Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Peter "Leo" Tauroza, a prisoner at HMP Wandsworth, on 6 March 2020

A report by the Prisons and Probation Ombudsman

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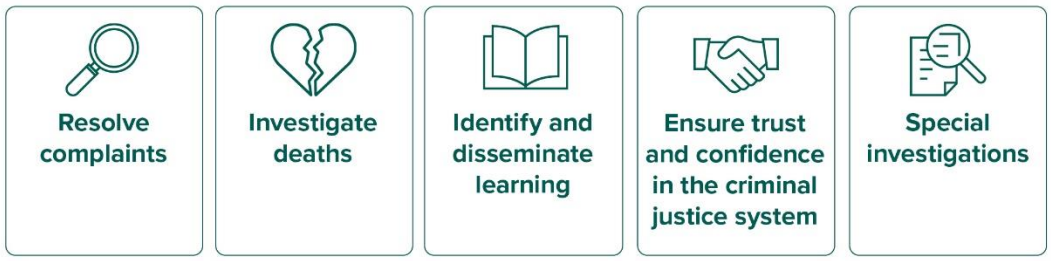
OUR VISION

To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.

WHAT WE DO



WHAT WE VALUE

The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out independent investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

My office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Peter “Leo” Tauroza died on 6 March 2020, when he was found hanged in his cell at HMP Wandsworth. He was 35 years old. I offer my condolences to his family and friends.

Mr Tauroza had a long history of substance misuse and mental health problems, although he was stable during his time at Wandsworth. I am satisfied that his healthcare at Wandsworth was equivalent overall to that he could have expected in the community.

Although Mr Tauroza did not express any thoughts of suicide or self-harm, he repeatedly told his key worker that he was concerned about his sentencing hearing, and I am concerned that wing staff were not alerted that he could be at risk if he received a custodial sentence.

I am also concerned about the quality of the reception risk assessment process at Wandsworth. When Mr Tauroza first arrived with a suicide and self-harm warning form in August 2019, reception staff failed to consider starting ACCT procedures.

Mr Tauroza was sentenced on 5 March, the day before he was found hanged. When he returned to Wandsworth from court that evening, prison and healthcare staff in reception failed to assess his risk of suicide and self-harm as they should have done. In addition, staff had moved him to a new cell in his absence, without considering whether this might increase his risk. I am also concerned that Mr Tauroza did not receive his medication that night because he returned late from court.

This version of my report, published on my website, has been amended to remove the names of staff and prisoners involved in my investigation.

Sue McAllister CB
Prisons and Probation Ombudsman **January 2021**

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Summary

Events

1. On 26 August 2019, Mr Peter "Leo" Tauroza was remanded to HMP Wandsworth. It was not his first time in prison. He had schizophrenia and a significant history of depression and substance misuse.

2. When Mr Tauroza arrived at Wandsworth, his person escort record (PER) included a reference to a suicide and self-harm warning form that had been completed at court because of concerns about his mental health and his offence. However, prison and healthcare staff did not identify this or consider starting suicide and self-harm prevention procedures, known as ACCT.

3. Mr Tauroza was under the care of the mental health team at Wandsworth and was prescribed antipsychotic and antidepressant medication. He settled well and had a job on the wing. He never expressed any thoughts of suicide or self-harm. From November onwards, his main concern was the sentence he may receive at his forthcoming trial, something he raised repeatedly with his key worker and others. This made it difficult for him to make plans for his future, although he had hopes of receiving a community sentence and had accommodation arranged.

4. On 5 March, Mr Tauroza appeared in court and was sentenced to two years and six months in prison. When he returned to Wandsworth, no one assessed his risk of suicide and self-harm. While he was at court, staff had moved him into a new cell, separating him from his long-term cellmate, who was a friend. Mr Tauroza did not know about the move until he returned to the wing late that evening. He did not receive his antipsychotic medication that night.

5. At 8.13am the following morning, a prisoner saw Mr Tauroza hanging in his cell. The prisoner alerted staff, who radioed a medical emergency code promptly and an ambulance was called. Mr Tauroza showed no signs of life, and it was evident that rigor mortis was present, so prison and healthcare staff did not try to resuscitate him. A prison GP arrived at Mr Tauroza's cell at 9.28am and recorded that he had died.

Findings

Assessment of risk

6. When Mr Tauroza arrived at Wandsworth, his PER noted that a suicide and self-harm warning form had been completed at court, but prison and healthcare staff in reception did not assess his risk in the light of this information or consider whether to start ACCT monitoring.

7. Although Mr Tauroza repeatedly discussed his anxieties about being sentenced with his key worker, most recently two days before he went to court, she did not alert wing staff that he might be at risk if he received a custodial sentence.

8. We found no evidence that prison or healthcare staff assessed Mr Tauroza's risk when he returned from court after being sentenced on 5 March, despite the change

in his custodial status. Reception staff should have identified Mr Tauroza's increased risk of suicide and self-harm and considered starting ACCT procedures.

9. We do not consider that wing staff gave sufficient thought to the possible impact of moving Mr Tauroza to a new cell while he was out at court.

Clinical care

10. The clinical reviewer found that, overall, the care that Mr Tauroza received at Wandsworth was equivalent to that which he could have expected to receive in the community.

11. She did, however, identify some concerns: the mental health team did not use recognised tools or have a system in place to review or record Mr Tauroza's mental health care and did not create a structured care plan for him; there was no integration or information sharing between the healthcare team and the substance misuse service; and there was no system in place to ensure that prisoners who returned late from court received their medication.

Recommendations

- The Governor and Head of Healthcare should ensure that reception staff thoroughly check the person escort record for all relevant risk information about newly arrived prisoners and, where appropriate, clarify risk information with escort staff.

- The Governor and Head of Healthcare should ensure that:

    - reception and healthcare staff assess and identify prisoners at increased risk of suicide and self-harm, including those who have returned from court; and

    - reception staff are appropriately trained.

- The Governor should ensure that key workers understand the need to alert wing staff if a prisoner may be at increased risk of suicide or self-harm.

- The Governor should ensure that any decision to move a prisoner while they are attending court is authorised by a wing manager, with the reasons for any move recorded in the prisoner's records.

- The Head of Healthcare and the lead for CGL should ensure that CGL's records are also recorded on SystmOne so that healthcare staff can access them.

- The Head of Healthcare, the Forensic Offender Mental Health Service and Business Development Manager should implement a zoning system so that mental health staff can easily identify which prisoners are under their care and create appropriate treatment plans to meet their needs.

- The Head of Healthcare and the lead pharmacist should ensure that there is an effective system in place so that prisoners who return to prison late receive their medication.

The Investigation Process

12. The investigator issued notices to staff and prisoners at HMP Wandsworth informing them of the investigation and asking anyone with relevant information to contact him. No one responded.

13. The investigator visited Wandsworth on 11 March. He obtained copies of relevant extracts from Mr Tauroza's prison and medical records.

14. NHS England commissioned a clinical reviewer to review Mr Tauroza's clinical care at the prison. The investigator interviewed four members of prison staff and one prisoner. Some interviews were conducted jointly with the clinical reviewer. The interviews were completed by telephone due to the restrictions imposed due to the COVID-19 pandemic.

15. We informed HM Coroner for Inner West London of the investigation. She gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

16. We contacted Mr Tauroza's parents to explain the investigation. They wanted to know all the events that led to his death, including the following:

    - Mr Tauroza had said he would kill himself in prison. Did the police pass on relevant information to the prison about his risk of suicide and self-harm?

    - What actions did the Offender Management Unit (OMU) at HMP Wandsworth take after receiving information advising them that Mr Tauroza was at risk of suicide? Was this information passed onto the prison's mental health team?

    - Did the mental health team have access to Mr Tauroza's recent medical records? Was the prison's mental health team aware of Mr Tauroza's history of suicide attempts? How did the mental health team support him?

    - Why was Mr Tauroza separated from his cellmate with whom he got on and moved to a different cell on the day he attended court.

    These questions are addressed in this report and the clinical review.

17. Mr Tauroza's parents received a copy of the draft report. They raised a number of questions that do not impact on the factual accuracy of this report and have been addressed through separate correspondence.

18. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

Background Information

HMP Wandsworth

19. HMP Wandsworth is a local Category B prison in London, with a Category C unit. It holds up to 1,452 men in eight residential wings. St George's University Hospital NHS Foundation Trust provides physical healthcare services at the prison. Mental health services are provided by South London and Maudsley NHS Foundation Trust. There is an inpatient unit for up to six prisoners.

HM Inspectorate of Prisons

20. The most recent inspection of HMP Wandsworth was conducted in March 2018. Inspectors noted that a third of prisoners were receiving psychosocial help for substance misuse problems and prisoners reported it was easy to obtain illicit drugs. They found that around 450 prisoners were referred to the mental health team each month. They found that healthcare was reasonably good.

21. The recently refurbished reception area had potential to improve the early experience for new arrivals. Despite good availability of private interviewing space, inspectors found that first night and healthcare interviews were conducted with open doors, compromising confidentiality. While the facilities were impressive and the system was promising, some deficiencies were identified. Inspectors observed that some first night interviews were cursory, where staff followed a template but not all questions were asked, and potential risks or concerns were not fully explored.

Independent Monitoring Board

22. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report for the year to 31 May 2019, the IMB reported that the redesign and enlargement of the reception area created a better initial impression for new prisoners and facilitated more efficient processing of those entering and leaving the prison. They found that the late arrival of Serco vans continued to have a knock-on effect on the processing of prisoners through reception.

Previous deaths at HMP Wandsworth

23. Mr Tauroza was the second prisoner at Wandsworth to take his life since March 2018. There are no similarities with our findings in our previous investigation.

Key Events

24. On 23 August 2019, Mr Peter "Leo" Tauroza was charged with grievous bodily harm. The police GP noted that Mr Tauroza presented as paranoid and had auditory hallucinations, telling him to kill himself.

25. On 26 August, Mr Tauroza was remanded to HMP Wandsworth. It was not his first time in prison. Mr Tauroza's person escort record (PER) noted that he had a history of self-harm, used crack cocaine, and had schizophrenia. When asked by the escort officer if he had any thoughts of self-harm, Mr Tauroza said "he was not suicidal today". The escort officer recorded that he opened a suicide and self-harm warning form (SASH) based on Mr Tauroza's identified mental health issues and his offence.

26. An officer completed Mr Tauroza's reception interview when he arrived at Wandsworth. He did not record whether he was aware that Mr Tauroza had arrived with a SASH form. Mr Tauroza did not name a next of kin.

27. A nurse completed an initial health screen for Mr Tauroza. He said he had paranoid schizophrenic disorder, had previously stayed in a psychiatric hospital and was prescribed olanzapine (an antipsychotic), sertraline (an antidepressant) and pregabalin (used to treat nerve pain but also used for anxiety). Mr Tauroza said he had no thoughts of suicide or self-harm. She noted it was not possible to complete a urine drug screen. She noted that Mr Tauroza's mood was stable, and he said he had not used any illicit drugs in the past week. She referred Mr Tauroza to the prison GP and sent a task for the pharmacy team to obtain a summary of his community medical records to check his prescriptions. She did not record that Mr Tauroza had arrived with a SASH form.

28. The investigator found no evidence of a SASH form, even though the PER referred to it. The SystmOne medical record does not indicate whether or not the PER was seen by the clinical staff in reception.

29. A prison GP examined Mr Tauroza in reception. Mr Tauroza said that he had drug-induced psychosis but had stopped misusing illicit drugs. The GP noted that Mr Tauroza appeared stable and had no thoughts of self-harm. He prescribed a continuation of Mr Tauroza's medication: olanzapine, sertraline and pregabalin (the latter on a reducing dosage).

30. On 27 August, a nurse completed Mr Tauroza's secondary health screen. The pharmacist had confirmed the prescription and dosage of Mr Tauroza's medication with his community GP practice. Mr Tauroza attended the smoking cessation clinic and said he wanted to stop smoking. He was prescribed nicotine patches and had to collect his medication daily from the medication hatch.

31. That day, Mr Tauroza's solicitors emailed the Offender Management Unit (OMU) as they were concerned that Mr Tauroza had had a "psychotic break" and may be at risk of suicide. OMU passed this information to the mental health team.

32. On 29 August, the healthcare team discussed the email from Mr Tauroza's solicitors and agreed that the primary mental health team would review him.

33. On 3 September, staff gave Mr Tauroza a disciplinary warning and restrained him after he was abusive towards a member of the healthcare team. Mr Tauroza had attended the medication hatch late to collect his nicotine patches. Mr Tauroza's nicotine treatment was stopped because of his poor behaviour.

34. The next day, the healthcare team received Mr Tauroza's summary community GP records which noted that he had a schizoaffective disorder and had a history of paranoid ideation, behaviour syndrome, substance misuse (heroin, cocaine) and had taken an overdose of benzodiazepine (October 2012). It confirmed his prescribed medication included sertraline, olanzapine and pregabalin (at 400mg).

35. On 5 September, a nurse from the primary mental health team examined Mr Tauroza. She noted that Mr Tauroza presented with no mental health risks. She wrote to Mr Tauroza's solicitors to update them about her assessment.

36. On 9 September, a nurse saw Mr Tauroza again after he complained that his pregabalin dosage was to be reduced. Mr Tauroza talked about his medication and history of substance misuse and told the nurse that he had schizoaffective disorder and attention deficit hyperactivity disorder (ADHD) and asked to see a psychiatrist. She noted that Mr Tauroza showed no evidence of psychosis or abnormal mood and that he had no current thoughts of self-harm. She offered to refer him for stress management support. She added his name to the psychiatric appointment waiting list and noted that the mental health in-reach team would take over his care.

37. On 10 September, healthcare staff discussed Mr Tauroza at a mental health team meeting. They concluded that he should attend the psychiatric clinic. Mr Tauroza's medical records noted that he had started to refuse his antipsychotic medication (olanzapine) because no one had discussed his treatment plan with him. He was again referred to the mental health team on 19 September.

38. A nurse from the mental health team saw Mr Tauroza on 20 September. Mr Tauroza told him that olanzapine at times made him unhappy, lethargic and suicidal. He said he heard voices. The nurse noted that Mr Tauroza engaged well, had no delusional or abnormal thoughts and no thoughts of self-harm. Mr Tauroza said that in the community, he was supported by a psychologist and wanted to continue with talking therapy treatment. The nurse created a care plan and noted that the mental health team would manage Mr Tauroza's mental health through medication and psychoeducation.

39. A consultant forensic psychiatrist saw Mr Tauroza on 24 September. He noted Mr Tauroza had had a trial of atomoxetine (ADHD medication) some months earlier in the community. Mr Tauroza admitted that he had misused alprazolam (a sedative) which he had obtained illicitly in the community. He said he was unclear to what extent his substance abuse had affected his mental health. He said he had "binged" on illicit substances in June and July 2019 and had also used 'spice' (a psychoactive substance - PS) in prison. This information conflicted with what Mr Tauroza had previously told other prison staff about not using drugs before coming to prison. He noted that Mr Tauroza's mood was unstable but that he had no psychotic symptoms. He referred Mr Tauroza to the substance misuse team, Change, Grow Live (CGL).

40. On 16 October, a CGL substance misuse worker assessed Mr Tauroza, who said he had misused drugs from the age of 16, and had issues with heroin, crack and cannabis. The CGL worker advised him about the risks of overdose and how to reduce his risk of harm. CGL maintain paper records and this information was not noted in Mr Tauroza's SystmOne medical records.

41. On 4 November, a specialist addictions psychiatrist saw Mr Tauroza. A CGL substance misuse worker also attended. Mr Tauroza said that he had misused multiple drugs for years, was known to the community drugs service team (Turning Point) and had taken methadone as a heroin substitute for around ten years. He said he had gradually withdrawn from methadone by using pregabalin. He said that he had smoked PS twice in prison. However, he disliked how PS made him feel and did not intend to smoke it again. On examination, the psychiatrist noted that Mr Tauroza's mood appeared normal and he neither displayed nor reported any thought or perception disorder. He noted that Mr Tauroza did not need substance misuse treatment. The CGL worker noted on SystmOne that CGL had reviewed Mr Tauroza. (This is the only CGL record noted in Mr Tauroza's medical records.)

42. The forensic consultant psychiatrist noted that on 5 November, Mr Tauroza failed to attend a psychiatric appointment. He noted that the appointment would be rescheduled for a routine review to consider how to reduce his olanzapine medication.

43. On 7 November, a prison GP examined Mr Tauroza after he complained that he had a pain in his back. He found no serious concerns and prescribed painkillers. The next day, Mr Tauroza refused to attend his court hearing. No further information was recorded.

44. On 23 November, an officer completed a key worker session with Mr Tauroza, who said that he was doing well. His only concern was deciding on his plea at his forthcoming court hearing. He wanted to work towards getting enhanced Incentives and Earned Privileges (IEP) status and had applied for several jobs and educational activities.

45. On 26 November, the forensic consultant psychiatrist saw Mr Tauroza, who was due to attend court in December and said he intended to plead not guilty by reason of insanity. He described his mental health as much better than when he was in the community, and he said he had received visits from his family. He said he had anxiety and complained of "brain freeze" during conversations. The psychiatrist noted that Mr Tauroza appeared restless, but displayed no evidence of psychosis, panic or anxiety and did not need medication for psychosis or depression. He noted that Mr Tauroza's main issue was substance misuse. He planned to seek further information about Mr Tauroza's ADHD from the hospital and noted that he would consider prescribing atomoxetine (for ADHD).

46. On 27 November, the forensic consultant psychiatrist wrote to Mr Tauroza's solicitor to ask about his court case to see if his olanzapine could be reduced slowly while in prison. There is no record of a response in Mr Tauroza' medical records. (Mr Tauroza's olanzapine dosage remained the same during his time in prison.)

47. On 29 November and 4 December, an officer competed a key worker session with Mr Tauroza. At both sessions, Mr Tauroza's mood was good, and he was positive

about progressing in prison. He said, however that he felt uncertain about his forthcoming court hearing which made it difficult to plan for the future.

48. At his key worker session on 21 December, Mr Tauroza said he had recently started a job on the wing. An officer noted that Mr Tauroza remained polite and compliant. Mr Tauroza told her that his recent court appearance had gone well, and his next hearing was scheduled for February 2020. He said that in the meantime, the probation and psychiatric services had to update the court about his current situation. Mr Tauroza hoped he would receive a community sentence order and talked about the continued support from his family.

49. In December, Mr Tauroza started to share a cell with another prisoner.

50. When an officer met Mr Tauroza on 31 December, she noted his positive attitude.

January 2020 onwards

51. On 13 January 2020, an officer completed a key worker session with Mr Tauroza and noted that he was thinking about his court hearing date in February and potential accommodation options if he was released. She discussed community support agencies (for his mental health and drug recovery) with him.

52. The officer met Mr Tauroza again on 24 January. She noted that he continued to do well but he was uncertain about the outcome of his forthcoming court hearing. She noted that Mr Tauroza was most concerned about his potential accommodation on release, and she agreed to contact the resettlement team for advice.

53. On 27 January, a CGL substance misuse worker saw Mr Tauroza to discuss support because he had tested positive after a mandatory drug test. Mr Tauroza denied that he had completed a drug test and said he had not used any illicit substances. The CGL worker gave him harm minimisation advice. None of this information was recorded in Mr Tauroza's medical records.

54. On 28 January and 3 February, an officer completed key worker sessions with Mr Tauroza. They again spoke about his housing situation, and Mr Tauroza said he had spoken to the resettlement team who had given him advice.

55. On 11 February, Mr Tauroza asked to see the specialist addictions psychiatrist to discuss his medication. The psychiatrist recorded that Mr Tauroza should see a substance misuse worker as he was not under the care of the substance misuse team and was not taking any substance misuse medication.

56. That day, an officer met Mr Tauroza and they discussed his plans if he were released from prison. She noted that Mr Tauroza's court hearing that he had attended the previous week had been adjourned as the probation service had not completed its report. Mr Tauroza was confident that he would receive a community sentence. He spoke positively about contacting community support agencies and getting a part-time job.

57. On 12 February, staff checking post found a letter addressed to Mr Tauroza which tested positive for PS. This was passed to the security team.

58. On 13 February, a nurse saw Mr Tauroza while on duty on the wing. The nurse noted that Mr Tauroza appeared mentally stable, denied misusing drugs and said he had no thoughts of suicide or self-harm. He was eating and sleeping well, had a job and was due to attend court on 18 February for sentencing. The nurse noted that he would arrange for Mr Tauroza to receive community psychiatric support on his release from prison.

59. On 18 February, staff checking post found a letter addressed to Mr Tauroza which tested positive for morphine. This was passed to the security team.

60. Mr Tauroza attended court on 19 February. His case was adjourned because the court ran out of time. On 20 February, an officer completed a key worker session with him. Mr Tauroza was disappointed that his court hearing had been adjourned and this had added to his feelings of uncertainty about whether he would be released.

61. Mr Tauroza failed to collect his medication from the medication hatch that evening as staff could not find him.

62. On 28 February, staff conducted a random drug test on Mr Tauroza. (The test results were available on 5 March and identified that he had used cannabis.)

63. On the afternoon of 29 February, security intelligence recorded that Mr Tauroza had asked a wing officer if he could give a newspaper to another prisoner who was locked in his cell and who was suspected to be a drug dealer. The officer watched Mr Tauroza as he did so. The officer reported that Mr Tauroza was acting coy and turned his back so that no one could see what he was doing. He saw Mr Tauroza take something from the prisoner and put it into his trousers. He confronted Mr Tauroza, who dropped his trousers and denied any wrongdoing. The officer noted that staff were not resourced to conduct a full search, so he dismissed the matter but told wing staff. No further information was recorded about this incident.

64. On 3 March, an officer completed a key worker session with Mr Tauroza, who was due to attend court on 5 March. He had accommodation plans in place for his potential release.

65. Mr Tauroza's cellmate said that Mr Tauroza had lost his job on 3 March and was feeling low and stressed about his court hearing. (There is no record that Mr Tauroza had lost his job or the reasons why.) The cellmate also said that on the evening of 4 March, Mr Tauroza was nervous about his court hearing.

5 March 2020

66. At 7.00am on 5 March, Mr Tauroza left prison to attend his court hearing.

67. The cellmate told us that when Mr Tauroza was at court, staff told him they were both to be moved. Staff asked the cellmate to help them move Mr Tauroza's personal belongings into his new cell.

68. At court, Mr Tauroza was sentenced to two years and six months in prison. He returned to Wandsworth at around 6.00pm. There is no evidence in Mr Tauroza's

records that he received a welfare and risk assessment check in reception after he returned from sentencing.

69. A Supervising Officer (SO) was the reception manager that evening. In her written statement, she said that Officer A was the only one who was well trained in reception procedures. She said that it was very busy in reception that evening as prisoners were late back from court. This meant that the processing of prisoners took significantly longer than usual. She said that she did not usually work in reception and had little knowledge of prison guidance about the assessment of risk of prisoners returning from court. She said she emailed the prison management team after her shift had ended to highlight her concerns.

70. Officer B escorted Mr Tauroza and four other prisoners to the wing. He told he had no recollection of Mr Tauroza but had no concerns about any of the prisoners he escorted.

71. The cellmate said Mr Tauroza visited him in his new cell shortly afterwards and asked him why they had been moved to new cells. The cellmate told him that his belongings had been put in his new cell. He said Mr Tauroza appeared to be panicking and was acting in a hyperactive manner. Mr Tauroza then left in search of a vape.

72. Officer C was on duty on Mr Tauroza's wing. At 7.18pm, CCTV footage shows him escorting Mr Tauroza to his new cell. Mr Tauroza asked if he could have a shower. The officer said he was busy but would return in around 15 minutes. Mr Tauroza used the in-cell PIN phone to check how much phone credit he had. CCTV footage shows at 7.21pm that the officer unlocked Mr Tauroza's cell door and escorted him to the shower room. At 7.33pm, Officer B took Mr Tauroza back to his cell.

73. At 7.35pm, Mr Tauroza pressed his emergency cell bell and Officer C responded within one minute. Mr Tauroza asked if he could get some items from his old cell. The officer told him that he could do so the next day.

74. At 7.53pm, Mr Tauroza pressed his emergency cell bell and Officer C responded within three minutes. Mr Tauroza said that he had not received his olanzapine that evening. The officer said he phoned the nurse on duty, who told him that the night nurse would administer Mr Tauroza's medication. He said that the night nurse visited the wing at around 8.00pm and told him that Mr Tauroza's name was not on the ledger of prisoners due to receive medication that night. She said she would add his name to it.

75. Mr Tauroza did not receive olanzapine that night. Two nurses were on duty that evening, but neither remembered receiving a call from an officer about Mr Tauroza's medication. Another two nurses who were on duty that night, both started their shift at 8.00pm. Mr Tauroza's medical records show that no one accessed his medical records that night.

76. Officer C told us that he had no concerns about Mr Tauroza that evening and that he displayed no signs of distress in any of the interactions he had with him. At around 8.30pm he handed over to the night duty officer, an Operational Support Grade (OSG). CCTV footage shows that the OSG completed the night roll check

on the wing at 9.37pm. He raised no concerns about Mr Tauroza. (The OSG resigned from HMPPS shortly after Mr Tauroza's death.)

6 March 2020

77. CCTV shows that at 4.55am on 6 March, the OSG completed a roll check and checked with his torch that all prisoners were in their cells and that the cell doors were locked. He raised no concerns about Mr Tauroza.

78. That morning, staff unlocked the cellmate at around 8.00am so that he could start work. At 8.13am, the cellmate went to Mr Tauroza's cell to see him. He looked through his cell door observation panel and saw him hanging from a ligature made from bedsheets. The cellmate immediately screamed for staff assistance.

79. An acting Supervising Officer, and three officers arrived at Mr Tauroza's cell in less than 60 seconds. The SO looked through the observation panel and saw Mr Tauroza hanging. At 8.14am, an officer radioed a medical emergency code blue (which indicates that a prisoner is unconscious or has breathing difficulties) and control room staff called an ambulance immediately.

80. The SO unlocked the cell door and went into the cell with two officers. She supported Mr Tauroza's body while an officer cut the ligature, which was hanging from the privacy curtain rail. She noticed that Mr Tauroza's body was rigid and stayed in the same position as staff lowered him to the floor. She said that it was evident that Mr Tauroza was dead so she told the staff that it would not be appropriate to try to resuscitate him.

81. CCTV footage shows that at 8.16am, a nurse arrived at Mr Tauroza's cell, closely followed by a colleague. The nurse examined Mr Tauroza. She confirmed that rigor mortis was present and that resuscitation efforts would be inappropriate, undignified and futile as Mr Tauroza had been dead for some time. At 8.24am, paramedics arrived. A prison psychiatrist and a nurse also attended and confirmed Mr Tauroza's death at 9.28am.

Contact with Mr Tauroza's family

82. Although Mr Tauroza had not provided any next of kin details when he arrived at Wandsworth, the prison identified his mother as his next of kin. They appointed a family liaison officer (FLO), and he visited her address with a Custodial Manager at around 10.45am. She was not at home and so the FLO therefore phoned her to break the news of Mr Tauroza's death. He offered support and arranged to visit Mr Tauroza's parents on 10 March. Wandsworth contributed towards the costs of Mr Tauroza's funeral in line with national instructions.

Support for prisoners and staff

83. After Mr Tauroza's death, the manager of the Care Team and Head of Business Assurance debriefed the staff involved in the emergency response to ensure that they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

84. The prison posted notices informing other prisoners of Mr Tauroza's death and offering support. Staff reviewed all prisoners assessed as at risk of suicide or self-harm in case they had been adversely affected by Mr Tauroza's death.

Post-mortem report

85. The post-mortem examination established the cause of Mr Tauroza's death as hanging.

86. Toxicology tests found that Mr Tauroza had sertraline and olanzapine (both of which he had been prescribed) in his system when he died. The pathologist requested hair toxicology tests for other drugs, including illicit substances, but these tests have not yet been completed because of the COVID-19 pandemic. We cannot, therefore, say whether Mr Tauroza had used any illicit substances before his death.

Findings

Assessment of Mr Tauroza's risk on arrival at Wandsworth

87. Prison Service Instruction (PSI) 64/2011 on safer custody lists risk factors and potential triggers for suicide and self-harm. Mr Tauroza had a number of risk factors: he had a history of self-harm and substance misuse; he had a schizoaffective disorder and had said in police custody that he would kill himself.

88. PSI 07/2015 on early days in custody requires that reception staff examine the PER and any other available documentation to assess a prisoner's risk. When Mr Tauroza arrived at Wandsworth in September 2019, his PER recorded that a suicide and self-harm warning (SASH) form had been completed and the escort staff identified that Mr Tauroza presented as at risk.

89. However, there is no SASH form in Mr Tauroza's prison records and prison staff did not record that they had seen one or record anything about the risk information in his PER (and the escort service told us that they did not have a copy). This is a significant concern as, if a SASH form had been completed, it would have contained important information to help staff assess Mr Tauroza's risk and ensure continuity of care.

90. If staff had assessed Mr Tauroza's risk fully when he arrived, we consider it is likely that they would have started ACCT procedures. Although this did not contribute directly to Mr Tauroza's death six months later, it was a missed opportunity to understand his risks and triggers. We make the following recommendations:

    The Governor and Head of Healthcare should ensure that reception staff thoroughly check the person escort record for all relevant risk information about newly arrived prisoners and where appropriate, clarify risk information with escort staff.

Assessment of Mr Tauroza's risk after sentencing

91. Mr Tauroza was sentenced at court on 5 March, the day before he was found dead.

92. Prison Service Order (PSO) 3050 on the continuity of healthcare for prisoners says that events such as attending court or being sentenced might have a significant impact on a prisoner's health. It requires prisons to have protocols for screening prisoners in reception to identify potential risks. PSI 07/2015 also says that prisoners should be medically assessed where they return to prison after a temporary absence with a change of status (such as when they have been sentenced).

93. All the evidence indicates that Mr Tauroza was anxious about his court hearing and had hoped to be released. He had raised his concerns with his key worker at every single meeting they had, most recently two days before he attended court for sentencing. We consider that Mr Tauroza's key worker should have alerted wing staff that the sentencing hearing was causing Mr Tauroza significant anxiety and that he was likely to be distressed if he received a prison sentence.

94. We are also concerned that there is no evidence that prison or healthcare staff assessed Mr Tauroza's risk of suicide or self-harm when he returned from court after sentencing, as they should have done. There is no record in Mr Tauroza's prison records that he had even returned to prison. This was a missed opportunity to put support in place for him.

95. We recognise that prisoners arrived from court late that evening and that this put pressure on reception staff. However, late arrivals are by no means unknown and, given the importance of assessing risk in reception, we consider that reception procedures need to be robust enough to cope. We are concerned that this was not the case that evening.

96. We were told that prison staff were sometimes redeployed to work in reception with little training. The SO in charge of reception that evening did not normally work in reception and said that she was had little knowledge of the prison instructions about assessing prisoners' risk after a change in status. We consider this to be unacceptable.

97. We are also concerned that Mr Tauroza did not receive a health screen when he returned to prison after attending court on 5 March. The Head of Healthcare told us that she expected a reception nurse to see any prisoner who had had a change of status. However, she said that this did not always happen as they relied on staff bringing prisoners from reception to the healthcare department. This was another missed opportunity to assess his risk.

98. We are also concerned that staff decided to move Mr Tauroza to a new cell while he was out at court. (The investigator was told this was because Mr Tauroza had lost his job, although Wandsworth provided no evidence to support this.) While we recognise that prisons must be able to move prisoners as they think necessary, we do not consider that staff gave sufficient consideration to the possible impact of moving Mr Tauroza to a single cell, away from his long-term cellmate, immediately after he was sentenced, particularly when he had hoped for release.

99. We recognise that Mr Tauroza was last monitored under ACCT procedures in October 2012. He had not harmed himself during his six months at Wandsworth and had not expressed thoughts of suicide or self-harm. However, we consider that staff should have recognised that Mr Tauroza might be at risk when he returned to prison after being sentenced and should have considered whether he should be monitored and supported under ACCT.

100. We make the following recommendations:

The Governor should ensure that key workers understand the need to alert wing staff if a prisoner may be at increased risk of suicide or self-harm.

The Governor and Head of Healthcare should ensure that:

- **reception and healthcare staff assess and identify prisoners at increased risk of suicide and self-harm, including those who have returned from court; and**
- **reception staff are appropriately trained.**

The Governor should ensure that any decision to move a prisoner while they are attending court is authorised by a wing manager, with the reasons for any move recorded in the prisoner's records.

Clinical care

101. The clinical reviewer found that, overall, the mental and physical healthcare Mr Tauroza received in prison was equivalent to that which he could have expected to receive in the community. However, she identified a number of concerns.

Substance misuse

102. Mr Tauroza did not initially reveal his level of substance misuse when he arrived at Wandsworth, and this led to a delay before the substance misuse consultant and the CGL team saw him. When he was seen, however, he was appropriately assessed and offered support.

103. However, CGL's records of their interactions with Mr Tauroza were not always included in his medical records. This meant that healthcare staff were not always aware whether he was engaging with the substance misuse service. For example, although CGL recorded that Mr Tauroza had allegedly tested positive for drugs in January 2020, it is not clear if CGL staff had shared this information with healthcare staff as it was not included in his medical record. We make the following recommendation:

The Head of Healthcare and the lead for CGL should ensure that CGL's records are also recorded on SystmOne so that healthcare staff can access them.

Mental healthcare

104. From September 2019 onwards, Mr Tauroza was under the care of the mental health team. The clinical reviewer said that it is common in mental health teams to use colour-coded "zoning" to establish how often a client is seen and to help staff easily identify which prisoners are under the care of the mental health team. Mental health staff did not use for Mr Tauroza, and it was unclear what routine reviews had been arranged.

105. For example, it was noted that in September 2019, Mr Tauroza had stopped taking his antipsychotic medication because no one had discussed a treatment plan with him. A mental health nurse noted on 13 February 2020 that Mr Tauroza's mental health was stable, but this was the first recorded mental health assessment in three months. Although Mr Tauroza appeared well at Wandsworth, there should have been a more structured approach to his care by his allocated primary nurse or other nurses in the mental health team, especially as he was prescribed antidepressant and antipsychotic medication. Having a zoning approach in place would have ensured that there was a regular review of his risk and would have helped to inform future planning for when he was released. We make the following recommendation:

The Head of Healthcare, the Forensic Offender Mental Health Service and Business Development Manager should implement a zoning system so that mental health staff can easily identify which prisoners are under their care and create appropriate treatment plans to meet their needs.

106. When Mr Tauroza returned from court on 5 March, he did not receive his dose of olanzapine. Although the omission of a single dose of olanzapine is unlikely to have had a significant clinical effect on Mr Tauroza, we were unable to establish if there was a clear system in place for administering medication for prisoners who arrive back from court late.

107. Although the prison officer on duty that evening reported that he spoke to a nurse about administering Mr Tauroza's medication on the wing, none of the nurses on duty recalled receiving such a message. We make the following recommendation:

The Head of Healthcare and the lead pharmacist should ensure that there is an effective system in place so that prisoners who return to prison late receive their medication.

Inquest

108. The inquest into Mr Tauroza's death was held in December 2022. The conclusion was that Mr Tauroza's death was by hanging. The inquest found that Mr Tauroza's death was suicide whilst the balance of his mind was affected. Factors that contributed to Mr Tauroza's state of mind included lack of extra support and care after his return from court and neither was a healthcare screening completed. Mr Tauroza was also separated from his friend (former cellmate) and placed in a single cell, without his prior knowledge, on his return from court.

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