

**Circumstances surrounding the death of a prisoner
at HMP Wormwood Scrubs, in July 2005**

Prisons and Probation Ombudsman for England and Wales

October 2006

This is the report of an investigation into the death of a man. The man died, at the age of 27, in July 2005 in hospital. He was a prisoner at HMP Wormwood Scrubs and had been found that morning hanging from the window bars of his cell in the prison's segregation unit.

I offer my sincere condolences to the man's family. He had suffered from poor mental health and was a drug user, but his family always remained loyal, loving and supportive. I have great respect for the dignity they have shown.

I also offer my sympathies to management and staff at HMP Wormwood Scrubs. As in many local prisons, they have to work under difficult circumstances with large numbers of vulnerable people who are withdrawing from drugs or suffering from mental health problems (or both). The number of deaths that have been prevented thanks to the care and diligence of prison staff can never be quantified. When a death does occur, it has a profound effect on staff and many feel personally accountable.

Two investigators from my office conducted the investigation. I regret the delay in completing this report.

I am grateful for the assistance they received from the staff and management of Wormwood Scrubs. I wish to acknowledge too the help of the Metropolitan Police at Hammersmith who carried out their own enquiry into the man's death and shared information. My thanks also go to the Professional Executive Chair from Hammersmith and Fulham Primary Care Trust, who conducted the clinical review.

Statistically, black prisoners are less likely to die at their own hands than white prisoners. Although the extent of his drug and mental health problems is evident from this report, the man's death came as a surprise both to staff and other prisoners.

Stephen Shaw CBE
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SUMMARY

This is the report of an investigation into the death of a man. The man was aged 27 when he died at 9.08am on 13 July 2005 in hospital. He was a prisoner at HMP Wormwood Scrubs and had been found hanging from the window bars of his single cell in the segregation unit at about 8.20am that morning.

The investigation team reviewed the man's prison records and interviewed both prison staff and prisoners. A review was prepared by Hammersmith and Fulham Primary Care Trust on clinical matters.

The man had been at Wormwood Scrubs intermittently since 8 July 2003. On two occasions he had been released from prison but then recalled. One of these releases was the result of an error and the man was unwittingly unlawfully at large.

His final period in custody began following recall on 2 June 2005. During his time at Wormwood Scrubs, the man was monitored regularly by the mental health in-reach team who appeared to know him quite well. He was not considered to be at risk of suicide when he died.

On 7 July 2005, whilst on C wing, the man refused to return to his cell and demanded to be taken to the prison's segregation unit. He would not give reasons for this or discuss the issue. He was assessed by a psychiatrist and authority was given for his segregation. While in the segregation unit, the man spent most of his time in bed and would not communicate with anybody. His behaviour was described as bizarre but was consistent with that which some staff had seen him display on previous occasions. He was last assessed by a psychiatrist on 11 July but refused to co-operate.

On the morning of 13 July, following two relatively uneventful days, the man was discovered hanging in his cell. Urgent medical assistance was given, but sadly he died shortly after arriving at hospital.

This report focuses on the man's time in prison custody and evaluates the systems in place to establish whether they were (and are) fully effective.

I make five recommendations.

INVESTIGATION OUTLINE

1. The investigation into the man's death was conducted by two of my investigators. They visited the prison and were shown the areas where the man would have been, including the segregation unit and the wing on which the man had previously been located.
2. They issued a notice to staff and prisoners inviting anyone with information relating to the man's death to make themselves known to the investigation team.
3. My investigators also spoke to the Chair of the Independent Monitoring Board (IMB), the Prison Officers' Association (POA), one of the prison chaplains, and various other members of staff, including the Safer Custody Manager. My investigators formally interviewed prison staff who were involved in the events surrounding the man's death. In addition, a number of staff and prisoners spoke to my investigators informally.
4. The prison gave my investigators full access to all the documentation surrounding the man's time in prison. The police also provided copies of the documents and statements in their possession. My investigators obtained some further information from probation and court services.
5. An investigator and one of my Family Liaison Officers visited the man's mother, to discuss her concerns about what had happened to the man. This was in the presence of her solicitors.
6. The Professional Executive Chair of Hammersmith and Fulham Primary Care Trust undertook a clinical audit of the man's care while in prison.

BACKGROUND

HMP Wormwood Scrubs

7. Wormwood Scrubs was built between 1875 and 1891. It has a maximum population of 1,229 prisoners, mostly held in single cells. The population is a mixture of adult male convicted and unconvicted prisoners, the average ratio being nine to five respectively. On the day of the man's death, 1,166 prisoners were held at the prison. The prison predominantly serves West London courts and has a high reception and discharge rate, averaging around 40 new prisoners each weekday.
8. At the time of the man's death, the overall establishment rating was three (four being the highest and one the lowest). The current rating is four. This rating is established from a number of factors, including performance against area targets, Prison Service National Standards and independent inspection by Her Majesty's Chief Inspector of Prisons (HMCIIP). In relation to Prison Service National Standards, the establishment attained a rating of 'Good' for both non-security and security, which were both marked as above 80% during the most recent audit in March 2004. Suicide awareness and self-harm procedures were rated as 'Good', achieving a mark of 94%.
9. Following the most recent HMCIIP inspection in November 2003, HM Chief Inspector wrote that, nearly two years on from the last inspection, she found a greatly improved prison, gradually implementing and consolidating fundamental changes with senior managers who were actively managing staff and wings. In areas such as the first night centre, the resettlement unit and drug strategy, there was evidence of real and sustained improvement. In respect of the prevention of self harm and suicide, HMCIIP commented that almost all of the concerns and recommendations arising from the previous inspection had been fully addressed or were in the process of being responded to.
10. Recommendations were made for further improvements:
 - there should be at least one appropriately decorated and furnished Listener suite capable of accommodating a prisoner and two Listeners overnight;
 - work to create five safer cells should be completed;
 - the range of support mechanisms and specialist services available to those who are at risk of self-harm or suicide should be expanded;
 - the rank and workload of the Safer Custody Officer should be reviewed;
 - staff should have sufficient personal contact with prisoners to enable them to assess and monitor changes in mood or behaviour and thereby anticipate and prevent incidents of self-harm.
11. My investigators found some progress has been made towards these recommendations. The range of support services has been augmented with the opening of a day centre for prisoners at risk of suicide or self harm. A second Safer Custody Officer has been appointed, and all staff have been

issued with their own booklet outlining the signs and procedures to follow when dealing with prisoners who are at risk of harming themselves.

12. Regarding anti-bullying, HMCIP commented that progress had been made since her last inspection but there remained considerable work to do. The policy was widely publicised and understood. However, communication and sharing of information about incidents on residential wings was poor. The completion of anti-bullying documentation was inadequate and there were no structured interventions to help and support identified bullies or victims.

Assessment Care in Custody Teamwork – ACCT

13. The Prison Service operates the ACCT system. It is used when a prisoner is identified as being vulnerable to self-harm or suicide. The aim of the system is to enable staff from all disciplines to work together to create a safe and caring environment, where anxiety is minimised and those who are distressed are able to ask for help. Properly implemented, ACCT should ensure that individual needs are identified and individualised care and support is offered before, during and after a crisis.
14. Staff are taught to recognise the signals that a prisoner who is in distress may display. When a member of staff is concerned, they should open an ACCT document which triggers a care planning system of management. The prisoner is encouraged to talk about their problems, and staff attempt to reduce them using a care plan, combined with extra support and possibly observation.

The Segregation Unit

15. The segregation unit is an area of a prison where a prisoner is held separately from the main accommodation wings. This can be for the prisoner's safety, for the safety of other prisoners or staff, or for a punishment following a disciplinary hearing.
16. Segregated prisoners are visited daily by a governor grade, chaplain and a medical officer. Those prisoners not on punishments are reviewed each week. The review concludes with a plan to assist the prisoner return to the main wings. The segregation unit works closely with the mental health in-reach team, with regular referrals for prisoners who cause staff concern.
17. When a prisoner is segregated, a Segregation Safety Algorithm must be completed within two hours. This takes into account current observations, known medical information and the view of a doctor or registered nurse. This information is assessed by a governor grade and a decision on continued segregation is made.
18. Each segregation unit should be staffed by officers who have been carefully selected and trained. When my investigators visited the segregation unit at Wormwood Scrubs, the atmosphere was calm and controlled with a good rapport evident between staff, prisoners and managers. In 2003, staff on the unit received a Butler Trust award for their outstanding contribution to the

- effective care of prisoners. All prisoners in the unit are observed hourly by staff, making it more staff-intensive than the main wings.
19. The accommodation is based on two landings and consists of 17 normal cells, one safer cell and two unfurnished cells. Each cell has a cell bell, which is used by prisoners who need to contact a member of staff in an emergency.
 20. At night, an Operational Support Grade (OSG) is on duty as night patrol. OSGs do not have keys, but carry a cell key in a sealed pouch in case of an emergency. When the OSG comes on and off duty, he or she is required to conduct a roll count. During the night, the OSG patrols the unit and answers cell bells. At specific times, the OSG has to go to specific points in the unit and press a button. This is known as 'pegging', and proves to prison management that the OSG has been patrolling the unit.

Follow-up to deaths in custody

21. Prison Service Order (PSO) 2710 gives instructions on action to be taken following a death in custody, including the support arrangements for staff and prisoners.
22. The PSO says that priority must be given to communicating the facts about the death to prisoners and staff. It says it may be useful to issue a written statement to prisoners to defuse rumour and myth, but this will depend on local judgement. Any prisoner who may have been particularly affected by the death should be offered support.
23. A record should be kept of all those entering where the prisoner died. There should be an immediate post-incident debrief (a 'hot debrief') of staff involved before they go off duty. A senior member of staff should act as a de-briefer and a duty care team member identified and, if necessary, called in on duty. (PSO 2710, Chapter 5.)

CHRONOLOGY OF EVENTS

7 July 2003 to 31 December 2004

24. The man was arrested on 7 July 2003 and was examined in the police station by a Forensic Medical Examiner (FME). The FME wrote that the man was diagnosed as suffering from paranoid schizophrenia and that he had a history of drug abuse. The FME determined that the man was fit to be detained and interviewed by the police. He was charged and appeared at court and remanded in custody the next day.
25. On remand to Wormwood Scrubs in 8 July 2003, the man told staff that he had no home address and did not name anybody as his next of kin. The man complained that he heard intrusive voices in his head telling him about himself but said that he had never attempted self-harm or suicide. He was diagnosed as suffering from drug induced psychosis. An immediate referral was made to a Community Psychiatric Nurse (CPN).
26. He then completed the first night induction where his immediate needs were discussed including an explanation of how to access the Listeners (prisoners trained to offer support to others) and Samaritans. There is and was no personal officer scheme in operation at Wormwood Scrubs, so the man was told to contact the nearest member of staff should he have a problem. He was then located in a cell on A wing.
27. On 14 October 2003, the man was segregated following an adjudication. On 30 October, he moved from the segregation unit to the healthcare centre for assessment, as staff in the segregation unit were concerned by the man's behaviour which they described as bizarre. The man said that he wanted to be left on his own. The doctor said that the man was suffering from drug induced psychosis and paranoia. Whilst in healthcare, the records show that the man was by turns aggressive and confrontational, suspicious, non-compliant, angry and threatening. Over time, he calmed down but was still unpredictable and aggressive. At times, he requested to be locked-up because he said that "the vibes were not right". The man was assessed to see whether it was possible to transfer him to a hospital under the provisions of sections 47/49 of the Mental Health Act.
28. On 3 November 2003, the man appeared at Crown Court where he was sentenced to two years for burglary and possession of an offensive weapon.
29. The man continued in a cycle of stable and unstable periods, located in either the segregation unit or the healthcare wing, being continually monitored and assessed. On 6 January 2004, the man was reviewed. It was noted that his behaviour had improved, he was causing no problems and his mental health was considered to be stable. He was not thought to have any enduring mental illness, but was diagnosed as being psychotic due to drug misuse.
30. On 23 January 2004, the man was discharged from healthcare to C wing. He had no reported problems and no ideations of self-harm. For additional

support and monitoring, the man attended the healthcare day centre twice a week.

31. On 19 April, the man was seen on C wing and was described as being listless and de-motivated. He was no longer attending the healthcare day centre.
32. On 27 May, the man was described as low in mood as he had nowhere to live when he was released. The man claimed that he did not get on with his family and therefore had to find a suitable hostel. On 7 June, the prison had made arrangements for the man to reside at probation approved premises (probation hostel). Additionally, a referral was made to the local mental health team, letting them know that the man's release date was a month away on 7 July. He would be on licence until 6 January 2005, with a sentence expiry date of 7 July 2005.
33. Little is known about the period of time immediately following the man's first release. However, on 24 December 2004 the man's behaviour in the hostel had deteriorated to a point that he was asked to leave, which meant he would be breaking the conditions of his licence. Following an application to the Sentence Enforcement Unit in the Home Office, the man was recalled to prison. He was arrested and taken back to Wormwood Scrubs on 31 December.

1 January 2005 – 12 July 2005

34. The man was again released on licence on 12 January 2005. He was to stay in supervised accommodation at night. However, he was unable to settle in a number of locations offered to him and became intentionally homeless. Because of the inclement weather, he stayed with his mother although this put his mother's tenancy at risk and he left her home. His mother claimed that the Probation Service was not doing enough for her son, although the man had in fact been offered at least three places to reside.
35. On 5 May, the man appeared before Magistrates, charged with offences of possession of a bladed article in a public place and threatening words and behaviour. The Court asked for an assessment of whether the man was fit to plead, having been told by his solicitor that he had previous contact with mental health services.
36. The man was interviewed on 5 May by a Senior Social Worker and a Psychiatrist from the Mental Health Services. At interview, it was difficult to establish the man's state of mind in that he was preoccupied with the outcome of his case. The man was aware that he might be recalled to prison as he had breached the terms of his licence. The Senior Social Worker said that the man was not forthcoming at the interview and she formed the opinion that he was withholding information. However, the interview confirmed that the man did not have any thoughts of self harm.
37. Following the mental health assessment, the man was deemed fit to plead. His mental condition at that time did not justify compulsory detention under

- the Mental Health Act. The man was remanded in custody for sentencing until 12 May. He returned again to Wormwood Scrubs.
38. Four days later on 9 May, the man was reviewed by a consultant psychiatrist and referred to the prison's mental health in-reach team. The consultant psychiatrist said that the man had disclosed no ideations of self-harm.
 39. The man went back to the Magistrates' Court on 12 May and was sentenced to 28 days (he had already served nine days on remand). The Court Service confirmed that they did not have any pre sentence reports in respect of the man. The court also did not have any details of his licence. Following his appearance at court, the man returned to Wormwood Scrubs that evening on the prison van.
 40. The next day, 13 May, the man was released from Wormwood Scrubs. I understand this was because the prison had not received any documentation from the Probation Service in respect of the man having breached the conditions of his licence and it being revoked. Without written authority, the prison was obliged to release him. There appears to have been a breakdown in communication between the Probation Service, the Magistrates' Court and the Prison Service.
 41. On 16 May, the man's Probation Officer contacted the Licence and Recall Section to inform them that the man had been released into the community erroneously. The Licence and Recall Section then contacted the Metropolitan Police who placed a marker on the Police National Computer (PNC) to indicate that, if the man was arrested, he should be taken back to Wormwood Scrubs as he had breached the terms of his licence and would have to serve the remainder of his sentence in custody.
 42. From 16 May, the man was unlawfully (but unwittingly) at large, although he was actually spending some time at his mother's home address. However, after 25 May the family lost contact with him which they considered to be unusual as he was in the habit of maintaining some contact. My investigation has not been able to establish where the man was or what he was doing in the weeks after he was released from Wormwood Scrubs on 13 May. He did not maintain contact with his Probation Officer.
 43. On 2 June, the man was arrested by police for threatening and abusive language and possession of an offensive weapon. They also discovered from the PNC marker that his licence had been revoked. At this time, the man's behaviour was deemed by the local Mental Health Services to have deteriorated to such a level that the risk to the public was considered to be unacceptable. He was recalled back to prison to serve out the remainder of his sentence which included added days, taking into account the time he had been unlawfully at large. At the time of his re-arrest, the man said he was of no fixed abode.
 44. On re-entering prison, the man went through the normal reception process for all prisoners and was allocated a new prison number. The man did not make

contact with his family, although he was given the opportunity of using the telephone.

45. Following the man's recall to prison, his sentence expiry date was re-calculated to take into account the time from the date of his recall to the date of his arrest. The new date of release and expiry of the sentence was 8 August 2005. This was communicated to the man via a notification slip which was sent to the wing. However, there is no procedure or system in place that has allowed my investigators to check whether the man received this notification.
46. On 16 June, the man was assessed by the prison's mental health in-reach team. He said that he was not hearing voices and had no ideations of self-harm. On 26 June, an officer noticed that the man did not associate with other prisoners, although he was compliant with the prison regime. This was quite usual for the man.
47. The man's mother was unaware that her son had been arrested and was back in prison. She made contact with the local Mental Health Services on 27 June as she was concerned about her son's whereabouts.
48. On 1 July, staff noted that the man's behaviour was strange and that he leered at female and civilian staff. They described the man as walking around with his head down and his eyes up. However, he spent most of his time in his cell and did not associate with anybody.
49. Six days later, on 7 July¹ at 12:35pm, the man refused to return to his cell on C wing. He also declined to discuss his reasons with anybody, despite a number of staff and psychiatrist, attempting to negotiate with him. The man simply insisted on being taken to the segregation unit. He said that he should have been released, and that the prison was attempting to kill him by not releasing him. The psychiatrist discussed the case with the consultant psychiatrist, who knew the man. The doctors agreed that at that time the man should be taken to the segregation unit, as this appeared to present no immediate threat to his mental health. He was also charged with an offence under the Prison Rules for refusing a lawful order.
50. A nurse assessed the man and considered him fit to remain in the segregation unit, although he was referred to the mental health in-reach team and psychiatrist assessed him that afternoon. Following a refusal to provide a urine sample and based on his observations, psychiatrist thought that the man was experiencing drug induced psychosis. Taking into account the man's refusal to communicate and his refusal to leave the segregation unit, the doctor advised segregation. This was authorised by a governor.
51. Another segregation safety algorithm was completed the following day by a doctor, before the man's adjudication for disobeying the order to return to his cell. Again, this doctor advised segregation but this was not authorised by a

¹ The man's original sentence expiry date.

governor grade. The adjudication paperwork was properly completed. Although the man refused to plead or offer any explanations, the evidence supported the charge and the man was found guilty with a punishment of seven days cellular confinement, suspended for one month.

52. At 2:00pm, the man refused an order to return to his wing and was again placed upon a disciplinary report. The adjudication was heard on 9 July at 10:30am by the adjudicating governor. Another doctor signed the paperwork to say the man was fit to attend the adjudication. The adjudicating governor noticed that the man kept his head down and would not make eye contact, although he answered some questions with a perfunctory yes or no. When the adjudicating governor enquired if the reason why he would not return to the wing was bullying, he thought the man nodded but could not conclude this avenue of inquiry as the man then refused to answer further questions. The adjudicating governor dismissed the charge, as he was uncomfortable with the man's mental state and asked that an assessment be carried out by the in-reach team. Although the adjudicating governor was not content to continue with the adjudication, he had no concerns for the man's safety.
53. The man refused to see anybody and prison staff described his behaviour as strange and bizarre. That night at 9:15pm, the man wanted to see a doctor. However, he refused to give night officer a reason. (At night-time there is not routinely a doctor in the prison. However, one can be called and will attend if required but this means it is essential that a reason for requesting a doctor is established). The man's cell bell was pressed every 15 minutes, but the man told night officer this was a mistake.
54. Following what night officer describes as a troublesome night, the man had calmed down by the morning and told night officer that he had served his prison sentence. Night officer told him to ask the daytime staff to double check his release date. There is no evidence that the man made this request.
55. On 11 July, psychiatrist once again went to the segregation unit to assess the man. Despite the doctor's repeated attempts to assess his mental health, the man refused to speak or leave his cell. The psychiatrist was aware that the man had been previously assessed by a doctor at the court - whose diagnosis was that the man was suffering from drug induced psychosis (although there is no evidence that the man had taken any drugs in prison) and not a chronic psychotic illness. The psychiatrist discussed the case with his superior, consultant psychiatrist, who agreed that the man should remain in the segregation unit pending a further review by consultant psychiatrist a few days later. Throughout this assessment, the man sat calmly on his bed and caused the doctor no immediate concerns.
56. On 12 July, the man spent much of the day not communicating with anybody and lying on his bed. A number of staff commented that the man had a poor appetite. Staff again referred his behaviour to the mental health in-reach team. Otherwise it was an uneventful day, with no problems noted.

57. At 8:30pm, the man had a conversation with the prisoner in the cell next door. The prisoner said that the man told him he was fed up being in prison and that he felt he had let people down. The prisoner did not pry, but tried to reassure the man and encouraged him to eat. (The prisoner told my investigators that he had overheard staff saying that the man had refused his meal.) The prisoner did not have any indication that the man was at risk. He assured my investigators that, if he had done, he would have told someone. He was very shocked to learn of the man's death.

13 July 2005

58. At about 3:00am on 13 July, the man rang the emergency cell bell and told the night-patrol, Operational Support Grade (OSG), that he had a headache. The night OSG said that the medical staff would not attend and that he should wait until the morning, which the man agreed to do. The man then continued to talk to night OSG for a few minutes, complaining that he should not be in prison. The night OSG advised the man to clarify the situation with the day staff as they could access his records. During this conversation, the man was polite, calm and not animated or agitated in any way. This did not lead the night OSG to think that the man was in any way at risk. The night OSG last saw the man when he checked on him at 5:15am. He was in bed and lifted his head to acknowledge the night OSG switching on the observation light.
59. At about 8:00am, the day staff came on duty and started to prepare the unit for breakfast. The cleaning officer and wing Senior Officer (SO) set up the hotplate so the meal could be served. An officer started to check each cell to ensure all the prisoners were awake and ready to go to the hotplate. (Prisoners in the segregation unit are unlocked individually to collect meals from the hotplate; the intention is that only one prisoner is on the landing at any time.)
60. At 8:20am, the officer arrived at the man's cell. He discovered him hanging by a ligature, made from a torn prison bed sheet, attached to the window bars. The officer finding the man raised the alarm by shouting to the wing SO who told the Emergency Control Room (ECR), via his UHF radio, that there was a "Code One" in the segregation unit. (This code tells anybody that hears the message that a prisoner has been found hanging and an urgent medical and management response is needed.) An ambulance was requested via the ECR when the Code One was called.
61. The officer who found the man opened the cell door and two officers went in and supported the man's weight whilst the officer who found the man, went to get the emergency cut-down scissors. The first officer to respond used the scissors to release the man and he was lowered to the floor. The healthcare response arrived and cardio pulmonary resuscitation (CPR) was commenced immediately by the Healthcare Principal Officer (HCPO) and Healthcare Senior Officer (HCSO). The HCSO was relieved by a nurse, who was Hotel One (the emergency response). Hotel One was an agency nurse who had worked at the prison for many months, and was being shadowed by HCSO.

This appears to have worked well as it brought another healthcare professional to the cell.

62. At 8:32am, the ambulance arrived at the prison. The paramedics were taken directly to the cell and took over the care of the man. At 8:37am, the paramedics removed the man from his cell and began to take him to the ambulance. It left the prison at 8:44am. At that time, the man was still breathing.
63. The ambulance arrived at hospital at 9:01am. Sadly, the man was pronounced dead at 9:08am.

Events after the man's death

64. The cell door was secured with a security lock, and the cell was treated as a potential crime scene until the police arrived. Staff involved submitted comprehensive statements to the Governor, providing a detailed account what had occurred. All necessary paperwork was completed in accordance with the local contingency plans for a death in custody.
65. At 12:00noon, the Governor chaired a 'hot debrief' for staff. It appears that all staff involved that morning attended and discussed what had occurred. The Staff Care team was made available to staff, and the Listeners were available to any prisoner affected by the man's death.
66. A governor was appointed as the Family Liaison Officer (FLO). At 12:25am, The FLO visited the man's mother's home address with another member of staff and explained the circumstances leading to the man's death.
67. The post mortem concluded that the man died from the effects of hanging. It confirmed that there were no defensive marks or evidence that a third party had been involved. The police investigation also concluded that no third parties were involved and that no criminal offences had been committed.

Comments made about the man

68. My investigators found throughout the formal interviews and informal conversations they held that there was great shock that the man could have taken his own life. This view was held in common by his family, prison staff, prisoners and other agencies that had worked with him. Nobody could recall an occasion where the man had said he was contemplating suicide or self-harm. And nobody had thought the man was vulnerable to suicide or self-harm.
69. The man's Probation Officer, told my investigators that the man had two sides to him. When he was using drugs, the man was loud and "larger than life". When he was not, he would be a very quiet person who found it very difficult to open up to anybody. She said he would probably feel uncomfortable in asking for help. This view was largely supported by the man's family and friends.

70. The officer who found him said that he knew the man from his previous time in the segregation unit. He said he remembered the man being in the unit a couple of years previously and being very quiet, not communicating very much with staff, prisoners or visitors to the unit. On this occasion, the man was much the same and would not participate in the regime, electing to remain in bed most of the time. Staff were concerned about this, and repeatedly reported it to the mental health in-reach team. However, whilst the man's behaviour was unusual, nobody formed the impression that he was at risk.
71. An officer told my investigators that, while in the segregation unit, the man rarely got out of bed before tea time (5:00pm). He would then spend the evening awake, sometimes making a nuisance of himself pressing the cell bell. Another officer, also from the segregation unit, said that he had built a rapport with the man, but he was always asleep and had to be motivated to join in the regime.
72. The HCSO had known the man for the last two or three years, but did not know he was back in prison. She described him as a naughty immature boy, with unpredictable behaviour at times but, to her knowledge, never violent. Some days he would not speak, on others he would have a full conversation. She also recalls that it was quite normal for the man to spend a lot of time in bed. When the HCSO responded to the emergency in the man's cell, she did not recognise him as he had lost quite a lot of weight.

Clinical review

73. The Chairman of the Professional Executive Committee of the Hammersmith and Fulham Primary Care Trust carried out the clinical review.
74. In preparing his report he reviewed the man's prison and medical records – including the previous medical records when the man was in Wormwood Scrubs in 2003 and 2004. The clinical reviewer also reviewed the man's treatment cards and a number of specialist reports including detailed psychiatric assessments, probation reports and risk assessment statements. The clinical reviewer relied on the records provided and did not interview any members of staff.
75. Following the man's first admission to Wormwood Scrubs on 8 July 2003, it was noted that he had an established mental health problem for which he was receiving regular medication to "stop hearing voices". He was referred to the community psychiatric nurse and a comprehensive mental health assessment was undertaken by the mental health in-reach team. The man was deemed to be clinically depressed and was treated with a combination of benzodiazepines and thiamine and managed on ordinary location.
76. Following concerns over his mental health, the man had a more formal mental health assessment with a consultant psychiatrist and was admitted to healthcare on 4 November for a more detailed assessment. He was deemed

to be psychotic at this time, with feelings of paranoia and possibly auditory hallucinations, and commenced on an anti-psychotic drug called olanzapine. By 21 November, a diagnosis of paranoid psychosis had been arrived at and it was noted that the man was responding to the olanzapine medication. His medication was then increased in December to 20mgs of olanzapine daily. A discharge plan was developed in June 2004 to ensure that the man was referred to the community mental health team on discharge from prison.

77. When the man was re-admitted to Wormwood Scrubs in June 2005, he said that he had not been receiving any regular prescribed medication for physical health reasons and did not know whether he had seen a doctor in the last few months. He claimed to drink socially and denied any usage of illicit drugs. The man told staff that he was on risperidone but was unsure of the dose. When asked about any deliberate self harm, he did not answer the question directly. He was referred to the doctor as a consequence of this initial health screen.
78. The medical record shows that the man was assessed by a medical practitioner on 3 May with a note that the nurse who carried out the initial health screen was concerned about "high risk for aggressive behaviour". It is also recorded that the man gave a history of suffering from "leukaemia – not medically proven according to him". In the medical notes, it states "also head injury for which he requests a bandage to keep his head together". the man admitted that he did not like being around people, that he had a previous psychiatric history of schizophrenia and that he had been on olanzapine which had been stopped. The clinical examination notes that he was acutely distressed and his speech was garbled. There was evidence of gross thought abnormalities with persecutory delusions and "flight of ideas" and thought blocking. There was no objective evidence of hallucinations and the man was assessed as suffering from a gross psychotic illness against a background of a history of possible schizophrenia. The management plan included a referral for a formal psychiatric assessment the following day and to be admitted to healthcare.
79. The doctor who prepared the psychiatric court report dated 5 May 2005. It noted that the previous diagnosis was drug induced psychosis. It questioned whether the man was suffering from auditory hallucinations with a diagnostic impression of a possible residual psychosis. The management plan included the continuation of risperidone 3mgs twice daily, with a recommendation to discharge the man to ordinary location on 12 May with on-going support and review by the in-reach team.
80. The man was seen on 16 June by the in-reach team. The evidence at this time suggested that he heard voices under the influence of cannabis. the man also admitted to feeling suspicious during the day and denied any history of deliberate self harm. He appeared pre-occupied, with a possibility of auditory hallucinations.

FINDINGS AND CONCLUSIONS

81. It is clear that the man was confused about his release dates. It was no fault of his that he was erroneously released from custody on 13 May 2005. However, I judge that no fault redounds to Wormwood Scrubs as they were not aware of the recall documentation which had not arrived from the Probation Service. There was a breakdown in communication between the Probation Service, the Court and the Prison Service.

I recommend that the Chief Officer of the London Probation Area, in collaboration with the Governor, reviews the breakdown in communication that led to the man's release in error to ensure that such circumstances could not recur.

82. The prison calculated the man's release dates correctly. However, there is no evidence that the calculation or its explanation was received or understood by the man.

I recommend the Governor reviews the system of informing prisoners of release dates, so that he is sure that prisoners understand when they are to be released.

Emergency Medical Assistance

83. The man was found hanging in his cell shortly after 8:20am. The ligature was made from a prison bed sheet, the most common means of suspension in prison but one that is usually relatively easy to cut. It took precious seconds for staff to leave the man's cell and collect the special cut-down scissors from the office. It would be better and safer for staff working with prisoners to be issued with a pair of cut-down scissors, or a fish-knife, which is specifically designed for the purpose of cutting ligatures.

I recommend that the Governor considers whether "Fish-knives" or similar equipment should be made available to front-line staff.

84. The prison's response to the emergency was immediate once the alarm was raised. Medical professionals were administering emergency aid within minutes of the man having been found. It is to the credit of all concerned that every effort was made to revive the man. The prompt arrival at the cell of the Ambulance Service was also impressive.

After the man was discovered

85. Procedures were followed in line with contingency plans. The various offices and individuals were informed of events as required.
86. The FLO played an important role in visiting the man's family and informing them of the sad events that had taken place at the prison that morning. This meeting was clearly difficult for all involved. It must have been particularly difficult for the man's mother, given that she had only recently been told that

her son was back in prison. My view is that the prison handled the breaking of the sad news of the man's death to his family with reasonable promptness and sensitivity. It was also conducted in a way consistent with PSO2710 (Follow up to deaths in custody).

87. PSO 2710 also requires that a "hot debrief" to be held. This happened too and it appears that all staff involved were able to contribute.
88. The memoranda and incident reports submitted to the Governor by staff gave a detailed account of what had occurred. This was particularly helpful to my investigators when they tried to piece together the sequence of events, and prevented some staff being needlessly subject to formal interview.

Medical Care

89. Paragraphs 97 – 101 represent the conclusions of the clinical review. The recommendation after paragraph 99 is my own.
90. The clinical review finds that the man had an established mental health problem and specific concern was raised by a number of staff from the date of his re-admission to Wormwood Scrubs. Indeed, his initial health screening assessment carried out by a nurse highlighted his mental health problems and the need for an urgent clinical review. This review triggered a referral for a formal psychiatric assessment.
91. When he was transferred to the segregation unit, there is clearly documented concern about the man's mental health. However, the clinical reviewer found the man's medical history to be brief in detailing the assessment and medical review around the transfer to the segregation unit on 7 July 2005. Dr Jefferies says the arrangement for a follow up appears loose given the man's presentation and this contributed to the risk of the situation. The clinical reviewer concludes that there appears to have been a failure to recognise the possibility that the man's problematic behaviour in fact represented an aspect of his mental health problems.
92. The clinical reviewer says the focus of risk assessment was primarily on the risk that the man may or may not have represented to other prisoners if he was cell sharing. At no time was there a consideration as to any risks he might present to himself as a consequence of his demonstrably abnormal behaviour. Indeed, the segregation algorithm appears to have been completed incorrectly (as a Governor failed to sign the algorithm).

I recommend the Governor reminds his senior colleagues of the requirement to countersign all elements of the segregation paperwork.

93. The clinical reviewer argues that the two fundamental questions are (i) whether the man should have been located within the segregation unit in the first instance; and (ii) whether his continued segregation was appropriate given his background of a significant psychiatric illness and substantial on-going concern by attending staff. Noting that the segregation unit is not a

therapeutic environment, he says it is difficult to understand how the man was deemed fit for adjudication and cellular confinement by the attending medical officer given his florid presentation which was well documented.

94. The clinical reviewer concludes that the segregation unit was not an appropriate for the man given his psychiatric history and his behaviour within the unit. Being located in the segregation unit meant the man was denied the opportunity for more appropriate clinical supervision within a healthcare setting.

Suicide Awareness

95. Wormwood Scrubs prison's local "Suicide Prevention Strategy" is a comprehensive policy document which is consistent with national policy.

Segregation Unit

96. The man refused an order to return to his cell on C wing, or indeed to locate on any wing. Despite staff encouragement and attempts to establish why he refused the order, the man was adamant on going to the segregation unit. In light of his refusal to obey a direct order, he was escorted to the unit.
97. The man was seen by a member of healthcare who determined that there was no medical reason why he should not be held in segregation. At 10.30am on 8 July 2005, the man was interviewed a doctor. The purpose of the interview was to complete the standard Safety Algorithm form, which determined at that time the man's suitability to be adjudicated upon following his refusal to return to his cell. the man's physical and mental presentation at the time did not give rise to any concern. In the early afternoon, the man appeared for his adjudication in front of the adjudicating governor. The adjudicating governor remanded the hearing, as he felt the man needed an assessment by the mental health in-reach team.
98. The man refused to discuss with anybody the reasons why he wanted to leave C wing. I think it likely that he simply wanted a break from the wing and some time on his own. However, there is no evidence that the wing pursued the issue once he had left the wing. I appreciate that residential wings are busy environments, but I consider that wing management should have made an effort to identify the reason, especially if it may have involved bullying.

I recommend that the Governor ensures that all incidents of refusal to locate are subject to review by the wing concerned.

99. As noted above, in the clinical review, the reviewer says that the segregation unit was an inappropriate environment to manage the man. I am myself acutely concerned at the use of segregation for prisoners with mental health problems and the number of deaths that have occurred in segregation units. They are (perhaps unavoidably) very risky environments. However, in the circumstances obtaining in the man's case, the decisions about his location were more finely balanced. It was after all he who had chosen segregation

and it is by no means certain that he would voluntarily have accepted location in healthcare. Moreover, he was known to a number of the staff in the segregation unit and was displaying behaviour that was being appropriately monitored.

100. Certainly there are no grounds for supposing that the man's death could have been predicted. Indeed, despite the fact that he was clearly a very troubled young man, his death came as a surprise both to staff and fellow prisoners.

RECOMMENDATIONS

- 1. I recommend that the Chief Officer of the London Probation Area, in collaboration with the Governor, reviews the breakdown in communication that led to the man's release in error to ensure that such circumstances could not recur.**
- 2. I recommend the Governor reviews the system of informing prisoners of release dates, so that he is sure that prisoners understand when they are to be released**
- 3. I recommend that the Governor considers whether "Fish-knives" or similar equipment should be made available to front-line staff.**
- 4. I recommend the Governor reminds his senior colleagues of the requirement to countersign all elements of the segregation paperwork.**
- 5. I recommend that the Governor ensures that all incidents of refusal to locate are subject to review by the wing concerned.**