Investigation into the circumstances surrounding the death of a man at HMP Wandsworth on 12 June 2009

Report by the Prisons and Probation Ombudsman for England and Wales

January 2011

This is the report of an investigation into the circumstances surrounding the death of a man. The man, a black South Londoner, was 25 years old when he died in HMP Wandsworth on 12 June 2009.

The man had been released from prison on licence in March 2009, but reoffended in April. He was remanded into custody for the new offences. (Unaware that the man was no longer in the community, the Probation Service began the process of recalling him to custody after he failed to comply with his licence conditions.) The man was taken to HMP Pentonville where he made a serious attempt to take his own life.

When the man returned from hospital after his suicide attempt, staff arranged to transfer him to Wandsworth in mid-May because he said he felt safer there. He was mistakenly taken to Brixton for a night but transferred to Wandsworth the next day. Towards the end of May, the man made a court appearance and afterwards returned to Pentonville rather than to Wandsworth. My report considers the circumstances of this move in some detail

A few days later, the man tried again to take his own life. He returned to Wandsworth on 9 June.

Overnight on 11 June, the man asked to be removed from his shared cell and was placed in a cell on his own. At lunchtime on 12 June, staff found him hanging in his cell. Sadly, their efforts to resuscitate him were unsuccessful.

I extend my sincere condolences to the man's family. They have acted with considerable dignity during what has been a very difficult period for them.

The investigation was completed by my investigators. Given the scope of the investigation, they were assisted at various junctures by other colleagues. The investigation team visited Wandsworth, Pentonville and Brixton and spoke with about 50 different members of staff. In addition, my Senior Family Liaison Officer contacted the man's mother and told her about my investigation. She and the investigator visited the man's mother to update the family on the progress of the investigation.

A clinical review of the treatment that the man received in custody was undertaken by a clinical reviewer, appointed on an independent basis by Wandsworth Primary Care Trust. The clinical reviewer assessed whether the care that the man received in custody was comparable to that he would have been offered in the community. I am grateful for his assistance. A copy of the clinical review is annexed to my report.

I would like to thank both staff and prisoners at Wandsworth, Pentonville and Brixton for their cooperation whilst the investigation was completed.

This has been a much more complex investigation than usual because three prisons were involved and many questions needed to be answered. I hope that my report provides the family and the other parties involved with as full an assessment as possible of what transpired.

I have also been conscious of the wider public concern about the transfer of prisoners between Pentonville and Wandsworth at the time of inspections by HM Chief Inspector of Prisons. The man was not moved directly as a consequence of the inspection of Wandsworth that took place at the beginning of June 2009. However, I conclude that his second spell at Pentonville may well have been influenced by the fact of the inspection, and my report also draws attention to the indirect effects on him of the series of transfers as a whole.

These matters had already been the subject of disciplinary inquiries. However, I recommended in the draft version of this report that the National Offender Management Service (NOMS) review the new evidence that it contained to determine whether a renewed disciplinary investigation was justified. Following publication of the draft report, NOMS accepted the recommendation and responded, indicating that the new evidence would not prompt them to conduct a further disciplinary investigation.

The man was a vulnerable prisoner who had experienced mental health problems for some years. Whilst I have made many recommendations to the National Offender Management Service, and am critical of some decisions that were made, I have also highlighted some elements of good practice in what is otherwise a very bleak story.

Acting Prisons and Probation Ombudsman **January 2011**

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GLOSSARY

Approved Premises

A hostel where the Probation Service can accommodate offenders released from prison on licence.

Assessment, Care in Custody and Teamwork (ACCT)

An ACCT document is opened if a prisoner is thought to be at risk of harming themselves. The prisoner is interviewed and a plan for their care is drawn up in response to their needs and concerns. The process is ongoing and the document remains open whilst the risk remains. An ACCT review should be held at least once a week. Any staff who have contact with a prisoner can make entries in the document. The frequency of observations by staff is set out on the front cover, for example, 'hourly'. Staff must check the prisoner at least this often, they should conduct their observations at random intervals and write down all the checks in the ongoing record. Some of the scheduled checks must be 'quality observations', meaning that the member of staff speaks to the prisoner at some length and has meaningful interaction with him in order to gauge his presentation and the risk he may present to himself.

ACO Assistant Chief Officer (in the Probation Service)

Adrenaline

A drug used to treat cardiac arrest

Appropriate adult

If an individual is vulnerable or has mental health problems, it may be necessary for an appropriate adult to accompany them to formal appointments such as a probation interview. This adult can offer assurance, assist with communication and make sure that the individual understands what is happening. They can be a friend or a professional person working with the individual such as a psychiatric nurse or a social worker.

Atropine

A drug which can be injected to increase a person's heart rate

Bedwatch

If a prisoner is admitted to hospital he is escorted by prison officers at all times as part of a bedwatch. He may be handcuffed to an officer depending on the risk he is assessed as presenting to the public and whether or not he is sedated. A bedwatch log is kept throughout the hospital stay and managers from the prison regularly visit the hospital to check on the prisoner.

Canteen

A prisoner has a weekly amount of money to spend on items such as cigarettes. The amount of money they can spend on items available from the canteen depends on factors such as whether they have a job in the prison.

Counselling, Assessment, Referral, Advice and Throughcare Services (CARATS)

There is a CARATS team in each prison which works with substance misusers.

CMHT Community Mental Health Team

CPN Community psychiatric nurse

CPR Cardio pulmonary resuscitation

CSRA Cell Sharing Risk Assessment

Defibrillator

A machine used to reset an irregular heart rhythm with a dose of electrical energy.

Escort chain

A chain approximately eight feet long with a handcuff on each end. It allows hospital staff to carry on treating the prisoner without the officer chained to him getting in the way.

FLO Family Liaison Officer

HEMS Helicopter Emergency Medical Service

HMIP Her Majesty's Inspectorate of Prisons

ICU Intensive Care Unit

IIS Inmate Information System

In-Reach Team

Healthcare staff with mental health training who treat prisoners with severe and enduring mental health problems.

Listener

Prisoners who are trained by the Samaritans to spend time with others who are in crisis. Any information that a prisoner may disclose to a Listener is treated confidentially, just as a telephone call to the Samaritans would be.

Medical hold

When a prisoner is prevented from transferring between prisons because he has to remain at his current prison on health grounds such as attending a hospital appointment.

Mirtazapine

An antidepressant

NOMS National Offender Management Service

NOMS comprises the Prison and Probation Services. However, I will continue to refer to the Prison Service and the Probation Service for reasons of clarity within the report.

OCA Department Observation, Classification and Allocation Department

The OCA team in a prison is responsible for organising prisoner transfers, both one-off moves and group moves, which are organised at a national level by the PMU.

Offender manager

Probation officers are now known as offender managers.

Olanzapine

An antipsychotic drug used to treat schizophrenia

OMU Offender Management Unit

Operation Trident

The division of the Metropolitan Police which addresses gun crime among young, black Londoners.

OSG Operational Support Grade (member of prison staff)

PCT Primary Care Trust

PER

Person Escort Record, completed every time a prisoner is transferred to or from a prison or taken to court.

PLO Police Liaison Officer

PMU Population Management Unit

Based in central London, the PMU department organises the movement of offenders between prisons in England and Wales. They inform a prison of the numbers to be moved, and the OCA department identifies suitable candidates for transfer.

PO Principal Officer

PSO Prison Service Order

Procyclidine

Medication used to treat the man's wry neck (torticollis, a condition whereby the individual tilts their head to one side whilst their chin points upwards and in the other direction.) The man would often hold his neck at an awkward angle which seemed to worsen when he was anxious. Staff and prisoners remembered that he frequently looked away from the person he was talking to.

Risperidone

An antipsychotic drug used to treat schizophrenia

Serco

A private company responsible for the running of the custody suites in London courts. Their staff transfer prisoners between prison and court.

SIR Security Incident Report

SO Senior Officer

St Mungo's

A charity which helps prisoners find accommodation upon release.

Telephone PIN number

Every prisoner is provided with a PIN number in order to use the public telephone on their wing to speak to friends and family. Each PIN number is unique and the prisoner's telephone calls are logged.

VPU Vulnerable Prisoners Unit

Some prisoners who cannot cope or who feel unsafe amongst the general prison population ask for vulnerable prisoner status. They are held in a VPU separate from the rest of the prison and can no longer associate with the other prisoners.

Anonymised report

A large number of staff at three different prisons are referred to in the report. As a result, when the report was anonymised, staff appearing in chronological order were given the following designation:

- Staff at Pentonville are referred to by their job title and a letter from the beginning of the alphabet eg: Governor A, Nurse A…

- Staff at Brixton are referred to by their job title and a letter from the end of the alphabet eg: Governor Z, Nurse Z…

- Staff at Wandsworth are referred to by their job title and a number eg: Governor 1, Nurse 1…

SUMMARY

The man was released on licence from HMP Wandsworth on 20 March 2009. He had been in custody before and been monitored by the Assessment, Care in Custody and Teamwork (ACCT) procedures on more than one occasion in the past. He had a history of mental health difficulties and was diagnosed with paranoid schizophrenia and a possible anti-social personality disorder. He attended his appointments with his offender manager and the local Community Mental Health Team (CMHT) during the next few weeks and resided at an approved premises run by the Probation Service. On 14 April, he reoffended. He was not recalled by the offender manager but was warned about his behaviour.

A week later, on 21 April, the man made a court appearance in relation to the new offences and was remanded into custody. He consequently missed an appointment with his offender manager the same day and, when he did not return to the approved premises, was recalled to custody.

Prisoners remanded at Camberwell Green Magistrates' Court are normally taken to HMP Brixton. However, because one of the man's relatives works at Brixton, he was taken to HMP Pentonville instead. A doctor opened an Assessment, Care in Custody and Teamwork document because the man said that he was hearing voices telling him to harm himself. The man said that he had recently misused drugs and alcohol in the community, but the doctor did not think that he had withdrawal symptoms.

The next day a prison officer interviewed the man as part of the ACCT process and organised a move to the detoxification unit. Later in the morning the man requested vulnerable prisoner status because he feared for his safety. He was worried that, coming from South London, he might be harmed by North London gang members. Staff planned to move the man to the Vulnerable Prisoners Unit (VPU) after lunch, but before this could happen he tried to hang himself using a ligature. Staff managed to revive him and he was taken to the Royal London Hospital. His condition was serious and he was visited in hospital by his family.

The man returned to Pentonville on 28 April. He was located in the healthcare centre and initially kept under constant supervision as a precaution. The ACCT document remained open, though the frequency of observations was reduced as the days passed. The man settled in but continued to ask to move to Wandsworth, where he said he would feel safer. Because of his serious attempt to take his own life, staff thought that the move was in the man's best interests. Healthcare staff liaised with their colleagues in Wandsworth and the Governors of both prisons agreed the transfer.

Following a court appearance at Camberwell Green on 12 May, the man was supposed to move to Wandsworth, but the instruction was not clearly marked on his Person Escort Record (PER) and he was instead taken to Brixton. Staff at Brixton were reluctant to receive him because their healthcare staff had not been advised of his arrival. The duty governor contacted both Wandsworth and Pentonville and, in the man's best interests, agreed to hold him in Brixton for one night to allow the

breakdown in communication to be resolved. The man was kept under constant supervision in the healthcare centre as a precaution.

The following day, 13 May, the confusion was resolved and the man transferred to Wandsworth. He spent two nights in the first night centre before being moved to the VPU (known as the Onslow Centre). On 19 May, the ACCT document which had been open for nearly a month was closed.

A week later, on 26 May, the man made another appearance at Camberwell Green. He was fined in relation to the recent offences but remained in custody because he had been recalled by the Probation Service. Brixton was asked to receive the man from court, so the duty governor at Brixton, Governor Z, spoke to his counterpart at Wandsworth, Governor 3. Governor 3 refused to accept the man and telephoned the duty governor at Pentonville, Governor A. Governor A initially refused to receive the man because she thought it inappropriate after his recent attempt to take his own life. Governor C, the then Governor of Pentonville, subsequently agreed to accept the man after he spoke to Governor 1, the then Governor of Wandsworth.

Governor C was concerned about the man and personally checked on him. The man was kept under constant supervision in the healthcare centre until the following morning. On 27 May, Governor C and Governor 1 agreed that the man would return to Wandsworth after 6 June, following a scheduled inspection by Her Majesty's Inspectorate of Prisons (HMIP) between 1 and 5 June. Later that morning, the man was discharged from the healthcare centre onto the VPU following a case review that was not part of the ACCT process. He was told by Governor A, who led the review, that he would return to Wandsworth after 6 June.

The same day, 27 May, Governor A asked an officer in the Observation, Classification and Allocation (OCA) department to organise the man's transfer back to Wandsworth. The booking was made and collection was scheduled for 1 June. However, none of the staff working with the man were told about the forthcoming move and no preparations were made. Over the next few days, the man remained on the VPU and was not assessed by any healthcare staff. On 31 May, he expressed suicidal thoughts to a senior officer (SO) and a second ACCT document was opened.

The man was interviewed and ACCT observations were set at half hourly intervals overnight. He showed a ligature to an officer and the holes in the light fitting that he planned to attach it to. The following morning, 1 June, the man was checked and found in the midst of a second attempt to hang himself. The officer prevented him from harming himself and he was moved to the healthcare centre where he was placed under constant supervision, preventing the scheduled transfer from taking place. A mental health assessment by the CMHT had been scheduled for 1 June at Wandsworth. It did not take place because the man was still located in Pentonville.

Observations were gradually reduced whilst the man remained in the healthcare centre. His mood seemed to stabilise and, from 4 June, he was observed every hour. He returned to Wandsworth, where he continued to say he felt safer, on 9 June. He travelled back with prisoners who had been temporarily transferred out of Wandsworth to Pentonville for the duration of the HMIP inspection. Following an

internal Prison Service investigation of their temporary transfers, charges were recommended against five managers at the two prisons. At subsequent disciplinary hearings, charges against two managers were dismissed. Charges against the other three managers were proved. In light of the new evidence in this report, I have recommended that the Director General of NOMS considers whether a renewed disciplinary investigation is warranted.

The man's ACCT document remained open and he went back to the Onslow Centre again. The following day, 10 June, the ACCT document was reviewed. The man spoke about his involvement with gangs. The staff running the review encouraged him to report any information to the police. The Police Liaison Officer (PLO) was consulted and arranged for the man to speak to an officer from Operation Trident. Following the review, the man went to speak to a Listener.

The most recent entry on the front cover of the ACCT document had been made at Pentonville and instructed staff to make hourly observations. However, between 9 and 12 June, staff on the Onslow Centre only maintained hourly checks at night, recording intermittent observations during the day.

The next day, 11 June, the man moved into a cell with prisoner 7 after both men approached staff. Their cell share lasted from late afternoon until about midnight, when the man asked to be removed from the cell, saying that prisoner 7 had made sexual advances towards him. He was relocated on his own to a different cell.

At the morning briefing on 12 June, staff were told that the man had been removed from the cell overnight. During the morning the man was observed by three different officers who all noted that he did not respond to them and was staring at the wall. The second officer asked a member of the In-Reach team to assess the man. An ACCT review was not scheduled that morning and the frequency of observations was not increased, remaining intermittent during the day.

Officer 10, the final officer to note the man's appearance during the morning, made an entry in the ACCT document at 12.30pm after locking him in his cell alone over lunch. The same officer returned to the cell shortly after 1.00pm to check if the man wanted to attend the Muslim prayer service, but got no verbal response. He did not make a further entry in the ACCT document but told his colleagues that he was worried about the man.

At 1.40pm, Officer 11 checked the man, prompted by her colleague's concern. She found him hanging in his cell and immediately called for assistance. Staff entered the cell, cut the man down, removed the ligature and began to try to resuscitate him. The emergency healthcare response nurse brought two doctors with her. Both paramedics and an air ambulance crew joined the effort to revive the man. He did not respond and was declared dead shortly before 2.20pm.

The prison's family liaison officer (FLO) reached the man's mother's home address just after 4.30pm. By this stage, a prisoner had already used a mobile telephone to inform her of her son's death.

My report explores a variety of issues, including the transfer of prisoners, the use of ACCT documents and the appropriateness of cell sharing arrangements. I have examined the man's recall to custody and the possibility that he might have gone to hospital instead. The investigation has revealed that the man was moved four times in a seven week period. I conclude that these transfers were not always in his best interests and that they interrupted the continuity of his care.

THE INVESTIGATION PROCESS

1. The investigators were notified of the man's death on 12 June. Notices were issued to staff and prisoners telling them about the investigation process and inviting them to contact my investigators.

2. The investigator contacted the liaison officer, the Safer Custody Manager at Wandsworth. When he visited Wandsworth on 16 June, he met the then Governor, Governor 1. On the same day, the investigator spoke to three prisoners. He was also provided with copies of the man's prison records. The originals were given to the coroner's office.

3. Two weeks later, on 1 July, the investigator returned to Wandsworth to examine the man's cell and collect further documentation. On 16 July, both investigators interviewed seven members of staff at Pentonville. On 4 and 5 August, they interviewed a further 12 members of staff at Wandsworth.

4. Some weeks later an internal Prison Service investigation was begun after HMIP identified attempts 'at a managerial level to subvert the inspection process'. Although the man was not moved with the prisoners who transferred to Pentonville on the weekend before the inspection at Wandsworth, my investigators obtained documents which suggested that consideration of the inspection may have influenced the decision to relocate the man to Pentonville on 26 May and the subsequent timescale for his return to Wandsworth. In order to determine the circumstances under which the man moved between prisons, my investigators decided to interview a number of governors.

5. The investigator liaised with the internal Prison Service investigator during this period. The internal Prison Service investigator was commissioned by the Director of Offender Management for London to conduct an internal Prison Service investigation of the circumstances surrounding the transfer of prisoners. Some cooperation was required on a practical level, as the two investigation teams were interviewing the same members of staff at Wandsworth and Pentonville at about the same time.

6. The investigator advised the internal Prison Service investigator of those staff he had already spoken to who had voiced suspicions about the influence of the inspection. The internal Prison Service investigator subsequently provided the investigator with copies of emails he had not previously seen. The internal Prison Service investigator requested copies of a booking form and a case review, which the investigator provided.

7. On 12 August, the investigator visited Wandsworth with two colleagues to interview Governor 3. That morning the investigators had also interviewed a number of prisoners. A week later, on 18 August, the investigators returned to Pentonville to interview four members of healthcare staff. Later that day they were joined by a colleague when they interviewed the then Governor of Pentonille, Governor C, and Governor A.

8. Two days later, on 20 August, the investigator visited Streatham CMHT to interview two members of staff. On 15 September, the investigatorsl interviewed Governor 1. A week later, on 23 September, the investigators interviewed three members of staff at HMP Brixton.

9. The investigators returned to Wandsworth on 1 October to interview a further five members of staff. Despite several requests, staff at Wandsworth had been unable to locate the first ACCT document opened between 21 April and 19 May. However, the document was located on 1 October after the new Governor asked staff to conduct a further search at my investigators' request.

10. The next day, 2 October, the investigators interviewed another governor who worked at Brixton when the man was in custody. The interview was conducted at my office.

11. My investigation team were provided with copies of the internal Prison Service investigator's report and relevant annexes when it was published in early October. As a result of the internal investigation, five governors faced disciplinary hearings. Following the hearings the charges against the Governors of Wandsworth and Pentonville were dismissed. Charges were proved against the other three managers, who were reprimanded. The investigator requested, and was provided with, transcripts of the hearings.

12. On 28 October, the investigator visited Wandsworth. He interviewed a nurse, reinterviewed a member of staff and spoke to two prisoners, recording one of the interviews. On 5 November, the investigator went back to Wandsworth to interview a nurse, and then visited the coroner's office to obtain copies of documents which had not been provided when he opened the investigation.

13. The investigator returned to Pentonville, interviewing three members of staff on 10 November and another two on 12 November, one of whom he had spoken to before. On 17 November, he visited Croydon to speak to staff at the NOMS Public Protection Casework Section. On 8 December, he made another visit to Pentonville to speak with two more members of staff. Finally, on 26 January 2010 the investigator interviewed two nurses at Wandsworth.

14. My investigators wrote to the local Coroner's office at the start of my investigation to inform them of its nature and scope. The Coroner later obtained a copy of the post mortem report. HM Coroner will be provided with a copy of my report.

15. The investigator contacted Wandsworth Primary Care Trust (PCT) to ask that a clinical review be carried out with regard to the medical treatment which the man received in custody. The purpose of this review is to establish whether the care which the man was offered in prison was comparable with that he would have received in the community. The man's family asked that the clinical reviewer should be independent of the PCT and should have some knowledge of mental health issues. A clinical reviewer was appointed to complete the review, which is annexed to my report.

16. My Senior Family Liaison Officer (FLO) contacted the man's mother on 7 July 2009. She told the man's mother about the purpose of my investigation and asked about the concerns she had regarding the treatment her son received in custody. The senior FLO and the investigator visited the man's mother on 28 July to offer further information and to hear her concerns first hand. Following the publication on 20 October 2009 of the HMIP reports relating to Wandsworth and Pentonville, the senior FLO and the investigator visited the man's mother on 29 October to update her on the progress of the investigation.

17. The man's mother had a number of concerns about her son's time in custody:

- She was distressed to learn from my investigator about his second attempt to take his own life on 1 June 2009 and wanted to know why prison staff had not told her about it at the time.

- The man's mother asked whether her son's neck condition (the man held his neck at an awkward angle which became more pronounced when he was stressed) was aggravated by prescription of the wrong medication whilst he was held during an earlier part of his prison sentence. My investigator advised the man's mother that the report would necessarily focus on her son's most recent period of imprisonment.

- She was concerned that Wandsworth healthcare staff told her on the telephone on 11 June 2009 that he would not be escorted to a hospital appointment on 17 June to treat his neck problem. There is no record of this conversation in the man's clinical record and neither is there a record of a planned hospital visit.

- The man's mother wanted to know what had happened to items of her son's property that she gave him whilst he was in hospital.

- She wanted to know how often her son had been checked before he died and, given his mental health difficulties, why he was allowed to be on his own in a cell when he took his own life. She wanted to know more about her son's cell sharing arrangements in the days before he took his own life.

- The man's mother and her solicitor also wanted to know more about her son's recall to custody and the Parole Board's decision not to recommend his re-release.

- Following media attention surrounding transfers between Wandsworth and Pentonville, my investigators advised the man's mother that the report would address her son's movements around the London prison system.

18. I hope that the draft version of my report provided the man's mother with the answers to at least some of her questions. Some of the details no doubt

proved to be upsetting for the man's family to read. Some of the report is regrettably but necessarily complicated. After the draft report of the investigation was published, the senior FLO and the investigator visited the man's mother and her solicitor on 11 May 2010 to explain the principal findings and recommendations. A response on behalf of the family was not received before the Ombudsman published the final version of the report in January 2011.

HMP WANDSWORTH

19. Wandsworth is the largest prison in England and Wales, holding a maximum of about 1,660 men. Prisoners are either held on remand, awaiting sentence or serving sentences. As a local prison, a large number of prisoners travel back and forth from Wandsworth each week day to make appearances at the London courts.

20. As a vulnerable prisoner, the man was held on the VPU (known as the Onslow Centre). This is a separate building from the rest of the prison and holds about 360 prisoners on three wings. The population is made up of prisoners who have asked for vulnerable prisoner status and might be at risk amongst the general prison population.

Healthcare

21. In July 2007 Wandsworth Teaching PCT commissioned a private company, Secure Healthcare, to provide healthcare at Wandsworth and employ the medical staff. However, the company went into liquidation in September 2009. The healthcare team are currently employed by the part of NHS Wandsworth which provides services, rather than commissions them.

22. Healthcare provision is divided between primary care (treating physical health problems), substance misuse (treating drug and alcohol users) and the In-Reach team (treating mental health problems), which is funded by South West London and St George's Hospital Mental Health NHS Trust. The In-Reach Team has the equivalent of one full time consultant psychiatrist and one staff grade psychiatrist post. The team also includes two CPNs, three dual diagnosis nurses and another CPN who doubles as the team manager.

23. The Addison Unit is a 12 bed inpatient unit accommodating prisoners with severe and enduring mental health needs who are experiencing acute difficulties. The unit won an award recognising the service it provides earlier in 2009. There are no inpatient facilities for prisoners with physical health problems. There are two treatment rooms on the Onslow Centre. The prison pharmacy uses a number of technicians to carry out its functions. When my investigators visited Wandsworth, all were temporary agency staff.

HM Chief Inspector of Prisons

24. HM Chief Inspector of Prisons completed an announced inspection of Wandsworth between 1 and 5 June 2009.

25. Prisoners who had transferred to Pentonville the weekend before her inspection, who did not include the man, returned to Wandsworth on 9 June. Shortly afterwards, some complained to HMIP. Members of the inspection team returned to Wandsworth and discovered, in the Chief Inspector's words, that efforts had been made 'at a managerial level to subvert the inspection process'. Five prisoners from Wandsworth's segregation unit and VPU were transferred to Pentonville to temporarily remove them from Wandsworth whilst

the inspection team visited. When the transfers took place, some of the prisoners objected and self-harmed.

26. The Chief Inspector found that there had been a reciprocal arrangement in place between Wandsworth and Pentonville to remove what were perceived to be 'difficult' prisoners from each prison whilst HMIP visited. Wandsworth had temporarily accepted some of Pentonville's prisoners when their inspection was held between 11 and 15 May.

27. The report of the inspection of Wandsworth, published on 20 October 2009, was critical. The Chief Inspector remarked that, had it not been for the attempt to 'subvert the inspection process', Wandsworth would have emerged as a prison making good progress. She wrote:

> '…the prison's reputation has been seriously tarnished by the irresponsible, pointless, and potentially dangerous actions instigated at managerial level …
>
> 'In terms of the effect on the inspection, the prisoner transfers were completely pointless.
>
> '…the transfers [have cast] doubt on the governance of the prison and the commitment, at senior level, to the safe and respectful treatment of those in its care.
>
> '[This] is deplorable, not only because of the effects on individuals, but because of the underlying mind-set: that prisoners are merely pieces to be moved around the board to meet performance targets or burnish the reputation of the prison.'

28. The man was not one of the five prisoners identified in a subsequent internal Prison Service investigation as having been deliberately moved out of Wandsworth to Pentonville. However, as I go on to describe in the 'Key Findings' section of this report, the man did move unexpectedly to Pentonville following a court appearance a few days before HMIP arrived at Wandsworth. He did not return to Wandsworth until the inspection concluded. My investigators have explored whether his movements around the London prison system were influenced by the inspection. I discuss the evidence they gathered in the 'Issues' section of the report.

29. The Chief Inspector recommended that senior managers in particular needed to be reminded that care for prisoners is their prime responsibility. She also recommended that prisoners who are at risk of self-harm are only moved to a different prison when it is in their best interests.

30. Aside from the attempt to affect the outcome of the inspection, the Chief Inspector found that staff awareness of the use of the ACCT process had improved, but that the quality of the documents was variable or even poor. The inspection team discovered a failure to put in place and monitor ACCT action plans following my investigations of previous deaths at Wandsworth.

Four prisoners had taken their own lives since the previous inspection, but only two action plans could be produced.

31. HMIP examined the response to my investigations of deaths in Wandsworth and prison staff reported that all the recommendations made by my office had been put into practice. However, the Chief Inspector found that that this claim was 'clearly false' in some instances. For example, prisoners were not being given prior notification of transfer out of the prison, nor were they being given the chance to have the proposed transfer reviewed if they protested. The inspection team were 'deeply concerned' that the prison management team appeared to have 'completely lost sight of the issues that had previously contributed to deaths in custody'.

32. The monthly safer prisons meeting was well attended and HMIP considered the suicide prevention strategy to be comprehensive, albeit with some qualifications. However, no investigations were carried out in relation to eight near-deaths (incidents where a prisoner could have died but was revived) which had taken place in the previous six months. The Chief Inspector recommended that all the recommendations resulting from my investigations of deaths in custody should be implemented consistently.

33. With regard to the delivery of healthcare, the Chief Inspector found that there was too much reliance on agency staff to fill vacancies. She recommended that the vacancies be filled permanently. She indicated that the different teams responsible for providing healthcare were not well integrated and recommended that sufficient mental health nurses were recruited to meet the demands of a prison the size of Wandsworth.

Previous investigations of deaths at Wandsworth

34. Since 2004, I have conducted 11 investigations of self inflicted deaths in Wandsworth. (Most involved the prisoner hanging himself, but one involved a man refusing food and another involved an overdose of medication.) Additionally, I have investigated the death of a man who took his own life very shortly after being released from Wandsworth.

35. When I investigated the death of a prisoner in August 2005, I recommended that the completion of new CSRAs should take into account information contained in previous assessments. I also recommended that the frequency of observations should be stated on the front cover of a prisoner's ACCT document. I revisit both issues in this report.

36. Following my investigation of the death of a prisoner in October 2007, I recommended that, if the In-Reach team is working with a particular prisoner, they should be included in the ACCT process and work in liaison with the Safer Prisons team. My investigators have found that the inclusion of the In-Reach team in the ACCT process remained a concern. When Wandsworth responded to the draft report about the man's death, they said that the situation had 'generally improved' and that a member of the In-Reach team was assigned to each wing to attend ACCT reviews.

37. The investigation with most direct relevance to the man's death was that into the circumstances of the death of a prisoner on the Onslow Centre in August 2007. I found that the man transferred to Wandsworth without records being made of who authorised the transfer. It was unclear what preparations were made for the man's arrival. He was held in the healthcare centre at the sending prison but placed on the Onslow Centre at Wandsworth. The man was located in a shared cell with another vulnerable prisoner with mental health problems. The arrangement was unsuitable and the man asked to be moved.

38. The man was the subject of an ACCT document. Despite staff being provided with new and concerning information, the risk he presented to himself was not reviewed and the frequency of observations was not increased. At the time that the man was found hanging in his cell, he should have been checked at least ten minutes earlier.

39. Following the investigation I highlighted the importance of keeping a proper transfer register. I discussed the suitability of cell sharing arrangements and recommended that staff take account of concerns about an existing occupant when placing a new prisoner in a cell. I recommended that the Governor satisfy himself that staff were properly trained in the use of ACCT documents. I highlighted the need to take account of new information during the ACCT review process to inform risk assessments. I drew attention to the need for senior staff to regularly check ACCT documents to ensure they are being properly completed. The man's experiences on the Onslow Centre are similar to those of the man who died in August 2007.

Independent Monitoring Board (IMB)

40. The most recent annual report published by the IMB at Wandsworth covers the year from June 2008 to May 2009. (The IMB at each prison is made up of members of the public who are both independent and unpaid. They monitor the day-to-day life in their local prison and ensure that proper standards of care and decency are maintained.)

41. The Board made their comments before HMIP's report was published. The IMB praised the efforts of the management team and noted that improvements continued to be made. It was felt that the 'old' Wandsworth, and the bad reputation it carried, was beginning to be replaced by a 'new' Wandsworth where staff treated prisoners 'fairly and with respect'. The Board commented that 'relationships between prisoners and officers [are] so much better than just a few years ago'.

42. The IMB expressed concern regarding the provision of primary healthcare, before it became clear that the company responsible had gone into liquidation. The Board was also critical of a reliance on agency staff. They commented on the high number of prisoners experiencing mental health difficulties at Wandsworth and expressed the concern that the In-Reach team was too small to 'have a real impact' on the scale of the problem.

43. The IMB thought that the process for referring a prisoner to the In-Reach team was unsatisfactory and asked that the provision of mental healthcare be reviewed to ensure that different agencies were working together effectively. They also noted that internal communication between those staff delivering primary healthcare and those treating mental health problems was poor, and that joint meetings to discuss prisoners were rare.

44. With regard to vulnerable prisoners, the IMB thought it inappropriate that they were having to be accommodated in the first night centre for 'days or weeks' when they first arrived, before moving across to the Onslow Centre when there was room to accommodate them. (The man spent two nights on the first night centre in mid-May before a place was found for him on the Onslow Centre.) The Board said that the Onslow Centre suffered from overcrowding. They asked that a decision be taken regarding its future:

> 'The future of [the Onslow Centre] … gives ground for considerable concern. The Ministry of Justice has delayed taking a decision on whether to rebuild or refurbish this unit and we have acute fears about the consequences of a major system failure …'

45. As far as the use of ACCT documents was concerned, the Board commented that:

> 'Staff awareness of prisoners' vulnerability appears heightened with a commensurate improvement in the quality of [entries].'

46. Despite the acknowledged improvement, the IMB found the recording of information in ACCT documents to be variable. They also noted that ACCT reviews were not always attended by representatives from other agencies. The Board highlighted the failure by wing managers to always monitor their staff's entries in ACCT documents. The IMB also said that:

> 'The high percentage of prisoners suffering from mental illness means that vulnerable men are held in conditions conducive to self harm and volatility.'

Performance rating

47. Prison quarterly ratings published on 26 June 2009 by the Ministry of Justice show that Wandsworth scored 3 overall, indicating a good performance. The prison achieved the same score in the previous and subsequent quarter. The minimum score is 1 (serious concerns) and the maximum is 4 (exceptional performance). The rating takes into account 34 different aspects of the way the prison is currently operating.

HMP PENTONVILLE

48. Pentonville is a category B prison holding a maximum of 1,152 men. As a local prison, it receives new prisoners from the London courts on a daily basis. In general, men remain in Pentonville whilst held on remand or serving short sentences. Those serving longer sentences are transferred to another prison.

Healthcare

49. As of 1 April 2009, NHS Islington assumed responsibility for delivering primary healthcare. Camden and Islington NHS Foundation Trust run the substance misuse and In-Reach teams. Barnet, Enfield and Haringey Mental Health Trust have responsibility for delivering forensic psychiatric services.

50. The prison provides 24 hour nursing cover. There is a dedicated team of psychiatrists attending to prisoners with severe and enduring mental health problems. Doctors visit the prison regularly to run general surgeries. Emergency out of hours doctors are provided by Camidoc, a local provider in the Camden area. There is a 22 bed inpatient facility in the healthcare centre, 16 of which are reserved for psychiatric treatment.

HM Chief Inspector of Prisons

51. HMIP completed an announced inspection of Pentonville between 11 and 15 May 2009. The Chief Inspector found that the then Governor, Governor C, had made undoubted improvements to the prison during his tenure. She credited his team with striving to ensure that prisoners receive a reasonable standard of care, something that has not always been the case previously. After recent poor inspections, the latest visit initially gave cause for optimism.

52. However, the Chief Inspector wrote that any improvements were overshadowed by the temporary transfer of six prisoners to Wandsworth for the duration of the inspection, putting the men at risk. (These events are described in the previous section entitled 'HMP Wandsworth'.) The Chief Inspector commented that the Pentonville inspection would be remembered for:

> '…exposing the irresponsible, pointless and potentially dangerous actions of some managers, who lost sight of their primary duty to the prisoners in their care.'

53. Despite her criticism of the deliberate movement of potentially vulnerable prisoners during the inspection period, the Chief Inspector found that there was in general terms a 'strong focus' on safer custody procedures at Pentonville. The Chief Inspector found that most vulnerable prisoners felt safe both in the VPU and in the prison as a whole. The men spoke highly of the staff who worked on the VPU (where the man was held between 27 May and 1 June).

54. HMIP examined the response to my investigations of deaths in Pentonville. They found that, although a consolidated safer custody action plan was in place, this did not address all of the recommendations I had made as a result of my investigations, nor all of the Coroner's findings at the subsequent inquests. The Chief Inspector wrote that ACCT assessments were generally good, but that few ACCT reviews involved other agencies.

55. With regard to healthcare provision, The Chief Inspector found that the medical staff enjoyed 'robust support' from the various Trusts involved. Despite an 'excellent' healthcare centre, she wrote that 'primary mental healthcare, and the speed of transfer to NHS facilities for those with acute mental illness, were inadequate'. The inspection team found a significant number of prisoners waiting for transfer to a secure mental health bed. The management of these transfers was judged to be 'poor'. The Chief Inspector wrote that a mental health nurse visited the wings on a weekly basis to support prison staff.

56. Prisoners' wing history sheets were not completed to the satisfaction of the inspection team. Staff made few entries and there was no reference to any special care needs that prisoners might have.

Independent Monitoring Board (IMB)

57. The most recent annual report published by the IMB at Pentonville covers the year from April 2008 to March 2009. The Board thought that 'too many' prisoners with mental health difficulties who required a higher level of support than resources would allow were being held at the prison. The Board found that a shortage of beds in the healthcare centre meant that prisoners who might receive specialist mental health treatment in the community were being cared for whilst living on the wings. (However, the man was able to be accommodated in the healthcare centre twice when this was considered appropriate.)

58. With regard to the VPU, the Board commented that staff shortages had affected prisoners' ability to access healthcare services. (When the man was held in the VPU in late May, he was not checked by any healthcare staff.) The IMB commented that a 'great deal' remains to be done if Pentonville is to be brought up to a satisfactory standard. However, they praised the efforts of Governor C.

Performance rating

59. Prison quarterly ratings published on 26 June 2009 by the Ministry of Justice show that Pentonville scored 2 overall, indicating that the prison's performance required further development. The prison achieved the same score in both the previous and subsequent quarters. (As noted in paragraph 47 above, the maximum possible score is 4.)

THE MAN

60. The man was a 25 year old, black South Londoner who, when he died, was making plans for a life abroad. He was interested in studying maths and English and was making efforts to address his substance misuse. He had three siblings and had been brought up by his mother.

61. The man first came into contact with psychiatric services in April 2003. He was admitted to hospital between November 2003 and February 2004 and between August and November 2004. In between these admissions he made three attempts to take his own life (on one occasion using a ligature) and was described as 'acutely psychotic' at the time of the second admission. He was diagnosed with paranoid schizophrenia and a possible anti-social personality disorder. His behaviour proved difficult to manage and staff struggled to engage with him. Whilst admitted to hospital, he went absent for periods of time.

62. In May 2005, the man was formally admitted to Lambeth Hospital under the Mental Health Act. He absconded shortly afterwards, but was returned to the hospital by the police in early July. His behaviour seems to have been particularly chaotic and his mental disorder particularly severe during this period. He heard voices and was prescribed anti-psychotic medication. He was misusing class A drugs and alcohol in the community.

63. It is unclear from the documents available to my investigators exactly when the man left hospital again. By the following month, he had returned to the community and committed offences of robbery and possession of an imitation firearm. He was remanded into custody and taken to Wandsworth. In February 2006, the man received a custodial sentence of four years (for robbery and possession of an imitation firearm). The probation officer who wrote the pre-sentence report at the time noted that the man required an appropriate adult to be present during interview.

64. Because of his time served on remand, the man's sentence expiry date was set as 31 August 2009. In 2006, he moved regularly between HMP Maidstone and HMP Swaleside. The following year, he was held at Maidstone, Swaleside, HMP Elmley, HMP Leicester and HMP Preston, HMP Nottingham, HMP Brixton and Wandsworth.

65. Early on in the man's sentence, concerns were raised about his suitability for cell sharing. In May 2006, a CSRA was completed at HMP Maidstone. Staff assessed that the man required a single cell because of his ongoing mental health problems. Later that year he tried to stab an officer in the neck and also attacked a prisoner. A couple of weeks later, he assaulted night staff using a shard of glass.

66. In January 2007, the man stabbed another prisoner in the buttocks with a knife. Later that year he again attacked a member of staff with a piece of glass. A further CSRA was carried out at HMP Swaleside in January 2007.

The man was still considered unsuitable to share a cell because of the high risk he presented to others.

67. During 2006 and 2007 concerns were raised about the possibility of the man harming himself in prison and a number of separate ACCT documents were opened. The man was initially released from Wandsworth on licence on 19 September 2007. However, in the middle of October 2007, he was recalled to custody after failing to comply with the terms of his licence. He returned to Wandsworth and remained there until March 2009.

KEY FINDINGS

Release on licence

68. In early 2009, preparations began for the man's second release on licence. The seconded probation officer in HMP Wandsworth completed a report for the Parole Board in early February indicating that the man was making progress. At the same time, the manager of the mental health in-reach team at Wandsworth liaised with Streatham Community Mental Health Team (CMHT) to ensure that support was in place for the man upon his release. The man's offender manager liaised with the CMHT and found accommodation for the man in a Probation Service approved premises in Tulse Hill, South London.

69. The man's Community Psychiatric Nurse (CPN) from the CMHT, assessed the man together with his colleague on 6 March in Wandsworth. Two weeks later, on 20 March, the man was released on licence on the condition that he lived and slept each night at the approved premises. He also had to report to both his CPN and his offender manager every week. The same day, the man's offender manager telephoned the CMHT because the man had been released from Wandsworth without his medication. A member of staff from the CMHT took his prescription to the approved premises.

70. The man kept all of his appointments with the probation service and the CMHT during the next few weeks, but committed four motoring offences on 14 April (driving a vehicle without a licence, driving whilst disqualified, failing to provide the police with a name and address and having no insurance).

71. The next day, 15 April, the man kept his prearranged appointment with his offender manager. She issued him with a verbal warning in relation to his reoffending but decided not recall him to custody for the new offences. She told the man that any further failure to comply with his licence conditions would result in a final warning and consideration of recall to custody. The man's offender manager contacted the CMHT to arrange additional support for the man.

72. The man visited the CMHT the same day where he was assessed by another nurse from the CMHT and a specialist registrar at the CMHT. They noted that his mood seemed lower, reviewed his medication and additionally prescribed an anti-depressant.

73. On 21 April, the man appeared at Camberwell Green Magistrates' Court in relation to the driving offences. He was remanded into custody at about midday. The man's offender manager told my investigator that her colleagues working in the court failed to notify either her or the approved premises of the man's court appearance and his remand into custody.

74. On the same day, the man was scheduled to keep his regular weekly appointment at the probation office. When he did not attend, the man's offender manager discussed how to proceed with her manager. She

attempted to telephone the man, she contacted the approved premises and she issued a warning letter. In her email to approved premises staff, she instructed them to initiate an immediate out of hours emergency recall if the man did not return before the nightly curfew.

75. Because the man was now in prison, he did not return to the approved premises and the emergency out of hours recall request was submitted at 11.50pm on 21 April. The decision to recall the man was prompted by his failures to attend the probation office and comply with his curfew at the approved premises. The circumstances of the breach of licence were detailed as follows:

> 'The man failed to return to [the] approved premises and comply with his curfew conditions on the night of 21 April 2009 and was recalled by the hostel staff on an emergency basis. He also failed to attend his supervision appointment on 21 April with the man's offender manager, his offender manager. He did not make contact with either his offender manager or the hostel staff to confirm reasons for failing to comply. Attempts were made to contact him but his mobile phone appeared to be switched off.'

76. Prisoners remanded into custody at Camberwell Green normally transfer to HMP Brixton. However, when he returned to his cell in the court, the man told a member of Serco staff that one of his cousins worked at the prison. Serco staff liaised with the duty governor at Brixton, Governor V. Governor V confirmed that, because the man's relative worked in the prison, it would be inappropriate for him to go there.

77. Governor W took over from Governor V as duty governor at about 12.30pm. Because she did not want to keep the man waiting unnecessarily at Camberwell Green, Governor W asked Principal Officer Z to use her contacts with colleagues at HMP Pentonville to arrange for the man to be taken there instead. Principal Officer Z told my investigators that she telephoned Pentonville and spoke to Principal Officer A. The duty governor at Pentonville that day, Governor A, remembers being advised by Principal Officer A that Brixton were asking them to accept the man. Governor A agreed because of the presence of the man's relative on the staff at Brixton. Brixton arranged with Serco staff at the court for the man to be taken directly from Camberwell Green to Pentonville.

HMP Pentonville
21 April – 12 May

78. The man left Camberwell Green at about 2.50pm and arrived at Pentonville just before 4.00pm on 21 April. He was allocated a new prisoner number, although he had been in custody before and already had a pre-existing number. In effect, an alternative second record for the man was created on the Prison Service's database.

79. In the reception area a Cell Sharing Risk Assessment (CSRA) was completed by Officer A. The man's history of self harm and suicidal thoughts and misuse of drugs and alcohol were recorded. His vulnerability and mental health problems were highlighted. When completing a CSRA, to a large extent staff depend on information supplied by the prisoner himself about his previous behaviour in custody. The man did not tell the officer that he had assaulted both staff and prisoners in the past. Officer A assessed the man as presenting a low risk of harm to others.

80. Nurse A assessed the man. She recorded the man's alcohol and heroin misuse during the initial health screening. She noted that he was diagnosed with schizophrenia, for which he said he was being prescribed 6mg per day of risperidone, 2mg per day of procyclidine and 5mg per day of olanzapine.

81. The nurse noted that the man suffered from epilepsy, seemed depressed and was under the care of Streatham CMHT. Because the man told her that he was hearing voices telling him to harm himself and she noticed self harm scars on his arms, Nurse A referred him to Doctor A, a prison doctor.

82. The man told Doctor A that he had been drinking up to four small bottles of whisky per day. He said that he had last consumed alcohol the day before, 20 April, and last misused heroin on 16 April. The doctor told my investigators that the man was not presenting with drug or alcohol withdrawal symptoms. Doctor A decided not to refer the man to the prison's detoxification unit for the time being and did not prescribe any medication to ease any withdrawal symptoms as none was evident. The doctor told my investigators that a subsequent check for withdrawal symptoms would take place during a secondary health assessment the next morning.

83. Based on the man's history of mental health problems and his vulnerable presentation, the doctor opened an Assessment, Care in Custody and Teamwork (ACCT) document. Doctor A also completed a mental health referral to the In-Reach team. Although the man told Nurse A that he was prescribed anti-psychotic medication in the community, Doctor A was reluctant to issue any drugs until the information was confirmed with the CMHT the next day. He prescribed the man 15mg per day of mirtazapine in the meantime. Completing the healthcare section of the CSRA, Doctor A did not identify any concerns about cell sharing, and assessed the man as presenting a low risk to others.

84. The first entry in the ACCT document recorded that the man did not want to be in Pentonville and wished to move to a South London prison. At 8.25pm, Senior Officer A completed the ACCT immediate action plan. The man was located with Prisoner A in a shared cell on the third landing of A wing (the first night centre, where prisoners generally spend the first week or so in Pentonville). Prisoner A had initially been placed in a different cell, but was moved to share with the man after 45 minutes because he did not get on with his original cellmate. As part of the ACCT process, staff checked on the man at least once an hour.

22 April

85. The following morning, 22 April, Officer B (a trained ACCT assessor) went to the man's cell where he was still asleep. Officer B told my investigators that his cellmate had gone to court. She woke the man and took him to an office on the wing to carry out his initial ACCT assessment interview (which must be completed within 24 hours of the ACCT document being opened). She told my investigator that the assessment interview began at 9.30am and lasted about 45 minutes.

86. Officer B remembered that the man was holding his neck at an awkward angle when they spoke. (Staff and prisoners agreed that this problem seemed more pronounced when the man became anxious.) The man said that he was hearing voices telling him to harm himself. The officer noted that the voices were strong and persistent and that the man had a history of mental health problems.

87. During the interview, the man said that he would be 'better off dead than alive'. He said that 'so much' was going on in his head. He told the officer that the recent death of a cousin had worsened his feelings of depression. The officer remembered the man saying that he wanted to 'be with his cousin'. She referred him to the prison chaplain with a view to bereavement counselling.

88. The man told Officer B that he wanted to transfer to Wandsworth to be nearer to his family, and she advised him that any move would need to be approved by a governor. He asked for help to address his substance misuse. The officer recalled that the man looked like somebody who might be withdrawing because his mouth was drooping and his eyes were watering. He did not look well but she could not be sure whether this was a result of his mental health problems or his substance misuse.

89. On the morning after a prisoner's first night in custody, a nurse carries out a secondary health assessment following the initial screening in the reception area the day before. Having finished the assessment interview, Officer B took the man down to wait outside the nurse's treatment room.

90. Because the man had asked for help with drug and alcohol withdrawal, Officer B walked over to the detoxification unit on B wing to speak to a substance misuse nurse, who agreed to organise a place for the man on the unit as soon as possible. Officer B referred the man to the CARATS (Counselling, Assessment, Referral, Advice and Throughcare Services) team and the In-Reach team.

91. When she returned from the detoxification unit, Officer B sat down with Senior Officer B and the man to complete the 'action following assessment' section of the ACCT document. It was noted that the man was quite clearly depressed but that, once his detoxification medication took effect, he might start to feel better. A space had been found on the detoxification unit and the man was supposed to move there later in the day. The risk the man presented to

himself was assessed as 'low'. Officer B told my investigators that she thought there was an 'imminent' likelihood of 'suicidal intent', but she believed the planned move to the detoxification unit would reduce the risk.

92. The ACCT document appears to indicate that the intended level of observations remained once an hour during the morning of 22 April, although this is somewhat unclear. Officer B remembered that she did not amend the frequency of the checks.

93. Following Officer B's referral, later that morning the man spoke to Chaplain A. The chaplain agreed to ask the Imam to visit the man as he was a Muslim. The man was escorted to the induction room by Officer C, where he met a variety of staff who could assist him in prison, such as a member of the CARATS team and a worker from St Mungo's.

94. As Officer C took the man back to his cell, he told her that he was scared of being in Pentonville. He said that, as a member of a South London gang, he was anxious about being placed amongst rival gang members in a North London prison. Because of the sensitive nature of their conversation, Officer C took the man back to the induction room, where they would have more privacy.

95. Officer C told the man that he could apply to move to Wandsworth. She also suggested moving him to another part of Pentonville. However, because the man was so anxious, Officer C offered him vulnerable prisoner status. In prison, this is known as 'taking rule 45'. It means that the person is removed from the general prison population for their own protection and placed on a dedicated wing with other vulnerable prisoners.

96. The man had previously been located on the Vulnerable Prisoners Unit (VPU) at Wandsworth (known as the Onslow Centre) before his release on licence. He feared for his safety if he stayed amongst the general prison population and decided to accept Officer C's offer of a move to the VPU in Pentonville. Officer C asked the duty governor to assist her.

97. Governor B (the duty governor) and Officer C interviewed the man at about 11.00am that day. They completed a 'Management of Vulnerable Prisoners' document. The interview lasted about an hour. Although the man was scared, Officer C recalled in interview that he remained calm and was grateful to be offered protection. She thought that he was afraid of being attacked by other prisoners. She knew he was currently the subject of an ACCT document, but she did not recall him mentioning any suicidal thoughts whilst they arranged the move to the VPU.

98. The man spoke clearly during the interview and Officer C thought that he understood what was going to happen. She did not observe any significant mental health problems. The officer remembered that the man held his neck at an awkward angle. He was granted vulnerable prisoner status. Governor B tried to ease his anxiety by proposing a transfer to Wandsworth (where he

said he had felt safe on the Onslow Centre) following his next court appearance in May.

99. Officer C told the man to pack up his belongings as he would move to a cell on Pentonville's VPU on G1 landing straight after lunch. (Officer C explained to my investigators that, because the meeting finished at about 12.10pm, the last time for movements around the prison before lunch had passed.) In the meanwhile Prisoner A was moved into a different cell because the man's 'rule 45' status meant that he could no longer share with a prisoner from the general population. Having collected his meal, the man was locked alone in his cell for lunch at about 12.30pm.

100. An entry was made in the man's ACCT document by a CARATS worker at 1.10pm, indicating that he agreed to an assessment following Officer B's referral earlier that morning. Officer C completed a Security Incident Report (SIR) outlining the man's concerns regarding gangs in Pentonville.

101. Following the lunchtime lock up from 12.30pm to 1.30pm approximately, the other prisoners were unlocked for afternoon exercise. Officer C had told the man that, as vulnerable prisoners had to be kept separate from the general population, he would have to wait until the other prisoners left before he was moved to the VPU. She told her colleagues who were unlocking cells with her that the man had signed up to rule 45.

102. A short while later, Officer C was walking past the man's cell when she acted on a feeling of concern. Looking through the observation flap at about 2.20pm, she saw the man in a seated position on the bottom bunk bed. She realised that he was suspended slightly above the mattress and had tied a towel around his neck, attaching it to the frame of the bed above him. Officer C immediately shouted for assistance and Officer D and Officer E, who were unlocking prisoners on the other side of the landing, joined her.

103. Officer C opened the cell door. She and Officer D used their anti-ligature knives to cut through the towel that the man had used to hang himself. The material was very thick and it took both officers' efforts with their knives to remove the ligature. In the meanwhile, Officer E told the control room that a 'level one' emergency was underway. Healthcare staff were instructed to attend immediately and an emergency ambulance was requested.

104. Supporting the man, the officers moved him to the floor. His pupils were fixed and dilated. Officer C tilted and supported his head and cleared his airway to give breaths whilst Officer E began giving chest compressions. The man began to respond to their efforts. Officer D stood by the entrance of the cell to ensure that the healthcare staff could see where to go and reach the man as quickly as possible.

105. Healthcare staff arrived at the cell at 2.22pm. Nurse B and Nurse C found a pulse and took over the resuscitation of the man. They were joined by colleagues including Doctor B, Doctor C and the Head of Primary Care Nursing at Pentonville. Paramedics reached the wing at 2.30pm and the crew

of an air ambulance arrived at 2.42pm. The air ambulance team attributed the man's survival to the initial efforts of the staff. He nearly died and his successful resuscitation was far from certain. The Head of Primary Care Nursing at Pentonville recalled in interview that he and Doctor B had not expected the man to survive.

Admission to hospital

106. At about 3.10pm the man was taken by ambulance to the Royal London Hospital. Given the seriousness of his attempt to take his own life, Governor C held a debrief meeting shortly before 4.00pm. The debrief was intended to give staff a chance to collect their thoughts, learn any immediate lessons from the emergency and access support if they had been affected by events.

107. The man initially stayed in the Intensive Care Unit (ICU) at the Royal London. He was in a critical condition to begin with and was not handcuffed whilst he was sedated. Escorting staff sitting with the man at the hospital were to contact the duty governor for advice regarding restraints when the man's condition improved.

23 April

108. The next day, 23 April, the mental health referral from Doctor A reached the prison's In-Reach team. The man remained sedated at the Royal London and a machine was helping him to breathe. His mother and sister arrived in the early afternoon. At about 5.00pm he regained consciousness and he became agitated overnight as the sedative wore off.

109. On the same day staff at the Tulse Hill approved premises had discovered that the man had returned to prison and was now under escort in hospital. They told the man's offender manager's line manager because she was away from the office.

24 April

110. The man was moved to a private room the following day. Given that he had made escape attempts in the past, the risk he presented as a prisoner and his difficult behaviour since waking, the man was cuffed to one of the officers from this point onwards by an escort chain.

111. On the same day, 24 April, the Request for Recall report completed by the man's offender manager was approved. The man's offender manager had noted that the man had complied with his reporting instructions until 21 April. She wrote that concerns had been raised about his mental health problems and behaviour at the hostel, but that these had been managed. The man's offender manager's line manager and the Assistant Chief Officer (ACO) for Lambeth had both approved the man's recall to custody and agreed that he had breached his licence conditions.

112. Staff at the Public Protection Casework Section, the department of the National Offender Management Service (NOMS) which administers recalls, were unaware of the man's whereabouts and had instructed the police to arrest him. The reasons given for the revocation of licence were:

> 'You have failed to be well behaved, not commit any offence and not do anything which could undermine the purposes of your supervision, which are to protect the public, prevent you from reoffending and help you to resettle successfully into the community.
>
> 'You failed to keep in touch with your supervising officer in accordance with instructions.
>
> 'You failed to live permanently at the address approved by your supervising officer and failed to notify him or her in advance of your change of address or proposed stay (even for one night) away from that approved address.'

113. Officer F spent time at the hospital as the bedwatch officer during this period. In interview, he recalled that the man was confused and did not understand why he was in hospital. Entries made in the ACCT document show that the man was disoriented and agitated in the days after he woke up in hospital and had no idea why he was a prisoner again. He asked questions about his family, his next court appearance and his prison sentence. Whilst the man was in hospital, the prison arranged and paid for taxis to take his mother to visit her son in hospital.

<u>26 April</u>

114. Two days later, on 26 April, the man was interviewed by a psychiatrist in hospital. He recalled the police arresting him for driving offences but could not remember trying to hang himself. He said that he had enemies in Pentonville and was hearing the devil's voice telling him to kill himself.

115. Still unaware that the man had re-entered custody, the Public Protection Casework Section checked the Prison Service's Inmate Information System (IIS) on 27 April. Their staff did not identify from the computer records that the man was back in prison, albeit presently discharged to hospital. On the same day, the man's offender manager returned to the probation office and telephoned the man's mother to discuss her son's remand into custody.

<u>27 April</u>

116. Principal Officer B submitted a Security Incident Report (SIR) on 27 April concerning the man's possible ties to gang culture. Whilst the PO was visiting the hospital, the man spoke about an 'ongoing feud' between North and South London gangs, his fears for his safety as a result and his wish to return to

Wandsworth. Principal Officer B told my investigator that the man was not completely coherent when they spoke and he was unsure of the accuracy of the information he provided. Nonetheless, he felt obliged to record it in an SIR.

Return from hospital to Pentonville

28 April

117. The man returned to Pentonville from the Royal London shortly before 2.00pm on 28 April. He was placed in a single cell on the healthcare centre and a CPN, Mental Health Nurse A, was allocated to him. The ACCT document remained open and he was kept under constant observation. Constant supervision at Pentonville means that a nurse stayed with the man at all times. He was in a dedicated cell with both a door and a barred gate so that he could easily be observed by staff. During the day, the door is pinned back and the prisoner can be seen through the bars of the locked gate. At night, the door is locked and staff use the observation flap to check the prisoner.

118. Later, on 28 April, the man's condition was reviewed by Doctor D (consultant forensic psychiatrist) and his colleague Doctor E (speciality doctor in forensic psychiatry). He told the doctors that he had been hearing voices and felt unsafe amongst the general Pentonville prison population, believing that other prisoners wanted to kill him. Doctor E remembered the man saying that this feeling had contributed to the attempt to take his own life on 22 April.

119. The man indicated that his suicidal thoughts were unpredictable, but that he was not feeling 'too suicidal' at present. He told the doctors that he had been 'doing well in Wandsworth' before his release on licence. Doctor D noted that the man seemed 'preoccupied' with returning there.

120. Doctor D told my investigators that the man spoke clearly and coherently. Both he and Doctor E told my investigators that the man had been 'pleasant and cooperative' during the consultation. Doctor E recalled that he seemed stable and calm. She remembered that each time she encountered the man in the healthcare centre during this period, he would talk about his desire to transfer to Wandsworth.

121. To assist understanding of the man's previous mental health problems, the manager of the mental health in-reach team at Pentonville contacted Streatham CMHT, who faxed across a discharge summary dating from 2004. Doctor D instructed that the man continue to be prescribed 7mg per day of risperidone and 15mg per day of mirtazapine. The man was visited by the duty governor at about 5.00pm. During the evening, he was seen talking to himself for a prolonged period of time.

29 April

122. At 3.00pm the next day, 29 April, on the advice of Doctor D, the ACCT observations were reduced from constant supervision to every 15 minutes

until 8.00am the next morning. (The checks were to be further reduced to every 30 minutes from 8.00am until 4.00pm on 30 April, and from then on the man was to be checked at hourly intervals.)

123. The first review of the ACCT document took place the same afternoon. Senior Officer C led the meeting with Doctor D in attendance. The man seemed relaxed and said that he was no longer thinking about harming himself. The risk he presented to himself was assessed as 'low' (as opposed to either 'raised' or 'high'). He voiced his desire to be transferred to Wandsworth and his anxiety at being held in Pentonville. He expressed a wish for increased contact with his family so visiting orders were to be issued. He was given a television in the hope that he would benefit from some distraction. The next ACCT review was scheduled for 6 May.

124. In interview, Senior Officer C remembered that the man appeared 'slightly paranoid and overly nervous' when he returned from hospital. He told my investigators that the man settled in quickly on the healthcare centre. He complied with his medication and mixed well with the other prisoners, attending reading and writing classes. His condition stabilised and slowly improved. The man was assured that his return to Wandsworth was in hand.

125. Doctor D wrote in the man's medical record that he felt safer in the healthcare centre but would feel safer still in Wandsworth. The doctor decided that the man should stay in the healthcare centre because the risk that he would harm himself would increase if he moved anywhere else in Pentonville. Doctor D supported the proposed transfer to Wandsworth and understood that Governor C was considering the man's request.

126. The doctor told my investigators that he spoke to the Head of Healthcare at Pentonville about the proposed transfer. The man continued to hear voices, seemed depressed and told the doctor that 'at times it would be easier to die than live'. However, there was no evidence of further self harm or that the man had a specific plan to take his own life. Doctor D recalled that the man complied with his medication and took it regularly whilst he was in Pentonville.

<u>30 April</u>

127. The chaplain visited the man on the afternoon of 30 April and they talked about his fear of Pentonville and his desire to return to a South London prison. The next day, 1 May, the man spoke to the Imam, who made an entry in his ACCT document noting similar sentiments. The same morning, Senior Officer C planned to pursue the proposed transfer to Wandsworth with the prison's Offender Management Unit (OMU).

128. Governor C told my investigators that he visited the man a couple of times in the healthcare centre to receive updates on his condition. He remembered the Head of Healthcare at Pentonville and his colleagues telling him about the man's anxiety at remaining in Pentonville and his wish to return to Wandsworth. Governor C took into account the man's serious attempt to take his own life, the reasonable nature of the request and the need to provide

greater stability. He planned to seek Wandsworth's assurance that they would accept the man as soon as it was appropriate to transfer him.

129. Governor C approached Governor 1 (the then Governor of Wandsworth) in early May to obtain his agreement to the man's transfer. Neither man could remember in interview precisely when or how they spoke, but both confirmed that they had had the conversation.

130. Governor 1 recalled Governor C explaining that the man had made a very serious attempt on his own life, that staff at Pentonville had been affected by the incident and it was thought inappropriate for him to remain at Pentonville for any longer than necessary. Governor 1 remembered Governor C telling him that the man was 'very keen' to return to Wandsworth, where he felt safer. Governor C asked Governor 1 to accept the man at Wandsworth and he agreed. Governor 1 could not recall any subsequent involvement in helping to oversee the planned transfer, but he thought that he would have had discussions with colleagues in advance of the man's arrival.

5 May

131. Doctor D reviewed the man's mental health again on 5 May. The man was in a better mood and said that the voices were 'not too harsh' at present. He continued to talk about his association with a South London gang and express his fear of being harmed if he was placed with the general prison population, which included prisoners who he said were demanding money from him. The doctor noted that the man was not currently expressing suicidal thoughts. Later that day, Doctor D wrote a referral letter to a specialist registrar at Streatham CMHT, asking him to visit the man in prison and assess him. He wrote:

> 'In view of the serious nature of the suicide attempt, I am of the opinion that he might benefit from further assessment in hospital …'

132. The man was provided with a telephone PIN number on 5 May. The same day, Officer G told the man that he was subject to 'medical hold' and could not be transferred out of Pentonville for the time being. However, Senior Officer C told healthcare staff later that the man would return to Wandsworth a week later, on 12 May, following a court appearance. Plans were made to liaise with the In-Reach team at Wandsworth prior to his arrival.

133. Staff at the Public Protection Casework Section made a second check of the Prison Service computer records on the same day. They discovered from the records that the man had been held in Pentonville since 28 rather than 21 April. Staff emailed a licence recall pack to Pentonville for immediate distribution to the man.

6 May

134. Senior Officer C and a mental health nurse completed the second review of the man's ACCT document at 7.00pm on 6 May. It was noted that he had

settled down and made excellent progress since arriving in the healthcare centre. He was taking his medication and his mood was stable, although he continued to hear the voices in his head. He had some thoughts about harming himself but said he did not plan to act on them. The man was content to remain in the healthcare centre until his transfer to Wandsworth on 12 May. He was to be checked at two hourly intervals and staff were to make an entry in his ACCT document each time. The risk he presented to himself was still assessed as 'low'.

135. Acting Ward Manager Nurse D liaised with the manager of the mental health in-reach team at Wandsworth to organise the forthcoming transfer. The manager of the mental health in-reach team at Wandsworth had worked with the man before his release on licence. Nurse D told her about the man's return to custody and his recent attempt to take his own life. The manager of the mental health in-reach team at Wandsworth planned to assess the man and manage his care when he arrived. She told the In-Reach team that the man would be coming to Wandsworth and his arrival was discussed at their referral meeting on 12 May.

136. Nurse D recalled that he telephoned the man's mother several times to update her on her son's progress. He arranged for her to send in money for the man to buy items such as tobacco. He also arranged for the Head of Healthcare at Pentonville , to confirm the man's transfer from Pentonville's healthcare department to Wandsworth's with the Head of Healthcare at Wandsworth.

137. During this period the man could not work and had very little money to spend on tobacco. Nurse D remembered that the duty governors who came to the healthcare centre to check on the man's wellbeing generously allowed him to have an emergency smoker's pack virtually every other day because he was such a regular smoker and it helped to keep him calm.

7 May

138. On 7 May, the man seemed lower in mood and asked to speak to a Listener. The same day, the Head of Primary Care Nursing at Pentonville noted in the man's medical record that a handover should take place between healthcare and discipline staff at both prisons before his transfer to Wandsworth on 12 May. The Head of Primary Care Nursing at Pentonville told my investigators that Senior Officer C and Nurse D took responsibility for this. He emphasised that the reception centre at Wandsworth should be told about the man's transfer. The Head of Primary Care Nursing at Pentonville stressed in the clinical record that it was 'extremely important' that the planned move be marked on the Person Escort Record (PER) that accompanied the man to court.

139. Later that day, Mental Health Nurse A telephoned Nurse 1 (a member of the In-Reach team at Wandsworth). She told her that the man would be arriving on 12 May and faxed his records across. Mental Health Nurse A wrote on the

fax that the man was 'relatively settled' and was taking his medication, but was still thinking about harming himself.

8 May

140. The next day, 8 May, Senior Officer C emailed Nurse 2 (a nurse at Wandsworth) about the transfer. He wrote that the man had 'attempted suicide because he was here' and 'there is a danger he will try again if he stays here longer than his court date'.

141. The man made no further attempts to harm himself before he left Pentonville. His mood remained relatively stable and he complied with the prison regime. His mother visited him on the afternoon of 9 May. She brought some things for him and he seemed to be in a positive mood . afterwards

10 May

142. Having spoken to Nurse 2, Nurse D emailed her a summary on 10 May of the man's recent medical history. He described the progress the man had made and the ongoing concerns. He indicated that the man did not appear to have sustained any brain damage as a result of his attempted hanging on 22 April. He wrote that the man had threatened to make another attempt on his life if he were to come back to Pentonville.

143. The same day, Senior Officer C emailed the Head of Primary Care Nursing at Pentonville asking him to telephone Serco to instruct them that the man must be taken from court to Wandsworth, naming Nurse 2 as a contact at Wandsworth. Senior Officer C made an entry in the man's wing history sheet stating that the ACCT document remained open primarily because he was still in Pentonville. The next day, 11 May, it was noted in the man's ACCT document that he was in an upbeat mood, was getting on well with staff and prisoners alike and did not expect to return to Pentonville after his court appearance.

12 May

144. On 12 May shortly after 7.30am, Senior Officer D, the Safer Custody Manager at Pentonville, emailed Senior Officer Y in the Safer Custody department at Brixton. He wrote to advise Senior Officer Y that the man would be arriving at Brixton following a court appearance later that day. (Senior Officer D had not been told about the plan to return the man to Wandsworth.) He indicated that staff at Brixton should contact Pentonville's healthcare centre for a handover after the man arrived. He noted that an ACCT document was currently open. Senior Officer E emailed Senior Officer D at 7.53am telling him that the man was actually supposed to go to Wandsworth. Senior Officer Y replied to Senior Officer D later that morning, confirming that reception staff at Brixton had been told to expect the man.

145. The man left Pentonville at 8.15am that morning and arrived at Camberwell Green Magistrates' Court just after 9.00am. The PER was not marked to

indicate the planned transfer to Wandsworth. The Head of Healthcare at Pentonville and Senior Officer C both confirmed that they worked on the mistaken assumption that prisoners leaving Camberwell Green are automatically taken to Wandsworth. This was the case in the past, but the situation had changed quite some time ago. Prisoners returning to custody from Camberwell Green are taken to Brixton as a matter of routine, unless Serco staff are aware of a particular reason why this should not happen.

146. At 10.40am, the man was assessed by the court psychologist in the cells. He appeared in court at about midday and was once again remanded into custody. His medical record was read out in court (in which it clearly stated that he should be taken to Wandsworth) but this information does not seem to have been acted upon.

HMP Brixton
12 May – 13 May

147. During the morning, Senior Officer Y forwarded the email from Senior Officer D to the duty governor at Brixton, Governor X. Governor X told Serco staff at Camberwell Green Magistrates' Court that Brixton could not accept the man because there had been no prior agreement between the healthcare departments at Brixton and Pentonville. (The London Area Male Locals Transfer Protocol states that the healthcare managers at both the sending and receiving prison must reach an agreement before a prisoner transfers from a healthcare setting.)

148. Finishing his shift at about 12.30pm, Governor X handed over to the incoming duty governor, Governor Y, who also spoke to Serco staff at the court. Governor Y then telephoned the Serco control centre, who seemed unaware of Brixton's objections to the man's transfer. At 4.28pm, the man was placed on an escort vehicle and taken to Brixton, arriving there at 5.35pm. He was held in the Serco van at the prison gate. Healthcare staff in the reception area checked the man's medical record, learnt about the planned transfer to Wandsworth and the need for a comprehensive handover to be conducted.

149. Governor Y telephoned Governor 2, the duty governor at Wandsworth. He told Governor Y that he was not aware of any pre-existing arrangement and refused to accept the man. Governor Y thought that Governor 2 had been dealing with another incident at Wandsworth when they spoke together. Governor Y telephoned the duty governor at Pentonville, Governor D. Governor D apologised and acknowledged that there had been a breakdown in communication.

150. Concerned about the man's continuity of care, Governor Y initially thought that the London Transfer Protocol should be followed and the man should return to Pentonville's healthcare centre. However, Governor D told Governor Y that the man had felt unsafe at Pentonville. He asked if the man could be held at Brixton for the night and taken to Wandsworth the next day, once the relevant staff at Pentonville and Wandsworth were at work and could resolve

the confusion. (It was early evening at this point and most healthcare staff would have left for the day.)

151. Governor Y decided to accept the man as a prisoner overnight on the proviso that he would go to Wandsworth the next day. He considered that it would take too long to return the man to Pentonville, and he was mindful of the distress that returning there might cause him. Governor Y was also aware of the considerable time the man had already spent sitting in the Serco van whilst a decision was made. He thought that accepting the man was the 'least risky, and most decent thing to do'.

152. The third review of the man's ACCT document was carried out by Brixton staff, Governor Y and Senior Officer Z, at 7.15pm. They noted that the man was surprised to have arrived at Brixton but seemed settled. The man was placed in a double cell on the healthcare wing with a prisoner who was not subject to ACCT monitoring. Although the man presented as stable, staff were conscious that the planned transfer to Wandsworth had been disrupted and he was now in unfamiliar surroundings.

153. Observations were increased from once every two hours to three checks per hour (although they actually took place every 15 minutes during the night). Governor Y recalled placing the man under what he referred to as constant supervision as a precaution. The risk of the man harming himself was assessed and increased to 'raised'.

154. Governor Y telephoned Pentonville and spoke to 'the charge nurse on duty', who told him that the man had been stable and had not made any further attempts to harm himself since 22 April. Governor Y read the man's file to familiarise himself with his recent history and telephoned Governor 2 (at Wandsworth) to request the transfer the next day. He was told that Wandsworth would first need to clarify who had arranged the transfer. Governor Y went to visit the man in his cell before he left the prison for the evening.

155. The man was assessed by a doctor at 8.15pm. He told the doctor that he felt settled. They discussed his recent attempt to take his own life at Pentonville. He showed insight into his mental health problems and said that he was able to manage the voices he could hear. He said that he was not currently having any suicidal thoughts. The doctor prescribed 5mg of procyclidine, 15mg of mirtazapine and 7mg of risperidone. The man slept through the night.

13 May

156. The next day, 13 May, healthcare staff at Pentonville arrived at work and realised that the plan to transfer the man to Wandsworth had gone awry. The Head of Healthcare at Pentonville telephoned the Head of Healthcare at Wandsworth, who agreed to accept the man from Brixton.

157. Nurse D spoke to the manager of the mental health in-reach team at Wandsworth. They agreed that the man would be transferred to Wandsworth later that day and the manager of the mental health in-reach team at Wandsworth would assess him the following morning. Nurse D contacted Brixton to tell them that Wandsworth had accepted the man.

158. An escort was organised by Pentonville, as the failure to clearly mark the PER was theirs. Governor Y asked Principal Officer Z to arrange for the man to be escorted to Wandsworth by three prison officers. They left Brixton at 5.50pm and arrived at 6.35pm. It was noted in the man's ACCT document that he was 'in rather good spirits' and was 'happy' to be at Wandsworth.

HMP Wandsworth
13 May – 26 May

159. Officer 1 completed a CSRA and assessed the man as a low risk of harm to others. The man was examined by Nurse 2 in the reception area at 9.15pm. Nurse 2 completed the healthcare section of the CSRA and referred the man to Doctor 1.

160. Although the man was reluctant to speak about his recent attempt to take his own life, Doctor 1 read about it in his medical record. The man told her that he was hearing voices but 'was managing to block them out' and was not currently having suicidal thoughts. He said that he was glad his recent suicide attempt had been unsuccessful.

161. Doctor 1 noted in the man's medical record that the Onslow Centre, where he was anxious to be located, was currently short of beds. As a vulnerable prisoner, he had to be kept away from the general prison population. She reassured the man that he would be moved to the Onslow Centre as soon as there was space available. Doctor 1 continued his prescription of 15mg of mirtazapine and 5mg of procyclidine daily.

162. Overnight, the man was checked every 20 minutes instead of 15 minutes as he had been at Brixton. This actually adhered to the original decision the previous night for ACCT monitoring to take place three times an hour.

<u>14 May</u>

163. The man spent the next two nights in a cell on the first night centre, waiting to move to the Onslow Centre. His ACCT document was reviewed for a fourth time at 8.45am the next morning, 14 May. Senior Officer 1 and Senior Officer 2 on the first night centre carried out the review but did not comment on the risk of the man harming himself. They recorded that the man was still hearing voices, but his medication was helping him to control his thoughts.

164. The frequency of observations was amended from three times an hour to hourly both during the day and at night. (This frequency was marked clearly on the front cover of the ACCT document, in the record of the review and in the ongoing record. However, as I discuss later in the Issues section of my

report, this frequency was not adhered to by staff.) It was planned that a member of the In-Reach Team should attend the next ACCT review on 19 May. It was also noted that the man had a lot of queries because 'he has been in a few prisons lately'.

165. Shortly before midday, the man was assessed by the manager of the mental health in-reach team at Wandsworth in the Listeners' Suite on the first night centre. They had a lengthy discussion about his recent attempt to take his own life and the events leading up to his recall to prison. The man confirmed that he had wanted to end his life and was afraid of other prisoners in Pentonville. He denied having any current suicidal thoughts. In interview, the manager of the mental health in-reach team at Wandsworth remembered that the man engaged with her and was glad to be back in Wandsworth. He was very keen to get his old job back on the Onslow Centre. The manager of the mental health in-reach team at Wandsworth was 'really reassured' by his presentation. They agreed to focus on preparations for his likely release at the end of his sentence in August. The man asked the manager of the mental health in-reach team at Wandsworth to refer him to an organisation that might be able to help him with accommodation upon release. The manager of the mental health in-reach team at Wandsworth agreed to contact the man's sister to update her on his progress.

166. The manager of the mental health in-reach team at Wandsworth telephoned the man's CPN at the CMHT. She told him that the man had arrived at Wandsworth. (The man's CPN had most recently received a letter from Doctor D at Pentonville asking the CMHT to assess the man, with a view to admitting him to hospital.) The manager of the mental health in-reach team at Wandsworth arranged for the man's CPN and a specialist registrar at the CMHT to assess the man in Wandsworth on 1 June. The manager of the mental health in-reach team at Wandsworth wanted the man's CPN to make plans to support the man after his release in August.

15 May

167. At 3.30pm the man spoke to a Listener. At 10.15am the next day, 15 May, he moved from the first night centre to K wing on the Onslow Centre. The man was assigned a personal officer, who wrote in his wing history sheet that he was settling in well. He told staff that he wanted to share a cell with 'somebody suitable'. The man's mood appears to have been good throughout the rest of the day.

16 May

168. The following day, 16 May, the man's cellmate took an overdose of diazepam. Afterwards, the man was thought to be 'a bit upset, but OK'. Having returned to the Onslow Centre, he wanted to obtain employment as a wing cleaner. However, he was unable to work due to a long standing injury (deep vein thrombosis in his right leg).

169. The man was allocated a new cellmate, Prisoner 1. An officer noticed that the two men seemed to 'click'. Prisoner 1 remembered that the man kept active and took his medication regularly. He recalled that they had got on well.

19 May

170. The ACCT document was reviewed for a fifth time and closed at 8.15am on 19 May. The man, Senior Officer 3, Senior Officer 4 and a member of the IMB attended the review. The manager of the mental health in-reach team at Wandsworth had planned to be there but was out of the prison at Springfield University Hospital at the time. The risk that the man presented to himself was reduced to 'low'. It was recorded that he was 'happy' for the ACCT document to be closed, and would access either the Listeners or the Samaritans telephone service if he had any further thoughts of harming himself. A post-closure ACCT review was scheduled for 11.00am on 26 May.

24 May

171. At 6.10pm on 24 May, the man activated his cell bell and asked to speak to the Samaritans. He was placed in the care suite to make a telephone call, returning to his cell at 7.00pm. The post-closure ACCT review was conducted by Senior Officer 5 at 10.00am the next day, 25 May, a day earlier than scheduled. The SO noted that the man had settled back onto the Onslow Centre well. No further concerns regarding self harm were recorded.

Camberwell Green Magistrates' Court
26 May

172. The man left Wandsworth to make a scheduled court appearance at 7.50am on 26 May. His PER was not marked to indicate that he should return to Wandsworth. He appeared at Camberwell Green and was sentenced for the four driving offences committed in April. He was fined £50 or a day's imprisonment in relation to the offence of having no insurance, and £100 or a day's imprisonment in relation to the offence of driving whilst disqualified. No separate penalties were imposed for the offences of failing to give a name or address to the police and having no licence. Because the man had been held on remand for over a month, the sentence was deemed to have been served. However, the man remained in custody because of the recall initiated on 22 April and he returned to the court cells.

173. Serco staff at the court telephoned reception staff at Brixton and asked them to accept the man. (As previously indicated, Brixton is the prison where men remanded at Camberwell Green are supposed to be taken as a matter of course.) Reception staff telephoned the duty governor, Governor Z. They advised him that the man could not be held at Brixton because of the previously identified conflict of interest.

174. Governor Z told my investigators that he telephoned the Serco supervisor in the cells at Camberwell Green. He explained to the supervisor that Brixton would not be able to receive the man because a family member worked at the

prison. Governor Z thought that the man 'must have been' in the court cells at the time of his telephone call and had not yet left in the Serco van. The member of Serco staff he spoke to told Governor Z that the man had come from Wandsworth that morning. For this reason, Governor Z decided to telephone the duty governor at Wandsworth, Governor 3.

175. During interview, Governor Z recalled telling Governor 3 that Serco were asking him to accept the man, but that he could not because of the conflict of interest. He told the investigators that he was certain that he told Governor 3 that the man had come from Wandsworth that morning. Governor Z remembered knowing about the attempt which the man made to take his own life in Pentonville in April, although he could not recall if he mentioned it to Governor 3.

176. Governor Z said in interview that Governor 3 refused to accept the man into Wandsworth, instead telling Governor Z that he would have to resolve the problem because Camberwell Green was a court served by Brixton. He remembered during interview that Governor 3 said, 'He's not ours, he's yours'. However, Governor Z recalled that, after he re-emphasised the conflict of interest, Governor 3 replied, 'Leave it with me'.

177. After speaking to Governor 3, Governor Z was left with the impression that the man would return to Wandsworth. He did not remember thinking that Governor 3 would try to place the man in a different London prison. He told my investigators that he spoke to Governor 3 'once or twice' about the man.

178. Governor 3 told my investigators that he had two or three telephone conversations with Governor Z. Afterwards, Governor 3 telephoned Pentonville and spoke to the duty governor, Governor A. He asked her to accept the man. He thought that the man should either go to Brixton, the prison serving Camberwell Green, or Pentonville, where he had begun his recall to custody.

179. By his own admission, Governor 3 did not investigate the man's background or the reason he had transferred to Wandsworth two weeks earlier. He told my investigators that the forthcoming inspection at Wandsworth influenced his reluctance to accept the man, something I discuss in the 'Issues' section of the report. Governor 3 perceived Wandsworth as having accepted too many transfers in the past, whilst, in his opinion, other London prisons had not made similar efforts in return.

180. During interview, Governor A recalled having a disagreement with Governor 3 on the telephone. She remembered mentioning the recent attempt the man had made on his own life. For this reason she thought it was inappropriate to accept the man back at Pentonville. Governor A remembered that Mr Governor 3 told her that Governor C had already agreed the transfer with Governor 1. She told my investigators that Governor 3 made a direct reference to the forthcoming inspection at Wandsworth, suggesting that she would be assisting him if she accepted the man. (Governor A only told

Governor C about this part of her conversation with Governor 3 some weeks later.)

181. Unhappy with the conversation, Governor A wanted to clarify with Governor C whether he had agreed to the transfer. Governor C told her that he had not agreed to it and he was displeased that Governor 3 was claiming otherwise. Governor C told my investigators that he immediately telephoned Governor 1 in his office at Wandsworth. The telephone call took place at 1.17pm.

182. Governor C established with Governor 1 that he had not yet agreed to accept the man at Pentonville. Governor C expressed his reluctance for the man to return to Pentonville (given his recent attempt to take his own life in April and his anxiety about the prison) and Governor 1 agreed that the man belonged at Wandsworth. During interview, Governor C recollected his thoughts at the time:

> 'And I can assure you, you know when I've thought about those issues and I think if I'm being honest with myself I wish things hadn't occurred full stop because I think actually just some better organisation, he shouldn't have come back [to Pentonville].'

183. The conversation ended with Governor C agreeing to accept the man back into Pentonville in the short term. Governor C obtained Governor 1's agreement in principle that the man would return to Wandsworth. Governor C thought that he offered a timescale of two weeks before the man returned. Governor 1 could not recall discussing a timescale.

184. Governor C told my investigators that he agreed to accept the man because he was under the impression that he had already left the court and was en route to Pentonville in an escort vehicle. Governor A thought that it was she who made this assumption and then gave Governor C the same impression. Neither of them had spoken to Serco staff or knew for certain that the man was already on his way. The PER relating to the man's transfer indicates that he actually left Camberwell Green for Pentonville at 2.37pm, an hour and twenty minutes after the telephone call.

185. Governor 3 made an entry regarding the man in the Wandsworth duty governors' log. He wrote:

> 'The man out to court – meant to be Brixton court, but is family member to officer. Had come here from Pentonville, re-directed back there on agreement between Governor 1 and Governor C.'

186. Neither Governor C nor Governor 1 recorded their decision making. Governor 3 told my investigators that he had not been asked to accept any other prisoner transfers that day. On 26 May, the population of Wandsworth was below the maximum number and there was space for the man to have returned that evening.

HMP Pentonville
26 May – 9 June

187. Governor A advised Nurse D that the man was returning to Pentonville. Nurse D telephoned the manager of the mental health in-reach team at Wandsworth to obtain an update on his condition. She told him that the man had been located on the Onslow Centre and that his ACCT document had been closed a week before. They discussed the man's forthcoming appointment with the CMHT on 1 June.

188. A CSRA was completed by Officer A. The officer spoke to the man, who told him that he felt 'much happier within himself and … mentally stronger'. The man told the officer that he was a vulnerable prisoner and would need to be placed on the VPU. The recent serious suicide attempt and subsequent hospital admission were noted. Officer A assessed the man as presenting a low risk of harm to others.

189. In view of the man's reluctance to return to Pentonville and his previous attempt to take his life there, Nurse D thought it prudent to place him under constant supervision overnight in the healthcare centre until he could be assessed the following day. Governor C agreed to constant supervision as a precaution. An ACCT document was not opened. Nurse D said that the decision to begin constant supervision resulted from the man's history of self harm, rather than his presentation on 26 May. He recalled that the man made no threats to harm himself on this occasion.

190. Shortly after his arrival, Governor C went to visit the man in the healthcare centre to check on his welfare. (Governor A told my investigators that she was busy elsewhere in the prison and Governor C agreed to go on her behalf.) Governor C spent about ten minutes with the man. He recalled in interview that the man did not present as a prisoner 'in crisis'. Governor C told the man that he should not have come back to Pentonville and that he (Governor C) had sought assurance that the man would return to Wandsworth. The man asked him to locate his missing property.

191. Nurse D telephoned the man's mother whilst Governor C was present to tell her that her son was 'safe and well'. They talked about a postal order she wanted to send her son. Nurse D reassured the man that he had spoken to his mother. Governor C commended Nurse D for the sensitive way he had spoken to the man's mother.

192. The man told Mental Health Nurse B that he was apprehensive about returning to the wings at Pentonville. However, he seemed to settle down and said that he was not thinking about harming himself. Mental Health Nurse B wrote in his medical record that the man would be assessed by 'the ward doctor' the following day. Later in the evening, the man asked for his medication but his chart could not be located either in the healthcare centre or the reception area. (He was given risperidone, mirtazapine and procyclidine by a doctor the next day.) The man settled down and slept through the night.

27 May

193. At 8.40am the next morning, 27 May, Governor C emailed Governor 1 the following message with the subject heading 'The man':

> 'Governor 1'
>
> 'As promised we took him - he came from court though without his possessions. The prisoner nearly died at the Ville [Pentonville] so I would be grateful if you could get someone to send these over as we will look very silly if this isn't resolved. We took him back with others who you kindly held during our inspection. The only request I have is that post your inspection if you could take the man back - probably at his next court date after the inspection. The reasons for this are:
>
> 'He is actually a Brixton court but has a relative in the prison that means they can't hold him.
>
> 'His near miss at Pentonville did cause some obvious concern - the reason he gave for self harm being the location of the Ville and those he knows at the prison.
>
> 'He has requested Wandsworth as a favoured location and in the short term you had him he seemed to have got to normal VP location and working.
>
> 'My suggestion will be to do a case review to see if we can progress to our VP unit (because of the last incident hear [sic] we managed overnight through the HCC [healthcare centre] - his family already showing some concern he is hear [sic]). I spoke to him personally and he seems much more settled than when we first had him.
>
> 'Hope the above makes sense.
>
> 'Governor C'

194. Governor 1 replied at 8.42am, copying in Governor 4 (a manager at Wandsworth) and Wandsworth's Deputy Governor, Governor 5:

> 'Governor C
>
> 'Happy to take him back any time from 6 June. I will get his possessions to you today
>
> 'Governor 4 - please organise
>
> 'Governor 1'

195. Governor C forwarded both emails to Governor E, the Head of Healthcare at Pentonville , the Head of Primary Care Nursing at Pentonville and Governor A at 8.43am, adding:

> 'Governor E
>
> 'Can you get him reviewed to see if we can reasonably progress [the man] to the VP unit – I will pursue the return to Wandsworth with Governor 1. He does seem much better if we can get him to the VP unit that I understand he asked for on his return.'

196. The Head of Healthcare at Pentonville replied to Governor C at 10.11am:

> 'Governor C:
>
> 'Nurse D aware of the case now. Governor A to meet up there [the healthcare centre] at 10.30am and hopefully we can manage his care here and transfer until 6th June. (D-Day!)'

197. Governor A conducted the man's case review in the healthcare centre at about 11.00am. (This review was not a formal part of ACCT monitoring. The most recent ACCT document had been closed a week previously.) As well as Governor A and the man, the meeting was attended by Nurse D (a registered general nurse) and Senior Officer A. Senior Officer A remembered being asked by Governor A to come to the review because the man was likely to be discharged to the VPU, where she worked. Nurse D remembered that the man said that he would move to the VPU as long as he was provided with tobacco.

198. No mental health staff, doctor or psychiatrist were at the ACCT review, although this seems to have been the intention the previous evening. It was nonetheless noted that medical advice had been sought and the healthcare team at Wandsworth would need to be contacted to confirm what medication the man was currently taking.

199. During the review the man's recent attempt to take his own life at Pentonville was discussed. It was recognised by those present that Pentonville had a negative impact on the man and he felt vulnerable amongst the general prison population. He told Governor A and her colleagues that he felt threatened by prisoners in Pentonville and expressed his desire to return to Wandsworth. It was noted that the issue of self harm had been addressed in detail when the man arrived the previous day.

200. The man said that, if he was going to stay at Pentonville for the time being, he wanted to be placed on the VPU. Nurse D and Senior Officer A both thought that the man was 'happy' to be moving to the VPU. Senior Officer A remembered that he had appeared 'cheery' during the review. She remembered that his main worry was getting some tobacco. She thought that the man understood what he was told and managed to articulate himself well

during the review. Governor A recalled that the man participated fully in the decision to relocate him and was in an 'upbeat' mood following the meeting.

201. Governor A told the man that he would return to Wandsworth after 6 June. (She offered this date after the emails between Governor C and Governor 1 that were forwarded to her earlier that day.) It was noted that the man's mood improved upon being given this news.

202. During the case review the man complained that his property had not followed him from Wandsworth. He was told that arrangements were being made for it to be forwarded to Pentonville. The man had still not received a pair of trainers that his mother gave him when he was in hospital in April. Governor A asked Senior Officer A to ensure that the man's property was returned to him.

203. The man expressed concern that his mother had just been sent a Wandsworth Visiting Order and he might not be able to see her having since transferred to a different prison. He was told that she would be able to use the same order to visit him at Pentonville. The man was a heavy smoker and was anxious that, having submitted his canteen form at Wandsworth, he might miss out on his weekly supplies. Staff agreed to confirm how much the man had to spend and resolve his worries about getting cigarettes.

204. The man was prescribed 7mg of risperidone per day, 15mg of mirtazapine and 5mg of procyclidine. He was discharged from the healthcare centre at about 3.00pm once a cell had been found for him on the VPU (located on G1 landing). He does not seem to have been allocated an In-Reach worker to monitor his mental health.

205. After the review, Governor A telephoned Officer H in the Observation, Classification and Allocation (OCA) department to ask her to arrange for the man to be moved to Wandsworth. Officer H explained that this would have to be organised at a national level by the Population Management Unit (PMU) in central London. She did not remember Governor A giving her a timescale for the planned return, although Governor A told my investigators that she thought she had asked for the move to take place from 6 June.

206. Officer H booked the move for the following week commencing 1 June. She completed a PMU Inter-Prison Escort Booking Form which named Governor 1 at Wandsworth and Governor A at Pentonville as the governors agreeing the transfer. The request was sent electronically to the PMU shortly before Wednesday lunchtime, after which no more requests are accepted.

207. Between 27 May and 1 June, there is no evidence that the man was assessed by a member of the In-Reach team, or indeed anybody from the healthcare department. No entries were made in his medical record.

208. The man was located in a shared cell on the VPU. Senior Officer A encountered the man several times during the next few days. On each

occasion, he told her that he did not like Pentonville and asked when he would return to Wandsworth.

30 May

209. At about 4.00pm on 30 May, Prisoner B was placed in the man's cell. He had just arrived from Wandsworth. (The Prison Service investigation conducted by the internal Prison Service investigator later established that he was one of the prisoners who had been moved out of Wandsworth temporarily whilst Her Majesty's Inspectorate of Prisons visited between 1 and 5 June.)

31 May

210. Senior Officer A was asked to speak to the man by a colleague at 2.35pm on Sunday 31 May. She became concerned about him and opened an ACCT document. She was aware of his attempt to take his own life in April. She told my investigators that he seemed more 'reflective' in comparison with his presentation during the case review four days earlier on 27 May. The man told her that he was hearing voices telling him to harm himself. His mood was low and he said that he was reliving the events of 22 April (when he had tried to hang himself from the bunk bed).

211. Completing the 'Immediate Action Plan' section of the ACCT document, Senior Officer A noted the concern about the man's cell sharing arrangements. She wrote that he was to move to a single cell. Senior Officer A initially decided that the man would be checked once an hour. However, until the man's initial assessment was completed, after consulting Principal Officer B, the level of observations was quickly amended to every 15 minutes at 3.05pm.

212. Senior Officer A asked Officer F (a trained ACCT assessor who worked elsewhere on G wing) to carry out an assessment interview with the man at about 3.15pm. The man told Officer F that he was not getting on with his cell mate (Prisoner B) and was told that he would be moved to a different cell. When he spoke to my investigator, Officer F recalled that the man's difficulties with his cell mate were contributing towards his thoughts of harming himself. The officer could not recall the specific nature of the problem with Prisoner B.

213. The man told the officer that he was 'very stressed and anxious' since leaving Wandsworth. He expressed a wish to return to the Onslow Centre. The man talked about recent problems with his post, canteen and money. He told the officer that having no tobacco and sweets was not helping him to settle and he asked for a smokers' pack. Officer F told my investigator that the man smoked quite a lot and had mentioned to him that the small amount of tobacco he received was insufficient to meet his needs.

214. The man said that he had not spoken to his family since he arrived at Pentonville on 26 May. He was concerned about the lack of contact and worried that he might be perceived as a burden by his family. He was not

sleeping properly. He said that he could not relax and felt that everybody was 'against him' and that people were 'looking at him'.

215. During the interview, the man seemed nervous, panicky, restless and confused. He told Officer F that he was hearing voices telling him to do things. The officer wrote that the man had 'obvious mental health concerns' and struggled to distinguish between what was real and what was delusion. He recalled that the man was quite hard to engage with.

216. The man told Officer F that he felt 'awful [and] depressed'. The officer noted the man's fear that 'it might happen again' (meaning an attempt to take his life) and wrote that he was having 'mild thoughts' of suicide. The man told Officer F that he was not sure if 'it is better to live or die'. When asked how he might attempt to take his own life, he replied that he had thought about swallowing a razor or cutting his throat.

217. No members of the In-Reach team work in the prison at the weekend (the ACCT document was opened on a Sunday). Officer F said that he did not consider seeking advice from an out-of-hours doctor, and did not discuss the possibility of doing so with Senior Officer A.

218. Officer F accompanied the man to his cell after the interview. The officer wanted to find out whether the man had made any firm plans to take his own life. He obtained the man's consent to look around his cell. The man showed Officer F holes in the light fitting that he had thought about using to hang himself. (The officer was unsure whether the man had made the holes himself or whether they had already been there, but he thought it unlikely that the man had made them.)

219. The man also produced a length of torn bed sheet from under his pillow. He told the officer that he planned to use it as a ligature. Officer F told my investigator that he confiscated the ligature, although he could not specifically recall doing so.

220. At about 4.10pm, Senior Officer A rejoined the man and Officer F and they completed the 'Action Following Assessment' and 'Care Map' sections of the ACCT document together. Senior Officer A remembered that the man was not upset, but was 'adamant' that he did not want to remain in Pentonville.

221. It was agreed between the man and the officers that he would try to spend time out of his cell on exercise and association and would tell them if he started to make specific plans to take his own life. The man planned to write to his family and Officer Taylor agreed to telephone his mother. Concerned about the man's presentation, Officer F completed a referral to the In-Reach team requesting a mental health assessment.

222. The officers recorded the risk the man presented to himself as 'raised'. Senior Officer A set the level of observations at every half hour throughout the day and night. When he spoke to my investigators, Officer Taylor confirmed

that he was satisfied after finding the ligature that the frequency of observations was appropriately set at half-hourly intervals.

223. At about 5.00pm, Officer F left a message on the man's mother's answering machine. He also asked a governor about the possibility of the man returning to Wandsworth. (When he spoke to my investigator, Officer F could not recall either the name of the governor or the outcome of the conversation.) The officer told the man about the actions he had taken and recalled that he seemed calmer. By 5.20pm the man was placed on his own in a different cell on the VPU.

224. On 31 May, Governor F completed the last section of the CSRA which was begun on 26 May. (I presume that he wrote his comments after the ACCT document was opened.) He noted that the man was to stay in a single cell because of his 'erratic behaviour' and because he had been 'threatening to harm his cell mate'. He indicated that the decision should be reviewed in four weeks time.

1 June

225. On the next day, Monday 1 June, the man's CPN and the specialist registrar at the CMHT were due to assess the man at Wandsworth (coincidentally the date when the inspection was due to begin). However, the manager of the mental health in-reach team at Wandsworth telephoned the man's CPN to cancel the visit as the man was by now in Pentonville. The manager of the mental health in-reach team at Wandsworth told the man's CPN that she expected the man to return to Wandsworth within a short period of time, and that they could rearrange the assessment when this happened.

226. Although the man was checked at half hourly intervals throughout the night, the pattern seems to have been interrupted during the handover from the night shift to the day shift. After a check was recorded in the ACCT document at 7.10am on 1 June, no further entries were made until 55 minutes later when Officer I went to see the man at 8.05am in his cell on the VPU. Officer I told my investigators that the morning roll check (which includes seeing each prisoner in their cell) and the daily briefing took place during this period. Although no entry was made in the ACCT document, it is possible that the man was checked by the day staff coming on duty during the 55 minute gap.

227. Officer I told my investigators that he began his shift on the VPU at 7.30am and led the morning briefing. After the meeting, he said that his first task as 'officer in charge' was to personally check those prisoners with an open ACCT document and make a note in their ongoing record. Arriving at the man's cell, Officer I looked through the observation flap and saw him standing on a chair in the middle of the cell. The man had a torn bed sheet tied around his neck, which was attached to the light fitting on the ceiling. As the officer opened the cell door, the man jumped off the chair.

228. Going immediately into the cell, Officer I grabbed the man's waist with one arm in order to lift and support him. He used his other hand to reach for his

anti-ligature knife and used it to cut through the bed sheet. Once it was cut, he lowered the man to the floor. The man was still conscious. Officer I blew his whistle and used his radio to call for the emergency healthcare staff to respond. He remembered the nurse arriving very promptly.

229. The ligature was removed from the man's neck and he was treated by Nurse B in the nurses' station on the VPU. Officer I remained with the man whilst the nurse assessed him. He did not appear to have sustained any significant injury as a result of what was his second attempt to take his life. The man had made superficial cuts to his arms which were cleaned and dressed.

230. Officer I and Principal Officer B agreed that the man should be placed under constant supervision in a gated cell in the healthcare centre. The officer told my investigators that the man was admitted to a single cell in the healthcare centre within approximately 45 minutes. Officer I walked the man over to the centre. He was assessed by the duty doctor and remained under constant supervision in a single cell. Officer I remained and had a conversation with the man before he returned to the VPU.

231. Staff from G4S (another private company which escorts prisoners for the Prison Service) were booked to collect the man and transfer him to Wandsworth the same morning, 1 June. The move was a result of the request Officer H had made on 27 May. However, an apparent breakdown in communication meant that neither G4S nor the Pentonville OCA department told the staff working with the man about the scheduled move.

232. Prisoners due to be transferred have to be assessed as fit to travel by a member of healthcare staff 24 hours beforehand. The healthcare team also have to prepare the prisoner's medical records for transfer. Neither of these things happened. Neither the man nor the healthcare staff were aware of the planned move until later in the morning on 1 June.

233. Senior Officer C told my investigators that he was telephoned in the healthcare centre by a member of staff working in the reception area. The member of staff told him that the man was due to transfer to Wandsworth immediately as part of a 'planned national move'. The SO estimated that the call took place between 10.00am and 11.00am. He could not recall in interview if the man had yet arrived in the healthcare centre following his attempt to take his own life.

234. Wanting to find out more, Senior Officer C contacted reception staff at Wandsworth who confirmed that they were expecting the man that day. Wandsworth had received details of the move from the PMU by email at the end of the previous week. Senior Officer C confirmed that no details of the transfer had been diarised on the prisoner information system at Pentonville.

235. The move did not go ahead because the man had been located in the healthcare department under constant supervision. Senior Officer C discussed the transfer with the Head of Healthcare at Pentonville and they agreed that it would be inappropriate to move the man in the circumstances.

236. The man's new ACCT document, opened the previous afternoon, was reviewed for the first time at 10.15am. The review was chaired by Senior Officer C with the man and the manager of the mental health in-reach team at Pentonville present. The level of risk that the man would harm himself was increased from 'raised' to 'high' following the attempted hanging earlier that morning. The change to constant supervision from half-hourly observations was noted.

237. Because of the man's unpredictable behaviour, the manager of the mental health in-reach team at Pentonville thought that constant supervision should remain in place for at least 24 hours until he had been assessed by a psychiatrist. The manager of the mental health in-reach team at Pentonville did not think that the man was showing any signs of active psychosis but was worried that his behaviour remained unpredictable. The manager of the mental health in-reach team at Pentonville told my investigators that the man was calm and engaged with the staff at the review. Senior Officer C recalled in interview that the man had not been able to speak very clearly.

238. The man told the staff that he had not planned the attempt to take his own life that morning, and it was an impulsive act. The manager of the mental health in-reach team at Pentonville wrote in the man's medical record that he was hearing voices. He had felt both unsafe and unable to seek out assistance from staff before he made the second attempt on his life. The man said he felt safer in the healthcare centre, indicating that he was no longer thinking about harming himself. He said that he still wanted to return to Wandsworth and did not feel safe in the VPU at Pentonville. He asked for a television, a smokers' pack and to telephone his family.

239. At 12.30pm, the Imam spent time with the man and described him as agitated and restless. At 1.00pm, Senior Officer C told the man that his actions that morning had delayed his return to Wandsworth which, initially, he took badly. They agreed that the man should 'sit out his time' at Pentonville until a new transfer could be organised. In addition to constant supervision, hourly quality observations were recorded in the ACCT document. Senior Officer C told my investigators that the man settled into life on the healthcare centre.

240. By 5.00pm that day, the man had been given some tobacco and had a television in his cell. During the evening he seemed restless and was observed talking to himself and hearing voices. At about 10.00pm, he had a lengthy discussion with agency Healthcare Assistant A about his frustration at remaining in Pentonville. Healthcare Assistant A stayed with him to continue the constant supervision overnight. She sat outside the cell and checked the man through the observation flap every 15 minutes.

241. Healthcare Assistant A recalled in interview that the man was reluctant to discuss the attempt to take his own life earlier that day. She remembered his mood being 'very flat'. She thought that he had resigned himself to the likelihood that he would again attempt suicide at some point, sensing that he was 'biding his time' in this regard. The man was worried about his

possessions and said that he missed his mother. Healthcare Assistant A suggested that he should talk to the day staff about organising a telephone call home. He took his medication and slept through the night.

2 June

242. On the following day, 2 June, the man was assessed by Doctor D, who had been unaware of his return to Pentonville until he moved to the healthcare centre on 1 June. Also present were Doctor E and Doctor F (another doctor specialising in forensic psychiatry).

243. The man told the doctors that he initially felt well after moving to the VPU on 27 May. He started to experience paranoid thoughts the next day because of his fear of a gang member who, he believed, wanted to harm him. He said that he started to have panic attacks and hear voices telling him to harm himself. He confirmed that he had not planned to take his own life on 1 June and that it had been a spontaneous act. The man was not currently thinking about suicide but still thought other prisoners were talking about him.

244. Doctor E recalled that the man seemed stable and engaged with the conversation. Doctor D remembered that the man had not seemed especially low in mood. Doctor D thought that he was gradually recovering from the events of the previous day. He drew a parallel with the man's presentation when he returned from hospital at the end of April.

245. Doctor D was inclined to believe that the man's fear of rival gang members might have some basis in fact. When he had previously assessed the man in April and May, he was unsure whether his mental health difficulties had exaggerated his perception of any danger he might be in. Doctor D thought that there was a 'significant possibility' that the man's anxiety was based on a genuine risk to his safety from other prisoners.

246. Although the man reported symptoms of psychosis, the doctors could not find any evidence of it. They decided that the ACCT observations should continue to be made every 15 minutes and he should remain in the healthcare centre until he was transferred back to Wandsworth. (Mental Health Nurse B wrote in the man's medical record later in the day that he would be returning to Wandsworth on 8 June.)

247. The second review of the man's ACCT document took place in the healthcare centre at 11.00am the same day. Senior Officer E, the man, a nurse and two officers attended the meeting. As per the doctors' assessment, the level of checks was set at every 15 minutes. (Hourly entries were made in the ACCT document.) The risk the man presented to himself was still assessed as 'high'.

248. The man thought other prisoners in Pentonville were talking about him. He felt scared and paranoid. He said that he felt more secure in the healthcare centre but would feel safer still in Wandsworth. It was noted that the risk of self harm resulted predominantly from being in Pentonville. The man had not

spoken to his family following the second attempt to take his own life. Staff made the arrangements and he spoke to his mother on the telephone at about 3.00pm.

3 June

249. At about 4.30pm the next day, 3 June, the ACCT document was reviewed for a third time. Senior Officer E chaired the meeting with the man, an officer and Nurse D in attendance. The man was told that he would be transferring back to Wandsworth on either Saturday 6 or Monday 8 June and he was pleased to hear this news. He said he was not thinking about harming himself. Asked if he would talk to either prison staff or the Listeners if he was considering harming himself again, he replied that he 'did not know'.

250. The risk that the man presented to himself was reduced to 'raised'. On the advice of Doctor D, the level of observations was kept at every 15 minutes. The next ACCT review was scheduled for 7 June. It was noted in the man's wing history file that he was mixing with the other prisoners in the healthcare centre. Senior Officer E told my investigators that he was not 'excessively concerned' about the man 'at the time', having met him and reviewed his ACCT document on two consecutive days.

251. The same day, 3 June, the Parole Board reviewed the man's recall to custody. The panel made no recommendation as to release and the recall remained in place.

4 June

252. The man was assessed by Doctor D just after midday the following day, 4 June. The doctor thought that the man's mood was improving. He was sleeping and eating well and taking exercise. He was not thinking about harming himself and felt safe in the healthcare centre. The man said that he was hearing voices telling him that his family would be harmed. He believed that other prisoners were talking about him. However, Doctor D considered that the man's feelings of paranoia were less intense. Because the man was still experiencing some psychotic symptoms, the doctor increased his dosage of risperidone from 7mg to 8mg per day.

253. Doctor D thought that the man should remain in the healthcare centre until he transferred back to Wandsworth. He advised that the ACCT observations could be reduced from every 15 minutes to hourly. Later that afternoon, Senior Officer C confirmed in the ACCT ongoing record that hourly observations had started, although a review was not held to formally acknowledge this decision. Constant supervision ended at 3.15pm. (Although the man was to be checked every hour as part of the ACCT process, Senior Officer E told my investigators that prisoners in the healthcare centre are checked on a half hourly basis as a matter of routine.)

5 June

254. The man was seen talking to himself on 5 June. However he remained calm, associated with other prisoners and took his medication. Senior Officer C noted in the ACCT document on 6 June that the transfer to Wandsworth had been organised for 9 June. The only other outstanding issue was the man's canteen. During the early evening of 7 June, the man was heard shouting loudly in response to the voices he was hearing. He was checked every hour by staff and settled down later that night, although he continued to talk loudly in his sleep.

8 June

255. At about 9.30am on 8 June, Officer J in Pentonville's OCA department emailed healthcare staff, identifying six prisoners who needed to be assessed as fit for transfer to Wandsworth the next day. Amongst the names were the man, Prisoner 3 and Prisoner 2. (The subsequent internal NOMS investigation established that the latter two prisoners transferred to Pentonville at the end of May so that they would not be present during the inspection at Wandsworth. As I discuss in the 'Issues' section of the report, although he returned to Wandsworth at the same time as these prisoners, the man had moved to Pentonville before them following a court appearance.) Beneath the names he commented:

> 'Please note that the Wandsworth inmates are all going back after doing them a fav[our] by holding them here for a week.'

256. Later that morning the man was assessed by a member of healthcare staff as fit to transfer back to Wandsworth the next day. Officer J then emailed Wandsworth to confirm that the man would be transferring there 'tomorrow with the rest of your … inmates'. He noted that the man would be leaving Pentonville's healthcare centre and that the transfer had been agreed by Governor 1.

257. The same day, the Head of Healthcare at Pentonville telephoned the Head of Healthcare at Wandsworth. The Head of Healthcare at Wandsworth was not available so the Head of Healthcare at Pentonville spoke to a female colleague. The Head of Healthcare at Pentonville told her that the man would be returning to Wandsworth the next day from Pentonville's healthcare centre. He told her about the attempted hanging on 1 June and said that the man's condition was stable and improving. The Head of Healthcare at Pentonville did not make an entry in the man's medical record about their telephone conversation.

9 June

258. The man's ACCT document was reviewed for a fourth time at 8.10am on 9 June, the same morning that he returned to Wandsworth. He seemed to be in a good mood. Senior Officer C led the meeting, with the man and a healthcare officer present. The level of risk which the man presented to

himself was reduced to 'low'. (The SO based his decision on the man's presentation, his stabilised mood in the last eight days and his positive attitude towards his transfer back to Wandsworth.) The frequency of observations remained at hourly. Senior Officer C noted that the ACCT document should remain open whilst the man moved to Wandsworth and be reviewed the next day.

259. On 9 June, the Parole Board's review of the man's recall to custody was published. The decision not to release the man was communicated electronically to Pentonville, but it is unclear whether it reached the man, as he moved to Wandsworth on the same day. The email may have been forwarded to Wandsworth, but there is no clear indication whether or not the information was given to the man.

HMP Wandsworth
9 – 12 June

260. Just after midday on 9 June, the man was placed on an escort vehicle and arrived at Wandsworth at 1.40pm. He returned with other prisoners including Prisoner B, Prisoner 3 and Prisoner 2.

261. Prisoner 3 and Prisoner 2 both told my investigator that they remembered the man being quiet and subdued during the journey. Prisoner 3 remembered that the man had said during the journey that he wanted to kill himself. Prisoner 2 confirmed that the prisoners had discussed their suspicions about the reason for their removal from Wandsworth during the journey. (The internal Prison Service investigation established that these men were deliberately transferred from Wandsworth to Pentonville over the weekend of 29 May to 1 June prior to the inspection.) Prisoner 2 told the investigator that the man was convinced that he had also been moved because of the inspection.

262. The man was interviewed at about 3.00pm. A CSRA was completed by Officer 2. She did not comment on the cell sharing risk concerns identified by Governor F on 31 May. She told my investigators her interview with the man was 'unremarkable'. She did not remember the man crying (which is what the other prisoners said about him). She said that, if he had seemed especially upset, she would have offered to place him with a Listener and made an entry in his ACCT document.

263. As a vulnerable prisoner, Officer 2 said that the man was separated from the other prisoners during the reception process and she expected him to progress to the Onslow Centre. Although the man had come from Pentonville's healthcare centre, Officer 2 did not remember any discussion of a move to Wandsworth's healthcare centre. During the reception process, only healthcare staff are allowed to open the prisoner's confidential medical record.

264. The man underwent an initial health screening conducted by Nurse 3, who referred him to the doctor. Nurse 3 completed the medical section of the

CSRA. Both Officer 2 and Nurse 3 assessed the man as representing a low risk to other prisoners.

265. Prisoner 2 recalled that the man became more disturbed whilst they waited in a cell for the doctor on the first night centre. He said that the man started talking to himself, his mood deteriorated and he started crying. Prisoner 2 tried to comfort the man, who he described as looking like a 'small child in distress'. Prisoner 2 told my investigators that he tried to alert Nurse 4, to the man's distress. He remembered that the nurse told him not to interfere. Prisoner 2 claimed that Nurse 4 told the man to 'pull himself together'.

266. My investigator interviewed Nurse 5, a nurse who Prisoner 2 said worked on the first night centre on 9 June. Nurse 5 recalled that he had unlocked both Prisoner 2 and the man to be assessed by Doctor 1. He did not remember Nurse 4 working with him that day. He remembered that Prisoner 2 told him that the man 'was not looking good'. From his presentation, Nurse 5 thought that the man was 'not quite himself' and 'a bit more disturbed'. My investigator also spoke to another of Nurse 4's colleagues, Nurse 6. She said that she worked with Nurse 4 on 9 June but did not recall that either of them visited the first night centre.

267. Doctor 1 assessed the man at about 6.30pm. She told my investigator that the man was 'very, very tearful' and 'very upset' about his recent return to Pentonville. However, the man told her that he was glad to be back at Wandsworth and was not thinking about harming himself. Doctor 1 continued his prescription of 8mg of risperidone, 15mg of mirtazapine and 5mg of procyclidine. Nurse 5 explained to my investigator that he collected the medication from another wing and gave it to the man in the consultation room.

268. At about 7.00pm, the man arrived on the Onslow Centre and was placed with Prisoner 4 in a cell on the fourth landing of G wing. He spoke with his mother on the telephone that evening. Senior Officer 5 remembered speaking to the man and thought that he seemed 'genuinely happy' to be back on the Onslow Centre. He asked the man if he had any immediate concerns. He replied that he did not. Senior Officer 5 told him that, because of the late hour and the number of prisoners on open ACCTs on the Onslow Centre, his own ACCT document might not be reviewed until the morning.

269. The actual frequency of ACCT observations decreased following the man's arrival at Wandsworth, although the final entry on the front cover of the document (made by Doctor D on 4 June) remained 'hourly'. Until he left Pentonville, the man had been checked every hour both during the day and night and entries made accordingly in the ACCT document. Although hourly night time observations remained in place, hourly day time checks stopped at Wandsworth. This level of intermittent observations during the daytime remained in place after the ACCT review on 10 June until the man's death.

10 June

270. Shortly before 11.00am the next day, 10 June, the man's ACCT document was reviewed for a fifth time by Senior Officer 5 (the ACCT case manager) and Officer 3 (a member of the Safer Prisons team). Officer 3 had talked to Senior Officer 5 whilst making a routine check of open ACCT documents on the Onslow Centre. Senior Officer 5 told his colleague that he thought the review might lead to the ACCT document being closed because the man had returned to familiar surroundings on the Onslow Centre. Officer 3 agreed to attend the review because Senior Officer 5 was considering closing the document. Officer 3 remembered that Senior Officer 5 was surprised that the man had returned with a new ACCT document, as the last one had been closed just before he left Wandsworth.

271. Officer 3 was unaware of the man's two recent suicide attempts at Pentonville when he helped to carry out the review. He confirmed that he had not read the open ACCT document and relied on what Senior Officer 5 told him beforehand.

272. Senior Officer 5 told my investigators that the meeting lasted from about 11.00am to 1.00pm, including a short break. Officer 3 agreed that the three men talked for about two hours. He thought the formal review lasted until about midday, whilst the remaining hour was spent trying to address the concerns the man raised.

273. The two men noticed that the man seemed withdrawn, frightened and nervous. He spoke in a low voice, almost whispering. Officer 3 told my investigators that the man was 'quiet, apprehensive, reticent and subdued'. The man was worried that other prisoners were outside the door eavesdropping on their conversation. Officer 3 offered to leave the room because Senior Officer 5 thought that the man would be more comfortable talking one-to-one with a familiar face. However, the man was content for Officer 3 to remain.

274. The man said that he had been threatened by rival gang members in Pentonville. He thought that his family were in danger if he did not hand over compensation money that the men knew he was due to receive. He said that the gang members knew where his family lived. He explained that he had considered taking his own life to remove the threat to his family's wellbeing. Officer 3 told my investigators,

> 'I asked [the man] directly … whether taking his own life … would solve his problem for his family and he said it would.'

275. Once the man said this, Officer 3 recalled that all parties present agreed that the ACCT document should remain open. The man started to provide specific information about gangs, at which point Senior Officer 5 started to make written notes. He alluded to a recent fatal shooting outside the prison.

276. Senior Officer 5 encouraged the man to report the information to the police. With the man's agreement, and whilst he was still in the room, Senior Officer 5 telephoned the prison's police liaison officer (PLO) to discuss the best way to address the man's concerns about gangs.

277. Officer 3 recalled that the man's mood began to lift as the conversation went on and he seemed reassured by the measures being taken to act on his concerns. The officer was encouraged by the man's presentation at the end of the interview and did not consider that he was actively considering taking his own life. Senior Officer 5 thought that the man seemed 'a lot more buoyant' as he left. However, he remembered turning to Officer 3 and saying, 'That's not the [man] I know.'

278. The risk that the man would harm himself was increased from 'low' to 'raised'. Although the risk level was raised and Senior Officer 5 ticked to indicate that the frequency of observations had been reviewed, the records were not amended either on the front cover of the ACCT document or elsewhere inside. The two men recollected that the man was supposed to be checked once an hour during the night and that three 'quality observations' were to be recorded during the day. (However, as I have said above, the last entry on the cover remained 'Doctor D' at Pentonville on 4 June.) The next ACCT review was planned for 17 June.

279. Shortly after the ACCT review finished, the man spoke to a Listener at 1.30pm and returned to his cell at 3.15pm. (He did the same at 9.25pm that evening, returning to his cell at 10.15pm.) Later that afternoon, Senior Officer 5 told the man that the PLO had contacted Operation Trident (the Metropolitan Police division which addresses gun crime among young, black Londoners) and was arranging for an officer to visit him to discuss his concerns about gangs. Senior Officer 5 told my investigators that he reassured the man that the meeting would be arranged discreetly away from the wing so that other prisoners would not find out about it.

280. A police officer from Operation Trident originally planned to interview the man on 11 June. However, he thought that the information staff had so far passed on was unreliable and so he delayed his visit until 15 June. (The man was not told about the specific timing of the police officer's visit and would not therefore have known that he had postponed it.)

281. During the day, Nurse 7 brought the man's risperidone prescription to his cell, as he had not come to collect it from the hatch. the man told her he was also prescribed 30mg of mirtazapine. Nurse 7 gave the man this medication but subsequently discovered that the dosage should have been 15mg. She went back to speak to the man and apologised for the error. Nurse 7 advised him that he might feel a little sleepier than usual, but recalled that he did not seem worried. She reported the error to her line manager.

282. Following their arrival back in Wandsworth on 9 June, Prisoner 3 told my investigators that he continued to be concerned about the man. He remembered the man visiting him in his cell on 10 and 11 June. He seemed

depressed and anxious, and he held his neck at an awkward angle in an even more pronounced manner. Prisoner 5 noticed that the man seemed troubled, stressed and withdrawn after returning from Pentonville. He thought that the man was not his usual self and that his mental health might be 'deteriorating'. Prisoner 1 told my investigators that he saw the man speaking to healthcare staff 'on a number of occasions' between 9 and 12 June, 'pleading to see a psychiatrist'. Prisoner 6 remembered seeing the man approach wing managers (SOs) asking for help with his mental health problems. There are no references to these incidents in the clinical record completed by staff.

11 June

283. The next morning, 11 June, the man was seen 'laughing and joking' with other prisoners. He was still in a good mood at lunchtime. Later that day, Senior Officer 4 told my investigators that the man and Prisoner 7 approached him and asked to share a cell. Senior Officer 4 said he checked with the man (in case pressure was being put on him) but he confirmed that he wanted to share with Prisoner 7. The SO did not think at the time that the arrangement would have a detrimental effect on either man. At about 4.50pm, at Senior Officer 4's request, Officer 4 (the movements officer responsible for organising cell sharing) placed the man and Prisoner 7 in the same cell.

284. Senior Officer 4 issued the man with an emergency smokers' pack because his canteen had not followed him from Pentonville. At 5.25pm it was noted that the man was 'a little bit subdued'. When spoken to at 7.15pm, the man said very little in reply and nodded.

285. At 9.40pm that night, Prisoner 7 activated the cell bell and Officer 5 answered. Prisoner 7 asked to speak to a Listener. The officer consulted the Listeners, who advised him that Prisoner 7's care plan did not allow him to speak to them because he had abused the facility in the past. Prisoner 7 was permitted to telephone the Samaritans instead.

286. The officers patrolling the Onslow Centre overnight do not have keys, but they carry a sealed pouch (containing keys) which they can break open in an emergency. To open prisoners' cells, they ask one of the officers in charge of the prison (the night orderly officer or Oscar 2) to come over with keys. Officer 5 recalled that Officer 6 (Oscar 2) opened the cell door to let Prisoner 7 out. The man was standing near the door.

287. At 9.55pm, whilst Prisoner 7 was being escorted to the Listeners' suite, he threatened to harm himself. He also told Officer 5 that he was worried about the man. Whilst Prisoner 7 was out of the cell, Officer 5 checked on the man, who was quiet but said that he was 'fine'. Prisoner 7 went into the Listeners' suite to make his telephone call and returned to the shared cell at 10.20pm. Officer 5 again took the opportunity to check on the man, who again replied that he was 'fine'. The officer knew the man quite well, and thought that he seemed 'alright'.

288. Prisoner 7 told my investigators that the man talked to himself during the evening, saying, 'Leave me alone, you are not going to kill me.' He remembered the man putting a blanket over his head and tying a towel around his neck. Prisoner 7 said that he told Officer 5 about the ligature that the man had placed around his neck and warned him that the man might try to kill himself. Officer 5 told my investigator that he did not see the man with anything tied around his neck.

289. At 11.45pm, the man rang the cell bell. Officer 7 went to the cell and spoke to the man through the observation flap. He asked to be taken to the Listeners' suite. Ten minutes later Officer 6 arrived and unlocked the man with Officer 5. They escorted the man to the Listeners' suite. Officer 7 had already gone to the suite and was waiting for them.

290. Standing outside the suite, the man spoke to Officer 5, explaining that he did not want to go back to the cell. Officer 5 thought the cell share with Prisoner 7 was working and so the man's comments were unexpected. He recorded in the wing observation book and the ACCT document that the man did not feel comfortable. Officer 5 wrote that the man felt threatened and was worried for his safety. He noted the man's anxiety that Prisoner 7 would do something to him whilst he slept.

291. When my investigators interviewed Officer 5, it became clear that the man had told him that Prisoner 7 made sexual advances towards him. The sexual element of Prisoner 7's intimidating behaviour was not recorded by the officers at the time in either document. (Prisoner 2 remembered that the man told him the next day that Prisoner 7 had threatened to kill him.)

292. Officer 5 told Officer 6 that the man did not want to return to his cell. He thought that he had conveyed the sexual nature of the threat to Officer 6. Officer 7 recalled that he went to the main office on the Onslow Centre and determined with a colleague that the only unoccupied cell was on the third landing of K wing. Officer 5 remembered that Officer 6 made the decision to move the man into a different cell. Within a few minutes, Officer 7 returned to the man who was still speaking to Officer 5 and gave him the option of moving to the empty single cell. The man agreed.

12 June

293. Just after midnight on 12 June, the man agreed to move and was located on his own in cell K3-22 by Officer 5. He did not go back into the cell shared with Prisoner 7 and the officers moved his belongings for him. Officer 7 recorded in the wing observation book that the new arrangement was to be reviewed when the day staff came on duty. The frequency of the ACCT observations did not change. The man appeared to settle and did not make any further requests that night. Officer 7 and Officer 5 both remembered that the man seemed relieved to be moving out of the cell.

294. Although the man told staff that he wanted to move because he felt threatened by Prisoner 7, Prisoner 7 told my investigator that he and the man

did not argue. He thought that the man intended to take his own life and wanted to move to a single cell in order to do so. At 3.35am, Prisoner 7 activated his cell bell and asked to telephone the Samaritans. He was told that he had used up his allocated quota of call time. He threatened to harm himself, an ACCT document was opened and he was taken to the Listeners' suite.

295. At the morning briefing shortly after 7.30am on 12 June, staff coming on duty were told that the man had asked to move out of the cell he shared with Prisoner 7 and had been placed on his own overnight. An ACCT review was not scheduled for later that day, even though the man had changed location.

296. At 7.50am, Officer 8 opened the man's cell. He seemed quieter than usual and was sitting on the bed. In interview, Officer 8 remembered asking the man a couple of times if he was alright, without getting a reply. Instead of engaging with the officer, he stared at the wall, appearing blank and unresponsive. Officer 8 made an entry to this effect in the man's ACCT document.

297. Between 8.00am and 8.30am, Senior Officer 5 spoke to the man and asked him how he was. The man said that he had had trouble sleeping because Prisoner 7 would not stop talking in the night and had been 'driving him mad'. Senior Officer 5 told my investigator that he was not concerned about the man's likelihood of harming himself following their conversation.

298. Later on, Prisoner 1 invited the man for coffee in his cell because he was concerned by his low mood. He remembered that the man struggled to express himself and was nearly crying. Prisoner 1 'thought [the man] was having a breakdown'. Several other prisoners had gathered in the cell because they were concerned about the man.

299. Another prisoner recalled that the man's mood brightened when Prisoner 1 offered to share a cell with him. Prisoner 8 recalled that he spent about 20 minutes in Prisoner 1's cell with the man at about 10.00am trying to cheer him up. He said that the man's mood was low and he was 'very emotional'. Prisoner 8 also offered to share a cell with the man. He told my investigators that the man said he 'could not cope' on his own.

300. When he spoke to my investigators, Prisoner 8 remembered the man telling him on 12 June that he had tied a towel around his neck the previous evening, frightening Prisoner 7 and causing him to press the cell bell. Prisoner 8 said that the man told him that Officer 5 had entered the cell, removed the towel and transferred him to another cell. Prisoner 8 said that he asked Officer 5 on the evening of 12 June if it was true, to which the officer replied it was. However, when my investigators interviewed Officer 5, he did not remember the man tying anything around his neck. Equally, the officer could not have entered the cell without a senior colleague with keys being present. Officer 5's keys were in a sealed pouch which was not opened during that night.

301. At about 10.00am, Officer 9 (who was working on the fourth landing of the Onslow Centre that day) was asked by Prisoner 1 and another prisoner to come and speak to the man. They were worried about their friend and asked for him to be assessed by a member of healthcare staff. The prisoners accompanied Officer 9 to Prisoner 1's cell on the fourth landing of K wing. They found the man sitting on the bed, looking vacantly upwards at the wall.

302. Officer 9 asked the man if he had taken his medication or if he would like to speak to a Listener. He got no response to either question and the man avoided eye contact. Officer 9 became concerned about his 'bizarre' behaviour and told the other prisoners that he would arrange for the man to be assessed. Officer 9 was unaware at the time of the two recent attempts by the man to take his own life at Pentonville.

303. Officer 9 telephoned the In-Reach team from an office on the second landing and spoke to the manager of the team. The officer described his concerns, mentioned that the man was the subject of an open ACCT document and asked for somebody to come to the Onslow Centre and assess the man. The manager of the mental health in-reach team agreed to carry out the assessment herself.

304. Whilst Officer 9 was on the telephone to the In-Reach team, coincidentally Officer 8 went to check on the man following his observation earlier that morning. Officer 8 could not find the man in his cell and returned to the office where he found Officer 9 still on the telephone talking to the manager of the mental health in-reach team about the man.

305. The manager of the mental health in-reach team had an appointment at Springfield Hospital at 12.00pm, and returned to the prison shortly after 2.00pm. She planned to assess the man upon her return. Officer 9 did not remember a specific timescale being mentioned on the telephone. The manager of the mental health in-reach team said that a call from the Onslow Centre requesting an assessment was 'not at all unusual'. She only remembered the telephone conversation because she was surprised to learn that the man had returned to Wandsworth. This was the first time anybody had let her know. The manager of the mental health in-reach team had most recently assessed the man on 14 May. Between 9 and 12 June, the man was not referred to the In-Reach team and nobody from the team assessed him.

306. Finishing his telephone conversation, Officer 9 told Officer 8 that he had seen the man in Prisoner 1's cell and was concerned about his behaviour. He told Officer 8 that he had asked a member of the In-Reach team to assess the man. Officer 9 did not recall Officer 8 mentioning his similar observation of the man earlier that morning. Officer 8 did not go and check on the man after talking to Officer 9 because he realised that his colleague had just checked and taken steps to help him.

307. Officer 8 was working on the third landing where the man's ACCT document was kept in the office. The officer made an entry in the document reflecting Officer 9's encounter with the man and the action taken. Officer 9 did not

make his own entry about his concerns and his conversation with the manager of the mental health in-reach team (although he knew that the man was the subject of an ACCT document) because he was working on the fourth landing and did not have ready access to it. The officer was unaware until after the man died that Officer 8 had made an entry for him. Neither officer asked a manager to review the ACCT document or the frequency of observations.

308. To allay the other prisoners' concerns, Officer 9 told Prisoner 1 and another prisoner that he had asked for the man to be assessed. He did not tell the man, who was still in Prisoner 1's cell a few feet away. Officer 9 thought that the information might be better conveyed by the man's friends, as he still did not respond to the officer.

309. The man did not withdraw completely from daily prison life during the morning. A number of staff told my investigators about seeing him mix with other prisoners and walking along the landings. Prisoner 2 remembered the man visiting him in his cell. He told my investigator that the man had not spoken to him about any suicidal thoughts.

310. Officer 4 was the movements officer that morning. She heard at the morning briefing that the man had been moved to a single cell overnight as a temporary measure. However, she told my investigators that she did not want to allocate a new cell mate and return the man to a shared cell until he had been assessed by the In-Reach team. She had not spoken to the man about relocation by the time that he took his own life later in the day.

311. Because he was worried about the man, risoner 1 asked Officer 4 if they could share a cell. (They had previously shared a cell in May.) Because she knew that both prisoners had mental health problems, Officer 4 told Prisoner 1 that she would first need to consult her SO and the In-Reach team regarding the suitability of the proposal. Officer 4 was concerned that locating two vulnerable prisoners with mental health difficulties together might not be the most appropriate decision.

312. Prisoner 7 told my investigator that he remembered the man walking along the landing with a laundry bag on his head at about midday. However, nobody else my investigators spoke to recalled the incident taking place.

313. The man was a practising Muslim. At about 11.30am, Prisoner 8 helped to prepare the faith room on the second landing of the Onslow Centre for the Muslim prayer service. Muslim prisoners moved the chairs out of the way to allow the prayer mats to be laid out for the 1.00pm service. Prisoner 8 told my investigators that the man helped to set up the service before collecting his lunch and being locked in his cell. Officer 8 remembered seeing the man collect his lunch. Officer 10 recalled seeing the man return to his cell carrying a full plate of food between midday and 12.30pm.

314. At about 12.30pm, Officer 10 began locking prisoners in their cells for lunch. When he got to the man's cell, he saw him sitting on a chair. He was facing

away from the door towards the window, bent over in a seated position with his elbows on his knees and his head in his hands. Officer 10 asked repeatedly if the man was alright, but he did not respond. The man glanced over his shoulder back at the officer, but did not say anything. Officer 10 could not recall if the man had eaten his meal.

315. By now it was about 12.40pm. Officer 10 told my investigators that he locked the cell, went to the landing office and recorded his observation in the ACCT document. He could not remember reading the entries made earlier that morning by Officer 8 and Officer 9. He remembered one of his colleagues mentioning that the In-Reach team were planning to assess the man.

316. Officer 8 remembered having a short discussion with Officer 10 when he made the entry, saying words to the effect that the man was 'still not right'. No further entries were made in the ACCT document after Officer 10 wrote in it.

317. Officer 10 was responsible for unlocking the Muslim prisoners on his landing so that they could go to the Friday prayer service. He told my investigators that he would normally refer to a list of Muslim prisoners provided by the Imam. However, he recalled that he had not received a list that day so relied instead on the information written on each prisoner's cell door plate.

318. The officer began unlocking the cells at about 12.50pm, but he initially overlooked the man although he was a registered Muslim. He thought he might have missed him because the man had only just arrived back on the Onslow Centre and he was not used to him being present for Friday prayers.

319. Those prisoners who had been unlocked made their way to the second landing. The service was due to begin at about 1.00pm. When the man did not arrive, Prisoner 8 shouted up to Officer 10 asking him to check if the man wanted to come.

320. Shortly after 1.00pm, Officer 10 returned to the man's cell. He could not be certain in interview if he looked through the observation flap or unlocked the door to ask the man if he wanted to attend the prayer service. However, Officer 10 said that he remembered that the man was still sitting at the table facing away from the door, but this time his head was up and he was looking at the window at the back of the cell.

321. Officer 10 told my investigators that he asked the man if he wanted to go to the service, but did not get either a physical or verbal response. He said that he shouted down to Prisoner 8, 'I've got no answer.' Prisoner 8 confirmed that Officer 10 asked the man if he wanted to attend the prayer service. Officer 10 did not make a further entry in the man's ACCT document to reflect his visit to the man's cell.

322. Before he left the Onslow Centre at about 1.15pm to take his lunch break, Officer 10 told his colleagues that the man did not look very well. He recalled telling Officer 11 that the man had neither replied nor wanted to go to Muslim

prayers. Officer 11 was working during the lunch patrol state (when prisoners are locked in their cells) with Senior Officer 3, Officer 12 and Officer 13. (Senior Officer 3 and Senior Officer 5 were in charge of the Onslow Centre that day.)

323. Prompted by Officer 10, Officer 11 went to check on the man in cell 22 on the third landing of K wing at about 1.40pm. Her concern was also triggered by reading the most recent entry made by Officer 10 in the man's ACCT document.

324. As I have noted, the last entry on the front cover of the ACCT document regarding the frequency of observations had been made by Doctor D at Pentonville on 4 June. Staff on the Onslow Centre should have checked the man every hour. However, observations in the daytime were intermittent between 9 and 12 June. Officer 11 checked the man 70 minutes after Officer 10 made the last written entry in the ACCT document. (Although the man had been seen by Officer 10 in between these times when he asked about the prayer service.)

325. Advising Senior Officer 3 where she was going, Officer 11 walked to the man's cell and looked through the small observation hole in the door. She could not see anything so she opened the observation flap fully. The man's privacy curtain was pulled across and he was partly obscured. However, Officer 11 realised that he was too high up to be standing on the ground and so she knew that something was wrong.

326. Officer 11 ran back towards the centre of the Onslow Centre and shouted from the third landing for Senior Officer 3 and her other colleagues to assist her urgently. She was joined by Senior Officer 3, as well as Officer 13 and Officer 12, both of whom had been overseeing the Muslim prayer service which continued in a locked room on the second landing.

327. After Officer 11 opened the cell door, Senior Officer 3 and Officer 13 went into the cell. Officer 11 remained outside in order to direct staff to the emergency. The man was hanging by a ligature (made from a torn bed sheet) from the bars on his cell window. He was facing towards the door. Senior Officer 3 and Officer 13 supported the man's weight, whilst Officer 13 used his anti-ligature knife to cut through the bed sheet. Once the ligature had been cut, the man was lowered to the ground and placed on his back on the floor of the cell, with his head towards the door. The remaining piece of the ligature was removed from his neck. Officer 13 knelt by the man but could not find a pulse. He was still warm but his pupils were fixed and dilated and he was not breathing.

328. Officer 14 was working in his office on the third landing of K wing when he heard a commotion and went to help. He arrived at the cell and Officer 13 sought his advice about beginning resuscitation. Senior Officer 3 and Officer 11 stood outside the cell. Senior Officer 5 (a qualified first aider) reached the cell. The man did not respond to Senior Officer 5's voice or gentle shaking.

The SO cleared the man's airway and began giving compressions and rescue breaths.

329. Officer 12, who followed shortly behind Officer 13, was asked to use his radio to inform the control room that a 'code 1' emergency was underway. (A 'code 1' call lets staff know that the prisoner is in an immediately life-threatening situation.) The officer did so and asked for urgent healthcare assistance to come immediately to the third landing of K wing where a prisoner had hanged himself.

330. Control room staff initially relayed an incorrect location to the healthcare team, and Officer 12 immediately requested via the radio that the error should be corrected. Although control room staff relayed the correct wing and landing to healthcare staff across the radio net, Officer 12 had given the number of the adjoining cell.

331. Officer 12 went to check if any nurses were by chance present on the wing, but found none. Once sufficient discipline and emergency healthcare response staff attended, Officer 12 returned to the Muslim prayer service, where he had left the prisoners locked in with the Imam.

332. Doctor 1 and Doctor 2 were at lunch with Nurse 8 in the staff cafeteria when, as the designated healthcare emergency response that day, she received the 'code 1' call over the radio. The doctors and Nurse 8 arrived at the man's cell at approximately 1.45pm, within about two minutes of receiving the call. (The cafeteria is located next to the Onslow Centre, and Doctor 1 explained that they could not have been any closer to hand.)

333. The prison's incident log confirms that an ambulance was called at 1.47pm. Officer 15 collected an oxygen cylinder from the second landing at the doctors' request and brought it to the cell.

334. Doctor 1 and Nurse 8 completed an assessment of the man and could not find a pulse. They took over cardio-pulmonary resuscitation (CPR) from Senior Officer 5. The doctors and Nurse 8 continued to give rescue breaths and chest compressions in rotation but the man remained unresponsive. Doctor 1 inserted a plastic airway into the man's throat and placed a face mask attached to an inflatable bag over his mouth so that oxygen could be administered. A defibrillator (a machine which can be used to reset an irregular heart rhythm with a dose of electrical energy) was attached to the man. However, no heart rhythm was detected and consequently the machine advised that an electric shock should not be administered.

335. Principal Officer 1 (the prison's orderly officer) arrived on the landing and told Senior Officer 3 that a member of staff should keep an ongoing record of the emergency. Senior Officer 3 assigned this task to Officer 15. The doctors asked Officer 15 to request adrenaline (used to treat cardiac arrest) and atropine (used to speed up a person's heart rate) from the prison pharmacy. Because she was busy recording the emergency log, Officer 15 asked Officer 14 to telephone the pharmacy.

336. Officer 14 made the telephone call and told a male pharmacy technician that a prisoner had hanged himself. The officer said that staff working on the man had asked for adrenaline and atropine. Officer 14 remembered the technician asking him to collect the medication. He recalled emphasising that it was an emergency and that the prisoner was in a critical condition.

337. During interview, Officer 14 said that the technician continued to suggest that he collect the drugs. (The pharmacy is a considerable distance from the Onslow Centre wing on the other side of the prison.) The officer did not think that the technician grasped the severity of the situation. He raised his voice and repeated his request before ending the telephone conversation.

338. Very shortly afterwards, Officer 14 received a telephone call from the pharmacy. A female member of staff suggested to him that supplies of adrenaline and atropine were kept on the wing. The officer firmly suggested that the healthcare team working on the man would not be asking for pharmacy staff to provide the drugs if they could be easily accessed on the Onslow Centre.

339. Officer 14 continued to emphasise the critical nature of the emergency and became frustrated at his inability to make the female member of staff understand how important it was to bring the drugs without delay. The second telephone conversation ended with the female member of staff agreeing that the drugs would be brought to K wing.

340. My investigator spoke to the principal pharmacist. She confirmed that the technicians working that day were temporary agency staff who no longer work at Wandsworth. She was unable to identify the male technician, but identified the female technician.

341. The principal pharmacist said that the female technician approached her during the emergency. She remembered that the female technician then left the pharmacy to take the adrenaline to the man's cell. The principal pharmacist told my investigator that she telephoned Officer 14 to let him know that the female technician was on her way. The principal pharmacist explained that the pharmacy does not carry atropine in stock, and therefore this could not be provided during the emergency.

342. The ambulance arrived at the prison gates at about 1.50pm. At approximately 1.53pm, the ambulance technicians reached the wing and joined the resuscitation attempt. The technicians were not carrying adrenaline or atropine because they are not qualified to administer these drugs. The duty governor, Governor 4, arrived on the landing at 1.55pm. Governor 1 attended a few minutes later, at 1.58pm.

343. Shortly before 2.00pm, the Helicopter Emergency Medical Service air ambulance crew touched down near the prison. The air ambulance doctor and a paramedic arrived at the gate at 1.59pm and were taken to the Onslow

Centre. The air ambulance doctor brought adrenaline, which Doctor 1 administered. (The adrenaline from the prison pharmacy had not yet arrived.)

344. Doctor 2 and Doctor 1 moved out of the cell to allow Nurse 8, the air ambulance doctor and the paramedics space to continue their efforts. A tube was inserted down the man's throat to try to help him breathe and he was given medication to try to restart his heart via a drip in his arm. However, staff were unable to revive him and all involved agreed that the resuscitation attempt should end. The air ambulance doctor declared the man's death at 2.18pm.

345. Doctor 1 approached Governor 1 on the landing. Upset, she voiced her suspicion that the man had been deliberately removed from Wandsworth during the inspection. Governor 1 told my investigators that he was concerned about Doctor 1's claim and went to check prisoner movement records. He remembered speaking to the deputy governor at Pentonville, Governor G, to allay his concerns.

346. A hot debrief was led by Principal Officer 1. At 2.45pm, Governor 1, Governor 4, Governor 5 (the deputy governor), Governor 6, Governor 7 and the chaplain met to plan how te man's family should be informed of his death. Governor 7 was asked to act as the prison's family liaison officer (FLO) and it was agreed that he would take the chaplain with him to visit the family. The man's mother lives in South London, not very far from Wandsworth.

347. At 3.00pm, Prisoner 7 asked to speak to a Listener and was placed in the care suite. All the prisoners in the Onslow Centre who were subject to ACCT monitoring were reviewed at approximately 4.20pm.

348. Searching through the core record, Governor 7 could not firmly establish the name and address of the man's next of kin. He checked the social visits records. He had to assume that the man's mother was her son's nominated next of kin (the information is not recorded on the visits paperwork). Governor 7 estimated that locating these details took about half an hour.

349. Governor 7 decided not to use his own car to visit the family, but instead to find a driver and make use of a 12 seater minibus. He was concerned about getting lost and told my investigators that the Prison Service vehicle was equipped with a satellite navigation device, something his own car did not have. The minibus has an orange stripe down the side and Prison Service markings. Governor 7 assumed that the vehicle was parked inside Wandsworth, but it was actually located outside the prison.

350. During interview, Governor 7 told my investigators that he asked an Operational Support Grade (OSG) member of staff to drive, as he did not want to waste time parking when they arrived. He also did not wish to leave a Prison Service vehicle parked close to the home, where the man's relatives might see it.

351. Having left the prison, Governor 7 and his colleagues had to travel approximately three to four miles to reach the address. Governor 7 remembered that it was a Friday afternoon and the traffic was very heavy.

352. Shortly after 4.30pm, the man's mother telephoned the prison. She had been informed of her son's death by a prisoner on the Onslow Centre who used a mobile telephone. Governor 7 and the chaplain knocked on her door as she was on the telephone to Governor 4 at the prison.

353. The man's post mortem was held a week later on 19 June with a family representative present. Some of the man's family attended a memorial service held at Wandsworth on 24 June. His funeral took place on 14 July at Brixton Seventh Day Adventist Church. Governor 7 and the Safer Custody Manager at Wandsworth attended on behalf of their colleagues. The prison contributed £3,470 towards the costs of the funeral.

354. Doctor 1 told my investigator that she was not advised of a follow-up critical incident debrief after 12 June. She was similarly unaware of Secure Healthcare organising a review of the man's treatment with the healthcare staff involved.

ISSUES

355. The man's experiences in custody prompt a significant number of questions. Although it became clear that his transfers between prisons require explanation, this was far from the only area of concern identified by my investigators. Amongst the issues I explore are the man's recall to custody, the possibility of his hospitalisation, his location within each prison, the use of the ACCT document and the appropriateness of cell sharing arrangements. Where possible, I try to order my discussion of the issues to reflect the way in which events unfolded.

Drug and alcohol withdrawal

356. The man's original pre-sentence report recorded a history of crack cocaine, heroin and alcohol misuse. When the man arrived at Pentonville on 21 April, he was referred by a nurse to Doctor A for assessment during the reception process. The man told the nurse that he had last used class A drugs on 16 April, and last drank alcohol on 20 April. Doctor A did not refer the man to the detoxification unit. He did not issue any medication to treat either drug or alcohol withdrawal.

357. The next day, Officer B completed an ACCT assessment interview and noted that the man was asking for help with his drug and alcohol problem. A nurse agreed to accept him on the detoxification unit. However, before the man could begin detoxification, he attempted to take his own life.

358. My investigator interviewed Doctor A. He explained that the man did not present with any withdrawal symptoms when he assessed him. He recalled that the man's description of his alcohol and drug use was 'moderate and vague'. He told my investigators:

> '[The man] didn't come across as a full alcoholic or someone with a dependency and he didn't come across as an opiate addict who needed support medication and transfer to the special unit.'

359. With regard to the possible impact of alcohol withdrawal on the man's state of mind, Doctor A acknowledged that alcohol has a calming effect and that withdrawal can cause the prisoner to become either 'physically or mentally upset'. However, he did not consider the man to be withdrawing.

360. On the evidence available, Doctor A did not consider that the man's substance misuse needs warranted referral to the detoxification unit. He did however make a referral to the In-Reach team and opened an ACCT document. The man reported using four small bottles of whisky a day before he came into prison, but Doctor A said that he was not shaking and his physical presentation did not indicate an immediate withdrawal from alcohol.

361. Whilst in his experience most prisoners request an opiate substitute at the first opportunity, Doctor A remembered that the man did not ask for help with his substance misuse. He explained that Pentonville does not allow the

prescription of an opiate substitute on the first night in custody. Therefore, although a request for detoxification was identified the following day, the man could not have been prescribed methadone or subutex on his first night and so he did not lose any 'treatment time'.

362. Doctor A knew that a nurse should complete a secondary assessment of the man the next morning. The doctor explained that the follow-up check presents another opportunity to check for signs of withdrawal and acts as a 'safety net'. I concur with the clinical reviewer, who found that Doctor A's decision not to admit the man for detoxification was 'entirely appropriate'.

Medication

363. The man told the nurse in reception on 21 April that he was prescribed olanzapine and risperidone. However, Doctor A acted cautiously and only prescribed mirtazapine. Doctor A confirmed that he is only willing to prescribe mirtazapine to prisoners with mental health problems on their first night in custody, because this drug 'carries no danger'. Although prisoners may tell him that they take other anti-psychotic drugs in the community, the doctor expressed reluctance to provide prisoners with them until a nurse has contacted their community doctor to verify the information.

364. Doctor A said that he balanced the risk associated with the prisoner being temporarily deprived of anti-psychotic medication against the risk associated with providing it if they were lying. He chose not to prescribe until their information could be corroborated. If the prisoner could produce evidence of the prescription, Doctor A told my investigator he would accept this.

365. The doctor said that confirming medication with community surgeries is a daily task for healthcare staff when new prisoners arrive in reception. Doctor A expected staff to confirm the prescription and issue the prisoner's medication the day after he arrived in custody.

366. Although the prisoner might miss a day's anti-psychotic medication, Doctor A explained that he did not think that the drug would leave the bloodstream entirely if the individual has been taking a continuous prescription. He did not believe that the prisoner would completely lose the therapeutic effect of the medication if the prescription was resumed after one day's absence. Doctor A accepted that failing to continue the prescription during the reception process carries some risks but said that missing a dose is manageable. The doctor explained that this way of working is his personal choice and he has not discussed the policy with colleagues.

367. Doctor A has particular concerns about anti-psychotic medication. He explained that experience had taught him that some prisoners would lie to obtain it because they enjoy the sleepy sensation which it gives. He expressed concern that, once he wrote a prescription, there was no process to review it until days or weeks later.

368. The clinical reviewer does not agree with Doctor A. He comments:

'Anti-psychotic medication should always be prescribed to a prisoner at reception for first night if he informs a member of staff he is prescribed it. Prison staff have understandable concerns that prisoners can falsely inform staff they are prescribed anti-psychotics because they are misused for their sedative effects. However if there are delays in prisoners receiving prescribed anti-psychotics the risks of relapse of a psychotic illness are high. Further information to confirm the prescription can be obtained in the following days.'

369. I endorse the clinical reviewer's recommendation and make another regarding the need to review prescriptions.

If a new prisoner tells a doctor during the reception process that he is being prescribed anti-psychotic medication, the Head of Healthcare at Pentonville should ensure that the prescription is continued on the first night in custody. The prescription should be confirmed with the community provider by the end of the next working day.

The Head of Healthcare at Pentonville should ensure that all prescriptions are reviewed at pre-determined intervals and that staff understand the review process.

Medication error

370. The man returned to Pentonville unexpectedly on 26 May. His regular medication could not be given to him that night because the healthcare staff could not locate his medication chart in either the reception area or the healthcare centre. He was given his prescription the next day.

371. On the evening of 10 June, by mistake Nurse 7 gave the man 30mg of mirtazapine rather than the 15mg that he was prescribed. She provided my investigators with the following statement:

'15mg [of mirtazapine] once daily at night is the introductory dose - the doctor reviews the patient after a couple of weeks, and decides whether he remains depressed enough to need to receive 30mg once daily at night, which is the commonest dose, or whether 15mg is sufficient. A few patients then progress to 45mg once daily at night in due course.

'We cannot know whether the man's dose would have been increased, had he lived, and I obviously would not have intentionally increased it in the absence of a prescription. The 30mg that the man received would not have been toxic, and would not have caused agitation (mirtazapine is a sedative antidepressant, hence prescribed at night) or lowered his mood.

'The brief interaction that I had with the man gave me no cause for concern, other than in regard to my own culpability for the drug error - he had a right to know that this had happened, and that I would be reporting

it to the Sister in charge, and he had a right to an apology, which I made to him. His presentation did not differ in any way from that which was normal for him - courteous, pleasant, and with no apparent evidence of mental distress, allowing for the fact that I was not conducting a formal assessment of his mental state.'

372. Nurse 7 showed admirable honesty in providing my investigators with a full account of her actions. She also fulfilled her responsibility as a registered nurse by reporting her error to her own line manager. The clinical reviewer confirmed that 30mg is the usual therapeutic dose of mirtazapine and would not have caused the man any ill effects. I commend Nurse 7 for her personal apology to the man at the time and her subsequent candour. I consider that her error was unintentional and that she acted swiftly to correct the mistake.

Recall to prison

373. Having examined the paperwork relating to the man's recall to custody, my investigators had a number of questions about the way it was implemented. They had identified breakdowns in communication between the different agencies involved and sought further clarification about what can be a complicated process.

374. The investigator approached the Public Protection Casework Section, part of the NOMS Public Protection Unit. This department oversees the recall process. The investigator interviewed the Head of the Post-Release Casework Section and the Deputy Head of the Section. They assisted the investigator to understand what the Head of the Post-Release Casework Section observed to have been 'an unfortunate collision of events'. The recall process was not as straightforward as it might have been because of initial communication problems between the different criminal justice agencies involved.

375. The man was released on licence on 20 March. He was required to attend weekly appointments with both his offender manager and his CPN. It was a condition of his licence that he return to an approved premises run by the probation service each night to sleep. Until he came into custody on 21 April, I understand that the man complied with his licence conditions. However, it was noted that his mental health problems appeared to be worsening and he was causing some concern in the approved premises. Nonetheless, the man's offender manager thought that his behaviour was being managed satisfactorily.

376. However, on 14 April, the man was arrested by the police after committing new driving offences. He was charged but initially remained on bail. Because the offences were not related to the offence of robbery for which he had received the original four year prison sentence, because the offences were less serious and because the man was otherwise complying with the terms of his licence, the man's offender manager chose not to recall him to custody. Instead, she met him at the probation office on 15 April and issued a warning relating to the new offences. She told the man that any further problems with

his behaviour or failures to comply with his licence would result in a final warning and consideration of recall to custody.

377. The man appeared at court in relation to the driving offences on 21 April. It does not seem that he told staff at the approved premises where he was going before he left that morning. The court remanded him into custody prior to sentencing. Neither the man's offender manager nor the approved premises were told by their probation colleagues at the court that the man had made an appearance and been taken to prison. The man was due to attend an appointment with his offender manager later that day.

378. Believing he was still in the community, the man's offender manager thought that the man had chosen not to attend their scheduled appointment and had therefore failed to comply with his licence conditions. She took the appropriate action based on the information available to her at the time and instructed staff at the approved premises to initiate an out of hours recall if the man did not return before his curfew that night. The hostel staff carried out the recall as directed just before midnight on 21 April, citing the man's failure to return to the approved premises.

379. The man was assessed as presenting a high risk of serious harm to the public, and was therefore the subject of an emergency 'standard recall'. Such a recall had to be processed within two hours, and it was completed shortly after 1.00am on 22 April. The man's final risk assessment was completed on 24 April 2009. The risk he presented to others was assessed as high.

380. Because he had been recalled to custody, the man was not in a position to attend either his probation appointment or go back to the approved premises. The Probation Service's 'Request for Recall' cited the man's failure to report at the probation office on 21 April, his failure to return to the approved premises and comply with his curfew conditions and his failure to contact either the hostel or his offender manager. The recall was not triggered by the recently committed driving offences as the man's offender manager had issued a separate verbal warning in relation to these on 15 April.

381. The man's offender manager has confirmed to my investigator that she was not told of the man's remand into custody on 21 April. When an individual being supervised by the probation service appears in court, probation staff should advise the judge of the offender's response to supervision and also inform the supervising officer so that they can take appropriate action. The offender management IT system used by London Probation should clearly provide court staff with the offender manager's name and the case history.

London Probation Trust should ensure that staff working in court promptly inform the relevant offender manager and other colleagues working with the offender (such as approved premises staff) of the outcome of a court appearance.

382. The Public Protection Casework Section processed the recall and notified the police that they should arrest the man. The revocation of the man's licence is

dated 21 April. (The Casework Section were also unaware at this stage that the man had returned to prison.) The Head of the Post-Release Casework Section said that his team next become involved in the recall process when the individual has been arrested by the police and returned to prison. He confirmed that it is the prison's responsibility to inform the Casework Section immediately because he and his colleagues are legally obliged to prepare and send a recall dossier to the Parole Board within 28 days of the offender's return to custody.

383. In the man's case, Pentonville did not notify the Casework Section of the man's arrival on 21 April (the day that he came back into prison). This is understandable because, when the man arrived from court that day, the recall had not yet been processed (it was only initiated shortly before midnight) and consequently no information had been entered on the Inmate Information System (IIS) by the Head of the Post-Release Casework Section's team for prison staff to check.

384. The Head of the Post-Release Casework Section and his deputy indicated that prisons do not always inform the Casework Section immediately of the return of a licence recall prisoner to custody. Therefore, as a precautionary measure, they carry out 'unlawfully at large' checks using IIS to confirm whether the offender has re-entered the prison system.

385. The deputy head of the section told my investigator that her team's first check was carried out on 27 April. Her staff consulted the computer records but did not identify that the man was back in prison and therefore took no action. This may have been because he had been discharged to the Royal London Hospital under escort. My investigators have looked at IIS themselves and the man's removal to hospital as a serving prisoner was correctly recorded by Pentonville staff.

386. IIS is a very out-of-date and basic piece of computer software that is due to be replaced. There is no facility to record significant detail about the prisoner's circumstances. If Casework Section staff only checked the front page of the man's records, his return to custody may not have been readily apparent. However, further examination of the pages relating to the man's movements would have revealed his imprisonment and subsequent escort to hospital.

The Head of the Public Protection Casework Section should ensure that staff carrying out 'unlawfully at large' checks are trained to access and correctly interpret a prisoner's complete IIS record.

387. I note that approved premises staff and the man's offender manager's line manager were eventually told about the man's return to custody on 23 April. The man's offender manager confirmed this information when she returned to the office on 27 April. It would have helped the Casework Section if probation staff had communicated this information to them at the first opportunity.

London Probation Trust should remind staff to check with the Public Protection Casework Section if they discover from another source that a recalled offender has been returned to prison.

388. The man returned to prison from hospital on 28 April. By this stage, details of the recall had been entered onto IIS by the Casework Section and were available to prison staff. However, the deputy head of the section said that Pentonville staff did not inform the Casework Section that they were holding the man. Because the man was not a newly arrived prisoner and was returning from hospital, it is possible that a full check of IIS was not completed. The deputy head of the section also thought that the second failure by prison staff to notify her section on 28 April may have resulted from confusion over his prison number.

389. The man was mistakenly assigned a second prison number when he returned to custody which may have led to staff not checking details of his recall. Nonetheless, the deputy head of the section told my investigator that prison staff should search for all the records relating to a prisoner using their surname and date of birth. Had Pentonville staff done so, they would have located the man's original prison number, together with the details of his recall.

The Governor of Pentonville should ensure that staff perform a thorough search of prison information systems when a new prisoner arrives in custody. As well as the individual's prison number, staff should also check their surname and date of birth.

The Governor of Pentonville should remind staff of the importance of notifying the Public Protection Casework Section immediately when a prisoner whose licence has been revoked arrives at the prison.

390. The Casework Section performed a second IIS check on 5 May and identified for the first time that the man was back in custody. Consulting the computer records, the Head of the Post-Release Casework Section's team mistakenly thought that the man returned to Pentonville on 28 April, rather than 21 April. My investigators have looked subsequently at IIS, and the records show the man's return to custody on the earlier, correct date.

391. The deputy head of the section explained that information about the man's recall was issued to Pentonville on 5 May. (Although the copy of the letter in the man's prison file is dated 8 May.) It was emailed to the custody mailbox at Pentonville for staff to print off and distribute. The Licence Recall Officer at Pentonville told my investigator that this paperwork would normally have been passed to the man by the Legal Aid Officer, who is also required to explain the recall process.

392. We do not know if the man received the recall pack. Amongst the documents was Annex A, which the man was supposed to sign and date to confirm that the recall process had been fully explained to him. Pentonville had to return the signed copy of the annex to the Casework Section within five days. The

man did not sign Annex A and it was not returned. A blank copy remains in his prison file. It is not clear whether the man saw the document, still less whether he read and understood it.

393. Annex A asks the offender to indicate if they wish to instruct a solicitor to make representations to the Parole Board via the Casework Section. The deputy head of the section confirmed that the man made no such representations. There is nothing in the recall file to indicate that the man ever instructed a legal representative to contest his recall to custody.

394. Annex 4L of Prison Service Order (PSO) 2700 suggests a strategy for reducing risk amongst recalled prisoners:

> 'Staff [could be] trained to guide prisoners as to their entitlements, give them early advice about their right of appeal and opportunities for re-release and help them make contact with a solicitor if required …'

395. My investigator asked the Head of the Post-Release Casework Section and his deputy about the difficulty a prisoner with mental health problems, such as the man, might have in understanding the recall process. It is relatively complex and some of the prison staff interviewed by my investigators suggested that the man did not always seem to fully grasp his circumstances. The original pre-sentence report recorded that, in some circumstances, the man required an appropriate adult to accompany him to interviews and appointments.

396. We do not know whether the man understood either his right to contest the recall, the reasons for the revocation of his licence or how to find a solicitor. The deputy head of the section confirmed that the Casework Section has not issued any set guidance to prison staff regarding delivering recall information to offenders with mental health needs.

The National Offender Management Service should consider whether to issue guidance to prison staff in England and Wales outlining how best to explain the recall process to prisoners with mental health difficulties. They may wish to recommend that, if a prisoner is registered with an In-Reach team, a member of that team is present.

397. The Head of the Post-Release Casework Section and his deputy explained to my investigator that the Casework Section is legally required to submit a recall dossier to the Parole Board for their consideration within 28 days of the offender's return to prison. They accepted that their staff were late to submit the man's dossier and breached the target.

398. My investigator explored the logic behind the man's recall to custody with the Head of the Post-Release Casework Section and his deputy. They agreed that the reasons the offender manager gave for the recall were the man's failures to attend the probation office and the approved premises on 21 April, rather than his reoffending on 14 April. Given that the man was taken to prison on 21 April, he could not reasonably have been expected to meet his

licence conditions. The stated trigger for the recall does therefore, in retrospect, seem unfair, and might indeed have appeared so at the time from the man's perspective.

399. The Head of the Post-Release Casework Section described an 'unfortunate sequence of events'. However, I am satisfied that the man's offender manager acted in good faith on the basis of the evidence available. Neither the Probation Service nor the Casework Section realised straightaway that the man had returned to prison.

400. Although the Request for Recall report referred to the man's failure to attend the office and the approved premises, it also stated that the man had breached another (more general) condition of his licence, which the Head of the Post-Release Casework Section said is 'commonly, but not invariably' cited as a reason for revocation:

> 'You have failed to be well behaved, not commit any offence and not do anything which could undermine the purposes of your supervision, which are to protect the public, prevent you from reoffending and help you to resettle successfully into the community.'

401. The Head of the Post-Release Casework Section confirmed that offender managers can ask the Casework Section to consider rescinding a recall if the offender is still in the community. The Casework section did not receive a request to rescind from the Probation Service. However, because the man had already entered custody, the Head of the Post-Release Casework Section and his deputy said that the Casework Section could not have taken any action anyway. As well, the Head of the Post-Release Casework Section explained that, because the man was assessed as representing a high risk of serious harm to the public, his re-release could only be considered by the Parole Board. The Casework Section does not have the authority to re-assess the reasons for recall before the Board meets.

402. The man was held in custody between 21 April and 26 May in relation to the recent driving offences. This period of imprisonment was concurrent to, but separate from the recall. The Casework Section could not have intervened to release the man from prison during this period. The recall dossier arrived at the Parole Board on 27 May. It should have been sent by either 19 or 26 May, depending on which date one considers correct. In either case, the dossier was supposed to reach the Board before the man was sentenced for the driving offences.

403. From the point the dossier reached the Board, the man's case was out of the Casework Section's hands. No action could be taken regarding his recall until the Parole Board made their decision. As it turned out, the Board decided not to release the man and acknowledged the problematic nature of the original reasons for recall. I am satisfied that the man's continuous imprisonment during this period can be accounted for.

Consideration by the Parole Board

404. The deputy head of the section indicated that the Casework Section would not review a specific prisoner's recall until after the Parole Board had considered the case. Due to the volume of recall dossiers being compiled, no single case can be explored in detail during the first 28 days unless a solicitor or offender manager approaches the section. The man did not instruct a solicitor and the Probation Service did not contact the section again after completing the recall paperwork.

405. The Head of the Post-Release Casework Section stressed the importance of the Parole Board's final decision. Both he and his deputy pointed out that an offender's behaviour is looked at 'in the round' by the panel. The risk assessment process involves consideration of a variety of information, and the panel is not confined solely to the specific reasons for recall. Even when recent reoffending does not trigger a recall, it can be a factor in the decision not to release an offender. Reoffending is an indication that supervision on licence may not be working. Although the offender is attending appointments, they may not be engaging to reduce their likelihood of reoffending.

406. The Parole Board was asked to review the man's recall to custody on 27 May. They carried out the review in a timely fashion on 3 June and made no recommendation as to the man's release. The Board acknowledged the confusion over the original reason for recall:

> 'The panel now understands that [the man] failed to comply with licence conditions on 21 April 2009 because he had been remanded in custody in relation to the driving offences pending the preparation of a [pre sentence report]. He subsequently attempted to commit suicide and received CPR and spent a period of time in intensive care.'

407. The Board agreed that the man had complied with his licence conditions prior to 21 April. In refusing to release him again on licence, they explained their reasoning. The man's offender manager did not support the man's re-release on licence. Her assessment dated 5 May indicated that the man's behaviour was presently unmanageable in the community. The Board took into account the seriousness of the original offence of robbery, the man's history of offending behaviour, his previous failures to comply with the instructions of courts and the fact that he had previously had to be recalled to custody when first released on licence in 2007. They also bore in mind the commission of further offences on 14 April.

408. Although a comprehensive risk management plan had been put in place, the Board noted that a similarly thorough plan was implemented in March, but it did not prevent the man from reoffending. The panel was therefore not satisfied that the risk the man presented to the public could be satisfactorily managed in the community. They acknowledged that, in making their decision, they did not possess either detailed information about the recently committed driving offences or an up-to-date assessment of the man's mental health.

409. The Head of the Post-Release Casework Section pointed out that the original pre-sentence report and the offender manager's newly produced assessment of the suitability for re-release both mention the man's mental health problems. However, the writer of the original pre-sentence report did not have access to a psychiatric report.

410. The man's offender manager's report considering the possibility of re-release was submitted to the Casework Section on 7 May. The Parole Board were unaware of the outcome of the man's court appearance on 26 May. They would not have known about his second attempt to take his own life on 1 June. No accommodation was in place for the man if he were to be released. The man would have lost his place in the Tulse Hill hostel after coming back into prison and places are relatively scarce and can take some while to organise.

411. The Board's findings were emailed to the Licence Recall Officer at Pentonville at 11.33am on 9 June. She told my investigator that, because the man left Pentonville that morning, she would normally have forwarded the information by email to Wandsworth's custody inbox. (She no longer had a copy of the email and could not remember the man's case specifically.)

412. It is unclear whether the man was ultimately told of the Board's decision by a member of Wandsworth staff before he died. The Head of the Post-Release Casework Section expressed concern that news of the Parole Board's refusal might have contributed towards the man's decision to end his own life. However, there is nothing in his records to indicate that the information was passed on or that the man reacted to the news.

413. The 28 day timescale for submission of the recall dossier to the Board is a legislative requirement designed to prioritise public protection and return the offender to prison as quickly as possible. The Head of the Post-Release Casework Section said that it is not feasible to commission a full psychiatric report within 28 days. He explained that his section has agreed with the Parole Board that a full mental health assessment will take three months to prepare.

414. The work done by the Casework Section during the initial 28 day period from the time the offender re-enters prison is, in the words of the deputy head of the section, 'process-driven'. The time scale only allows the Casework Section to gather existing documents (such as the original pre-sentence report) and ask the offender manager to prepare a report commenting on the prisoner's suitability for release. The offender manager can make reference to new developments in their report.

415. If the Board considers the recall and makes no recommendation for release, then the Casework Section is obliged to conduct an ongoing review of the case. (Unfortunately The man died before this could take place.) The Head of the Post-Release Casework Section and his deputy both thought that, given that the man's sentence was due to expire in August, there would

probably not have been time for further reviews. It is likely that he would have stayed in prison until his release date.

416. Offenders are entitled to appeal against the Parole Board's decision and can request an oral hearing within 14 days. In the meantime, the Casework Section can begin to gather new evidence such as a psychiatric assessment. The deputy head of the section told my investigator that it is during this latter stage that a senior caseworker can consider individual cases in greater detail. During the initial 28 days, it is not practical to do so because of the hundreds of recalls to custody that are dealt with.

Prison transfers

417. Between 21 April and 12 June, the man transferred between London prisons four times. I do not know whether the number of transfers had any bearing on his decision to take his life. I am satisfied that some transfers were expressly for his own benefit. I have explored all of the evidence available to determine as far as is possible why each move took place. At each stage, I have assessed whether, as a prisoner with mental health problems who had previously attempted to take his own life, the man's continuity of care was affected.

418. The clinical reviewer has considered the impact that the number of transfers had on the man. He explains why the man's movement around the prison system was unhelpful:

> 'The man's frequent and unpredictable transfers from prison to prison are likely to have exacerbated his fragile mental state. Even in the best functioning system there is difficulty in transferring information from prison to prison, and his frequent moves compounded this. There were frequent breakdowns in communication and a lack of information on transfer. Communication between agencies became stretched and finally broke down.
>
> 'Good quality mental health care is best provided by a single team, who are able to develop a personal relationship and acquire knowledge of an individual's illness and personal needs. In these circumstances patients can begin to feel safe, and the risks, particularly of self-harm or suicide, diminish. This failed to happen during the man's period of imprisonment, despite the efforts of a number of prison officers and the healthcare staff.
>
> 'In my opinion the number of transfers were likely to have had a significant effect on the man's mental state, significantly increasing his risk of harm to himself.'

<u>21 April</u>

419. As the man had appeared at Camberwell Green Court, he would normally have been remanded in custody at Brixton. However, staff at Brixton correctly identified a conflict of interest because the man's cousin worked at the prison.

They needed to make alternative arrangements and time was pressing as the man was waiting in the court cells. There was no obligation to locate the man in another prison in South London, and I am satisfied that consideration could not be given at such short notice to placing him in the London prison closest to his family's home. Equally, it would not be reasonable to have expected staff to have tried to place the man in the prison where he was held prior to his release on licence (which happened to be Wandsworth).

420. Governor W (the duty governor at Brixton) asked Principal Officer Z to use her contacts to locate the man in another London prison. Principal Officer Z had ties with Pentonville and telephoned Principal Officer A. When Principal Officer A spoke to her, Governor A agreed to accept the man. At this stage, staff at Brixton and Pentonville could not reasonably have known about the man's mental health problems, his dislike of Pentonville or his desire to return to Wandsworth. They were issues that would subsequently become apparent.

421. I consider that staff acted promptly and reasonably to locate the man. His best interests were prioritised to ensure that he was not located in Brixton even temporarily, only to then have to be moved again because of the conflict of interest. My investigators have established that Governor 3 (the duty governor at Wandsworth) was not asked to accept the man on 21 April, although the prison had space to accommodate him. From the moment Principal Officer Z was asked to facilitate a transfer, it would seem that Pentonville was always the intended destination.

12 May

422. Having attempted to take his own life, the man was taken to the Royal London Hospital. He returned to Pentonville and was kept under close observation in the healthcare centre. He repeatedly expressed his anxieties about remaining in Pentonville and his wish to transfer to Wandsworth, where he said he felt safer and had been held before he was released on licence. Such was the concern about the man that plans were made to return him to Wandsworth.

423. The Pentonville Governor, Governor C, spoke to the Wandsworth Governor, Governor 1, about the man's circumstances in early May and Governor 1 agreed to accept him. Preparations for the transfer took place over more than a week and the man was given several days notice of the move. Nurse D liaised with the manager of the mental health in-reach team at Wandsworth to allow her team to prepare for the man's arrival. The Heads of Healthcare at both prisons spoke to each other. Nurse D provided Wandsworth with a discharge summary.

424. Regrettably these excellent preparations did not include Senior Officer D (Pentonville's Safer Custody Manager) who was apparently unaware of the plan. On the morning of 12 May, he still thought the man would automatically transfer to Brixton after his appearance at Camberwell Green. He emailed Brixton to complete a handover. Whilst this oversight was unfortunate, I do not make a recommendation. However, the Governor of Pentonville may wish

to review the channels of communication between the Safer Custody department and healthcare staff.

425. I am satisfied that the move to Wandsworth was organised in the man's best interests and was well intended. Staff listened to what the man told them about his feelings of anxiety at Pentonville and acted appropriately to reduce the risk he presented to himself. His continuity of care was considered, and measures were put in place to ensure that staff at Wandsworth were prepared for his arrival.

426. HMIP carried out an announced inspection of Pentonville between 11 and 15 May. I consider that the scheduling of the man's transfer to Wandsworth near the beginning of this period was coincidental. The move had been planned since early May and was intended to make the man feel safer, rather than remove him from Pentonville during the inspection. The transfer to Wandsworth was supposed to be permanent.

427. The man was supposed to move to Wandsworth after his court appearance. Despite the intentions of healthcare staff, the PER was not marked accordingly. During interview, Governor C accepted that the failure to transfer the man to Wandsworth on 12 May was a consequence of Pentonville staff not properly communicating their intention on the PER. Even though portions of the man's medical record were read out in court, the intention to move him to Wandsworth was not acted upon. (Judges can offer guidance to Serco staff if relevant information is presented in court.) Instead, the man was placed on a van to go to Brixton.

428. Governor Y (the duty governor at Brixton) realised that the man was arriving, via court, from the healthcare centre at Pentonville. However, he thought it inappropriate to accept the man into Brixton's healthcare centre without prior agreement by their healthcare manager. Prior agreement is a requirement of the Prison Service London Area Males Local Transfer Protocol. (There is no evidence in the man's records of a London Protocol pro forma being completed by Pentonville staff as should have happened.) Liaising with the other prisons involved, Governor Y found that the duty governor at Wandsworth also did not know about the transfer organised by healthcare staff.

429. The duty governor at Pentonville recognised the error when Governor Y contacted him. Governor Y prioritised the man's safety and accepted him into Brixton for the night. He acted cautiously, keeping the man under constant supervision in the healthcare centre. Governor Y knew about the man's recent attempt to take his own life and seems to have been very much attuned to the risk he presented.

13 May

430. I consider that Governor Y acted appropriately on the evening of 12 May. He obtained relevant information, took account of the risk issues and acted in the man's best interests. Although the man's continuity of care was disrupted, I

am satisfied that the disruption was kept to a minimum and the action taken was reasonable. The man's temporary location in Brixton could not have been reasonably avoided by that prison's staff. The man moved promptly to Wandsworth the following day.

26 May

431. The transfer which took place on 26 May was the one which least appeared to have been arranged in the man's own interests. Establishing the chronology of events involved speaking to several governors as well as considering other evidence. The investigation was further complicated by additional evidence coming to light in the course of the Prison Service's own investigation.

432. The man stayed at Wandsworth until he was taken to Pentonville after appearing in court on 26 May. He was no longer the subject of an open ACCT document and was not subject to medical hold. Doctor 1 told my investigators that she only tended to use the option of placing a prisoner on medical hold if they had an upcoming hospital appointment or an operation scheduled. She could not recall placing a prisoner on medical hold solely because she thought that they would benefit from a stable environment, although she thought it might be possible.

433. The man's transfer to Pentonville from Wandsworth following a court appearance was authorised by the Governors of the two prisons as their respective duty governors were unable to agree. The move was not scheduled and an explanation was not readily apparent. My investigators interviewed those who made decisions regarding the man's transfer to Pentonville on 26 May and those who influenced the timescale of his return to Wandsworth. They spoke to Governor 3, Governor C, Governor A, Governor 1 and Governor Z to clarify their understanding of events.

434. Concerns about the transfer were initially raised by two prisoners on the Onslow Centre. Prisoner 3 and Prisoner 2 first complained to my investigator when he visited Wandsworth in June, soon after the man died. The two prisoners also wrote to HMIP. They alleged that they had been deliberately moved out of Wandsworth prior to HMIP's visit between 1 and 5 June. They had transferred to Pentonville the weekend before the inspection and returned on 9 June in the same van as the man. The prisoners thought that the man's transfer to Pentonville on 26 May was also intended to remove him from Wandsworth for the duration of the inspection.

435. HMIP returned to Wandsworth and concluded that short term transfers had been organised to remove prisoners temporarily during the inspection period. An internal investigation was then carried out by the Prison Service which confirmed that managers at both prisons had made a reciprocal arrangement. When HMIP visited Pentonville from 11 to 15 May, six prisoners had been temporarily transferred to Wandsworth. Similarly, it was established that five men moved from Wandsworth to Pentonville on a short term basis before HMIP visited.

436. As I have said earlier, the Chief Inspector of Prisons has criticised the 'attempts, at a managerial level, to subvert the inspection process'. I have reflected her opinions in the earlier sections of this report entitled 'HMP Wandsworth' and 'HMP Pentonville'. In her annual report, issued several months after the original inspection reports, the Chief Inspector said that some managers had made 'the welfare of prisoners subordinate to the desire to impress inspectors'.

437. Following the internal Prison Service investigation, charges were recommended against five managers at the two prisons. At subsequent disciplinary hearings, charges against two managers were dismissed. Charges against the other three managers were proved. One received a final written warning and was removed from the field of promotion. Another received a written warning. The other received formal guidance.

438. As far as the man is concerned, the internal Prison Service investigation found that he was not one of the five prisoners who were deliberately escorted to Pentonville on the weekend prior to the inspection. His move took place a few days earlier after a scheduled court appearance.

439. Nonetheless, both the Prison Service's investigation and the enquiries of my own investigators found evidence to suggest at the very least a connection between the forthcoming inspection and the failure to return the man to Wandsworth after court on 26 May. The evidence also suggests some association between the duration of the inspection and the failure to return the man to Wandsworth until 9 June. (Although a transfer back to Wandsworth was booked for 1 June, staff at Pentonville working with the man were not aware of it and it did not take place after he tried to take his own life for a second time.)

440. During interview, Doctor D and Nurse D at Pentonville and the manager of the mental health in-reach team and Doctor 1 at Wandsworth voiced their suspicions that the man transferred to Pentonville because of HMIP's imminent visit. Given the effort staff put in to organise the original transfer in mid-May and the amount of liaison involved, it is perhaps not surprising that some were baffled by the man's return to Pentonville only two weeks later.

441. The man left Wandsworth for Camberwell Green on the morning of 26 May. There was nothing marked on his PER to indicate that he should return to Wandsworth afterwards, rather than being taken to Brixton (as prisoners normally are from Camberwell Green). PSO 1025 guides staff in completing PERs. The PSO does not require them to mark a PER to this effect.

442. However, had the PER been marked accordingly, the subsequent involvement of a number of governors would have been unnecessary, and I am confident that the man would have returned to Wandsworth. The same mistake had been made on 12 May, when Pentonville healthcare staff failed to mark the PER to indicate the man's intended transfer to Wandsworth. On both occasions Serco staff at Camberwell Green tried to transfer the man to

Brixton because they were not provided with pertinent information on the PER.

To ensure continuity of care, Offender Health should instruct In-Reach teams to write under 'Health Risks' on the Risk Indicator page of the PER the intended return destination of a prisoner under their care if that prisoner is appearing at a court that will not automatically return them to the dispatching prison.

Governor 3

443. The first governor my investigators spoke to was Governor 3, the duty governor at Wandsworth on 26 May. Governor 3 remembered receiving two or three telephone calls from Governor Z (the duty governor at Brixton). He said Governor Z explained that the man was currently at Camberwell Green Magistrates' Court and that a conflict of interest meant it was inappropriate for Brixton to receive him.

444. Governor 3 refused to accept the man. He remembered telling Mr Governor Z, 'He's not our court.' Governor 3 did not consider the man to be a 'Wandsworth prisoner'. He formed this opinion because prisoners leaving Camberwell Green are normally taken to Brixton. Governor 3 also knew that the man had started his recall to custody in Pentonville. He thought that either Brixton or Pentonville should accept the man and that it was nothing to do with Wandsworth.

445. During interview, Governor 3 said that he was unaware of the efforts made earlier in the month to transfer the man to Wandsworth. When he spoke to Governor Z, he could not be sure whether he realised that the man had been held in Wandsworth for the previous two weeks. He thought on reflection that he must have known.

446. When he spoke to my investigators, Governor 3 commented that he would not normally refuse to assist another duty governor. He was not especially anxious about population pressures and the prison was not full that day. Governor 3 commented that the prison population was 'relatively low' in late May 2009.

447. Governor 3 told my investigators that he did not think it was a 'sensible decision' to accept a prisoner who 'was coming with certain issues' and who was not (he believed) a 'Wandsworth prisoner'. He considered that to accept such a prisoner would create additional pressure during the stressful inspection period.

448. If another prison was asking Wandsworth to accept a prisoner, Governor 3 thought it likely that the prisoner had 'issues'. He was not minded to 'do favours' for other prisons at the time. He felt that Wandsworth sometimes accepted prisoners too readily without this being reciprocated. However, he confirmed that he was not asked to accept any other prisoners on 26 May,

and was not asked to facilitate any other 'governor to governor' transfers around that time.

449. During interview, Governor 3 accepted in retrospect that the man had been in Wandsworth until the morning of 26 May and therefore his return would not have created any new pressures for staff. However, at the time he thought that the man was a prospective new arrival.

450. Having refused Governor Z's request, Governor 3 decided to ask the duty governor at Pentonville, Governor A, to accept the man. He approached Pentonville because he knew the man had recently been held there. Governor 3 recalled that Governor A refused to accept the man and advised him of the man's recent attempt to take his own life in Pentonville.

451. Governor 3 did not recall discussing the man's recent transfer to Wandsworth. He remembered Governor A expressing her belief that the man was a 'Wandsworth prisoner'. Governor 3 persisted but Governor A still refused and they failed to reach an agreement.

452. After finishing the telephone call with Governor A, Governor 3 remembered speaking to Governor 1 in a corridor in the administration block. He remembered telling Governor 1 about his dealings with Governor Z and Governor A, and saying that he did not want to accept somebody with 'issues' who was either a Brixton or Pentonville prisoner.

453. Governor 3 could not recall whether he and Governor 1 discussed the information Governor A provided (about the man's recent attempt to take his own life) or the man's presence in Wandsworth until that morning. He said that they did not discuss the forthcoming inspection. Governor 3 told my investigators that Governor 1 then went away to make a telephone call to Governor C. Later, he recalled Governor 1 telling him that Pentonville had agreed to accept the man.

454. With the benefit of hindsight, Governor 3 said that he unequivocally regretted his decision to refuse to accept the man back into Wandsworth. He recognised that the man had no particular association with Pentonville, that efforts had been made to remove him from that prison, and that Brixton acted legitimately in avoiding the conflict of interest created by the presence of a family member.

455. I consider that Governor 3 was disinclined to assist Brixton when Governor Z approached him on the telephone. His unwillingness resulted, to some extent, from the pressure he felt because of the imminent inspection. Governor 3 said that the inspection influenced 'every decision' he made during this period, including his refusal to accept the man. He thought that the man's transfer was 'somebody else's issue' and their responsibility. Governor 3 told my investigators about the prison's preparation for the inspection, which he described as the most important event to take place at Wandsworth that year:

'It was a bit like you know the Olympics, you prepare for it, you want to be as good as you can.'

456. I am satisfied that Governor 3 did not refuse to accept the man in particular because of his unique background or circumstances. He did not attempt to familiarise himself with the man's background or find out whether he was truly a 'prisoner with issues'. He did not contact the Onslow Centre. He told my investigators that his telephone conversations with Governor Z were brief. In my assessment, Governor 3 refused to accept the man because he was conscious of the pressure on Wandsworth during a very busy period. He was reluctant to accept any prisoners above and beyond those who he knew should automatically return to Wandsworth.

457. Governor Z is certain that he advised Governor 3 during their earliest telephone calls on 26 May that the man had been held at Wandsworth until that morning. Yet Governor 3 continued to ask other prisons to accept the man and did not check with colleagues on the Onslow Centre.

458. Governor A told the investigators that Governor 3 suggested to her that she accept a prisoner in part because an inspection was taking place at Wandsworth. Governor 3 also apparently misled Governor A when he claimed that Governor C and Governor 1 had already agreed to the transfer to Pentonville. Neither Governor was aware of any such agreement. Furthermore, Governor 3 ignored Governor A when she expressed her serious doubts about the suitability of the man's transfer to Pentonville because of recent events.

Governor Z

459. My investigators also interviewed Governor Z. His reception staff told him that Serco were asking Brixton to accept the man from Camberwell Green. Governor Z was aware that the conflict of interest meant the man should not be held at Brixton. He telephoned the Serco cell supervisor at Camberwell Green, who, he recalled, told him that the man had come from Wandsworth that morning.

460. This information prompted Governor Z to telephone Governor 3. He told Mr Governor 3 about the conflict of interest. He remembered Governor 3 saying that Camberwell Green was a court that Brixton served and that therefore Governor Z should agree to receive the man. He recalled Governor 3 saying, 'He's not ours, he's yours.' Governor Z was certain that he informed Governor 3 that the man had been held at Wandsworth until early that morning. He did not recall Governor 3 making reference to the forthcoming inspection at Wandsworth.

461. When he spoke to Governor 3, Governor Z thought that the man 'must have' still been waiting in the cells at Camberwell Green to be transferred. Governor Z recalled speaking to Governor 3 once or twice about the man. He did not recall Governor 3 saying that he would ask Pentonville to accept the

man. After they finished speaking, Governor Z thought that Governor 3 was going to accept the man at Wandsworth.

462. Governor Z said that, in his experience, it was rare for Serco to place a prisoner on an escort vehicle without the destination prison first being properly agreed. During his time working at Brixton, he said that this situation had not arisen.

Governor A

463. My investigators spoke to Governor A to obtain her account of her conversation with Governor 3. She said that she recalled the man's circumstances as soon as Governor 3 mentioned his name. His attempt to take his own life had had a significant impact on staff in Pentonville. Although Governor A had not met the man, he was the only recent example of a prisoner coming close to taking his own life and consequently she remembered it well.

464. When she spoke to Governor 3, Governor A told my investigators that she refused to accept the man and explained her concerns. She told him about the man's recent attempt to take his own life. She stressed that a return to Pentonville would be unwise and inappropriate because it would increase the risk that the man might harm himself.

465. During interview, Governor A recalled that Governor 3 insisted that the man transfer to Pentonville because he was not a 'Wandsworth prisoner'. Governor A replied that the man was also not a Pentonville prisoner. (She knew from her dealings in relation to the conflict of interest on 21 April that the man was originally a Brixton prisoner.) She was also aware of the efforts made in early May to return the man to Wandsworth. She reiterated recent events to Governor 3, her unhappiness with his request and her objections to the proposed transfer.

466. When she spoke to my investigators, Governor A remembered that Governor 3 made an explicit reference to the inspection. She recalled that he referred to the forthcoming visit to Wandsworth by HMIP, alluded to his belief that the man was a difficult prisoner to manage and asked for her assistance in accepting the man.

467. Thinking back, Governor A said that she did not tell her Governor, Governor C, about Governor 3's reference to the inspection on 26 May, instead mentioning it several weeks later when the influence of the inspection on prisoner movements became an issue. She said that she had apologised to Governor C for not mentioning it earlier, but told my investigators that her main concern on 26 May had been the impact that returning to Pentonville would have on the man.

468. Following her refusal to accept the man, Governor A said that Governor 3 told her that their respective Governors had already agreed the transfer. She was confused by this and did not understand why Governor C had not advised her

if this was the case. Governor A ended the telephone call in order to clarify the position with Governor C. She discovered that Governor C had not agreed to the transfer.

469. Governor A remembered that Governor C immediately telephoned Governor 1 while she was in the room. During their telephone conversation, Governor A recalled that Governor C told Governor 1 that the man had tried to take his own life at Pentonville. She remembered that the conversation ended with Governor C agreeing to accept the man into Pentonville because he was 'already en route', with the proviso that he should return to Wandsworth after a 'settling in' period at Pentonville.

470. Governor A said Governor C firmly believed that staff had a duty of care to accept a prisoner who was already en route to Pentonville rather than redirect him once he reached the prison. Governor A confirmed that she had been told to accept a prisoner in the short term as a general rule and assess the situation afterwards. In this instance, Governor A told my investigators that the instruction to accept the man because he was en route took priority over her original concerns about risk. However, the final decision rested with Governor C.

471. When she spoke to my investigators, Governor A thought she might have given Governor C the impression that the man was already being transported to their prison. She had made an assumption and neither she nor Governor C confirmed with Serco staff whether the man had actually left the court. She thought the Serco staff at the court had to obtain permission before placing a prisoner on a van to Pentonville.

472. A case review was conducted in the healthcare centre at Pentonville on 27 May to assess the man before he was discharged. Governor C had suggested that the man be located on the VPU. Governor A chaired the review and told the man that he would return to Wandsworth from 6 June. My investigators asked Governor A why she chose this specific date and she said that she could not give an explanation.

473. The internal Prison Service investigation addressing the transfers of prisoners subsequently provided my investigators with the emails exchanged between Governor C and Governor 1 which are reproduced in the 'Key Findings' section of my report. The emails (in which the Governors agreed that the man would return to Wandsworth from 6 June after the inspection team had left) were forwarded to Governor A before she carried out the case review.

Governor C

474. Governor C thought that the man's transfer to Wandsworth on 13 May would last for the remainder of his time in custody. He had not foreseen a reason why the man would transfer to a different London prison after that date. In interview, Governor C remembered that the man felt that he had moved to an environment where he felt safer and wanted to be.

475. My investigators spoke to Governor C about the events of 26 May. He recalled that Governor A entered his office and asked him if he had agreed with Governor 1 to accept the man. Governor C told Governor A that he had made no such agreement. He remembered her saying that Governor 3 had claimed that such an agreement had been reached. Governor C decided to telephone Governor 1 immediately whilst Governor A remained in the room because he was upset that he was supposed to have agreed to a transfer when he had not. He did not like being 'misquoted', particularly because he was familiar with the man's history.

476. During interview, Governor C said that he did not make a record of his conversation with Governor 1 because he did not think he would need to. He remembered telling Governor 1 that he had not agreed to accept the man. He recalled referring to the man's attempt to take his own life at Pentonville.

477. Governor C did not think that a return to Pentonville should happen because it was neither the 'right move' nor a 'very clever move'. He told my investigators that this remained his opinion at the time of their interview. He pointed out that both prisons had worked hard to transfer the man to Wandsworth. He thought that the man should 'return' to Wandsworth after his court appearance. He wondered whether Governor 3 was using Governor 1's authorisation without the latter's knowledge. Governor C thought that Governor 3 was misquoting both of them and that Governor 1 had not been fully briefed by Governor 3 before the two Governors spoke.

478. Governor C said that the telephone conversation lasted at most five minutes. He established with Governor 1 that Wandsworth had accepted the man earlier that month. He told Governor 1 that the man should not be in Pentonville and should return to Wandsworth.

479. Governor C recalled that he and Governor 1 discussed the fact that the man was a person at serious risk of self harm and established that the risk was exacerbated at Pentonville. Governor C said that there was 'an awareness in [his] mind' of the man's recent history at Pentonville. He remembered Governor 1 agreeing that Wandsworth was where the man should be located.

480. During interview, Governor C remembered that he had been under the impression that the man was already en route to Pentonville. Despite believing that a transfer to Pentonville was not sensible, he accepted the man because he thought he was on his way and he did not want him travelling back and forth across London.

481. Governor C stressed his belief that prisoners should not be turned away from Pentonville if they are either en route or 'on the forecourt'. He said that it was his policy to accept a prisoner in the first instance and then assess their circumstances. At the time, he thought to refuse the man would have been a 'silly decision'. He said that he wished that he had 'done a bit more digging' to find out exactly where the man was.

482. Governor C confirmed that Governor 1 was willing to accept the man back into Wandsworth and did not raise any objections. Governor C thought that it was he, rather than Governor 1, who set the timescale for return of two weeks. He agreed to hold the man for a short while, although he did not want the arrangement to 'drag on and on'. He could not remember why he thought the man was already en route, or whether somebody else told him this.

483. After the man arrived at Pentonville, Governor C visited him in his cell in the healthcare centre. He wanted to satisfy himself that the man felt safe. Governor C said that it was very rare for a Governor to do this but he was aware of the man's vulnerability and the risks surrounding him. He made sure that the man had been assessed by a nurse. He told the man that he would only be held at Pentonville on a temporary basis and that Wandsworth had agreed to his return.

484. Governor C's acceptance of the man on 26 May might seem to contradict the concerns he and Governor A shared. Additionally, Nurse D was sufficiently worried to recommend constant supervision and Governor C sufficiently concerned to check on the man personally. My investigators asked why, if the man was accepted because he was en route to Pentonville, he could not have returned to Wandsworth under escort the next day (a situation mirrored by the man's unintended stay for one night at Brixton between 12 and 13 May and the prompt transfer to Wandsworth on that occasion).

485. Thinking back, Governor C did not consider that the man presented as a 'prisoner in crisis' when he saw him in the healthcare centre. Nurse D also told my investigators that he placed the man under constant supervision not because of his presentation on 26 May, but because of his history of self harm. Governor C said that, if he had had acute concerns about the man, he would have held him overnight and then organised an escort back to Wandsworth the next morning. However, the man did not give Governor C any additional cause for anxiety.

486. Governor C said that he knew enough about the risk the man presented to himself to recognise that he should not remain in Pentonville 'in the long term'. He thought he had made a decision which was 'reasonable and safe' for the man. However, he commented that he would not have accepted the man at Pentonville if he had 'dug that little bit deeper' on 26 May.

487. Emails exchanged between Governor C and Governor 1 early on 27 May show that they agreed the man would return to Wandsworth from 6 June after the inspection ended. At the time my investigators interviewed Governor C, the emails had not yet been retrieved. My investigators did not therefore raise the issue. (Governor C produced a further statement after the email was located during the course of the Prison Service's internal investigation.)

488. During interview, Governor C was 'as certain as he could be' that neither he nor Governor 1 discussed the forthcoming inspection at Wandsworth when they spoke on the telephone. He thought that he would remember if such a discussion had taken place because it would have been inappropriate. He

said that the timescale he set for the man's transfer back to Wandsworth of two weeks was 'completely arbitrary' and he could not remember why he settled on it.

489. When he spoke to my investigators, Governor C maintained that the forthcoming inspection at Wandsworth did not affect his decision making. He said that the first time he realised that there might be a link between the inspection and the man's transfers was some weeks later, when Governor A told him that Governor 3 had made reference to it.

490. My investigators asked Governor C why Governor A told the man that he would return to Wandsworth after 6 June. He could not explain the choice of date and agreed that it did not look 'very sensible or clear'. He acknowledged that the date was 'random', particularly since it was a Saturday, which is not a day on which transfers normally occur. The investigator suggested that, given the effort both prisons had put into relocating the man to Wandsworth in early May, the action taken in late May did not appear to be consistent. Governor C agreed and acknowledged that he and his colleagues might have placed more emphasis on the man's history at Pentonville when organising the transfer back to Wandsworth. He said that he wished that he had considered returning the man more quickly, perhaps using a specially arranged escort vehicle.

491. Some weeks after their interview with Governor C, my investigators were provided with a copy of the emails exchanged between the Governors on 27 May. The content of Governor C's correspondence seemed to conflict with what he had said during interview. He told my investigators that Governor A had come to him some weeks after the man died and explained for the first time the reference Governor 3 had made to the inspection when he tried to persuade her to accept the man at Pentonville on 26 May.

492. During interview, Governor C was also unable to satisfactorily account for the choice of 6 June as a return date for the man. (This date was determined by the Governors in their emails.)

493. As I have indicated, Governor C provided my investigators with a further statement when he returned a signed copy of his transcript. He had been provided with a copy of his own email dated 27 May. He said that he had not remembered writing the email when my investigators spoke to him. He acknowledged that his email showed an intention not to return the man to Wandsworth until the completion of the inspection. He wrote in his statement:

> 'I am as confident as I can be this was my view rather than that of Governor 1 (nor that asked by Governor 1).'

494. Governor C acknowledged that his email demonstrated an awareness of the dates of the inspection at Wandsworth. He expressed the hope that the eventual booking of a transfer for 1 June (albeit one not carried out because the man had attempted to take his own life for a second time) showed that a quicker return was subsequently planned.

495. The reappearance of the email caused Governor C to consider whether he and Governor 1 had discussed the inspection during their telephone conversation on 26 May. He said that he did not think that the inspection was discussed.

496. In his statement, Governor C maintained that he accepted the man into Pentonville for the reasons explained in his original interview (namely his belief that the man was already en route). However, he agreed that the email demonstrated that he had considered the Inspectorate's visit to Wandsworth at some stage between the telephone conversation on 26 May and the sending of the email on 27 May.

497. Governor C thought that he agreed that the man should stay at Pentonville until after the end of the Wandsworth inspection because he knew that this was 'about two weeks away'. He emphasised that he did not make the arrangement 'as a way of deliberately affecting the care plan for [the man]'.

498. With regard to the email, Governor C said that he could not be sure exactly why he had written it, other than to resolve the issue of the man's property. Governor C emphasised that he was not aware in advance that the man might be transferred from court on 26 May. He reiterated that he checked on the man's welfare personally, took up the issue he raised regarding property and asked for a case review to take place. Governor C did not think that the decision he made had an impact on the man's death.

499. The outcome of the telephone conversation between Governor C and Governor 1 on 26 May would seem to contradict their previous decision making relating to the man, whom they had previously agreed to transfer to Wandsworth where he felt safer. Both men acknowledged that this was supposed to be a permanent transfer. None of the other staff my investigators interviewed interpreted the move as anything other than a long term one to help the man. Many were surprised by his sudden return to Pentonville.

500. Both men also accepted that their involvement in the movements of particular prisoners was a rare event for them, so it seems reasonable to surmise that they would remember the man's situation. Governor C in particular was aware of the man's recent attempt to take his own life and knew that he presented a risk to himself in Pentonville. He chaired the hot debrief on 22 April and personally checked on the man's welfare when he returned to Pentonville on 26 May. (Whilst his action in this regard was commendable, it also highlights how worried his staff were.)

501. Governor C's agreement to the man's return is difficult to understand. Governor A protested when Governor 3 suggested the transfer. A serious attempt by the man to take his own life was still fresh in the minds of Pentonville staff. Furthermore, Governor 1 said he was willing to accept the man back at Wandsworth.

502. Governor C told my investigators that he agreed to accept the man during the telephone conversation with Governor 1 because he thought that he was already en route from court. Neither he nor Governor A spoke to Serco staff to confirm this. During interview, none of the governors my investigators spoke to were able to recollect with certainty when their discussions about the man took place on 26 May. (As the duty governor, Governor A pointed out that she would have dealt with numerous telephone enquiries and worked in all areas of the prison. As such, she emphasised that she would struggle to recollect the timing of one particular call.)

503. My investigators have since obtained records confirming that Governor C made his telephone call to Governor 1 at 1.17pm. The PER shows that the man actually left Camberwell Green for Pentonville an hour and twenty minutes later, at 2.37pm. Governor A has agreed that it was she who probably gave Governor C the impression that the man was en route.

504. If Governor C thought that the man was en route to the prison, and was sufficiently concerned about him to approve constant supervision after he was assessed by healthcare staff, then it is surprising that Pentonville did not endeavour to return the man to Wandsworth at the earliest available opportunity. Governor C acknowledged that this could have been done. I note that space was available to accommodate the man at Wandsworth throughout this period, particularly after the weekend of 30 and 31 May, when Prisoner 3, Prisoner 2 and the other prisoners were temporarily removed.

Governor 1

505. Having interviewed Governor C, my investigators spoke to Governor 1 to discuss his recollection of events. Before the interview began, Governor 1 made my investigators aware that the internal Prison Service investigation had just retrieved the emails exchanged between the two Governors dated 27 May.

506. Governor 1 confirmed that Governor C explained the reasons why the man needed to leave Pentonville when they spoke in early May. He remembered authorising the transfer to Wandsworth. He could not remember whether he was aware of the man then arriving in Wandsworth. He commented that '[the transfer] certainly wasn't agreed as a temporary move' but was rather intended to be permanent.

507. When Governor 1 received the telephone call from Governor C on 26 May, he did not think that Governor 3 had briefed him about the man beforehand. He recalled not really knowing what Governor C was 'exasperated' about and having to ask him to explain the man's circumstances. He therefore thought it was unlikely that Governor 3 had already spoken to him. With regard to Governor C's exasperated tone, Governor 1 presumed that he was annoyed because he was being asked to involve himself in an individual prisoner's move, something that does not normally fall to a governing Governor.

508. Governor 1 said that he only subsequently realised that Governor C was agitated because he had been told by Governor A that he was already supposed to have agreed to accept the man, when he had not done so. He did not recall Governor C mentioning Governor A's assertion during the telephone conversation. He said that, if he had been told at the time that Governor 3 was making claims on his behalf, he would have taken the matter up with him immediately after the telephone call (and he did not do so).

509. During interview, Governor 1 recalled the gist of their conversation. He remembered that Governor C asked him why Governor 3 would not accept the man back into Wandsworth, given that Governor 1 had previously agreed to accept him. As the conversation progressed, Governor 1 remembered realising who the man was and what he had been told about his recent circumstances.

510. Governor 1 told my investigators that Governor C agreed to take the man for the time being because he did not want him to travel back and forth across London. Governor 1 explained that he made a commitment to subsequently accept the man back into Wandsworth and acknowledged the two men's original agreement. He did not believe that he discussed a timescale for the man's return with Governor C on the telephone. He told my investigators that he did not discuss the forthcoming inspection at Wandsworth with Governor C during the telephone call.

511. Governor 1 remembered that Governor C perceived the man to be at risk in Pentonville and was initially very reluctant to receive him. My investigators asked Governor 1 why more effort had not been made to move the man back to Wandsworth immediately once the situation was clarified. Governor 1 said that responsibility for returning the man lay with Governor C, as the sending prison has to organise an escort. He acknowledged that Governor C was very worried about the man in early May, but thought he might have considered the risk to be reduced when he checked him on 26 May.

512. My investigators spoke to Governor 1 about the emails dated 27 May. He said that it did not make sense for him to 'scheme' for the man to be removed from Wandsworth during the inspection period. Governor 1 explained that he had agreed to receive the man after 6 June because he was replying directly to Governor C's offer to keep the man until the inspection concluded (on 5 June). My investigators asked him why he had agreed to the suggestion. Governor 1 explained that he knew from what Governor C had said that the man was being well cared for. He said that he relied on Governor C's judgement and would have been prepared to accept the man back in Wandsworth immediately if this was what Governor C had suggested.

513. Governor 1 was clear that the man did not transfer to Pentonville because of who he was or the problems he might represent during the inspection. He thought that Governor C's probable intent in writing that he would return the man to Wandsworth after the inspection was to offer to do another Governor a favour and relieve pressure at Wandsworth during an especially hectic period.

Governor 1 said that it was what he would have done if a colleague had been going through a similarly busy time in their prison.

514. During interview, Governor 1 said that he had not directed his staff to refuse to accept 'difficult prisoners'. He denied that Governor 3 would have felt it right to do so because of anything he had said as the Governor. He said that the man, as a vulnerable individual, was exactly the type of person he wanted the inspection team to meet, to demonstrate the level of care now being afforded to prisoners.

515. Contemporaneous evidence is generally to be preferred to any other. However, emails may be drafted speedily and usually without a great deal of thought. I have quoted Governor C and Governor 1 at length because, as senior governors with distinguished records, their accounts of their decision-making deserve to be heard with respect. The question, therefore, is how much weight to place on the wording of the emails Governor C and Governor 1 exchanged on the morning of 27 May. The content of Governor C's exchange in particular leaves the reader with the impression that the forthcoming inspection certainly influenced the man's movements. Furthermore, Governor 1 accepted Governor C's suggestion that the man would not be returned to Wandsworth until after the inspection ended and replied that the man would return to Wandsworth from 6 June (the day after the inspection finished). Governor A subsequently provided the man with this date at the case review.

<u>1 June</u>

516. Although the man was told he would transfer after 6 June, my investigator has confirmed that a move to Wandsworth was organised by Pentonville staff for 1 June. On 27 May, Governor A asked Officer H in Pentonville's OCA department to arrange for the man to move to Wandsworth. Although Officer H did not remember Governor A providing a timescale for the planned return, Governor A told my investigator that she had said it was to be 6 June. Governor A said she asked Officer H to try to organise an automatic transfer that would not mean paying for additional staff to transport the man.

517. Officer H told my investigator that she emailed a completed booking form to the PMU before lunchtime on Wednesday 27 May. She requested that the move should take place in the following week, commencing 1 June. G4S Care and Justice Services have provided inter-prison transfer documents which confirm that the requested move was booked for 1 June. Their staff planned to collect the man in a van that morning and take him to Wandsworth. Officer H told my investigators that the response to her request was 'very, very quick'.

518. However, an apparent breakdown in communication meant that either G4S or the OCA department in Pentonville did not inform healthcare or discipline staff working with the man of the scheduled move. Prisoners due to be transferred have to be assessed as fit to travel by a member of healthcare staff 24 hours in advance of the move. Because 1 June was a Monday, Officer H said that

the healthcare assessment of fitness for transfer should have taken place on Friday 29 May. Senior Officer C told my investigators that the healthcare team would normally be asked to prepare a prisoner's medical file for transfer in advance of a nationally organised move. Neither of these things happened.

519. None of the staff my investigators spoke to at Pentonville were given advance warning of the transfer taking place on Monday 1 June. Senior Officer C was told on the telephone in the middle of the morning. The planned move had not been recorded on Pentonville's prisoner information system. The SO was certain that the man had not been told about the transfer before he made a second attempt to take his own life. By the time the news reached staff, the man was on his way to the healthcare centre under constant supervision. Senior Officer C and the Head of Healthcare at Pentonville agreed that a transfer in the circumstances would be inappropriate, so the van left without the man.

520. Because a prisoner cannot leave the prison without being assessed as fit for transfer, it is unlikely that the move could have taken place on the morning of 1 June even if the man had not tried to harm himself. With no advance warning, staff would have struggled to assess the man for transfer, print off his medical records and collect his core prison record before the van left.

8 June

521. On 8 June, Officer J emailed Pentonville healthcare staff identifying six prisoners who needed to be assessed for transfer to Wandsworth the next day. Amongst them was the man. Officer J commented that the prisoners were returning to Wandsworth after Pentonville had "done them a favour by holding them" for a week.

522. Officer J agreed that, in retrospect, the email he sent might be misleading. He said he had been referring to the other five prisoners when he mentioned 'doing Wandsworth a favour'. He had not meant to refer to the man. He explained that, to the best of his recollection, there had been a space left on the escort vehicle after transport was organised for the other prisoners. He said that the man had been added to the group when the OCA department were told that he was ready to return to Wandsworth.

523. From the evidence of the governors and staff, I am satisfied that, on both 26 and 27 May, anticipation of the forthcoming inspection at Wandsworth influenced the thinking of those responsible for the man's movement around the London prison system. The failure to return the man to Wandsworth as quickly as Brixton managed on 13 May is marked.

524. I have borne in mind throughout my consideration of the man's transfers between prisons that he was a vulnerable prisoner with mental health difficulties. I consider that the transfer on 26 May was not in his best interests. It was an avoidable disruption to his continuity of care triggered initially by the failure to mark his PER for return to Wandsworth. The man was removed from a prison where he said he felt safe and was returned to a

prison that had caused him considerable anxiety. Officer 3 remembered the man saying on 10 June that he had recognised prisoners he was afraid of when he returned to Pentonville, reawakening old anxieties.

525. After the man arrived on 26 May, a great deal of concern was shown for him during the first 24 hours. However, as I detail elsewhere, this degree of concern fell away. Between 27 May and 1 June the man was not assessed by any healthcare staff. He had been discharged from the healthcare centre onto the VPU without authorisation from a staff member with mental health training. He was told he would not return to Wandsworth until after 6 June. (Although a move was organised by the PMU for 1 June, neither the man nor the staff working with him were told about it.)

526. The man was under the impression that he would have to remain in Pentonville for at least another ten days. He had previously lived in the healthcare centre for his own safety. This time, he was placed on the VPU and was not assessed by healthcare staff in the days that followed.

527. I consider that the man's return to Pentonville did not assist any recovery he might have been making in the Onslow Centre at Wandsworth. His mood deteriorated and he made a second attempt to take his own life early on 1 June before the requested national move could occur. He was deprived of a planned visit from his CMHT at Wandsworth, also scheduled for 1 June.

528. Following the second attempt by the man to take his own life, Doctor D told my investigators that he would not have wanted to keep the man in Pentonville for any longer than at all necessary, as the environment had such a negative effect on him. He thought a transfer to Wandsworth as soon as practicable was the right way forward.

529. Although some transfers took place to improve the man's welfare or occurred accidentally, I consider that the number of times he moved around the London prison system was undesirable. His continuity of care was disrupted. I believe that the man's second period of detention in Pentonville had further negative repercussions for him which did not serve to make him feel safer.

<u>Contact with other transferred prisoners</u>

530. I am also concerned that the movement of prisoners to, in the words of the Chief Inspector of Prisons, 'subvert the inspection process', may have had an additional, unanticipated consequence. Regardless of the degree of influence the inspection had on the man's own movements, he seems to have been exposed to the suspicions which other prisoners had over their own sudden transfers when he shared a cell with one of them and later travelled on the van back to Wandsworth. The other prisoners were upset about their own treatment. The internal Prison Service investigation established that Prisoner 3 and Prisoner 2 were so affected by the unexpected move on the weekend of 30 and 31 May that they tried to harm themselves.

531. As I have said, on 30 May the man was joined in his cell on the VPU at Pentonville by Prisoner B. Prisoner B was subsequently identified by the internal Prison Service investigation as one of the prisoners who was moved deliberately and temporarily. We do not know what the two men talked about. Within 24 hours of Prisoner B's arrival, the man became upset and was moved to a cell on his own. It was noted in the CSRA that the man was threatening to harm his cellmate. The next day he tried to take his own life for the second time.

532. The man travelled back to Wandsworth on 9 June with prisoners who were temporarily transferred during the inspection period. Prisoner 2 told my investigator that the prisoners had a conversation on the van back to Wandsworth during which they shared their suspicions about what had happened to them. Prisoner 2 said that he was determined not to let the temporary transfers go unchallenged. He told my investigator that the man was aware of the other prisoners' anger and their belief that he had been moved for the same reasons as them.

533. During interview, Prisoner 2 remembered talking to the man on the journey back to Wandsworth. The prisoners were sitting in separate cells on the van but could hear each other's voices. Prisoner 2 said that he was in the cell next to the man. He described the man's mood as 'subdued'. He told my investigator that the man was 'quite adamant' that he had also been moved to Pentonville because of the forthcoming inspection at Wandsworth.

534. Prisoner 2 thought the man had held this conviction before they boarded the van and he had not had the idea after listening to the suspicions of the others. During interview, he said that the man could not find another explanation to account for his transfer to Pentonville. Regardless of the ambiguous reasoning that lay behind the man's own move, his own perception of why he was moved (at least according to his fellow prisoner) may carry some significance. I acknowledge that Prisoner 2's evidence has proved both reliable (he correctly alerted the Inspectorate to the deliberate transferring of prisoners) and less reliable (his criticisms of Nurse 4, as I go on to discuss, were contradicted by the testimony of other nurses).

535. As I already indicated, the broader actions taken by managers at Wandsworth and Pentonville to remove prisoners prior to their announced inspections have been considered by an internal Prison Service investigation. The investigation resulted in disciplinary hearings against five managers and charges being proved against three. There are strong arguments of fairness against re-opening a disciplinary investigation – especially one conducted at the most senior level. However, I should say for the record that, in other circumstances, the evidence I have discussed in relation to the man's transfer on 26 May would certainly have prompted me to recommend that the Prison Service should investigate the conduct of the managers involved. More to the point, my investigation has revealed some new facts not known at the time of the internal investigation – and it also draws attention to the indirect consequences for the man of the series of transfers as a whole. I have chosen, therefore, to make the following recommendation:

The Director General of NOMS should review the new evidence in this report to determine whether a renewed disciplinary investigation is warranted.

Transfer register

536. My investigators have evaluated Wandsworth's action plan in response to my investigation of the death of another prisoner on the Onslow Centre in August 2007. I recommended that the Governor should remind staff of the importance of keeping a transfer register. In the action plan Wandsworth confirmed that a transfer register was in place and that a Governor's Order had been issued to staff. However, although my investigator asked to see a copy of the Order, staff were unable to provide one. Several staff interviewed by my investigator were unaware of the existence of a register.

537. The Governor, Governor 1, told my investigators that he remembered accepting the original recommendation. He thought that he had actioned it, but was unsure how he had intended the register to work. My investigators found no evidence of a single, comprehensive transfer register which detailed prisoners' movements and the reasons for them. Instead, they were shown a number of ring binders and diaries which, whilst they detailed some names and dates of movements, did not explain why the person was transferring. There was no mention of the man in any of the documentation.

538. Governor 3 made a note of his involvement in the man's case on 26 May in Wandsworth's duty governor's log. Neither Governor C nor Governor 1 recorded their decision making on the same day (nor were they obliged to). My investigators subsequently had difficulty establishing the reasoning behind the decision to transfer the man. Had the Governors' thinking been clearly recorded at the time in a transfer register, this would have been of assistance to both them and the subsequent investigation.

The Governors of Wandsworth and Pentonville should each introduce a central transfer register. The register should be used by all departments. Staff should record their decision making in relation to all ad hoc transfers which are not organised at a national level.

539. Following the confusion about the man's intended destination on 12 May, Governor Y rang the duty governor at Wandsworth. Despite plans having been put in place over a period of more than a week by healthcare staff, Governor 2 was unaware of the planned transfer from Pentonville and refused to accept the man. Neither the Head of In-Reach nor the Head of Healthcare seem to have notified the duty governor. This incident supports the need for a proper transfer log in which healthcare staff could have made an entry and to which Governor 2 could have referred.

The Head of Healthcare at Wandsworth should ensure that the relevant duty governor is always informed on the day if a healthcare to healthcare transfer is anticipated.

Care of the man's property and canteen

540. It would seem that the man's movements back and forth between Wandsworth and Pentonville disrupted his access to his belongings and a regular supply of tobacco.

541. Governor C wrote in his email dated 27 May that the man had arrived at Pentonville from court without his belongings. He asked Governor 1 to arrange for the man's property to be sent on from Wandsworth. Governor 4 (a Wandsworth governor) checked and initially understood that the man had no stored property (which is returned to a prisoner upon release) other than a mobile telephone.

542. Replying, Governor C wrote that the man was missing items he had kept in his cell such as his prayer mat, Qur'an and canteen. He indicated that the man had been provided with new canteen in the interim. Governor 4 asked Senior Officer 5 to check the man's former cell on the Onslow Centre. By the end of the day Senior Officer 5 had confirmed with Prisoner 1 that the man had taken the majority of his belongings and his canteen with him. However, he had left behind his Qur'an, prayer mat and trainers. On 29 May, Governor 4 arranged for these items to follow the man to Pentonville.

543. It does not appear that the man was able to work in prison because of a long standing injury to his leg and therefore he had little money. He became stressed without tobacco. Staff told my investigators that they would issue emergency smokers' packs to the man so that his mood did not deteriorate.

544. Officer Taylor sat with the man in the hospital in April and interviewed him on 31 May. He recalled that the man was a 'medium to heavy smoker' for whom £2.50 per week income was insufficient to purchase the amount of tobacco he needed. He thought that, when the man said that he did not have his canteen, what he meant was that he did not have funds to buy what he wanted.

545. Prisoner 8 remembered that the man complained when he returned to Wandsworth on 9 June that he had not had any canteen at Pentonville. The same day staff at Wandsworth issued the man with an emergency smokers' pack. It is conceivable that it had been a little while since the man had last been issued with tobacco at Pentonville. Senior Officer 4 issued another emergency smokers' pack on 11 June because the man's canteen had not followed him from Pentonville. It is disappointing that the man's belongings did not accompany him on his moves between prisons. Their loss may well have added to his distress. However, I am satisfied that staff at both prisons tried as best they could to provide the man with tobacco because they understood how agitated he became without it.

Mental health treatment and hospitalisation

546. The man had a history of psychiatric treatment and was diagnosed with paranoid schizophrenia. In 2005, he was detained in hospital under the Mental Health Act. Although he complied with his licence conditions between 20 March and 21 April, it had been noticed by both the offender manager and the CMHT that his mental health problems seemed to be worsening again. The deterioration in his condition caused the man's offender manager to ask the CMHT to reassess the man.

547. Once he returned to custody, the man immediately became distressed and made a serious attempt to take his own life. Returning from the Royal London Hospital, he gradually seemed to stabilise. On 5 May, Doctor D, a psychiatrist working at Pentonville, wrote to Streatham CMHT seeking their help. The clinical reviewer describes this referral as 'timely'. Doctor D was sufficiently concerned about the man's mental health to write the following:

> 'In view of the serious nature of the suicide attempt, I am of the opinion that [the man] might benefit from further assessment in hospital …'

548. Having received Doctor D's letter, the man's CPN spoke with he manager of the mental health in-reach team at Wandsworth on 14 May. The man had just returned to Wandsworth. The man's CPN and a specialist registrar at the CMHT arranged to visit him on 1 June. The man's CPN said that this was the earliest date both he and the specialist registrar at the CMHT could attend together to complete an assessment.

549. Doctor D judged that the man was no longer suicidal. The man's CPN did not recall thinking that the assessment needed to be completed urgently. He told my investigator that he and the specialist registrar at the CMHT planned to visit the man 'with an open mind' as far as treatment options were concerned. He planned to check if the man's presentation had changed and whether he might benefit from hospital admission.

550. In other words, although Doctor D had suggested the possibility of hospitalisation, neither the man's CPN nor his colleague definitely thought that this would be necessary. The removal of a prisoner to hospital under section is not undertaken lightly, and the man's mental health problems had not been sufficiently severe as to warrant sectioning whilst he was being treated by the CMHT in March and April. The man's CPN told my investigator that, following the proposed assessment on 1 June, he might equally have been making plans for the man's treatment in the community after his release from prison.

551. Nonetheless, since the man's CPN had last assessed him, the man's mental health had worsened and he had attempted to take his own life. Doctor D had more recent experience of the man's mental health needs and thought that transfer to hospital under section 47 of the Mental Health Act was one avenue worth exploring. The doctor thought it important that mental health workers with experience of the man's presentation in the community should assess whether his condition in prison was markedly different.

552. Unfortunately, because the man transferred to Pentonville on 26 May and did not return to Wandsworth until 9 June, the man's CPN had to cancel his visit. He planned to assess the man once he returned to Wandsworth. The manager of the mental health in-reach team at Wandsworth advised the man's CPN that the man was supposed to be returning in the very near future when she would arrange a new appointment. The man's CPN thought that this made sense because the In-Reach team at Wandsworth knew the man well. The lack of urgency in rearranging the appointment suggests that the man's CPN and his colleagues did not see immediate hospitalisation as a likely possibility.

553. Additionally, staff at Pentonville who treated the man in the healthcare centre after his first and second attempts to take his own life (in early May and early June) observed that his mood soon stabilised. Nurse D told my investigator that the man did not present as having a 'severe and enduring' mental disorder (although I note that Nurse D has no formal mental health training). He considered that the man was somebody whose paranoid schizophrenia was 'well controlled' by medication.

554. Prisoner 2, who travelled back to Wandsworth with the man on 9 June, said that there were 'any number of inmates with far more serious psychological[ly] disruptive issues than [the man]' on the Onslow Centre. Doctor D and Doctor E both noted on 2 June that the man showed no signs of psychotic symptoms.

555. Doctor D himself indicated that he was not surprised that the man returned to the VPU at Wandsworth rather than the healthcare centre. He said that the man was only held in the healthcare centre at Pentonville because he felt so unsafe in any other location in the prison. In other words, he did not feel that the man was experiencing mental health problems that required treatment in a healthcare setting.

556. The manager of the mental health in-reach team at Wandsworth did not think that the man's CPN and his colleague were likely to transfer the man to hospital because he was glad to be back on the Onslow Centre. She told my investigators that there had been some discussion of the man's diagnosis when he was held at Wandsworth prior to release in March 2009. There was some debate over whether he had a mental illness or a personality disorder. The In-Reach team at Wandsworth referred the man to a personality disorder specialist in 2008, who referred the man back to the CMHT. The specialist considered that the original diagnosis of a mental illness was correct and the problem was not a personality disorder.

557. I cannot entirely discount the possibility that the man could have been removed to hospital under the Mental Health Act. Because of the transfer to Pentonville, the mental health assessment did not take place. On the day the man's CPN's visit was supposed to have seen him at Wandsworth (1 June), the man made a second attempt to take his own life at Pentonville.

The man's location in each prison

558. Between April and June, the man was variously located amongst the general prison population, on VPUs and in healthcare centres, seemingly without any consistency. My investigators explored the thinking that lay behind these choices.

21 April – 13 May

559. On 21 April, the man arrived at Pentonville and was placed in a shared cell amongst the general prison population. The next day he asked for vulnerable prisoner status and was moved to a cell on his own pending transfer to the VPU. He made an attempt to take his own life before he could be moved and was taken to hospital. He returned to the healthcare centre, where he remained in a single cell for approximately two weeks. Doctor D kept the man in the healthcare centre because he felt unsafe in any other location in Pentonville.

560. The man transferred to Brixton for one night and was placed in a cell on the healthcare wing as a precaution with another prisoner who was not the subject of an ACCT document.

13 May – 26 May

561. On 13 May, the man transferred to Wandsworth. Although the move was organised by the healthcare teams at Pentonville and Wandsworth, the man was not initially admitted to a healthcare setting as one might have expected. Instead, he spent two nights in the first night centre before moving to the Onslow Centre. This seems confusing, as the intention was a 'healthcare to healthcare' move. Nurse D liaised with the manager of the mental health in-reach team at Wandsworth and the Head of Healthcare at Pentonville with the Head of Healthcare at Wandsworth. When the man inadvertently arrived at Brixton, the main reason Governor Y was reluctant to accept him was because he had come from Pentonville's healthcare centre, and nothing had been agreed with the healthcare centre at Brixton.

562. The decision to place the man on the VPU at Wandsworth was based partly on his familiarity with the unit, which offered stability and continuity. Staff were keen to locate the man on the Onslow Centre because he said he felt safe there. However, the move took place in the context of a lack of available healthcare facilities in Wandsworth.

563. In comparison, Pentonville is a smaller prison but with ten more inpatient beds than Wandsworth and a better staffed psychiatric team. Wandsworth holds more than 1,600 men but only has 12 inpatient beds, all located in the Addison Unit. This facility is occupied by prisoners with severe and enduring mental health difficulties awaiting relocation to a secure unit in the community. The manager of the mental health in-reach team at Wandsworth said that the

Onslow Centre was a more appropriate location for the man than the Addison Unit.

564. An example of the limited provision of inpatient facilities at Wandsworth is the way in which constant supervision is carried out. Prisoners are normally moved to a suitable cell in a prison's healthcare centre. And each time the man was placed under constant supervision at Pentonville, he was immediately located in the healthcare centre. However, constant supervision of Wandsworth prisoners usually has to be carried out in the prisoner's original location.

565. Wandsworth responded to the draft version of this report. They stressed that it can be beneficial for a prisoner to remain amongst friendly prisoners and familiar staff on their own wing. They also said that, if the psychiatric team identified that a prisoner was feeling actively suicidal due to severe and enduring mental health issues, he 'would likely' be moved to the Addison Unit under constant supervision.

566. The London Area Male Locals Transfer Protocol states that a prisoner leaving a prison's healthcare centre should initially be located in a similar healthcare setting when they transfer to a new prison. This is not what happened to the man. In theory, either the man should have been discharged onto the VPU at Pentonville a few days before the transfer to acclimatise him to a non-healthcare setting. Or the man should (again in theory) have been located in the healthcare centre at Wandsworth for a few days to monitor him before discharging him to the VPU.

567. However, neither of these courses of action was open to staff. The man did not feel safe outside the healthcare centre at Pentonville and so a discharge to the VPU could not be trialled there. Wandsworth only has healthcare beds available to prisoners with the most severe mental health problems (which the man was not considered to be). The move from Pentonville's healthcare centre to the Wandsworth VPU is therefore understandable, if not ideal. The logic of the move might have been better documented in the man's medical record.

568. The inpatient healthcare facilities at Wandsworth seem inadequate in comparison with Pentonville. Pentonville is smaller but has more inpatient beds. There were few available options for healthcare staff to consider when the man transferred to Wandsworth. The clinical reviewer highlights his experience of a smaller prison that has twice as many inpatient beds.

Wandsworth Primary Care Trust should review the inpatient healthcare facilities at Wandsworth. Consideration should be given to increasing the capacity for prisoners with mental health problems and suicidal thoughts who do not fit the criteria of the Addison Unit.

26 May – 1 June

569. Returning to Pentonville on 26 May, the man was kept in a single cell in the healthcare centre overnight as a precaution after his previous attempt to take his own life. The next day the man was discharged to a shared cell in the VPU following a case review, even though the CSRA completed the day before indicated the need for a single cell.

570. Paragraph 18 of annex 8G of PSO 2700 states:

> 'Where referrals have been made to specialist staff or those staff are already involved in the care of the prisoner, they must be invited to attend the next case review. Where attendance is not possible, they must provide input in writing or by telephone to that case review (and subsequent reviews if requested).'

571. Neither a psychiatrist nor another member of healthcare staff with mental health training was present during the case review. The only nurse present, Nurse D, had no mental health training. Mental Health Nurse B spoke to the man the night before but did not attend the review.

572. Nurse D thought that a psychiatrist did not attend the case review because there was not a 'medical reason' for the man to be in the healthcare centre. Rather, staff used it as a 'place of safety'. Nurse D thought that the man's presentation seemed the same as when he was last at Pentonville. He had no additional concerns about the man's mental health.

573. The logic dictating the man's location during this period is somewhat confused. Nurse D said that the man was initially admitted to the healthcare centre under constant supervision because staff were concerned about the risk he might present to himself after returning to Pentonville, rather than as a result of his mental health problems. However, the two issues seem indivisible. The man's state of mind was deemed sufficiently fragile to warrant continual observation at first, but his discharge the next day was achieved without advice from a mental health specialist.

574. Governor A led the case review, which lasted about an hour, although it was not part of her regular duties. (She was asked by Governor C to carry out the review because she had been the duty governor when the man arrived. This decision made sense in the circumstances and demonstrated good practice.) She thought that Nurse D was able to offer sufficient advice about the man's ongoing care. In interview, she remembered that the man wanted to return to Wandsworth and was in a 'relaxed' and 'upbeat' mood. Senior Officer A, who also attended, agreed that the man seemed 'cheery'.

575. During interview, Governor A recalled that the man did not want to stay in the healthcare centre and asked to move to the VPU to find employment. Nurse D recalled that the man was happy to move as long as he was given tobacco. Governor A was keen to replicate the recent 'period of stability' the man experienced on the VPU at Wandsworth. She did not realise that the man

had been kept on the healthcare centre at Pentonville in late April and early May for his own safety. Governor A considered discharge to the VPU appropriate and said that the decision was arrived at with the man's consent. She told the man to approach staff on the VPU if he became anxious.

576. Senior Officer A remembered that the decision to discharge the man to the VPU was effectively taken before the review began. The SO was asked to attend because she was a manager on the unit. Governor C suggested discharging the man to the VPU in the email he forwarded to Governor A before the case review. Nurse D remembered that the case review was intended to resolve how the man was to be discharged, not whether.

577. I am satisfied that Governor A thought she was acting in the man's best interests. However, whilst the man consented to move to the VPU, he had not previously spent any length of time outside the healthcare centre at Pentonville. Senior Officer D, the clinical reviewer, thinks it possible that a psychiatrist might have decided not to discharge the man at the case review. They might have balanced the man's stable presentation on 27 May against his history of paranoid schizophrenia and his recent attempt to take his own life.

578. Doctor D oversaw the man's psychiatric treatment in early May. He only became aware of the man's return to Pentonville after the second attempt to take his life on 1 June. Nobody who dealt with the man on 26 and 27 May in the healthcare centre appears to have asked a psychiatrist to assess him or referred him to the In-Reach team. Doctor D told my investigators that he might have been inclined to keep the man in the healthcare centre until he returned to Wandsworth as a precaution. Doctor D commented that the centre is physically separate from the main prison buildings, which allowed the man to feel removed from the danger he perceived himself to be in.

579. During interview, Doctor D told my investigators that a review of forensic psychiatric services at Pentonville was conducted in spring 2009. As a result, it is now expected that a doctor should attend a case review when there is a possibility of a patient with mental health problems being discharged from the healthcare centre. There will also be a follow-up assessment of the prisoner by a psychiatrist within seven days of discharge.

580. Paragraph 27 of annex 8G of PSO 2700 states:

> 'A pre-discharge Case Review must take place before a prisoner is returned to ordinary location from being resident in the Healthcare Centre… What healthcare will be doing to continue support of the prisoner must be clearly documented in the ACCT Plan.'

581. A commendable amount of attention was paid to the man's care during his first 24 hours back in Pentonville. Senior Officer A remembered that the man initially seemed content on the VPU. However, he repeatedly asked when he would be returning to Wandsworth. The man was not assessed by any healthcare staff between the case review on 27 May and 1 June when he

again tried to take his life. He had not been examined by a psychiatrist since coming back to Pentonville and does not seem to have been allocated an In-Reach worker. An ACCT document was opened on 31 May. The man had only previously spent one night in Pentonville outside the healthcare centre, on 21 April.

582. When my investigators spoke to Governor C, the email he sent on 27 May in which he suggested moving the man to the VPU had not been retrieved. Governor C told my investigators in interview that he would have preferred the man to have remained in the healthcare centre and did not expect him to be discharged to the VPU.

583. The man had significant mental health problems and was prone to feelings of paranoia. Doctor D thought that any location outside the healthcare centre at Pentonville caused the man anxiety. On both 22 April and 1 June he attempted to take his own life in non-healthcare settings. Had his discharge to the VPU been combined with regular monitoring by the In-Reach team, it would have been more understandable.

The Head of Healthcare at Pentonville should ensure that the primary healthcare team makes an immediate referral to the In-Reach team when a prisoner is placed under constant supervision.

1 June – 12 June

584. Having attempted to take his own life, the man returned to the healthcare centre at Pentonville and stayed there until he went to Wandsworth. Once again, and for the same reasons as before, on 9 June the man moved from the healthcare centre at Pentonville to the VPU at Wandsworth. The In-Reach team did not learn that he had come back until three days later when Officer 9 telephoned the manager of the mental health in-reach team at Wandsworth. She intended to assess the man that afternoon but he took his own life shortly before she planned to visit.

585. The decision not to locate the man in the Wandsworth healthcare centre was supported in retrospect by the Pentonville doctor, who did not necessarily expect him to transfer to another healthcare centre. Doctor D said that he kept the man in healthcare because of the particular anxiety being at Pentonville provoked. He said that there was no other reason to keep the man there once he stabilised and made steady progress after the attempts on his life in April and early June. Doctor D and the Head of Healthcare at Pentonville both confirmed that improved presentation could be expected to lead to discharge to the VPU.

Preparing for the man's return to Wandsworth on 9 June

586. Although the man transferred from the Pentonville healthcare centre on 9 June, the Wandsworth In-Reach team did not know about his return until the morning of 12 June. Officer 9's telephone call to the manager of the mental

health in-reach team was when she realised that he was back in Wandsworth. The clinical reviewer comments:

> 'It was particularly unfortunate that the In-Reach team in HMP Wandsworth was not aware of [the man's] final move until the last moment, and he was therefore not assessed by a mental health professional, despite an obvious deterioration in his mental state.
>
> 'The significant deterioration in the man's mental state from 9 to 12 June was not fully recognised and appropriate intervention was not requested until the morning he died. Had the mental health team known of his return and assessed him, they could have considered further treatment.'

587. Staff at both prisons successfully organised a healthcare-to-healthcare transfer in early May when the man moved to Wandsworth for the first time. However, it appears that their effective planning was not repeated when he moved in June. Pentonville's In-Reach team do not appear to have informed their counterparts at Wandsworth. The Head of Healthcare at Pentonville telephoned the Head of Healthcare at Wandsworth's office on 8 June to advise the primary healthcare department at Wandsworth of the man's imminent return, but this message does not seem to have been conveyed to the In-Reach team.

588. Doctor 1 and Nurse 3 did not refer the man to the In-Reach team when he arrived on 9 June. I understand from the Head of Healthcare at Wandsworth that referrals are not made automatically and reception healthcare staff may have been at a disadvantage because, as I will go on to outline, the man's up-to-date medical records do not seem to have accompanied him. Although the manager of the mental health in-reach team prepared for the man's return to Wandsworth, she did not have a specific return date. She thought that either Wandsworth reception staff or Pentonville healthcare staff would tell her when he was due to return.

589. Prisoner 1 said that he saw the man speaking to healthcare staff on the Onslow Centre 'on a number of occasions' between 9 and 12 June, 'pleading to see a psychiatrist'. Prisoner 8 told my investigators that the man was 'very distressed' in the days before he died. Prisoner 6 remembered that the man was a 'completely different person' when he returned from Pentonville. He recalled the man getting worse over those three or four days.

590. Prisoner 6 said that staff ignored the man's repeated requests for help. He remembered that he had 'dragged' the man to the medical hatch to ask healthcare staff to assess him, but was told that the man was receiving his medication. Given that the manager of the mental health in-reach team at Wandsworth was surprised to learn of the man's return from Officer 9 on 12 June, it would appear that the In-Reach team were not told about the requests the other prisoners said the man made.

591. As well as the In-Reach team, the Safer Prisons team responsible for monitoring self harm were not given advance warning of the man's return either. Officer 3 did not recall any communication with staff at Pentonville before the man arrived. The ACCT document that travels with the prisoner is the main source of information about the risk of self harm. However, Officer 3 thought that some communication between Safer Custody Managers at the two prisons regarding the transfer of particularly vulnerable prisoners would be advisable.

The Heads of Healthcare and In-Reach at Wandsworth should review the way in which information is communicated between them. The Head of Healthcare should ensure that prisoners with a history of mental health problems are referred to the In-Reach team for an assessment during the reception process.

Assessment, Care in Custody and Teamwork (ACCT) monitoring

Pentonville - 22 April

592. Staff at Pentonville opened ACCT documents on 21 April and 31 May, in both instances followed by an attempt by the man to take his life a day later. On both occasions, staff recognised the risks and their monitoring meant that the man was found and kept alive. However, there were gaps in the procedures.

593. On the morning of 22 April, although observations were supposed to be recorded every hour, the entries were made less frequently. However, during the course of the morning the man had several contacts with staff. He attended an assessment interview with Officer B, an induction appointment with Officer C, and then spent over an hour with the duty governor and Officer C dealing with his request for vulnerable prisoner status. Therefore, although the entries made do not indicate regular checks, the man did spend most of the morning with staff. The exception was between 1.10pm, when a CARATS worker made an entry in the ACCT document, and 2.20pm, when the man was found hanging.

594. The ACCT document for 21 and 22 April does not make the intended level of observations clear. Although Senior Officer A indicated the need for hourly observations in the 'immediate action plan' on 21 April, neither Officer B nor Senior Officer B referred to the frequency of checks in the assessment interview notes, 'Action following assessment' section or 'Care map'. A review of the ACCT document did not take place until after the man returned from hospital.

595. The front cover of the ACCT document, where the frequency of observations is supposed to be recorded, is unclear. It contains three entries stating '1 x hourly', '2 x hourly' and '30 minutes', before a further entry which is dated 23 April. The first entry was presumably made by Senior Officer A. It is not clear whether the next two entries were made before the man attempted to take his life. The ongoing record in the ACCT document shows initial hourly entries

throughout the night of 21 April before, as already detailed, entries become intermittent the next morning. Paragraph 45 of annex 8G of PSO 2700 states:

> 'Whenever changes are made to the frequency of conversations and observations, the member of staff noting that change on the front of the ACCT Plan must write their initials and the time and date by that note.'

596. I therefore make the following recommendation:

The Governor of Pentonville should ensure that, when staff write the intended frequency of observations on the front cover of an ACCT document, they note their initials, the date and time next to their entry.

597. Officer B told my investigator that she felt unable to increase the frequency of observations on the morning of 22 April above an hourly check whilst the man remained in the first night centre. She thought that increased monitoring required a move to a healthcare setting where nursing staff were equipped to make more frequent checks. Officer Taylor expressed a similar view regarding the possibility of going beyond half-hourly observations on the VPU on 31 May. He thought an increase would amount to constant supervision and necessitate a move to the healthcare centre. It would appear that staff require clarification on this point.

The Governor of Pentonville should ensure that staff understand the maximum frequency of ACCT checks possible on normal location before a prisoner has to be moved to a healthcare setting for observation.

598. Having carried out her assessment interview with the man, Officer B completed the 'Action following assessment' section of the document with Senior Officer B. They decided that the risk the man presented to himself was 'low'. This seems to contradict Officer B's recollection when she spoke to my investigator. She thought that the man was depressed and that there was an imminent risk of possible self harm. However, the entry in the ACCT document signed by Senior Officer B and Officer B indicates that they thought a referral to the detoxification unit would improve the man's mood. The risk assessment seems to contradict the man's comments in the assessment interview that he would be 'better off dead than alive', not to mention Officer B's observation that his mood was 'very low'.

<u>Pentonville - 29 April</u>

599. The man returned from hospital on 28 April. At the first ACCT review held the following day, the risk that he would harm himself was assessed as low. Yet he was placed under constant supervision. These decisions seem contradictory. Paragraph 3 of annex 8Y of PSO 2700 states:

> '[Constant supervision] is required when it is believed that the prisoner could, at any time, make an attempt to kill themselves.'

600. Given that the man was recovering from a serious attempt to take his own life and had only just returned to a custodial environment the previous day, I am surprised by the decision to assess the risk as low. The use of constant supervision implies that the risk assessment should have been commensurately higher.

Wandsworth - 13 - 19 May

601. Staff at Brixton were sufficiently concerned on 12 May to increase the man's observations to three times an hour and locate him in their healthcare centre. In the event, a written entry was actually made every 15 minutes. After the man moved to Wandsworth on 13 May, staff made entries in the ACCT every 20 minutes until the following morning. Wandsworth staff seem to have followed the original, intended supervision level.

602. On the morning of 14 May, the man's ACCT document was reviewed and the frequency of observations was altered to hourly during the night and day. The frequency was clearly marked on the front of the document, in the ongoing record and on the review itself. However, the number of recorded observations did not match the intended level. Staff initially recorded entries on an hourly basis. However, after 10.15am on 15 May, staff wrote in the document at 2.00pm, 5.30pm, and 7.40pm before recommencing hourly observations at 9.00pm.

603. Similarly, on 16 May, after 7.15am staff made entries at 8.30am, 11.45am, 12.15pm, 2.30pm, 4.30pm, 5.50pm, 6.55pm and 7.25pm before recommencing hourly recording at 9.00pm. On 17 May, after 7.30am officers wrote in the document at 8.45am, 12.30pm, 3.10pm, 5.00pm, 5.50pm and 6.55pm before hourly entries started again at 8.00pm. The next day (18 May), after 6.00am staff recorded observations at 7.20am, 7.45am, 8.15am, 12.15pm, 5.25pm and 8.15pm before returning to an hourly schedule overnight. The next morning (19 May), shortly before the ACCT document was closed, officers did not make an entry between 6.00am and 7.20am.

604. Staff did not carry out the planned hourly checks. Although the man did not try to harm himself during this period, the way in which the ACCT document was completed might indicate either the need for further training or a fundamental misunderstanding by staff.

605. I note that for two days running there was a gap in recorded observations between 6.00am and 7.20am. This time of day, when night staff hand over to day staff, was identified as a problem when I investigated the death of another prisoner in August 2007. It was difficult for my investigators to discern from the wing observation book when the handover took place and who was responsible for the prisoners.

606. This was especially important because ACCT observations tended to be overlooked or to decrease during the handover period. The prison introduced the use of a stamp to encourage staff to record in the wing observation book when they came on shift and took responsibility for the prisoners. My

investigators saw examples of the use of this stamp when they investigated the man's death. The stamp requires the member of staff to write the date but not the time, which was not always recorded by staff manually.

The Governor of Wandsworth should ensure that the stamp used during the handover period between the night and day staff is amended so that it requires staff to record the date and time of the handover.

Pentonville - 26 – 27 May

607. The man returned to Pentonville on 26 May. Staff were understandably cautious following the recent events. Governor A, Governor C and Nurse D were sufficiently concerned about the risk the man might present to himself to place him in the healthcare centre under constant supervision. My investigators asked why an ACCT document was not opened, given that the risk they were concerned about was presumably one of self harm.

608. As I have already indicated, PSO 2700 makes it clear that constant supervision should be employed when a prisoner is at imminent risk of taking their own life. The simultaneous opening of an ACCT document would therefore seem to be both logical and strongly advisable.

609. Governor A said that constant supervision was deemed necessary as a precautionary measure because of the man's attempt to take his own life in April, which she described as having come 'out of the blue'. She did not identify any signs of increased risk when she spoke to the man on 27 May. Governor A was unsure whether an ACCT document should be opened if there is sufficient concern to place a prisoner under constant supervision.

610. Governor C could not recall whether the man had been the subject of ACCT monitoring on 26 May. He thought the case review held on 27 May was an ACCT review. In retrospect, he agreed that opening an ACCT document when the man arrived at Pentonville was a 'sound suggestion' that he did not think of at the time. Governor C agreed that an open ACCT document might have prompted staff to keep a keener eye on the man's welfare across the days that followed.

611. Nurse D told my investigator that the decision to place the man under constant supervision had been his as he was the acting ward manager. He wanted to make sure the man was safe. His decision was based on the man's history at Pentonville, rather than a response to his presentation on 26 May. Nurse D remembered there being 'no indication that [the man] was going to self harm'. Nonetheless, if Nurse D was sufficiently worried about the man on the basis of what he had done and might do, I consider that opening an ACCT document would have been a sensible safeguard.

The Governor of Pentonville should ensure that an ACCT document is always opened if a prisoner is placed under constant supervision.

Pentonville - 31 May

612. Over the next few days, it seems that the man presented no serious concerns to the staff on G1 landing. Officer I remembered him being a 'polite and compliant' prisoner who gave no cause for particular concern.

613. Because the second ACCT document was opened on a Sunday, none of the In-Reach team was on hand and staff did not consult the out-of-hours doctor. Officer F told my investigator that he did not consider consulting a healthcare professional or discuss the possibility with Senior Officer A, who opened the ACCT document.

614. Officer F said that he found assessment interviews more productive if they were conducted on a one-to-one basis. He suggested that he would adopt a multi-disciplinary approach during subsequent ACCT reviews. Officer F highlighted the need to begin the assessment interview as quickly as possible once the decision to start ACCT monitoring had been taken.

615. The man had not been assessed by a psychiatrist since he returned to Pentonville, and had not had any contact with the In-Reach team since 27 May. Officer F referred the man to the In-Reach team because he was concerned about his mental health following their interview. The man said that he had experienced difficulties with his cellmate and was moved to a single cell.

616. After the assessment interview, the man showed Officer F a ligature he had fashioned from a torn bed sheet and holes in the light fitting in his cell which he had thought about hanging himself from. Officer F could not remember confiscating the ligature but was sure that he had done so. He did not make a written record to confirm this. He remembered telling Senior Officer A about the ligature. The next morning, the man used the same method to make a second attempt on his own life.

The Governor of Pentonville should ensure that staff make a record in a prisoner's ACCT document when they find and confiscate a means of self harm such as a ligature.

617. Senior Officer A opened the ACCT document on 31 May and set the frequency of observations at hourly. On the advice of a Principal Officer, the frequency was increased to every 15 minutes before the assessment interview. Following the completion of the assessment interview, it was reduced to half hourly. Senior Officer A set the frequency of observations based on Officer F's assessment of the man.

618. Both members of staff were familiar with the man's recent circumstances. Senior Officer A was involved in the opening of the first ACCT document on 21 April and attended the man's case review on 27 May. Officer F sat with the man at the hospital in April.

619. Thinking back in interview, Officer F considered the decision to set the level of risk at 'raised' was appropriate. He said that the setting of half-hourly observations was consistent with the information available. Officer F indicated that the level of observations was consistent with the monitoring afforded other prisoners presenting with similar concerns.

620. Officer F thought that the next step from half hourly checks would be constant supervision in a healthcare setting (although the frequency had been set at every 15 minutes earlier in the day). He remembered being surprised when he heard about the man's attempt to take his own life the next day.

Pentonville - 1 June

621. The man was discovered in the process of trying to take his own life at 8.05am on 1 June. Until Officer I entered the cell, there is no record in the ACCT document of the man having been checked for 55 minutes, despite the frequency of observations being set at every half hour. Officer I told my investigators that this period was when the oncoming day staff carried out their roll check to ensure prisoners were accounted for. He thought that, although an entry had not been made in the ACCT document, a member of staff had almost certainly checked the man at around 7.30am. Senior Officer A and Senior Officer D agreed that the handover from night staff to day staff might explain the failure to record half-hourly observations.

Pentonville - 4 June

622. On 4 June, Doctor D assessed the man during his rounds and decided that the frequency of observations should be reduced to hourly. The reduction in observations was implemented without the ACCT document being reviewed. A review was last held on 3 June and another would be conducted on 9 June.

Pentonville - 9 June

623. At the final ACCT review held at Pentonville, the risk the man represented to himself was reduced to low. However, the reduction in risk does not correlate with the maintenance of hourly observations.

Wandsworth - 9 - 12 June

624. Paragraph 12 of annex 8G of PSO 2700 indicates that an open ACCT document must be reviewed within 24 hours of transfer to a new prison. In the meantime the prisoner must be kept safe. A review had been held at Pentonville early in the morning of 9 June. The man transferred to Wandsworth at lunchtime and arrived on the Onslow Centre in the early evening. Because he wanted a colleague to join him for the review, Senior Officer 5 spoke to the man and decided to hold the next ACCT review the following morning.

625. Senior Officer 5 and Officer 3 carried out the final review of the man's ACCT document on 10 June. The man was anxious and expressed suicidal

thoughts. The two men did not think the man was 'actively contemplating suicide', although Officer 3 acknowledged that they did not ask him if he planned to take his own life. The two men increased the risk of self harm from 'low' to 'raised'. Senior Officer 5 said he would have considered setting the risk as 'high' had the man's mood not improved during the meeting. Officer 3 commented that, had he known about the man's two previous attempts to take his own life, he would have assessed the risk as 'high'.

626. I am concerned that the frequency of observations was not amended to reflect the increased level of risk. Paragraph 42 of annex 8G of PSO 2700 states:

> 'The frequency of conversations and observations (day and night) must be appropriate to the individual's assessed level of risk …'

627. When they spoke to my investigators, staff on the Onslow Centre were under the impression that the man was supposed to have been checked hourly during the night. However, they thought that only three 'quality interactions' with staff were to be recorded during the day around the breakfast, lunch and dinner periods. Staff seemed to think that prisoners were being regularly observed on association during the day, even if specific checks were not recorded in the ACCT document.

628. The perception of the staff tallies with the frequency of observations entered in the ACCT document between 9 and 12 June, both before and after the review. Officer 3's recollection of the level of observations was 'hazy'. He said that he did not think he and Senior Officer 5 discussed changing the frequency during the review.

629. After the review, Senior Officer 5 wrote up the ACCT document. He did not indicate any amendment to the frequency of observations. (He ticked a box indicating that the frequency had been reviewed, but did not make any written remarks as to the outcome.) Paragraph 43 of annex 8G of PSO 2700 states:

> 'Conversations with and observations of the at-risk prisoner must take place at least as frequently as stated in the 'required frequency of conversations and observations' box on the front cover. Staff responsible for observing particular prisoners – including night staff – will need to ensure they are familiar with the requirements in that individual's ACCT Plan. The Manager – for each shift – of the unit where the prisoner resides is responsible for ensuring that conversations and observations are completed as per the requirements set out on the front cover the ACCT Plan.'

630. Senior Officer 5 did not alter the front cover of the ACCT document, where the frequency of observations is supposed to be written for ease of reference. (Following a previous investigation of a death at Wandsworth, I stressed the need for staff to use the front cover.) The last entry on the cover was made by Doctor D at Pentonville on 4 June. It indicated the need for hourly observations day and night. No further changes are evident.

631. Staff on the Onslow Centre did not follow the instructions on the cover and, instead, made intermittent entries during the day. After the ACCT review finished at about 1.00pm, only two entries were made in the document before 9.00pm that evening. The man was then checked every hour overnight, but between 7.00am and 9.00pm the next day, 11 June, he was only checked six times. He was once again monitored on an hourly basis overnight, but after 6.30am on 12 June he was checked at 7.50am, 10.00am and 12.30pm.

632. The last entry was made in the ACCT document at 12.30pm by Officer 10. He told my investigators that he also asked the man if he wanted to attend the Muslim prayer service at about 1.10pm, but he did not record this observation in the ACCT document. He told his colleagues that he was concerned about The man. Prompted by Officer 10, Officer 11 checked the man at 1.40pm. More than an hour had passed between the last written observation and Officer 11 finding the man hanging in his cell.

633. The cover of the ACCT document is unambiguous. There should have been an entry once an hour, day or night. The Safer Custody Manager at Wandsworth recognised that staff on the Onslow Centre did not correctly carry out the ACCT observations. I consider that staff and managers require further training in the use and running of an ACCT document. I also consider that managers chairing ACCT reviews would benefit from retraining with regard to the relationship between risk levels and the frequency of observations, as well as the accurate completion of an ACCT document. I repeat a recommendation I made in relation to the death of another prisoner in August 2007.

The Governor of Wandsworth should ensure that all staff working on the Onslow Centre receive further training in the use, completion and day-to-day operation of the ACCT document as soon as is practicable. Particular emphasis should be placed on identifying new risk indicators, holding ACCT reviews promptly and amending the frequency of observations to reflect the level of risk.

ACCT review - Wandsworth - 10 June

634. Officer 3 told my investigator that he had not read the man's ACCT document before he and Senior Officer 5 began the review. Instead he relied on Senior Officer 5, as the case manager, to tell him about the man. Officer 3 was not aware that the man had come from Pentonville's healthcare centre the day before. He did not know about the man's two previous attempts to take his own life in Pentonville. Although I have made a previous recommendation in this regard, nobody from the In-Reach team was either consulted or asked to attend the review. In fact, the team were not told of the man's return to Wandsworth until 12 June.

635. The man expressed his fears that North London gang members were threatening to harm his family if he did not give them money. It remains unclear whether his fears were well founded. Staff were unsure of the extent the man's mental health problems amplified his anxiety. Prisoner 8 said that

the man would hear 'powerful voices' telling him that other people were going to harm his family. Nonetheless, whether or not the man's fears for his family were real, the important thing is that they caused him genuine concern.

636. Officer 3 remembered that Senior Officer 5 wanted to show the man that they were taking the apparent threat to his family seriously. Senior Officer 5 asked the man to provide specific details so they could help him. The man suggested that he had information about the recent shooting which had taken place outside Wandsworth. Senior Officer 5 wrote down the information and telephoned the police liaison officer (PLO) whilst the man was in the room. The PLO then contacted Operation Trident. During the afternoon, Senior Officer 5 told the man to expect a visit from a police officer.

637. The ACCT review lasted about two hours which, in my experience, is unusually long, although there was a break. Officer 3 thought that the actual review took about half that time, whilst the remainder was spent addressing the issues raised. At the start, the man was noticeably anxious. By the end, the two SOs said his mood had improved. However, within half an hour, the man asked to speak to a Listener.

638. I have no doubt that the approach of the two senior officers to the ACCT review was well intentioned. Officer 3 told my investigator that the review was 'supportive and collaborative'. He said that the man agreed to the police's involvement after he was given different options for proceeding with his concerns. Officer 3 thought that the man seemed reassured by the steps taken and trusted them to treat the information confidentially.

639. Officer 3 thought that the man appeared 'visibly relaxed' when the review ended. He recalled feeling reassured because the man was smiling. Officer 3 remembered that the man became more responsive as the conversation progressed. He thought that the man seemed relieved to talk about his concerns and to be listened to.

640. When the interview started, the man was worried that other prisoners were listening outside the door. He expressed anxiety that other prisoners would discover that he was going to provide Operation Trident with information. Operation Trident is a high profile police unit and, although Senior Officer 5 promised that his interview with the police would be conducted discreetly, the man told him that he was frightened of being thought an informer.

641. Officer 3 and Senior Officer 5 made strenuous efforts to take the man's fears seriously and act decisively in order to reassure him. However, given his vulnerability, recent history of self harm and mental health difficulties, the presence of a mental health professional at the review would have been highly desirable. A multi-disciplinary approach may have greatly assisted the officers to gauge the way in which the man would respond to the involvement of the police and the escalation of his concerns. The clinical reviewer comments:

'Following an ACCT review at HMP Wandsworth a decision was taken to report [the man's] concerns [about gangs] to the police, and the man was told he would be interviewed. The man's mental state was fragile at the time, and it is possible that he may have been worried about the consequences for him or his family of police involvement. In retrospect the decision to report these concerns to the police should have been taken in a more considered way, and with the support of the mental health team at HMP Wandsworth.'

642. Paragraph 17 of annex 8G of PSO 2700 recommends a multi disciplinary approach to successive ACCT reviews involving 'a wider range of staff and specialists'.

The Governor of Wandsworth should remind staff conducting ACCT reviews to invite contributions from the In-Reach team when a prisoner has a diagnosed mental disorder.

Indications that the man was at risk of harming himself

Wandsworth - 11 - 12 June

643. During the night of 11 June, Officer 7 and Officer 5 removed the man from his cell after he said that he had been threatened by Prisoner 7. The officers did not record that the threats were of a sexual nature. Neither the officers nor the overnight management team (Oscar 1 and Oscar 2, who were present) amended the frequency of observations following the trauma the man had reported and his move to a cell on his own.

644. Officer 7 told my investigators that he had not received any ACCT training. He did not know about the man's two recent attempts to take his own life at Pentonville. He did not realise that the man had recently arrived at Wandsworth from Pentonville's healthcare centre. Nevertheless he said that he felt able to increase the frequency of ACCT checks during the night after he had liaised with the night orderly officer.

645. During interview, Officer 5 explained that he is a trained ACCT assessor. (This means that he can interview prisoners considered to be at risk of harming themselves, assess them and make recommendations to managers.) Officer 5 was also unaware of the man's recent attempts to take his own life. The officer thought that the man settled after he was moved to his own cell and he believed that the problem had been dealt with appropriately.

646. The man told Officer 5 that Prisoner 7 had made sexual advances towards him. He recalled telling Officer 6 at the time, but did not record the particular nature of the threats for the day staff who arrived the following morning.

647. Prisoner 7 and Prisoner 8 both told my investigators that the man tied a towel around his neck on the night of 11 June. This action supposedly prompted Prisoner 7 to press the cell bell. They said Officer 5 entered the cell and removed the towel. The man apparently told Prisoner 8 about the incident the

following morning. Prisoner 8 said he asked Officer 5 the following evening if it was true, and the officer said it was. However, when my investigators spoke to Officer 5 he denied having seen the man with anything tied around his neck. There is no written record of such an incident. Equally, the officer could not have entered the cell without the night orderly officer (who had keys) being present. Officer 5's keys were in a sealed pouch which was not opened during that night.

648. Had the day staff known of the specific nature of the threats, it is possible that they would have given more consideration to reviewing the ACCT document. Officer 5 explained that, although he did not record the sexual nature of the threat, he felt that he had conveyed it by writing that the man felt uncomfortable and unsafe. He thought that his colleagues would understand, by implication, that there had been a sexual aspect to the threat.

649. Officer 7 thought that moving the man to a cell on his own effectively resolved his anxiety. Both he and Officer 5 remembered that the man seemed relieved when he moved. The officer recalled that it was as if 'a weight had been lifted from his shoulders'. He considered that the man had been made 'comfortable and safe'.

650. Given the man's altered circumstances overnight, his upset and removal to a single cell, as well as the allegation of sexual threats, I consider that a review of the ACCT document and the frequency of observations should have been held early on the morning of 12 June. Officer 3 (a member of the Safer Prisons team) confirmed that he would normally expect an ACCT document to be reviewed the next morning if a prisoner moved into a single cell overnight or fell out with his cellmate.

651. The Cell Sharing Risk Assessments (CSRAs) demonstrate a lack of agreement as to whether the man should share a cell. A review of the ACCT document would have prompted staff to consider whether it was safe for the man to remain in a single cell. Prisoner 8 told my investigators that he was unhappy for the man to be locked in a single cell over lunchtime. He thought the man seemed distressed earlier that morning and was hearing voices.

652. The day staff were told at the morning briefing of the man's removal from the cell. Officer 8, who checked the man immediately afterwards, said that this would not have been a particularly unusual event and the news did not prompt him to be additionally concerned about him.

653. Officer 8 found that the man did not reply when he checked him. He noted his concerns in the ACCT document but did not suggest to a manager that a review be held. He told my investigators that the man 'could be very up and down sometimes' and, although quieter than usual, there was nothing to indicate that something was 'drastically wrong'. Officer 8 said that he did not know the full extent of the man's recent attempts to take his own life at Pentonville. He made a mental note to check the man later.

654. Prisoners alerted Officer 9 to the man's behaviour at about 10.00am. He asked the In-Reach team to assess the man because his behaviour 'was something out of the norm'. He did not ask his manager to schedule an ACCT review. He thought that he had addressed the situation by involving the In-Reach team. Officer 9 was not aware of the man's recent attempts to take his own life in Pentonville. The officer thought the man's behaviour was sufficiently worrying to ask for a mental health assessment, but he did not think the man was going to harm himself.

655. Officer 8, who had made the earlier entry, went to check the man because he was still concerned about him. Officer 9 told Officer 8 about the referral to the In-Reach team. Officer 8 made an entry for Officer 9 in the man's ACCT document although staff should make their own contemporaneous records. Officer 8 explained that he had been keen to make it clear that the man had been checked.

656. Officer 9 did not recall Officer 8 mentioning his worries about the man when they spoke together. Officer 9 did not read the ACCT document that morning because he was working on a different landing. Officer 8 recorded a pattern of concerning behaviour in the ACCT document. He thought that the man could sometimes behave in this manner and might be 'back to normal' by lunchtime after speaking to friends.

657. Officer 10 made the final entry in the man's ACCT document at about 12.30pm. It was similar to the previous two entries. Officer 10 told my investigators that he had not been especially concerned about the man when he made the entry, and ascribed his unresponsiveness to the 'ups and downs' in his behaviour that he had exhibited in the past.

658. During interview, Officer 8 said that he and Officer 10 shared their concerns about the man not being 'right'. He commented that, by lunchtime, it was beginning to become clear that 'it's probably a bit more than just a mood swing'. Officer 8 recalled that staff were starting to become more concerned. He could not remember anybody telephoning the In-Reach team to hasten their assessment.

659. Officer 8 was aware of all three observations made that morning. When my investigators asked him for his views of how the ACCT document was used, he said that he regretted that staff left the man alone in his cell over the lunch period. Officer 8 agreed that, with the benefit of hindsight, the ACCT document should have been reviewed.

660. Checking if he wanted to go to the Muslim prayer service shortly after 1.00pm, Officer 10 did not get a reply from the man. The officer was not 'overly worried' by his silence, and ascribed it once again to his 'ups and downs' in prison. Officer 10 found it a 'little strange' that the man, with whom he considered he had a good relationship, would not talk to him.

661. However, Officer 10 recalled how the man could sometimes be obstructive with staff and sometimes was very quiet and withdrawn. The officer said that

he had 'no thought' that the man might try to harm himself before he left for lunch. He believed that the man's unresponsive behaviour was just 'the man being the man'. In isolation, it appeared to Officer 10 that his experience was within the normal parameters of the man's behaviour. He did not make an entry regarding his second observation of the man. However, he did advise a colleague to check the man over lunch, which was commendable.

662. Officer 8 and Officer 10 were both aware that Officer 9 had asked the In-Reach team to assess the man (although none of the three knew when the manager of the mental health in-reach team planned to visit). Officer 10 did not read the most recent entries in the ACCT document which might have helped him to identify a pattern of behaviour. Officer 10 said that, as the officer responsible for checking that prisoners go to work, he tended to move on and off the wing and probably did not spend much time on the Onslow Centre that morning. He would not have been in a position to observe the man's ongoing lack of engagement with staff.

663. Senior Officer 3, one of the managers on the wing, knew about the observations made by the different officers. He did not recall knowing that the In-Reach team had been asked to assess the man. During the morning, three officers made separate observations about the man's withdrawn attitude. He was in a cell on his own, following the disagreement with Prisoner 7, and remained locked up alone when he took his own life. The In-Reach team were asked to assess him. Any of these events might have triggered a review of the ACCT document and the frequency of observations, but did not. Paragraph 8.6.12 of PSO 2700 states:

> 'If an at-risk prisoner is allocated to a single cell… additional measures must be put in place to compensate for any added risk involved in the individual being alone… Options include:
>
> 'Locating the prisoner in a cell that is easier to supervise by staff
>
> 'Increasing the frequency of staff conversations and observations
>
> 'Combining attendance at work, education or day-centre activities during the day with increased levels of staff conversations and observation when the individual is in his/her cell.'

664. Staff at Wandsworth were largely unfamiliar with the man's recent history of serious self harm. The second, open ACCT document detailed the events of 1 June at Pentonville. Although the man's first attempt to take his own life on 22 April was mentioned in the second document, it might have been difficult for staff to grasp the significance of it.

665. Wandsworth officers do not seem to me to have been as keenly attuned as their colleagues at Pentonville to the risk the man presented to himself. This is understandable, as both previous serious self harm attempts took place in Pentonville. Concern at Pentonville was inevitably heightened because the experiences were vivid and traumatic for officers. Nonetheless, some of the

information was available to staff at Wandsworth if the ACCT document was read carefully.

666. The day staff were told at the morning briefing about the failure of the cell share the previous night and the man's move to a single cell. This information seems to have represented the clearest opportunity to review the risk the man presented to himself.

667. Although the man repeatedly failed to engage with staff during the morning, he was also seen out on the landings at different times, whether to set out the prayer service or collect his lunch. Staff made their observations and completed the ACCT document appropriately. Some information was shared, for instance about the In-Reach referral. If the ACCT document is to be a meaningful document, it is fair to suggest that staff should learn about the ongoing situation by reading recent entries. Officer 3 said that he would expect staff to tell their managers if a prisoner continued to be uncommunicative and unresponsive. Some of the officers thought the man's behaviour that morning was not unusual. In this context, his lack of engagement with staff following the incident in the middle of the night of 11 June only really assumes significance with the benefit of hindsight.

ACCT training

668. During the course of the investigation, both Doctor 1 at Wandsworth and Doctor A at Pentonville told my investigators that they had not received any formal training regarding use of the ACCT document. Nonetheless, both doctors have familiarised themselves with the process over time and felt confident about making entries. Doctor A opened the ACCT document on 21 April. I make the following recommendation.

The Heads of Healthcare at both Wandsworth and Pentonville should ensure that all staff, including doctors, who have contact with prisoners receive formal training in the use of the ACCT document.

Cell Sharing Risk Assessments (CSRAs)

669. Earlier on in the man's sentence, concerns were raised about his suitability for cell sharing. Staff assessed that the man required a single cell because of his ongoing mental health problems and the risk he presented to others. He had assaulted prisoners and staff in 2006 and 2007.

670. The completion of CSRAs between April and June 2009 was somewhat inconsistent. My investigators were provided with four assessments completed on 21 April, 13 May, 26 May and 9 June. (There is no evidence of a CSRA being completed on 12 May at Brixton.) The quality of the CSRAs varies and they sometimes contradict each other. None accurately records that the man had previously assaulted other prisoners.

671. Because CSRAs are completed in reception when time is often limited, officers rely to a significant degree on the prisoner to disclose information

about himself. Information about the man's assaults on other prisoners was contained in previous CSRAs and security incident reports, but staff do not seem to have consulted these documents.

672. The assessment completed at Pentonville on 21 April indicated that the man presented a low risk of harm to other prisoners and was suitable to share a cell. When asked if the man had previously been the subject of an ACCT document (or its predecessor, the 2052SH), Officer A ticked 'no' (although the man was the subject of extensive suicide and self harm monitoring in 2006 and 2007). Based on what the man told him, the officer did not identify any previous assaults on staff or prisoners. However, Officer A recognised the man's vulnerability and mental health difficulties. The man shared a cell for one night amongst the general prison population before requesting vulnerable prisoner status and making an attempt on his own life.

673. Officer 1 completed a CSRA at Wandsworth on 13 May. Once again, the officer relied on the man to disclose relevant information. No previous assaults on staff and prisoners were recorded. The man was assessed as presenting a low risk of harm to others. The likelihood of self harm was identified. Much of the information was copied from the last CSRA.

The Governor of Wandsworth should ensure that staff completing CSRAs do not copy information verbatim from another CSRA, but rather combine previous assessments with the prisoner's presentation to support and inform their own judgement.

674. When the man arrived at Pentonville on 26 May, Officer A completed the front page of the CSRA. The man again did not disclose previous assaults on staff or prisoners and so the officer did not identify concerns about cell sharing. However, helpful and detailed information about the man's state of mind, the recent attempt to take his life and his status as a vulnerable prisoner was included. Nurse D completed the healthcare section of the form and assessed the man as presenting a medium risk to other prisoners.

675. The final section of the form, which is supposed to be completed by an officer locating the prisoner after their arrival, was filled in five days later by Governor F on 31 May. He presumably wrote his comments after the man spoke to Senior Officer A, was relocated to a single cell and an ACCT document had been opened. Governor F identified the need for the man to be held in a single cell because of his erratic behaviour and because he was threatening to harm his cellmate. He indicated that this decision should be reviewed in four weeks time.

The Governor of Pentonville should ensure that staff complete all four sections of a prisoner's CSRA the day the prisoner arrives.

676. The last CSRA, completed at Wandsworth on 9 June by Officer 2 and Nurse 3, contains very little detail and makes no reference to any of the concerns relating to cell sharing raised on 31 May. They had been noted both in the previous CSRA and in the ACCT document opened on 31 May (where Senior

Officer A wrote that the man should be located in a single cell because he was 'high risk'). Still relying on the man for information, Officer 2 did not identify his previous violent behaviour in custody. The man was assessed as presenting a low risk of harm to others.

677. CSRAs rely on staff making a professional assessment at the time in question. However, reference to previous CSRAs would have helped staff to accurately and consistently have assessed the man's suitability to share a cell. There is no easy solution when a prisoner like the man may sometimes be at risk on his own, but may equally occasionally present a risk to cellmates. Sharing with another prisoner on the night of 11 June probably had a negative impact on the man. Yet locating him alone in a cell over lunchtime the next day was something about which other prisoners expressed concern, as they felt the man should not be left on his own.

678. There is no indication that the man was actually violent towards either staff or prisoners during his final period of imprisonment. Nonetheless, it seems to have been recognised at various junctures that sharing a cell might not be appropriate. At other times this information does not seem to have been considered. I amend a recommendation I made following a previous investigation at Wandsworth:

The Governors of Pentonville and Wandsworth should ensure that staff completing Cell Sharing Risk Assessments (CSRAs) consult previous CSRAs for relevant information. Previous CSRAs should be stored together in date order.

Cell sharing on 11 June

679. When I investigated the death of another prisoner at Wandsworth in 2007, I recommended that staff should think very carefully before placing together two vulnerable prisoners who both had significant mental health problems. Whilst sometimes prisoners can support each other, bringing two fragile prisoners with histories of self harm together may also be counter-productive.

680. During the afternoon of 11 June, the man was located in the same cell as Prisoner 7. Seven hours later, the man asked to move out of the cell. The man told Officer 5 that Prisoner 7 had made sexual advances towards him. The officer recorded that the man felt threatened but did not write that the threats were of a sexual nature. In the early hours of the morning, staff opened an ACCT document in relation to Prisoner 7. The next morning the man did not speak to staff and the In-Reach team were asked to assess him.

681. Officer 5 suggested that threats of a sexual nature were unremarkable on the Onslow Centre, which was why he did not specifically refer to the sexual element at the time. He thought that his phrasing adequately communicated to his colleagues what had transpired. However, the man's mood changed the next morning, and it might have been useful for staff to have had a fuller understanding of the situation.

The Governor of Wandsworth should ensure that detailed information about the nature of any threats towards a prisoner are clearly recorded by staff, particularly in an ACCT document if one is open.

682. Without exception, staff on the Onslow Centre described Prisoner 7 as a demanding prisoner who used up a lot of staff time and resources. He had a history of being unable to share with other prisoners, and staff tried on several occasions to place him with an appropriate cellmate.

683. Officer 10 thought that the proposed cell share was unsuitable. He said that it was well known on the Onslow Centre that nobody wanted to share with Prisoner 7. He recalled that Prisoner 7 would be 'up all night, banging and crashing'. He explained that Prisoner 7 had a lot of problems and staff had tried a variety of strategies to facilitate a successful cell share over 'days and days'. Officer 10 was not surprised to be told at the morning briefing the next day that the man had moved out overnight.

684. Officer 7 explained that prisoners who shared with Prisoner 7 often asked to be moved, saying that they did not 'want to go back in there'. Officer 5 said that both staff and prisoners found it difficult to cope with Prisoner 7. Senior Officer 5 remembered the man complaining on 12 June that Prisoner 7 was constantly talking to him in the night, 'driving him up the wall' when he wanted to sleep.

685. Officer 8 said that Prisoner 7 had difficulty sleeping and that 'one night [of cell sharing] was enough for most people'. He said he was unsurprised that the cell share did not work out and commented that it was never going to be a long-term proposition because Prisoner 7 was so demanding.

686. During the ACCT review on 10 June, Officer 3 remembered discussing the prospect of the man sharing a cell with Prisoner 7. He recalled that it was an arrangement that both men requested. Officer 3 thought that the man seemed content with the arrangement, and he did not see any reason to object to it. He commented that it was not unusual for two vulnerable prisoners with histories of self harm to share a cell on the Onslow Centre if they both asked for the move.

687. Senior Officer 4 asked Officer 4 to organise the cell share on 11 June. Senior Officer 4 told my investigators that Prisoner 7 is a 'poor coper' who has long had trouble sharing a cell. The SO was trying to find a cell mate who might stabilise his behaviour and be a positive influence. During interview, Senior Officer 4 said that Prisoner 7 came to his office with the man and suggested the cell share. The SO checked with the man if he felt pressurised to share with Prisoner 7. The man said he was not and told the SO that he would 'give it a go'.

688. Senior Officer 4 did not know the man very well. He thought the man was a 'poor coper' and seemed troubled. He knew that the man was the subject of an ACCT document, but was not fully aware of his two recent attempts to take his own life at Pentonville. (The ACCT document recorded the second

attempt.) Senior Officer 4 had a better understanding of Prisoner 7's history and problems. The SO thought that the proposed share might be a good idea as a 'trial run' and asked Officer 4 to organise it. Officer 4 only knew that the man had made one suicide attempt at Pentonville. She was not aware of the seriousness of the attempt in April. Officer 4 was aware that Prisoner 7 regularly asked for a new cell mate and knew that he experienced mental health problems.

689. When he spoke to my investigators, Senior Officer 4 said that he would not have authorised the proposed cell share if he had thought it would prove unsafe. If either man had been assessed as a high risk of harm on their most recent CSRA, Senior Officer 4 said he would not have allowed the arrangement to proceed. Had he thought that either man was a medium risk, Senior Officer 4 said he would have discussed the proposed share with a colleague.

690. Recent evidence of the difficulty the man had in sharing a cell was available to Wandsworth staff. Senior Officer A opened the second ACCT document on 31 May at Pentonville and wrote 'high risk – to remain in single cell'. The man told her that he was not getting on with his cellmate. For much of his time in custody since 21 April, the man had been held in single cell accommodation in the Pentonville healthcare centre.

691. Senior Officer A accepted that Prisoner 7's risk assessment varied. My investigators looked at entries made in the wing observation book before, during and after the man's location on the Onslow Centre in May and June. A disproportionate number of entries relate to Prisoner 7, whose behaviour was frequently disturbed and disruptive, affecting other prisoners. On more than one document from March and April 2009, 'high risk' was clearly marked. Prisoner 7 tried to set fire to his cell in March. In August 2009, Officer 4 told my investigators that Prisoner 7 was located in a 'high risk single cell' at that time.

692. Prisoner 7 frequently asked to visit the Listeners' suite. On 10 June, he did so in the afternoon and evening, coincidentally following the man on both occasions. Prisoner 7 had moved cells on 10 June. Although not the subject of an ACCT document the day he was allocated to share with the man, he was both before and very shortly after the man died. Paragraph 8.6.9 of PSO 2700 states:

> 'Two prisoners on open ACCT Plans or in the post-closure phase of ACCT, or a combination of each, must not be located together in a double cell, unless a case review team – having considered the care of both prisoners – decides they will both benefit from sharing with each other. Similar consideration needs to be given where staff are aware that prisoners have recently had an ACCT Plan closed.'

693. Senior Officer 4, Officer 4 and Senior Officer 3 all said that they considered two prisoners' willingness to share to be a primary consideration and a strong indication of compatibility. Whilst the wishes of prisoners are important, I am

concerned that they should not override professional risk assessment. Prisoners may not always be the best judges of the suitability of cell sharing. Following publication of the draft report, NOMS provided the following response to this paragraph:

> 'Yes, it should not override professional risk assessment, but in many instances we need to base a risk assessment on the opinion of the prisoner and what they feel will help them. By not doing so, we are discouraging them from taking responsibility for their own care and ignoring their opinion of what they think is best for them. It is a difficult balance to achieve, but it seems unfair to criticise staff for a judgement call that was considered amongst staff and with the man on definitely two occasions. It was then agreed that it would be put into place on a trial basis.'

694. A slightly fuller risk assessment might have identified reasons why the man should not share a cell with Prisoner 7. Senior Officer 4 could have benefited from the In-Reach team's advice since both men had mental health problems.

695. Senior Officer 4 was not helped by the most recent CSRA, which he consulted before agreeing to the proposed share and which contained little detail. Officer 4 was familiar with the man's history of mental health problems and agreed with my investigators that the CSRA did not adequately reflect these.

696. Officer 4 also looked at the most recent CSRA when she carried out Senior Officer 4's request. She said that she would normally only consult other documents if time allowed. She would not necessarily read a prisoner's ACCT document which did not automatically pertain to the risk they represented to others. She agreed that the ACCT document could provide useful information about a prisoner's state of mind.

697. Neither Senior Officer 4 nor Officer 4 recorded their decision making regarding the proposed cell share. Paragraph 8.6.8 of PSO 2700 states:

> 'When locating an at-risk prisoner in shared accommodation account must be taken of the suitability of the cellmate, and consideration given of the impact on and ability of the cellmate to cope with the individual situation. The F2052A (history sheet) is a suitable place to document such consideration.'

698. The desire to address the disproportionate demands Prisoner 7 was making on staff by finding a suitable cellmate was understandable. I am concerned that this wish may have overridden consideration of the impact his behaviour would have on somebody like the man. From what staff told my investigators, Prisoner 7 would not have offered stability and support. I acknowledge that the man jointly requested the cell share, but note that he spoke to Senior Officer 4 in Prisoner 7's presence.

699. Wandsworth's own CSRA Management Booklet indicates that a prisoner's assessment should be reviewed if there is 'a significant event that triggers concern'. The booklet gives the examples of triggers such as acute mental

illness or staff receiving new information. A new CSRA was not completed on the morning of 12 June.

700. Officer 4 was the movements officer on the morning of 12 June. It was her job to review the man's location and find a suitable new sharing arrangement. Another prisoner with mental health problems asked if the man could move into his cell. Officer 4 decided to seek the manager of the mental health in-reach team's advice when she assessed the man later that day because she was concerned about placing two prisoners with mental health difficulties together. I consider that Officer 4 showed sound judgement. She doubted whether the newly proposed share would be in the man's best interests. Thus, the man had not been allocated a new cell mate by lunchtime. Senior Officer 3 confirmed that the intention had been for the man to be relocated with a new cellmate before the end of the day.

Clinical records

701. When my investigator collected the man's file from Wandsworth, he was only given a clinical record printout from Pentonville between 21 April to 12 May. There was no copy of the part of the man's clinical record relating to the second period at Pentonville between 26 May and 9 June. My investigator later obtained a full printout from Pentonville.

702. The missing record would have contained pertinent information for any healthcare staff who assessed the man between 9 and 12 June at Wandsworth. Clinical records at the two prisons cannot be shared electronically and a physical printout has to be sent with the prisoner when they transfer. It would appear that an up-to-date printout was not sent with the man on 9 June.

The Head of Healthcare at Pentonville should ensure that an up to date copy of a prisoner's clinical record is always sent with them when they transfer out.

703. The Head of Healthcare at Pentonville told my investigators that he failed to record two telephone conversations in the man's clinical record. On 13 May, he spoke to the Head of Healthcare at Wandsworth to resolve confusion about the transfer which had gone awry. On 8 June, he spoke to one of the Head of Healthcare at Wandsworth's colleagues to let his healthcare team know that the man was transferring back to them the next day.

The Head of Healthcare at Pentonville should remind staff of the importance of recording all correspondence about a patient in their clinical record.

Pharmacy

704. During the emergency on 12 June, Officer 14 was asked to request adrenaline and atropine from the prison's pharmacy. He said that he spoke to two members of staff in succession who were unhelpful. He thought that they

seemed reluctant to respond to the emergency and did not seem to grasp the urgency of the situation. They suggested to the officer that he visit the pharmacy to collect the adrenaline. They thought that the doctors working on the man should use the adrenaline in the emergency drug box or the emergency bag, both of which are in the treatment room on the Onslow Centre. The pharmacy is located on the opposite side of the prison to the Onslow Centre, quite some distance away.

705. My investigator discussed the officer's concerns with the principal pharmacist. She explained that the pharmacy technicians Officer 14 spoke to were agency staff (although the female technician was regarded as semi-permanent, having worked at Wandsworth for over a year). Both members of staff have left the prison, and my investigator was unable to interview them.

706. The principal pharmacist confirmed that the female technician carried a set of keys and knew her way around the prison. The principal pharmacist was unsure how long the male technician had worked in the pharmacy. She could not say whether he carried keys, or would have felt confident to find his way to the Onslow Centre. It is conceivable that the first person the officer telephoned lacked confidence within the prison environment. This may have resulted in his unhelpful attitude and failure to respond immediately to the emergency. However, this does not adequately explain why the male technician did not immediately ask a colleague to take the adrenaline.

707. When my investigator talked to the principal pharmacist, she suggested that staff trying to resuscitate the man could have made use of adrenaline stored on the wing. However, Nurse 8 explained why the doctors requested adrenaline from the pharmacy. She said that, in her experience, the emergency drug box containing adrenaline is often locked away in a cupboard in the treatment room. The principal pharmacist said that this box is not supposed to be locked away and should always be located on top of the cupboard.

708. Every nurse has a key to the treatment room. However, they do not automatically have keys to the cupboards. Because the emergency happened over lunchtime, the nurse in charge of the treatment room and in possession of the key to the cupboard was not present on the wing.

709. With regard to the adrenaline found in the emergency bag, Nurse 8 indicated that this is a small amount contained in an Epipen (a pre-filled syringe designed to be given when a patient suffers an allergic reaction or anaphylactic shock). She did not think that this type of equipment would have proven adequate because there was only a small amount of adrenaline and the way the Epipen is designed would make it difficult to deliver the drug directly into a vein.

710. As far as the request for atropine is concerned, the principal pharmacist told my investigator that the pharmacy does not stock this drug. She explained that she has encountered problems obtaining supplies.

711. The reaction of the pharmacy technicians to Officer 14 was disappointing. It is hard to understand why the officer apparently had to argue with pharmacy staff and justify his request. The technicians should have responded unquestioningly, even if the telephone call had been a false alarm. In the event, adrenaline brought by the air ambulance crew was administered to the man before the female technician reached his cell.

712. One of the reasons why pharmacy staff responded in the manner they did may be that all the technicians are temporary workers sourced from agencies. The principal pharmacist confirmed that she has no permanent staff at this grade. I am concerned that technicians may lack confidence moving around the prison quickly in an emergency, and may not understand the shorthand used by staff communicating over the radio and telephone.

Wandsworth Primary Care Trust should renew attempts to recruit permanent pharmacy technicians.

The Head of Healthcare at Wandsworth should devise a protocol with the Principal Pharmacist to ensure that pharmacy staff respond immediately and unquestioningly when asked to provide drugs for prisoners, especially during an emergency.

The Head of Healthcare at Wandsworth and the Principal Pharmacist should explore the possibility of stocking atropine in the pharmacy.

The Head of Healthcare at Wandsworth and the Principal Pharmacist should ensure that the emergency drugs boxes in each treatment room are not locked away at any time. Consideration should be given to mounting them on the wall.

Nurse 4

713. When my investigator visited the Onslow Centre shortly after the man died, he spoke to Prisoner 2. He said that he had been concerned about the man when they returned together to Wandsworth on 9 June. Prisoner 2 remembered that the man became increasingly distressed whilst they were waiting to be assessed by Doctor 1 on the first night centre. Prisoner 2 said that he explained to Nurse 4 that the man was disturbed and was talking about taking his own life. He claimed that Nurse 4 said that this was 'none of his business' and told the man to 'pull himself together'. Prisoner 2 said that, a few days after the man died, the nurse warned him not to say anything about what had happened.

714. My investigators spoke to Nurse 4 on 5 August whilst they were conducting interviews on the Onslow Centre. He denied working on the first night centre on 9 June and suggested that the investigator should speak to the Head of Healthcare at Wandsworth to confirm the shift pattern for that day. The investigator met the Head of Healthcare on 28 October and was provided with a copy of the rota, which showed that Nurse 4 worked in Wandsworth on 9 June but was not scheduled to be on the first night centre. On 28 October,

my investigator also conducted a further, taped interview with Prisoner 2, during which he reiterated his claim. Another prisoner, Prisoner 3, supported his statement.

715. On 5 November, the investigator conducted a recorded interview with Nurse 4. He said that he did not work on the first night centre on 9 June and was working elsewhere in the prison with his colleague, Nurse 6. He told my investigator that he had not worked on the first night centre for a long time. He said that the incident described by Prisoner 2 did not take place.

716. My investigator interviewed Nurse 6. She confirmed that she worked with Nurse 4 on 9 June but could not recollect visiting the first night centre with him. Prisoner 2 said Nurse 5, another nurse, was present on the first night centre at the time of the alleged incident. My investigator also spoke to Nurse 5. He confirmed that he worked on the first night centre with Doctor 1 on 9 June. Nurse 5 could not recall Nurse 4 being present and confirmed that he unlocked both Prisoner 2 and the man from their cell to take them to see the doctor. Given that the statements provided by Nurse 4's colleagues support his version of events, I am satisfied that nothing untoward occurred.

Preserving the man's dIgnity after his death

717. After the man died, Prisoner 6 said that he walked past the cell and saw the man's body. He was upset by this and thought that the doorway should have been covered. However, statements given by two other prisoners to the police at the time indicate that a sheet had been placed across the entrance by the time they were released from their cells. On balance, I am satisfied that staff took appropriate steps to preserve the man's dignity.

Informing the man's family of his death

718. The man was declared dead shortly before 2.20pm on 12 June. His family live in a nearby part of South London, just under four miles away. The family liaison team reached the address two hours later, just after 4.30pm. By this stage, the man's mother had already been telephoned by a prisoner on the Onslow Centre who had a mobile telephone and informed her of her son's death. She was actually on the telephone to the prison when Governor 7 and the chaplain arrived. My investigators asked Governor 7 if anything had prevented him from informing the man's mother more promptly.

719. Governor 7 was assigned as the FLO at 2.45pm. He was unable to firmly establish the name and address of the man's next of kin in his core record. Instead, he found the man's mother's name and address in social visits paperwork. Governor 7 made an assumption that the man's mother was the nominated next of kin.

720. Having found the man's mother's address, Governor 7 considered how best to travel there. He decided against using his own car as he was concerned about finding the address and did not want to struggle to park the car when they arrived. He also decided against using a taxi as the company with whom

Wandsworth have an account is not located in the vicinity and waiting times for collection are often unreasonable.

721. In the event, Governor 7 and the chaplain opted to use an eight seater prisoner escort vehicle. Governor 7 asked an OSG to drive them, drop them off and park the vehicle a discreet distance away. Governor 7 was conscious of getting lost and told my investigators that the Prison Service van was equipped with a satellite navigation device, something his own car did not have.

722. Governor 7 assumed that the vehicle was parked inside the prison but it was parked outside the grounds. Some additional time was taken up meeting the driver, exiting the prison and reaching the vehicle. Governor 7 explained that the traffic was heavy, first because that part of London is regularly congested, and secondly because it was Friday afternoon.

723. I have no doubt that the decisions made by Governor 7 were well intentioned. He believes that he and his colleagues could not realistically have made the journey any quicker than they did. He told my investigators that, even with the benefit of hindsight, he would not do anything differently.

724. However, when a relative lives so close to the prison, it is regrettable that notification takes over two hours and a prisoner is able to make contact first. Because mobile telephones are an acknowledged (albeit illegal) part of prison life, rapid notification can be crucial.

725. Although Governor 7 could not initially determine the details of the nominated next of kin from the man's records, my investigators subsequently found three different forms providing this information. One was completed as part of the core record on 21 April and gave the man's sister's name and the family's address. The other two forms, completed on 21 April and 26 May at Pentonville as part of the induction process, named the man's mother as the next of kin and recorded the same address. Because he could not identify the required information from these documents, Governor 7 spent (by his estimate) half an hour looking through the social visits paperwork.

726. In my experience, it is common for a FLO to use their own transport in order to hasten the notification process. Although Governor 7 was worried about parking and getting lost and wanted a vehicle with a satellite navigation device, the choice of a prisoner escort vehicle may not have been appropriate. The van and the driver seem to have taken a little while to locate. The vehicle was also conspicuous, being a 12 seater minibus with an orange stripe down the side and Prison Service markings.

727. As regards the taxi account, from what my investigators have gathered this is a far from adequate arrangement. Prison staff often need taxis at short notice, for example when following a prisoner escort to hospital. The firm is located in another part of London and the arrangement is impractical such that staff actively seek alternatives.

728. Governor 7's avoidance of the prison's usual taxi firm is understandable. However, another member of staff mentioned that he uses an alternative company based very close to Wandsworth. In future, the designated FLO may wish to keep several alternative taxi telephone numbers to hand for just such an emergency. The Governor of Wandsworth may wish to think about reassigning the prison's taxi account to a company in the immediate locality.

The Governor of Wandsworth should remind the designated FLO to use the quickest form of transport available to reach the next of kin.

729. My investigator and FLO visited the man's mother some weeks later. It became apparent that she did not realise that her son had made another attempt to take his own life on 1 June. She was aware of the first attempt and the family had visited the man in hospital. However, staff at Pentonville do not seem to have advised the family of the second attempt.

730. Paragraph 13.3.3 of PSO 2700 indicates that, after an incident of self harm, staff should ask the prisoner if they want their family to be contacted. The nominated next of kin must be notified unless the prisoner refuses to consent. There is no record in the ACCT document of a conversation with the man on 1 June about informing his family. This is surprising given the considerable care that was previously taken to accommodate the man's family when he stayed at hospital. The lack of contact is also unusual given how aware staff at Pentonville were of the man's circumstances.

The Governor of Pentonville should remind staff of the requirements of PSO 2700. After an incident of self harm, staff should ask the prisoner if they want their nominated next of kin to be informed. The next of kin should be told unless the prisoner refuses to provide their consent.

Good practice

731. I am conscious that my investigation has been necessarily critical of both Pentonville and Wandsworth. I would like to conclude by highlighting examples of good practice. First, I note the efforts to which the manager of the mental health in-reach team at Wandsworth and her colleagues went to prepare for the man's release on 20 March. The pre-release liaison that took place between the CMHT, the prison, the offender manager and the approved premises provided the man with appropriate support in the community. I also note the man's offender manager's attempts to put in place support for the man in the community.

732. The clinical reviewer praises the efforts of the In-Reach teams at both prisons between April and June:

> 'Many professionals appeared sympathetic to [the man's] circumstances. In my opinion his overall treatment for his mental illness was equitable with services available outside prison. There are a number of examples of good practice by professionals in the In-Reach teams.'

733. I also draw attention to the commendable actions of Officer C and her colleagues on 22 April. Just when the man tried to take his own life, Officer C decided to check him because she was concerned. When she found the man hanging in his cell, she and her colleagues took swift action to cut him down and begin resuscitation. I understand that, without the rapid intervention of the officers and healthcare staff, the paramedics who subsequently attended said that they would not have been able to successfully revive the man.

734. The hot debrief meeting run by Governor C later the same day was a thorough exploration of the lessons to be learnt from the emergency. During the man's stay in hospital over the next few days, the management team at Pentonville showed sensitivity in not cuffing him whilst he was sedated. They paid for the man's mother to travel to the hospital by taxi. When the man returned to the healthcare centre, effective liaison took place between the two prisons to keep the man safe and return him to Wandsworth.

735. Governor Y's acceptance of the man at Brixton on 12 May showed very sound judgement. He gathered information, considered what was in the man's best interests and acted cautiously in monitoring his safety. He contacted the other prisons and attempted to resolve a confusing situation which was not of his making.

736. Returning to Pentonville, the man made a second attempt to take his own life at the beginning of June. Officer I checked him and acted quickly to cut him down.

737. That the man subsequently took his own life should not detract from any of these achievements.

CONCLUSION

738. The man was a prisoner with mental health difficulties held in an imperfect prison system. He moved four times in a seven week period, something which I believe interrupted his continuity of care. My investigation highlights examples of good practice by individual members of staff. For example, plans for the man's first move from Pentonville to Wandsworth were made in considerable detail (albeit they were not implemented successfully). However, my investigators found strong evidence to suggest that one of the transfers between prisons was not in the man's best interests. Of the four moves, two were at his own request, one happened accidentally and his return to Pentonville on 26 May may well have been influenced by the forthcoming inspection of Wandsworth.

739. The Prison Service has already mounted a disciplinary investigation into the series of transfers between Pentonville and Wandsworth at the time of inspections by HM Chief Inspector of Prisons. The man was not one of the prisoners transferred directly as a consequence of the inspection of Wandsworth at the beginning of June 2009. However, the circumstances of his transfer on 26 May would certainly have led me to have recommended a disciplinary investigation had one not already taken place. As it is, my report reveals new facts not known at the time of the Prison Service's internal inquiry and draws attention to the indirect impact on the man of the transfers as a whole. For those reasons, I have recommended that the Director Genral of NOMS reviews the new evidence to determine whether a renewed disciplinary investigation is required.

740. Individuals with mental health needs, drug and alcohol misuse problems and a history of associated offending too often fail to get the help they need. The man was most probably not so unwell as to warrant sectioning in a hospital. However, his mental health problems were still pronounced and resulted in poor decision making in the community.

741. Before too long the man reoffended, despite the efforts of his offender manager and his local mental health team. The prison system is poorly equipped to give people such as the man the care and support they need. He was held in large local prisons, where a significant proportion of the population may have similar mental health concerns.

742. The man was unwell and I believe that he should have had a stable environment where he felt safe. This did not happen for the reasons I have explored. Paradoxically, it was at Wandsworth, where he said he would feel safe, that he took his life.

743. A number of staff had tried to make sure that the man moved to Wandsworth after a very serious suicide attempt at Pentonville. Yet within a fortnight their good work was undone and he was back in a prison to which he had been assured he would not return. The man transferred back to Wandsworth after another suicide attempt at Pentonville. It is impossible to gauge with certainty the impact the various moves had on his mental health, but frequent transfers

are a known risk factor for self-harm and suicide, especially amongst the already vulnerable.

744. In the last few days of his life, the man was placed in a cell with a prisoner who was well known for being extremely difficult to share with. He told staff that his cellmate had made a threat of a sexual nature towards him. He was encouraged to speak to Operation Trident, although we cannot know what impact their involvement had on his state of mind. His changing circumstances and concerning presentation on the morning of 12 June unfortunately did not prompt staff to review the ACCT monitoring.

745. There are many lessons to be learned from the circumstances surrounding the man's death. Above all, prisoners with significant mental health needs should be provided with continuity of care and a stable custodial environment. For a variety of reasons – some by chance, some by design – these benefits were not afforded to the man.

RECOMMENDATIONS

Recommendations for Wandsworth

1. The Head of Healthcare at Wandsworth should ensure that the relevant duty governor is always informed on the day if a healthcare to healthcare transfer is anticipated.

   NOMS accepted the recommendation and provided the following response:

   'The Head of Healthcare will (and remind healthcare managers also) to notify the duty governor (duty manager 1) once a healthcare to healthcare transferred has been requested by another establishment (i.e. requesting that a prisoner transfer to HMP Wandsworth) or that the HMP Wandsworth healthcare department is considering a transfer to another prison. In both of these cases, healthcare is to advise the duty governor in terms of clinical suitability, potential risk factors, availability of beds etc. However, the decision lies with the duty governor (duty manager 1) in terms of agreeing the transfer formally with their counterpart in the sending/ receiving establishment. Duty managers will be advised accordingly.'

2. Wandsworth Primary Care Trust should review the inpatient healthcare facilities at Wandsworth. Consideration should be given to increasing the capacity for prisoners with mental health problems and suicidal thoughts who do not fit the criteria of the Addison Unit.

   NOMS accepted the recommendation and provided the following response:

   'This will be discussed as a part of the current service level agreement review with South West London and St George's Mental Health NHS Trust. The primary care trust and prison are currently looking at capacity issues.'

3. The Heads of Healthcare and In-Reach at Wandsworth should review the way in which information is communicated between them. The Head of Healthcare should ensure that prisoners with a history of mental health problems are referred to the In-Reach team for an assessment during the reception process.

   NOMS accepted the recommendation and provided the following response:

   'The Head of Healthcare is currently developing Primary Mental Health services including a management role to assist in establishing clear information and referral pathways. Referral to in-reach services will include direct referral from reception.'

4. The Governor of Wandsworth should ensure that the stamp used during the handover period between the night and day staff is amended so that it requires staff to record the date and time of the handover.

   NOMS accepted the recommendation and provided the following response:

'Stamps will be adjusted accordingly'

5. The Governor of Wandsworth should ensure that all staff working on the Onslow Centre receive further training in the use, completion and day-to-day operation of the ACCT document as soon as is practicable. Particular emphasis should be placed on identifying new risk indicators, holding ACCT reviews promptly and amending the frequency of observations to reflect the level of risk.

   NOMS accepted the recommendation and provided the following response:

   'A training plan will be developed specifically for the Onslow unit, so that training will take place every six months. The training will incorporate concerns that have been raised as a result of death in custody investigations as well as focusing on specific risk indicators for this population.'

6. The Governor of Wandsworth should remind staff conducting ACCT reviews to invite contributions from the In-Reach team when a prisoner has a diagnosed mental disorder.

   NOMS accepted the recommendation and provided the following response:

   'It is accepted that the In-reach team should be involved in ACCT reviews of prisoners who come under their remit. There is currently a member of the In-reach team assigned to attend reviews in each area.

   'However, due to medical in confidence, it would cannot be assumed that prison staff will always know whether a prisoner is presenting with severe and enduring mental health issues and therefore, under the care of In-reach.

   (1) The safer custody team will provide, on a weekly basis, a list of prisoners currently on ACCT forms.

   (2) If a prisoner is assigned to a CPN, In-reach will make a clear note on the ACCT form of who the prisoner's CPN is.

   (3) Staff will be advised to contact this CPN to update them and get advice and input if an ad hoc review takes place due to changes in the prisoner's situation e.g. act of self-harm. '

7. The Governor of Wandsworth should ensure that staff completing CSRAs do not copy information verbatim from another CSRA, but rather combine previous assessments with the prisoner's presentation to support and inform their own judgement.

   NOMS accepted the recommendation and provided the following response:

'This will be focused on in the induction training for new officers and the current Violence Reduction Training for operational staff.'

8. The Governor of Wandsworth should ensure that detailed information about the nature of any threats towards a prisoner are clearly recorded by staff, particularly in an ACCT document if one is open.

NOMS accepted the recommendation and provided the following response:

'A Governor's Order will be published accordingly.'

9. Wandsworth Primary Care Trust should renew attempts to recruit permanent pharmacy technicians.

NOMS accepted the recommendation and provided the following response:

'Recruitment and short-listing has taken place. Interviews and appointments should be completed by end of July 2010.'

10. The Head of Healthcare at Wandsworth should devise a protocol with the Principal Pharmacist to ensure that pharmacy staff respond immediately and unquestioningly when asked to provide drugs for prisoners, especially during an emergency.

11. The Head of Healthcare at Wandsworth and the Principal Pharmacist should explore the possibility of stocking atropine in the pharmacy.

12. The Head of Healthcare at Wandsworth and the Principal Pharmacist should ensure that the emergency drugs boxes in each treatment room are not locked away at any time. Consideration should be given to mounting them on the wall.

NOMS accepted recommendations 10, 11 and 12 in principle and provided the following response:

'The Head of Healthcare will review the local resuscitation policy including the range of drugs for emergencies. These will be available within the drug pouch in the emergency resuscitation bags.'

13. The Governor of Wandsworth should remind the designated FLO to use the quickest form of transport available to reach the next of kin.

NOMS accepted the recommendation and provided the following response:

'The Governor will remind all FLOs. It will also be considered whether a phone call to the family initially, particularly if they live far from the prison, would be at times appropriate to ensure that the family are informed by the FLO rather than another prisoner.'

Recommendations for Pentonville

14. If a new prisoner tells a doctor during the reception process that he is being prescribed anti-psychotic medication, the Head of Healthcare at Pentonville should ensure that the prescription is continued on the first night in custody. The prescription should be confirmed with the community provider by the end of the next working day.

    NOMS accepted the recommendation and provided the following response:

    'To be discussed at the next patient safety committee and recommendation implemented.'

15. The Head of Healthcare at Pentonville should ensure that all prescriptions are reviewed at pre-determined intervals and that staff understand the review process.

    NOMS accepted the recommendation and provided the following response:

    'To be discussed at the next patient safety committee and recommendation implemented.'

16. The Governor of Pentonville should ensure that staff perform a thorough search of prison information systems when a new prisoner arrives in custody. As well as the individual's prison number, staff should also check their surname and date of birth.

    NOMS accepted the recommendation and provided the following response:

    'With the introduction of P-NOMIS, an offender is now given one prison number which remains with them every time they enter prison, retaining all their previous details and alerts, including case notes and self harm behaviour.'

17. The Governor of Pentonville should remind staff of the importance of notifying the Public Protection Casework Section immediately when a prisoner whose licence has been revoked arrives at the prison.

    NOMS accepted the recommendation and provided the following response:

    'Instructions to be issued to Offender Management unit by the Head of Reducing Re-offending'

18. The Head of Healthcare at Pentonville should ensure that the primary healthcare team makes an immediate referral to the In-Reach team when a prisoner is placed under constant supervision.

    NOMS accepted the recommendation and provided the following response:

'To be discussed at the next patient safety committee and recommendation implemented.'

19. The Governor of Pentonville should ensure that, when staff write the intended frequency of observations on the front cover of an ACCT document, they note their initials, the date and time next to their entry.

NOMS accepted the recommendation and provided the following response:

'To be incorporated in a Notice to Staff and this action point will be included in all future ACCT training. This will also be included as part of the managers weekly ACCT checks.'

20. The Governor of Pentonville should ensure that staff understand the maximum frequency of ACCT checks possible on normal location before a prisoner has to be moved to a healthcare setting for observation.

NOMS accepted the recommendation and provided the following response:

'Draft protocol currently with the head of Healthcare for comment, final draft to be discussed and agreed at the patient safety committee and then published.'

21. The Governor of Pentonville should ensure that an ACCT document is always opened if a prisoner is placed under constant supervision.

NOMS accepted the recommendation and provided the following response:

'Draft protocol currently with the Head of Healthcare for comment, final draft to be discussed and agreed at the patient safety committee, then published.'

22. The Governor of Pentonville should ensure that staff make a record in a prisoner's ACCT document when they find and confiscate a means of self harm such as a ligature.

NOMS accepted the recommendation and provided the following response:

'To be incorporated in a Notice to Staff and this action point will be incorporated into all future ACCT training.'

23. The Governor of Pentonville should ensure that staff complete all four sections of a prisoner's CSRA the day the prisoner arrives.

The recommendation was incorrectly addressed to the Governor of Wandsworth in the draft report. With the publication of the final report, I would ask the Governor of Pentonville to consider it.

24. The Head of Healthcare at Pentonville should ensure that an up to date copy of a prisoner's clinical record is always sent with them when they transfer out.

NOMS accepted the recommendation and provided the following response:

'To be discussed at the next patient safety committee and recommendation to be implemented.'

25. The Head of Healthcare at Pentonville should remind staff of the importance of recording all correspondence about a patient in their clinical record.

NOMS accepted the recommendation and provided the following response:

'To be discussed at the next patient safety committee and recommendation to be implemented.'

26. The Governor of Pentonville should remind staff of the requirements of PSO 2700. After an incident of self harm, staff should ask the prisoner if they want their nominated next of kin to be informed. The next of kin should be told unless the prisoner refuses to provide their consent.

NOMS accepted the recommendation and provided the following response:

'This will be incorporated into the work of Pentonville's Family Liaison Officer.'

Recommendations for Wandsworth and Pentonville

27. The Governors of Wandsworth and Pentonville should each introduce a central transfer register. The register should be used by all departments. Staff should record their decision making in relation to all ad hoc transfers which are not organised at a national level.

NOMS accepted the recommendation and provided the following response:

'A protocol has been introduced for all transfers within prisons in the London area.'

28. The Heads of Healthcare at both Wandsworth and Pentonville should ensure that all staff, including doctors, who have contact with prisoners receive formal training in the use of the ACCT document.

NOMS accepted the recommendation and provided the following response:

'Wandsworth. ACCT foundation training is currently a part of the induction training for all staff. In liaison with healthcare, a training plan will be developed specifically for healthcare staff, both permanent and locum.

'Pentonville. To be discussed at the next patient safety committee and recommendation to be implemented.'

29. The Governors of Pentonville and Wandsworth should ensure that staff completing Cell Sharing Risk Assessments (CSRAs) consult previous CSRAs for relevant information. Previous CSRAs should be stored together in date order.

NOMS accepted the recommendation and provided the following response:

'Wandsworth. This process has changed significantly due to the introduction of P NOMIS. Although an electronic version of the CSRA is not yet available, if there are particular concerns about a prisoner's risks to others and a single cell is advised, an update will be inputted by the duty governor in the prisoner's case notes which can be accessed by prison staff nationally. Additionally, when a prisoner arrives from another prison, their current CSRA level is clearly visible on the system.

'Pentonville. P NOMIS will hold all previous CSRA information. Reception staff will ensure they check through all documentation which arrives with the prisoner and collate previous CSRAs together.'

Recommendations for London Probation Trust

30. London Probation Trust should ensure that staff working in court promptly inform the relevant offender manager and other colleagues working with the offender (such as approved premises staff) of the outcome of a court appearance.

London Probation Trust accepted the recommendation and provided the following response:

'This is standard practice. Court staff routinely check to see whether or not anyone appearing in Court is currently known. They then communicate the result to the relevant Offender Manager.'

31. London Probation Trust should remind staff to check with the Public Protection Casework Section (PPCS) if they discover from another source that a recalled offender has been returned to prison.

London Probation Trust accepted the recommendation and provided the following response:

'There is a section in the recall report submitted to PPCS that asks specifically whether or not the offender being recalled is already in custody. PPCS would therefore know if a recalled offender has been returned to prison.'

Recommendation for the Public Protection Casework Section

32. The Head of the Public Protection Casework Section should ensure that staff carrying out 'unlawfully at large' checks are trained to access and correctly interpret a prisoner's complete IIS record.

NOMS accepted the recommendation and provided the following response:

'PPCS staff are trained to access and use IIS. PPCS will arrange for refresher training to be given to all casework staff. This will be completed by the end of August 2010.'

Recommendation for the National Offender Management Service

33. The National Offender Management Service should consider whether to issue guidance to prison staff in England and Wales outlining how best to explain the recall process to prisoners with mental health difficulties. They may wish to recommend that, if a prisoner is registered with an In-Reach team, a member of that team is present.

NOMS accepted the recommendation and provided the following response:

'Guidance has been issued to prison staff which explains the recall process in simple terms. PPCS will develop guidance for staff to use specifically for prisoners with mental health issues.'

34. The Director General of NOMS should review the new evidence in this report to determine whether a renewed disciplinary investigation is warranted.

NOMS accepted the recommendation and provided the following response:

'A careful review of the evidence presented in the PPO Report has been completed and as a result the Chief Executive Officer has decided that further disciplinary investigation is not warranted.'

Recommendation for Offender Health

35. To ensure continuity of care, Offender Health should instruct In-Reach teams to write under 'Health Risks' on the Risk Indicator page of the PER the intended return destination of a prisoner under their care if that prisoner is appearing at a court that will not automatically return them to the dispatching prison.

Offender Health accepted the recommendation and provided the following response:

'Improving Health Supporting Justice, the national delivery plan of health and the criminal justice programme board are working with the PCTs and Commissioners to develop a pathway model and disseminate it.'

Response from the man's family

The draft version of the report was published in May 2010. At the time of publication of the final report, my senior family liaison officer had not received any comments from the man's family.