

**INVESTIGATION INTO THE CIRCUMSTANCES SURROUNDING
THE DEATH OF A MAN IN HOSPITAL
IN FEBRUARY 2007 WHILST IN THE CUSTODY OF
HMP WORMWOOD SCRUBS**

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

November 2007

This is the report of an investigation into the death of a man in February 2006. The man was found collapsed on the floor of his cell at HMP Wormwood Scrubs. A snapped belt was hanging from his upturned bed. Although it was not immediately obvious to the staff who found him, it soon became clear the man had used the belt to hang himself and that the belt had snapped under his weight.

The man was 24 years old. He had been in custody for just three days.

I offer my sincere condolences to his family and many friends for their untimely and tragic loss.

The investigation was conducted by one of my colleagues. I also commissioned an independent clinical review of the management of the man's health needs while he was in custody. This was carried out by a panel from the Hammersmith and Fulham Primary Care Trust. I am grateful to their team for their invaluable contribution.

I should also like to thank the Governor and his staff at Wormwood Scrubs for their help and co-operation. I pay particular tribute to the investigation liaison officer for his contribution.

The Hammersmith and Fulham Primary Care Trust review has criticised a number of aspects of the way in which the man's healthcare needs were managed. They make eight recommendations, of which I endorse six. I also make one recommendation and one commendation of my own.

This is a report that illustrates the current pressures on the prison system in having to care for many thousands of prisoners with histories of drug abuse and mental ill-health.

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Prisons and Probation Ombudsman

November 2007

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SUMMARY

On 7 February 2007, the man who died was arrested on suspicion of theft and taken to the police station. The following day, he appeared at the Magistrates' Court where he was remanded in custody. He was ordered to appear at the Crown Court on 15 February. He was taken to Wormwood Scrubs prison in West London shortly after 5.00pm that day.

In reception at Wormwood Scrubs, the man appeared to be psychotic and paranoid. However, he told staff he did not feel suicidal. He was referred to a doctor who saw him the same evening. The doctor decided that he should be admitted to the healthcare centre but there were no vacancies. Ordinarily, he would have been allocated to the First Night Centre but, as that unit was also full, he was instead sent to D Wing. The cell sharing risk assessment concluded that he presented a risk of harming others because of his history of violence. As a result, and because he was not considered to be at risk of self-harm or suicide, he was placed in a single cell.

On 9 February, the man was moved to the First Night Centre. Here he was seen by a nurse who was sufficiently concerned about his mental state that he asked for him to be seen by a psychiatrist and the manager of the Mental Health In-reach Team. They did so after trying and failing to track down the GP with whom the man said he was registered before his arrest. Both specialists took the view that he should be admitted to the healthcare centre. However, this was still not possible as there were no vacancies. A review of all in-patients with mental health problems failed to identify any prisoner who could be safely moved out of the healthcare centre to make room. It was later discovered that a space would be created the following morning when a prisoner was due to be transferred to an NHS hospital. In the event, the prisoner was not moved. It was therefore decided that the man should remain where he was until 12 February when a space would be guaranteed. The man was prescribed medication for a stomach complaint and to help him sleep and relax.

Throughout 10 February, he behaved in a bizarre fashion. He told a member of staff there was someone in his single cell trying to set fire to a sheet. Later that day, he barricaded himself in his cell by placing his mattress against the door, covering the observation panel. The next day (the day of his death) he barricaded himself again. On both occasions, he was quickly persuaded to remove the barricade so that he could be properly observed.

The man was seen on the evening of 10 February by a prison GP who ensured that he was given his prescribed medication. The doctor also noted the telephone number of his wife in the hope that she could tell him more about the man's medical history. It is not clear whether the doctor was successful in contacting her.

During the morning of 11 February, he continued to behave strangely. As noted, at one stage, he placed his mattress against his cell door. Later, he made a 'den' under his bed and hid inside it. At 12.45pm, the officers who

were patrolling the wing during the lunchtime break heard a loud noise coming from the man's cell. When they investigated, the officers found that he had damaged some of his cell furniture. On the advice of the orderly officer, they continued to make occasional checks on him. He was last seen alive shortly before 1.30pm when a wing officer checked him.

At 1.55pm, two officers approached his cell to check on him again. They found him slumped on the floor of his cell, apparently unconscious. His bed had been turned on its end. A snapped belt was still attached to the upper end of the bed. The man had hanged himself by his belt which had snapped under his weight. All attempts to revive him in his cell failed. The man was transferred to the local hospital at about 2.30pm. He was pronounced dead at the hospital.

A thorough clinical review of his healthcare was undertaken by representatives of the Hammersmith and Fulham Primary Care Trust. The review panel has criticised a number of aspects of the way in which his healthcare needs were managed.

The PCT make eight recommendations. I endorse them all. I also make two recommendations of my own and offer one commendation.

The man's family raised a number of points of concern. These are addressed in the report.

INVESTIGATION PROCESS

The investigation was opened on 13 February 2007 when my colleague met with the Governor of Wormwood Scrubs, a representative of the prison's Independent Monitoring Board and two representatives of the Prison Officers' Association. The investigator explained to them the nature and scope of the investigation. On the same day, he issued notices to staff and to prisoners announcing the investigation and inviting anyone with information or concerns about the man's death to make themselves known. Seventeen members of staff and one prisoner were interviewed.

I also commissioned an independent review of the management of the man's health needs while he was in custody at Wormwood Scrubs. This was undertaken by a panel of the Hammersmith and Fulham Primary Care Trust.

On Friday 30 March, the investigator and one of my family liaison officers met the man's wife in the presence of her solicitor. The meeting was to offer her an opportunity to express any concerns she wanted the investigation to address. The points the widow raised are examined in this report.

The man's father spoke separately on the phone with my family liaison officer. He asked to be kept in touch with the investigation and to be consulted about the report.

HM PRISON WORMWOOD SCRUBS

Wormwood Scrubs is a category B local prison in West London. It serves Crown and Magistrates' Courts in the north west of the city. The prison can hold up to 1,239 male prisoners. The accommodation comprises five wings, a detoxification unit named Conibeere, a segregation unit and a healthcare centre.

The prison was last inspected by Her Majesty's Chief Inspector of Prisons in October 2005. The report of that inspection was published in December that year. It contained no issues relevant to this investigation.

However, in their report on the prison for the period 1 June 2005 to 31 May 2006, the prison's Independent Monitoring Board made the following comments about the healthcare centre:

“The healthcare centre has a 17 bed inpatient facility for patients with physical and mental healthcare needs. It is frequently full of patients with mental health issues. These patients often display challenging behaviour. During the reporting period, a number of cells were smashed up by such patients. Such behaviour coupled with a poor physical environment can make the unit a depressing place for patients and staff alike. During the reporting period an admissions policy was drawn up ensuring that admissions can only be made by medical staff. The Board was concerned that on occasion there were insufficient places for patients in the prison who needed them. This has meant that staff on the residential wings have had to deal with very challenging prisoners who really should have been inpatients.”

The Board drew to the attention of the then Home Secretary their concerns about mentally ill prisoners at Wormwood Scrubs. They commented as follows:

“The plight of mentally ill prisoners continues to be a concern for the Board. The work undertaken by the mental health in-reach team provided by Central North West London Mental Health Trust and the Seacole Centre, which provides day care services, is acknowledged. Is prison an appropriate place for those suffering from mental illness?”

KEY EVENTS

Wednesday, 7 February 2007

Arrest and police detention

On 7 February 2007, the man was arrested on suspicion of theft. He was taken to Wembley police station, arriving shortly before 9.00am. The man told the police he was a drug addict and had been taking methadone before his arrest. He said he was suffering from depression and had tried to harm himself whilst in custody two months earlier.

The man was seen by three different Forensic Medical Examiners (FMEs) that day. The first examiner saw him at 11.17am. The examiner made the following notes on a medical examination form:

“Does not show any signs of intoxication/withdrawal. Heroin user. Fit for interview. To be reviewed by FME after interview. Remanded. Half hourly observations.”

The man was examined by a second examiner at 4.50pm. The form shows that his personal use medication was not authorised, but that medication was provided to the police for his use. The form shows he was already on Zispin, an anti-depressant. The examiner wrote at the end of the form that there were no signs of self-harm. The examiner nevertheless directed that he should be observed every half hour and should be monitored by closed circuit television.

A third FME saw the man shortly after 9.00pm that day. The form completed on this occasion records the following information:

- Medication was given to him at the time of the examination.
- The man's personal use medication was authorised by the FME.
- Medication was provided to the police for his use.
- The man was still regarded as being fit for detention.

In the box section entitled, “Medical findings/advice to the police”, the following notes were recorded:

“Depression. Heroin addict. Ulcerative colitis. Being detained for court am. Alert. Coherent and rational.”

The notes also show that the following medication was given:

Zispin 45mg x 1	(This is an anti depressant)
FES 04 200mg x1	(This was prescribed for his colitis)
lanzoprazole 30mg x1	(This is an antibiotic))
Asacol 400mg x2	(This is prescribed for bowel disorder)
DF 118 30mg x 3	(This can be prescribed in relation to a bowel disorder)

Valium x2

(This is prescribed as a relaxant)

Finally, the FME directed that the following drugs should be administered at 8.00am the next day:

Asacol x 2

FES 04 x1

Valium x1

DF 118 x2

A police form 57M was also completed at the police station. This is a form used for gathering information about the detained person. Written on the top of the form is the instruction that the information must lead to an action plan for the detainee's care.

The questions and answers recorded on the form are as follows:

Part A

Question: Are you suffering from any injury or illness?

Answer: Yes. Drug addiction and H/C marks.

Question: Are you suffering from a medical condition, mental condition or depression?

Answer: Yes. Depression.

Question: Are you receiving any treatments for injury, illness or condition?

Answer: No.

Question: Are you taking any medicine or any other sort of medication?

Answer: Yes. Depression and methadone.

Question: Have you ever tried to harm yourself?

Answer: Yes. Months ago x 2 in custody.

Question: Do you have any learning difficulties or learning disabilities?

Answer: No.

Question: Do you require special food and/or any special help while you are at the police station?

Answer: No.

Question: Do you need help with reading or writing?

Answer: Yes.

Question: Do you need help for any other reason?

Answer: No.

Question: A drug referral scheme operates at this police station. If you are interested I can arrange for you to be seen by an independent drug worker in due course. Are you interested?

Answer: No.

Part B

Question: Was force used on the detainee?

Answer: Yes. Handcuffs (front).

Question: Is there any suspicion that this person has swallowed drugs?

Answer: No.

Question: Does the detainee appear to be injured or unwell in any form?

Answer: No.

Question: Does the detainee have any tablets, medication, drugs or drug paraphernalia with him?

Answer: No.

Question: Is there any suspicion of alcohol consumption or use of a drug or other intoxicating substance?

Answer: No.

Question: Does the detainee have any visible scars that could have resulted from previous self-harm?

Answer: No.

At the foot of Part B of the form, a number of warning markers are listed. The following warning markers were ticked as applicable in the man's case:

Violent
Conceals weapons
Escape risk
Suicidal
Ailment
Other: "alleges epileptic."

At part C of the form, the following information is recorded:

- The man was strip searched at the police station.
- He was to be examined by a healthcare professional for the following reasons: "drugs, epilepsy, suicidal, detention interview".
- The man was placed in cell 13 which was covered by closed circuit television.
- The man presented a risk. (The risks he presented were listed as ailment and drug user, suicidal and escaper.)
- The man was to receive irregular cell visits.
- The time limit between each cell visit was to be 30 minutes.
- The custody staff were briefed immediately about him.

- He had no dietary needs.
- He had no disability needs.
- The man presented a risk to the safety of police officers.

The form was signed by a police constable.

Thursday, 8 February

Court appearance

On 8 February, the man was taken from the police station to the Magistrates' Court. The Prisoner Escort Report (PER) for the journey shows he was considered to be at risk of self-harm or suicide. The following comment was recorded on the form:

“PNC markers weapons, violent escaper, alleges ailment. Suicidal. Class A drug user. Depression. Self-harm in police detention. Methadone user. Epileptic.”

The man arrived at the court building at about 9.50am. At 10.30 he was seen by his legal representative. Shortly before 11.00am, he appeared before magistrates. He was remanded in custody and ordered to appear at the Crown Court on 15 February.

At 11.50am, the man told the court custody staff he felt unwell. No details are recorded to show what was wrong with him. However, the PER shows that for the remainder of his time in court cells he was alright. The man left the court building for Wormwood Scrubs at 5.00pm.

Reception at Wormwood Scrubs

Cell sharing risk assessment

A cell sharing risk assessment was completed as part of the reception procedures. This noted that he had a quick temper and had self-harmed three weeks earlier. The assessor noted that he was addicted to drugs, and had in the past been on an open F2052SH (a self-harm monitoring form) but that no such form was currently in force for him. The assessor also recorded that the man said he was the sort of person who would quickly become angry or frustrated and he was concerned about sharing a cell. The assessor thought the man presented a medium risk of harming others, but his risk would need to be reviewed regularly.

The senior nurse in charge of reception and the first night centre, completed the healthcare section of the cell sharing risk assessment form. She wrote, “Appears to be having auditory hallucinations. Appears paranoid. Please locate single cell until further review.”

This decision was endorsed by the duty manager who considered that the man's case should be reviewed again after seven days.

First reception health screen

The senior nurse also carried out a reception health screen on him. He told her he had not been homeless during the previous year, but had been in prison at HMP Highdown in 2005. The man said he had registered with a GP in the Holloway Road and had recently seen a doctor “for medication”. He did not give any further details. However, he disclosed that he was currently receiving lansaprazole (*a protein inhibitor to protect the stomach*) and other drugs he could not name. The man said he had received no physical injuries in the previous few days. He said he did not suffer from asthma, diabetes, epilepsy, chest pains, tuberculosis, sickle cell disease or allergies. He was worried about a “stomach problem”. The nurse noted that he “appeared well”.

The man told the nurse he suffered from depression and had received treatment from a psychiatrist whilst in the community. He said he had been an inpatient in a psychiatric hospital in Ireland. He claimed he had a psychiatric care nurse and had been prescribed mirtazapine, an anti-depressant drug. The nurse told my investigator that the man gave her the name of the care worker and then told her to remove the name from his record because he (the man) did not want to have any contact with him.

The man admitted to consuming seven cans of beer most days and to drinking vodka occasionally. He said he had used heroin three days earlier, and cocaine three weeks earlier. At 7.00pm, he was asked to produce a urine sample. He was unable to do so at that time, but provided a sample at about 8.00pm. He tested negative for heroin, methadone, benzodiazepine and amphetamine, but positive for cocaine.

The man also told the senior nurse he had tried to hang himself six months earlier and, some years previously, had cut his left arm. He did not go into detail during the health screen. It is not clear whether these events relate to the self-harm attempt noted in his PER. However, he said he did not currently feel suicidal. The nurse nevertheless described his mood as low.

At interview, the senior nurse told my investigator she thought that he looked “troubled”. She explained that by this she meant he had mental problems. She remembered that he was clean shaven and well kempt. She said that during her interview with him, the man occasionally talked to himself “as if he was talking to someone else”. She thought he was experiencing auditory hallucinations and noted this on the health screen form. My investigator asked her whether she thought his current state of mind might have been affected by his taking cocaine three weeks earlier. She thought this unlikely. Neither did she think he was withdrawing from drugs.

The man told the nurse that he wanted to see a doctor. She therefore referred him to the GP, who saw him later that day. The GP is employed by Hammersmith and Fulham Primary Care Trust as a General Practitioner at the prison with responsibility for seeing all newly received prisoners. After seeing him, the doctor made the following entry in his medical record:

“24 year old Caucasian. North Irish/British born. Living in a caravan with his wife and two children – a son aged seven and a daughter aged five. Registered with GP, on remand now for theft. In prison: Smoke: 0 Alcohol: quite a lot, 7 cans most days. Drugs: Heroin daily. Claims on methadone prescribed by GP. Urine: Cocaine.....

Past medical history: Colitis. Mesalazine 400 three times daily. (*This is a drug prescribed for the treatment of Colitis.*) Lansaprazole 30mg once a day. Mirtazapine 45mg by night. (*This is an anti-depressant.*) Stool 3x (*In other words, he opened his bowels three times a day.*)

Mentally: Depressed? I don't know. All the time voices talking to him; no to eat food. Self harm history 6/12 attempted hanging. Says he was playing. 'Nobody cares for me.' Not at risk of self-harm now. Obviously known to psychiatrist. General condition squinting. Pulse rate 92. Refuses to be examined.

Mentally: cas dressed. no signs of self neglect. low in mood. hallucinations +. poor rapport. Suspicious, why do you smile 'at me?'

Impression: acute psychotic illness. Plan: H3 single cell. To be assessed by detox and cocaine positive.

Lansaprazole 30mg
Mesalazine 400mgs two tablets three times a day.
Ferrous sulphate 200mg.

Had these tablets with him.

Confirm other medication. Blood tests? Still needs urine test. 19:50 Cocaine positive.”

The GP told my investigator that, although the man had tested positive for cocaine, he did not think he was actively withdrawing from drugs. However, as he thought the man was suffering from an acute psychotic illness, he believed the healthcare centre was the safest environment for him. There he could benefit from 24 hour nursing support. The GP also said he thought the man should be in a single cell because he could be dangerous to other people. He told my investigator that, having recorded his recommendation for the man to be allocated to H3 landing in the healthcare centre, his expectation was that he should have been located there that night.

Interviews conducted during the clinical review of the management of the man's health needs revealed that, at the time, two cells in the healthcare centre were out of use because they had been damaged. Staff told the review panel that there was also a protracted emergency bed watch in a nearby hospital, causing a shortage of staff in the healthcare centre. Staff also told the panel that the inpatient unit was being used to house disruptive prisoners.

As there were no vacancies in either the healthcare centre or the first night centre, the man was located in D Wing, a unit that normally holds enhanced prisoners (i.e. those on the top tier of the Prison Service's incentives and earned privileges scheme). My investigator was told that the man was to be admitted to the healthcare centre the following day, when it was known that a bed would become vacant as another prisoner was due to be moved to an outside hospital.

As the man was not thought to be at risk of suicide, no ACCT (Assessment, Care in Custody and Teamwork) form was raised. (This is a document used to assess, monitor, support and manage at risk prisoners.)

Friday 9 February

On 9 February 2007, the man was moved from D Wing to the First Night Centre. An entry made in his core record shows he was placed in a single cell "because of his medical history".

The senior nurse carried out a general assessment of the man's health. At interview, she said she thought he had not slept well the night before. She was concerned that he was still experiencing auditory hallucinations. The man asked her for his medication, but she told him he could only have what the doctor prescribed.

A prison officer, who regularly worked in the First Night Centre, told my investigator he remembered seeing the man that day. He said he allowed him a telephone call. He thought the man used it to call his wife. The officer said the man seemed fine when making the call. He told my investigator he knew from the man's history sheet that he had been made "medically high risk" when he came through reception. The man was located in cell X4-04. The prison officer said he tried to chat with him during the afternoon but "couldn't really get much out of him". He said the nurses told staff on the First Night Centre that the man was not to be unlocked when other prisoners were out on the landing because he "would cause an alarm bell". The prison officer told my investigator that the man refused his meal that afternoon. However, he said arrangements were made for a meal to be left in the hotplate in case he changed his mind. The officer did not know whether the man eventually took his meal. Another officer who worked in the First Night Centre, also had contact with the man. She told my investigator that he "just wanted to be banged up". She said that during the first day the man came out of his cell to collect his food, but the next day he refused to do so at designated meal times. However, she pointed out that he would ask for bread and cereals to eat after the meal time had passed. She said staff did their best to take him something to eat.

The officer said that he would occasionally come out of his cell to talk to a friend whom he had met outside prison, but she could not remember his name. She suggested that when he talked to this friend he was normal, but when he talked to staff he would "start to change a bit".

At about 5.00pm, the man was seen by the manager of the mental health in-reach team. At interview, he said that a nurse had gone to the healthcare centre to see him and the psychiatrist because he was very concerned about the man. The nurse described the man as psychotic. The psychiatrist decided to see him. Before doing so, she tried to ascertain which GP the man had seen before coming into prison. The psychiatrist searched on the internet for all the General Practitioners listed in that area and rang them. None had heard of him. The manager and the nurse therefore called his wife on her mobile phone to ask for details of his doctor. There was no answer. The manager and the psychiatrist then went to an office in the First Night Centre to see the man together. Afterwards, the manager wrote in his medical file as follows:

“He said he lives in a mobile home on a site with his wife and 2 young children. He gave a history of domestic dispute and arguments with his wife around his drug use. He explained he had used violence against property in the past, including breaking a window in his caravan in the past 2 weeks. He said he was registered with a GP in the Holloway Road and had been diagnosed with depression. He said he had been prescribed Zispin and Diazepam in the past and had taken medication 2 weeks ago.

“He gave a history of a previous admission to psych hosp a few weeks ago near Dublin. He said he spent 3 days in hosp following his arrest by police after he had caused considerable damage to the house of his uncle in Dublin. He has stated he had been admitted to hosp as an adolescent.

“On examination today, he appeared extremely suspicious and paranoid. He thought people were talking about him. He appeared not to trust our motives and constantly sought reassurance. He said he had heard people talking about him when no-one was there. He cannot read or write. He was not able to explain to us why he was in prison. He denied any feelings of suicide or self-harm.

“He requested that he remain in a single cell.

“Plan: Transfer to H3 for observation and assessment.
Seek further info from GP
Diazepam to relax
to be seen on ward round on H3”

At interview, the manager and psychiatrist said they had expected him to be admitted to the healthcare centre that evening. However, they were told there were no vacancies. They said they therefore reviewed the cases of any prisoners who were already inpatients as a result of their mental state to assess whether any of them could be moved to make room for him. They came to the conclusion that none could be moved. They were told that the following morning a patient was due to be transferred to an NHS hospital. In

the event, he was not moved. Finally, it was decided that the man could be admitted on Monday, 12 February. The manager made a note to this effect in the man's core prison record. (My investigator was given a copy of the healthcare centre waiting list. The man's name is included in the list on 9 February as being a planned admission for 11 February.)

Saturday, 10 February

During the morning of 10 February, the man was behaving strangely. At one stage, he told a wing officer he thought there was someone in his cell telling him to set fire to his sheets. He said he had no matches as he did not smoke. When the officer told him that he would be admitted to the healthcare centre the following Monday, he asked her if the other person in the cell would be allowed to go with him. The man was in a single cell at the time. The officer told him he would be taken to the healthcare centre by himself.

On another occasion, the man said to the prison officer, "They're flying through the hatch". The officer said to him, "Don't worry. No one's coming to get you. You'll be alright up here." The man again said, "They're coming through the hatch," at which point the officer advised him to calm down. The prison officer thought this took place at about 9.30am.

At interview, another wing officer said that at tea time the man came out of his cell to call his wife. She explained that after the tea meal, which he refused to collect, she and two colleagues approached his cell after one of them had noticed that he had covered his cell observation panel. They tried to persuade him to uncover the panel. She said he began to behave strangely at that point. She and her colleagues therefore decided to ask a doctor who was already in the First Night Centre to see him. She said the doctor agreed to do so. The man told the doctor his wife would know what medication he was taking.

The wing officer said she and her colleagues considered removing the television set from his cell for his own safety. However, he pleaded with them not to do so. They therefore decided to leave the television set in his cell at that stage. The officer said this had a calming effect on him. He stopped covering his observation panel and seemed alright by the time she and her colleagues went off duty at 5.30pm.

The following entry was made in the man's prison file later that day by another officer:

"Inmate pressed cell bell. On answering it, door hatch was covered up with newspaper. With two other officers present, I went into his cell, turned the lights on. He was lying in lower bed. Asked him if there was a problem or if he needed anything, everything was ok."

The officer then made another entry. This time he wrote:

“Soon after the event above, another wing officer discovered that prisoner had barricaded his door with a mattress. Informed orderly officer who said to contact Healthcare to speak with the prisoner. Shortly after, the nurse on duty and the doctor spoke with prisoner in his cell after removing the mattress from the door. Two wing officers present. Dr was given a phone number of prisoner’s wife to find out medical history. Prisoner was left in cell. Explained not to barricade his door. Prisoner agreed.”

At 5.30pm, the man was seen by a prison doctor, who made the following note in his medical record:

“Seen in FNC as he had barricaded his cell. Has put chair and supported mattresses against it so he cannot be seen. Spoken to him. Was lying on his bed with his coat on over his clothes. Did not get up off bed when spoken - went into cell - pushed mattress back and chair. Then he sat up. ‘These people are harassing me.’ Points to staff in front of him. ‘Why are they doing this?’ When asked whether anybody else in room said there was. But would not expand.

Coherent. When asked medication – only wife knows. Gave telephone number. Not currently under psychiatrist on the outside.

No recent inpatient care. Says he was inpatient in Ireland.

- agitation
- Agitation/.....
- Review pm
- All medication given as prescribed.”

A separate note made in his core prison record also shows the doctor asked the man to give him his wife’s telephone number so that he could find out more about his medical history. It is not clear from the record whether any calls were made to his wife or, if they were, whether they were successful in contacting her. At the time of the investigation, the doctor was not available for interview. Neither was one of the wing officers.

A prisoner was in the cell next door to the man’s cell. He explained that he was in the First Night Centre for five days and moved into the cell next door on 10 February. He told my investigator he thought the man “was not a very well man”. He said he saw him looking out of his cell through the hatch in the door. The prisoner said that the man was just staring without saying anything. He said the man repeatedly banged on the cell wall as if to attract his attention. He shouted back to him, “What do you want mate?” He said the man did not answer.

He said the man was never let out of his cell. Staff brought him his food but he did not eat any of it. He told my investigator that the man hardly uttered a

word in his cell. He said he did not hear the man say anything to indicate he was contemplating suicide.

Sunday, 11 February

At 11.40am on 11 February, the following entry was made in the man's prison file by an officer:

"Prior to lunch, he once again placed his mattress up against his door, blocking observation. He was persuaded to remove the mattress but insisted his observation had remained closed (*sic*). I informed him that we would have to observe him from time to time which he agreed to let us do. He refused his lunch stating that things had been put in it. SIR (*Security Information Report*) submitted. Duty governor and orderly officer informed."

My investigator was told that there was only one Security Information Report in the man's security file. The serial number of that report was 070515. A copy of a report bearing that serial number was presented to my investigator but it related to a separate matter. The office said the man's claim that his food was contaminated was not investigated because staff believed he only thought this because of his mental state. The investigation found evidence that the man frequently asked for and accepted bread and cereals after designated meal times, without suggesting that these were contaminated.

At interview, the officer explained that it was one of his colleagues who first noticed that the man had blocked his observation panel. The officer led the way to the man's cell to investigate. He told my investigator that, while he was trying to persuade the man to take his mattress down, he kept saying things were flying through the air at him. The officer thought this was the reason why he placed an obstacle - his mattress - against his door. The officer also explained that, in order to ensure that staff could continue to observe him, he reached a compromise whereby part of the observation hatch was left shut but the man could still be seen through another part of the same hatch.

The officer told my investigator that a little later he returned to the man's cell to see if he was alright. On this occasion, he and his colleagues noticed the man lying under his bed on his mattress. He had suspended his bedsheet from his bunk as if to create a den. He had also placed a chair in such a position as to make it difficult for staff to see him. He and another wing officer entered the cell and removed the chair. They also removed the television set for his own safety. They asked him if he wanted lunch but he declined. They then telephoned the duty governor to report what they had done. The governor was content with their decision to remove the furniture and TV set.

One of the wing officers told my investigator that, during the lunch period between 12.30 and 1.30pm, he was sitting in the television room when he heard a loud bang as if someone had kicked against a cell door. At the time,

another wing officer was patrolling the landing. The patrol officer thought the noise had come from the man's cell.

At interview, she said,

“At about 12:45 I was in the office and I heard a loud bang. Another wing officer was on the unit as well but he was in the TV room. So I heard the loud bang. I came out of the office and so did the other officer, so I said to him ‘follow me down to the man's cell because I think it's his cell.’ When I went down there he had thrown his chest of drawers down. Well, it's like a cupboard. He had thrown that down and that was the loud bang that I heard. I asked him if he was alright. He didn't reply so I asked him again. He was just looking straight, not at me at all. At that point I went and called the Orderly Office again just to let them know what he had done now, so if there's anything that needed to be done they would tell me, whatever. They said fine just keep an eye on him.”

The officer said she observed the man again at about 1.26pm but did not hear anything else.

Discovery of the man collapsed in his cell

At about 1.35pm, a duty officer started his shift in the First Night Centre. At about 1.55pm, a wing officer mentioned to him that the man had been “playing up”. They both decided to go to see him. Another officer was also in the vicinity. On arrival at the cell, the duty officer noticed the door was closed and the observation hatch was in the down position. He opened the hatch and saw the man lying face down on the floor. He shouted the man's name but he did not respond. He opened the cell door and entered. In interview, he remembered the man was wearing a dark blue jumper and jeans or trousers. He was sure the man was not wearing a coat of any sort. The wing officer noticed the man's bed had been upturned and there were pieces of broken plastic on the floor. He knew these were from the man's food tray. He thought the man had broken them himself.

Realising that the man was unconscious, the duty officer checked for signs of life. He discovered the man was not breathing and his lips were blue. He and the wing officer placed the man in the recovery position, and the wing officer sent a Code 2 message over the radio. (This is a means by which staff, without unduly alarming other prisoners, can alert the control room and other colleagues to someone who has collapsed and is unconscious.) The wing officer also asked another officer to get the duty nurse, who works in the First Night Centre, and the senior officer who was in charge of the centre at the time. He then asked over the radio for an ambulance to be called.

At this stage, no one knew what had caused the man to collapse. However, the duty officer said he noticed a belt hanging from the man's bed. He thought the man had probably put it around his neck and this was the reason

behind his collapse. He also noticed that the buckle on the belt had broken. He told my investigator, "There was a piece of buckle on the bottom and the actual belt was hanging from the buckle down." The duty officer said he saw a puncture mark on the right hand side of the man's neck. As he had not seen the man hanging, he could only speculate that this was the cause of the puncture mark on his neck. The wing officer said he too thought the man had tried to hang himself with his belt, but the belt had snapped at the buckle because it could not take the man's weight.

Meanwhile, the staff nurse, who was on duty in B Wing, heard the Code 2 message on the radio. She knew the emergency was in the First Night Centre, but did not know who was involved or in which cell. She collected the emergency first aid bag and the defibrillator and followed one of her colleagues, the second nurse to the First Night Centre. There she was directed towards the man's cell. The staff nurse remembered that, when she entered the cell, she saw colleagues were already administering cardio pulmonary resuscitation (CPR) to the man. The second nurse said in her incident report that she saw markings around the man's neck. She also said there was "good colouring" and that the man was "warm to the touch throughout".

The staff nurse helped to maintain the man's airway while her colleagues, the second nurse and the officer continued to administer CPR for about 15 minutes until a paramedic crew arrived at the cell. They decided to transfer him to the local hospital, adjacent to the prison, at about 2.30pm. The paramedic crew continued to apply CPR in the ambulance but there was no cardiac output or respiration.

The man was pronounced dead at the hospital at 3.12pm. No letter was found in his cell.

Informing the family

My investigator interviewed the deputy head of prison safety at Wormwood Scrubs. He explained that on 11 February, he was off duty at home. Just before 4.00pm, he received a telephone call from the duty governor who told him the man had been found hanging. He asked the governor if he should attend the prison. The deputy head of Prison Safety said he was told the police had informed the man's family, who were on their way to the local hospital. He told the duty governor he would go to the prison and then to the hospital with the chaplain and another family liaison officer in order to meet the man's family.

He told my investigator he arrived at the Incident Command Suite in the prison at about 5.40pm. It was at this point that he was told the family had not in fact been informed of the man's death. He left the prison at about 9.00pm.

My investigator was told by the duty governor that the confusion as to whether the man's family had been told of his death was the result of poor communication within the Metropolitan and Hertfordshire police forces. She

explained that a police contingent had been assigned the task of going to the caravan site where the man's relatives lived and informing them of his death. At some point when the appropriate arrangements were being made, another serious incident occurred elsewhere. The same contingent therefore had to be redeployed. At about 4.25pm, whoever was in charge of the contingent told the police officer in the prison command suite that the family had been told of the man's death. This was passed on to the duty governor. In fact, because of the redeployment, this was not the case. The family were told of his death by the police at about 10.00pm that night.

Tuesday, 13 February

On 13 February, a prison officer met representatives of the man's family at the prison. They had asked to see his cell. The family asked him to explain how the man had hanged himself. He turned the bed on its end so that the family could see for themselves the position it was in when the man was found. The officer, who was not amongst those staff who responded to the emergency, did his best to demonstrate how the man had probably suspended himself from the upper end of the bed with his belt. He speculated that the belt had snapped because of the man's weight. The officer explained that this was most likely to be the reason why the man was found slumped on the cell floor rather than still in the suspended position.

The officer and the deputy head of prison safety and appointed family liaison officer helped the family as they viewed the man's cell. Both tried to answer their questions to the best of their ability, but were inhibited in doing so by the fact that they had not been involved in the emergency.

Later that day, the deputy head of prison safety asked the man's mother-in-law if she wanted support in meeting the costs of the man's funeral. He told her he wanted to arrange for flowers to be sent to the undertakers and for a representative of the prison to attend the funeral. At interview, he told my investigator the family did not want to give an immediate response. He later contacted the funeral directors who confirmed that the funeral was to take place on 20 February. He then telephoned the man's mother-in-law to offer further support. He said the family told him they wanted no contribution from the Prison Service towards the funeral costs and did not want flowers or a Prison Service representative at the funeral. My investigator put to the deputy head of prison safety a comment made by the man's wife that he (deputy head of prison safety) had tried to minimise the amount of money to be offered towards the cost of the funeral. He said this was not true. He confirmed that he offered her up to £3,000.

The widow also claimed that she and other members of her family cleaned up the man's cell when they visited on 13 February. The deputy head of prison safety confirmed that no members of the man's family were expected to do this. He imagined that the cell had been cleaned by prisoners before the visit took place, but could not be sure. The widow thought there was dust on the mattress, indicating perhaps that the cell had not been properly prepared for

them. The deputy head of prison safety said that when the bed was upturned by the officer there was no sudden dust cloud. He said he was not aware of this issue as the family had not raised it during or after their visit.

The widow was also concerned that there were no toiletries or blankets in the cell that day. She believed her husband was not provided with any. At interview, the deputy head of prison safety said he could only imagine that the person sent in to clean the cell had removed the toiletries and blankets. He said that if a similar event occurred again, the prison would make sure that items such as toiletries were left in the cell for a family visit.

ISSUES

Here I examine the following:

- Were the man's health needs properly assessed and managed while he was in Wormwood Scrubs?
- Was the man's risk of suicide properly assessed, monitored and managed?
- Was the response to the discovery of the man in a collapsed state in his cell prompt and effective?
- Were appropriate courtesies offered to the man's family in the aftermath of his death?

I also provide answers to the concerns raised by the man's family.

Were the man's health needs met while he was in custody at Wormwood Scrubs?

A comprehensive clinical review of the management of the man's health needs while he was in custody at Wormwood Scrubs was undertaken by a panel of specialists from the Hammersmith and Fulham Primary Care Trust. The review draws attention to the following concerns:

- Reception

The ability of reception staff to obtain reliable information, especially about prisoners' substance misuse and mental health history, is affected by time constraints linked to the volume of prisoners received.

- Healthcare centre

The review panel was told that, at the time when the man should have been admitted to the healthcare centre, two inpatient cells had been damaged and were consequently out of use. The panel was told that there were staff shortages caused by a protracted emergency bedwatch (escort) in a nearby hospital. The panel also learned that the inpatient unit was being used to accommodate disruptive prisoners.

- Nursing care

The panel found that no arrangements were made by the Mental Health In-reach Team in the prison to ensure that the man received one to one nursing care until a place became available in the inpatient unit.

- Observations

The man was prescribed Zopiclone (a hypnotic drug) and Diazepam (an anxiolytic drug) on 9 February and recommended for an increased level of observations. The panel found no documentary evidence to show that the required observations were made.

After barricading himself in his cell on 10 February, the man was assessed by a member of the healthcare staff. The action plan agreed was for further observation and a review during the evening ward round. The panel found no documentary evidence that the review took place.

- Multidisciplinary care

The panel noted that after hours care was provided by prison officers with no evidence of input or advice sought from healthcare professionals. The panel found no documentary evidence of a multi-disciplinary care plan.

- Documentation

The panel noted that valuable clinical observations were only documented in prisoners' history sheets which are not readily available to reviewing clinical staff. The panel took the view that, if the information described in the history sheets had been available to healthcare staff, the man might have been risk assessed as needing an urgent and higher level of care. They felt that this, in turn, may have influenced the outcome. The panel found large gaps in the man's medical record.

The review panel was drawn to the following conclusions:

- The man's state of health was not such that he could voluntarily avail himself of the health services at Wormwood Scrubs.

I should say here that, at consultation stage, the Prison Service pointed out that during all the assessments carried out on him, no health professional questioned his ability to consent to treatment or had the need to assess his capacity to consent to treatment. The Prison Service therefore feels that this particular conclusion is unsubstantiated.

- The lack of information available to all members of the clinical team, combined with the lack of care coordination and proactive health protection, contributed to the tragic outcome. Had the record keeping, communications and care escalation systems been more robust, it might have been possible to reduce the risk of his death.
- The man's self-reported substance misuse, mental health history and his observed behaviours required a coordinated care approach. Although he received input from the in-reach team, no arrangements were put in place to ensure he received one to one nursing until a place became available in the inpatient unit.

The panel makes eight recommendations. These are paraphrased as follows:

There should be robust system designed to flag actions for follow-up by members of the healthcare team.

There should be a policy to address the stepping down of care, whereby offenders with stable needs can be transferred out of the inpatient unit to allow for the admission of offenders with greater care needs.

There should be a re-launch of the one to one observation/care policy.

NB: I do not endorse the above recommendation. See page 33 for further information.

The importance of care planning should be reinforced to all clinical staff via staff meetings, one to one performance reviews and clinical supervision.

When seeking information from external authorities, all information available to healthcare professionals, i.e. name, aliases, date of birth, address, physical description, should be provided to obtain clinical histories.

Communication processes should be reviewed to ensure that all observations of behaviour that cause concern are highlighted to relevant clinical staff.

All clinical information should be documented in prisoners' medical records, in keeping with nationally accepted record keeping standards.

There should be a review of admission criteria to the inpatient unit, to ensure offenders with health needs that require inpatient admission have timely access.

Where the latter recommendation is concerned, I should add my own views about the fact it was not possible for the man to be admitted as an inpatient immediately after the doctor saw him in reception. The doctor did not realise until after the man had died that he had not been admitted.

The clinical review panel was told the inpatient unit was being utilised to house disruptive offenders. My investigator was also told that the Certified Normal Accommodation figure of 1,239 for the prison included the inpatient beds. As a result, it was possible for prisoners with nothing wrong with them to "lodge" in the healthcare centre if there were no spaces elsewhere in the prison.

My investigator asked to see the register of prisoners located in the healthcare centre on 10 and 11 February. He was told that all the prisoners listed in the register were in the healthcare centre for medical reasons.

At interview, the psychiatrist said she and her colleague, the mental health manager, reviewed the cases of all the inpatients to see if it was possible to make a space for him. She said the review showed this was not possible. I believe the psychiatrist and the manager made every effort to move the man into the healthcare centre urgently. Although his admission did not

materialise before he died, I do not believe that this was due to poor management or to the presence of disruptive prisoners in the healthcare centre at the time. Neither can I safely draw the conclusion that the failure to admit the man to the healthcare centre contributed to his death. Nevertheless, this is a very important matter and I therefore make the following recommendation:

If, as said by some of his staff, it is the case that disruptive prisoners have been held in the healthcare centre, the governor should take urgent steps to bring this practice to an end.

Was the man's risk of suicide properly assessed, monitored and managed?

Whilst in police custody on 7 February, the man said he was depressed and had tried to harm himself during an earlier period of custody. It is not clear where and when this occurred. As a consequence of what he said, the man was prescribed anti-depressant medication and instructions were given that he should be observed at half hourly intervals. Nevertheless, the Forensic Medical Examiner thought he was coherent and rational.

When he was taken from the police station to court the next day, the Prisoner Escort Record (PER) for the journey contained a reference to a risk of suicide. At 11:50am that day, the man told the court custody staff he felt unwell. There are no details recorded to show what was wrong with him. However, the PER shows that for the remainder of his time in court cells he was alright.

During the reception health screen at Wormwood Scrubs, the man said he was not feeling suicidal. With the benefit of hindsight, it is easy to judge that he was in fact at risk of suicide. However, I am satisfied that when he arrived at Wormwood Scrubs he gave no indications that there was a current risk. His behaviour in the First Night Centre, although strange, was not indicative of any intention or desire to self harm or to kill himself.

I do not believe staff had any grounds for initiating formal self-harm monitoring procedures. Had they done so, they would probably not have observed or monitored him any more closely than they did in any event.

Was the response to the discovery of the man in a collapsed state in his cell prompt and effective?

The man was discovered in a collapsed state in his cell at 1.55pm on 11 February. An officer saw him on the floor before he saw the snapped belt still attached to the bed. As a result, it was not immediately obvious to him that the man had hanged himself. Nevertheless, he raised the alarm over the radio straightaway. Emergency first aid was applied and, at 1.58pm, an ambulance was called. A paramedic crew arrived at the man's cell at 2.05pm. Further efforts were made to revive him, and at about 2.35pm he was transferred to the local hospital. The ambulance crew continued in their

attempts to revive him during the short journey to the hospital. Sadly, he was pronounced dead at the hospital at 3.12pm.

I am satisfied that the alarm was raised immediately and that cardio pulmonary resuscitation was applied with no delay. Appropriate emergency first aid equipment was taken to the cell as quickly as possible and was used by trained staff.

I commend all those staff at Wormwood Scrubs and the paramedic crew for the manner in which they conducted themselves in attempting to revive the man in such harrowing circumstances.

Were appropriate courtesies offered to the man's family in the aftermath of his death?

Prison Service Order 2710 policy requires governors to:

- Arrange notification of the death of a prisoner to the next of kin as soon as possible.
- Appoint a senior member of staff or a dedicated family liaison officer as a named point of contact for the family to make and maintain contact with the family.
- Send a letter of condolence to the family and invite them to visit the establishment.

The investigation found that these requirements were, in large part, met.

There were clear difficulties in informing the man's family of his death, not helped by poor communication between the Metropolitan and Hertfordshire police forces. However, I am satisfied that the appointed family liaison officer, and his colleagues at Wormwood Scrubs did their best, under difficult circumstances, to pass the news of the man's death to his family as quickly as was practicable.

Arrangements were made for a large number of the man's family to visit the prison on 13 February, two days after he died. The deputy head of prison safety as family liaison officer and another officer took them to the man's cell and answered their many questions to the best of their ability. However, they were inhibited in doing so by the fact that they were not in the First Night Centre when the man was found collapsed.

There was no evidence that a letter of condolence was sent or handed to the family. However, the investigation found that the family liaison officer expressed his condolences to the family, in person, when he met them on 13 February.

On the governor's behalf, the family liaison officer offered to contribute £3,000 towards the cost of the man's funeral. He told the family he wanted to send flowers to the undertakers. He also offered to send a representative of the establishment to the funeral. These offers were declined. The widow told my

investigator that the family liaison officer tried to minimise the amount of the contribution he made towards the cost of the man's funeral. I am satisfied this was not the case. The £3,000 he offered the family represents the upper limit of that which is normally offered.

Family concerns

Was the man disadvantaged in any way because he was a traveller?

I have investigated eight previous deaths at Wormwood Scrubs since 1 April 2004. None of these prisoners was a traveller, although one was of Irish descent.

The man was in custody at Wormwood Scrubs for only three days before he died. In that short time, he was cared for by prison officers, and a range of medical and specialist staff. I am satisfied that they did their best to respond to his mental state. The investigation found no evidence that he was ill-treated or in any way disadvantaged because he was a traveller. Neither the Chief Inspector of Prisons nor the Independent Monitoring Board at Wormwood Scrubs have expressed any concerns about such matters in their recent reports.

The man's family have claimed that other travellers in Wormwood Scrubs at the time of the man's death heard him shout, "Don't kill me". They also believe that another prisoner has told the man's wife that he had been talking to the man 20 minutes before he died and he seemed fine then.

The man joined the First Night Centre on 9 February. My investigator interviewed a prisoner who was in the cell next to the man's cell in the First Night Centre during the five days period preceding the man's death. The prisoner said the man hardly uttered a word while he was in the cell next to him. The investigation found no evidence that the man shouted "Don't kill me".

There were no prisoners by the name given in the First Night Centre at the time the deceased was there.

The man's family want to know how the man, a young fit man, came to die by his own hand so quickly after arriving at Wormwood Scrubs.

The investigation found no clear reason for the man's apparent suicide. However, his behaviour whilst at Wormwood Scrubs suggests he may have been mentally ill. He was thought to be psychotic and paranoid.

The man's family have asked whether he was denied medication while he was in police custody.

The man was seen by three different Forensic Medical Examiners while he was in police custody.

The records show that, although he was described as coherent and rational, felt depressed and was suffering from colitis. The man was given the following medication:

Zispin 45mg x 1	(An anti-depressant)
FES04 200mg x1	(For colitis)
Lansoprazole 30mg x1	(An anti-biotic)
Asacol 400mg x2	(For bowel disorder)
DF 118	(This can also be prescribed for bowel disorder)
Valium	(A relaxant)

The family are suspicious about what happened in the prison. The widow said their suspicions were not helped by various conflicting stories told to them by prison staff. She said that a woman from the chaplaincy told her she had never seen the man, but then went on to say she felt so sorry for him "on the floor". The widow felt suspicious about what the family liaison officer said to her on 13 February. She could not understand how a six foot man could hang himself from an upturned bed.

The widow said she was horrified at how dirty the man's cell was when she visited the prison on 13 February. She said she wished it had been left as it was. She was also concerned that he had not been issued any blankets or toiletries.

The members of staff who were in attendance when the widow and other family members visited the cell on 13 February included the chaplain, the family liaison officer and another officer.

The chaplain confirmed that she had not met the man, although she said she was in the First Night Centre on one of the occasions when he barricaded himself in his cell. The chaplain told my investigator she administered a decade of the Rosary with the widow and gave her a patch of the mattress and the pillow in the cell as a memento.

The officer told my investigator that he demonstrated to the family to the best of his ability how the man would have been able to hang himself from the upturned bed. I should emphasise that describing to a bereaved family how their loved one died is not something that is normally done because of the obvious distress it can cause. However, the officer did so at the request of the man's family.

It was not possible during the course of the investigation to clarify precisely what state the cell was in on 13 February. However, the officer as one of the members of staff in attendance with the man's family, told my investigator that, after the police had confirmed that the cell could be used for another prisoner, it was cleaned and made ready for occupation. The family liaison officer was not prepared to say that the cell was clean but he thought it was not untidy. It is most likely that the bedding issued to the man and whatever used toiletries were in his cell when he died were removed by whomever cleaned the cell.

My investigator was told that the staff at Wormwood Scrubs had to press the police to release the cell so that the family visit could take place when it did. The investigation found that the cell was only released a short time before the visit began. It is much to the credit of the staff involved that they ensured, in a very short space of time, that the man's cell could be seen by his family.

I am satisfied that adequate arrangements were made for the family to visit the man's cell and that the family liaison officer, the officer and the chaplain were sincere in their attempts to comfort the family and to answer their questions about the circumstances of the man's death.

The widow wanted to know what the GP thought about the man's mental state on reception.

This is covered in the main body of this report. (See page 14.)

The widow wanted to know why the man was placed in a single cell and allowed to have a belt in possession despite having a history of mental health problems.

The decision whether a prisoner should be placed in shared or single accommodation turns upon the findings of a cell sharing risk assessment, completed routinely in respect of every new prisoner. The decision has to draw a balance between the risk that the prisoner may harm his cellmate and the risk that he may harm himself.

On 8 February, the day the man first entered Wormwood Scrubs, he underwent an assessment of that risk. The man told the officer who carried out the assessment he had concerns about sharing a cell. He also said he was a person who became angry or frustrated quickly. The officer judged that he presented a medium risk of harming others. This meant there was no perceived immediate risk, but the situation would have to be reviewed regularly. In keeping with normal Prison Service procedures, a nurse completed a further assessment of the man's suitability for sharing a cell. As she thought he was experiencing auditory hallucinations, she concluded that he presented a high risk of harming others. The nurse did not think he man was at risk of harming himself. It was therefore decided that the man should occupy a single cell, but that this decision should be reviewed after seven days. The man was initially allocated to a single cell in D Wing as there were no vacancies in the healthcare centre or in the First Night Centre. On 10 February, he was moved to a single cell in the First Night Centre. His behaviour during the short time he was in that unit was such that his single cell status remained in force.

As to the question of his access to a belt, the provision of articles of clothing has to draw a balance between any risk that the prisoner might use them inappropriately and the need to treat him with decency. It is not normal for items such as belts and shoelaces to be withdrawn from a prisoner unless he

is considered to be at a very high risk of suicide. The man was not judged to be suicidal. I offer no criticism of the judgements made.

How long did it take for the ambulance to reach the prison?

The investigation found that the man was found collapsed in his cell at about 1.55pm on 11 February. An ambulance was called at 1.58pm. An ambulance arrived with a first paramedic car at the prison at 2.02pm. A further paramedic car arrived at 2.07pm. The first paramedic crew arrived at the man's cell at 2.05pm.

The man left the prison in the ambulance at 2.35pm and arrived at the local hospital five minutes later.

How was the man able to hang himself?

I believe that the man turned his cell bed on its end and attached his belt to the upper end of the bed. He then attached the belt to his neck and suspended himself.

How many previous deaths have there been at the prison, particularly of travellers?

I have investigated the deaths of eight prisoners at Wormwood Scrubs since 1 April 2004. Only one of those prisoners was Irish.

LIST OF RECOMMENDATIONS

Ombudsman's recommendation:

1. If, as said by some of his staff, it is the case that disruptive prisoners have been held in the healthcare centre, the governor should take urgent steps to bring this practice to an end.

Recommendations made by the Primary Care Trust:

1. There should be robust system designed to flag actions for follow-up by members of the healthcare team.

2. There should be a policy to address the stepping down of care, whereby offenders with stable needs can be transferred out of the inpatient unit to allow for the admission of offenders with greater care needs.

3. There should be a review of admission criteria to the inpatient unit, to ensure offenders with health needs that require inpatient admission have timely access.

4. There should be a re-launch of the one to one observation/care policy.

At consultation stage, the Prison Service pointed out that there were no indications that one to one observation was considered necessary for the man who died. The Service also took the view that the above recommendation implies that staff were failing in their duties. I must emphasise that the investigation found no evidence that staff at Wormwood Scrubs failed in their duties. Neither did the investigation find any evidence suggesting that one to one observation was necessary. I therefore do not endorse this recommendation.

5. The importance of care planning should be reinforced to all clinical staff via staff meetings, one to one performance reviews and clinical supervision.

6. When seeking information from external authorities, all information available to healthcare professionals, i.e. name, aliases, date of birth, address, physical description, should be provided to obtain clinical histories.

At consultation stage, the Prison Service expressed the concern that this recommendation has no basis, pointing out that staff at Wormwood Scrubs made tremendous efforts to obtain details of the man's medical history but without success. I agree with this viewpoint. I do not endorse this recommendation.

7. Communication processes should be reviewed to ensure that all observations of behaviour that cause concern are highlighted to relevant clinical staff.

8. All clinical information should be documented in prisoners' medical records, in keeping with nationally accepted record keeping standards.

Commendation

I commend all those staff at Wormwood Scrubs and the paramedic crew for the manner in which they conducted themselves in attempting to revive the man in such harrowing circumstances.