time in prison.

I extend my condolences and those of my colleagues to his family. I trust this report goes some way to answering any questions they may have. I regret that my report has been delayed and apologise for any additional distress that this may have caused the man's family.

The investigation into the man's death was undertaken by one of my investigators. In addition, a clinical review was led by two doctors on behalf of NHS Hammersmith and Fulham. I am most grateful to the doctors for their review and a copy is annexed to this report.

The man was an educated and articulate man who, although making a few acquaintances whilst in prison, for the most part kept himself to himself. He previously had significant contact with mental health services in the community and was well aware of the bipolar disorder from which he had suffered for many years. I believe his mental health difficulties and trial may have become too much for him to bear. However, no one can be sure as to what was on his mind during the last few days of his life, or be sure of the reasons he took the actions that he did.

My investigation reports a number of failings with regard to the provision, and organisation of mental health care at Wormwood Scrubs. However, I do not believe that discipline staff at the prison could have foreseen his actions, given the limited information available to them.

In addition to several recommendations relating to the provision of mental health services, I also make a number of recommendations relating to the operation of the Listeners scheme, use of the Samaritan telephone, operation of the personal officer scheme and record keeping. I note, with regret, that a number of these issues have previously been highlighted by the Inspectorate of Prisons in her inspection of Wormwood Scrubs in 2008.

The version of my report, published on my website, has been amended to remove the names of the man who died and those of staff and prisoner involved in my investigation.

Jane Webb
Acting Prisons and Probation Ombudsman **May 2011**

CONTENTS

Summary	4
The Investigation Process	6
HMP Wormwood Scrubs	9
Key Events	11
Healthcare Issues	19
Other Issues	23
Conclusion	29
Recommendations	30

SUMMARY

The man was remanded into custody at HMP Wormwood Scrubs on 13 May 2009, having been arrested the previous day. During the reception process he told a nurse that he suffered from bipolar disorder, for which he was taking lithium carbonate and that he had recently been treated at a local mental health unit. The nurse noted that the man had no thoughts of harming himself and described his mental state as "stable". She referred him to the prison doctor who, again, assessed him as not being suicidal. The man was given the same medication he had been receiving whilst in the community and confirmation of this was sought from his community general practitioner (GP) the following day.

On 28 May, having submitted an application to see a social worker, the man was seen by one of the prison's probation service offender managers. On learning that he suffered from bipolar disorder, the offender manager made and referred him to the prison's mental health in reach team (MHIRT). An attempt was made by a nurse from the MHIRT to assess the man the following day. However, the man declined the assessment saying that he was not ready.

Little is known about the man's time at Wormwood Scrubs, however, an entry in his wing history sheets on 13 June recorded that he followed the wing's regime. He was also described by staff as an intelligent and articulate man, who assisted other prisoners, and enjoyed music and writing.

Late in the evening on 17 July, the man asked to use the prison's cordless Samaritan telephone. Although it is not clear whether he used the telephone, the following evening an officer noted that he had complained that it did not work in his cell.

On 21 August, the man was assessed for the first time by a locum psychiatrist. The psychiatrist noted that his mood was low and he was frustrated since coming into prison. Although it is clear from the records that the psychiatrist discussed his assessment of the man with a member of the MHIRT, there is no evidence that any follow up action was taken.

The man complained again to an officer about the Samaritan telephone not working on 29 August. On 15 September, he again asked to use the telephone. During an assessment on 18 September, the psychiatrist noted that he was was "stable", and recorded in his medical record that he did not feel depressed. However, the man told the psychiatrist that he was worried about depression and having a manic relapse.

In the weeks leading to his death the man made a number of telephone calls to family and friends, including many to his daughter. During one call on 10 October, they discussed his recent behaviour towards her, for which he apologised. He also told his daughter that, as his trial date approached, he felt he was entering a period of depression and was not getting any help from the prison. He said that if he told staff of his situation they would put him on "suicide watch" which would mean being checked every half an hour. The man said he could not cope with this in the days leading to his trial.

On 23 October, the prison psychiatrist saw the man for what was to be the last time. He wrote that the man presented with no thoughts of self harm or suicidal ideas and was of “normal mood”. The man told the psychiatrist that he feared his forthcoming trial might disturb his normal sleep.

In a telephone conversation with a friend on 24 October, the man said that he had been for a pre-trial review and hoped that things would be okay. The man also told an officer of his hope that he might be admitted to hospital for mental health treatment rather than to prison at the end of his trial.

Having been to court on 28 October, the man’s trial was adjourned until 18 December in order for court reports to be prepared. That evening he spoke with his daughter telling her that he was okay, for her to be positive for the future but to prepare for the worse, adding that there was always scope for appeals and mitigation.

On 29 October, the man was described by fellow prisoners as being in a bad mood. However, the following day they said that his mood had settled and he mixed with them, playing chess as normal. During the day the man was assessed by a consultant psychiatrist for a court report. The consultant noted that the man showed no evidence of mania or any significant symptoms of depression, although he did note that he had significant worries and was under a great deal of stress. The consultant noted that the man denied any thoughts of harming himself and concluded that he was not, apparently, suffering from any mental disorder.

The man’s cell was unlocked the following morning at about 9.40am. Approximately 25 minutes later he was found hanging by other prisoners. The alarm was immediately raised. Although staff considered that the man had been dead for some time, healthcare staff commenced cardio pulmonary resuscitation (CPR) until his death was pronounced by the prison doctor at 10.27am.

My report makes a number of recommendations, the most significant of which relate to the delivery of mental health services at the prison. I also make a number of other recommendations, some of which were made by Her Majesty’s Inspector of Prisons in 2008.

THE INVESTIGATION PROCESS

1. One of my investigators from my office carried out the investigation into the man's death. During the opening of the investigation he met with the then Deputy Governor of HMP Wormwood Scrubs, to explain the nature and scope of the investigation. Notices were issued to staff and prisoners informing them of the investigation and inviting them to contact the investigator should they wish to. My investigator also met the Governor of Wormwood Scrubs on several occasions to provide feedback during the investigation and followed this up in writing.

2. My investigator liaised with the chair of the Independent Monitoring Board (IMB), and with members of the Prison Officers Association. (IMB members are independent and unpaid. They monitor day-to-day life in the prison to ensure that proper standards of care and decency are maintained.)

3. My investigator was shown the cell and wing where the man had spent the last weeks of his life. My investigator reviewed the man's prison and health records and other documentation, including telephone records. (Although recorded, the telephone calls were not monitored by staff and so their contents were not known until after his death.) The investigator also interviewed a number of staff at the prison and spoke to some of the prisoners who had known and associated with the man.

4. A clinical review was undertaken on behalf of NHS Hammersmith and Fulham, using a panel approach, led by two clinical reviewers, one of them a consultant and honorary senior lecturer in forensic psychiatry and the other one, a general practitioner. It is unfortunate that there was a delay in finalising the clinical review, which has caused the delay of my own report. There were some delays in arranging interviews with healthcare staff at the prison. The final clinical review was received on 2 November 2010, and is annexed to this investigation report.

5. My investigator also liaised with the prison's family liaison officer, and with a detective sergeant from the Metropolitan Police, acting on behalf of the Coroner. The investigator contacted with the Coroner's office and a copy of this report will be sent to Her Majesty's Coroner for Western London District, to assist her enquiries.

6. One of my family liaison officers, contacted the man's ex-partner, and mother of his daughter, to discuss any concerns that she had. The man's ex-partner said that he was good at hiding his feelings and would have concealed any intentions to harm himself. She said that his behaviour would have been known to people who had supported him outside of prison, she believed that they could have helped when he was at risk of harming himself if they had been involved by staff.

7. The man's family raised a number of other concerns, including:

    - How much was known about his psychiatric history by prison healthcare?

- Was he seeing a psychiatrist in prison?

- Was he receiving his medication?

I trust that this report goes someway to answering these and any other questions that the man's family have.

In response to the draft report the man's ex-partner and mother of his daughter, said that having read the report she felt that there was neglect of care in relation to the man's mental health care and it was not equitable to what he would have received within the community. She mentioned a number of reasons why. These included that:

- On reception the man was seen by an RGN who declared him stable and as the nurse was not an RMN she was not the right person to make such an assessment.

- The man was not seen by a mental health professional until the 21st August, which was a significant delay.

- Although the man was offered an earlier appointment with the MHIRT, and refused this, the man's ex-partner believed that this should have been followed up sooner and the delay in his being seen was too long.

- The prison healthcare did not request the man's medical records from outside of the prison to look fully at his mental health needs.

- The prison did not discuss the man's needs with his family, who had important information to share with them.

- The man's medication was changed regularly without him even being physically seen by a doctor.

- The man, having been seen by a psychiatrist to assess him for the Crown Prosecution Service, acknowledged that he was showing great signs of stress in the run up to his trial. His ex-partner believes anyone with a psychiatric background should recognise that stress is a major trigger of a manic depressive episode, or breakdown, yet the man was described as stable. The man's ex-partner believes this was a missed opportunity to offer him help.

- The man's ex-partner, although recognising that the Prison and Probation Ombudsman could not look into the matter, said that she thought it was important to add that someone with the man's background should have been admitted to hospital and not to prison in the first place. She said that the man was a manic depressive who had been sectioned three times in the past and prison was not an appropriate place to send him whilst on remand.

The man’s ex-partner said that when her daughter found out her father was in prison she was relieved, as she felt he was in a safer place there, and yet this is where the man’s life ended.

HMP WORMWOOD SCRUBS

8. Wormwood Scrubs is a large Category B local male prison that serves the courts of West and North West London. It is a Victorian prison that holds in excess of 1,200 prisoners and often operates close to capacity.

9. The prison has four large residential wings holding around 240 prisoners each. A fifth wing was added in the 1990s. A super enhanced unit holds 17 prisoners at a higher level of security. The prison also has a detoxification unit and healthcare unit. D wing, the man's wing, is one of the prison's largest and is made up of single cells. The wing houses a number of high risk prisoners.

10. Healthcare at the prison is provided by the lead healthcare commissioning organisation, NHS Hammersmith and Fulham. It provides primary care nursing services from Central London Community Healthcare (CLCH) and specialist substance misuse and mental health in reach services from Central and North West London NHS Foundation Trust (CNWL).

11. The mental health in reach services treat prisoners with severe and enduring mental illness. Community psychiatric nurses are part of this service and the in reach service provides cover during weekdays between 9.00am and 5.00pm. Any member of staff or prisoner can make a referral for someone to be assessed by a member of the mental health in reach team (MHIRT).

12. Since the Ombudsman started investigating deaths in custody in April 2004, there have been 24 deaths in custody at Wormwood Scrubs, 17 of which have been apparent suicides, including that of the man. Since the death of the man there have been a further three deaths at the prison, one of which was also an apparent suicide. I note that one issue identified in this report was also raised in a previous investigation.

IMB Report – June 2008 to May 2009

13. The most recent report by the prison's Independent Monitoring Board covered the period June 2008 to May 2009. The report raised a number of issues and concerns about Wormwood Scrubs a number of which relate to my own findings.

14. The IMB commented that healthcare services within the prison have suffered from the difficulty of recruiting permanent staff and as a consequence relied heavily on agency staff.

15. Reporting on the Listener scheme the Independent Monitoring Board (IMB) said that:

> "The situation with regard to Listeners has worsened since our last Annual Report. There are currently no Listeners available for prisoners since the one Listener remaining is not allowed to work without a companion. This is a matter of grave concern since the Listeners have regularly received 30 plus contacts per month."

(Listeners are prisoners trained by the Samaritans to offer confidential support for prisoners in distress. They operate in all prisons and are available 24 hours every day and will meet, upon request, prisoners to listen to their concerns.)

Inspectorate Report 9-13 June 2008

16. The last full inspection of Wormwood Scrubs, Her Majesty's Inspector of Prisons was in 2008. My report into the man's death highlights a number of concerns raised by the then Chief Inspector during her inspection. Her subsequent report noted that, "Healthcare was in general improving, but in a large local prison it was disappointing that mental health services were under-resourced." The Chief Inspector reported that there was no administrative support for mental health services and commented on how she was unable to obtain accurate details of the number of patients on the in reach team's caseload.

17. The Chief Inspector went on to report that: "There were no policies in place to ensure the efficient sharing of relevant health and social care information." My investigation has also found that there appears to have been no improvement in the sharing of relevant health and social care information between providers. I consider this issue in more detail later in this report and make a related recommendation.

18. The Chief Inspector said that, although they observed some positive interaction between staff and prisoners, staff in general were insufficiently proactive and did not appear to know the prisoners. The Chief Inspector reported that entries in wing history sheets were "poor" and she noted that in effect there was no personal officer scheme in operation at the prison, recommending that, "An effective personal officer scheme should be introduced."

19. Finally, the inspection report also commented upon, and made recommendations with regard to, increasing the number of Listeners and improving governance structures to train and support peer supporters. Again, this matter will be considered later in my investigation report.

KEY EVENTS

20. On 12 May 2009, the man was arrested and charged with offences against his partner, with whom he had recently separated. During his detention at Hounslow Police Station, the man told police that he had consumed a significant amount of alcohol in the preceding 24 hours, he suffered from bipolar disorder, formerly known as manic depression, and was taking 1000mg of lithium carbonate to control the symptoms of his illness. The man told police that he had never tried to harm himself, attempted to commit suicide or had any current thoughts of doing so. He was checked routinely every 30 minutes whilst in police custody.

21. The following day, 13 May, the man was remanded into custody at HMP Wormwood Scrubs, arriving at the prison at 3.30pm. On his arrival in reception, the first officer who saw the man recorded the man's personal details on page 1 of his Core Record F2050 (a reception record completed for all new prisoners). In addition to recording general personal data about the man, the officer noted his ex-partner as his next of kin and that he suffered from depression. A Cell Sharing Risk Assessment (CSRA) was completed by the officer who recorded that it was the man's first time in prison, that he had concerns about sharing a cell and suffered from bipolar disorder. (A CSRA is an assessment used to determine the risk that a prisoner would present to others when sharing a cell.)

22. At 8.10pm the man was given a first night reception health screen by the first nurse an agency Registered Mental health Nurse (RMN). (All prisoners are given a first night reception health screen when entering prison. The aim of the screen is to identify any needs or health concerns that the prisoner might have. It includes identifying a prisoner's past medical history, including mental health.) The nurse recorded that the man said he did not have any concerns with regard to his physical health or issues surrounding substance misuse. However, the man told the nurse that he suffered from bipolar disorder and was taking 1000mg of lithium carbonate. The man provided the contact details of his own GP and those of Lakeside Mental Health Unit, where he had previously received treatment. The nurse recorded that the man denied any thoughts of suicide or of harming himself and that his mental state was stable. The nurse made a referral for him to be assessed by the prison doctor. She did not make a mental health referral.

23. The first nurse also completed the healthcare section of the CSRA. She noted that no concerns had been raised about the man being at risk of self harm, but that he suffered from mental health issues for which he was taking medication. She also noted that the man was to be referred to the MHIRT. However, my investigator has found no evidence to suggest that a referral was made at this time. Due to the nature of his alleged offence and history of bipolar disorder, the man was given a single cell.

24. In their clinical review, the two clinical reviewers report that the man's medical record identifies that he was referred to and seen by a locum general practitioner on the night of his remand. He was assessed as "not suicidal" and suffering from "no injuries". The GP requested that more information should be sought

about the man's clinical management from the services in the community. The man was subsequently transferred to the first night centre. The first nurse having sought consent from the man for disclosure of his medical records, confirmed his medication details with his GP the next day.

25. In the clinical review, one of the clinical reviewers notes that on 28 May, the man was reviewed by a member of medical staff, whose signature could not be identified. It was recorded that the man was not suffering from any mental health condition, yet he was receiving treatment with the antidepressant, clonazepam.

26. The man put in an application to the prison's probation team saying that he wanted to see a social worker. On 28 May, the man was seen by one of the probation service offender managers at the prison. She explained to the man that, as a remand prisoner, he would not be allocated a probation officer. However, having been told by the man that he suffered from bipolar disorder, she agreed to refer him to the prison's MHIRT. The offender manager subsequently completed a referral form and passed it to the MHIRT, providing the contact details of the man's consultant psychiatrist in the community. The offender manager had no further contact with the man. In interview for this investigation, she said she observed no indications that he was at risk of harming himself during her brief contact with him

27. On 29 May, a community mental health nurse (CMHN), wrote in the man's medical record that having been referred to the MHIRT the previous day, by the offender manager:

    "Attempt was made to assess him [the man] but he declined stating that he is not mentally ready to go through with the assessment but that he will contact the team when he's ready. Plan: (Manager In reach) to offer him an appointment to see him."

    No further follow up plan was recorded in the man's medical records. There was a note on the referral form that a further appointment had been offered to the man on 10 June. However, this appointment was not recorded in the unit's diary and there is no evidence to suggest that the man either accepted or attended the appointment.

28. The following day, 30 May, the first significant entry by an officer was made in the man's wing history sheets. The officer wrote that the man had been warned about misusing his cell bell (cell bells are provided for use by prisoners to seek the assistance of staff). In an entry on 13 June, another entry noted that the man followed the wing's regime.

29. On 17 July, shortly after 11.00pm, the man requested and was given access to, the Samaritan's telephone. (The Samaritan telephone is a dedicated cordless telephone which can be used by prisoners, at any time of the day or night, to access the services of the Samaritans. The telephone is programmed so that calls attempted to any other number are barred.) At around 8.00pm the following evening another unidentified officer wrote in the man's wing history

sheets:

> "Complains about Samaritan telephone not working in his cell. I spoke to Oscar 1 about the issue. I was told that the man needs to be patient for dial tone, and if it does not work there is nothing anyone can do to it."

30. The man's mental health was reviewed for the first time following his reception by a locum psychiatrist, on 21 August. After the assessment, the doctor wrote in the clinical record that the man had been low in mood and frustrated since being in prison. He said that the man had suffered from bipolar disorder since the age of 17 and had experienced his first manic episode when he was 24. During the assessment, the man left the room abruptly, saying that he was frustrated and did not want his mental health history relayed to the court. The doctor continued to treat the man with lithium carbonate, which he had previously been prescribed in the community, and the antidepressant clonazepam, prescribed shortly after he came into prison.

31. On 24 August, the locum doctor wrote in the man's medical record that he had discussed his case with the MHIRT. The team explained to the psychiatrist that they were not taking any new referrals, but would consider one of their trainees taking the man on to their case load. In fact, my investigator found no evidence to suggest any further action was taken by the MHIRT.

32. The man complained for a second time about the Samaritan telephone not working on 29 August. One of the wing officers noted in his wing history sheets that he was:

    > "Still complaining about the Samaritan telephone not working. Has issues with his daughter and had an argument on visit a couple of weeks ago. Conforms to regime. Still seems to have potential major anger issues."

    In the early hours of 15 September, the man again requested, and was given, the Samaritans telephone.

33. The man was seen a second time by the locum doctor, the psychiatrist, on 18 September. The doctor noted in the medical record that the man was stable and did not feel depressed. The man told the doctor that he was due to attend trial on 2 November, and was worried about having a manic relapse. However, the doctor found the man to be "fully orientated and insightful" and was taking his medication with no side effects.

34. In the two weeks before his death, the man made a number of telephone calls to friends and family. On 17 October, he spoke with a friend who was assisting him with some financial arrangements. Later that day he spoke briefly with his daughter, apologising for his behaviour during a telephone conversation a couple of nights previously. He told his daughter that he loved her and hoped she would speak again with him soon. The next day the man left a telephone message for his daughter, telling her that he would try and contact her again the following day.

35. The man spoke with his daughter on the telephone again on 19 October. During their ten minute call his daughter told him how she was cross with him about his behaviour the previous week. She told him that he had been acting strangely and she did not know what was wrong with him. The man explained to his daughter how he suffered from manic depression. He said that he was crying for much of the time and felt he was going into a depression in the days leading to his trial. He said that he was feeling miserable and was not getting any help from the prison.

36. The man told his daughter that, if he told staff he was depressed, he would be put on suicide watch which meant being checked every half hour. He said that he could not deal with being checked regularly in the nights before his trial.

37. The man and his daughter discussed the trial and his actions towards her the previous week. He said that the horrible things he said to her were a consequence of his depression. Having discussed further details surrounding the man's alleged offence, his daughter asked for him to look at things positively, and that she had no issue about his depression. (There is no evidence to suggest that the man told officers or a member of the healthcare team about his depression or his discomfort at being checked.)

38. On 21 October, the man went to court. The following day, 22 October, he was unable to speak with his daughter so he left her a telephone message. He explained that he had been unable to telephone her the previous evening as he had been in court for preliminary hearings. The man told his daughter that he would try and speak with her that evening, that he loved and missed her, and she was not to worry about him.

39. The man's final psychiatric assessment by the locum doctor took place on 23 October. The doctor wrote in the man's medical record that he was mentally stable with "euthymic mood" (used to describe being with the normal range of mood). The doctor also said that he presented with no thoughts of self harm or suicidal intention and had a good insight into his illness. The man told the doctor that he was concerned his sleep pattern would be affected by his forthcoming court appearance. As a consequence, the psychiatrist prescribed promethazine, used to treat insomnia.

40. On 24 October, the man left a message on his daughter's telephone. He said that he was okay and that his trial would start in just over a week's time. He said that he was still in "one piece" and loved her. Later that afternoon, the man again spoke with his friend. He said that he had been for a pre-trial review and hoped things would be okay. He explained that, having pleaded guilty to one offence, it was unlikely that he would be going home after the trial. The man and his friend then discussed financial arrangements.

41. The man told a second officer that he believed he might be offered the chance of going to hospital for mental health treatment instead of prison at the end of his trial. He told the officer that he would prefer to be admitted to hospital as he had been an inpatient on several previous occasions. During his interview with my investigator, the second officer who saw the man described the man:

“He was very intelligent, articulate, a quiet man. Always very pleasant to staff and very compliant in terms of the wing regime. Never a problem. I used to find him a very interesting person to talk to you. I think he used to approach me from time to time just to talk about issues that we had in common, music for example.”

42. At a court appearance on 28 October, the man’s trial was adjourned until 18 December in order that reports could be prepared. That evening the man again spoke with his daughter. He told his daughter that he was okay and she commented that he “sounded good”. The man said he felt like a “fish out of water” and had never dreamt that he would end up in prison. He asked his daughter to be positive about the future, but also to brace herself for the worse, adding that there were always appeals and mitigation. The man told his daughter about the preliminary hearings and his legal representation, adding that psychiatrists had written a report saying that he was a serious manic depressive and would not have known what he was doing. His daughter told him to keep up his positive attitude.

43. Two prisoners who knew the man and regularly played chess with him, the two prisoners, told my investigator that the man had been upset when he returned from court the previous Wednesday, 28 October. He told them that his court case had been adjourned and he would need to see a psychiatrist. They described him as “in a bad mood” the following morning and said he could be heard kicking his cell door. That afternoon the man left a message for his daughter saying that the trial had been delayed until December. In a call shortly afterwards, he told his friend that his trial had been delayed and asked him to complete a financial transaction on his behalf.

44. In his clinical review one of the clinical reviewers notes that on 30 October, the man was assessed by a consultant forensic psychiatrist to provide a report for court purposes. The psychiatrist interviewed the man for nearly two hours. He recorded that:

“The man was co-operative at the interview. He obviously had a great deal of information to tell me and he was able to give a very lucid description of events. I did not feel there was any evidence of mania at my assessment and he did not appear to have any significant symptoms of depression although had significant worries and is obviously under a great deal of stress. There were no psychotic symptoms. The man described his mood on a scale from -100 to +100 as being 0 (-100 indicating the most severe depression and +100 indicating the most severe mania). The man denied any current suicidality but acknowledged his previous suicidality when depressed.”

The psychiatrist concluded, “In broad terms, at my assessment, the man was not apparently suffering from any mental disorder.”

45. The man left a final telephone message for his daughter. In the message, he said that his trial had been postponed, and he appeared to sound “down”. In a

call about 30 minutes later, he told his daughter that he loved her a lot and asked her to look after herself, adding that he would explain the delay in the trial when they next spoke.

46. My investigator spoke with a third prisoner who knew the man. He too regularly played chess with the man, including on the morning of 30 October. The prisoner said that they would speak French together and he was aware that the man suffered from depression. He said that the man would sometimes look out of the window for hours. The prisoner said that, having appeared at court the previous Wednesday, the man was down and had said it was his mother's birthday.

47. The first and second prisoners told my investigator that the man's mood had settled by 30 October, and they played chess with him as normal. The second prisoner told police that he played chess with him at about 4.00pm when the man was in good spirits and appeared fine. The first and second prisoners said the man said goodnight to them that evening as he always would, and told them he would see them in the morning.

October 2009

48. At 6.30am on 31 October, the night patrol officer, Operational Support Grade (OSG), carried out a roll check, a head count of the prisoners, on D wing. Having found nothing unusual, the OSG provided a full handover to a third officer at 7.30am before finishing his shift.

49. At approximately 9.40am a fourth officer told police that he was asked to unlock the prisoners on the third floor landing. He said,

    "I remember opening the observation panel to his [the man's] cell and seeing nothing untoward, unlocked the cell door slightly open leaving it ajar. I did the same with all other cells that morning. It is not normal protocol to either enter the cells or speak to the prisoners unless we see or hear anything untoward."

50. At approximately 10.08am, the first prisoner approached the man's cell to ask him if he wanted a game of chess. He said that the cell door was shut and there was no response from inside. He said that, when he looked through the door flap, he saw a dark figure by the window. He said he went into the cell, approached the man and shook him, thinking that he was messing around. He said that the man was not breathing and he left the cell to call for help. The second prisoner who knew the man, said that he too went into the cell, and on discovering what had happened, checked the man for signs of life. Finding no sign of life, he left the cell and joined a number of other prisoners who had begun to gather around the cell door.

51. A governor was walking on the landing where the man's cell was located when he observed the first prisoner running away from the cell. Having shouted to the first prisoner to stop running, the governor noticed a number of other prisoners

standing outside the cell.

52. On his arrival at the cell, seconds later, the governor saw that the man was suspended by a ligature from the cell window. He went into the cell and lifted the man to ease the pressure of the ligature. Having been told by the first prisoner of the emergency, the fourth officer and a fifth officer immediately made their way to the cell, arriving seconds after the governor. The fourth officer cut the ligature from around the man's neck and the fifth officer radioed for immediate medical assistance.

53. The governor and the fourth officer laid the man on the cell floor. The governor described to my investigator the "deep indentation" that the man had around his neck, caused by the ligature. He described his appearance as "gaunt". The governor said that rigor mortis was clearly present and that he and the officers present could find no signs of life. The governor said he believed that the man had been dead for "quite some time".

54. Having responded to the emergency call with their emergency response equipment, two staff nurses arrived at the man's cell. Although unable to find any signs of life, the nurses started cardio pulmonary resuscitation (CPR). The paramedics arrived approximately ten minutes later and continued CPR with a defibrillator, a machine that sends an electrical shock to the heart. The machine advised not to shock and CPR to continue. The prison's doctor pronounced the man's death at approximately 10.27am.

55. Wormwood Scrubs's death in custody contingency plans were implemented. A hot debrief took place and staff who had involvement with the man that day attended. Reviews were undertaken of those prisoners who were at risk of harming themselves and the prison care team were informed of the situation, making themselves known to staff who had been involved in the response efforts.

56. The prison's family liaison officers, prison chaplains visited the home of the man's ex-partner and his daughter, his nominated next of kin, to break the news of his death. However, on learning that the man's ex-partner and his daughter were not in, they were able to obtain a mobile telephone number from a neighbour. One of the chaplains subsequently broke the news of the man's death to his ex-partner by telephone.

57. The man's ex-partner told my family liaison officer, that she had nothing but praise for the way she had been supported by the prison. She described the chaplain as "fantastic". She felt it was not her fault that she had to break the news of the man's death over the telephone as the family were away from home on an outing. She said that she had been given the chaplain's personal mobile number in case she needed to speak to someone. Although she did not use it, she told my family liaison officer that the gesture meant a lot as a symbol of support and care. A financial contribution was made by the prison to assist the man's family with funeral expenses. The man's funeral took place on 16 November. Although the prison offered to send a representative, the family

asked that no one from the prison attend.

HEALTHCARE ISSUES

Mental health referrals

58. The man was identified at reception as suffering from bipolar disorder, a severe and enduring mental illness, for which he was receiving treatment with lithium. However, he was not referred at that stage for a mental health assessment. The clinical review panel reports that, as a consequence, he had no contact with mental health services at the prison until 29 May. In the clinical review attached as an annex to the investigation report, the panel concludes that:

    "We think he [the man] should have been referred directly from reception, and are concerned that the staff who were involved appeared to have different views of the referral process when interviewed. We therefore recommend review of the mental health in-reach referral policy."

59. The clinical review panel made the following recommendation, with which I agree:

    The Head of Healthcare must satisfy themselves that all prisoners identified at reception with severe or enduring mental illnesses should be referred to the mental health in-reach team for assessment. In order to ensure that this takes place, we recommend review of the mental health in-reach referral policy.

Medication

60. The man's medications were re-prescribed on a number of occasions without him being assessed in person by a healthcare professional. The clinical review panel concludes that this is inappropriate. They make the following recommendation, which I endorse:

    The Head of Healthcare should ensure that all individuals are seen face-to-face when anti psychotic medications are re-prescribed.

61. During his time at Wormwood Scrubs, the man was prescribed clonazepam, although the rationale for this prescription was not recorded. The clinical review panel recommends that the rationale should be recorded when medications are prescribed. They go on to report that they:

    "… would be concerned if the routine prescribing of clonazepam, an addictive benzodiazepine tranquiliser which tends to have a street value in prison, had entered into the culture at HM Prison Wormwood Scrubs, as it was apparently prescribed in the man's case without a supporting rationale.

    The clinical review panel go on to recommend:

    The Head of Healthcare, in consultation with senior clinicians and pharmacist, should devise a protocol for prescribing benzodiazepines at

Wormwood Scrubs.

Team work within healthcare

62. The clinical review panel reports that there was no evidence of multidisciplinary meetings involving primary and secondary health care staff whilst the man was in prison. Consequently, the panel make the following recommendation, which I endorse:

    The Head of Healthcare, working through clinical governance arrangements in the prison, and in collaboration with other interested parties (including providers, prison representatives and commissioners), should ensure collaborative and better integrated arrangements between primary and secondary health care providers.

63. The panel also concludes that there was limited evidence of teamwork within the mental health in-reach team (MHIRT). They note that, although the man had been seen by two individuals from MHIRT, neither discussed his case at healthcare team meetings. There was no evidence of team meetings taking place. They report that robust follow up arrangements were not made following his first mental health assessment on 29 May. Additionally they are concerned that the man was not held on the caseload of the nursing team, as might be expected in the community. I agree with the subsequent recommendation made by the panel:

    The Head of Healthcare should review existing team processes within the mental health in-reach team. This review should extend to a review of protocols for the following: receiving and processing referrals; arrangements for multi-disciplinary discussion and planning for each referred case.

64. Healthcare staff confirmed the details of the man's medication with his community GP shortly after his arrival at the prison. Otherwise, no attempt was made by healthcare staff at Wormwood Scrubs to obtain information from the other agencies from which he had received treatment. Perhaps most significantly, no attempt was made to contact the community mental health unit under whose supervision the man received treatment and where he was previously an inpatient.

    The Head of Healthcare, in collaboration with local clinicians, should establish a protocol to ensure that primary care information is requested from community general practitioners for all new prisoners.

65. The panel comments that, in the absence of effective team working, important aspects of the man's care were overlooked. In particular, the panel notes deficiencies in family liaison throughout his time at the prison. From my investigation it is apparent that the man felt comfortable discussing his concerns and feelings with his family. However, there appears to have been no apparent consideration by members of the healthcare team at the prison to contact them. The panel identified other deficiencies as being, information gathering (including

information requests from general practitioners and other health agencies), care planning and risk assessment documentation. The clinical review panel said that there is an expectation for such background work to be allocated to a case co-ordinator, but that in the man's case no such person was apparently identified to complete the task.

66. I share the panel's concerns about the lack of co-ordination in the man's mental health treatment especially for someone with his complex mental health needs experiencing the stress of a criminal trial. I agree with the clinical review's conclusions and the following recommendations:

    The Head of Healthcare should ensure that the parameters of case co-ordination should be reviewed and set down as a matter of policy and expectation with primary and mental health in reach care.

    The Head of Healthcare should ensure that mental health services consider using appropriate family liaison for all individuals on the caseload, if consent is obtained from the relevant individual.

67. The clinical review panel identifies that individuals suffering from bipolar disorder, who are essentially "stable" as the man was described, are effectively managed within primary care services in the community. Often a GP will manage the individual's care and on occasions involve the support of primary care mental health services. The panel commented that,

    > "Although this could have been an appropriate way to manage the man's health in prison, there is limited evidence that any of the involved teams collaborated sufficiently to think through his care and agree an ongoing care plan."

Cardio Pulmonary Resuscitation

68. All the staff reacted promptly when the man was discovered. In his clinical review the clinical reviewer reports that, "It would appear that all staff, following the identification of a medical emergency, performed their duties in line with Resuscitation Council UK guidelines."

69. I do not disagree with the clinical reviewer's findings, and I understand the commitment of the nurses to conduct CPR in difficult situations. However, I would ask staff to reflect on the appropriateness of performing CPR on this occasion, given that no signs of life could be found and rigor mortis was present. Prison Service Order (PSO) 2700 Suicide Prevention and Self Harm Management, Annex 13A, requires that CPR should always be attempted unless rigor mortis has clearly set in. Officers did not begin CPR on the man for this reason.

70. I appreciate that in circumstances such as this nursing staff often take a differing view as to whether CPR should be undertaken. Although I make no criticism of nursing staff and make no formal recommendation, I would ask the Head of Healthcare to remind staff of the guidance in PSO 2700 with regard to the

resuscitation of those who have clearly died.

Record keeping

71. The clinical review panel and my investigator have both commented about the standard of record keeping within healthcare at Wormwood Scrubs. In particular, my investigator has brought to my attention the poor quality of entries in the continuous medical record. In their clinical review, the panel notes that the prison is progressing with its plans to implement an electronic record system. I understand that the electronic record system is now up and running at the prison. However, I agree with the clinical reviewer's recommendation and would ask the Head of Healthcare to ensure that all staff are aware of information recorded on it when completing any handwritten documentation outside the scope of the electronic records.

    The Head of Healthcare should remind staff of their record keeping responsibilities as set out by professional bodies (General Medical Council and National Midwifery Council) and within local records management policies and record keeping standards.

Induction

72. In the clinical review the panel expressed their concerns, raised during the investigation that some healthcare staff appeared to be working at Wormwood Scrubs without first having received and appropriate induction to prison life. Although I make no formal recommendation I would ask the head of healthcare to ensure that all healthcare staff receive appropriate package of induction before they start working at the prison.

73. In conclusion the clinical review panel said,

    > "Although we have identified a number of short-comings in respect of care delivery at HM Prison Wormwood Scrubs, we do also note that the man did not present with ideas or intentions regarding deliberate self harm or suicide at any stage when seen by staff. On the day before his death, he was interviewed at length by a consultant forensic psychiatrist, who did not elicit the presence of symptoms of mental illness, or of significant risk of self harm. On that basis, we do not think that his death could have been prevented."

OTHER ISSUES

Listener scheme

74. Although there is no evidence to suggest whether the man either made use of, or enquired about speaking with a Listener, I am extremely concerned to learn that there is no Listener scheme in operation at Wormwood Scrubs. Writing to the governor of Wormwood Scrubs at the beginning of the investigation, my investigator was told that the Listener scheme at the prison was suspended in June 2009 for a number of reasons. They included that the Samaritans liaison manager withdrew his support due to personal issues and that two supporting Samaritans branches (Brent and Harrow) could not find a suitable replacement manager. The Governor also said that the population pressure on Wormwood Scrubs had increased significantly over the last few years and the number of prisoners assessed as suitable to be Listeners had decreased significantly.

75. The Governor said that the prison had had positive meetings with other Samaritans branches and hoped to restart the service again in the very near future. He said that, in the meantime, all staff and prisoners had been made aware of other support services, including access to Samaritans telephones.

76. I note that the IMB report published in the summer of last year comments that the Listener scheme had deteriorated over the previous year. Deterioration in the Listener scheme is concerning in itself, but having no Listener scheme in place is most worrying. Listener schemes provide prisoners' access to other peers who have been formally trained to provide a listening ear and support for those experiencing emotional difficulty whilst in prison.

77. I understand that efforts continue to be made by the safer custody team at Wormwood Scrubs to reintroduce the scheme. However, given the importance of such support, I invite the Governor to look at this issue further to ensure that the matter is dealt with most urgently. As such I make the following recommendation:

    The Governor should ensure that a Listener scheme, or equivalent scheme, is in operation at Wormwood Scrubs at the earliest opportunity and that staff are aware of its operation.

    I appreciate that in implementing the above recommendation the Governor is reliant on the local Samaritan group. I would ask that the Governor that if this continues to be the case urgent consideration should be made with regard to the possibility of setting up an alternative scheme.

Reliability of the Samaritan telephone

78. It is apparent from entries in the man's wing history sheets that he either requested, or made use of the Samaritan telephone on several occasions. However, due to the confidentially of Samaritan services, my investigation is unable to ascertain how many times he actually spoke to the Samaritans, and this information has not been recorded by the prison. However, the man's wing

history sheets mention use of, or request for, the telephone on four separate occasions during the night.

79. On two of these occasions, 18 July and 15 September, staff record that the man had difficulty getting the telephone to work in his cell. During the investigation my investigator tested the telephone on the wings. He established that the telephone worked in the landing office and in the communal areas of D wing. However, the telephone did not work in the man's cell, due to there being no reception. The senior officer who regularly works on D wing, told my investigator that she was not surprised, adding that it was not possible to get a signal in other areas of the prison as well. A number of other officers also told my investigator that there were problems getting reception on the Samaritan telephone in certain parts of the prison.

80. Although there is no evidence to show that this had any bearing on the man's death, it is of great concern to me. Indeed as a consequence of no Listeners being available, the cordless Samaritan telephone becomes an even more important means of providing access to support for prisoners in need of emotional support during the night. (During the day all prisoners can access the Samaritans through wing telephones.)

81. My investigator reviewed staff local instructions about prisoners' access to the Samaritan telephone at night. Local Instruction 2.77B, Nights – Use of Samaritan Telephone, provides guidance with regard to staff providing the telephone to prisoners during the night. However, paragraph four states that, "If a signal cannot be obtained for the telephone, then the use of a Listener will be considered." Given the non-operation of the Listener scheme at Wormwood Scrubs and the difficulty obtaining reception in some cells, it is imperative that alternative arrangements are introduced to ensure that prisoners have access to the Samaritans irrespective of the time of day. This could for example mean moving the prisoner to the Listener Suite or other appropriate location in order to use the Samaritan telephone.

    The Governor should consider amendment of Local Instruction 2.77B, in order that all prisoners have access to the Samaritan telephone at night.

Unlocking the man and morning roll checks

82. The senior officer explained to my investigator that, on weekends, two landings on D wing are unlocked for association in the morning and two in the afternoon. She said that at about 8.45am, when all the staff have arrived, prisoners on the two landings which do not have morning association are unlocked for their medical treatments before being locked up again at about 9.15am to 9.30am. the senior officer said it was then that the landings on morning association were unlocked, the other landings remaining locked until the afternoon association period. She said that the man, who was accommodated on the third landing would have had morning association that Saturday.

83. At 8.30am, when day staff come on duty at the weekend on D wing, there is no requirement for them to conduct a roll check to ensure that all prisoners are

present and well. Although a designated officer arrives early, at 7.45am to relieve the night OSG, the incoming officer is not required to check the roll. The next full roll check of the wing is not completed until 12.30pm. Consequently the last roll check on D wing was conducted by the OSG at 6.30am, when nothing untoward was noted.

84. At approximately 9.40am, the fourth officer unlocked the man's cell for association. Although not required to make a formal count, he too said that on unlocking the man's cell, he noted nothing untoward. The senior officer said that staff did not need to check a prisoner during unlock, explaining that an unlock was different to a roll check. She told my investigator that she had concerns about roll checks no longer being completed as often as they were a few years ago.

85. The governor on the wing told my investigator that, on going into the man's cell once the alarm had been raised, it was apparent that he had been dead for some time. Similarly it is noted in the medical record that the paramedics said, that given the man's condition, he had probably been dead for the past two hours before the fourth officer opened his door.

86. In a previous investigation into the death of a man who took his own life at Wormwood Scrubs in July 2008, my office also commented about there being no requirement for day staff to conduct a roll check when coming on duty. In that instance, the man was not found until lunchtime when his cell was unlocked. On that occasion I asked that the Governor to consider reviewing the times of roll checks at weekends to ensure that prisoners are checked at regular intervals. The recommendation to review the situation was accepted. However, the review of the roll checks concluded that the current process would continue and that incoming staff would not conduct a further roll check between the early morning check and the lunch roll call.

87. As this is the second time at Wormwood Scrubs when a prisoner has been unlocked who has apparently died some time earlier, I invite the Governor to review the unlock procedures again. Even if a formal roll check is not reintroduced he may wish to consider providing guidance to staff when unlocking cells to check the occupant before doing so. I therefore make the following recommendation:

    The Governor should again review the times of roll checks at weekends again to ensure the chain of custody is effectively handed over between shifts. Should he conclude that day staff are not required to conduct a formal roll check, he should consider introducing guidance which ensures that staff observe that a prisoner is present and well before his cell is unlocked.

Assessment, Care in Custody and Teamwork training

88. The clinical review panel concurs with my own investigator's findings that there were no documented concerns for the man's health and wellbeing in the period leading to his death. The panel reports that this is confirmed by the assessment

of the visiting psychiatrist on the day before his death. My investigator has not seen any evidence to suggest that staff missed signs of the man's intention to take his own life. The panel conclude that it was an appropriate decision not to open an Assessment, Care in Custody and Teamwork (ACCT) procedures in this case. (ACCT procedures are used by the Prison Service to assess, observe and support prisoners at risk of harming themselves.)

89. During the investigation it became apparent that at least one member of staff had confirmed that they had not received any ACCT training. All the staff who have contact with prisoners should have the necessary ACCT training in order to identify a prisoner's increased risk of self harm. Although I make no criticism of any individual or suggest that this deficiency contributed in anyway to the man's death. However, the Governor will wish to ensure that all staff, including healthcare and those employed by outside services, are in receipt of ACCT training to foundation level.

Wing history sheets

90. My investigator was unable to establish any detail about the time that the man spent in custody from written prison records and, in particular, his wing history sheets. Of the eight entries made before his death only one, on 24 October, records any meaningful information about the man, the others being predominantly reactive statements. Four of the other entries relate to problems with the Samaritan telephone, whilst the remaining three briefly record an action by staff and are of poor quality. One of these simply records that the man was warned for misuse of the cell bell, but with no explanation as to why. I note that if the references about the Samaritans had not been written in the man's record, he would not have had a history sheet entry for two months.

91. My office has commented before on the inadequacy of wing history sheets. I am saddened that prisoners such as the man, who are not disruptive to the prison regime and therefore have lower profiles on the wings, are less demanding of staff time and attention, may go unnoticed. As a consequence less is recorded in their history sheets and less information is therefore available to staff or for investigations such as this.

92. I appreciate that much interaction between staff and prisoners goes unrecorded, due to the constraints upon time and staffing levels. However, it is essential that staff take time to record their contact with prisoners in order to demonstrate that not only interaction is taking place, but so that they and their colleagues are aware of a prisoner's history. With the introduction of the prisoner national offender management system (P-Nomis), all officers should be in a position to make meaningful and quality entries on prisoners in their case notes.

93. Her Majesty's Chief Inspector of Prisons, said in her report that:

> "We were not assured that staff, in general, knew their prisoners well. Staff entries in prisoner wing files were poor. On most wings, they averaged just three or four per month, and most were short, observational and showed limited interaction. There was insufficient guidance for staff and management

> checks of wing history sheets. Both staff and managers constantly explained away weaknesses in staff performance or engagement as due to shortages of staff. However, some of the prison's problems needed to be thought through more carefully."

As a consequence of her enquiries Her Majesty's Inspector of Prisons made a recommendation that entries in wing history sheets should be improved and effectively monitored. Two years after her recommendation my own findings here echo those of Her Majesty's Inspector of Prisons. I therefore repeat her recommendation.

The Governor should ensure that the quality of staff entries in prisoner wing history files should be improved and effectively monitored.

Personal officer scheme

94. During his opening visit my investigator was surprised to learn that there is no personal officer scheme operating at the prison. It appeared that there was little one to one contact between prisoners and staff, although the second officer confirmed that he had spoken to the man on a number of occasions.

95. In response to our enquiries as to why there was no personal officer scheme in operation the Governor of Wormwood Scrubs explained that, for various reasons, a conventional personal officer scheme was difficult to manage in an establishment the size and type of Wormwood Scrubs. The Governor said that there were far more prisoners than staff, meaning that officers did not get the time to get to know the prisoners. He said that instead, Wormwood Scrubs promoted the approachability of all staff and asked prisoners to speak to their landing officer if they had concern.

96. The Governor also said that the high turnover of prisoners made it difficult for a conventional personal officer scheme to be implemented. He said that Wormwood Scrubs receives an average of 120 new prisoners each week and that in the near future this was set to increase with the introduction of a new Crown Court in the local area. He said the current system allowed discretion on the part of induction staff, who are responsible for identifying any prisoner of concern, to allocate them a "Support Officer" if they have any problems.

97. In her report of Wormwood Scrubs, the Chief Inspector also reported on the absence of a personal officer scheme and how this linked with the quality of entries in wing history sheets which I have already reported on. She said that:

> "There had been attempts to run personal officer and support officer schemes, but these had not worked, and there was no formal personal officer system. Landing officers acted as the first point of contact for prisoners, and were expected to complete any reports on them and make at least weekly entries in prisoners' wing history sheets. Those that we sampled showed that this was generally achieved, but most entries were observational and did not necessarily reflect any contact with prisoners or record significant events affecting them."

The Chief Inspector subsequently recommended that a personal officer scheme should be introduced. I repeat her recommendation:

The Governor should introduce an effective personal officer scheme.

Post incident care for prisoners

98. During his initial visit, my investigator spoke with three of the prisoners who raised the alarm on the morning of 31 October. My investigator was surprised to learn that only one of these prisoners had been identified by staff at the time of the incident. After his interviews with the prisoners, my investigator established that the men had been affected by finding the man, and needed to talk about their experience. At that time, they had not had the opportunity.

99. The Governor of Wormwood Scrubs acknowledged to my investigator that this highlighted a failing in the post incident care provided to those prisoners affected by the man's death. He assured my investigator that appropriate steps had been taken to minimise any future risk of the same thing happening again.

CONCLUSION

100. When the man came into prison, he immediately told medical staff about his history of bipolar disorder. Despite providing details and contacts about his care in the community, he was not referred to be assessed by the mental health in-reach team until he asked to be referred over two weeks later. Declining to be assessed, there was no further mental health input until his assessment by a locum psychiatrist almost three months later. It is unfortunate that in the five and a half months that the man spent at Wormwood Scrubs, the investigator was unable to establish little about his time at the prison, other than that gleaned from the medical entries of the locum psychiatrist.

101. In the clinical review, the clinical reviewers conclude that the man's death could not have been prevented, even given the limited interaction with mental health services.

102. However, it is clear that the man was suffering from increased stress and depression in the days leading to his trial, as evidenced in the telephone conversation with his daughter on 19 October. The man, an articulate and well educated man, with clear insight and understanding of his illness, appears to have concealed his true feelings from staff out of fear that speaking to them would bring him under greater scrutiny. Given his behaviour, I do not believe that his subsequent actions could have been foreseen by staff. However, had they known him better, for example, by way of a good personal officer scheme his care may have been enhanced. I believe that early consistent and quality mental health interventions should have been provided to the man at Wormwood Scrubs.

RECOMMENDATIONS

1. The Head of Healthcare must satisfy themselves that all prisoners identified at reception with severe or enduring mental illnesses should be referred to the mental health in-reach team for assessment. In order to ensure that this takes place, we recommend review of the mental health in-reach referral policy.

   Accepted - *Mental Health pathways has been reviewed. Currently with Associate Director of CLCH and Director CNWL for further comments. It is expected that an action plan will be forthcoming early in the New Year.*

   All prisoners with mental health issues identified at reception are currently referred to the in reach team but this relies mostly on the prisoner informing us of such. Records do not always accompany the prisoner as they arrive. GP records are requested but records relating to severe and enduring mental health would normally not be held by the GP but by specialist services.

2. The Head of Healthcare should ensure that all individuals are seen face-to-face when anti psychotic medications are re-prescribed.

   Partially Accepted - *We are currently reviewing the re-prescribing of all medications. NICE guidance is quite clear about frequency of face to face reviews and we are aligning our polices to reflect best practice as published.*

3. The Head of Healthcare, in consultation with senior clinicians and pharmacist, should devise a protocol for prescribing benzodiazepines at Wormwood Scrubs.

   Partially Accepted - *We have protocols for prescribing benzodiazepines. We need to build a checking mechanism into the electronic records system to flag when this particular type of drug is prescribed. Electronic prescribing and administration of medication electronically is currently a piece of work in progress.*

4. The Head of Healthcare, working through clinical governance arrangements in the prison, and in collaboration with other interested parties (including providers, prison representatives and commissioners), should ensure collaborative and better integrated arrangements between primary and secondary health care providers.

   Accepted - *Working relationships are being developed further all the time. There is a robust governance structure within the establishment. All providers are invited to the clinical governance forum and senior leads within the services are members of the patient safety and governance forum.*

5. The Head of Healthcare should review existing team processes within the mental health in-reach team. This review should extend to a review of protocols for the following: receiving and processing referrals; arrangements for multi-disciplinary discussion and planning for each referred case.

   Partially Accepted - *The mental health contract for specialist provision is held by*

the Commissioners at present and CLCH have no control over this. New contracting arrangements are expected to be in place certainly by the commencement of the new financial year and at that point the contract will be managed by CLCH as the lead contractor. CNWL will be a sub contract. At that point we will be able to manage more directly the protocols as suggested in this recommendation.

6. The Head of Healthcare, in collaboration with local clinicians, should establish a protocol to ensure that primary care information is requested from community general practitioners for all new prisoners.

   Accepted - *This is already in place for those prisoners who know who their GP is. However, we have identified there is not a robust system in place for following up such requests and this is currently being developed.*

7. The Head of Healthcare should ensure that the parameters of case co-ordination should be reviewed and set down as a matter of policy and expectation with primary and mental health in reach care.

   Accepted - *As in (5) above this will be more within our gift to manage when CLCH manage the mental health contract.*

8. The Head of Healthcare should ensure that mental health services consider using appropriate family liaison for all individuals on the caseload, if consent is obtained from the relevant individual.

   Accepted - *As in (5) above this will be more within our gift to manage when CLCH manage the mental health contract.*

9. The Head of Healthcare should remind staff of their record keeping responsibilities as set out by professional bodies (General Medical Council and National Midwifery Council) and within local records management policies and record keeping standards.

   Accepted - *The NMC are currently sending out updated information to all staff on the register regarding record keeping responsibilities. We will also locally send out reminders to both staff on the NMC and GMC registers.*

10. The Governor should ensure that a Listener scheme, or equivalent scheme, is in operation at Wormwood Scrubs at the earliest opportunity and that staff are aware of its operation.

    Accepted - *The Samaritans are now engaged with the prison and jointly working on the implementation of a new Listeners scheme. A full staff briefing will be undertaken to introduce the new scheme.*

11. The Governor should consider amendment of Local Instruction 2.77B, in order that all prisoners have access to the Samaritan telephone at night.

    Accepted – We *are currently investigating alternate methods of facilitating the*

use of Samaritans phones; this is to ensure a better reception within the cells on all wings. This will also be addressed in point 11 above on the completion of implementing the new listeners' scheme.

12. The Governor should again review the times of roll checks at weekends again to ensure the chain of custody is effectively handed over between shifts. Should he conclude that day staff are not required to conduct a formal roll check, he should consider introducing guidance which ensures that staff observe that a prisoner is present and well before his cell is unlocked.

    Partially Accepted - *A Governors Order will be published reminding all staff of the importance of checking the presence and condition of each prisoner at the point of unlocking the cell door*

13. The Governor should ensure that the quality of staff entries in prisoner wing history files should be improved and effectively monitored.

    Accepted - *A Governors Order will be published reminding all staff of the importance of quality and regular entries into PNOMIS for all prisoners this is to be monitored by residential managers.*

14. The Governor should introduce an effective personal officer scheme.

    Partially Accepted - *Because of the prisoner / staff ratio on residential units a Personal Officer scheme in it originally conceived format is not practical within the establishment. However work is currently taking place between the Head of Residence and the prison's Safer Custody Team to identify a scheme, intended to introduce a limited, but more individually targeted support scheme for use with identified vulnerable prisoner groups.*