Investigation into the circumstances surrounding the death of a man at HMP Wandsworth in April 2010

Report by the Prisons and Probation Ombudsman for England and Wales

January 2011

This is the report of the investigation into the circumstances surrounding the death of a man. He was found hanging in his single cell at HMP Wandsworth in April 2010. He was 31 years old and, having been convicted of several serious offences, was waiting to be sentenced. I offer my sincere condolences to his family and all those touched by his death.

The investigation was conducted by an investigator on my behalf. I would like to thank the Governor of Wandsworth and his staff for their co-operation with the investigation. I am particularly grateful to one senior officer for his work as the investigation liaison officer.

The local primary care trust commissioned a clinical reviewer to review the clinical care the man received. I am grateful to him for his timely review.

The man had been in prison before and, when arrested and remanded into custody in July 2009, had several other outstanding charges progressing through the court system. Because he had several court cases pending, he was transferred between three London prisons from his remand in July until his death. Sadly this is not the first time that I have commented on the impact of such transfers.

During his period in custody, he gave staff no indication that he was vulnerable or a risk to himself. In fact, this investigation has identified no particular reasons for him to have acted as he did. It is possible that he was worried that he might be facing a long prison sentence, although he did not raise any such concerns with staff or friends.

It is also possible that the man suffered with mental health problems, although medical opinion was divided. Certainly, on some occasions he told staff that he had a history of mental ill health and on others denied this. Regardless of whether he did or did not have mental health problems, I am concerned to find procedural failings in the transfer of clinical information between the prisons involved. It is not the first time that I have identified such an issue in relation to a death at Wandsworth. I make one recommendation to the Head of Healthcare. I also make one recommendation to the Head of the Mental Health Inreach Team to clarify the referral procedures between prisons.

Although generally his time in prison was uneventful, the man claimed to have a violent temper and on one occasion, allegedly punched a fellow prisoner several times. My third recommendation relates to the prison’s failure to deal with or explore this violent outburst.

However, I do not think that his actions were foreseeable or, for that reason, preventable. While I have identified procedural omissions, I do not think that the recommendations I make would have altered the outcome.

The final version of my report includes the National Offender Management Service’s (NOMS) response to the recommendations made.

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

Jane Webb
Acting Prisons and Probation Ombudsman **January 2011**

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SUMMARY

The man was remanded into the custody of HMP Wandsworth on 20 July 2009, having been charged with wounding with intent, attempted robbery and possession of a knife in a public place. It was not his first time in prison and, when remanded, he also had a number of other cases proceeding through court.

On his arrival at Wandsworth, he told staff that he had no physical or mental health problems and had never tried to harm himself. However, he said that he had a quick temper, was aggressive and should not share a cell. Except for his first night at the prison, he occupied a single cell.

In August, the man appeared in court in relation to another matter and, following his appearance, transferred to HMP Pentonville. He had been in Pentonville before and staff there believed that he suffered with mental health problems. During his three weeks there, he received intervention from the prison's specialist mental health team. On 24 August, he was sentenced to 12 months in prison for a previous offence of robbery.

The man transferred back to Wandsworth on 3 September. This investigation has not been able to establish whether his Pentonville clinical records transferred with him. Certainly, healthcare staff at Wandsworth do not appear to have known about his contact with the Pentonville mental health team. Reception healthcare staff did not refer him to the Wandsworth mental health team. Pentonville staff recorded that they had left a message alerting the Wandsworth mental health team to his transfer. However, he was not assessed and did not receive any mental health intervention while at Wandsworth.

In November, a member of staff saw the man punching a fellow prisoner in the face several times. As a result, he was moved to the Care and Separation Unit (CSU) and adjudication proceedings began. (The CSU is a small, separate unit within the prison where prisoners who cannot be managed on the main wings are held. They are held in single cells and have a restricted regime. When a prisoner is accused of breaking a prison rule, they must appear in front of a governor who listens to the evidence and decides whether the prisoner is guilty of the charge. If the prisoner is found guilty, the governor may impose a punishment, such as loss of earnings or cellular confinement for a period of time. This process is known as adjudication.)

Eventually, the adjudication was dismissed because too much time had passed since the incident. However, it seems that no other action was taken to explore the man's violent outburst. It was not recorded in any relevant documents and no work was carried out to address his behaviour.

On several occasions, he refused to attend court, claiming that he was unwell. However, following a court appearance on 15 February, he was transferred to HMP Wormwood Scrubs, where he spent about three weeks. His time there appeared to be relatively uneventful.

He moved back to Wandsworth on 8 March. Again, it has not been possible to confirm whether his clinical records transferred with him; certainly there was no

evidence of them in his medical file. However, following publication of the draft version of this report, Wormwood Scrubs provided a copy of the electronic record relating to his time there.

The man was convicted of the July offences in March 2010 and remanded back into custody to await sentencing, which was due on 30 April. It seems that he might have been told that the court was considering an indeterminate sentence for public protection (IPP). (IPP sentences apply to those who commit certain serious violent or sexual offences and who are deemed to pose a "significant risk of serious harm in the future". The sentencing court sets a minimum period of imprisonment required, but the individual will only be released after that point if the risk to the public has been reduced.) He gave no outward signs of being concerned about this possibility.

In the days prior to his death, he gave no indications that he was vulnerable or struggling to cope. He asked a member of wing staff about a Playstation he had brought from another prison, talked normally with his friend and appeared to be his normal self.

In April a member of staff carrying out a routine check at about 8.00pm, looked into the man's cell and saw that he had a ligature around his neck. Staff responded quickly and the ligature was cut and emergency first aid began. Despite the best efforts of officers, two prison nurses and paramedics, he could not be resuscitated.

I make three recommendations as a result of this investigation. One is to the Head of Healthcare and relates to transferring clinical information between prisons when a prisoner transfers. The second is for the Head of the Wandsworth mental health team and concerns the referral of prisoners to the team. The final recommendation is for the Governor and concerns how allegations or incidents of violence should be dealt with. Despite these failings, I take the view that the man's death could not have been foreseen, or therefore, prevented.

THE INVESTIGATION PROCESS

1. The Ombudsman's office was notified of the death of the man in April 2010. The investigation was initially allocated to an investigator. In May, a colleague took over the investigation.

2. Notices were issued inviting staff and prisoners to contact the investigator with any information they felt might be relevant to the investigation. There was no response to the notices. The investigator carried out interviews with staff and prisoners at Wandsworth in July 2010. Additionally, she made telephone contact with the man's community offender supervisor and healthcare staff at HMP Pentonville.

3. She was provided with relevant documentation covering the man's time at Wandsworth, including a copy of his prison records and the staff incident reports written after his death. Copies of the electronic medical records relating to his time at Pentonville and Wandsworth were provided but the medical file relating to his time at HMP Wormwood Scrubs is missing and despite searches has not been located.

4. The local PCT appointed a clinical reviewer to review the clinical care the man received at Wandsworth. He had access to the medical record and transcripts of the interviews the investigator carried out at Wandsworth. I am grateful to him for his timely review.

5. HM Coroner for Inner West London was informed of the nature and scope of the investigation. A copy of this report will be sent to him to assist with his inquiries.

6. One of the Ombudsman's family liaison officers contacted the man's family to explain the investigation process and invite them to raise any concerns or questions. They said that staff and another prisoner at Wandsworth told them that he had seemed fine in the days before his death. There were no signs that he was struggling to cope or was vulnerable.

7. When the family visited the prison to see his cell, they were told that a day or two before his death the man asked for access to a Playstation. Later they were told this was not the case, which left them confused. His family told the family liaison officer that he thought he would be released soon and was looking to the future. They felt that something was not right as there was no indication he was thinking of taking his life. His family also wanted to know if he had broken any prison rules or been in any trouble in the months leading to his death. I hope this report helps to answer their questions and build a picture of his time in prison.

8. Since the Ombudsman began investigating all deaths in prisons in 2004, 15 prisoners (including the man) have apparently taken their lives while at Wandsworth. In three other cases, aspects of the relevant paperwork have been missing. In two of those cases, the paperwork appears to be missing as a result of the prisoner transferring between London prisons. Investigations into deaths at other London prisons have highlighted similar issues and so the Ombudsman

will raise the matter by letter with the National Offender Management Service (NOMS) and the National Health Service regional offender lead.

HMP WANDSWORTH

9. HMP Wandsworth is the largest prison in the United Kingdom, holding up to 1,665 adult male prisoners. It is a local category B prison, accepting prisoners on remand, convicted and sentenced from courts within the catchment area. The prison is formed of five residential wings and two specialist units. The original prison buildings date from 1851, but since 1989, the prison has been undergoing extensive refurbishment and modernisation.

10. The National Offender Management Service (NOMS) publishes quarterly performance ratings for all prisons in England and Wales. The ratings are based on a set framework, and prisons can be rated from one to four (with four indicating 'exceptional' performance). Wandsworth has achieved a rating of three ('good' performance) for the last four published quarters.

HM Chief Inspector of Prisons (HMCIP)

11. The former Chief Inspector of Prisons conducted a full announced inspection of Wandsworth in June 2009. She noted the "troubled" modern history of the prison, remarking that during the 1990s and the beginning of the present century the prison received several "highly critical" inspection reports.

12. The inspection highlighted that under the then Governor, considerable steps had been taken to "change a previously resistant staff culture, increase the quality and quantity of activities, and improve prisoners' resettlement chances". The suicide prevention strategy was "comprehensive" if "not user-friendly". On the wings, relationships between staff and prisoners were "generally relaxed and supportive" with staff responsive to prisoner requests. However, black and minority ethnic prisoners were less positive about staff.

Independent Monitoring Board (IMB)

13. Prisons in England and Wales are also subject to monitoring by an IMB, made up of volunteers from the local community. Members of the IMB have access to every part of the prison and each prisoner there. They produce an annual report, the latest available for Wandsworth covers the period June 2009 to May 2010.

14. The IMB report noted that while recent years had seen improvements across the establishment, "for a number of reasons, this change has been reversed". The Board considered that some of the difficulties were caused by an area-wide shortage of officers. Such shortages were identified as leading to deteriorating staff-prisoner relationships, with prisoners' frustration "palpable". The Board noted that self harm figures had doubled during the past year.

15. The Board noted that the healthcare providers went into receivership at the start of the Board's reporting period. Healthcare services were taken over by Community Services Wandsworth, part of the Primary Care Trust. Mental healthcare is provided by a separate local organisation. Recruitment of

permanent staff was recognised as a difficulty, and the impact on administration was particularly noted.

HMP Pentonville

16. HMP Pentonville is a large local prison in North London, with capacity for 1,152 adult male prisoners coming from courts within the catchment area. The prison was last inspected by HMCIP in an unannounced visit in May 2009. The report noted the "undoubted improvements" at the prison and the "strong focus" on safer custody procedures.

HMP Wormwood Scrubs

17. HMP Wormwood Scrubs is a local prison serving the courts of North West London. The prison can hold up to 1,239 adult male prisoners on remand or sentenced. The prison was last inspected by HMCIP in June 2008. The report noted that, over recent years, the prison had been making "slow but steady" progress which appeared to have "halted". However, there was no evidence of a negative staff culture and violence reduction and suicide prevention work was good.

Cell Sharing Risk Assessment (CSRA)

18. The CSRA assesses the risk a prisoner poses to other prisoners and whether they are suitable for sharing a cell. The assessment considers a range of factors including the prisoner's past offences, whether they have displayed bullying or violent tendencies in the past, and any substance misuse or mental health problems. The prisoner is asked whether they have any concerns about sharing a cell and this is also taken into account. One part is completed by a discipline officer and the other by a member of healthcare staff. The staff conducting the assessment must decide whether the prisoner poses a low, medium or high risk to other prisoners. Prisoners assessed as high risk will generally be placed in a single cell, but the risk assessment will be reviewed frequently. The prisoner may be required to work on those factors that make them high risk.

Assessment, Care in Custody and Teamwork (ACCT)

19. ACCT is the Prison Service process for supporting and monitoring those prisoners thought to be at risk of harming themselves. An ACCT plan can be opened by anyone working in the prison if they have any concerns that a prisoner might have tried, or, in the future, might try to harm himself. The purpose of ACCT is to try to determine the level of risk posed, the steps that might be taken to reduce this and the extent to which staff need to monitor and supervise the prisoner. Levels of observations (where staff must check the prisoner) and interactions (where staff must have a conversation with the prisoner) are flexible and can be set according to the perceived risk of harm. If staff perceive the risk of harm to be very high, the prisoner may be constantly observed, with a member of staff positioned outside their cell at all times. Where the perceived risk is lower, the level of observations may be several times an hour or day. Observations also take place during the night. As part of the

process a CAREMAP (plan of care, support and intervention) is put in place and there should be regular multi-disciplinary review meetings. Wherever possible, the prisoner at risk is also included in review meetings.

KEY EVENTS

20. The man grew up in London. Having completed his GCSEs and gained a qualification in leisure and tourism, he worked in sales, security and retail. His life had become less stable, with some alcohol and drug use and he had been unemployed since 2006. He had been convicted of a number of offences, some of which were serious and led to earlier periods of imprisonment.

21. On 20 July 2009, the man was remanded into the custody of Wandsworth having been arrested by the British Transport Police and charged with wounding with intent, attempted robbery and carrying a knife in a public place. He also had ongoing charges of robbery and abduction against him.

22. On his arrival at Wandsworth, the man underwent a Cell Sharing Risk Assessment (CSRA). The officer completing the assessment noted that he said he had no substance misuse problems and that there was no evidence that he had a history of harming himself. The officer recorded, however, that he had convictions for violence. The man said that he was concerned about sharing a cell and was quick tempered and very aggressive. He told the officer that "small things set him off and he will fight with cell mate". The officer judged that he posed a medium risk to other prisoners. A nurse completed the second part of the assessment, noting no concerns and judging him to pose a low risk to other prisoners.

23. The man was also assessed by a nurse who completed the First Reception Healthscreen. (The purpose of the healthscreen is to identify any immediate physical or mental health concerns requiring referral to the doctor or other specialist service. It is largely reliant on the prisoner disclosing information himself.) She recorded that he had no medical problems, was of normal mental state and had no history of attempting to harm himself. The nurse noted that he had no alcohol or drug problems. She concluded that he did not need any further medical treatment at that time and that he could be given a cell on one of the main prison wings. On his first night in the prison he was allocated a double cell, sharing with another prisoner. He moved to a single cell on 21 July.

24. During his first days in prison, the man received his induction, providing him with information about life at Wandsworth. Staff noted that no issues had been raised about him, or by him, during the process. On 23 July, an officer completed the Local Initial Screening and Reducing Reoffending Tool (LISSART) with him. He told the officer that, prior to coming to prison, he had no fixed address and that he needed help with accommodation. The officer recorded that she would refer him to St Giles (a voluntary organisation providing housing assistance and advice).

25. The man told the officer that he had not been in contact with his family and that he was not expecting to receive any contact with friends or family while in prison. When asked if he had children, he said he did and that they lived with their mother. He said he did not want any help with his personal relationships. He told the officer that he had been working part time as a self-employed freelance writer and the job would be available on his release from prison. He said he was

not interested in undertaking any education courses while in custody. He said he had no debts but needed help arranging his benefits. The officer arranged to refer him to the Job Centre.

26. The man told the officer that he used neither drugs nor alcohol. He said he had no mental health problems, and had not had any in the past. He did not want to be referred to the doctor or a mental health specialist. He said he had no thoughts of suicide or self-harm. Finally, he said that he was not interested in completing any offending behaviour courses because he was innocent of the charges against him.

27. On 11 August, he appeared at court, where he was remanded into the custody of HMP Pentonville. (Court cases are generally heard at the court in closest geographical proximity to the location of the offence. Similarly, courts will usually remand prisoners into the custody of the prison nearest to the court. Because he had three ongoing cases being heard at separate courts across London, he was remanded into three different London prisons between July 2009 and April 2010.) At about 8.30pm, he was assessed by a nurse in reception who completed the First Reception Healthscreen. She noted that he had transferred to Pentonville from Wandsworth. She recorded that he had no substance misuse problems, was not considered to be a risk to himself and had no mental health problems. However, a separate entry by her made the same day noted that he had told her that he "had mental health problems before but he is better now … states he is not on medication anymore, he has stopped taking them".

28. In fact, the man had been in custody at Pentonville before, most recently from 8 November 2008 to 11 June 2009. The medical notes from that period detail that he said he had been diagnosed with schizophrenia and was being prescribed medication. He told doctors that he sometimes heard voices which told him to hurt himself or others and that he suffered with anxiety. While in custody, he received intervention from the Mental Health In-Reach Team (MHIT, specialists in mental health) and was prescribed diazepam (a sedative) and risperidone (an antipsychotic medication).

29. However, a psychiatric report ordered by the court, completed in June 2009 concluded that the man did not suffer from a mental illness and had never been admitted to a psychiatric hospital. The psychiatrist noted that he had a "tendency to mislead … [In his view], he did it so that he could get out of prison quicker". He concluded that the tendency to mislead was not related to a mental illness but was related to an "underlying antisocial personality". (This report had been attached to his clinical records and so was available to healthcare staff at Pentonville.)

30. On 12 August, an entry in the medical record noted that the man had been referred to the MHIT for a psychiatric assessment. A psychiatrist and a social worker conducted the assessment on 27 August. Few notes were made in the medical record, but the entry recorded that healthcare staff would continue the "medication-free assessment" and review him in four weeks, or earlier if there were any concerns, and that he would be referred to the day centre.

31. The man was convicted of robbery on 24 August and received a 12 month prison sentence. He appeared in court again on 3 September, in relation to the wounding with intent, attempted robbery and possession of a knife offences and was remanded into custody. On leaving court, he was taken back to Wandsworth. A healthcare assistant (HCA) assessed him on his arrival, noting that he was “fit and well”. Each prisoner arriving from another prison should be accompanied by his medical record. However, there is nothing to indicate whether his record accompanied him from Pentonville. If it did, there is no evidence that any member of healthcare staff read the entries relating to his mental health or referred him for further assessment.

32. The CSRA assessment was completed in reception. The officer conducting the assessment recorded that the man had no substance misuse problems and was not being monitored under the ACCT procedures. However, he told the officer that he had concerns about sharing a cell, saying he had been assessed as high risk at Pentonville (there was no CSRA relating to his time at Pentonville in his prison file) and, in the past, at Wandsworth. He said he would fight any cell mate. As a result, the officer judged him to pose a high risk to other prisoners. The nurse completing the healthcare section of the form assessed him as posing a low risk from a healthcare perspective and had no concerns about him. He was given a single cell on one of the main prison wings.

33. Five days later, on 8 September, a wing governor conducted a CSRA review. She recorded that the man had not displayed any violent or aggressive behaviour and there was no security information relevant to the assessment. He remained high risk because he would not share with anyone and threatened to fight any cell mate. She noted that his personal officer should work with him to reduce his risk and encourage him to share.

34. An entry on the Pentonville medical record notes that a member of staff telephoned Wandsworth MHIT on 8 September and left a message telling them that the man had been transferred. During the investigation, the investigator spoke to the Head of the MHIT at Wandsworth. She said that he had not been referred to the MHIT or discussed at any referral meetings. She explained that Pentonville MHIT staff should know that in order to transfer a case, they must complete referral paperwork and fax it to Wandsworth. She said this is an established system and if any member of Wandsworth’s MHIT had received a message about him, Pentonville would have been instructed to complete the referral paperwork. The Head of the Pentonville MHIT told the investigator that he was unaware of any such process. She confirmed that, on the basis of the information in his Pentonville medical record, her team would have wanted to assess and work with him.

35. The man appeared in court twice over the following few weeks and was remanded in custody on both occasions. There appeared to be few concerns about him at Wandsworth, other than those relating to his CSRA level. However, on 1 November, he was seen punching another prisoner in the face several times. He was taken to the Care and Separation Unit (CSU) and placed on report, awaiting adjudication.

36. When a prisoner is moved to the CSU they must be assessed by a member of healthcare staff. The assessment, known as an algorithm, checks whether there are any physical or mental health reasons not to segregate the prisoner. The algorithm relating to 1 November is missing and has not been located, despite searches at the prison. On 3 November, the man was examined by a nurse who recorded that the swelling to his hand had reduced. (No further information about the cause of the injury is recorded, but it is possible it was a result of his having punched the other prisoner.) His time in segregation was uneventful.

37. The man's adjudication was held on 3 November and he pleaded not guilty. As the officer who had placed him on report did not attend to give evidence, and so that he could seek legal advice, the hearing was adjourned. Prison Service Order (PSO) 2000 - Adjudications, sets out the guidelines for conducting adjudications. It stipulates that where an adjudication has been adjourned for more than six weeks, the adjudicator must decide whether *"natural justice has been compromised by the delay in hearing the charge"* (all mandatory instructions in a PSO are written in italics). The man's adjudication was not heard until 26 January 2010, by which point it was "out of time" and was dismissed.

38. He returned to a normal cell on D wing on 3 November. His CSRA was reviewed and he remained high risk. There is no evidence in his prison file that any action was taken to address his violent behaviour. Although the adjudication had been adjourned, the investigator was told that staff should have initiated anti-bullying procedures or at least tried to investigate the cause of the incident. As well, it should have been noted in his wing file.

39. On 5 November, the man refused to attend court, saying he was unwell. He was examined by a nurse and said that he had suffered with diarrhoea during the night. This was the first of six occasions over a two month period when he refused to attend court, often saying he felt unwell. The Deputy Head of Healthcare said that it was quite common for prisoners to claim to be ill in order to avoid attending court. She explained that any prisoner who makes such a claim is examined by a nurse but it is difficult to ascertain whether they are genuinely ill or making an excuse to avoid court. The nurse advised him to come to the wing treatment room (where nurses are often located during the day) if he felt unwell.

40. While at Wandsworth, the man applied for two work positions, Radio Wanno (the prison radio station) and the canteen (where prisoners can buy a number of items for personal use from their personal money). Both applications were rejected because he was thought to have a quick temper and sometimes be unco-operative, but he attended education classes between November 2009 and January 2010. His tutor described him as knowledgeable, friendly, co-operative and keen to participate in classes. It appears that he got on well with other students and the tutor.

41. On 25 January 2010, the man was placed on report for a second time for refusing to move from D wing to B wing. The adjudication was held two days later and he was charged with disobeying a lawful order. He pleaded not guilty,

saying that he had refused to move because he had not thought the officer was giving him an order. He also said that he had “lots of trouble on B wing”. He said that he had told the senior officer in charge of D wing that, if she checked his file, she would find evidence of this. During the adjudication, the senior officer said that she had checked his file and found no mention of problems with other prisoners, or any specific problems on B wing. (There is nothing in his file to suggest that he had problems with other prisoners, except for the occasion when he was alleged to have punched another prisoner.) He said he did not know the names of the prisoners he was having problems with. The governor who was in charge of the adjudication found him guilty. The punishment was seven days cellular confinement, loss of 80 percent of his earnings for a period of 28 days (prisoners earn money for attending education) and loss of canteen for 28 days. However, the punishment was suspended for three months.

42. During the course of the investigation, the investigator spoke to an officer who was the man’s personal officer while he lived on D wing. (Wing officers are allocated to work with particular prisoners and be their first port of call should they have any questions or concerns.) The officer said that the man was a quiet prisoner who was polite and respectful to staff. He was not aware that he had any problems with other prisoners. The officer said he had never had any concerns about him, either in terms of his risk to himself or his mental health. He said that his cell was often quite dirty (which can be a sign of mental ill health) but otherwise there were no indications that he might be struggling to cope.

43. On 15 February, the man appeared in court and the trial for the charge of abduction began. At the end of the day, he was remanded into the custody of Wormwood Scrubs. Once again, a CSRA was completed on arrival. He told the officer undertaking the assessment that he had previously been convicted of manslaughter and so he was assessed as high risk. However, the duty manager overseeing the process that day made a later entry noting that he had lied about his previous convictions and assessed him as low risk.

44. Two days later, on 17 February, he was found not guilty of abduction. He remained at Wormwood Scrubs until 8 March. During his time at the prison, staff apparently found him to be quiet, rarely mixing with other prisoners. They did not record any concerns about him. A copy of the medical record relating to his time at Wormwood Scrubs was provided to the investigator after the draft report was published. The notes show that he sought no medical attention during his time at the prison and that there were no indications of any mental health problems. Healthcare staff recorded no concerns that he might pose a risk to himself.

45. The man appeared in court on 8 March and was remanded into Wandsworth’s custody. He was seen in reception by another healthcare assistant, who noted that he had transferred from Wandsworth and that he was “fit and well”. Again, the Wandsworth medical notes do not record whether the Wormwood Scrubs medical record arrived with him, and if so, whether any member of staff read it.

46. On this occasion, staff agreed that the man’s CSRA risk level should remain high for one month. He agreed that he needed to address his anger management problems and work towards sharing a cell. He was told he should apply to do the

Enhanced Thinking Skills course (a prison programme targeting offending behaviour) and an anger management course. He was given a single cell on A wing.

47. Two days afterwards, on 10 March, he was found guilty of wounding with intent, attempted robbery and carrying a knife in a public place. The judge asked his offender manager (formerly known as a probation officer) to review his dangerousness to help decide what sentence he should receive. It appears that the judge was considering sentencing him to an indeterminate sentence for public protection (IPP) and may have said so to him in court. In the meantime, he was remanded back into custody.

48. On his return to Wandsworth, he was seen by a third healthcare assistant. She recorded that he was “fit and well”. The deputy head of healthcare explained that, ideally, a “change of status” examination is carried out when a prisoner returned from court, in practice, this does not always happen. (When a prisoner is convicted or sentenced at court, this is known as a “change of status”. Because receiving bad news in court may increase a prisoner’s risk to himself, it is considered good practice to carry out a healthcare screen to assess their mental state.) It appears that he did not undergo a change of status assessment.

49. A nurse examined the man on 26 March and made two entries in his medical record. The first noted that he had “superficial lacerations” on his left hand. He said he did not need any pain killers but the nurse cleaned and dressed the wound. The second entry recorded that he was refusing to transfer to another prison, saying he felt unwell. The nurse took his pulse and blood pressure (which were both normal) and read his temperature (which was also normal). The investigator spoke to the nurse about her examination of the man. She could not remember ever having met him and could not recall any further details about her entries, including how he had injured his hand. The prison has no information regarding the transfer she mentioned in her entry. There is no other mention of him having cut his hand and neither is there any indication that the nurse considered opening the ACCT procedures.

50. The man appeared in court again on 8 April. Due to staff sickness, the review of dangerousness had not yet been completed and so sentencing was adjourned until 30 April.

51. During the course of the investigation, the investigator spoke to the man’s community offender manager. She thought it likely that he knew the court was considering an IPP sentence. She completed the Assessment of Risk of Serious Harm for court (the review of dangerousness). She highlighted that he had previous convictions for other violent offences, which, together with his current offences demonstrated a “pattern of behaviour which places the public at risk”. She concluded that he posed a “high risk” to the public. In the report, she concluded that custody was “inevitable”.

52. As part of the investigation, the investigator interviewed a senior officer (SO), one of the A wing managers. He said that A wing has a high turnover of prisoners

and holds a very mixed population, with some prisoners on remand and some sentenced. He explained that, because of these factors, it can be hard for staff to get to know the prisoners living on the wing. However, the SO said that he is generally more familiar with those prisoners who cause trouble or who are being monitored (for example under the ACCT process). He said that A wing is considered to be a relatively stable and quiet wing.

53. The SO said that he did not know the man well. A few days before his death, he spoke to the SO about getting access to a Playstation he had brought with him from another establishment. The SO told him he would look into the matter. He said that he had never had any reason to worry about him and that staff on A wing did not raise any concerns about him, either during daily staff briefing meetings or at other times. The SO was aware that he was assessed as high risk on his CSRA (and was one of 26 such prisoners on A wing at the time) but had never been told of any problems between him and other prisoners. The SO said that he was polite and a “model prisoner” who attended Muslim prayers and often prayed in his cell.

54. The investigator asked the SO whether staff would normally be told if a prisoner had received news about the sort of sentence he could expect. The SO said that this does not happen often as the courts do not routinely pass such information to the prison. In his view, although it might be helpful for staff to know, the number and turnover of prisoners on the wing meant that it would be difficult to remember the specific circumstances of each individual. He said, however, that prisoners are often confused about IPP sentences and may be told incorrect information by other prisoners. He thought it would be helpful if staff were able to explain how the sentence works and allay their concerns.

55. The SO said that he saw the man every day that he was on duty in the days before his death. The man acknowledged him on each occasion that they saw each other and gave no signs that anything was troubling him.

56. The investigator also spoke to a distant cousin of the man and also living on A wing. He described the man as chatty and open and said he was often laughing and joking with other prisoners. As far as he was aware, the man had no problems with other prisoners and was not being bullied or in any trouble.

57. As the man’s cousin had been living outside the United Kingdom for some time, he did not know very much about the man’s life outside prison, but he said that there were no signs that anything was wrong. The man’s cousin attended full time education at Wandsworth so did not spend a great deal of time with him. However, he said that the two men talked daily and attended prayers at the mosque together every Friday.

58. The man’s cousin told the investigator that in the period before the man’s death, prisoners were locked in their cells much more than usual due, he thought, to staff shortages. He said that some prisoners found this easier to cope with than others. He thought that the man was someone who could cope, but said that it could be hard when prisoners were not allowed out of their cells for showers or to

make telephone calls. He said he last saw him on Saturday 17 April, the day before he took his life, when they had said hello to each other.

59. One Sunday in April, the A wing SO was working on the wing from 7.30am until 5.00pm. He remembered that, due to staff shortages, prisoners were not unlocked very much over the weekend. However, he thought that A wing prisoners had been unlocked for a period of exercise during the day. The SO saw the man when he came to collect his lunch and again at tea time, at around 4.00pm. He appeared to be fine and did not talk to the SO, or raise any concerns with staff. The SO was clear that if he, or any other member of staff, had any concerns about a prisoner, they would begin the ACCT process.

60. A second SO began his shift at 5.00pm that evening. Due to staff shortages, he was working as an officer on A wing. He was interviewed during the investigation and said that he received a handover from the day staff at the beginning of his shift. No mention was made of the man, or any concerns about him. He was the only officer on A wing until 8.45pm. He explained that all of the prisoners on the wing were locked in their cells at 5.00pm and that only those being monitored under the ACCT process, or for some other reason, had to be checked regularly. There was no reason for him to check the man, who was not being monitored under any special procedures. He said that he walked around the A wing landings and responded to cell bells. (Each cell at Wandsworth is fitted with an emergency cell bell which prisoners can use to alert staff. They are intended to be used in emergency situations and can only be turned off by a member of staff pressing a button outside the cell.) The man did not use his cell bell that evening.

61. At about 8.00pm, the SO began to carry out his roll check before the night staff arrived. During a roll check, each prisoner is checked and counted and the cell doors are checked to make sure they are locked. When he reached the man's cell, he looked through the observation panel in the cell door and saw him sitting at the end of his bed. Although the cell was only occupied by him, it contained bunk beds. The SO spoke to him and, on receiving no reply, looked more closely. He realised that he had tied a ligature made from a bedsheet around his neck and to the frame of the top bunk bed.

62. The SO unlocked the cell and went in. As he did so, he blew his whistle to alert staff on other wings to an emergency. In his statement, written shortly after the man's death, he explained that he also used his radio to tell staff in the control room that there was a "Code 1" situation and giving the cell location. He explained that Code 1 signifies that someone is hanging. On hearing the call, a member of staff from the control room called for an emergency ambulance.

63. The SO lifted the man's body weight to relieve the pressure on his neck and used his anti-ligature knife to try to cut the ligature. Because the ligature was thick, he could not cut through it. By this point he had been joined in the cell by an officer, who had heard the Code 1 call over his radio and made his way to the cell with the duty manager, and the Developing Prison Service Manager (DPSM) on duty. The officer and SO untied the ligature and laid the man on the cell floor.

64. Two nurses were the only two members of healthcare staff on duty that evening. They were in the A2 treatment room (which is on the landing below the man's cell) sorting out the evening medication when they heard the emergency radio call. One of the nurses was carrying the emergency healthcare radio, meaning that he had to respond to any medical emergency in the prison. He picked up the emergency response bag and the other nurse brought the bag containing the oxygen cylinder. As they were already nearby, they arrived at the cell very quickly.

65. The nurses arrived as the officer and SO were laying the man on the floor. They checked him for signs of breathing or a pulse. On finding neither, they began cardio pulmonary resuscitation (CPR), with assistance from the officer. The emergency response nurse attached the automated external defibrillator (AED). (An AED is a portable device which detects whether the heart is beating and, in some circumstances, automatically delivers electric shocks to attempt to re-establish a normal heartbeat.) The AED instructed the staff to continue CPR as the man's heart was not beating.

66. The ambulance arrived at the prison at 8.10pm and the paramedics took over the care of the man. An air ambulance team, including an emergency doctor, arrived at 8.25pm. Attempts to resuscitate him continued until 8.36pm, when the emergency doctor pronounced that he had died.

Contact with the man's family

67. On his arrival in prison, the man had not provided any next of kin details. On Monday 19 April a governor who was appointed as the prison family liaison officer and the prison Imam visited what was thought to be the man's parents' address but there was no reply. Prison staff found the mobile telephone number for the man's sister in her brother's file and she agreed to meet the governor and the Imam at her parents' home.

68. Members of the man's family visited Wandsworth to see his cell. During their visit they met members of A wing staff and spoke to his cousin. The prison family liaison officer and another member of prison staff attended the funeral and, in line with Prison Service Order (PSO) 2710 - Follow up to a Death in Custody, the prison offered to make a financial contribution towards the cost.

Support for prisoners

69. The man's cousin found out that the man had died the morning after his death. He was given support by staff and he had one session of counselling. He told the investigator that a memorial service was held at the prison mosque.

70. The A wing SO confirmed that all prisoners being monitored under ACCT procedures were reviewed and offered additional support. (This allows staff to check whether other vulnerable prisoners have been affected by the news of the death.)

Support for staff

71. Shortly after the man's death, a hot debrief was held for all of the staff involved. (The hot debrief should be held immediately after the incident and provides a chance for staff to talk about events and share their feelings. It is a requirement of PSO 2710.) Staff interviewed during the investigation said they had been offered support by the prison, although one nurse said he would have liked more support.

ISSUES

The man's mental health

72. The local PCT commissioned a clinical reviewer to undertake a review of the clinical care the man received. His review is attached as annex 1. The man presented with only minor physical health problems while in custody but the issue of his mental health was rather more complicated.

73. It is worth noting from the outset that mental health professionals were unable to agree on whether he did indeed suffer from any mental illness. The medical records relating to his periods at Pentonville provide the most comprehensive discussion of this matter. They indicate that, while held at the prison, he had regular contact with the MHIT and was prescribed medication as a result. He told staff that he had spent time as an inpatient at a local psychiatric hospital (although this was never confirmed and he later denied it).

74. Staff recorded that he might suffer with schizophrenia. However, in June 2009, in relation to a previous court case, the man was assessed by a psychiatrist. The author of the report concluded that he did not suffer with a mental illness. The psychiatrist suggested that, in fact, he frequently gave untrue or misleading information to healthcare staff, perhaps to facilitate an earlier release from prison. On his arrival at Wandsworth in July 2009, he denied any history of mental illness. Staff and prisoners at Wandsworth interviewed during the course of this investigation said that they had never had reason to worry about his mental health.

75. However, I am concerned that the transfer of medical information between the prisons involved is not sufficiently robust. Prison Service Order (PSO) 3050 - Continuity of healthcare for prisoners, paragraph 5.3 instructs that *"[c]urrent healthcare needs are assessed and continuity of care ensured when prisoners are transferred between establishments …"* (all mandatory instructions are printed in italics). According to the PSO, this includes *"[t]he identification of physical and mental health problems …"*.

76. The Deputy Head of Healthcare explained that any prisoner transferring to Wandsworth from another establishment should be accompanied by their medical record. (This takes the form of either a full paper record, or a print out of the electronic record. At present, prisons across England and Wales use a variety of clinical recording systems. Although the majority of prisons now keep electronic records, those created in one prison are not accessible to staff working in another prison. As a result, a paper print out of the record must be provided.) She said that, in theory, reception staff should refuse to accept any prisoner whose record has not been provided. However, she also said that in practice it is more common for the transferring prison to be asked to courier the medical record to Wandsworth immediately.

77. The man transferred from Pentonville to Wandsworth on 3 September. The Deputy Head of Healthcare explained that reception is normally staffed by both a nurse and a healthcare assistant. The nurse should review all the medical

records as they are received and decide whether there are any health concerns requiring a referral to the doctor or other specialist service. Where there are no concerns about the prisoner's health, he will be briefly assessed by the healthcare assistant before leaving reception.

78. An entry in the man's medical record indicates that he was seen by a healthcare assistant. She noted that he was fit and well. The entry does not record whether the Pentonville medical records arrived with him or not. If they did, there is nothing to indicate that any staff read them or noted his extensive mental health history. The Deputy Head of Healthcare explained that the healthcare assistant has since been dismissed from her position (on unrelated matters). The two nurses on duty that day are unable to recall whether they saw his medical records.

79. On 8 March 2010, the man transferred from Wormwood Scrubs to Wandsworth. Again, there is no mention of any medical record accompanying him or any staff noting his complex mental health history.

80. The man is not alone in being transferred between different London prisons. My office has investigated the deaths of several prisoners whose circumstances were not helped by frequent moves and relatively short stays. The reasons for his moves are related to the location of his offences and the various courts which he was remanded to. This is a complex issue which no doubt taxes many officials in the National Offender Management Service. As such, I accept that transfers are likely to continue and so make no recommendation in this regard. However, because they are undoubtedly inevitable, it is all the more important that prisoners' records are moved at the same time.

81. While I accept that Wandsworth staff saw no signs that the man suffered mental health problems, I am very concerned that they were unaware of his recent history and treatment. The Deputy Head of Healthcare confirmed that, on the basis of the information contained in the Pentonville records, reception staff should have referred him to the MHIT.

82. The clinical reviewer notes that "throughout the NHS, patient care is hampered by the lack of availability of paper records". This is a situation which, he says, has been "markedly improved" in general practice by the use of effective electronic clinical systems. The Deputy Head of Healthcare confirmed that Wandsworth is moving to the SystmOne electronic clinical system in mid-October. She said that this should bring about improvements as every prison using SystmOne will be able to access all of the records held on the system (including prisoners held at different prisons).

83. Clearly, I welcome any improvements to the current system. However, until SystmOne is in place in all prisons in England and Wales, there is still the opportunity for omissions like this to occur. Moreover, this is not the first investigation concerning a death at Wandsworth in which crucial paperwork relating to the prisoner's time at another prison has been missing. Nor is it the first time that the medical record relating to a prisoner's time at Pentonville has either not arrived or not been acted upon at Wandsworth. The clinical reviewer

suggests that the medical record transfer process be reviewed and so I make the following recommendation:

The Head of Healthcare should:

- **review the medical record transfer process**
- **ensure that a robust policy exists, providing clear guidelines on receiving and responding to information contained in medical records.**

84. It is also disheartening to learn that the system for referring patients between the MHITs at Pentonville and Wandsworth failed on this occasion. An entry in the Pentonville record indicates that a member of staff left a message for the Wandsworth MHIT, telling them that the man had transferred to the prison. I have not been able to establish whether anyone at Wandsworth was aware of the message, certainly the MHIT had no contact with him while he was at the prison. The Head of the MHIT at Wandsworth said that the team does not accept telephone referrals in any case, and a paper referral form must be completed and sent or faxed to the prison. She thought that most other London prisons were aware of this procedure. The Head of the Pentonville MHIT had no knowledge of such a system.

The Head of the Mental Health Inreach Team should ensure that the referral process is widely publicised and explained to relevant staff at those prisons most likely to refer patients.

The man's alleged violent behaviour

85. On 1 November 2009, the man was allegedly seen punching a fellow prisoner in the face several times. As a result he was placed on report and spent two days in the CSU. Although adjudication proceedings began, the charge was eventually dismissed because too much time had elapsed.

86. According to PSO 2750 - Violence Reduction, *"[p]risoners involved in unacceptable behaviour towards others must be appropriately and consistently challenged and given support to improve their behaviour"*. The PSO includes a number of mandatory directions for how the prison should respond to such behaviour. It directs that *"[a]ny incidence or pattern of unacceptable behaviour must be clearly recorded on the prisoner's history sheet"*. Furthermore, *"[t]he officer in charge of the wing must ensure that important information affecting prisoner safety arriving on the wing … is prominently recorded in the wing observation book and drawn to the attention of wing staff."* No mention of the man's alleged assault on the other prisoner is made in either his wing history sheet or the wing observation book.

87. The investigator was provided with a copy of Wandsworth's local Violence Reduction Strategy 2009-10. The strategy directs that incidents of physical violence be reported and recorded accurately. Perpetrators of violence should be monitored via anti-social behaviour booklets. The strategy goes on to list a number of places where information about the incident should be logged. There

is no evidence that any action was taken in response to the incident, save for moving the man to the CSU to await adjudication.

The Governor should remind staff of their responsibilities under both PSO 2750 and the local Violence Reduction Strategy.

Staff shortages

88. During the course of the investigation, the man's friend and fellow prisoner mentioned that staff shortages in the weeks before the man's death had meant that prisoners on A wing were locked in their cells more than usual. It is possible that additional time spent alone, without access to telephones and the support of friends, might negatively impact on the frame of mind of an already vulnerable prisoner. As such, it is an issue I have given some consideration to.

89. Wandsworth's Minimum Staffing Levels Document details that from Monday to Thursday, A wing should be staffed by a minimum of eight officers (including a senior officer) during the day and six in the evening. On Friday, when no evening association is held, the minimum staffing levels are eight officers during the day and two during the evening. At the weekend, there is no evening association and so the wing must be staffed by at least seven officers during the day and one in the evening. The minimum staffing levels allow for a "decent, basic regime" to be provided, including serving meals, exercise, visits, association, changing bedding and clothes and access to healthcare.

90. The prison also provided a breakdown of staffing levels across the establishment for the period between 5 April and 20 April and the diary sheets noting restrictions to the normal regime for the same period. A wing was staffed by fewer than the minimum level set out above on six occasions (once after the man's death). However, according to the diary, the wing regime was affected only three times (again, once after the man's death). On 9 April, the diary sheet notes that the wing regime was "curtailed". On Sunday 18 April, all of the main prison wings were shut down early (after the meal had been served at about 4.00pm).

91. On the evidence provided, it appears that A wing suffered relatively minor regime changes during the two weeks prior to the man's death. Staff shortages will inevitably impact on the lives of prisoners, but it seems that this impact was limited, as far as possible, by the prison management team. I have seen no evidence to suggest that he made any official or unofficial complaints about the impact staffing shortages were having on him. It is also worth noting that his cell was equipped with a television and that staff said that they often saw him reading holy books in his cell.

The sentence the man was likely to receive

92. At the time of his death, the man had been found guilty of three serious offences and was awaiting sentencing. He had quite recently been found guilty of robbery and sentenced to 12 months in prison. Documents considered during the

investigation and interviews and conversations with staff indicate that he might well have known that the sentencing court was considering an IPP sentence.

93. Reviews by HMCIP and the Prison Reform Trust suggest that prisoners who receive IPP sentences are confused by them. They are not always clear how long they will have to serve before release, or what courses they will need to complete before release is considered by the Parole Board (the independent body charged with assessing a prisoner's risk and deciding when they are suitable for release).

94. Of course, there is no way of knowing what was going through the man's mind in the days leading to his death. However, it is possible that the knowledge that he might be facing a considerable sentence increased his vulnerability. That said, he gave no indications, either to staff or his friend at the prison, that he was particularly worried about his upcoming sentencing. Certainly, he gave staff no opportunity to calm his fears or put in place any additional support.

The emergency response

95. The man was found during a routine check at about 8.00pm on 18 April. The SO who found him, used his radio and the correct code to alert the prison to the incident. He quickly went into the cell to try and cut the ligature and help the man. Other staff joined him within minutes, and due to their proximity, healthcare staff arrived very quickly with emergency first aid equipment. Despite their best efforts, the use of a defibrillator and the arrival of the paramedics, he could not be resuscitated.

96. I am pleased to find the response on this occasion was very efficient. Neither the clinical reviewer nor I have identified any shortcomings and I am pleased to note staff's professional handling of the situation.

CONCLUSION

97. The man was remanded into the custody of Wandsworth on 20 July 2009, charged with several serious offences. He had been convicted of other serious offences in the past and had served several prison sentences. At the time of his death, he was awaiting sentencing and, it seems, knew he might be facing an indeterminate sentence.

98. Whether or not he suffered mental health problems is a matter of some question. He had received treatment in the past and at other prisons, but there was evidence to suggest he fabricated details of his illness, perhaps in the hope of a shorter sentence.

99. During his time in prison, he moved between Wandsworth, Pentonville and Wormwood Scrubs. He is not alone in moving so often and, on this occasion, it seems that the transfers were inevitable. Sadly, this investigation has highlighted procedural failures which meant that important information about his mental health did not transfer with him. However, despite these failures, I have found no evidence to suggest that staff at Wandsworth had reason to worry about his vulnerability or risk to himself. At no point during his time on remand was he monitored under suicide or self harm prevention procedures and I have seen nothing to suggest that he should have been. I do not think that staff at Wandsworth could have anticipated his actions or, therefore, prevented them. I make three recommendations, but do not think that any would have prevented his death.

RECOMMENDATIONS

At the draft report stage, the National Offender Management Service (NOMS) responded to the recommendations made. That response is included in italics below each recommendation.

1. The Head of Healthcare should:
    - review the medical record transfer process
    - ensure that a robust policy exists, providing clear guidelines on receiving and responding to information contained in medical records.

    This recommendation was accepted. NOMS responded:

    "The prison service national IT system, System 1, has now been introduced at Wandsworth. This will greatly enhance the transfer of data from prison to prison. We are reviewing our reception processes and will produce within that review a robust policy for nursing staff. This policy will address issues on receiving and responding to information contained in medical records."

2. The Head of the Mental Health Inreach Team should ensure that the referral process is widely publicised and explained to relevant staff at those prisons most likely to refer patients.

    NOMS accepted this recommendation, noting that

    "A referral protocol will be sent to all London, local prison In-Reach teams explaining how that team should refer to our service if a prisoner has been transferred to Wandsworth. The protocol will include a copy of our referral form which can be faxed directly through to in-reach's team base."

3. The Governor should remind staff of their responsibilities under both PSO 2750 and the local Violence Reduction Strategy.

    NOMS accepted this recommendation:

    "The local Violence Reduction Policy and Strategy has recently been updated – copies are available in all areas.

    There is currently a full review being conducted on the reporting and recording of violent incidences to ascertain how the current systems can be improved. There was recently a full review of the IEP scheme at Wandsworth. Significant changes have been made and the new system is due to roll out in the coming weeks."