Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Waleed Ali, a prisoner at HMP Wandsworth, on 22 October 2022

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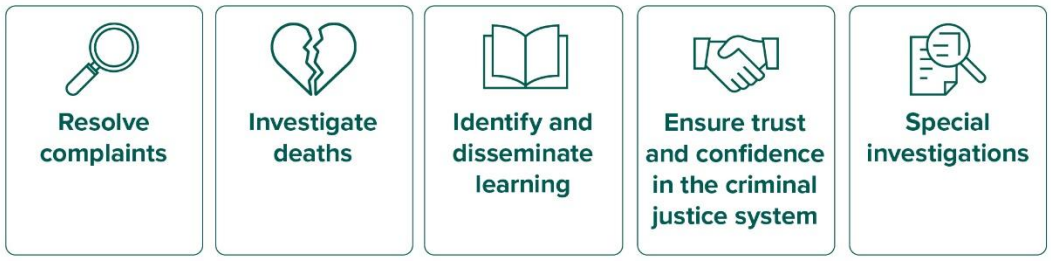
OUR VISION

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.

If my office is to best assist His Majesty's Prison and Probation Service (HMPPS) in ensuring the standard of care received by those within service remit is appropriate, our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.

Mr Waleed Ali was found hanged in his cell on 22 October 2022 at HMP Wandsworth. He was 54 years old. I offer my condolences to his family and friends.

Mr Ali died within a few hours of arriving at Wandsworth. He was a man presenting with a clear risk of suicide, who was distressed, possibly mentally unwell and vulnerable. The police identified Mr Ali as at risk of suicide following his arrest two days earlier. Although this information was recorded in documentation, which was available to court staff, escorting staff and prison officers, no one checked it and, despite other signs of risk, he received little targeted support. Once at Wandsworth, there were a number of missed opportunities to have identified his risk.

Wandsworth has been subject to substantial very public criticism in the past year. This report will not help. In a recent report into the self-inflicted death of another prisoner at Wandsworth, I took the unusual step of writing that I thought the prisoner might not have died had he been in another prison. In this case, I find that Mr Ali's death was absolutely foreseeable and therefore possibly preventable. The failures to identify his risk make for depressing reading.

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

Adrian Usher
Prisons and Probation Ombudsman **April 2025**

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Summary

Events

1. On 20 October 2022, Mr Waleed Ali was arrested after he stabbed his ex-partner in a public place. He also stabbed himself and was taken to hospital, where he indicated he wanted to kill himself.

2. Later that day, Mr Ali was discharged from hospital to Charing Cross police station, where he told police officers that he wanted to die. He was placed under constant supervision. The police updated his digital person escort record to reflect that Mr Ali needed constant supervision due to his risk of suicide.

3. On 22 October, Serco escort staff took Mr Ali to Westminster Magistrates' Court, where he was charged and remanded to HMP Wandsworth. On the way there, Mr Ali appeared distressed and agitated. Serco staff did not check his escort record at any point, were not aware of his risk of suicide and did little to check his welfare.

4. At 3.55pm, Mr Ali arrived at Wandsworth, where reception staff saw him briefly and the reception nurse carried out an initial health screen. Mr Ali's medical records could not be found as the date of birth on his warrant was incorrect. The nurse referred him to the mental health team because his behaviour was strange.

5. No one at Wandsworth checked Mr Ali's digital person escort record and despite several known risk factors they did not identify that he was at risk of suicide.

6. Mr Ali was taken to the induction wing and placed in a double cell with another prisoner. Within one hour, Mr Ali had pressed his cell bell five times and asked to be moved to another cell. There is no record that staff explored the nature of his concerns.

7. At 8.04pm, an officer carried out a routine check and looked into Mr Ali's cell. He said he saw Mr Ali standing by the window and his cellmate sitting on the bottom bunk.

8. At 9.06pm, Mr Ali's cellmate pressed the emergency cell bell after he saw that Mr Ali had hanged himself. An officer arrived at Mr Ali's cell at 9.12pm, immediately went into the cell to assist Mr Ali and radioed for help. An ambulance was called, and healthcare staff arrived within a minute. Attempts were made to resuscitate Mr Ali, but paramedics pronounced him dead at 9.59pm.

Findings

Identifying the risk of suicide and self-harm

9. Despite the police making it clear on the dPER that Mr Ali was at risk of suicide and self-harm and the requirement for both Serco and prison staff to check his dPER as part of their standard process, no one who came into contact with Mr Ali checked this document and consequently they failed in their duty of care.

10. There were also other missed opportunities for staff to have considered if Mr Ali was at risk of suicide and self-harm given his known risk factors, his unusual behaviour and the lack of available information.

11. Mr Ali used his cell bell five times before he died and asked on multiple occasions to be moved to a different cell. When responding, the officer should have asked Mr Ali why he wanted to move and addressed any reasonable concerns.

Clinical care

12. The clinical reviewer found that the care that Mr Ali received at Wandsworth was not equivalent to that which he could have expected to receive in the community. She identified that risk management and the sharing and accessing of information were poor.

Recommendations

- **The Governor, Head of Healthcare and Head of Operations at Serco should ensure that they have an audit process in place to provide assurance that staff are following the mandatory actions for person escort records.**

The Investigation Process

13. HMPPS notified us of Mr Ali's death on 23 October 2022.

14. 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.

15. The investigator visited HMP Wandsworth on 14 and 15 November 2022 and Westminster Magistrates' Court on 23 February 2023. He obtained copies of relevant extracts from Mr Ali's prison and medical records and documents from the police and ambulance service. He was also provided with the relevant Serco (a contractor appointed by the Government to provide court and escort services) procedures and a copy of their factual report about Mr Ali's death.

16. The investigator interviewed eight members of staff and one prisoner at HMP Wandsworth on 14 and 15 November 2022. He carried out a further three interviews using Microsoft Teams on 30 November 2022, 7 December 2022 and 9 February 2023.

17. The investigator interviewed four members of staff from Serco at Westminster Magistrates' Court on 23 February 2023. He interviewed a further four Serco staff on 24 May 2023 and 13 June 2023.

18. NHS England commissioned a clinical reviewer to review Mr Ali's clinical care at the prison. She joined one of the interviews by Microsoft Teams.

19. The PPO asked to interview the prisoner who shared a cell with Mr Ali, but he declined to be interviewed.

20. Another investigator took over the investigation in May 2024.

21. We informed HM Coroner for Westminster of the investigation. The Coroner gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

22. The PPO wrote to Mr Ali's next of kin to explain the investigation and to ask if they had any matters they wanted us to consider. The family asked whether Mr Ali was fit to be held at Wandsworth given his mental health concerns and whether he was fit to share a cell with another prisoner. They also wanted to know about his cellmate's actions after he found Mr Ali hanged.

23. Mr Ali's family received a copy of the draft report. They did not make any comments.

24. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out some factual inaccuracies, and this report has been amended accordingly.

25. The police have confirmed that they have concluded their investigation into Mr Ali's death.

Background Information

HMP Wandsworth

26. HMP Wandsworth is a local category B/C reception and resettlement adult male prison. As a reception prison, a large proportion of the prisoners are on remand or convicted but unsentenced. Oxleas NHS Foundation Trust provides physical and mental healthcare services at the prison.

HM Inspectorate of Prisons

27. The most recent inspection of Wandsworth was in April and May 2024. The inspectors identified that there were failings in almost all aspects of the prison's operation and there was a degree of despondency among prisoners that the Chief Inspector had not inspected sooner. So grave were their concerns that HMIP issued an urgent notification on 8 May 2024 to the Secretary of State.

28. HMIP inspectors concluded that reception processes were inefficient, and most prisoners spent around four or five hours there before they could move to the induction wing. They found that most first night cells were dirty, heavily graffitied and contained broken furniture.

29. They also identified that approximately 40% of emergency cell bells were not answered within five minutes and prisoners told them that they frequently waited for long periods before they were answered.

30. HMIP noted that there had been 10 self-inflicted deaths since the last inspection, seven of which had occurred in the last 12 months. They said that an action plan to learn from the self-inflicted deaths was in place and had been reviewed but not all actions were up to date. They noted that while appropriate data was reviewed at the monthly safety meeting, the meeting was poorly attended by significant senior leaders which meant there was insufficient drive to implement the actions identified to improve safety and reduce self-harm.

31. Inspectors concluded that the poor outcomes they found at Wandsworth stemmed from poor leadership at every level of the prison, from HMPPS and the Ministry of Justice, leading to systemic and cultural failings which had led to a shocking decline.

Independent Monitoring Board

32. 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 May 2023, the IMB reported that conditions in Wandsworth reflected the failures of the prison system as a whole. They noted that no real progress had been made in resolving problems caused by years of underinvestment in the fabric, facilities and staff.

33. The IMB noted that during the year, the shortage of available staff seriously undermined the ability of the prison to function effectively. The percentage of

available officers rarely reached above 50% of full staffing levels. They stated that limited staffing, the increase in the occupancy level of the prison, courts working late leading to later arrivals and new vans delivering prisoners in larger groups were adversely affecting the safety and efficiency of the reception process.

Previous deaths at HMP Wandsworth

34. Mr Ali was the fifteenth prisoner to die at Wandsworth since October 2019. Of these deaths, nine were self-inflicted, two were from natural causes, one cause of death could not be determined, and one was drug-related. In our previous investigations, we have highlighted failings in relation to staff not checking the information in the PER and delays in staff answering cell bells.

35. Since Mr Ali died, there have been a further nine self-inflicted deaths at Wandsworth. Due to the number of deaths, the prison is receiving additional support and monitoring from regional and national safety teams.

Person Escort Record (PER)

36. A PER is completed for any external prisoner move from the point of police arrest to court and then to and between prisons. It provides escort staff and receiving establishments with relevant information about the detained person, including any risks or vulnerabilities. There are two types of PER. For HMPPS escorts, a paper PER is completed. For Prisoner Escort and Custody Services (PECS) moves, a digital PER is used (dPER). Court and escort staff have handheld devices, named CORA and VERA, which allow them to access and update the dPER whilst the prisoner is in their custody. Prison staff can view the dPER via computer terminals.

Key Events

37. On 20 October, Mr Waleed Ali attacked his ex-partner with a knife in a public place. He then stabbed himself and was taken to hospital for treatment to his wounds. A psychiatric liaison team also assessed him in the hospital. It was noted that he appeared distressed and had said that he *"hated his life"* and wanted to end it.

38. The hospital accessed Mr Ali's summary health care record and noted that he had been prescribed sulpiride (used to treat schizophrenia and similar conditions) and fluoxetine (an antidepressant) but there was no clear record of a psychiatric diagnosis. Mr Ali told staff that he did not know why he had been prescribed the medications.

39. The psychiatric liaison team recommended that Mr Ali should be discharged to police custody and reviewed by the Liaison and Diversion Team at a later point, if necessary. (The Liaison and Diversion Team identifies people who have mental health concerns, learning disabilities, substance misuse and other vulnerabilities when they first encounter the criminal justice.) The hospital discharge paperwork stated *"self-stabbing with intent to end life".*

40. At around 1.40pm, Mr Ali arrived at Charing Cross police station. The police custody record noted he had said he wanted to die and that he was placed under constant supervision.

41. At 2.50pm, a police custody nurse tried to assess Mr Ali. She recorded that he did not engage with the examination and was under constant supervision because he was behaving oddly. She said that he was complaining that he could not breathe, and he had brief moments where he was hyperventilating.

42. At 4.00pm, Mr Ali was heard screaming and shouting that he wanted to kill himself and to die.

43. On 21 October, Mr Ali was charged with attempted murder and told that he would appear at Westminster Magistrates' Court.

44. At 11.00am that day, a police custody nurse was called to assess Mr Ali. She found him on the floor, hyperventilating. She took his clinical observations and decided that no further medical intervention was needed.

45. At some point that day, a police liaison nurse referred Mr Ali to Westminster Magistrates' Court's Liaison and Diversion Team. A mental health nurse with the court's liaison and diversion team told the investigator that she had been told that Mr Ali was under constant supervision as he had been harming himself, he was quite agitated and would not be attending court until the next day (Saturday).

46. As the court's liaison team did not work at the weekend, the mental health nurse emailed the generic email address for HMP Wandsworth's mental health in-reach team, reception and NHS offender healthcare team at 2.33pm to highlight Mr Ali's risk to himself. She wrote that Mr Ali was due to appear at the magistrates' court on 22 October and that he had tried to take his own life. She attached an email from the psychiatric liaison team and the police liaison nurse.

47. An officer was responsible for monitoring the reception email inbox at Wandsworth. However, he did not check the inbox and so the mental health nurse's email was not read until 25 October.

48. The mental health nurse told the investigator that she had also told the Deputy Court Managers at Westminster Magistrates' Court in person about Mr Ali's risk. Neither of them could recall her speaking to them about Mr Ali.

49. The dPER completed at Charing Cross police station at 8.06pm, ahead of his transfer to court the following day, stated that Mr Ali was at risk of suicide and self-harm, and he had said he wanted to die. It stated that due to his high level of risk, he had been under constant supervision.

Saturday 22 October

50. At 8.20am on 22 October, records indicate that Mr Ali was handed over to a PCO (in fact the PCO told the investigator the PECS van driver collected Mr Ali from the police instead). The prisoner activity report indicated that Mr Ali left the police station at 8.32am and arrived at Westminster Magistrates' Court at 9.03am.

51. The PCO said he could not recall if he received a paper copy of the dPER and he was not made aware that Mr Ali was at risk of suicide and self-harm. He said that at the time, Serco was transitioning from paper PERs to dPERs and they often had problems accessing the electronic version. He had a VERA which allowed him to view and update the dPER. He told us that he was not able to access it on the day as it was *"playing up".*

52. At 9.20am, Mr Ali was escorted into the reception area at court, where the Deputy Court Custody Manager and the Court Custody Manager (CCM) were carrying out detainee reception duties. CCTV footage indicates that neither of them had any significant interaction with Mr Ali who was in the reception area for less than forty seconds.

53. The Deputy CCM told the investigator that it had been exceptionally busy that day as Holborn Magistrates' Court had closed unexpectedly, and detainees were redirected to them. He said that normally, they checked all the dPERs before detainees arrived and when they arrived, they would ask them a number of questions about their medical and welfare needs. He told the investigator he could not recall seeing the dPER that day.

54. The CCM accessed the Serco escorting recording system and viewed the summary of markers which included a suicide and self-harm marker for Mr Ali. However, neither the Deputy CCM nor the CMM identified that Mr Ali was at raised risk of suicide.

55. At around 9.37am, Mr Ali was placed in a cell which had CCTV cameras. As no one had identified that Mr Ali was at risk of suicide and self-harm, he was placed on standard 30-minute observations and was not monitored by CCTV.

56. CCTV footage showed Mr Ali crying, removing all but his underwear, lying on the floor of the cell and showing signs of distress. A PCO told us that the CCTV monitor was located in the office behind the reception area. She said she did not check Mr

Ali's dPER and she could not recall Mr Ali nor seeing him in distress. The checks that she carried out were recorded on the hand-held device (CORA). She told us that on the occasions she saw Mr Ali he had appeared okay.

57. At around 11.41am, Mr Ali appeared before the Magistrate, charged with attempted murder. He was refused bail and remanded into custody at Wandsworth.

58. At around 2.45pm, Mr Ali was handed over to Serco escort staff to take him to Wandsworth. PCO A was the escort officer and PCO B was the driver of the escort van. There were five other prisoners on the van. Mr Ali was placed in cell two and immediately removed all his clothes, apart from his underwear. Both PCOs had not been given any information about Mr Ali's risk of suicide in the handover.

59. At approximately 2.48pm, the escort van left the court and Mr Ali began to cry loudly. In footage of the journey, PCO A can be heard saying, "O*h bloody hell, really? I don't want to listen to that"*. The prisoner in cell three started shouting and telling Mr Ali to *"shut up"* and PCO A can be heard saying, "Y*eah, be quiet, oh my god"*. The other prisoner tells him to *"shut the fuck up"* and PCO A can be heard laughing.

60. CCTV shows that during the journey, Mr Ali was often crying and wailing. He could also be seen moving from the chair to crouching on the floor and back again. There were times when he appeared in distress and as though he was having difficulty breathing.

61. At 3.15pm, Mr Ali banged on the floor and stood at the cell observation panel. He told PCO A that he could not breathe, and he could be seen fanning himself with his hand. She asked him if he was hot and told him to fan himself and that they would arrive shortly. She also asked if he needed water. Mr Ali responded by shouting that he could not breathe. After a while, he sat down, looking distressed and clutching his chest. He appeared to stop breathing and slumped into his seat, motionless for approximately sixty seconds. PCO A did not react or check on Mr Ali.

62. At 3.46pm, the escort van arrived at Wandsworth. PCO A told the investigator that she did not record Mr Ali's behaviour on VERA during the transfer and instead wrote "cell check OK". She also said that she knew she was supposed to check the prisoners' dPERs but had not done this because of difficulties accessing the wi-fi. She said that she had felt rushed due to the high numbers of prisoners at court that day.

HMP Wandsworth

Reception

63. PCO B escorted Mr Ali into the prison reception area. He told us that he was not aware of Mr Ali's risks and had not been told of any during the journey to the prison.

64. An officer directed Mr Ali into a holding cell. CCTV footage shows that Mr Ali sat on the floor by the door while other prisoners arrived. The officer said he could not recall Serco officers telling him that Mr Ali was at increased risk of suicide and self-harm or that he had seen the dPER.

65. At around 4.02pm, CCTV footage shows Mr Ali lying on his side in front of the glass door to the holding cell. A minute later, a Supervising Officer (SO) opened the door and Mr Ali slumped into the doorway. After a short conversation with him, the SO left and returned a minute later with an officer and a nurse.

66. The nurse told us that Mr Ali was conscious, and she carried out a verbal assessment. She told the investigator that it was strange to see someone sitting on the floor and she wondered if Mr Ali was okay. She said that it was this bizarre behaviour that had later led her to refer Mr Ali to the mental health team.

67. A few moments later, the officer and SO guided Mr Ali back into the reception area, where the officer took his photograph and fingerprints. The SO spoke to Mr Ali for approximately thirty seconds before he was taken back to the holding cells.

68. The SO told the investigator that in the past, prisoners arrived with a paper PER and the warrant. However, since moving to the dPER, this did not always happen. He said that the escort officers did not tell him there were any risks for Mr Ali and he did not ask them. He said he did not check Mr Ali's dPER as he did not see why he should check it. He said that if there were any risks, he would have expected to be given a suicide and self-harm warning form and if he was not given one, he presumed that there were no risks. He also said he had not asked Mr Ali if he felt suicidal or wanted to harm himself as he knew officers would cover this in the first night interview. Ministry of Justice Digital told the PPO that no-one at Wandsworth accessed Mr Ali's dPER.

69. A new medical record was created for Mr Ali as healthcare staff were not able to find an existing record because his date of birth on the warrant was incorrect.

70. At around 4.47pm, the nurse carried out a first night reception health screen and updated Mr Ali's medical record. She recorded that Mr Ali had said he had no thoughts of suicide and self-harm and she noted that he appeared mentally stable, made good eye contact and was calm. However, she also noted his strange behaviour and thought he may have mental health issues. She recorded that Mr Ali had been seen in A&E and treated for lacerations.

71. The nurse told the investigator that healthcare staff did not have access to the dPER and that normally, they were given a copy of the PER. She said she remembered that Mr Ali's police custody record had stated he had attended A&E and had had a scan but there was no significant injury. She said she did not see anything about him being at risk of suicide or self-harm or that he had been under constant supervision.

72. The PPO was given a copy of Mr Ali's police custody record, which was 102 pages long. The details which the nurse recalled seeing were on page 21 (detained person's medical form). This form had Mr Ali's correct date of birth and the second page said that he was under constant supervision. We do not know if she was given all or part of the record (and it seems that none of the prison staff in reception read the custody record).

73. In her statement to the coroner, the nurse said that Mr Ali had been evasive, especially about his injuries. She referred him to the GP to check his summary health care record and to the prison's mental health team because she thought he

seemed slightly disturbed, but he was not giving any further information. She told the investigator that she did not consider starting suicide and self-harm prevention procedures, known as ACCT, as she did not consider his mental health needs needed this intervention.

74. At 5.43pm, Mr Ali and the other prisoners arrived in the first night centre and they were locked into a holding room.

First night centre

75. At approximately 5.53pm, Officer A collected Mr Ali from the holding room and took him to an interview room for his first night interview with Officer B. Officer A stayed with Mr Ali for all but the last two minutes of the interview.

76. Officer B told the investigator that he carried out the first night interview and completed the required form. A copy of the form could not be found. He said that when he asked Mr Ali if he had thoughts of suicide or self-harm, he replied that he did not. Officer A said that he had also heard Mr Ali say no.

77. At the same time, Officer B completed Mr Ali's cell sharing risk assessment. He was assessed as a standard risk and suitable to share a cell. He noted that the first night interview had been completed and that Mr Ali had no thoughts of self-harm. He also checked the box on the form to indicate that he had looked at the PER. However, he told the investigator that he could not remember seeing a PER and he did not have access to the dPER. He said that he did not consider opening an ACCT on the basis of Mr Ali's responses. He said he assessed him based on his communication, presentation and interaction.

78. At 5.55pm, a GP operating at Wandsworth working on the first night centre, noted in Mr Ali's medical record that he was unable to see him as he had already transferred to the wing (he had not yet) but he planned to review him the next day. He told us that he could not recall why he had made that entry and that he had not been able to find a summary care record for him. He said he did not see the nurse's reference to his mental health, and he may not have read the notes. He concluded that Mr Ali could wait to be seen by a GP the next day.

79. CCTV shows that at around the same time, the GP went to the office where Mr Ali's interview was taking place and stood at the door, talking to the officers for around thirty seconds. He then left and returned to his office. Officer B told us that the GP had said that he wanted to see Mr Ali once the interview was over.

80. At around 6.02pm, Officer A escorted Mr Ali back to the holding room. The GP told the investigator that the holding room was where he would go to call the prisoners one by one when it was their turn to be seen.

81. At approximately 6.09pm, the GP left the first night centre having finished for the day. CCTV footage shows that he walked past the holding room and looked in while Mr Ali was in the room.

Echo wing

82. At around 6.34pm, the prisoners were taken to Echo wing. Officer B told the investigator that when they got to Echo wing, a SO told him that there were two double cells available. He said that two of the four prisoners had said they wanted to share with each other which left Mr Ali and another prisoner, who had also been assessed as posing a standard risk and suitable to share a cell, to share the other cell.

83. Mr Ali and his cellmate were taken to their allocated cell. Officer A opened the cell door and a decency orderly (a prisoner who provides assistance to officers) arrived and gave Mr Ali a bed pack containing further kit and food. Mr Ali went into the cell and his cellmate remained outside.

84. In his statement, Officer B said Mr Ali was given his bed pack and he appeared calm. He said that his cellmate refused to go into the cell. CCTV footage shows that Officers A and B spoke to the cellmate outside the cell before walking down the landing with him.

85. At around 6.51pm, Officer B, the SO, Officer A and another officer returned the cellmate, in a guiding hold (the lowest form of physical restraint), to the cell, locked the door and left.

86. At 6.56pm, the emergency cell bell was activated. About a minute later, a female officer nearby stopped at the cell door for approximately two minutes before walking away. We were not able to speak to this officer as she had left the Prison Service, so we do not know which of the two men pressed the bell or why.

87. Mr Ali's cellmate provided a statement to the prison after Mr Ali's death. He said he had not wanted to share a cell with anyone and that early in the evening, he and Mr Ali had had an argument because Mr Ali had repeatedly touched his bed. He said that he asked Mr Ali to stop, and he did. The emergency cell bell was activated a further four times and, on each occasion, Officer C attended:

Cell bell activated	Cell bell answered	Duration at cell door
7.00pm	7.29pm	14 seconds
7.39pm	7.44pm	5 seconds
7.44pm	7.52pm	25 seconds
7.57pm	7.58pm	6 seconds

Officer C told the investigator that he only recalled responding to the cell bell twice and both times, Mr Ali had asked him in a crying voice if he could change cells. He told Mr Ali that he would not be able to move him that night and asked him if there was anything else he could help him with. He said Mr Ali had replied: no. He said that prisoners often pressed the cell bell and so it was not unusual that Mr Ali had pressed his bell several times. He said he saw and heard nothing which led him to

think that Mr Ali needed to move or that he was not safe. He told the police that he did not ask Mr Ali why he wanted to move, and Mr Ali did not say why.

88. At approximately 8.03pm, an officer checked Mr Ali's cell as part of his evening routine check. This was the last time that prison staff saw Mr Ali alive. He said he knocked on the door, but no one answered. He said both occupants were awake, and he recalled Mr Ali was standing by the window looking outside and the cellmate was sat on the bottom bunk vaping.

89. A prisoner who lived in the cell next to Mr Ali told police that while watching television, he had heard weird, groaning noises from Mr Ali's cell which went on for five to ten minutes. He said he had turned up the television volume as a result. He said that he then heard screaming from the cell and some knocking on the walls before prison officers arrived at the cell.

90. Another prisoner who lived in the other cell next to Mr Ali, said that during the evening he heard someone crying and groaning.

91. At 9.06pm, Mr Ali's cellmate rang the emergency cell bell. In his statement to prison staff, he said that he had got up to charge his vape pen, turned on the light and saw Mr Ali hanging. He said he went over and put his hand on his heart to see if he could feel it beating but it was not. He said that he then pressed the cell bell.

92. In his statement to the police, the cellmate said that once he had been put in the cell, he lay on the bottom bunk and watched television. He said that initially, Mr Ali had been shouting and pacing the cell and had pressed the cell bell to ask the officers if he could move rooms. The cellmate said that he turned off the lights and Mr Ali had continued to act erratically, including moving chairs in the cell. He said after ten minutes of quiet he got up to charge his vape pen and found Mr Ali hanging. He said he pressed the cell bell and had banged on the door. He said it took around five to seven minutes before anyone arrived.

93. At approximately, 9.07pm, a nurse walked past Mr Ali's cell. She told the investigator that she did not notice that the emergency cell bell light was on or recall any noise coming from the cell.

94. At 9.12pm, Officer D answered the emergency cell bell. In his statement, he said that as he got nearer to the cell, he heard banging. When he arrived, he said that Mr Ali's cellmate was on the bottom bunk, vaping and when he asked what was wrong, he had pointed towards Mr Ali. He said that Mr Ali had tied a ligature, made from prison tracksuit bottoms, around his neck and that he was topless, with his prison bottoms on. He appeared to be kneeling on the floor in front of the window, with the ligature attached to the window.

95. Officer D said he immediately radioed for help, opened the cell door and used his cut-down tool to cut the ligature.

96. At 9.13pm, the control room officer called for an ambulance and was placed in a queue.

97. Within one minute, Officer E and a nurse arrived at the cell. Officer E told the police that she saw Mr Ali at the back of the cell, on the floor near the toilet. The nurse told the investigator that when she arrived, Officer D had already cut the ligature from

Mr Ali's neck and he was on the floor near the toilet, and Officer D was moving the cellmate outside the cell.

98. At 9.13pm, CCTV footage shows that Mr Ali's cellmate was placed outside the cell and Officer D could be seen running along the corridor, passing Officer F, who was heading towards the cell. Officer F helped Officer E and the nurse move Mr Ali onto the floor. He said as soon as Mr Ali was lying on the floor, the nurse began chest compressions. He then left the cell and escorted the cellmate away.

99. A few seconds later, an officer arrived and went into the cell, followed by another nurse and Officer D, who had returned with the medical emergency bags. The nurse told the police that her colleague was in the process of doing chest compressions and that Mr Ali showed no signs of life but was warm to touch. She said she inserted an airway into Mr Ali's nose and attached a defibrillator, but no shock was advised.

100. At 9.19pm, the prison control room, while still on hold for the Ambulance Service, made another call to the emergency services. Ambulance records show that this call was answered at 9.19pm.

101. At 9.22pm, an ambulance was sent to the prison, and it arrived at 9.23pm. The paramedics arrived at the cell at 9.28pm. Mr Ali was moved from the cell to the landing. The paramedics took over resuscitation efforts.

102. At 9.36pm, the rapid response paramedic team arrived at Wandsworth and were on the landing at 9.38pm.

103. At 9.59pm, paramedics pronounced Mr Ali dead.

Contact with Mr Ali's family

104. The prison appointed a family liaison officer (FLO). She was unable to find the first-night paperwork to check for Mr Ali's next of kin details, so she contacted the police. On 24 October, the police identified Mr Ali's brother as the next of kin.

105. On 24 October, the FLO visited Mr Ali's brother and broke the news of his death. She offered support and provided him with a leaflet and her contact details. The prison told us that in line with national policy, they offered to contribute to Mr Ali's funeral costs, but the family declined.

Support for prisoners and staff

106. After Mr Ali's death, the Head of Offender Management debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

107. The prison posted notices informing other prisoners of Mr Ali'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 Ali's death.

Post-mortem report

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

Police investigation into Mr Ali's death

109. The police were immediately notified of Mr Ali's death and two officers attended the prison at 2.15am on 23 October. They took photographs of the cell and initial statements from the officers and healthcare staff who were involved in the emergency response. They also took an initial statement from Mr Ali's cellmate. The police arranged to obtain a formal statement from him on 24 November, but he was released from prison the day before the appointment and this never took place.

110. The police told the investigator that they had contact with Mr Ali's cellmate earlier in 2024 and he was asked to give a formal statement, but he refused. The police said that the Coroner had issued him with a Schedule 5 Notice (which required him to attend the inquest). The police confirmed that they have concluded their investigation.

Inquest into Mr Ali's death

111. The inquest into Mr Ali's death was held between 16 February and 4 March 2026 and a verdict of suicide was recorded.

112. The coroner concluded that Mr Ali intended to take his own life but there were systemic failures to properly assess and communicate risk.

Findings

Assessment of risk

Serco

113. Mr Ali had been arrested after stabbing his former partner in a public place. Shortly after, he had stabbed himself and been treated in hospital. He said more than once in the hours after his arrest that he wanted to die.

114. The police completed a dPER for Mr Ali on 21 October. This contained warning markers for violence, suicide and self-harm and noted that he had been under constant supervision in police custody. This was Mr Ali's first time in custody.

115. None of the escort staff who accompanied Mr Ali to and from court checked the dPER to establish if Mr Ali was at risk of suicide. Before Mr Ali arrived at court, Serco officers should have checked the PECS move platform (a web-based system used to arrange moves for detainees) to identify if he had any risk markers. This information should have been recorded on the custody board when he arrived at court. On his arrival, Mr Ali's vulnerability should also have been assessed based on the information provided on the PER and a suicide and self-harm warning form should have been initiated. This did not happen.

116. Serco confirmed to us that the CCM viewed the summary of risk markers for Mr Ali, but this information was not added to the custody board. Therefore, the court team was not aware of Mr Ali's risks. The Deputy CMM told us that he could not recall checking Mr Ali's dPER that day as the court was very busy. CCTV also shows that there was minimal contact between court reception staff and Mr Ali when he arrived. Had these fundamental checks been completed, staff would have been aware of Mr Ali's risk and likely managed him appropriately.

117. Mr Ali was placed in a cell with CCTV cameras. However, he was not monitored by camera, as his known risk had not been picked up by the reception court custody staff, and he was therefore only checked once every 30 minutes. Given the levels of Mr Ali's distress captured on the cell CCTV, we consider it unlikely that had the officer responsible for his 30 minute checks conducted proper cell checks she would not have seen signs of his distress. But in any case, court staff raised no concerns about Mr Ali and did not complete a suicide and self-harm warning form.

118. The CCTV footage of Mr Ali's escort from court to prison showed that he was distressed, wailing, crying and appeared to have difficulty breathing. The escort officer could be heard telling Mr Ali to shut up and laughing when another prison was shouting at Mr Ali. The escort officer did not check on his welfare and did not update his dPER to reflect his level of distress. This information was therefore not passed on to the prison.

119. Following an internal investigation, Serco told us that disciplinary investigations were carried out into the actions of two of the escort officers and the Court Manager and action was taken (they provided no more specific information about the outcomes of the investigations).

120. Serco have completed the following briefings, reminding:

- all court staff of the need to use a CORA device to record all prisoner movements and interactions as they happen.
- all vehicle base managers and escort officers that the escort officer (not the driver) must be the officer responsible for collecting or handing over prisoners, and that on collecting prisoners, they must view the whole dPER to identify risks.
- all court managers and officers that they must view the whole dPER before accepting a prisoner and that they must give a verbal briefing to the escort officer for each prisoner before handover.
- all officers of the need to complete a suicide and self-harm warning form for prisoners showing signs of suicide or self-harm risk.

121. Serco told us that they are reviewing whether they could provide a dPER monitor for the reception desk at Westminster Magistrates' Court (and other high-footfall courts) so that court staff could more easily access the dPER.

122. While we recognise that Serco have taken actions to address their failings, we are making a recommendation about PERs (set out after paragraph 122).

HMP Wandsworth

Assessment of Mr Ali's risk on arrival

123. Prison Service Instruction (PSI) 07/2015 on early days in custody requires reception staff to examine the PER and any other available documentation to assess a prisoner's risk. No one at HMP Wandsworth accessed Mr Ali's dPER and if they had done so, they would have seen his risk and should have opened an ACCT, which may have prevented Mr Ali from taking his own life.

124. The issue of reception staff not looking at PERs has been identified in previous investigations and we are concerned that leaders at Wandsworth are failing to tackle this issue effectively. Since Mr Ali's death, we have investigated another death where staff again failed to consider the information contained in a PER.

125. The Head of Safer Custody told the investigator that the printing of dPERs in reception is now mandatory and is the responsibility of reception staff. First night staff have been told only to complete their assessment if they have the relevant paperwork. She said that healthcare staff have also been given access to the dPER and that a follow-up check to ensure that there were no issues with access was completed in May 2024.

126. The prison confirmed that they completed investigations into the actions of two officers, Officer B and another officer. While they were unable to tell us the outcome, as they could not find any of the associated paperwork, they identified a number of actions and process changes to ensure that emails are identified and processed appropriately. We consider that this case demonstrates serious and widespread failings that require a robust approach. We make the following recommendation:

The Governor, Head of Healthcare and Head of Operations at Serco should ensure that they have an audit process in place to provide assurance that staff are following the mandatory actions for person escort records.

127. However, the failure to identify Mr Ali's clear risk of suicide goes beyond staff's failure to read the dPER.

128. PSI 64/2011 on safer custody lists risk factors and potential triggers for suicide and self-harm. It says all staff should be alert to the increased risk of suicide and self-harm posed by prisoners with these risk factors and should act appropriately to address any concerns. Any prisoner identified as at risk of suicide and self-harm must be managed under ACCT procedures.

129. Mr Ali had a number of risk factors for suicide. He had been charged with a violent offence against a close family member (his ex-partner), he had recently attempted suicide by stabbing himself, had expressed thoughts of suicide and had a history of mental ill health. It was his first time in prison, and he was in the first hours of his stay there – both of which are factors known to increase the risk of suicide.

130. The investigation found no evidence that staff in reception or who had contact with Mr Ali in his few hours at Wandsworth considered his objective risk factors. Too often we find that staff relied on how the prisoner presented when assessing suicide risk. In this case, we are alarmed to find that staff at Wandsworth did not even pick up on the clear and repeated indications that Mr Ali was distressed, possibly mentally unwell and obviously vulnerable.

131. Evidence that Wandsworth has been a prison in crisis for some years is plentiful and public. We consider that staff's failure to identify Mr Ali as a man at risk of suicide was symptomatic of that.

132. We are aware that Wandsworth have recently developed an action plan to respond to the concerns that were identified following the HMIP inspection in May 2024 and that this includes taking steps to address the high and rising levels of self-harm and suicide. Furthermore, we welcome the development and launch of their Suicide and Self-harm Strategy in August. In light of the considerable work underway at Wandsworth to improve outcomes for prisoners, we make no recommendation.

Cell bells

133. Mr Ali first rang his cell bell at 6.56pm. He then rang the bell a further four times within the hour. On one occasion, it took 29 minutes before an officer responded. This is an unacceptable length of time. When Mr Ali's cellmate pressed the cell bell, it took six minutes before it was answered. The Head of Safer Custody told us that staff are expected to respond within five minutes, and they should record anything of note but they are not expected to record every response to a cell bell.

134. HMIP's most recent report identified the issue of cell bells not being answered within five minutes. The Head of Safer Custody told the investigator that cell bell answering times were monitored daily and a summary produced weekly. She said that this has been in place for 18 months. She said that cell bell information had been added to the agenda of the monthly safety meeting since May 2024 and

senior leaders scrutinised the information to identify trends and areas for improvement, including challenging teams when answering times were inadequate.

135. We note that the timeliness of responses to cell bells is included in the action plan put forward by Wandsworth to address the concerns identified by HMIP following their last inspection. We are therefore not making a recommendation.

136. CCTV footage showed that the same officer responded on four occasions. The officer recalled two occasions and both times, Mr Ali had asked to be moved. The duration of the conversations varied from 5 seconds to 25 seconds and the officer failed to ask Mr Ali why he wanted to move. The officer said that cell bells were routinely misused and based on his experience and his assessment of the situation, he had no concerns about Mr Ali.

137. Whilst we cannot be certain that Mr Ali would have told the officer the reason why he wanted to move or that the reason would have warranted any action, we are concerned by the lack of empathy and professional curiosity.

138. We note that Wandsworth's Suicide and Self-Harm Strategy includes the importance of staff having meaningful interactions with prisoners and that the prison have put in place a standards coaching team, to improve staff confidence and a professional standards lead to improve professional standards. The Governor will want to assure himself that this work considers the findings of this report.

Clinical care

139. The clinical reviewer found that the care Mr Ali received at Wandsworth was not equivalent to that which he could have expected to receive in the community. The clinical reviewer identified poor risk management and poor communication between the different agencies involved. She found that healthcare staff had considered Mr Ali's risk of suicide and self-harm in isolation and based on his presentation alone and staff did not actively seek out Mr Ali's recent history to assess his risk holistically.

Assessment and management of risk of suicide and self-harm

140. Shortly after he arrived at Wandsworth, the reception nurse saw Mr Ali and noted his strange behaviour in the holding area. In her statement to the Coroner, she said that when she assessed him, Mr Ali had been evasive, especially about his injuries and she had referred him to the mental health team as his mental health seemed slightly disturbed.

141. We appreciate that the wrong date of birth on the warrant meant that healthcare staff were unable to find Mr Ali's medical records. However, the police custody record contained the correct date of birth. Given his earlier strange behaviour, the risk factors for suicide and the lack of information available to her, we consider that the reception nurse could have taken a more proactive approach and either asked the reception staff to provide her with a copy of the dPER or considered opening an ACCT.

142. The Quality and Governance Manager for Oxleas told us that they had completed a number of actions which they identified following their review into the circumstances of Mr Ali's death. These include:

- the majority of healthcare staff having access to the dPER in reception and those who did not have access were asked to apply;
- ACCT awareness training to ensure that staff were proactive in identifying when an ACCT should be opened; and
- generic email accounts were checked at least once in the morning and once in the afternoon and assurance checks were carried out.

While we note these actions, we consider the issue of reviewing a prisoner's PER to be a sufficiently serious issue to require a recommendation. This is set out after paragraph 122.

Head of Healthcare to note

GP's involvement with Mr Ali

143. The doctor was asked to check Mr Ali's summary care record. He told us that he tried but could not find Mr Ali's medical record. The doctor did not record (in the newly created medical record) that he had done this.

144. During his interview the doctor said he may not have read the notes made by a nurse, which included a reference to possible mental health issues. We are concerned that the doctor responsible for seeing prisoners as part of the reception process would not check the reception nurses' records entry as a matter of course.

145. The doctor wrote in Mr Ali's medical record that he had been unable to see him because he had already been transferred to the wing. This was not true as Mr Ali was still in the first night centre. The doctor was unable to provide an explanation for this.

146. The doctor told the officers interviewing Mr Ali that he wanted to see him after they had finished, but then left the prison shortly after without following up. The Head of Healthcare may wish to consider our findings and whether any follow up with the doctor is appropriate.

Governor to note

147. PSI 04/2017 states that body-worn video cameras must be used and set to record when staff respond to reportable incidents. However, cameras were not activated when staff discovered Mr Ali or the subsequent emergency response.

148. The prison did not provide the PPO with all documents we asked for as they could not find them. This reflects poor housekeeping and negatively impacted on our investigation as we could not be certain that we had identified all the relevant issues.

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