# Investigation into the circumstances surrounding the death of a man at HMP Wormwood Scrubs in December 2007

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

**March 2009**

This is the report of an investigation into the circumstances of the death of a man on 21 December 2007 at HMP Wormwood Scrubs. The man was found in his cell with a ligature around his neck attached to his upended bed. He had also cut his wrist. The man was 25 years old, and from Iran.

I would like to offer my sincere condolences to the man's family and all those touched by his death. I must apologise for the delay in issuing this report.

The investigation was undertaken by two of my colleagues. Both they and I would like to thank the Governor of Wormwood Scrubs and his staff for their cooperation during the course of our inquiries. In particular, I thank the prison's liaison officer. I must also thank Hammersmith and Fulham Primary Care Trust for their review into the clinical care afforded to the man.

The man had been remanded into Wormwood Scrubs on 29 November 2007. The healthscreen conducted when he arrived does not appear to have considered concerns raised about his strange behaviour in the police station and at court.

After seeming to settle into prison life, the man then began to harass a member of staff and was placed on a basic regime. Later, he allegedly attempted to assault a member of staff and was restrained and held overnight in the segregation unit. It appears the man faced further charges, and as a result attended a police station on 20 December. Here he divulged that he felt like harming himself. The police enhanced his supervision, but unfortunately did not pass this information to the prison. The following morning the man was found dead in his cell.

I make nine recommendations. Three relate to the monitoring and management of prisoners held on the basic regime. I also make recommendations about the information clinical staff consider during the reception healthscreen, and referrals to the Mental Health In Reach Team. My final recommendation concerns cutting the ligature when a person is found hanging.

**Stephen Shaw CBE**
**Prisons and Probation Ombudsman** **March 2009**

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## SUMMARY

The man arrived at Wormwood Scrubs on 28 November 2007. He was 25, from Iran and spoke Farsi. He had never been in a British prison before. When he arrived, the Prisoner Escort Record contained notes that the man had been behaving strangely, and it was noted on the warrant that he had been referred for a mental health assessment. There is no evidence that this was further explored, and it was impossible for my investigators to ascertain whether he underwent the induction process. He also did not see the wing foreign national orderly, although he initially shared a cell with another Iranian prisoner.

The first week of the man's time in Wormwood Scrubs was unremarkable. However, after several attempts to harass a member of staff, he was placed on the basic level of the Incentives and Earned Privileges (IEP) scheme. He was moved to a single cell, had his television removed and was escorted to collect his meals. During the next three weeks, his behaviour deteriorated. At times he would continuously press his cell bell, and move or throw furniture. He was also seen repeatedly removing his clothing from his locker and then placing it back.

The man spoke limited English but seemed to understand some. On 18 September, as a result of allegedly attempting to assault a member of staff, he was restrained and taken to the segregation unit. Here he was seen crying and to have a bloodied nose. He stayed overnight before attending court via video link the following morning. He then returned to C wing.

On 20 September, the man was taken to a Central London police station to face further questioning. Here, he told staff he had thought about harming himself. The police increased his observations but did not communicate the information to prison staff on their return. This is subject to a separate investigation by the Independent Police Complaints Commission.

The following morning during a routine roll count, the Operational Support Grade (OSG) found the man hanging from a ligature attached to his upturned bed in his cell. He summoned assistance. Staff found there was evidence of rigor mortis and decided not to attempt resuscitation. They also did not cut him from the ligature. I am critical of this decision.

My investigation found that some improvements monitoring basic regime were required in terms of reviews and daily checks from wing managers.

During the man's time in prison, it appears two referrals were made to the Mental Health In Reach Team (MHIRT). The first they did not receive, the second they did but on an out of date form with no indication of the urgency. The man's mental health was not assessed prior to his death, and I believe that much greater clarity about the procedures to be followed when making a referral is needed.

## THE INVESTIGATION PROCESS

1. I appointed one of the two investigators to lead the investigation on my behalf. On her initial visit to HMP Wormwood Scrubs, she met a second Governor. She was also given a tour of the prison, including the cell where the man died. Notices were issued to both prisoners and staff in Wormwood Scrubs inviting anyone who might have information relating to the man to make themselves known to the inquiry. No one came forward as a result of the notices.

2. One of my Family Liaison Officers, made efforts to contact the man's family through the Iranian embassy. In January 2008, she wrote a letter of explanation about the investigation and sent a leaflet about the work of the office. We were assured by the embassy that this would be passed on. Further attempts will be made to inform the family of the issuing of this draft report.

3. The two investigators, interviewed prison staff and prisoners at Wormwood Scrubs both formally and informally. The team examined the man's prison record, medical records and a series of prison documents. Several staff members and prisoners the investigation team wanted to interview had since moved from Wormwood Scrubs. My investigator wrote to one prisoner who had declined to speak with her. A Senior Officer spoke to my investigator on the phone, and agreed to be interviewed and I am grateful for his flexible approach. A nurse spoke to my investigator but declined to be interviewed. My investigator followed this up in writing and further telephone calls but received no response. The Governor will wish to draw this to the attention of the PCT. I understand that the nurse no longer works at Wormwood Scrubs, but I do not know if he works at another prison.

4. My investigator also spoke with court staff, and made efforts to contact escort staff.

5. A clinical review was conducted by a panel, set up by Hammersmith and Fulham PCT, and can be found at Annex 1 of this report.

**HMP WORMWOOD SCRUBS**

6. HMP Wormwood Scrubs is a large category B local prison predominantly serving the courts of North-West London. It holds both convicted and remanded adult men. The prison population is fluid with a high number of receptions and discharges each day. The jail can hold up to 1,277 prisoners in total.

7. In 2005, the prison was recorded as holding more foreign national prisoners than any other establishment in England and Wales with approximately 52 per cent of the population being foreign nationals.

8. HM Chief Inspector of Prisons inspected Wormwood Scrubs in an unannounced short follow-up inspection in October 2005. She noted that Wormwood Scrubs had made “gradual, but discernible, progress” over the last few years. Significant improvements had been made to the resettlement work available at the prison and plans were advanced for similar improvements to the first night and induction procedures. Staff-prisoner relationships remained “relaxed and cordial”. However, record keeping across the prison was deemed poor. The prison’s main weakness continued to be the insufficient provision of purposeful activity for the population.

9. Several recommendations were made by the Chief Inspector of Prisons concerning the use of force. In particular, that the proper written authority for the use of force was not consistently obtained and the use of force documentation was not being properly certified by appropriate managers.

10. The last published annual report from the prison’s Independent Monitoring Board (IMB) covers the period 1 June 2006 to 31 May 2007. The Board noted a few issues of concern. The retention and recruitment of staff, generally across the prison and in particular in Healthcare, was seen as problematic. This had a negative impact on aspects of the regime and the delivery of programmes. The Board reported that the Segregation Unit was generally well run by “competent and concerned officers”. However, they agreed with HM Chief Inspector of Prisons that Segregation Unit documentation was not always of a high enough standard.

11. The IMB commented that, in April 2007, 44 per cent of the prisoners were foreign nationals (15 of whom were from Iran). The Board was concerned about the anxiety levels amongst foreign national prisoners who were often worried about their immigration status and what might happen at the end of their sentence.

## KEY EVENTS

12. On 28 November 2007, the man was charged at Acton police station with harassment and held overnight. He did not have any injuries or any illness and did not have any medication on him.

13. The next day, the man was given a notice explaining that he had been charged with harassment. In addition, it was explained to him that the court might consider the possibility of deportation under the Immigration Act 1971. The man signed to say that he had received this notice.

14. The man was taken from Acton police station to Ealing Magistrates Court. The Prisoner Escort Report (PER) showed that no risks had been identified. His defence solicitors requested a mental health report as they were unable to take sufficient instructions from the man to determine his plea, and his case was adjourned until 5 December. The man was taken to HMP Wormwood Scrubs. The part B of the PER indicated that the man was acting very strangely by talking to himself, and was unpredictable. The escort officer wrote on the man's core file detailing his next court appearance, and recording that he was 25 years of age. Below the picture of the man, the escort officer wrote, "Doesn't care what happens". (My investigator wrote to an employee at the escort contractor but received no reply and was unable to interview him. I do not know if he is still employed by the escort contractor, but the Governor will wish to draw this to their attention.)

15. The fact that the court had requested a mental health assessment, which was to be conducted by a mental health team based in the community, was documented on the warrant. My investigator spoke with the court clerk who explained that the man's solicitors did not know what plea to make as they found his behaviour strange. The referral for a mental health assessment was made to a local hospital that would then make appointment to assess the man in prison. The assessment did not take place before his death.

16. Little is currently known about the man. After his death, the Coroner's officer found that he had been in England for about two years. He had claimed asylum saying he had taken photographs at a demonstration in Iran, and been beaten badly. He had a number of scars on his body, some consistent with previous self harm, but also consistent with the man's alleged experience. He had been declined asylum. Wormwood Scrubs did not have this information when the man was alive.

17. On arrival at Wormwood Scrubs on remand, an Officer carried out the Cell Sharing Risk Assessment (CSRA). (The CSRA is completed to determine if a prisoner is a risk to a cell mate). The Officer told my investigator that the assessment can also allow staff to find out how a prisoner feels about themselves and whether a prisoner is down in mood. The Officer said that the man answered no to all of the questions on the assessment form which meant that he was low risk to other prisoners. The Officer did note that the man's English was not good, and the only thing that he had made clear was that he wanted to be located with another Iranian prisoner.

18. A Nurse then undertook a reception healthscreen with the man. The man said he did not have a doctor. He had not been in prison before. The man said that he had never received treatment from a psychiatrist, did not use drugs, and only drank alcohol socially. The healthscreen contains questions regarding self harm. The man replied that he had not self harmed and did not feel as though he would. The Nurse noted, “appears mentally stable, good eye contact”. The man did not report any physical ailments or injuries. The Nurse took the man’s blood pressure and pulse, and both were within the normal range. There was no evidence that the man was questioned about the comments contained within his warrant or PER.

19. As part of the reception process, the man went through a strip search. In interview for this investigation, no officer recollected seeing scarring on his body. They said it would only alert them to risk if the wounds were recent.

20. The man was then taken to the first night centre (FNC) and the following entry was made in his clinical record: “Seen in FNC very little English able to respond to the screening questions-states fit/well declined to see the doctor.”

21. On 30 November 2007, the man was moved to C wing into a shared cell. C wing has four landings and holds 290 prisoners. Another Senior Officer (SO) told my investigator that that the second landing on C wing was used for new prisoners. He said that prisoners would come from the FNC to C wing. He explained that prisoners would receive their induction and get their Pinphone numbers, be given a general explanation of the prison (the “do and the don’ts”), and receive an assessment for education. He explained that they would then be moved to another landing on C wing or to another wing.

22. My investigator asked the other Senior Officer whether anything was done differently or in addition if the prisoner was a foreign national. The SO replied:

> “Yes, they get told that they are entitled to a foreign national phone call once a month providing they don’t have visits in the UK, they have access to airmail letters, they have an international rep who is a member of staff and also on the wing we have an international rep who is an inmate and who is quite useful, we try to pair them up if they want to be with a fellow foreign national obviously because of problems with the language.”

23. On the same day, the man had a general health assessment with a registered general nurse. The purpose of the secondary healthscreen is to assess immediate physical and mental health needs and make referrals for future care. The nurse told my investigators that during the general health assessment a prisoner’s blood pressure is checked, and they are asked whether they have any disability, smoke or whether there is a family history of illness. He told my investigators that the man was polite and did not do or say anything that would suggest he might have mental health problems. He said that the man understood what he was saying to him which was made easier as diagrams were used and so there was no need for a translator. My

investigators asked the general nurse whether he had seen the man's warrant as it was stated on his warrant that the court had requested a mental health assessment. The Nurse replied that he had not seen the man's warrant. However, he did confirm that the reception nurses view both the PER and the warrant.

24. The man signed a compact (agreement) regarding his behaviour, confirming he understood the Incentives and Earned Privileges scheme (IEP). (This is a scheme to encourage and reward good behaviour by prisoners.) Principal Officer (PO) explained to the investigation the three levels of IEP. He said that new prisoners would start on the standard level and would be allowed to have a television in their cell. They can work their way up to the enhanced level with good behaviour and are then entitled to certain employment, regular activity, and possibly receive extra privileges such as additional visits. However, if a prisoner's behaviour deteriorated they would be put on the basic level which was below the standard level. He said a prisoner on the basic level was allowed two periods of association, one during weekdays and one during weekends, and was not allowed to have a television but could have a radio and reading materials.

25. On 2 December, another Officer noted in the man's history sheet that he was new to the wing but there were no concerns. Three days later, the man signed the public protection harassment form that was completed by a different SO. The SO told my investigator that the man stood out to her as he smiled, but for no other reason. She said he spoke some English. When she was unsure whether he understood what she said, she used another prisoner to help translate.

26. The man's warrant stated that he was convicted of common assault and four accounts of harassment on 5 December. The next court appearance was for sentencing on 19 December which was to be conducted by video link.

27. The Foreign National Orderly on C wing said that he did not meet the man. He said that he is given a list of foreign nationals on C wing every week but, as he has limited time out of his cell, he did not have enough time to see everyone on the list. He said that his name and cell number were displayed on the foreign nationals notice board. In addition, he wore a t-shirt with the logo "FN orderly" and there was a notice on his cell door which said the same thing. He said that he helped foreign nationals and linked new prisoners with others who spoke their language. He told my investigator that there should be three FN orderlies but at the time there was only one. He felt that foreign national prisoners were not served well in prison with regard to food, jobs or family contact.

28. The Foreign National Coordinator explained that she holds three foreign national groups each week. The groups help prisoners who are vulnerable and those with problems such as depression, drug and alcohol abuse, and those with English as a foreign language.

29. Induction takes place in classrooms on C wing. My investigator could find no evidence relating to the man undergoing any induction or education assessments.

30. On 6 December, a third Officer went to see the Senior Officer about the man's behaviour. The other Senior Officer explained that the third officer had become quite concerned as the man had been following her around on more than one occasion and had asked her to go into his cell. At lunch time, another officer had had to intervene and ask the man to return to his cell. Senior Officer told my investigator that she looked on the computer information system to see what was known about the man, and remembered that his offence included harassment. She decided to speak to the man and warn him informally that his behaviour was unacceptable. She asked a trusted prisoner to help translate as she knew he also spoke Farsi. The Senior Officer said that she asked the man to stop harassing and following staff and that he should not do that. She also told the man that, if he persisted, she would put him on to the basic regime which meant that he would be in a single cell and not allowed out of his cell as much. She told my investigator that she had asked the man if he understood what she had been saying to him, and he said that he had. My investigator asked what the man's behaviour was like when she spoke to him. The Senior Officer replied:

> "He was still smiling … then he went all stern and then he walked to the back and come back, then he was quite serious, and then when I left he was smiling again."

31. At tea time that day, the third officer returned to the Senior Officer and told her that the man had just asked her to go to his cell again. He had collected his tea and was walking to his cell when he saw the third officer on the other side of the landing. The third officer said that the man walked back round, started following her, and again asked her to go into his cell.

32. That evening, the man went from the second floor to the fourth floor landing. The fourth Officer had been working with the third officer on the fourth landing that day and the man came and stood next to her. Wherever she moved to, he also moved. The fourth officer said that this made the third officer feel very uncomfortable and so he asked the man what he was doing. The man did not reply so the fourth officer asked him to return to his own landing. The fourth officer told my investigator that he thought the man had understood what he was saying as he seemed to acknowledge it and went down the stairs. Although the fourth officer could not remember issuing the man an IEP warning, he said it was something he would give the warning for. The man's history sheets show that he was given an IEP warning.

33. The third officer told my investigator that the man had made her feel extremely uncomfortable. This was largely to do with the fact that he would stare at her wherever she was and would try and approach her, even if it meant deliberately going to a different landing. Compared to some of the foreign nationals they had on the wing, the man had broken English but could broadly make himself understood. The third Officer told my investigator that

she had identified vulnerable prisoners before but did believe the man came into this category. She said that the man did not seem to understand that there was anything wrong with his behaviour and did not realise it was unacceptable.

34. As it was the evening and an IEP review could not realistically be convened, the Senior Officer left a note asking another Senior Officer to hold one with the man. It took place on 8 December attended by the man, the fourth SO, the fifth Officer, and a Farsi speaking prisoner.

35. The result of the review was to place the man on the basic regime. The fourth SO told my investigator that staff had raised concerns about the man previously, and he had himself seen the man acting in a bizarre way. He had realised that the man's offence was harassment and he had been behaving similarly in custody. The fourth SO was concerned for staff and decided that the man needed extra attention and control. During the interview the fourth SO said,

> "I felt that he needed to go on the basic regime to restrict his movements a little bit, until … we can sort of assess if he had any mental health issues and get him assessed by healthcare."

36. My investigator asked the fourth SO what it meant to be on a basic regime at Wormwood Scrubs. The fourth SO explained that a prisoner on basic regime would have a limited period of association twice a week and limited use of the gym. He said that facilities in their cell are reduced, they have reduced canteen (access to the prison shop), and they are escorted to meals. When asked how a prisoner progresses from the basic regime to the standard regime, the fourth SO replied:

> "… their behaviour is logged everyday … there'll be entries in the morning and the afternoon on the evening, made in the booklet and if their behaviour is acceptable over the period of time it will reviewed again and they generally tend to remind you when their review is due as well."

37. When asked if there were set periods between reviews, the fourth SO replied:

> "It has been set at 14 days but I don't believe, under the new document it's now seven days where a review will take place. We have put people on seven day reviews and then reviewed them … it would be on the front of their book anyway and they would be notified of that."

38. The fourth SO told my investigator that, when they explained to the man that his behaviour towards the third officer was inappropriate, the man made a comment that he felt she was beautiful. This was verified by a fifth officer. The man said this in English in response to being asked why he was following the third officer.

39. The following entry was therefore made on the man's history sheet by the fifth officer.

> "Although he stated he didn't speak English at all, when asked during talk why he followed he stated that she was beautiful, when I repeated what he said he said didn't, but a sixth officer clearly heard him too. Refer to in reach. SIR submitted."

40. The fifth officer explained that the man had been put on a basic regime because of his actions towards the third officer and because he was quite aggressive. She submitted a security information report (SIR). (A security information report is passed to the security department to decide whether action should be taken and keep on record any incidents.) She was also concerned that he might have anger management problems and she completed a referral for the Mental Health In Reach Team (MHIRT) which she handed to a third nurse, the wing based nurse.

41. The Acting Manager for the MHIRT explained that the team provide secondary care for prisoners who have severe and enduring mental health problems and also conduct primary assessments. She explained that, depending on the level of urgency, the prisoner will be seen first by a nurse and then by a doctor, or by a doctor immediately. Prison staff also telephone to discuss prisoners with a team member who completes a referral form as they speak. The manager for the MHIRT said that the team accepts referrals from anyone, including self referrals. She told my investigator that, when a written referral is received, the team checks the medical record to see if there are any indications that it is urgent. Urgent referrals are seen within three days or sooner and routine appointments normally take about two weeks. She said that the team use an interpretation service if a patient cannot communicate in English.

42. In interview with my investigator, the wing based nurse said he did not think he had received a referral about the man. If he had, he would have passed it onto the doctor and filed it in the medical record.

43. My investigator asked the fifth officer whether she thought that the referral system worked well. She thought it would be helpful if the in reach team could wrote in the prisoner's wing history sheet when they saw someone, as often staff would be unaware.

44. The man was moved into a single cell on the third landing just before 4.00pm on 8 December 2007. This was in order to move him away from the second landing where the third officer was based.

45. About an hour later, the fifth officer went to escort the man to dinner but he refused saying that he was not hungry and would eat the next day. The man was drinking water. Staff checked on him that evening and wrote in his IEP book that "no inappropriate remarks or behaviour were made".

46. The following day, the man was escorted to lunch and collected his meal. The fifth officer emailed the Multi Agency Public Protection Arrangements (MAPPA) clerk and copied the message to C wing staff. She detailed the events of the previous few days and asked that they check the man's files for information. A note was made in the wing observation book that the man's mail should be monitored.

47. The MAPPA clerk replied to the email. She explained the man's offence and that the court had ordered a medical report due to mental health concerns.) A worker from the C-wing staff replied suggesting she refer him to the Seacole Centre (this is a day care centre for prisoners), "so that we can assess him to attend groups here. This way we can observe his mood and behaviour whilst he is awaiting a mental health assessment." The clerk replied saying that she would pass the suggestion to wing staff and forwarded the email to the fifth officer and another SO. In interview, an SO could not remember receiving this email, and the man was not referred to the Seacole Centre.

48. On 10 December, the man was unlocked for exercise and showers. He declined lunch. The man stayed in his cell for most of the afternoon but at 4.00pm he tried to make four telephone calls. (When prisoners come into prison they make a list of telephone numbers which the prison records and issues them with a Pin number. Prisoners then use this Pin number when dialling numbers and all calls are logged.) None of the numbers the man tried to dial were authorised on the Pinphone system.

49. The next day, when the man's cell was unlocked so that he could go for exercise and a shower, he was reluctant to talk to staff. Later, when he was taken for lunch it was noted that he had to be coaxed out of his cell to collect his food. A seventh Officer recorded that it appeared that the man was refusing meals out of embarrassment, but took his food if he was encouraged.

50. Later that afternoon a window in the man's cell was smashed and the works department in the prison came to repair it. The man seemed very withdrawn and there was little communication. He collected his dinner and there were no problems at night. The man tried making two telephone calls, one at 10.25am and one at 19.13pm, but again the number was not permitted from his list.

51. The following day (12 December), the man approached a teacher on the third landing and enquired about one of her female colleagues. A fourth Officer noticed that the man was standing next to a female member of staff who was about to take a class. When the Officer caught her attention she told him that the man would not go away. The fourth officer said he asked the man whether he was part of the class, to which the man replied he was not. The Officer escorted the man back to his cell and explained that he could not stand outside classes and that he was making two teachers feel uncomfortable. The fourth officer said that the man did not acknowledge what he was saying to him but he thought that he understood what was said.

52. The man was taken to lunch by an eighth Officer and a note was made on his history sheet that no female staff were to deal with him. The officer said that he had no problems with the man. He told my investigator that he would explain to the man when it was time to shower or collect food. The man would come out of his cell but would not respond. He felt that, although the man's English was limited, he did understand some.

53. Later that evening, the man was out of his cell briefly for association. He was quiet for the rest of the night. The following morning, the seventh officer unlocked the man for exercise and a shower. She noted that he looked miserable and was also very quiet when he collected his lunch. During interview my investigator asked the seventh officer about this. She replied:

> "I don't think I saw him smile once … a generally miserable character. But I would say miserable grumpy, not miserable sad, you know he didn't look upset or emotional, he just looked blank, just uncooperative, uncommunicative and just grumpy."

54. The same day the seventh officer made the following entry in the wing observation book:

> "Still on basic. Smashed cell window at some point yesterday (fixed now), does not communicate well. Apparently speaks Farsi but is reluctant to talk with other prisoners who translate. They all imply he is a 'bit crazy'. Prisoner in neighbouring cell says he is very noisy – difficult for officers to monitor as he is in north end of the wing. I feel although he is a pain he is also vulnerable and check on him often as he is in cell a lot due to basic. I feel he is unpredictable and needs monitoring regularly for own safety."

55. My investigator asked the seventh officer about the noise the man's neighbours complained about and whether she had been aware of it. The seventh officer said there were six cells in the north end of the wing, five on one side and one on the other. The man was in the middle of the group of five cells. He apparently moved his furniture around during the night, and in the morning his neighbours would ask her to do something about the noise. The Seventh officer said she would sometimes walk down to listen and see what the man was doing. Most of the time he would be moving his furniture around, but he was not particularly noisy.

56. When asked why she felt that the man was vulnerable and needed regular monitoring for his own safety. The seventh officer replied:

> "Just because he didn't communicate … because he didn't really speak to anybody and nobody really knew what was going on in his head, I kind of thought that maybe because he was on this basic regime and he was new to the prison, that maybe he didn't really understand what was going on … he did seem a little bit vulnerable but with no real cause for concern … he was never saying anything, he was never doing anything that made anybody think that he was going to hurt

himself but instinctively I just kind of thought, there's something not quite right about him."

57. On the afternoon of 13 December, the man remained in his cell and was either pacing or sitting staring each time the seventh officer checked. The seventh officer said that the man had to be coaxed out for food again. She said that he often refused at first but would collect food if "you make out that it's no big deal". When asked whether she had ever felt uncomfortable or threatened by the man, The seventh officer replied:

> "No never, this was the strange thing … he never acted inappropriate towards me whatsoever, he never looked at me strangely, you know, he just used to do the vacant look, he wasn't the sort of checking me out or anything like that, he never stepped into my personal space, he never, just he never did anything like that and that's why I was happy, I said in my experience he doesn't even come near me so I said you know I'm quite happy to deal with him."

58. That evening the seventh officer took the canteen round and saw that the man was busy rearranging the cupboards in his cell. There were no problems in the night. The following morning when the man was unlocked he came to the landing office and said he was "hungry". The seventh officer told him that he had to wait until lunchtime and he accepted this. When the man was taken for lunch the seventh officer noticed that he had stripped his bed and all his bedding was in his cupboards in his cell. The man expressed no problems that afternoon, and collected his food.

59. The following day, the man was unlocked for association and kit change. He collected new bedding/clothing and wandered around the wing. He collected his lunch without any problems.

60. Later that afternoon, prisoners in neighbouring cells complained that the man was banging around very loudly during the day and night. They said he was possibly hitting things against the door. The man refused his meal after repeated attempts to encourage him by the seventh officer and another Officer. There was nothing to report during the night.

61. On 16 December, the man remained in his cell for the morning. He collected his lunch with an officer. An officer told the investigation that the man was not a problem and there was no threat of violence or any sort of bad behaviour. He told my investigator that the man's English was not good but, when he wanted something, he would make himself understood and when he was not interested he would act as if he did not understand.

62. The prisoners in the cells neighbouring the man continued to complain about banging in his cell. An officer told my investigator that he could not be sure if it was coming from the man's cell. Another prisoner had said to him that he had heard rumblings coming from the man's cell. That evening, the man collected his dinner and no problems were reported that night.

63. On 17 December, a fifth officer agreed with the seventh officer that the man was vulnerable but said he was unpredictable and therefore female staff had to be aware. As the fifth officer was not sure whether the MHIRT had seen the man, she completed another referral form. The fifth officer wrote on the referral that the man had:

> "… an aggressive manner, follows female staff, loses his temper regularly and anyone who translates say that he is crazy and won't listen and he understands and speaks English when he wants to."

64. This second referral was received by the MHIRT. However, it was completed on an out of date form, and there was no indication of how urgently he was to be seen. No appointment had been made for the man up to his death.

65. The next day, the man received a warning for continued misuse of his cell bell and was warned that the bell was only for use in emergencies. The man asked for Pin credit but was told he would need to purchase it from his canteen on Thursday 20 December. On hearing this the man threw his food on the floor. He kept tutting and throwing his furniture around. It was noted in his history sheet, "He is a time bomb waiting to go off." The fifth officer said that he was becoming a drain and when he was escorted to dinner he leered at Officer eleven. Another SIR was submitted.

66. Officer twelve placed the man on a Governor's report (disciplinary charge) for continuing to misuse the cell bell. He refused the direct order to stop misusing the cell bell and continued to bang the bell and the furniture.

67. The Operational Support Grade (OSG) said that between about 11.00pm and midnight he remembered the man moving his furniture around in his cell. The OSG explained that a prisoner had complained and therefore he had gone to speak to the man. At the cell the OSG said he could see that the man was pulling the table and chair forward and then back again. The OSG said he told the man to stop and explained that it was noisy and keeping others awake. At this point the OSG said that the man stopped moving his furniture and sat on his bed. The OSG said that the man did not speak or answer but just stared at him.

**18 December**

68. On the morning of 18 December, the light in the man's cell was broken and he was put on another disciplinary report for smashing his light cover. The fifth officer told our investigators that the man's bulb was broken the previous day, but the cover was not. However, when she opened his door in the morning, he said it broke when he switched the light on. She said that the man became aggressive so she closed the door.

69. Officer thirteen told the investigation that the man came out of his cell that morning with some papers in his hands. He went to speak to another prisoner who spoke Farsi. The prison told Officer thirteen that the man had a query regarding telephone numbers. Officer Thirteen said he explained to the

prisoner that they would see what they could do, but the man misunderstood this and stormed off. Officer thirteen said he later noticed the man in the fifth officer's office where he was "almost in her face" He said the man looked at him and went back to his cell. Officer thirteen followed the man back to his cell and the man slammed his door shut and seemed angry. Officer thirteen told my investigator that he and my fifth officer felt a bit wary of opening the man's cell at lunchtime.

70. Nevertheless, come lunchtime the fifth officer and thirteenth officer went to unlock the man's door. The fifth officer said that, as they opened the door, the man just ran at her and lunged. She explained that Officer thirteen had to restrain the man. She had no idea why the man had lunged at her. She knew that they had to get away rather than risk the man harming himself or others with the Perspex from the window panel.

71. Officer Thirteen told my investigator that he had seen the man lunge towards the fifth officer as she opened the door. He said that he had feared for the fifth officer's safety and therefore they had tried to restrain the man as best they could. The thirteenth officer explained that the man was putting up a struggle and they had to push him on the floor into a prone position.

72. On hearing noises coming from the man's cell, another Senior Officer went to the cell. He told my investigator that the man was already being restrained when he got there. Fourth Senior Officer also arrived after hearing a whistle being blown. He said that another SO stood up and it seemed that he had either been hit, or had hit the side of his face. Fourth Senior Officer said he supervised the situation once the other Senior Officer left. He placed the man in handcuffs and oversaw his escort to the Segregation Unit.

73. The fourteenth officer said that, at about 12.10pm, he heard and saw officers running past. He said that he followed them to the man's cell. The man was in the prone position being held by officers five and thirteen. The officer noticed that the cell window had been smashed. He said he tried to explain what was going to happen to the man. The Fourth Senior Officer and fourteenth officer took hold of the man's head (in accordance with approved Control and Restraint techniques). He said that Officer thirteen and five moved their lock positions from the rest position to final lock, but the man did not respond. He said that Fourth Senior Officer helped the man get onto his feet. They applied handcuffs and walked him to the stairs. Officer fourteen said that the man kept trying to lift his feet to make staff carry him and was told not to do this. Officer fourteen said that he kept explaining to the man what was happening but said that he did not respond. Staff said that, although the man struggled with officers at first, he soon calmed down.

74. Upon reaching the first floor landing, most of the staff involved told my investigator that the man started to cry and had a slight nose bleed. The fourth Senior Officer said that the healthcare staff were present and he asked them if they were happy for them to take the man to the Segregation Unit. They confirmed that the man could continue walking.

75. The third nurse was the nurse based on C wing. In interview, he told my investigator that his day-to-day duties were based around medication, assessing people for the gym, dentist, optician, and chiropodist, and then doctors surgeries twice a week. The C based wing nurse told my investigator that on this particular day he had been on lunch when he was asked by officers to assess whether the man was fit to go to the Segregation Unit. The C Based Wing Nurse explained that officers were crowded around the man so he was unable to see him very well. He told my investigator that as he had been on lunch he told the officers to call one of his fellow nurses. They should either call Hotel 1 (the nurse assigned to respond to emergencies) or call the segregation nurse to the Segregation Unit to assess the man. The C Based Wing nurse said that this was normal practice. He explained that one of the officers told him not to worry and that they would take the man down to the Segregation Unit. The Nurse said that he decided to follow them through the wing, but could still not see the man clearly as he was surrounded by officers.

76. A PO said that the man was quite tearful and he was concerned whether he could understand English. He was told by the wing staff that they knew the man well and that he had a good understanding of English. The PO said the man was taken to the Segregation Unit. The PO asked the segregation staff to make sure that the man was seen by healthcare, even though he knew this was standard practice.

77. My investigator asked the fourth Senior Officer whether the segregation staff were prepared for the man's arrival. He replied:

> "They would have been. Because something like that, i.e. when the alarm has been raised, once the decision is made, the orderly officer would arrive and obviously take the decision, we're going to relocate them wherever and in this case it was in the Segregation Unit so they would have been alerted by their radios that there was a prisoner en route, so they would have been waiting for us … a handover is done of who the prisoner is, his name and number, go through there with the processes, paperwork and history sheets."

78. On arrival at the Segregation Unit, the man was met by three officers. The man was placed in the unit under Rule 53 whilst awaiting adjudication for allegedly assaulting staff on C wing. This meant that the man could be held in the Segregation Unit pending the adjudication for up to 72 hours.

79. One of the three officers told my investigator that as soon as a prisoner is brought to the gates of the Segregation Unit, the segregation staff takeover. He said that the prisoner is then escorted into a special cell. He explained that this was a normal sized cell, without furniture. It was equipped with two cameras to monitor the prisoner's behaviour, to prevent acts of self harm, and generally to observe them. The prisoner undergoes a full body search, new clothing is given and they then wait for a doctor to see them before being moved to a furnished cell. He went onto explain that a Rule 53 prisoner would have the very basics in their cell which include a toothbrush, toothpaste, soap,

towel, cutlery and bedding. He explained that prisoners in the Segregation Unit are seen daily by the healthcare department and chaplaincy staff. The Governor will wish to satisfy himself that the routine use of the special cell when a prisoner first enters the Segregation Unit is necessary and proportionate.

80. The officers who conducted the full body search told my investigators that they did not remember seeing any scars on the man's body. They said that if they saw something that gave cause for concern they would report it to the doctor.

81. Another one of the three officers explained that a safety algorithm (this is a check that is done to make sure the prisoner can stay in the Segregation Unit) must be completed, and signed by a doctor or a nurse and by a Governor. Officer fifteen told my investigator that a Rule 53 prisoner would have paperwork which explains the reasons why he has been placed on Rule 53 which must be signed by the Governor. He said that the prisoner would also have an admission form containing details of their diet, any injuries, their ethnic code, the names of the officers who searched them and any other problems they might have. He told my investigator that prisoners in the Segregation Unit are checked every half an hour to make sure they are okay.

82. My investigator asked a sixteenth officer whether any reviews were to be done in the Segregation Unit, and he said that under Rule 53 a prisoner is only kept in the unit for two days. He considered that was not a very long period for a review to be done and so it was really up to segregation staff to add any concerns.

83. The Sixteenth Officer said that when the man came to the Segregation Unit he was crying and talking. However, Officer sixteen was unable to understand him as he spoke in a foreign language. He told my investigator that the man was slow to react but did comply with instructions. The seventeenth Officer agreed that the man complied with the instructions but was unaware of a language barrier. The seventeenth officer told my investigator that they should be notified by the escorting officers if there is a language barrier, but he did not remember whether this happened.

84. The sixteenth officer remembered seeing blood on the man's face. The seventeenth officer said that the man was unsteady on his feet and had a little blood coming from his nose. The sixteenth officer told my investigator that it was not a large quantity of blood and he thought it was because the man had been restrained. A male officer eighteen also said he saw a trickle of blood from the man's nose. He handed him over to the medical staff to assess whether he was physically and psychologically fit to stay in segregation. The eighteenth male officer told my investigator that the man seemed quite distant during the Segregation Unit processing, so he specifically asked for a doctor to see him.

85. It was judged that there were no clinical reasons not to segregate the man. No mental health issues were identified on the safety algorithm and the Duty

Governor signed the relevant section confirming the man should remain in the unit. The man was moved to a furnished cell.

86. The man was seen by the doctor who reported to the investigation that the man said few words, was cooperative with some eye contact, but was difficult to assess. The doctor asked a nurse to accompany him as he was concerned by how quiet the man was. He noted that the man had a bruised nose. He wanted to conduct a mental health assessment with an interpreter over the next few days. He signed the segregation safety algorithm to say there were no reasons against segregation.

87. An F213SH form (report of injury to a prisoner) was completed by a fourth nurse. The man did sustain an injury to the nose but did not need to be referred to hospital.

**19 December**

88. On the morning of 19 December, the man appeared at Ealing Magistrates Court via video link. It is unclear how the man reacted, but it appears he was remanded in custody for further offences until 9 January 2008.

89. A second doctor attended the Segregation Unit that morning, but did not see the man as he was at his video link appearance.

90. At the same time as the man attended the videolink, his adjudication took place in his absence. He was charged with disobeying a lawful order and damaging property. The adjudications were opened in his absence and adjourned to be heard by the independent adjudicator (a District Judge who visits the prison).

91. That afternoon, the man was taken back to C wing. Fourth officer told my investigator that, as there was limited space on the wing, the man was placed into a single cell on the fourth floor. The fourth officer said the man did not respond. My investigator asked what he meant by this, was it that he did not reply or in his manner. The fourth officer said, “He just didn’t seem to acknowledge, he just didn’t seem to acknowledge that we were there, he just wanted to do his own thing.”

92. My investigator asked the fourth officer whether he had any experience of the man making any noise on the four’s landing, like moving his furniture around. Fourth Officer said:

> “Yes. On the threes as well he would throw his furniture, there were occasions, especially over meal breaks where you would hear and you’d go up and he would be putting his furniture back … I never saw it on fours … but definitely on threes, there were occasions when he would throw his chair around his cell. But again for C wing, that’s not uncommon, there’s quite a few that do that in frustration or just because they want to, it isn’t uncommon … But moving his furniture, no, I’ve no recollection of that on the threes or fours.”

**20 - 21 December**

93. On 20 December, the man's cell was unlocked at about 8.10am so he could have a shower. British Transport Police wanted to question the man at a police station about further matters and he was taken to reception at 9.35am. Senior Officer five told the investigation that the man was quiet.

94. The police told my investigator that, whilst at the police station, the man told them that he had been considering harming himself whilst he was in prison. Arrangements were made to watch the man more closely whilst he was in the police station, but this information was not written on the Prisoner Escort Record, and was not communicated to prison staff on his return. This is the subject of an investigation by the Independent Police Complaints Commission.

95. The man arrived back at Wormwood Scrubs at about 5.40pm and was met by a fifth Senior Officer. He said that the man remained quiet. The Senior Officer explained that he signed to receive the man back into the prison. The man was then taken to a holding room whilst he waited to be searched. He underwent a full body search before going to another holding room where he waited to be escorted back to the wing. He did not see a nurse, as it is only those new into the prison who are seen by a nurse unless the prisoner requests otherwise.

96. The man was taken back to his cell on C wing at about 8.10pm by a seventh officer. She said that, as they were expecting him back, they had saved his cell for him. About 20 minutes later she had noticed that the man's cell bell light was on. When she reached his cell she asked him what was wrong but he did not say anything and just stood there. She kept asking what he wanted but, as he turned around and walked to the back of his cell, she left his cell.

97. The OSG saw the man at the evening roll check soon after 9.00pm. He said the man was sitting on his bed. At around midnight, whilst answering a cell bell near the man's cell, the man knocked on the cell door. The OSG said he looked in and asked if he was okay but the man did not say anything, turned and walked to the back of his cell.

98. At about midnight, the OSG walked past the man's cell because another prisoner had pressed his cell bell. The man knocked on the door and the OSG opened the observation flap. The OSG told my investigator that the man was standing close to the door but did not say anything.

99. In the early hours of the morning, the OSG started conducting his roll check from the fourth floor landing. The OSG began on the side of the wing that was opposite to the man. The OSG explained that the lighting in the cells could sometimes be very poor as prisoners would often obscure the bulb to stop the light from being too bright.

100. The OSG told my investigator that when he checked the man's cell at around 5.00am he found the lighting to be poor. Nevertheless, he could see that the bed was upturned and that the man's hand had blood on it. The OSG said that he could also see a noose but could not see the full position of the man. At this point the OSG used his radio to call a code 1 (an emergency code to indicate a prisoner is hanging); assistance arrived within under a minute. The OSG said that he then left the wing.

101. A Senior Officer told my investigator that he remembered getting an urgent message over the radio just after 5.00am. He went to C wing and up to the fourth floor. He told my investigator that he opened the cell and found the man hanging from an upturned bed. He went into the cell and checked to see if the man had a pulse but none was present. It was his opinion, and that of the nurse, that there was nothing that could be done to help the man. My investigator asked a Senior Officer whether he carried a cut down knife (a knife specially designed to cut through ligatures) and the Senior Officer replied he did. My investigator therefore asked the Senior Officer why the man had not been cut down. In response the Senior Officer replied:

> "… I felt that it was better because of the evidence rather than disturb [the scene] and then the ambulance crew came and they were of the same opinion … I know the ambulance staff didn't want him cut down … the police didn't want him cut down … so there's no need … [the police] wanted it photographed so I can add that as my support why I didn't as none of the agencies did either."

102. Three Officers all responded to the Code 1 message. In interview, they all said that the man had been found hanging with his bed upturned. His is wrists had been cut and there was blood on his clothes and the floor.

103. The nurse no longer worked at Wormwood Scrubs when my investigator conducted interviews. She made several attempts by phone and in writing to interview the nurse but he declined. (I have noted earlier that his refusal to co-operate should be drawn to the attention of the PCT.) He had made the following entry in the clinical record:

> "… on reaching found it was not discovered on time, the inmate was already stiff and body was cool – no neurological response, tried to give O2 [oxygen] if was told late tried to resuscitate was too late. No response to any stimuli. Ambulance paramedics came tried to defibrillate was already too late inmate was completely cool and stiff."

104. In his incident report, the nurse wrote:

> "… ligature around his neck which he had used on his bed to hang after he cut himself on his L [left] wrist because dried blood stain was on his floor. It was not discovered in time, but on assessment no response to stimuli and no neurological sign of life in him – body cool and stiff – nothing medically possible to have saved the life due to late discovery."

105. Officer nineteen wrote in his incident statement that the nurse told a Senior Officer not to cut him down. In his interview, Officer twenty said he remembered the nurse saying “don’t cut him down, there’s no way he is going to be resuscitated,” albeit the Senior Officer was in charge of the situation.

106. At 5.14am the ambulance arrived. The paramedics examined the man and made no attempts at resuscitation. A Third doctor attended and confirmed the man’s death at 6.49am.

107. I remain unclear as to what time staff cut the ligature from the man’s body. However, it was certainly after the ambulance crew, doctor and police had seen him some hours after his discovery.

108. Following the man’s death, contingency plans for a death in custody were activated. Staff attended a debrief and were offered support. The news was broken to other prisoners and they too were offered support.

109. A family liaison officer was appointed. It was difficult to locate a next of kin as none had been identified when the man first arrived in prison. Considerable attempts were made on 21 December to identify a next of kin by phoning the man’s solicitor, examining his Pinphone records, and speaking to the trusted Farsi speaking prisoner. Eventually, the prison family liaison officer spoke with the police who said they had an interpreter and would contact the family. Much of the contact was through the Iranian embassy. Arrangements were made by the prison’s family liaison officer and the funeral directors to take the man’s body back to Iran. The prison offered to meet the costs of the funeral and the other expenses.

## ISSUES

### Clinical Care

#### *First reception health screen*

110. At the first reception healthscreen, the nurse noted "appears mentally stable, good eye contact". As my investigators were unable to interview him, it was not possible to ask whether the nurse had read the extracts on the PER form or the warrant regarding the man's strange behaviour and pending mental health assessment. This is certainly information any nurse should have whilst making their initial assessment.

111. The clinical review also raises concerns about the reception healthscreen. The reviewers found it had not been completed fully. Furthermore, it was ticked that referral was needed to other agencies although this was not reflected in the planned action section of the document. This appears to be as a result of ticking all the boxes regardless of the question and casts doubt over the care with which the document was completed.

**The Governor and Head of Healthcare should ensure that important information from PER forms and warrants are communicated to staff, in particular healthcare staff. Healthcare staff should note whether they have seen the forms.**

#### *Referrals to the Mental Health In-Reach Team*

112. A fifth officer told my investigator that she completed a referral on 10 December as she felt the man was acting strangely. She noted this action in his wing history sheet. She said she gave the form to the wing based nurse based in the wing treatment room. The MHIRT had no record of this referral.

113. The same officer completed a referral on 17 December which did reach the MHIRT. However, the form used had been replaced some eight months earlier and the old form did not have a place to record the urgency of the referral. The man was not seen by the MHIRT before his death. I make no criticism of the MHIRT, but clearly there was a failure of communication. My investigator found that the C based wing nurse could not explain clearly the process for referring prisoners to the MHIRT.

**I recommend that all staff, including healthcare staff, are reminded of the process for referring prisoners to the MHIRT, including the correct forms to complete.**

#### *Other health issues*

114. The clinical review has found that details of the man's court appearances, and further charges were not made in the clinical record. The review panel noted this as significant as there had been some evidence to link suicide with receiving bad news.

**Foreign national prisoners**

115. Foreign national prisoners account for around half the population at Wormwood Scrubs. There is a strong policy and appear to be good systems to cater to the needs of foreign national prisoners. When prisoners first arrive, they are seen by a foreign national orderly who speaks many languages and helps them with basic information. There is also a list which is regularly updated of all staff and prisoners who speak other languages so they can be called upon to translate. The prison uses Language Line (a telephone translation service) if necessary, but does not do so routinely as I understand experience has shown that some meaning is lost when using the phone.

116. There was some confusion about the extent of the man's English. Some staff thought his understanding was better than his spoken English. Having lived in England for two years, it would appear likely that he could understand some English. However, following instruction is quite different to understanding the nuances in a conversation and being able to express how you are feeling. The foreign national coordinator was able to show my investigator a large amount of information regarding different processes and facilities that has been translated and available on the intranet. However, staff did not appear to know how to access the information. The man did not receive information in his own language regarding the basic regime, but did have another Farsi speaking prisoner at the review.

117. When a foreign national prisoner arrives at Wormwood Scrubs, it is recorded and reported to the foreign national coordinator who compiles a list for each wing. There are foreign national orderlies on each wing (all of whom are able to speak different languages) whose role it is to speak to the foreign national prisoners on their wing to confirm their first language, invite them to a foreign national group, and link them to other prisoners who speak the same language.

118. The foreign national orderly on C wing said the list of new prisoners he is given each week is three pages long and he has limited time out of his cell. As such he never met the man. The foreign national orderly on C Wing said that he worked well with staff on the wing and they would often ask him for his help with prisoners.

119. The foreign national co-ordinator told my investigator that efforts were being made to give the foreign national orderlies "red band" status. This would afford them more time out of their cell to perform their duties.

120. It seems that the man was not given the opportunity to meet the foreign national orderly and, unfortunately, they did not seek him out. He did have the opportunity to mix with other prisoners who spoke his own language. Although these prisoners referred to him as "crazy," they did not report any concerns to wing staff or the orderly. Contact with the orderly could have been a valuable source of support for the man and I am pleased the prison is endeavouring to give them more time for their duties.

**I support the efforts to increase the time out of cell for foreign national orderlies to devote to their duties.**

121. The foreign national co-ordinator was very committed but had limited resources available to her. She said she had support from senior management.

**Basic Regime**

122. I am satisfied the decision to place the man on basic regime was reasonable. The regime does not appear to be over used in Wormwood Scrubs. At the time, only three prisoners were on basic including the man out of a population of around 1,200. Nor do I believe that the man's nationality played a part in the decision, although the Governor will wish to remain alert to any indications of bias on grounds of nationality, religion or ethnicity.

123. I am concerned, however, about the restrictions placed on prisoners on the basic IEP level. The man was allowed out of his cell every morning to have a shower for about 45 minutes. He was escorted to collect meals after everyone else had collected meals. He might have had other periods out of cell during association periods. Certainly the majority of his time was spent in his cell, with little to do. He was moved to a single cell and his television removed. His behaviour deteriorated to the point he went through stages of continuously pressing his cell bell, he moved his furniture, and it seems he may have thrown it at times. He acted strangely by removing his clothes from his cupboard, then putting them back several times over. He also broke his cell light.

124. Officers were aware that Farsi reading material would be available in the library, but this seemed to depend on the prisoner asking for it. With no knowledge of the prison, it is unlikely the man would have realised that he could have asked. Long periods alone in a cell are likely to exacerbate any frustrations, as well as bring mental health issues to the fore.

**I recommend the Governor provides guidance about the provision for prisoners on basic regime to occupy their time, such as reading materials.**

125. I am also concerned about the level of monitoring by wing managers. The senior officers told my investigator that they checked the IEP was being completed daily. My investigator could not find entries from the wing managers, or signatures to verify they had seen it. As noted above, there were occasions that gave cause for concern as to the man's mental well-being. I would expect these events over the course of several days to prompt a case review.

**I recommend the booklet used to monitor and record the behaviour of a prisoner on the basic regime should be adapted to require a signature and comment from a wing manager on a daily basis. The Governor should remind wing managers to be vigilant to deteriorations in behaviour and mental wellbeing.**

126. The man was on basic regime for nearly three weeks before his death without being reviewed. PSO 4000 “Incentives and Earned Privileges” 2.16 states:

> “… prisoners placed on basic level must be reviewed within seven days and informed of the steps they need to take to return to standard level. This should include realistic targets to assist them to progress from the basic level”.

**The Governor should remind all managers that prisoners on the basic regime must be reviewed within seven days.**

**Use of force and segregation**

127. Following an alleged attempted assault on an officer, the man was restrained and taken to the Segregation Unit on 18 December 2007 and stayed overnight.

128. The decision to use force was unplanned and I judge it was reasonable. It would appear that, as a result of being restrained in a prone position until other staff were able to assist, the man sustained a bloody nose. He was also seen crying. The doctor examined him and decided a more detailed examination should be conducted with an interpreter. However this did not happen. No one who spoke Farsi spoke to the man whilst he was in the Segregation Unit (although I recognise he was only there overnight).

129. Whilst in the segregation unit, the man underwent a full body search. This was one of four full body searches during his time in Wormwood Scrubs. The police told my investigator that there was considerable scarring to the man’s body. No one who searched the man could remember noticing scarring. They also said that, unless it looked recent, it was not something that would cause them alarm.

**I recommend the Governor reminds staff to be vigilant to scarring and to ask prisoners regarding the source.**

**Crisis management**

130. When the man was found, staff including the nurse attended quickly and entered the cell. It was clear to all staff the man was dead, and had been so for some time. A nurse believed there was nothing that could be done to save the man and apparently said they should not attempt resuscitation. However, the statements he made regarding this matter suggest that he did try to use an ambubag, and that paramedics attempted to use a defibrillator without the man having been cut from his ligature. Other staff who were there at the

same time have assured my investigator that this is not true and no attempts were made to save the man.

131. Without interviewing the nurse who was in this scene, several questions remain regarding his conduct. I am concerned to know whether he saw the PER form and the warrant when the man arrived in Wormwood Scrubs, and whether this was explored. I also have concerns as to his conduct on the night the man was found. When an individual is clearly dead, it can be disrespectful to the individual and highly traumatic for staff to attempt resuscitation. However, I remain unclear as to what action he actually took. He was not employed directly by the prison. I understand the prison did ask for him to stop being employed there.

**The PCT may wish to review the nurse from this scene's treatment of the man and take any appropriate steps to avoid a repetition.**

132. PSO 2700 "Suicide Prevention" Annex 13A states, "[in the event of hanging] support the body … Cut the prisoner down … place the prisoner on his back on a flat, solid surface … check for signs of life…attempt resuscitation unless rigor mortis of the limbs has clearly set in".

133. Officers and the nurse described signs of rigor mortis in the man's body. Therefore I do not criticise the decision not to attempt resuscitation. However, I find it unacceptable that the ligature was not cut. I understand staff felt that it was a crime scene and others could also have taken the decision to cut the ligature. However, the man was in a single cell with no other person having access to the cell at night (unless staff use the cell key held in a sealed pouch). I consider it disrespectful to the deceased to have left the ligature in place.

**I recommend the Governor reminds all staff that, in accordance with PSO 2700, if someone is found hanging the ligature should be cut.**

## RECOMMENDATIONS

**The Governor and Head of Healthcare should ensure that important information from PER forms and warrants are communicated to staff, in particular healthcare staff. Healthcare staff should note whether they have seen the forms.**

*The Prison Service accepted this recommendation and said;*

*"The PCT's record keeping policy and records management policy were adopted in June '06 and are located of the establishment's shared drive. The PCT's policies have been updated in line with NHSLA recommendations and will be launched post review."*

**I recommend that all staff, including healthcare staff, are reminded of the process for referring prisoners to the MHIRT, including the correct forms to complete.**

*The Prison Service accepted this recommendation and said;*

*"An Instruction to Staff has been published that outlines the procedure and also included the correct referral forms."*

**I support the efforts to increase the time out of cell for foreign national orderlies to devote to their duties.**

*The Prison Service accepted this recommendation and said;*

*"Foreign national orderlies are now unlocked throughout the core day."*

**I recommend the Governor provides guidance about the provision for prisoners on basic regime to occupy their time, such as reading materials.**

*The Prison Service accepted this recommendation and said;*

*"Prisoners on basic regime are given appropriate access to regime activities (association, gym, work, education and library)*

*The IEP scheme and level restrictions/privileges are published to all prisoners and also accessible in PSO 4000."*

**I recommend the booklet used to monitor and record the behaviour of a prisoner on the basic regime should be adapted to require a signature and comment from a wing manager on a daily basis. The Governor should remind wing managers to be vigilant to deteriorations in behaviour and mental wellbeing.**

*The Prison Service partially accepted this recommendation and said;*

*“A separate management checklist is in operation and the wing manager must sign daily to state that the IEP process is being managed appropriately. This pays particular attention to those basic regime and its poor use is a training issue that is being addressed by the Head of Residence.*

*Staff and managers are vigilant to deterioration in a prisoner’s behaviour and mental well being. The man was subject to two mental health team referrals.”*

**The Governor should remind all managers that prisoners on the basic regime must be reviewed within seven days.**

*The Prison Service accepted this recommendation and said;*

*“A Notice to Staff was published on 24/10/08 reminding all managers.”*

**I recommend the Governor reminds staff to be vigilant to scarring and to ask prisoners regarding the source.**

*The Prison Service accepted this recommendation and said;*

*“A Notice to Staff was published on 24/10/08 reminding staff to report scarring to prisoners bodies in case it is a previous attempt at self harm.”*

**The PCT may wish to review the nurse’s treatment of the man and take any appropriate steps to avoid a repetition.**

*The Primary Care Trust had not responded to this recommendation at time of issue.*

**I recommend the Governor reminds all staff that, in accordance with PSO 2700, if someone is found hanging the ligature should be cut.**

*The Prison Service accepted this recommendation and said;*

*“Although this was an isolated incident a Notice to Staff will be issued to remind staff of their responsibilities.”*