Investigation into the circumstances surrounding the death of a man at HMP Wandsworth in May 2007

Report by the Prisons and Probation Ombudsman for England and Wales

December 2009

This is the report of an investigation into the circumstances of the death of a man at HMP Wandsworth. He was nearing the end of a three year sentence when he was found hanging in his cell in the prison's care and separation unit in May 2007. He was 44 years of age.

I extend my sincere condolences to the man's family and friends for their loss.

The investigation was carried by one of my colleagues. A clinical review was carried out by the local Primary Care Trust. I would like to thank the then Governor of Wandsworth, and his staff for their help and assistance.

A feature of the last few months of the man's life were repeated incidents of disruptive behaviour: causing damage to cells and engaging in what are known as 'dirty protests' (smearing cells with his own excrement). He also refused food on many occasions. I believe that his death is the first I have investigated where the prisoner was actively engaged in a dirty protest at the time. The indications are that it was his feelings of perceived injustice that triggered this behaviour. Unfortunately, it seems that he would not engage with most of the staff which limited Wandsworth's chances of helping him with any problems.

The first draft of this report was issued in September 2008. In response to comments received from the solicitors representing the man's family, I agreed to conduct further inquiries. This report reflects my reconsideration of the issues. I make five recommendations in this report. The text also draws one other matter to the attention of the Governor.

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.

Stephen Shaw CBE
Prisons and Probation Ombudsman **December 2009**

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SUMMARY

The man was 44 years of age and was serving a three year sentence for arson. He was discovered hanging in his cell in Wandsworth's care and separation (CSU) unit on an evening in May 2007.

The man had been transferred to Wandsworth in July 2006 having spent his first eight months of custody in HMP Brixton. This was arranged as an inter-prison transfer following an allegation that the man had assaulted an officer in Brixton.

From March 2007 onwards the man's files record a number of instances of him causing damage to cells and of engaging in dirty protests. A feature in his case was his apparent refusal to engage meaningfully with the majority of staff he encountered so it is not entirely clear why he was taking part in dirty protests. However, one clearly documented instance was when he told an officer that he was going to start a dirty protest as his toilet roll had run out. On another occasion he started a dirty protest after complaining that he had not received his medication.

In April, the man damaged his cell. He was charged under Prison Service rules for his actions and this led to him being punished two days later with cellular confinement and loss of certain privileges. Later on that day he told staff that he had taken an overdose of his in-possession medication. An ambulance was called and staff also opened an ACCT[1] form. The ACCT form was closed the following day when the man admitted that he had not in fact taken an overdose. He explained that he made the claim because he was angry about the way he felt he was being treated. To try to defuse the situation he was moved to a different prison wing and the punishments of cellular confinement and loss of privileges were suspended.

The man's conditional prison release date was May 2007. However, 42 days were added to his release date in punishment for the dirty protest in March (the consideration of his actions had been adjourned a number of times). His new conditional release date then became July 2007.

In May, the man was involved in a fracas with another prisoner. It seemed to staff that he was the aggressor and after being restrained he was first taken to the CSU before being relocated to a different prison wing shortly after. Within 90 minutes of being located in the new wing the man damaged his cell and he was moved back to the CSU.

The following day, the man damaged his cell in the CSU and was moved to the only other cell available in the unit. This was a 'special accommodation' cell[2]. At around midday, the man started a dirty protest. At about 4.40pm that afternoon staff went to his cell to give him the opportunity to end his dirty protest and to have a shower.

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[1] ACCT (Assessment, Care in Custody and Teamwork) is the process for monitoring and supporting prisoners who might be at risk of self-harm or suicide.

[2] Special accommodation cells are designed to deal with particularly challenging or refractory prisoners where time is needed to de-escalate the situation. These cells may also be used for prisoners on a dirty protest for whom the safest and most hygienic option is a cell with no furniture.

They also offered him food and water. He is documented to have become aggressive and staff again restrained him.

Because the man was occupying a special accommodation cell he was visited that same afternoon by a member of the Independent Monitoring Board (IMB)[3]. He told the IMB member that he was going to hang himself. His comment was part of an angry tirade. The IMB member recorded the comment in the man's history sheet, in the special accommodation record (the OTO13) and in the IMB report book. The IMB member said he thought that two or three officers were within earshot of the man's shouted comments (including the one about hanging himself), but none of the staff who spoke with my investigator recalled hearing his comments. The IMB member did not open an ACCT form, partly because he understood that there were no ligature points in the cell, but also because the remark was part of a long aggressive 'rant' about the prison, its staff, the doctors and the IMB. He did not believe that the man had any real intention to kill himself. None of the staff present read the entry made by the IMB member, although he said that he brought his entries in the records to the attention of the duty senior officer on the unit and the desk officer. Neither of these two staff recalled being told of this. The man ended his dirty protest not long afterwards and, after taking a shower, was moved to a new cell.

The following morning the man started a new dirty protest, this time apparently because of a delay in delivery of his medication (prescribed for a trapped nerve). He continued on his dirty protest throughout that day and into the next.

Problems with delivery of the man's medication again arose on an evening in May and one of the officers in the CSU made several calls to nursing staff to try to resolve the problem. At one stage the officer was told that the man's prescription chart could not be found. At some time nearing 8.30pm a nurse confirmed that the prescription chart had been found and he would come to the wing to deliver the medication. The officer went to his cell to let the man know. When the officer looked into the cell the man appeared to be sitting on the floor with his back to the wall adjacent to the door. All that the officer could see of the man were his legs. He failed to respond to any questions and so the officer decided that staff had to enter the cell. When they did so, they found the man hanging from a ligature, which he had looped around the light switch. All efforts to try to resuscitate the man proved unsuccessful. At the time of his death, he had only six more weeks to serve of his sentence.

The evidence given by staff at interview was that they did try to engage with the man. However, their efforts would be met either with profanities or by silence. My investigator met only two officers who felt they had a reasonable relationship with him. One of the two said the man would get annoyed over comparatively trivial issues. He would then brood for a while before acting in what appeared to be a disproportionate way.

I make five recommendations. One of these is about 'safer' cells and another is about record keeping and communication. I have made two recommendations about

[3] Each prison has an IMB which is independent of the Prison Service. Its function is to monitor day-to-day activities to ensure that proper standards of care are maintained. Prisoners can speak in confidence to IMB members. IMB members are unpaid volunteers.

monitoring arrangements and have also made a recommendation about the quality of building materials. One other matter is drawn to the Governor's attention.

THE INVESTIGATION PROCESS

1. The investigation was opened in May 2007 when one of my colleagues visited Wandsworth and met a number of prison staff, including the Governor and a representative from the Prison Officers' Association. The investigator informed all those he met of the nature and scope of the investigation. Notices were issued to staff and prisoners notifying them of the investigation. On a subsequent visit he met the chair of the Independent Monitoring Board (IMB).

2. The investigator interviewed 14 members of staff and he spoke to two IMB members who had contact with the man. The investigator also spoke to one of the prisoners who had been in the care and separation unit at the same time as the man. No additional prisoners came forward to give evidence in response to the published notices.

3. The local Primary Care Trust agreed to carry out a review of the man's clinical care and treatment while at Wandsworth.

4. The investigator, together with one of my Family Liaison Officers met one of the man's brothers and with his solicitors. The man's brother was particularly concerned that his brother was being victimised by the staff at Wandsworth. He said one incident included an adjudication punishment that added 42 days to his sentence.

5. The investigator subsequently met the solicitors acting for another of the man's brothers. This brother's concern was about events in May 2007 when his brother was restrained by staff and then taken to the CSU. He said he had heard from other prisoners that staff had used excessive force. He provided the names of the officers whom he had been told were responsible. He said that his brother's solicitor observed the injuries during a visit. He added that the pathologist identified a number of bruises during the post mortem (the post mortem report does mention a number of injuries including fractured ribs as well as bruising). Another of his concerns was about the prison's contact with him following his brother's death. He considered that it should have been easily possible for Wandsworth to discover his address to inform him what had happened.

6. The corridors in the CSU are covered by closed circuit television (CCTV). My investigator viewed the footage taken when the man said he would hang himself and also that taken two days later when he was found hanging in his cell. Timings taken from the CCTV are used in this report to help clarify the sequence of events. However, my investigator discovered that the time shown on the CCTV recording was later than the true time. My investigator was told that any interruption to the electricity supply causes the CCTV clock to stop causing it to lose time compared to real time. Staff at Wandsworth are not able to adjust the system. Comparing the CCTV footage to the time recorded for the emergency call to the ambulance service would suggest that the CCTV clock was running around eight minutes late by then. It is not possible to verify the CCTV timings compared to real time for any other occasion.

HMP WANDSWORTH

7. HMP Wandsworth was built in 1851. It is a local prison and is the largest in London. In May 2007, Wandsworth's operational capacity[4] was 1475 and its actual population was 1473. At that time it ranked as the 11th most crowded prison in the country. The main prison has five wings leading out from a central hub, each with four landings.

8. Although Wandsworth's residential areas remain in the original buildings, extensive refurbishment and modernisation of the wings has taken place. All cells have in-cell sanitation and in-cell electricity is presently being installed throughout the prison.

9. The most recent inspection of Wandsworth by, Her Majesty's Chief Inspector of Prisons was a full inspection in July 2006 following up a previous inspection in May 2004. In her introduction to her report she wrote:

> "This inspection found an effective and united management team that was taking steps to move the prison forward. They had inherited a prison that was performing even less well than it had been at the time of the last inspection … Since then, the prison had clearly improved: with greater confidence among staff and managers, more time out of cell and more activities for prisoners, and an improved focus on safer custody …"

10. She found that the staff working in the CSU had been specially selected for the unit. She reported prisoners saying that most of the staff in the unit treated them well.

11. In their report for the year June 2006 to May 2007 the Independent Monitoring Board (IMB) referred to the man's death saying:

> "One area of concern raised in our report last year has unfortunately had tragic consequences. [We] reported … serious concerns about the robustness of the fixtures and fittings and their potential use in self-harm incidents. Unfortunately there was a suicide in the CSU this year where the light switch fitting was used as a ligature point. The safety for all prisoners is paramount and we strongly recommend that detailed fabric checks are made in the existing CSU and critically in the new CSU [when it moves to E wing] to minimise the possibility of this happening again.
>
> "IMB Board members spend a significant part of their rota visits in the CSU and have continued to be impressed by the professionalism of the CSU staff, particularly when dealing with 'difficult' prisoners.
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> "IMB members attend weekly CSU reviews and are called in when the Special Cell is used or there are serious incidents."

[4] The operational capacity is the total number of prisoners an establishment can hold taking account of organisational factors.

12. Wandsworth's CSU is staffed by six officers on the morning shift (7.30am to 1.00pm), five officers on the afternoon shift (2.00pm to 5.00pm), two officers during the evening shift (5.00pm to 8.30pm), and one officer during patrol shift (the lunch hour and overnight).

13. There were four apparently self-inflicted deaths in 2007 at Wandsworth including that of the man. I have identified no significant similarities between his case and any of the other three. My colleagues and I believe that this man's death is the first I have investigated where a prisoner was actively engaged in a dirty protest at the time of his death.

14. There will usually be a minimum of two officers present when unlocking a prisoner in the CSU. In the case of potentially violent prisoners, the minimum level will be increased.

KEY FINDINGS

Events leading up to the man's death

15. In November 2005, the man was arrested following an incident of fire-setting at the flat where he was living at the time. After spending the night in police custody, he was remanded into HMP Brixton the following day. He was subsequently convicted of arson at the Crown Court.

16. To assist the court with sentencing, a consultant psychiatrist saw the man on two occasions in May and June 2006. During these consultations the man described becoming increasingly depressed in the period leading up his offence. He described injuring his arm months before[5], resulting in difficulty working and loss of income. He said that he had been asked to leave his flat. He reported setting a small fire in the flat early on a morning in November and then spending the rest of the day travelling around central London thinking repeatedly about jumping into the Thames. The psychiatrist concluded that the man's account was consistent with a diagnosis of severe depressive episode without psychotic symptoms. The psychiatrist explained that in general, depressive episodes last between several weeks to several months at a time. It is a condition that often improves on its own without recourse to medical treatment. The man's improvement on this occasion was spontaneous. The psychiatrist pointed out that individuals who have suffered from one depressive episode can experience further episodes in later life and that the man was therefore at risk of this. The psychiatrist also concluded that the man was not currently suffering with a mental illness.

17. The man remained in Brixton until July 2006 when he was transferred to Wandsworth (this was an 'inter-prison' transfer arranged following an allegation that he had assaulted one of the officers at Brixton). He was due to attend court in September for sentencing, and ahead of that the court asked for a further psychiatric assessment. The psychiatrist who saw him on this occasion noted, among other things, that he was not suicidal and that there was no evidence of mental illness. At court, the man was sentenced to three years imprisonment. His conditional release date was May 2007.

18. The man's records at Wandsworth contain little of note until the middle of March 2007. At that time, he damaged his cell in A wing and he was taken to the CSU.

19. On a morning in March, he started a dirty protest. A report on the incident written by one of the officers said:

> "… at [approximately 9.45am] … the man pressed his [cell bell] saying he was going to 'shit up' because he had used up his toilet roll. When I passed one to him he became verbally aggressive. I then checked him again at [10.20am] and he had started a dirty protest by smearing his walls with human excrement, also pushing it into the electric plug points."

[5] This would seem to have been an accidental injury resulting in a trapped nerve.

20. On the following day the man was charged with an offence under the Prison Rules (Prison Rule 51, paragraph 5: "intentionally endangering the health or personal safety of others …"). An adjudication hearing was opened but immediately adjourned because the man was continuing with his dirty protest. He ended his dirty protest later that day and he was moved from the CSU back to A wing.

21. Another adjudication hearing to consider the man's dirty protest was opened later in March. The man said that he would not comment until he had spoken to his legal representative so the adjudication was again adjourned. Arrangements were made for the man to speak to his legal representative. On the next occasion Wandsworth attempted to proceed with the adjudication hearing, the governor dealing with adjudications that day recorded that the man denied the evidence against him. She went on to note: "You have had advice from your solicitor. I'm going to refer the matter to the [district] judge[6] …" The governor told my investigator that her reasons for referring the matter to the independent adjudicator included that the man had created a biological hazard, that he had been refractory and had refused to plead.

22. An entry in the man's records in April said:

> "Smashed up cell, taken toilet and sink off the wall and smashed TV, cellmate had to be moved out of cell and put in new location … very aggressive and abusive. Threatened to throw shit in my face."

23. The man's actions were considered at a further adjudication hearing where he was punished with seven days cellular confinement in the CSU and loss of certain privileges.

24. Later that month, the man told a Senior Officer (SO) that he had taken an overdose of his in-possession medication. The medication was Gabapentin tablets that he had been prescribed to treat a trapped nerve in his elbow. (Gabapentin is not apparently harmful in overdose so it is reasonable for prisoners to keep this medication in their own possession.) One of Wandsworth's doctors noted in the man's medical records that paramedics had been called and they found that his clinical observations were normal, as was an electro cardiograph (ECG). Clinicians at Wandsworth kept him under observation. Staff opened an ACCT form for him to be made subject to special monitoring and support.

25. The following day, the man was seen by the Principal Officer (PO) for an assessment interview. The PO told my investigator that he worked in Wandsworth's safer custody team and his responsibilities included developing awareness of suicide prevention, including staff training such as training in ACCT. The PO had not previously met him. He said that initially the man was suspicious, aggressive abusive and threatening. He made threats of violence

[6] Adjudication hearings are usually conducted by prison governors. However, certain cases can be referred to an independent adjudicator, usually a district judge.

against the staff and he threatened to take his life. The PO said that he allowed the man to vent his aggression after which it became possible to start talking about what it was that he wanted. It emerged that the man was angry about being moved back into the CSU, angry that he was alleged to be a bully and angry about his loss of canteen (prison shop) privileges. The PO told my investigator that it became clear to him that the man's inappropriate behaviour was because he believed he had been treated unfairly. The PO said that he was a nurse by profession and the signs of an overdose of pain killers (Gabapentin) can include confusion and disorientation. The man was showing no such signs and as he calmed he admitted that he had not in fact taken an overdose. He also denied having any intention of harming himself. The PO told my investigator that he negotiated with a governor for the adjudication punishments to be suspended for three months and for the man to be moved to B wing. The PO closed the ACCT form noting:

> "[The man] denied self harm … this form was opened following a claim that an overdose was taken. There is no history of self harm prior to this event … He pointedly denies he is a risk to himself. Given his denial of intent, his relocation to B wing (close to his brother) form closed."

26. The PO said that it was shortly after this day that he next saw the man. The man was much more relaxed and was drinking tea while leaning on the banister rails on B wing. The PO asked the man how he was and he replied that he was fine.

27. A landing officer on B wing told my investigator that he knew the man from his times on the wing. The officer said that he got on quite well with him. The man supported West Ham United and the officer supports Fulham so they exchanged banter about that as well as generally chatting about football. The officer wrote a 'conduct report' in April ahead of an adjudication hearing: "[The man] is normally polite to staff, however on occasion can get frustrated and show this by being abusive and aggressive towards staff." The officer said that comparatively minor issues would annoy the man and, rather than speaking to staff about them, he would brood and then over-react.

28. In May, a district judge considered the circumstances surrounding the events of March when the man began a dirty protest. The man attended the hearing accompanied by his solicitor. The district judge's written comments included that: "[It is] difficult to conceive of a graver risk to health and safety …" The district judge decided to impose 42 additional days – that is, that 42 days should be added to the man's conditional release date. (This is the maximum penalty that could have been imposed and meant that the man's conditional release date of May 2007 was adjusted up to July 2007.)

29. The PO told my investigator that he spoke to the man the day after these days had been added. He said that the man did not seem to care about the decision. That was the last time that the PO saw the man. The PO also said that while the man was a very demanding prisoner, he (the PO) also found him a very rewarding prisoner to work with. The PO said that on a good day, the man was a good person to know.

30. In the early afternoon of a day later in May, the man was involved in an altercation with another prisoner in B wing. The man was restrained before being taken from B wing to the CSU (the purpose of moving a prisoner to the CSU following such an incident is for de-escalation of the situation ahead of relocation of the prisoner to a different prison wing). An officer told my investigator that he was in the B1 landing office when he heard something going on outside. The officer said he saw the man punching another prisoner while holding him in a headlock. The officer said that he was the first officer to arrive and he began to restrain the man. The man continued to lash out so the officer took him to the floor. Other officers arrived and the man ceased struggling. He was placed in handcuffs. The officer helped in escorting the man to the CSU. Two officers walked either side of the man, each holding an arm. Another officer walked just in front of the man, with a further officer just behind. A fifth officer might have been present. The officer said that staff were fully compliant with control and restraint (C & R) procedures and did not use excess force. The officer added that prisoners were out of their cells for association so there were many independent witnesses to the events. He said that once restrained, the man did not struggle. (This area of the prison is not covered by CCTV.)

31. Another officer told my investigator that he heard shouting on B1 landing and then saw the man holding another prisoner against a door. It seemed that the man was striking the other prisoner. The officer, together with two colleagues, restrained the man following the approved procedures for doing so. The man stopped fighting the moment the officers intervened. The officer said that the man appeared to be the aggressor while the other prisoner was passive. For that reason, the other prisoner was not restrained. The officer did not think that he was involved in escorting the man to the CSU.

32. A third officer said that he was on B2 landing when a colleague said that prisoners were fighting on B1 landing. The third officer looked over the railings and saw two prisoners fighting directly below. He could also see officers on their way to break up the fight. The third officer ran across the landing, down a flight of stairs to where the man was being restrained by two officers and an SO. The third officer thought that it would have taken him around 25 seconds to arrive. He said the man was not struggling. The third officer was one of the two officers who held the man by his arms as he was escorted to the CSU. The man did not put up any resistance during the escort. The third officer said that officers receive annual refresher training in control and restraint procedures and those procedures were followed in this instance. Nothing untoward occurred either in the initial restraint or in the subsequent escort to the CSU. The third officer completed an incident report in which he recorded that none of the parties involved seemed to have sustained any injury.

33. The Senior Officer on B wing said that he responded to a whistle call and found the man being restrained on the floor by three officers. By the time of his arrival the man was not struggling. The SO put on handcuffs and the man was allowed to stand. The SO said that all staff acted professionally during the

restraint and in the escort to the CSU. He added that the man was compliant during the walk over to the CSU.

34. My investigator interviewed two other officers named by the man's brother as being involved in the control and restraint incident on this day. Both denied being involved and the control and restraint paperwork supports their assertion.

35. The man's records show that he arrived in the CSU at 3.00pm. While there he was assessed for any injuries by a nurse. The nurse told my investigator that he assessed the man in his cell. Several prison officers were also in the cell. The nurse said that he asked the man how he was and he replied that he was fine and that it was the other prisoner who had started the fight. The nurse told my investigator that the man was angry as he believed he was being treated unfairly. The nurse thought that he spent around five minutes with the man and he recorded that he had sustained no injuries.

36. At 3.30pm the man was re-located to D wing but was returned to the CSU 90 minutes later after damaging his cell on D wing. Control and restraint was not used on this occasion.

37. At just after midday on the following day, the man flooded his cell in the CSU and was moved to a new cell. The only cell available in the CSU was a 'special accommodation' cell. The man was noted to have started a dirty protest within a few minutes of being moved into the special accommodation cell.

38. Prison Service Order (PSO) 1700 covers the use of special accommodation. It explains that:

> "Special accommodation is only to be used to hold, for the shortest necessary time, a violent or refractory prisoner to prevent that prisoner from injuring themselves (as a product of the violent or refractory behaviour) or others, damaging property or creating a disturbance."

39. PSO 1700 also sets out that:

> "Any prisoner who is placed in special accommodation must be taken out of it, or have conditions normalised, as soon as the reasons for its use no longer exist. Planning for the prisoner's return to normal location must begin as soon as he or she is placed in special accommodation.
>
> "Form OTO13 … must be used to record all observations and decisions regarding the use of special accommodation …
>
> "The … designated manager who must be an operational grade of not less than Senior Officer rank … must assess the prisoner's continued location in special accommodation … at least once every hour …
>
> "The duty governor … must specify the frequency at which prisoners will be observed. As a minimum, this will be five times an hour at irregular intervals.

"… Healthcare must be notified immediately and a doctor or registered nurse must attend.

"The time that Healthcare were notified and the time that a doctor or registered nurse attended must both be recorded on Form OTO13.

"An IMB member must be notified and invited to attend as soon as possible and in any case within 24 hours of the prisoner entering special accommodation."

40. The man's OTO13 form records that he was located into the special accommodation cell at 12.35pm. His move was authorised by Wandsworth's Head of Residence who was also the acting duty governor that day. The Head of Residence initially noted that the man should be observed at 15 minute intervals (indicating four observations per hour). The Head of Residence later (at 5.00pm) amended this to five observations per hour. The OTO13 form shows that throughout his time in special accommodation the man was checked, with few exceptions, at very precise intervals: on the hour, at a quarter past the hour, on the half hour and at three quarters past the hour. This pattern continued even after the Head of Residence had increased the observation to five times per hour. There is no evidence of hourly checks by the designated manager.

41. The OTO13 shows that notification to healthcare was made at 1.00pm and that a nurse visited the CSU five minutes later. The OTO13 occurrence log for 1.10pm states:

"Staff and governor at door talking to the man. Medication given."

42. The entries in the OTO13 form show that for most of the first few hours after being placed in the cell the man was sitting asleep in a corner. An entry timed 4.30pm stated:

"Given opportunity to have shower and finish dirty protest. Also given food and hot water. Whilst food was being put in cell [the man] punched the shield[7] hitting staff. [The man] then placed under restraint."

43. The CCTV footage, which covers the corridor but not the inside of the cells, shows that staff opened the man's door hatch at 4.39pm to start talking to him and a minute later the door was unlocked. The reason that staff went to the cell seems to have been to offer the man the opportunity to end his dirty protest as well as to offer him food and water (the special accommodation cell does not have a wash hand basin so any occupant of the cell is reliant on staff for provision of drinks). A total of four officers were involved.

44. In a statement about the incident, one officer wrote that the man accepted a cup of water but declined food and declined to end his dirty protest. The officer

[7] This was a clear plastic shield used to prevent the man from throwing anything at staff.

wrote that the man would not follow instructions to move to the back of the cell but was, instead, standing in the near corner of the cell. As the officer began to close the door the man kicked it causing it to hit the frame and to bounce open again. The officer wrote that at that point he entered the cell holding a security shield in front of him. The man punched the shield which then hit him (the officer) in the face. Two more officers then came into the cell; they placed the man under restraint and with him under control the staff exited the cell. The CCTV recording shows staff exiting the cell at 4.43pm, having entered the cell two minutes and twenty seconds earlier. A report of the incident was noted that handcuffs were not used during the restraint.

45. Another of the officers told my investigator that the man was quite agitated at the time that he hit out at the first officer's shield. He said that it would not have been safe for staff to attempt to lock the door without first putting the man under restraint. The reason for this is that, in order to close and lock the door, the first officer would have needed to put aside his shield and the space was too confined to allow other officers to protect him had the man made a further attempt to hit him.

46. The officer explained to my investigator the Prison Service approved method for safely exiting a cell when dealing with a potentially violent prisoner. He said that the prisoner is lain chest down on the floor with their head facing away from the door. One officer will take control of the prisoner's head and one officer will hold each arm. The prisoner's legs are then put into a figure of four position (one leg being placed behind the knee of the other leg and that leg being bent behind the prisoner's back). The prisoner's arms will also be behind the prisoner's back. In the seconds before the cell is exited, one officer will lay his chest on the prisoner's legs and take hold of the prisoner's arms. This allows two of the officers to leave the cell at which point the final officer leaves also. The position that the prisoner is in, including the position of his legs, means that there is not enough time for him to leap to his feet before the final officer has left the cell. The officer said that he was the officer who applied the leg lock and was therefore the final officer to leave the cell.

47. My investigator asked the officer whether he was aware that the man had a long standing ankle injury and whether applying a leg lock had caused him discomfort. The officer said that he thought the man sometimes used a crutch but he could not recall any reaction from him that day to suggest that the control and restraint process had caused him any pain.

48. None of the statements written by the officers following the control and restraint incident indicates anything unusual about the episode.

49. Following a control and restraint incident a nurse should always try to ascertain whether the prisoner has sustained an injury. The nurse, who had made an entry on the man's OTO13 form earlier that day, was called back to the CSU to examine him. The nurse made a note in the man's records: "Complaining of pain in left hand and knee. [On Examination] no visible injuries."

50. The nurse said that he could not recall whether he went into the cell to physically examine the man or whether he just spoke to him through the door hatch. The nurse said that in the case of a head injury he would want to carry out neurological examinations, but in the case of a non life threatening injury he would be guided by staff in deciding whether or not to go into the cell.

51. A member of the IMB was telephoned at home and told that the man had started a dirty protest and had been moved into special accommodation. The paperwork shows that he was contacted at 4.15pm. He told my investigator that he had been an IMB member for 14 years. When he was contacted that afternoon he decided that he should go into Wandsworth to offer his support both to the man and to the staff. CCTV footage shows that the IMB member arrived in the CSU at 4.56pm and he then went to the man's cell. He told my investigator that the man was in an angry mood. He said that an officer was standing at the cell door and a male nurse arrived with medication. The man had obscured the observation panel with excrement and the officer asked him to clean it so he could see into the cell. The man cleared the obstruction and went to the back of the cell. The officer lowered the observation panel and the nurse dropped medication into his hand. The IMB member could see through the open panel that the man had written an offensive comment on the cell wall.

52. The IMB member told the man that he was from the IMB and asked him if he wanted to come out of the cell and have a shower. The man responded with a general tirade of abuse about everyone working at or associated with Wandsworth: the officers, the clinicians and the IMB. He also said that he would hang himself. The IMB member told my investigator that the man was shouting at the top of his voice and there were two or three officers within earshot at the time. The IMB member commented that the man would not be able to hang himself in the special accommodation cell as there were no ligature points. He said that the officers agreed. The IMB member did not know the names of the officers but he gave my investigator a detailed description of one of them.

53. The IMB member said that he had received training in the ACCT process and in the F2052SH process that was replaced by ACCT. He had opened ACCT forms on previous occasions but he had two reasons for not opening a form for the man. One was that he thought it would have been impossible for the man to kill himself in that particular cell. The other reason was that he did not think it was a serious threat given that it was one remark within a general tirade of abuse. Had he considered the man's threat to be genuine, he would have opened an ACCT form. He might also have opened an ACCT form had he thought it possible for a prisoner to take his life within the special accommodation cell. The IMB member acknowledged though that in his ACCT training he had been told that one should always err on the side of caution. He said that, in retrospect, he should perhaps have opened an ACCT form.

54. My investigator viewed the CSU CCTV footage for that part of the afternoon. At a few seconds before 4.57pm the IMB member is seen standing several feet away from the man's cell door. An officer is shown standing much closer holding a plastic shield in front of the open door observation panel to prevent

the man from throwing anything at either the staff or the IMB member. The officer remained in that position for several minutes during which time the nurse passed him his medication. The CCTV footage shows other officers present at times and also passing his cell as they were going about their duties. For a time another officer was in attendance but was standing further back and to the side of the IMB member. At times, a further officer can be seen standing close to the cell but can also be seen moving away altogether. After standing in front of the man's cell door for just over four minutes the IMB member walked away from the cell to the CSU desk a few metres away.

55. At interview, the officer who was holding the shield said that what passes between prisoners and IMB members is private. If possible, therefore, he tries not to listen to their conversations. The officer could not recall the conversation between the man and the IMB member that afternoon. The officer was still unable to recall the conversation when my investigator tried to prompt his memory by giving him the IMB member's description of it. My investigator asked the officer what he would have done had he heard the man say he would hang himself. The officer said that if he had heard the remark, and thought it a genuine threat, he would have opened an ACCT document. If, like the IMB member, he had not thought it a genuine threat, he would still have reported the comment to his senior officer and probably made a note in the man's records.

56. The nurse told my investigator that he could not recall the man saying that he would hang himself. Had he heard such a remark he would have opened an ACCT form or at least would have spoken to officers about the remark.

57. Two further officers interviewed by my investigator also denied hearing the man's comment that he would hang himself.

58. The CCTV recording shows that the IMB member reached the CSU desk at 5.01pm and he remained there until 5.20pm. In the 19 minutes that he remained at the desk he can be seen talking to staff and completing paperwork. The IMB member made entries in two separate sections of the man's records. These two forms were the man's 'history sheet' (the F2052A form) and the OTO13 form. Both entries were timed 4.55pm. The entry in the history sheet, in its entirety, was:

> "Refused to come out quietly from special cell. Took medicine from nurse. Said he would hang himself."

59. The IMB member's entry in the OTO13 form was very similar. He said that he brought his entries to the attention of both the desk officer and the duty senior officer.

    (Both of the IMB member's entries were timed at 4.55pm. A subsequent entry in the man's history sheet by an officer is timed at 4.35pm.)

60. The desk officer told my investigator that he had worked in the CSU for just over a year. He also said that he was a trained ACCT assessor. The desk officer knew the man from the times he had been in the CSU. He described

him as a challenging prisoner. The desk officer explained that the CSU officers take turns in acting as the day's desk officer. The role comprises sitting at the desk at the head of the CSU observing what was happening in the unit and making entries in the prisoners' records. Although the IMB member spent 19 minutes at the desk, talking and making entries in the man's records, the desk officer could not recall him saying that the man had threatened to hang himself. Although the desk officer made entries in both the man's history sheet and the OTO13 form immediately following the entries made by the IMB member, the desk officer said that he did not read the IMB member's entries. He explained that because of the amount of form filling required when acting as desk officer it was not his practice to read preceding entries in the various forms. As a result he was not aware at the time of what the IMB member had written. The desk officer said that if he had been aware of the threat made by the man he would have spoken to the IMB member about opening an ACCT form.

61. The CSU SO told my investigator that his shift finished at 5.00pm. He would have left the CSU before that time to go to the centre office to brief the Orderly Officer. The CSU SO thought that he had already left the unit by the time the IMB member went to see the man. The CSU SO added that all of the officers in the unit would have opened an ACCT form if they were aware that the man had threatened to take his life.

62. The Head of Residence told my investigator that the role of the duty governor includes visiting the CSU to see all the prisoners in the unit. She will ask them if they are okay, if they have any complaints and whether there are any issues they wish to raise. For prisoners located into special accommodation, the duty governor is required to authorise the move and is also required to specify the frequency of observations by staff. The OTO13 form is used for this purpose. The Head of Residence said that she would have spoken to the man as a matter of course although she could not actually recall doing so. Nor could she recall any previous contact with him. The Head of Residence made two entries on the man's OTO13 form. The first entry was at 12.30pm and the second at 5.00pm. The Head of Residence did not read the man's paperwork and so did not see the entry made by the IMB member. She acknowledged that she should have read the papers and said, had she done so, she would have spoken to him about whether he thought the man intended to act on his threat. The Head of Residence said that the officer should also have checked the preceding entry in the man's records, although she pointed out that the desk officer's role can be a busy one with a lot of things happening at the same time.

63. At 5.30pm the OTO13 was noted to say that the man had squeezed his food under the cell door onto the landing. He shouted that he did not want the food so the staff could keep it. Half an hour later he was noted to have poured water under his door onto the landing.

64. The next entry in the OTO13, made at 6.15pm, said that staff had spoken to the man who had agreed to end his dirty protest. After having a shower he was moved to a new cell. This was a safer cell (one designed to minimise opportunities of self-harm). He was moved into this cell not because he was believed at risk of self-harm, but because it was the only clean and undamaged

cell remaining in the CSU. The final entry on the OTO13 form was made at 8.00pm.

65. At 9.45am the following morning another IMB member made the following entry in the man's records:

> "Spoke to [the man] who stated he would start a dirty protest unless he was given his medication immediately and [I] told him to give 5 [minutes] for me to determine position by which time he had smeared walls."

66. PSO 1700 stipulates that prisoners on a dirty protest must be seen by a doctor on a daily basis. The man was visited by one of the prison doctors who noted that he was fit and well.

67. Another CSU SO told my investigator that at the time the man was in Wandsworth medication would be issued to prisoners in the main prison first. Once that was done the nurses would then visit the smaller units, such as the CSU, to distribute medication to prisoners in those locations. One of the effects of that system was that there could easily be a delay before prisoners in the CSU received their medication. Since the man's death, the system has changed. The CSU now receives a separate delivery of medication direct from healthcare.

68. Talking in general terms, the second CSU SO said that the man was a difficult prisoner to deal with as he would not interact with staff. His response to offers of help would tend either to be to reply with profanities or with silence.

69. The man continued with his dirty protest throughout the rest of the day. His actions in damaging his cell the previous day were considered at an adjudication hearing. He was found guilty and he was punished with loss of access to canteen (purchases from the prison shop) for 14 days.

The day of the man's death

70. With the man continuing with the dirty protest started the previous day, an officer made the following note at 8.00am:

> "Tried to speak to prisoner. No response. Cell dirty and prisoner refusing food/showers. Being totally uncooperative."

71. At some time between about 9.00am and 10.00am, a doctor visited the CSU to see the man. The doctor made the following note: "CSU. Dirty protest. States well. No fresh complaint." The doctor told my investigator that to help in his work as a prison doctor he did some work as a psychiatric hospital doctor. He felt that this experience had equipped him in identifying those suffering from mental illness. He thought that he had a reasonable relationship with the man. He said that he would engage with him and answer his questions. His comment about "no fresh complaint" meant no fresh complaint of any type, whether clinical or non-clinical. There was nothing about the man's demeanour that morning to suggest that he might have been at risk. At around the same

time that morning a healthcare nurse assessed the man and found him fit to remain in segregation.

72. Wandsworth's Deputy Head of Operations was the duty governor on the day of the man's death. The Deputy Head of Operations saw the man at just after midday when she approved his continued segregation. She told my investigator that she tried to speak with the man but, as had happened with their several previous encounters, he failed to engage with her. (Almost all of the staff to whom my investigator spoke gave similar evidence about his refusal to interact or even to acknowledge them.)

73. The man's records show that he remained on dirty protest throughout the rest of that day. His records also show that he refused his lunch and evening meal. (The man regularly refused meals, tending instead to rely on items purchased from the canteen.) A note was made that he declined to answer when offered a shower (and therefore the opportunity to end his dirty protest) at 3.00pm.

74. An officer on duty that evening told my investigator that the man never wanted to interact with staff. The man would have been asked each time staff went to his cell whether he wanted to take a shower and end his dirty protest. Most of the time he would not acknowledge the officer, and when he did speak it would be to swear. A dirty protest monitoring sheet records 12 contacts with him between 8.00am and 8.00pm. The last three entries were made by the eveing officer. The penultimate entry was at 7.00pm when he was noted to have refused hot water. The final entry was at 8.00pm when he was noted to be asking for his medication.

75. The evening officer said that there had been a delay with the man's medication that evening as the nurse was unable to find his prescription chart. The evening officer telephoned the nurses' office several times to chase this and told one of the nurses that the delay was unacceptable. The evening officer's final telephone call to the nurse was at some time after 8.00pm when the nurse confirmed that he had found the prescription chart and would be coming to the CSU with the medication. The evening officer went to the man's cell to let him know. The CCTV recording shows the evening officer going to the man's cell at 8.16pm. His body posture as seen on CCTV indicates that he was having difficulty in observing the man (the eveniing officer can be seen leaning forwards with his face close to the cell door observation hatch. He appears to be straining to look into the right hand near corner of the cell). When my investigator observed the CCTV footage in company with the evening officer at a second meeting with him some time after the man's death, he (the evening officer) was unable to recall the detail of this contact with the man. The footage shows the evening officer placing his hand high on the wall outside the cell and my investigator asked if he was switching off the cell bell light[8]. The evening officer could not recall what he was doing with his hand but said it was too high on the wall for It to be connected with the cell bell light.

[8] When a prisoner presses the cell bell an audible alarm is sounded and a light outside the cell illuminates. The alarm can be muted from the wing office but the light can only be switched off at the cell itself.

76. The next time that the evening officer went to the man's cell was at 8.30pm. He told my investigator that the man would generally be on his bed but when he (the evening officer) looked into the cell at 8.30pm he could only see his legs. It seemed to the evening officer that he was sitting on the floor with his back against the wall adjacent to the door. The evening officer called the man's name but got no reply. The evening officer said that he was not sure what the man was doing, but he was very concerned as he would usually be on his bed. The evening officer was also concerned for his own safety in view of the man's history. After a few seconds of trying to obtain a response from him, the evening officer decided that staff should go into the cell. He went to the wing office to collect gloves, a protective shield and support from one of his colleagues. They went back to the cell where the evening officer again looked into the cell and again tried to speak with the man. There was still no response from him and at that point the evening officer unlocked the door. The CCTV recording shows staff entering the cell a little after 8.31pm. The evening officer said that the man was sitting on the floor. There was a ligature around his neck made from a strip of bedding material that had been looped around the light switch. Staff lifted his body and removed the ligature. The evening officer checked him for a pulse but found none. The evening officer had received medical training when in the army and he commenced efforts to resuscitate the man with chest compressions and mouth-to-mouth breathing using a face shield.

77. While the evening officer was attempting to resuscitate the man, his colleague contacted the control room to announce a code one alarm (indicating a medical emergency). The control room called for healthcare assistance and after doing that telephoned 999 for an emergency ambulance. The evening officer continued his attempts to resuscitate the man until relieved by healthcare staff at 8.36pm (as indicated on CCTV). Ambulance paramedics arrived nine minutes later and they assisted with the efforts at resuscitation. Records made by the paramedics indicate that at one stage the efforts at resuscitation were proving successful but, when the man was again checked with a defibrillator, it showed that there was no longer electrical activity in his heart. All efforts at resuscitating the man proved unsuccessful and he was pronounced dead at 9.01pm[9] by one of the prison doctors. He had not left a suicide note.

The method by which the man secured the ligature

78. The Head of Residence explained to my investigator that when prisoners are located into the CSU they are usually provided with a plate, a mug and cutlery. These items are made from hardened plastic (the exception in providing these items would be in the case of a prisoner deemed a risk to himself or others). Prisoners hand in their plates after they have eaten but they can choose to retain the mug and cutlery if they wish. One reason for retaining cutlery would be to eat canteen items.

79. It seems that the man sharpened his spoon and with that he scraped away the mastic and plaster between the light switch and the cell wall. This created a

[9] This was the time that the doctor entered in the man's clinical records. I assume that the doctor took this time from his own wrist watch.

small groove onto which he looped the ligature. He fashioned the ligature from a strip of material torn from his bed linen. My investigator was told that although the particular mastic is termed 'anti-pick' mastic, the phrase is something of a misnomer as it is still possible to pick away at it. We do not know when the man created this ligature point. Ordinarily, cells are subject to daily fabric checks with the primary purpose of ensuring that prisoners have not tampered with the cell fittings or compromised cell safety. However, in the case of a prisoner engaged on a dirty protest a decision might be taken not to carry out a fabric check on a particular day. For instance, in this case, to have carried out a fabric check a number of officers would have had to have dressed in full protective clothing and to have entered his cell with shields.

80. A copy of the photograph of the light switch appears below. The colour copy of this photograph shows unpainted areas. My investigator asked about the state of repair of the light switch before the man went into the cell; in particular, whether the area surrounding the switch had already been tampered with. My investigator was told that the photograph indicates previous damage. The damage would have been repaired before the man went into the cell, but the walls would not have been repainted after the repair as repainting of cell walls only occurs periodically.

[photograph deleted due to excessive size in megabytes]

After the man's death

81. The man had named his father as his next-of-kin and an address in Lincoln had been recorded for him. The police in Lincoln were contacted and asked to break the news but it seems that the man's father was no longer at the address.

82. One of the man's brothers had recently been in Wandsworth but he was of no fixed abode and Wandsworth had no contact details for him. The man's father had still not been traced by the following morning and Wandsworth contacted the local police for help in contacting his brother. The police telephoned the man's solicitor to see if they had his brother's contact details. By great coincidence, the man's brother was at the solicitor's office when the police telephoned and they informed him of his brother's death.

83. Wandsworth subsequently contacted the man's brother as well as his father and another brother. Wandsworth offered assistance with the funeral expenses.

84. Wandsworth's governing Governor, the chair of the IMB and one of the chaplains were contacted at home and all came into the prison that evening. The chaplain spoke individually to all of the other prisoners in the CSU to inform them about the man's death.

85. Two officers were allowed to go home early and were offered support from the prison care team. This was good practice.

ISSUES

Closure of the ACCT form in 12 April

86. An ACCT form was opened for the man in April when he told staff that he had taken an overdose of his in-possession Gabapentin tablets. He was examined by ambulance paramedics and by a healthcare nurse but none of them found evidence of any harm. The ACCT form was closed the following day when the man admitted during an assessment interview that he had not in fact taken an overdose and had no intention of harming himself. It seems that he made the original claim out of anger about the outcome of an adjudication hearing. The PO dealt with his grievances by negotiating his return to standard location and by the suspension of the punishment imposed at the adjudication.

87. I find that the decision to close the ACCT form was entirely correct. I commend the PO for the way in which he went about resolving the man's grievance.

The allegation that the man was assaulted by staff in May 2007

88. The man's brother alleged through his solicitor that officers assaulted his brother on an afternoon in May. This was the occasion when the man was restrained on B wing and then taken to the CSU. He said that his brother's solicitor observed the injuries on a visit. He added that the pathologist identified a number of bruises during the post mortem.

89. In the post mortem report the pathologist listed all the external injuries he identified on the man's body. He also recorded that four of his ribs had been fractured. In the 'summary and comments' section of the report the pathologist concluded that:

> "Minor abrasions to the hands, wrists and lower legs were present, but no deep bruising was found … to suggest the application of excessive force.
>
> "The external injuries could well have been sustained as a result of the restraint procedures used by officers …
>
> "There were no features to suggest systematic maltreatment of [the man].
>
> "The marks on the chest and rib fractures were consistent with resuscitation attempts (CPR)."

90. My investigator spoke to the man's solicitor. He said that from his records it seemed that the last time he visited him was May. He attended that day to support him at his adjudication hearing. The solicitor did not observe any injuries and could not recall the man ever complaining to him about physical maltreatment by staff.

91. My investigator spoke to the all of officers named by the man's brother as well as all those recorded in the paperwork as being involved. In the case of a

planned use of control and restraint, the episode must be filmed. As this was an unplanned episode, no filming took place.

92. There is no requirement to record the names of staff involved in escorting prisoners around the prison. However, from the interviews it seems my investigator was able to identify the officers who walked either side of the man when he was taken to the CSU.

93. The evidence of staff at interview was that the man was the aggressor in a fight with the other prisoner. One officer's evidence was that when he looked over the B2 landing railings he saw two prisoners fighting directly below him on B1 landing. He also saw officers on their way to break up the fight. The officer ran to the end of landing, down a flight of stairs and then to where the man was being restrained. He surmised that it took him about 25 seconds to arrive, by which time the man had ceased to struggle. This indicates that the incident was over very quickly and this accords with what other staff said. Two other officers each thought that they were first to arrive before being quickly joined by others. Both officers described the man ceasing to struggle very soon after arrival of the staff and then remaining compliant thereafter.

94. The accounts given by staff involved in escorting the man to the CSU indicate that this was totally uneventful. The officer who completed the incident report noted that no parties seemed to have sustained an injury. In the man's case this was endorsed by a nurse who examined him and found no injury.

95. I have found no evidence to suggest any improper conduct by staff. Nor have I found evidence to support any assertion that the incident caused the man any injury.

The control and restraint incident in May

96. On an afternoon in May, the man was occupying a special accommodation cell in the CSU. He had been moved to this cell as it was the only available cell remaining in the CSU after he damaged his previous cell. At just after 4.30pm, staff went to offer him the opportunity to end a dirty protest he had started a few hours previously. Staff offered him a shower as well as offering him food and water (special accommodation cells do not contain wash hand basins so he had no access to drinking water). The CCTV recording shows staff passing a clean blanket to him and shortly after that officers can be seen entering the cell. The officers' evidence was that the man had kicked the cell door and had then punched an officer's shield. The only way to lock the door while preserving staff staff's safety was to first place him under control and restraint. This included putting his legs in the figure of four position.

97. Because special accommodation cells are very basic, lacking in-cell sanitation for instance, prisoners should remain in them for only the briefest possible time. The situation with the man was compounded through the fact that he was engaged in a dirty protest. I consider that it was humane and entirely appropriate for staff to offer him the opportunity to end his dirty protest, to take a shower, and to have food and water. When he reacted as he did staff had no

option but to do as they did. There is no evidence that this control and restraint incident caused him any injury.

The man's threat that he would hang himself

98. Around ten minutes after the control and restraint incident an IMB member arrived in the CSU and went to speak with the man. After doing so, the IMB member made entries in the man's records to say that he had threatened to hang himself. The IMB member told my investigator that he did not think the threat was a genuine one. He said that the man threw in the comment with many others abusing all those working at Wandsworth. He said that he has opened self-harm/suicide monitoring forms in the past, and would have done so for the man if he had considered him to be at risk. He might also have opened an ACCT form had he thought it possible for a prisoner to take his life in the special accommodation cell. He also said that there were officers standing within earshot who would have heard the man's remark. He added that he passed a comment to the officers to indicate his view that it would not be possible for the man to harm himself in that particular cell. The officers, he said, concurred with this view.

99. The CCTV footage shows that certainly one officer was in a position to have heard the man's comments. This officer said, however, that he tried to avoid listening to conversations between prisoners and IMB members because of the confidential relationship between the two. He told my investigator that he did not hear the man's remark but, had he done so, would have opened an ACCT form if he thought it a genuine threat. Other officers might have been within earshot of the man's remark as they were either standing near to or passing the cell at various times, but it is not possible to deduce during this sequence of time when the man made the remark. All officers interviewed by my investigator denied hearing the remark.

100. The man's records were held at the unit desk. The IMB member went there to make his entries in the man's history sheet and his OTO13 form. He said that he pointed out to both the desk officer and the duty senior officer the entries that he made. The desk officer made entries in both forms immediately following the entries made by the IMB member about the man's threat to take his own life. The desk officer said that he had no recollection of the IMB member telling him that the man had made a threat to kill himself. The desk officer went on to say that it would have been easy for him to have spoken to the IMB member to suggest that he open an ACCT form for the man.

101. The CSU duty SO said that his shift finished at 5.00pm and before that time he would have left the CSU to go to the centre office to brief the Orderly Officer and to complete paperwork. He said that he had probably left the CSU before the IMB member even went to see the man and was not on the unit at the time the IMB member and the man spoke.

102. I cannot reconcile the differing recollections given by the IMB member, the desk officer and the duty SO about whether or not the IMB member advised uniformed staff about the entries that he made. What is clear, however, is that

he did not believe that the man intended to follow through with his threat. Instead, the comment had been part of an angry 'rant' about everything and everyone connected with the prison.

103. Opening an ACCT form is a relatively straightforward process, so I do not doubt that the IMB member would have opened one had he thought it appropriate. He acknowledged at interview that he should perhaps have erred on the side of caution and opened an ACCT form. That would have been the safest choice. It would also have been prudent for him to have included in his written record information on the context surrounding the man's comment.

104. As mentioned, the desk officer denied any recollection of the IMB member making reference to the records that he made. The desk officer also said that it was not his practice to read preceding entries when writing in a prisoner's records so did not see the IMB member's entries. If this is indeed the case, it represents very poor practice. A simple glance at the page would have alerted the desk officer to the fact that an entry by another hand had been made in the records. Moreover, the IMB member's entries are brief and would have taken just seconds to read. The purpose of making an entry is for it to be read by others. I recognise that prison staff deal each day with a lot of paperwork. However, prisoners whose behaviour is such that they come to be located in the CSU are those who are particularly challenging and who require the closest attention. It is for this very reason that the CSU has a higher staff to prisoner ratio than is found on a standard prison wing. The Governor will wish to consider if the desk officer should continue to work in the CSU or if there are training implications.

105. The Head of Residence was the duty governor that day. As part of her duties she visited the CSU where she signed the man's OTO13 to agree his continued location in special accommodation. She acknowledged at interview that she did not check the entries made on the form, one of which was that by the IMB member. She should have done.

I recommend that the Governor reminds all staff, including members of the Independent Monitoring Board, that no cell is entirely safe or free from ligature points.

I recommend that the Governor reminds all staff of the principles of good record keeping. This includes making full and unambiguous records, verbally sharing key information and reading records made by others. This section of my report should also be shared immediately with the Independent Monitoring Board.

Medical assessments during the man's final dirty protest

106. PSO 1700 requires that a doctor should visit on a daily basis any prisoner involved in a dirty protest. It is not necessary for the doctor to go into the cell to physically examine the prisoner, but the doctor should assess the prisoner by observation and interview through the door hatch. There is no evidence that the man received such an assessment on one of the last three days of the man's life. Of the other two days, on one day the man was noted to be fit and well. The note of the other day included that the man said he was well and had no complaints. The doctor who saw the man told my investigator that he had a reasonable relationship with the man and had no concerns about his well-being that day.

I recommend that the Governor should review the arrangements to ensure daily visits by a doctor for prisoners engaged on dirty protests.

The man's monitoring while in special accommodation

107. The man was moved into special accommodation at 12.35pm in May. PSO 1700 sets out the purpose of special accommodation cells and the monitoring requirements for prisoners located in such accommodation. The PSO requires that such prisoners be observed at least five times per hour and at irregular intervals. The Head of Residence initially noted on the OTO13 form that the man should be observed every 15 minutes. That would equal four observations per hour. Thereupon, the desk officer recorded checks on the man as occurring every 15 minutes at precise 15 minute intervals. At 5.00pm, the Head of Residence corrected her earlier error by noting that the man should be observed five times per hour (which is in accordance with the requirements of PSO 1700). This adjustment seems not to have been noticed by staff as the documentation continues to show four checks per hour and still, with few exceptions, at precise 15 minute intervals. The should also have been checked on an hourly basis by the designated manager but there is no evidence that any such checks occurred.

108. At 6.15pm, the man agreed to end his dirty protest and by 7.45pm he had showered and been relocated to a new cell (and the final entry on the OTO13 form was made at 8.00pm). This was a successful outcome, notwithstanding any inadequacies in monitoring through the time that he remained in special accommodation.

I recommend that the Governor reminds staff, including managers, of the procedures for monitoring prisoners located in special accommodation. In particular, they should ensure that observations should not occur at predictable intervals.

The evening of the man's death

109. The man was still engaged in a dirty protest on the evening of his death and staff were checking him on an hourly basis. At 8.00pm the evening officer noted at that time that the man was asking for medication. The evening officer

next visited his cell at 8.16pm when the CCTV recording shows him looking into the cell for around 20 seconds. The evening officer's body posture suggests that he was straining to look into the near right hand corner of the cell. At 8.30pm the evening officer checked on the man again. After only a few seconds he returned to the wing office to alert his colleague leading to their discovery that the man was hanging.

110. The evening officer's evidence included that ordinarily the man would be on his bed, and he was concerned on checking him at 8.30pm when he seemed to be sitting on the floor adjacent to the cell door. All that the evening officer could see of the man were his legs. When my investigator first interviewed the evening officer he was unaware that there had been an additional check; the one made at 8.16pm. When my investigator subsequently observed the CCTV recording of the 8.16pm check in company with the evening officer, he (the evening officer) could no longer recall what he had observed on that visit to the cell.

111. Although I cannot be certain on the matter, it seems to me that the most likely explanation for the sequence of events that evening was that it was at the 8.16pm visit that the officer first noticed the man in the unusual position where he seemed to be sitting on the floor adjacent to the cell door. That would account for that fact that the officer spent time peering into the corner of the cell at that stage. It would also explain why it took only a few seconds at the 8.30pm check for the officer to suspect that something was amiss (my presumption being that the man was in precisely the same position at 8.30pm as he was at 8.16pm).

112. If this is indeed what happened the evening officer's response at 8.16pm needs to be considered. The man was not on an open ACCT form and nor was there any other reason for the evening officer to suspect that he might be at risk of self-harm. Despite that, if the man was fully or partially concealed from view I would expect an officer to ask him to move to a position where he could be observed. It might be that the evening officer asked him to do so but got no response. The man was often unresponsive to staff so there would have been no reason at that point for the evening officer to believe that it was an emergency situation. Nevertheless, it might have been more appropriate to call for support, to check the man again and then to consider carrying out a controlled entry into the cell. As the man was engaged in a dirty protest I would expect them first to have put on protective (bio-hazard) clothing. In addition, with the possibility that staff might once again have needed to place him under control and restraint, they might well have wanted three staff to be present before unlocking the cell. All of this might easily have taken five minutes to arrange.

The method by which the man secured the ligature

113. It seems that the man had sharpened his plastic spoon and used it to gouge a shallow groove around the light switch over which he looped the ligature which he had made from his bed sheet. I have therefore considered whether he should have been in possession of these items. I conclude that he should. The

Prison Service must constantly balance risk against decency. For this reason, prisoners are provided with bed linen, even though some will use the material to fashion ligatures. Similarly, prisoners in the Wandsworth CSU are permitted to retain cutlery unless to do so would seem to pose a risk either to themselves or to others. The man, to a great extent, seems to have survived on items purchased from the canteen. Allowing him to retain cutlery enabled him to consume canteen purchased items in a civilised manner. I would not wish to see a change to this approach.

114. We do not know when the man gouged the groove around the light switch nor do we know how long it took him to do so. A cell fabric check might have discovered what he had done, but in the case of a prisoner engaging in a dirty protest a decision might be made not to conduct daily cell fabric checks. In the man's case, he was not believed by staff to be at risk of escape or at risk of self harm so I would not criticise staff for not conducting a cell fabric check.

115. I have been responsible for the investigation of deaths in prison custody since April 2004. In that time I have encountered many methods by which prisoners have been able to secure a ligature. The Prison Service is very aware of the constant need to improve safety and security.

I recommend that the Prison Service should satisfy itself that the mastic and sealants that it uses are those that are most resistant to tampering. If better products are available, these should be the products of choice.

The suggestion that the man was being victimised by staff

116. One of the man's brothers suggested victimisation by staff. I have found no evidence to support such a suggestion and I note that the man himself made no such complaints either to prison staff or to the IMB. The man was, of course, punished with 42 added days for his dirty protest in March. This is the maximum punishment allowed for a single incident. The decision, however, was made by a district judge whose function falls outside of my remit.

Delivery of the man's medication

117. A matter that appears to have caused the man great irritation was delay in the provision of his medication. At the time that he was in Wandsworth, medication was first dispensed to the main prison wings and only afterwards to the prisoners in the CSU. Such an arrangement would inevitably result in occasional delays in the dispensing nurses reaching the CSU. I am pleased to learn that since the man's death a revised arrangement has been put in place. The CSU now has a separate delivery of medication resulting, I understand, in greater consistency of dispensing times.

Summary of findings from the clinical review

118. The clinical review appears at Annex A. The reviewer's main findings included that the man's clinical records do not show whether any mental health issues leading up his alleged overdose in April were explored with him. The clinical

reviewer also comments that the clinical records were difficult to navigate and some of the writing was extremely difficult to read. The clinical reviewer concludes, however, that the health care provided to the man appeared to be appropriate.

The method by which the news of the man's death was passed to his brother

119. The supplementary guidance to PSO 2710, which deals with the follow-up to deaths in custody, recommends that the prisoner's family should be informed face to face as soon as possible after the death. The man had named his father as next-of-kin but the address held for him was no longer the current one. By the following morning the man's father had still not been traced so Wandsworth asked the local police to help trace the man's brother. The police telephoned the man's solicitor hoping they would have his brother's contact details. By coincidence, the man's brother was in the solicitor's office when the police telephoned and they informed him of his brother's death.

120. It is far from ideal that the news of the man's death was passed to his brother on the telephone by the police. However, this was largely due to an unfortunate set of circumstances including out of date contact details for the man's father and no direct contact details for his brother. I have recommended in other investigations that the Prison Service reviews prisoners' next of kin details at least once a year. However, I make no recommendation here as the man was serving a comparatively short sentence.

RECOMMENDATIONS

I make the following four recommendations:

1) I recommend that the Governor reminds all staff, including members of the Independent Monitoring Board, that no cell is entirely safe.

2) I recommend that the Governor reminds all staff of the principles of good record keeping. This includes making full and unambiguous records, verbally sharing key information and reading records made by others. This section of my report should also be shared immediately with the Independent Monitoring Board.

3) I recommend that the Governor should review the arrangements to ensure daily visits by a doctor for prisoners engaged on dirty protests.

4) I recommend that the Governor reminds staff, including managers, of the procedures for monitoring prisoners located in special accommodation. In particular, they should ensure that observations should not occur at predictable intervals.

5) I recommend that the Prison Service should satisfy itself that the mastic and sealants that it uses are those that are most resistant to tampering. If better products are available, these should be the products of choice.