Investigation into the circumstances surrounding the death of a man at HMP Wandsworth in October 2009

Report by the Prisons and Probation Ombudsman for England and Wales

July 2010

This is the report of the investigation into the circumstances surrounding the death of a man at HMP Wandsworth in October 2009. Staff found him hanging from the window bars in his cell and, sadly, attempts to resuscitate him were unsuccessful. He was 28 years old when he died.

I offer my sincere condolences to the man's family and partner, and all those touched by his death.

The investigation was carried out by one of the Ombudsman's investigators. I would like to thank the Governor of Wandsworth and his staff for their assistance. I am also grateful for the co-operation of the Governor of HMP Pentonville and his staff. I offer particular thanks to the investigation liaison officers at Wandsworth and Pentonville respectively.

The local Primary Care Trust commissioned a clinical reviewer to undertake a review of the clinical care the man received. I am grateful for his timely review.

In July 2009, the man was remanded into custody having been charged with a serious offence. He had never been in prison before and it is clear that he was daunted by the experience. He had a history of depression and anxiety and this, undoubtedly, made it all the harder for him to adapt to the situation.

Initially he was remanded to HMP Pentonville and, within days of arriving, tried to hang himself. As a result he was placed on suicide and self harm monitoring. However, having transferred to Wandsworth, staff thought they saw a gradual improvement in his demeanour. By mid-August, they were satisfied that he no longer posed a risk to himself.

The man was still on remand when he apparently took his own life. This is a sad story of a man who seems not to have been able to cope with the strain of life in prison and the uncertainties he faced in the future.

I make five recommendations concerning assessing prisoners' mental health and the operation of the personal officer scheme and suicide and self harm monitoring. The man was the 12th apparently self-inflicted death to occur at Wandsworth since the Ombudsman began investigating all deaths in custody in 2004. In the past, the Ombudsman has made recommendations that reviews of prisoners on suicide and self harm monitoring take place as planned. Otherwise, there are no particular similarities between the circumstances of this and other investigations at the prison.

At the draft report stage, the man's partner and parents provided detailed feedback. We are very grateful for their contribution to the investigation. Some changes have been made to reflect their comments, which have been annexed to the report. The family continue to have considerable concerns about the level of care he received while in prison and think that his death could have been prevented.

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

Jane Webb
Acting Prisons and Probation Ombudsman **July 2010**

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SUMMARY

The man was arrested and charged with a serious offence on 3 July 2009. He was held in police custody until he appeared in court three days later and was remanded into the custody of HMP Pentonville. It was his first time in prison. On his arrival, he told a nurse that he suffered with asthma and eczema and needed medication for both. He was assessed by the prison doctor who prescribed the appropriate medications. He told the nurse and doctor that he had no mental health problems and no thoughts of deliberately harming himself.

The man was placed in a shared cell on the vulnerable prisoners' unit, due to the nature of the alleged offence. During the night of 9 July, his cellmate awoke to find that the man had tried to hang himself. The following day, he was examined by a mental health nurse on the wing. He told the nurse that he felt he had let people down and admitted trying to kill himself. As a result of his actions, an officer opened an Assessment, Care in Custody and Teamwork document (ACCT - the system for monitoring and supporting prisoners at risk of suicide or self harm).

On 11 July, the man was interviewed by another officer as part of the ACCT process. He said he had suffered with depression in the past and had cut his arms some years previously. He said he was glad he had not succeeded in killing himself. The officer decided that he should be assessed by the prison's mental health team and referred him that day. (For unknown reasons, the mental health team did not receive the referral until 20 July when he had already been transferred to HMP Wandsworth. As a result, his mental health was not assessed at Pentonville.)

The man appeared in court again on 16 July, when he was remanded into custody once more. Because he appeared in court in South London, he was remanded to Wandsworth rather than returning to Pentonville. Staff at Wandsworth knew that he was on an open ACCT document and that he had tried to kill himself at Pentonville. On his arrival he saw the prison doctor who referred him to the mental health team and the prison counselling team.

On his first night at Wandsworth, the man moved to a cell on the Onslow Centre, which accommodates vulnerable prisoners. He was placed in a shared cell with a sentenced prisoner. It appears that his cellmate was a source of support and friendship during his time at the prison.

Towards the end of July, a psychiatric nurse assessed the man's mental health. He concluded that he required no further input from him or the mental health team. That same day, the man met one of the prison's counselling psychologists who assessed him as suitable for further counselling sessions. He told the counsellor that he frequently suffered with depression and anxiety and found it hard to interact with people.

Onslow Centre staff noticed that the man spent a great deal of time in his cell. They encouraged him to mix with other prisoners and become involved in activities on the centre. He told some staff that he preferred to read or watch television in his cell. However, he began attending IT classes and said he would like to work while in prison.

The man remained subject to suicide and self harm monitoring until 11 August, when staff conducting an ACCT review decided that his risk to himself had decreased sufficiently and the ACCT could be closed. It seemed that he had settled into life at the prison and staff thought his mood had improved. They noted that he was spending a little less time alone in his cell. A post-closure ACCT review should have been held a week later, but did not take place.

On 17 September, the man's cellmate became concerned about him and asked a senior officer on the centre to talk to him. The officer spent some time with him and thought that, by the end of their conversation, his mood had improved. He considered opening a second ACCT but decided that this was not necessary.

The man began counselling sessions, generally on a weekly basis. The counsellor started work to address his low self-confidence and self-esteem. She, and other staff who had contact with him on the Onslow Centre, had no concerns that he might be thinking of harming himself. In the days immediately prior to his death he received visits from his family and his criminal defence solicitor, none of whom raised any concerns with prison staff.

During the early evening of 1 October, some prisoners were unlocked from their cells to go to work around the centre. The man's cellmate was one such prisoner, but the man remained locked in their cell. At 7.40pm, the prisoners were to return to their cells for the night. Staff attempted to open the man's cell door but found it barricaded by the two single bed frames. Eventually, they managed to open the door and found him hanging from the cell window bars, with a ligature made from a bed sheet around his neck.

Staff and paramedics tried to resuscitate the man, to no avail. His death was pronounced at 8.29pm by staff from the Helicopter Emergency Medical Service.

I make five recommendations. The first is directed to the Governor and Head of Healthcare at Pentonville and concerns referring prisoners for mental health assessments. The remainder are for the attention of the Governor and Head of Healthcare at Wandsworth. They concern conducting formal mental health assessments on prisoners who make a serious attempt to harm themselves and the operation of the personal officer scheme and the ACCT process.

I conclude however, that in the weeks and days leading to the man's death, staff had no cause to suspect that he might be thinking of harming himself. I judge that his tragic actions were not foreseeable and, therefore, not preventable.

THE INVESTIGATION PROCESS

1. The Ombudsman's office was notified of the death of the man on 1 October 2009. The investigation was allocated to an investigator the following day. She visited HMP Wandsworth on 6 October to open the investigation. She met a representative of the Independent Monitoring Board (IMB) and the Prison Officers' Association and other staff and prisoners who knew the man.

2. The investigator issued notices inviting staff and prisoners to contact her with any information they felt might be relevant to the investigation. There was no response to the notices. The investigator and an Assistant Ombudsman interviewed staff and prisoners at Wandsworth between December 2009 and January 2010. Three members of Pentonville staff who had contact with the man while he was there were also interviewed in January 2010. The prisoner with whom the man shared a cell at Pentonville was contacted by telephone and provided information about events that occurred there. Additionally, the investigator made telephone contact with the man's criminal defence solicitor.

3. The local PCT commissioned a clinical reviewer to undertake a review of the clinical care the man received at Wandsworth. He also considered the care provided at Pentonville. The investigator and the clinical reviewer carried out some joint interviews with members of staff.

4. The investigator was provided with relevant documentation covering the man's time at Pentonville and Wandsworth, including his prison records, medical record and staff incident reports written after his death. Unfortunately, part of the prison file relating to his time at Pentonville is missing and searches at both Pentonville and Wandsworth have failed to locate it.

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

6. One of the Ombudsman's family liaison officers contacted the man's parents and partner to invite them to be involved in the investigation process. His parents expressed a number of concerns during telephone conversations with the family liaison officer. The investigator and another family liaison officer also visited the man's partner in March 2010. The concerns expressed by his family and partner about his time in prison have been considered during the investigation. In addition, one of the man's friends wrote to the Governor of Wandsworth following his death. His letter was passed to the investigator and, with the man's family's permission, his concerns have also been considered. His family and friend asked:

    - Whether he was given support to understand life in prison?
    - What action Pentonville staff took in response to his suicide attempt on 9 July?
    - What information was passed between Pentonville and Wandsworth?
    - What sort of assessment of his mental health was attempted and whether any treatment was offered as a result?

- Why was he sharing a cell with a long term convicted prisoner?
- What action Wandsworth staff took in response to his cellmate reporting concerns about him?
- Whether anything was done to encourage him to come out of his cell and to lessen his isolation?
- Whether the prison obstructed a planned visit by a psychiatrist?
- Whether his counsellor or any other member of staff noticed any deterioration in his mood and behaviour?
- How someone with a history of mental health problems and self harm had the opportunity to take his life?
- Whether all letters written and sent by prisoners are screened by prison staff?
- What procedures are in place to identify prisoners in distress, and whether those procedures are reviewed and updated regularly?
- How he had the opportunity to make a ligature from his bedding, given that this must have taken him some time?

I hope that my report helps to answer their questions.

HMP WANDSWORTH

7. HMP Wandsworth is the largest prison in the United Kingdom, holding up to 1,658 adult male prisoners. It is a local category B prison, accepting prisoners on remand, convicted and sentenced from courts within the catchment area. The prison is formed of five residential wings and two specialist units, one of which is the Onslow Centre. This unit holds around 360 vulnerable prisoners, most of whom are convicted sex offenders. The original prison buildings date from 1851, but since 1989, the prison has been undergoing extensive refurbishment and modernisation.

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

HM Inspectorate of Prisons

9. HM Inspectorate of Prisons conducted a full announced inspection in June 2009. The Inspectorate noted the "troubled" modern history of the prison, remarking that during the 1990s and the beginning of the present century the prison received several "highly critical" inspection reports.

10. In her introduction to the inspection report, HM Chief Inspector of Prisons commented that it

> " … could have been an inspection report that focused on continuing progress and improvement … considerable steps had been taken to change a previously resistant staff culture, increase the quality and quantity of activities, and improve prisoners' resettlement chances. "

However, the inspection revealed that following "irresponsible, pointless and potentially dangerous actions instigated at managerial level" a small number of prisoners perceived to be potentially "difficult" had been transferred from Wandsworth to another local London prison, HMP Pentonville, for the duration of the inspection. (Although the man also transferred from Pentonville to Wandsworth in July 2009, there is no suggestion that his transfer was one of those criticised by the Inspectorate.)

11. Aside from this important finding, the inspection highlighted that the suicide prevention strategy was "comprehensive" if "not user-friendly". While staff were aware of the value of the Assessment, Care in Custody and Teamwork (which I explain below), the quality of the documentation was "variable and sometimes poor", in spite of quality assurance systems.

12. On the wings, relationships between staff and prisoners were "mostly relaxed and supportive". While staff "understood their role" as personal officers, the system was not found to be functioning fully. The allocation of three personal officers to a block of cells on some wings (including the Onslow Centre) "resulted

in no one taking specific responsibility for individuals". As a result, the Inspectorate recommended that a single personal officer has the primary responsibility for named individuals. The inspection team identified that most files showed a "good number of reasonable quality entries, but these were rarely by a dedicated personal officer". There was also "minimal" personal officer engagement in sentence planning or other key processes. Prisoner perceptions of personal officers were particularly negative on the Onslow Centre and the Inspectorate recommended this be investigated and remedied.

Independent Monitoring Board

13. Prisons in England and Wales are also subject to monitoring by an IMB, made up of volunteers from the local community. Members of the IMB have access to every part of the prison and each prisoner there. They produce an annual report, the latest available for Wandsworth covers the period June 2008 to May 2009.

14. The IMB report was generally positive, noting the continued performance improvement over the previous year. Members were particularly pleased to report that staff treated prisoners "fairly and with respect" and that relationships between the two had much improved as a result.

15. Overcrowding was still a concern, as was the availability of drugs and mobile telephones in the prison. The provision of healthcare "appeared to be moving in the right direction". The IMB highlighted their concerns of a potential "systems failure" in the Onslow Centre, the scheduled rebuild or refurbishment of which has been delayed by the Ministry of Justice. The report also mentioned that the personal officer scheme still "left room for improvement".

HMP PENTONVILLE

16. HMP Pentonville is a large local prison in North London, with capacity for 1152 adult male prisoners coming from courts within the catchment area. The prison was last inspected by HMIP in an unannounced visit in May 2009. The report noted the "undoubted improvements" at the prison but again highlighted the "unnecessary and pointless" transfer of vulnerable prisoners between Pentonville and Wandsworth during both prison's inspections. The inspection found there had been a "strong focus" on safer custody procedures.

Assessment, Care in Custody and Teamwork

17. Assessment, Care in Custody and Teamwork (ACCT) is the Prison Service process for supporting and monitoring those prisoners thought to be at risk of harming themselves. An ACCT document can be opened by anyone working in the prison if they are concerned that a prisoner might have tried or, in the future, might try to harm himself. The purpose of ACCT is to determine the level of risk, the steps that might be taken to reduce risk and the extent to which staff need to monitor and supervise the prisoner. Levels of observations (when staff must check the prisoner) and interactions (when staff have a conversation with the prisoner) are flexible and should be set according to the assessed risk of harm. If staff perceive the risk of harm to be very high, the prisoner may be constantly observed, with a member of staff positioned outside their cell at all times. When the perceived risk is lower, the level of observations may be several times an hour or day.

Personal officers

18. Personal officer schemes are in place across the majority of prisons in England and Wales. Under the scheme, individual officers are allocated a small number of prisoners, often according to their cell numbers. Personal officers are expected to forge good working relationships with their prisoners. They should be the prisoner's "first port of call" if they have a question or concern and should be involved in sentence planning, the ACCT process and other important aspects of the prisoner's time in custody. Personal officers are expected to make regular written entries in the prisoner's file. In addition to their personal officers, prisoners are encouraged to seek support from all staff.

KEY EVENTS

19. On 3 July 2009, the man was arrested by the police on suspicion of attempted rape. The risk assessment carried out by a police officer in the custody suite at a police station recorded that the man's front tooth was missing and that he had cuts on his right knuckles and right elbow. (The document does not record where or how he received these injuries.) He told the police officer that he had drunk seven pints of strong beer over the course of that evening. He said he was not dependent on drugs or alcohol and was not prescribed any medication. (His blood was not tested for the presence of drugs while he was in police custody.) The police officer asked him if he had ever tried to harm himself or take his own life. He replied that he had not and that he had no such thoughts at the time. He said he had no mental health problems or depression. He was treated by a police doctor for the cuts to his hand and elbow.

20. The man appeared at the local magistrates' court on 6 July, charged with attempted rape, actual bodily harm and possession of a bladed article in a public place. Due to the seriousness of the charges, he was remanded into the custody of HMP Pentonville until 16 July when he would appear at the crown court. He arrived at Pentonville late that afternoon.

21. On his arrival, the man underwent a routine First Reception Healthscreen with a nurse. (The healthscreen is designed to identify any immediate physical or mental health problems needing referral to the doctor or other specialist service.) The man told the nurse that he suffered with asthma and eczema and had been prescribed medication for both conditions by his community doctor. The nurse recorded that the man had no mental health problems and no thoughts of harming himself. Because he needed prescription medication, she referred him to see the doctor in reception.

22. The prison doctor assessed the man following the nurse's referral and prescribed an inhaler for his asthma, an antihistamine (for hay fever, which he said he also suffered with) and white paraffin cream for his eczema. The doctor recorded that the man did not currently have any visible eczema but that he should return for further assessment if his skin condition worsened. He told the doctor that he had punched someone and, as a result, had a cut on his right fist. The doctor noted that he had been prescribed antibiotics while he was in police custody and that his hand was slightly red and swollen. He prescribed a further course of antibiotics and told him to keep an eye on the wound and return for further treatment if it did not heal. The doctor noted that he had "no other mental health issues, no thoughts of suicide or dsh [deliberate self harm]". He wrote that he made good eye contact during the appointment and demonstrated "appropriate speech and behaviour".

23. While in reception, an officer carried out the Cell Sharing Risk Assessment (CSRA). (This assesses the risk the prisoner poses to other prisoners and whether they are suitable for sharing a cell. It also provides a further opportunity to assess whether the prisoner shows any signs of being a risk to himself.) The officer recorded that the man had no previous convictions for violent offences but was currently charged with one. The man told the officer that he had never

misused alcohol or drugs. He said he had no concerns about sharing a cell and that he was not someone who got angry or frustrated easily. The officer wrote "no concerns at this time" on the form and concluded that the man posed a low risk to other prisoners. One section of the CSRA is completed by a member of healthcare staff. The nurse completing the assessment also judged him to be suitable for sharing a cell and recorded that there were no indications that he might harm himself.

24. The man was given a cell on G1 landing, the part of the prison set aside for vulnerable prisoners. (Vulnerable prisoners, also often called Rule 45 prisoners, are usually kept separate from the general prison population. They may be deemed vulnerable because of the nature of their offence, or because they are less able to cope with prison life.) Unfortunately, part of the prison file relating to his time at Pentonville is missing and so relatively little is known about his time on G1.

25. During the course of the investigation, the investigator spoke to a former Pentonville prisoner by telephone. He said that he had shared a cell with the man from 7 to 16 July. He described him as a "nice man" who was "intelligent and open". He said the man had seemed comfortable talking to him but not to other prisoners. When asked why he thought this was, he replied that the man "felt bad about what he had done". He did not think that he was someone who found it easy to talk about how he felt. While sharing the cell, the former prisoner said that he noticed scars on the man's shoulder. Neither man mentioned the scars but he said he guessed that the man had harmed himself in the past.

26. Two days after they began sharing the cell, during the night of 9 July, the man tried to harm himself. The former prisoner explained that he had seemed "normal" during the course of the day and they had eaten their tea, chatted and watched television until they went to bed at about 11.00pm. He was woken during the night by a thud and found the man on the cell floor with something tied around his neck. He said that the man had tried to hang himself but the material he had used (he was not sure what this was) had snapped. (In fact, the man later revealed to his cellmate at Wandsworth that he had attempted suicide twice that night, but had failed on both occasions.) The former prisoner offered to talk about what had just happened but the man did not want to. He told him that he should talk to a member of staff the following morning and, if he did not, he would not be prepared to share the cell with him any longer. He said that he would tell staff what had happened if the man chose not to. The man agreed to talk to staff the next day.

27. However, the following morning, the man changed his mind so the former prisoner raised his concerns with a wing officer. As a result, the officer asked a nurse to speak to him. He told the nurse he was "ok" and that he was a "loner". She asked him about the "crescent shaped, recent bruise" on his neck and he replied that it was a "scratch". The nurse told him it looked like an "attempt to harm himself". She wrote in his medical record that she "asked him directly if he had something tied around his neck". He then told her about his attempt to hang himself the previous night.

28. The nurse was interviewed as part of the investigation. She told the investigator she is a registered mental nurse (who specialises in mental health problems) and had been working at the prison for nearly ten years. Due to the passage of time, she could remember little of her meeting with the man in July. However, she recalled that initially he had been reluctant to talk about his actions, but later told her he felt ashamed and that he had let people down. The nurse passed the information about his attempted suicide to the wing officer.

29. At 5.10pm that day, the wing officer opened an ACCT document. She wrote that the man had a "ligature mark around the neck" and that "this was confirmed by his cellmate and the nurse". He told her that he was "finding it difficult" being in prison, particularly as it was his first time. The officer wrote that she had encouraged him to "interact more with others" but that he said he was a "very shy person". She noted that he spent "all his time behind his door", meaning inside his cell. She ticked the form to indicate that he had tried to harm himself and was very low in mood.

30. In interview, the wing officer explained that, although the man had only been on G1 for a few days, she had noticed him because he was very quiet. He did not come out of his cell much and she tended to keep an eye on such prisoners. The officer said she encouraged him to come out of his cell more as she thought this would help improve his mood. However, she recognised that many prisoners found their first days in prison difficult and that staff have to be patient and allow them time to settle. She and the mental health nurse, both of whom are largely based on G1, agreed to monitor him over the following days.

31. Following the man's attempt to harm himself, a form (known as an F213SH) which details the injuries received should have been completed. The wing officer said that, although she usually did fill in the form when necessary, she could not remember whether she had done so in his case. The investigator was not provided with a copy in the paperwork she received, but as some of the Pentonville file is missing, it is not possible to verify whether one was completed or not. The wing officer said she also recorded his actions in his prison file and in the wing observation book. (In most prisons, staff record important events and observations in a book, one of which is held on each wing. The wing observation book provides a useful way of communicating between staff who work different shifts.)

32. At 6.14pm, a senior officer (SO) completed the ACCT Immediate Action Plan form. She recorded that the man should remain in his shared cell and be checked once every hour. She reminded him that he could ask to speak to the Samaritans by telephone or to a Listener (a prisoner trained and supported by the Samaritans to offer a confidential listening service) at any time. The SO directed that staff check him at least once an hour throughout the night.

33. At 2.50pm on 11 July (a Saturday), another officer, trained as an ACCT assessor, carried out the ACCT assessment interview. He noted that it was the man's first time in prison and he was "feeling depressed". He was worried about the impact his actions would have on his family. He said that his partner and family were supporting him but that this was making him feel even more guilty.

The officer asked him about his attempt to harm himself two days earlier. He told him that, once his situation began to sink in, he felt "dazed, as if in a dream" and that he felt he had been in a dream when he tried to hang himself.

34. The ACCT assessor asked the man whether he had ever harmed himself in the past and he said he had, ten years previously. He explained that he had been subject to "(mild) bullying" because of a speech impediment. He said he was a "sensitive person" and showed the officer scars on his arms "from deep cuts". He said he "did not want to do it now" and that he felt "a lot better". He was looking forward to seeing his partner. He said he suffered with depression, which he described as "not severe", saying that he sometimes "just feels low". He described himself as a worrier, particularly about his eczema and medication. He told the officer that he was "glad" he had not succeeded in killing himself and did not think he would try again. However, he agreed that the ACCT document should remain open.

35. The officer told the man he would refer him to the prison mental health inreach team (MHIT), and he agreed to this. The investigator has been provided with a copy of the mental health referral form the ACCT assessor completed on 11 July. The officer details that the man had attempted suicide but that the "ligature failed". He wrote that his assessment interview had "indicated mild depression and anxieties". The officer judged that he posed a "medium" risk to himself and should be assessed by the mental health team "within one week". Had the officer wished to make an urgent referral, he could have done so by indicating that the man needed to be seen in "24/72 hours".

36. The date stamp on the referral form indicates that it was received by the mental health team on 20 July, some nine days later, and after the man had been transferred to Wandsworth. As a result, he did not undergo a mental health assessment while at Pentonville. During the course of the investigation, the investigator spoke to Pentonville's Head of Healthcare by telephone. He explained that paper referral forms should be delivered directly to the MHIT who process them twice a day. As the ACCT assessor completed the form on a Saturday, the MHIT should have processed it the following Monday, 13 July. It has not been possible to discover why his referral was apparently not dealt with until six working days later.

37. The Head of Healthcare told the investigator that he would expect staff (both healthcare and discipline) to urgently refer any prisoner who has seriously attempted to harm himself. Although the ACCT assessor had not marked the referral as urgent, the Head of Healthcare thought, given the amount of detail the officer provided, MHIT staff would have reassessed the urgency of the referral.

38. The ACCT assessor and the wing officer who opened the ACCT made entries on the second page of the ACCT document, detailing the triggers or warning signs which might change the level of risk the man posed to himself. The wing officer recorded that it was the man's first time in prison. The ACCT assessor wrote that the progress of his court case was likely to be significant for him, as was contact with his family.

39. Immediately following the ACCT assessment interview, The ACCT assessor briefed the SO on duty. The SO, the ACCT assessor and the man then met for the first ACCT case review. The SO wrote that "it was the initial shock, fear and embarrassment of coming into prison" that led the man to try to harm himself. He continued that he was "becoming used to the situation" and "most of his fears had been allayed by staff and other prisoners". The SO concluded that he was not thinking of harming himself "at present or in the future" and was trying to cope. The officers decided that ACCT monitoring should continue. The SO directed that the ACCT should be reviewed in a week but wrote that the man had been told how to seek support if he needed it in the meantime. The SO ticked to indicate that the current likelihood that he would try to harm himself again was low (the other options are raised and high). He also indicated that a routine referral to the MHIT should be made. The SO decided that the level of observation could be reduced to once every three hours. The next ACCT case review was to be held on 17 July.

40. The ACCT assessor could not remember the case review in question. However, he explained that decisions about the level of risk a prisoner posed to himself were made in the light of what the prisoner said and how he presented, as well as information contained in his file.

41. Following the case review, the officers completed the ACCT Caremap, which sets out the actions that should be taken to help reduce the risk the individual poses to himself. The ACCT assessor recorded that the man's "anxiety/depression" required referral to the MHIT (he noted that he would do this the following Monday, although the referral form is dated 11 July, the date of the review). In order to combat his fears about being in prison for the first time, the officer wrote that he had been encouraged to write to and telephone his family and partner. He was also encouraged to make use of the prison library and "other resources" to keep himself occupied.

42. The mental health nurse saw the man again on 12 July and completed the Secondary Healthscreen. (This must be carried out within one week of the prisoner's arrival and assesses their general physical health. It also provides another opportunity to assess the prisoner's mental health and whether they have any health related concerns.) The nurse recorded that he was on an ACCT but that he was "feeling a bit better" particularly as his partner was due to visit him the following day. She wrote that his mood was "depressed" and that he had put the ligature around his neck because he was "feeling a sense of dread about [his] situation and guilt for letting people down". He told her that he no longer had any desire to harm himself. In interview, the nurse said that she felt less concerned about him because his mood seemed brighter; he was "cheerful" and really looking forward to his partner's visit.

43. The man was examined by a second prison doctor on 14 July, complaining of eczema on his elbows. The doctor prescribed a different cream to that prescribed on 6 July.

44. On 16 July, the man appeared at the crown court. The investigator spoke to his criminal defence solicitor who explained that, due to workload pressures, the

magistrates' court the man had first appeared at was, at the time, committing cases to a crown court in south London, rather than any of the crown courts in north London. The Person Escort Record (PER) that accompanied him noted that he was on an open ACCT, might be violent and had been charged with a sexual offence. (The PER assesses the risks an escorted person might pose, for example physical and mental health problems, offence history and risk of suicide or self harm. It also serves as a record of the person's time under escort.) Escort staff who supervised him while at court recorded that there were no concerns about him during the day. He appeared in court at 2.00pm and the case was adjourned. He was remanded back into custody but, as the crown court is in south London, he was to be taken to Wandsworth rather than return to Pentonville.

45. The man arrived at Wandsworth at 5.40pm. On his arrival, a reception officer and nurse completed a second CSRA. The officer noted that the man was on an open ACCT and that it was his first time in prison. She assessed him as posing a low risk to other prisoners. The nurse recorded that he should see the doctor (presumably because he was on an open ACCT, although this is not made clear). She noted that there were concerns that he might harm himself. As a result of her assessment, she judged him to pose a medium risk to other prisoners.

46. While still in reception, the man was assessed by a prison doctor. She recorded that he was on an open ACCT "after an attempted hanging at Pentonville", continuing that he was "glad it did not work but this feeling does vary". He told the doctor he was "reflecting a lot … on his crime". He said he felt very well supported by his partner and that he had no thoughts of harming himself. She noted that he made "reasonable" eye contact and expressed himself well during the appointment. He thought he would be able to sleep that night, as he had had a "tiring, stressful" day in court. The doctor recorded that he should be referred to the MHIT and for counselling, and that he was happy for this to happen. She completed the referral form on 21 July, noting that she was referring him because of his risk of suicide and self harm. She recorded that he was keen to attend counselling.

47. At 8.20pm, an SO conducted an ACCT case review with the man on E wing, the First Night in Custody Centre. The SO recorded that his risk to himself was currently low and made no change to the level of observation (once every three hours). He wrote that he was "relaxed and happy being here at Wandsworth". The man asked the SO if he could move to the Onslow Centre (for vulnerable and Rule 45 status prisoners). The SO "explained the routine" and noted that the man was "happy with what he hears". He told the SO that he had no thoughts of harming himself and mentioned his "strong ties" with his partner and family.

48. That night, the man was taken to the Onslow Centre. He was allocated cell G4.06, sharing with a prisoner. One of the Onslow Centre managers (another SO who also carried out the ACCT case review on 28 July), was interviewed as part of the investigation and was asked how decisions about cell allocation are made. He explained that the first part of the process is the CSRA, which indicates whether the prisoner is suitable to share a cell. If the prisoner is

deemed suitable for sharing, the movements officer (who is responsible for recording the available cell spaces and making sure they are put to best use) will identify the most appropriate cell.

49. The SO was asked whether any consideration was given to the character, offences or sentencing status of the prisoners being placed in together in a cell. The cellmate had been convicted and given a long sentence, and had been in prison for some time before sharing with the man. The SO explained that it can be helpful for newly arrived prisoners, with little or no prison experience, to share with someone who can help them understand the regime and reassure them during their first weeks in the prison. He said that the cellmate was considered to be a "solid, humble" young man, and staff thought that the man would benefit from sharing with him. By all accounts, the man and the cellmate got on well. Staff described him as finding it hard to mix with prisoners on the unit, but said he spent a great deal of time with his cellmate.

50. First thing the following day, 17 July, the man met the induction orderlies (prisoners who are trained to provide information to new prisoners) and received further information about life at Wandsworth. At 3.30pm, another of the Onslow Centre managers and the man met for another ACCT case review. This SO wrote that the man was "still a little nervous" about being in prison, although he said he was "happier to be at Wandsworth than Pentonville". The SO explained that he could seek support from Listeners or staff, or ask to use the Samaritans telephone if he needed to. The man told the SO that he had spoken with his family who knew he had been transferred. He said he would like to work while in the prison. The level of risk he posed to himself was considered to be low. The SO reduced the level of ACCT observations, directing that staff ensure they had "three quality interactions" each day. ("Quality interactions" generally means that staff should have a full conversation with the prisoner in order to assess their frame of mind and address any concerns they might have. In fact, night staff appear to have checked him hourly each night in any case.)

51. An officer completed the Local Initial Screening and Reducing Reoffending Tool with the man on 18 July. (This is completed with all new prisoners and gathers information about their likely needs in prison.) He said he had no accommodation concerns, was in full time employment before coming to prison and that his job was available to him on release. He said he was interested in further education. The officer recorded that the man did not use drugs and drank alcohol only moderately. He reported no history of mental health problems, but said he was taking medication for asthma and eczema. He asked to see the dentist while at Wandsworth but said he had no other health concerns. The officer recorded that he was on an open ACCT and had recently thought of harming himself. She noted that he was not interested in attending any offending behaviour programmes because he was "not guilty".

52. At 5.00pm that day, an officer working on the Onslow Centre made an entry in the ACCT on-going record (where staff record their conversations with and observations of the prisoner). She noted that "the man's cellmate told me that the man has said that if he gets the chance he is going to kill himself".

53. The man's cellmate was interviewed as part of the investigation. He confirmed that he and the man had got on well as cellmates. He described him as quiet and easy going, but clearly very anxious about being in prison and said he "worried too much". The cellmate said that the man tended to stay in their cell reading. The investigator asked him about his conversation with the officer who had made the entry in the on-going record. He said that the man had not specifically told him he planned to kill himself, but "that was what he meant".

54. The officer who made the entry in the on-going record was also interviewed. She explained that she generally works on the 4s landing (where the man and his cellmate's cell was) of the Onslow Centre which means that she tends to get to know the prisoners there a little better. She said that she tries to get to know the quieter prisoners and encourages them to come out of their cells. She knew the man arrived at Wandsworth on an open ACCT and that staff were, therefore, keeping an eye on him. The officer said that when the cellmate told her of his concerns, she wrote in the man's ACCT, knowing that more senior staff, who carry out regular ACCT management checks, would read it. The investigator asked her if she had discussed the cellmate's fears with any other staff. Although she thought it likely that she would have, she could not remember if, in fact, she had done so. Neither could she recall whether she also recorded the comment in the wing observation book. (Unfortunately, the wing observation book for the Onslow Centre on that date could not be located for this investigation.) She did not note the concerns in his prison file.

55. In interview, the officer said that she had spoken to the man that day (although she acknowledged that this might have been prior to her conversation with his cellmate). He told her he was "fine" and she had no concerns about him. The officer said she spoke to him regularly on following days, but never had any cause to be concerned about him.

56. Another prison doctor wrote an entry in the man's medical record on 21 July. He had discussed his case with the primary care mental health nurse and said that "it was agreed that [the patient] needs to be screened by primary care".

57. On 28 July, the man attended an ACCT review with an SO and a member of the chaplaincy team. In interview, the SO explained that, at Wandsworth, staff try to ensure that ACCT case reviews are attended by staff from a variety of departments. To assist this, generally, case reviews on the Onslow Centre are held on a set day of the week. The review panel normally includes a member of the Crisis counselling service (a team of psychologists who provide a counselling service to prisoners), one of the chaplaincy team, a member of staff from the mental health team and representatives from other specialist services, where appropriate. If staff are unable to attend the review in person, they are invited to contribute by email or telephone.

58. During the review, the SO recorded that the man's risk to himself remained low. The man said he had noticed a "slight improvement" with his anxiety and was keeping himself busy by reading. The SO noted that he was "a bit tearful" during the review when he talked about being in prison. The man said that he had tried to harm himself once before when he was 16 years old. Again, he denied any

current thoughts of harming himself "although he still needs support". The ACCT remained open, with the same level of interactions. The investigator asked the SO whether he remembered reading the officer's entry in the on-going record on 18 July. He said that, although it was good practice for case managers to read the on-going Record before conducting an ACCT review, he did not always have time to do so. He could not remember whether he had read the officer's entry or asked the man about it during the review.

59. A psychiatric nurse also saw the man on the morning of 28 July. In interview, the nurse explained that he acts as a "gatekeeper" to the MHIT and psychology department. Any member of staff can refer a prisoner to him and he will conduct an informal assessment before deciding the most appropriate course of action or treatment. The main focus of his work is with prisoners suffering anxiety, depression and "mild mental health problems", while the MHIT largely work with prisoners diagnosed with severe and enduring mental health problems. Due to the large number of prisoners falling within his remit, he can make referrals to the Crisis counselling service, psychology department or the MHIT as appropriate.

60. The psychiatric nurse explained the assessment process. He visits prisoners on the wings and talks to them about, for example, whether they have any history of mental health problems and whether they have been prescribed medication in the past or seen a psychiatrist. As part of his assessment, he considers how the prisoner presents himself and whether he is able to hold a conversation or make eye contact. He emphasised the informal nature of the assessment, saying that he does not follow a set assessment framework.

61. In interview, the psychiatric nurse said he could not remember assessing the man. However, he recorded the assessment in the man's medical record, noting that he was "coping fairly ok" but was to remain on an ACCT. The man told the nurse that his trial was due to start in October. He reiterated that he had a supportive partner, who was able to visit him in prison. He was due to see a trainee counselling psychologist from the Crisis counselling service later that day. The nurse explained the various support systems available to the man, who said that he found his cellmate supportive. He said he was managing to sleep and would seek help if he needed it. The nurse could not recall having any particular concerns about him and thought he would have recorded them in the medical record if he had.

62. In the afternoon, following the reception doctor's referral a week earlier, the man had an appointment with the trainee counselling psychologist to assess whether he was suitable for Crisis counselling. At the draft report stage, the Crisis counselling team explained that all prisoners should undergo an assessment interview within one week of referral.

63. The psychologist was interviewed as part of the investigation. She explained that Crisis counselling is offered by a team of counselling psychologists and focuses on providing short term counselling to help prisoners cope in prison. The service offered by Crisis counsellors is separate from that offered by the psychology department (who deliver some of the offence related programmes) and the MHIT (who provide medical interventions, such as anti-depressant

medication). She said, however, that the three teams work closely with each other, as well as with the general healthcare staff, normally by making entries on the prisoner's electronic medical record. She explained that prisoners who have Crisis counselling might also be on the inreach team's caseload or the forensic psychologists, or both, as appropriate.

64. In order to assess whether the prisoner is suitable for Crisis counselling, the psychologist or her colleague spend about half an hour with them. She explained that the service prioritises prisoners who feel suicidal, have harmed themselves or are not coping well. Generally, she said, unless the prisoner did not want counselling, or it was felt that they would not be able to engage with a counsellor, all referrals are accepted. She told the investigator that the counselling sessions are confidential. However, all prisoners are warned that information relating to risk of harm (either to themselves or someone else) will be shared with other staff.

65. In their first meeting, the man told the psychologist that he had been feeling low and had a history of depression and harming himself. He described his depression as "coming in waves". However, he said he was not currently thinking of harming himself. She noted that he would plead not guilty to the offence he was charged with. She wrote that he was concerned about his speech impediment (although, in her view, it was difficult to notice) and generally kept to himself, although he got on well with his cellmate. She noted that he was "isolating himself from other prisoners and staff" and that he described himself as "always [finding] it hard to interact with people". She recorded that he "appeared very anxious" throughout the assessment. He said he had not had counselling before but "appeared motivated to give it a try". She concluded that he would benefit from counselling to "develop his coping skills in prison and to address his low mood … and social anxiety". He was placed on the waiting list (which, at the time, meant that prisoners should be seen within two months of assessment) and she noted this on the ACCT Caremap.

66. When the man arrived on the Onslow Centre, he was allocated three personal officers. On 30 July, one of those officers made an entry in the man's file noting that he was "quiet …keeping himself to himself … no current issues". This was the only entry this officer made.

67. On 4 August at 10.45am, the SO who chaired the ACCT review on 28 July chaired another ACCT case review. The man was present along with another SO, the psychologist, the chaplain and a member from the MHIT. The group concluded that his risk to himself remained low as he said he was feeling "slightly better". He said, however, that he found the thought of going to court "daunting". (The progress of his court case had been marked as a possible trigger when the ACCT was opened by Officer A at Pentonville.) The SO chairing the review noted that the man had been offered the chance to discuss his offence in confidence with Crisis counselling. He told the review that he was still not confident about mixing with others, which he "put down to shyness". He told them he was not going out on exercise but had started to attend IT classes. In interview, the SO said his impression was that his mood remained much the

same as at the previous ACCT case review a week earlier. It was decided that the ACCT should remain open.

68. That evening, another Onslow Centre officer recorded in the on-going record that he had spoken "at length" with the man about "his current feelings". The officer wrote that he "advised him of the value of Listeners and [the Samaritans] phone and also their availability". The man told the officer he felt "fine" at the moment and was "enjoying having the time to read". In interview, the officer said that, on checking him as he sat in his cell, he thought he did not seem his normal self and so went into the cell to talk to him. He told the officer that he was not sure what kind of sentence he would get if he was found guilty and that he was missing his family. However, the officer was not unduly worried and had no concerns that he might try to harm himself.

69. The officer explained that he is generally based on the 4s landing of the Onslow Centre, and so is able to get to know prisoners with cells there a little better. He said he had "quite a lot" of contact with the man, who he described as "very, very quiet", hardly leaving his cell. The officer agreed that such prisoners raise concerns for staff and that he tends to work harder to get to know them as a result. The officer tried to persuade him to come out of his cell more and mix with others on the unit. However, he would tell him that he preferred to read or watch television in his cell. The officer described him as seeming quite "cheerful" about this and said that some prisoners prefer not to mix on the wing. He knew that it was his first time in prison and that he was nervous, but also that he was being supported by his cellmate.

70. The man's mother and partner visited him on 8 August. An entry in the ACCT ongoing record notes that, as a result, he was in "good spirits". Two days later, he had an appointment with the doctor to assess his eczema. The medical record notes that he had a "dry rash" over his body, but there was no sign of infection. He was prescribed cream to apply as necessary, which he kept in his cell.

71. At 9.15am on 11 August, the man attended another ACCT case review. This time, the review was chaired by a different SO, with another Onslow Centre officer and a member of staff from the interventions team present. Unfortunately, despite investigations, the third attendee was only identified as the draft report was being issued and so has not been interviewed. Once more, the man was assessed as posing a low risk to himself. He told the staff that he was happy on the Onslow Centre and was settling in well. He said he was not as anxious and worried as he had been. The SO chairing the review noted that he was waiting for a response from the Activities department about work and that he would pursue this. The SO described him as "calm and relaxed" during the review. He said he wanted to come off the ACCT and that he would approach staff if he needed any help or advice. All present agreed that the ACCT should be closed.

72. The SO chairing the review had not been involved in the man's ACCT previously, but knew why the ACCT had been opened and why staff were concerned about him. He explained in interview that, when conducting a case review, he generally starts from the beginning of the document checking the progress made

and any continuing areas of concern. He also checks the wing observation book and the prisoner's file for further information.

73. The SO explained that, over time, staff had seen an improvement in the man's frame of mind and demeanour. As an example, they noticed he had begun taking more care of his appearance and shaved regularly. (The man's partner explained however that, on arriving at Wandsworth, he had spoken to prisoners who offered haircuts to other prisoners and was told that he would have to pay them with cigarettes. She said that, because of his anxiety and inability to ask for help, he had not pursued this. Eventually, he bought hair clippers from the prison shop and was then able to shave his own head.) Staff thought he seemed much more cheerful in his interactions with them. They also noticed he was coming out of his cell more and appeared to be more relaxed. (A number of staff interviewed during the investigation noted this apparent change in him and felt reassured that he had settled into life at the prison.)

74. Although the man had told the staff that he would like the ACCT closed, the SO chairing the review explained that it would only be closed if all the staff present agreed. The SO said that he, the officer and the third member of staff agreed that the ACCT could be closed. The man was told, however, that staff would continue to monitor him.

75. The officer who attended the review was also interviewed during the investigation. He is normally based on the 4s landing on the Onslow Centre. The officer explained that he had checked the man every day when he first arrived at Wandsworth. He described him as looking "dishevelled" at first, which he said could sometimes be an indication that the prisoner was more vulnerable. The officer agreed that the man preferred to stay in his cell but said that was not uncommon on the unit. However, he thought that he had preferred not to mix with other prisoners due to anxiety. The officer tried to engage him in conversation and encourage him to get involved with activities on the wing because he wanted to "see him progress".

76. The officer was asked about the decision to close the ACCT and explained:

> " … it was during, I'd say, the last ten days or so that he had started to come out of his shell a bit and he was taking care of himself. He'd had a shave, he was going for showers regularly and I saw him out and about, not really talking to anyone but out and about, and I thought OK I think we're getting somewhere now, the ball's rolling. And he was quite communicative in the actual review itself and gave no indication of any real major concern that he needed to be on this. It was almost, I mean I've been to loads of ACCT reviews before and it went along the same lines as most of the ACCTs that we've closed previously. He gave me no reason to think there was any difference with this one. I thought he'd turned a corner and was sort of settling into prison life … "

77. The SO chairing the review wrote on the ACCT document that it had been closed and that a post-closure review should be held on 17 August. (The post-closure review allows staff to reassess whether the ACCT should remain closed, and to

check whether there are any further concerns about the prisoner's state of mind or risk to himself.) It appears that no post-closure review of the man's ACCT document took place.

78. The man attended his first Crisis counselling session on 20 August (three weeks after his assessment interview). He and the psychologist talked about his family background, his history of low self-esteem and harming himself. By this point, she thought his mood had "picked up" and was "quite different" to how he seemed during the assessment. His second counselling session took place seven days later. Again, they discussed his low self-esteem and lack of confidence. He described himself as "quiet" and "odd". He explained that he tended to avoid social situations and said that, on the wing, he found it hard to get staff attention. He told her that he found it particularly difficult to interact with people in authority. In interview, she explained that she was working on this with him during their sessions. She thought his anxiety would not have stopped him seeking staff assistance if he had really needed it.

79. On 26 August, the man was assessed as suitable to work as a wing cleaner. He was placed on a waiting list until a vacancy arose (which had not happened before his death). At the draft report stage, staff confirmed that the only application for work received from him was for the cleaning role.

80. Another of the man's personal officers wrote in the man's prison file on 2 September, noting that he was a "quiet" prisoner who kept to himself but said he had no problems. He told the officer that he got on well with his fellow prisoners and had "no concerns at present". This was the last entry made in his prison file. The third personal officer made no entries.

81. The personal officer who made the entry on 2 September was interviewed as part of the investigation. He explained that he was the personal officer to about 20 prisoners who he tried to talk to every time he was on duty. The officer was not aware that the man had tried to kill himself while at Pentonville, but did know he was on an ACCT for some time. He told the investigator that he had no concerns that he might try to harm himself.

82. The third Crisis counselling session took place on 3 September. The man talked more about his feelings of failure and of being "odd". He said he had had a "mixed week with some ups and downs". He was "feeling anxious" about his court appearance the following week but was not sure whether it would go ahead. (His court appearance scheduled for 8 September was adjourned until 6 October.) The psychologist wrote that he had applied for bail and was waiting to hear the outcome.

83. The psychologist and the man met for the fourth time on 10 September. He told her that his court case had been adjourned and that he was pleased as he had been feeling anxious about it. He said he now felt more comfortable being in prison.

84. Around 16 September, there was an outbreak of salmonella in the prison. As a result, all visits to prisoners were cancelled. The man's criminal defence solicitor

had arranged for a psychiatrist to visit and assess the man's mental health. This visit, and other visits by the solicitor and the man's family, did not take place.

85. On 17 September, the man's cellmate approached the SO who chaired the ACCT review on 28 July, telling him that the man was "feeling down and was tearful". In interview, the SO said he went to speak to him "there and then". The SO recorded his conversation with him in a statement he made following his death. He wrote that the man had seemed "withdrawn and thoughtful", so the SO sat down with him and asked how he was feeling. In interview, he remembered that the man had also been tearful.

86. The man said he was "fine but wanted to keep himself to himself". The SO told the investigator that the man was "not forthcoming" despite his attempts to encourage conversation. After a while, he stopped crying and seemed to "brighten up" a little. The SO explained he had

> " … got him to promise me that if he needed help and he was in a really bad way, that he couldn't be on his own or wanted something done, to come and find me out. I told him where my office was."

87. The SO did not record his conversation with the man in either the wing observation book or his prison file. In interview, he explained that prisoners were quite often tearful and subdued, so his demeanour was not out of the ordinary. In hindsight, he said there were steps he could have taken following their conversation. He knew the ACCT had been closed, that his mood seemed to have improved and that staff had no particular concerns about him. The SO was asked whether he thought of re-opening an ACCT following their conversation. He said he had considered it but, at the time, did not feel it necessary. The following day, the cellmate thanked him for speaking to the man and reported that he seemed to be "in better spirits".

88. The man had his fifth counselling session on 28 September. The psychologist told the investigator that there was a two week gap between the fourth and fifth sessions due to the outbreak of salmonella and external training she had to attend. They discussed his upcoming court appearance on 6 October. He told the counsellor that his partner had not been able to visit due to the outbreak and that this had made him depressed.

89. They went on to talk about his meeting with his criminal defence solicitors on 25 September. The man's usual solicitor was on leave and a colleague visited in his place. During that visit, the solicitor had discussed the victim impact report (a statement by the victim, detailing how they have been affected by the alleged offence) with the man. He reiterated his concerns to the psychologist that people, including his solicitor, thought him "odd" and "a failure" because he had done something "bad". She encouraged him to recognise that other people, including his partner, family and friends thought he was "okay". She recorded in her notes of the meeting that he had torn up the "thought record" she had encouraged him to complete previously, because he had been feeling angry.

90. In interview, the psychologist said she had never had concerns that the man might harm himself. Although he told her he had torn up the thought record, she did not think that this marked a significant change in his demeanour. She was clear that, had she had any concerns about him, she would not have hesitated to open an ACCT document and speak to staff on the Onslow Centre.

91. The man's solicitor visited him on 29 September. During the meeting, he told him that he had arranged for him to undergo a psychiatric assessment at court on 2 October. The solicitor, who spoke to the investigator by telephone, said that the man had become increasingly anxious as his trial approached (it was listed to begin on 21 October). He knew that if he was found guilty, he might receive a lengthy prison sentence. The solicitor said he had never had concerns that the man might harm himself whilst in prison, although there were concerns about his mental health. He did not know that he had attempted suicide at Pentonville and, when told by the investigator, was shocked, both by the man's actions and that he had not been told. He said that, had he known, he would have dealt with his case differently.

1 October

92. By all accounts, 1 October was an unremarkable day on the Onslow Centre. No staff interviewed recalled having any particular contact with the man and certainly none remembered being concerned about him. The cellmate did not see him much during the day as he left in the morning to undertake cleaning duties. He returned to their cell at about 4.15pm, but then had a visit that ended at about 5.30pm. The man was in the cell leafing through a book. His cellmate asked him if he was alright, at which point he began to cry. He told him he was upset about his court case and said he had to see a psychiatrist at court the following day. The cellmate told the investigator that the man had not wanted to talk about what was upsetting him and so he had not pursued it. (After his death, the cellmate told a governor that, over the previous two weeks, the man had been "bothered" by his case and had seemed "suicidal". In interview, the cellmate did not mention raising any further concerns about him after 17 September.)

93. At 6.30pm, certain prisoners, including the man's cellmate, were unlocked to work around the unit. The man was not one of the prisoners unlocked and so he remained in his cell. At 7.40pm, staff called for the prisoners to return to their cells to be locked in for the night.

94. An Onslow Centre officer was responsible for locking up the prisoners on G4 landing. He and the man's cellmate walked to cell G4-06 and, on arriving, the officer unlocked and tried to open the cell door. It would only open "very slightly", even when the officer used force. Through the crack in the door, he saw that one of the bed frames was blocking the door. He looked through the observation panel but could see "very little". The officer called to the man to move the bed but got no response. For a short time, he continued to try to open the door by pushing against it, to no avail.

95. At this point, the officer called for assistance from colleagues. Another officer, who was locking up prisoners on the landing below, came to help. He also tried

to open the door, calling to the man at the same time. The cell light was off and the curtains were drawn, so the cell was dark. By this time, two more officers and an SO on duty had arrived to help. The officers realised that the two single beds in the cell had been used to barricade the door. The SO called for the on duty principal officer (PO) (who had the role of Orderly Officer and was in charge of the prison at the time). The PO arrived and decided to use a "door enforcer" to try to force the door open. However, before this could happen, one of the officers managed to move the beds enough to open the door.

96. The officer who opened the door and the PO went into the cell and saw that the decency curtain (which allows prisoners some privacy when using the toilet at the back of the cell and is almost floor to ceiling length) was pulled across. The officer found the man behind the curtain, hanging from the cell window bars with a ligature made from a bed sheet tied around his neck.

97. The PO directed the officer to use his anti-ligature knife (which is specially designed to safely cut ligatures from around a person's neck) to cut the ligature. The two officers laid the man on the floor and the officer began cardio-pulmonary resuscitation (CPR). As there was blood coming from his mouth, the officers used chest compressions only. The PO asked another member of staff to fetch a hard plastic mouth shield (used to deliver mouth to mouth resuscitation) from the wing office. Both the PO and the officer had recently received refresher first aid training (in fact, the PO is a trained first aid instructor) and felt confident about beginning CPR.

98. At 7.51pm (the approximate time when the officers managed to open the man's cell door), the PO used his radio to alert the prison to a 'code 1' medical emergency and ask that the on-duty emergency response member of healthcare staff attend. (A 'code 1' call indicates that a prisoner has been found hanging. The use of the code system allows medical staff to bring the right equipment to the incident.) The control room requested an ambulance at 7.55pm.

99. One of the nurses on duty, who was delivering medication to prisoners on the Onslow Centre, arrived quickly with emergency medical equipment and joined in the efforts to resuscitate the man. While the nurse maintained a clear airway, one officer used an ambu bag (a hand held device which pumps oxygen to the patient) to deliver breaths while the other delivered chest compressions. Shortly afterwards, another nurse (the on-duty emergency response nurse), who was delivering medication on the main prison wings, also arrived. She went to the Onslow Centre treatment room and collected oxygen and a defibrillator (a machine that reads whether there is any electrical output from the heart and can deliver an electric shock to help restart the heart in certain circumstances). The defibrillator found no shockable rhythm and instructed staff to continue with CPR.

100. The first paramedic arrived at the prison at 8.01pm. At this point, the PO also asked for the doctor based in reception to attend. The paramedic reached the man's cell and asked staff to continue resuscitation attempts while he assessed his condition. As the doctor had not yet arrived, a second radio call was made at 8.10pm. The doctor reached the cell at 8.12pm.

101. The Helicopter Emergency Medical Service (HEMS, the air ambulance) arrived at the prison at 8.19pm. The paramedics, including an emergency response doctor, took over care of the man and the PO and the officer left the cell. The paramedics administered drugs to try to revive him and the incident log indicates that medical staff managed to restore his heartbeat for a very short time (probably as a result of the drugs they gave him). However, at 8.29pm, the HEMS doctor pronounced that he had died.

Contact with the man's family

102. A governor and a member of the chaplaincy team were allocated as family liaison officers. They broke the news of the man's death to his nominated next of kin, his partner, that night.

103. The prison made an offer of financial support to assist with the cost of the man's funeral. His family were offered, and accepted, the opportunity to visit Wandsworth, see his cell and meet his cellmate.

Support for prisoners

104. In interview, the SO who was present when the man was found explained that, as staff and paramedics worked to resuscitate the man, he instructed other staff to return all prisoners who had been unlocked for cleaning duties to their cells. Prisoners who knew what had happened and were upset were offered the services of Listeners and the Samaritans' telephone.

105. The cellmate said that, on finding their cell door barricaded, he knew that the man had made another attempt on his life. He was initially taken to the Listener suite (a room designed for use by Listeners and prisoners using their services, which is usually equipped with comfortable seats) and was supported by two fellow prisoners. He said he was upset and shocked by the man's actions. Later, having been interviewed by the police, he was moved to share a cell with a prisoner who he did not know. Following the man's death, he was placed on an ACCT. He told the investigator that he had been very well supported by wing staff, who checked him regularly over the coming weeks.

106. Prisoners across Wandsworth were informed of the man's death by way of a notice from the Governor. A memorial service was arranged.

Support for staff

107. The SO present when the man was found led a 'hot debrief' shortly after the man's death. (A hot debrief is when staff involved in an incident are brought together to talk about what happened and how they feel. It is a requirement of Prison Service Order 2710 Follow up to deaths in custody.)

108. All staff interviewed as part of this investigation said they had been well supported by their colleagues and senior managers in the aftermath of the man's death. This included those staff who had contact with him during his time at the

prison but were not present on 1 October. The prison Care Team contacted staff who responded to the emergency.

ISSUES

Clinical care

109. Wandsworth PCT commissioned a clinical reviewer to review the clinical care the man received in prison. His review highlighted that, following his suicide attempt at Pentonville on 9 July, he was referred to the MHIT. The ACCT assessor completed the referral form on 11 July but it was not processed by the team until 20 July, by which time he had been transferred to Wandsworth. The Head of Healthcare explained that referrals to the MHIT are currently made via a paper referral form, which must be placed in a box for processing by the team, who do so twice a day. It has not been possible to establish why it took six working days for the man's referral to be processed.

110. The Head of Healthcare told the investigator that he was considering introducing an electronic referral in addition to the paper form, to safeguard against referrals going missing or being overlooked. I wholly support any changes which would make the current system more robust, and, given that steps are being taken to address the problem, make no formal recommendation in my report.

111. When completing the referral form, the ACCT assessor indicated that the man should be assessed by the MHIT within one week of referral (the other options being within 24/72 hours, or more than one week). The Head of Healthcare indicated that he expected all staff, whether discipline or healthcare, to make an urgent referral where a prisoner has made a serious attempt to harm himself.

The Governor and head of healthcare at HMP Pentonville should remind all staff that, when a prisoner makes a serious attempt to harm himself, an urgent referral to the MHIT should be made.

112. When the man transferred to Wandsworth, the open ACCT document accompanied him. On his arrival, staff were aware that he had attempted suicide the previous week. The doctor who examined him in reception referred him to Wandsworth's MHIT for assessment. On 28 July, the psychiatric nurse conducted an informal mental health assessment with him, to consider whether he needed further input from the MHIT or other specialist services. The clinical reviewer concludes that, given the man had attempted suicide, it would have been appropriate to carry out a formal mental health assessment, following a recognised framework.

The head of healthcare should ensure that all prisoners who make a serious attempt to self harm undergo a formal mental health assessment as a matter of urgency.

Missing documentation

113. It is disappointing that two important pieces of documentation (the man's Pentonville prison file and the wing observation book for the Onslow Centre covering his early weeks on the centre) could not be located during the course of

the investigation. Neither was found despite searches at both prisons. We share the family's concern that important documentation was able to go missing.

The personal officer scheme

114. On being allocated cell G4.06 on the Onslow Centre, the man was given three personal officers. Wandsworth has a local personal officer scheme policy dated March 2009. According to the policy, personal officers are expected to have a "formal" conversation with their prisoners at least once a week, and to record this in the prisoner's file. The policy directs that particular reference be made to the prisoner's "… attitude and behaviour … willingness to help or mix with other prisoners … any current concerns either in prison or in the community". Informal conversations should take place "whenever on duty". If a prisoner is on an ACCT, his personal officers are expected to speak to him "**every day** that [they] are on duty, recording this in the ACCT document" (the text is in bold in the policy). Personal officers also "must attend or make a contribution to [the prisoner's] ACCT case reviews".

115. The man remained in the same cell from the day he arrived at Wandsworth, 16 July, until his death. However, his file contains just two personal officer entries (by two of the three officers). One of the personal officers made three entries in the man's ACCT and the other two officers made none. None of the three officers attended or made a recorded contribution to any of his ACCT case reviews.

116. My investigation also highlights that senior and principal officers responsible for G4 landing on the Onslow Centre were not fulfilling the requirements of the local policy. The policy instructs that senior officers "will check and sign all wing files monthly to ensure that personal officers are completing their weekly wing history file checks … ". Principal officers are also expected to carry out monthly "quality checks" and sign accordingly. The lack of entries in the man's file was highlighted to the SO who carried out the ACCT review on 28 July, the senior officer responsible for G4 and the failings were also raised with the Deputy Governor and governing Governor following staff interviews.

117. In the most recent inspection by HMCIP, the personal officer scheme at Wandsworth, and particularly the allocation of three personal officers to each prisoner on the Onslow Centre, was criticised and recommendations made. When the draft version of this report was issued, no changes had yet been made to the scheme in the light of HMCIP's criticism. Given that this investigation has also identified major failings, I urge the Governor to give proper consideration to the effectiveness of the existing scheme.

The Governor should remind all staff of the local personal officer scheme and satisfy himself that it is operating effectively across the prison.

Assessing and managing the man's risk to himself

118. An ACCT document was opened by staff at Pentonville on 11 July following the man's admission that he had tried to hang himself. Staff at both Pentonville and Wandsworth described him as a quiet and anxious man, who preferred to stay in his cell and only seemed comfortable socialising with his cellmate. I am pleased to find that, despite deficiencies with the personal officer scheme at Wandsworth, other staff on the Onslow Centre took time to try to get to know him. Several mentioned encouraging him to come out of his cell and get involved in activities on the centre. They explained, however, that it is not unusual for prisoners to prefer spending time in their cells, particularly when it is their first experience of prison.

119. Staff knew that the man got on well with his cellmate, and received much support from him. He was attending IT classes and his application to work was being processed at the time of his death. The Crisis counsellor was working with him to combat his low self-confidence and self-esteem. In time, this work might have helped him feel more confident about mixing with other prisoners on the Onslow Centre. Having considered the above, I do not think staff could reasonably have done more to lessen his isolation.

120. On 11 August, staff present at the ACCT review agreed that the risk the man posed to himself was sufficiently reduced to close the ACCT. Staff interviewed for this investigation agreed that, in the weeks prior to the ACCT being closed, his mood appeared to have improved. He seemed more cheerful, appeared to be mixing more readily with other prisoners and was taking better care of himself. The goals on his Caremap had been or were continuing to be addressed. I am satisfied, therefore, that the decision to close the ACCT was reasonable.

121. The man's partner expressed concern about the way his ACCT document was closed. The man said that, during the final case review, a member of staff told him that, if he attempted to kill himself or seriously hurt himself again, it would cause them "hassle and paperwork". She said he felt that staff did not really care about him, or about keeping him safe. She thought he would have told staff he was coping, although he was not, because he did not want another ACCT to be opened. Evidently, staff must make decisions based on the information available to them, much of which will come from the prisoner himself. As noted above, I find the decision to close the ACCT was appropriate based on the information available.

122. However, mandatory guidance contained in Prison Service Order 2700 on Suicide prevention and self harm management, instructs that a post-closure review be held after the ACCT has been closed, and that unit managers ensure one takes place. The SO chairing the review on 11 August noted on the ACCT document that the post-closure review would take place on 18 August. No post-closure review was held with the man. It appears there is no robust system for logging post-closure review dates and ensuring that they take place. It is disappointing to note that the Ombudsman made a similar recommendation about this in 2007.

The Governor should strengthen the system for logging post-closure review dates and checking that they take place.

123. Consideration of the man's ACCT document also highlighted that senior officers and duty governors did not act in accordance with Wandsworth's local suicide prevention policy (dated September 2009 and updated annually). The policy directs that senior officers must check ACCT documents every day and record a comment. There are two clear senior officer management check entries in the ongoing record. The management quality assurance sheet, at the front of his file, shows that a senior officer checked the document on 15 of 24 days his ACCT was open at Wandsworth. Only four checks took place in August. Two checks were undertaken by a member of the senior management team, once on 28 July and once on 7 August. According to the local policy, members of the team should also check all ACCT documents every week.

The Governor should remind staff of all grades of their responsibilities under the suicide prevention policy to check ACCT documents.

124. On 17 September, after the ACCT had been closed, the man's cellmate became concerned about him. The cellmate told the SO who conducted the review on 28 July that the man was feeling down and tearful. The SO went to see him and spent time talking to him. Following their conversation, the SO believed that his mood had improved. He told the investigator that he considered opening an ACCT but concluded that it was not necessary. I am pleased that the SO took the cellmate's concerns seriously and took time to speak to the man. Whether or not to open an ACCT in such situations is clearly a matter of judgement for staff. They must use their judgement to differentiate between prisoners who are experiencing a short term, but nonetheless distressing, period of anxiety or upset and those whose mood poses a serious risk. On the basis of the available evidence, I think the decision not to place him on an ACCT that day was understandable.

125. In interview, the SO said he decided not to record the cellmate's concerns, or the nature of his conversation with the man in either the wing observation book or his prison file. He explained that this was, again, a matter of judgement. I think it would have been sensible for the SO to have made a written record of his contact with him. Undoubtedly, gathering together such pieces of information helps staff to understand the prisoners they look after and identify changes in their mood or behaviour which might signal increased vulnerability. I have already raised concerns about the frequency of staff entries in the man's prison file. However, the investigator had sight of the Onslow Centre's wing observation book covering the period around and including 17 September. Generally, unit staff make appropriate entries and several concerned similar contacts with prisoners. On that basis, I make no formal recommendation.

126. In the weeks before his death, the man continued to attend IT classes, had several sessions with the counsellor, was visited by his family and partner and his criminal defence solicitor. No specific concerns about him were raised or communicated to staff on the Onslow Centre. Staff on the centre who spent time

with him said they noticed no worrying changes in his demeanour and did not think his vulnerability had increased. After his death, his cellmate told a member of staff that he had seemed "suicidal" in the weeks before his death. The cellmate did not, it seems, tell staff about these concerns.

127. As noted earlier, the man was due to attend the crown court on 2 October, for a psychiatric assessment. Staff were asked in interview whether they are normally told when prisoners have upcoming court dates. They confirmed that a list is produced every day with the names of prisoners due to attend court the following day. This ensures that the correct prisoners are woken and unlocked in time to be collected by the escort service. However, they said that the current system does not allow staff to offer increased support or additional monitoring in the days preceding a court appearance. In the man's case, the progress of his court case had been identified as a source of anxiety in his ACCT document.

128. It is my view that, on the basis of the man's behaviour and demeanour in the weeks and day prior to his death, his actions could not have been predicted or prevented by staff. However, I would urge the Governor to consider how staff may be made aware of court appearances which are identified as triggers to self harm.

Emergency response

129. Staff returning the cellmate to his cell at 7.40pm found that the cell door had been barricaded by the two bed frames. After some minutes spent trying to open the cell door, an officer was successful and he and the PO went into the cell. They found the man hanging, cut the ligature and quickly began cardio pulmonary resuscitation. Both members of staff were well qualified to attempt CPR and I am pleased to find that they did so efficiently. Nursing staff arrived at the cell within minutes and assisted with attempts to resuscitate him. Ambulance staff arrived within 11 minutes of the emergency call and the HEMS team arrived within half an hour. I am satisfied that extensive attempts, although sadly unsuccessful, were made to resuscitate him.

Family concerns

130. During the course of the investigation, the man's parents and partner raised a number of concerns and questions about the circumstances of his death. I hope that the majority of those questions have already been answered in my report. They also asked what proportion of prisoners' outgoing mail is screened by prison staff. At Wandsworth, about 25 percent of both incoming and outgoing mail is screened, on a random basis. There is no indication that the man's mail was screened, or that there was any particular reason to do so.

131. The man also told his partner that, during an interview with the officer who conducted the LISSART shortly after he arrived at Wandsworth, the officer said the man might be facing a life sentence, causing him great distress. At the draft report stage, the investigator spoke to the officer by telephone. The officer denied having told him he might be facing a life sentence. She said that it would be very dangerous for staff to make such a comment as it might increase a

prisoner's vulnerability. Quite clearly, staff are not in a position to, and should not be, advising prisoners of the sort of sentence they might receive if found guilty.

132. Due to concerns about the man's mental health at the time of the alleged offence, his criminal defence solicitor arranged for a psychiatrist to visit him at Wandsworth and carry out a mental health assessment. The man's partner was concerned that the prison obstructed that visit, prevented the psychiatrist from assessing him and caused him additional distress. The solicitor was asked about this and said that the visit had been planned but it fell during the salmonella outbreak. During that time, the prison cancelled all visits, both legal and domestic, for all prisoners. Once visits had resumed, the psychiatrist tried to rearrange the appointment but due to the backlog of legal visits and his prior commitments, could not. As a result, the solicitor arranged for him to be produced at court on 2 October for the psychiatrist to assess him there. The solicitor confirmed that the prison had not objected to the psychiatrist visiting or otherwise obstructed the visit.

133. The man's partner was also concerned that he was not told why visits had been cancelled during the salmonella outbreak. As a result, she said that when his solicitor did not arrive for a scheduled visit, he became anxious and thought that the solicitor did not care about his case. I understand that between 16 and 19 September, four Prisoner Information Notices (PINs) were produced and distributed to all prisoners at Wandsworth. The notices informed prisoners of the sickness outbreak and the resultant changes to the regime – including the cancellation of all visits. Prisoners were told that visits had been reinstated on 19 September. I have been unable to find out whether he would have read the notices.

134. The man's family remain very concerned about the level of care afforded to him while in prison. In particular, they raised concerns about:
    - How the ACCT process was managed and risk assessments made
    - Staff failing to record important information in the relevant documents
    - How staff interacted with him on a day to day basis and assessed his risk to himself
    - The apparent failure of the Personal Officer scheme
    - The fact that his mental health was not assessed at Pentonville
    - Wandsworth's failure to act on earlier recommendations made by HM Chief Inspector of Prisons and the Prisons and Probation Ombudsman

    The family urge the Governor to ensure that existing policies are followed carefully and recommendations made are acted upon to prevent further deaths in the prison. They believe that, had the proper procedures been followed, the man's death might have been prevented.

CONCLUSION

135. The man was remanded into custody on 6 July having been charged with a serious offence. He had never been in prison before. Within days of his arrival, he attempted to hang himself and, as a result was placed on the ACCT suicide and self harm monitoring procedures. He remained on ACCT when he transferred to Wandsworth on 16 July.

136. Staff working with the man found him to be a very quiet prisoner who spent a great deal of time alone in his cell. He did not mix much with other prisoners, except his cellmate who he appears to have got on well with. He told staff that he suffered with depression and anxiety. He said he felt guilty about what he had done and ashamed for letting his friends and family down.

137. However, over time, staff believed he had settled into life in prison and noticed positive changes in his demeanour. The ACCT was closed in mid-August and staff had no further concerns that he might harm himself after that date. On 1 October, he was found hanging in his cell and attempts to resuscitate him were, sadly, unsuccessful. I make five recommendations, none of which, I think would have prevented his death.

RECOMMENDATIONS

At the draft report stage, the Prison Service responded to the recommendations made. The response to each recommendation is provided below.

To HMP Pentonville:

1. The Governor and head of healthcare at HMP Pentonville should remind all staff that, when a prisoner makes a serious attempt to harm himself, an urgent referral to the MHIT should be made.

   This recommendation has been accepted. The Mental Health In Reach Team (MHIT) eligibility criteria clearly states that any incidents of serious self harm will be referred to the team for a mental state examination. All staff will be reminded of this via staff briefings and as part of training delivered on a rolling basis by the Safer Custody Manager about caring for prisoners at risk.

To HMP Wandsworth:

2. The head of healthcare should ensure that all prisoners who make a serious attempt to self harm undergo a formal mental health assessment as a matter of urgency.

   This recommendation has been accepted. In partnership with the PCT will develop clear guidelines and procedures.

3. The Governor should remind all staff of the local personal officer scheme and satisfy himself that it is operating effectively across the prison.

   This recommendation has been partially accepted. We are aware that the personal officer scheme is not currently working effectively across all wings. This has been an ongoing issue due to the fluid nature of our population and the volume of movements of prisoners across areas. Also, the personal officer work does not currently have any specific staff time profiled.
   There will be some upcoming changes which are likely to impact this:

   1. *We are due to start a full re-profiling of officer's roles.*
   2. *P Nomis has just been introduced in Wandsworth, which is likely to have some impact it terms of ownership and recording of personal officer entries.*

   When both changes are embedded, we will then conduct a review of the personal officer scheme.

4. The Governor should strengthen the system for logging post-closure review dates and checking that they take place.

   This recommendation has been accepted. In January 2010, the ACCT document in Wandsworth was updated to include a post-closure review sheet. Post-closure ACCTs will be kept as live documents in which one daily summary will be

recorded until the post-closure review is held and the ACCT document is formally closed.

5. The Governor should remind staff of all grades of their responsibilities under the suicide prevention policy to check ACCT documents.

   This recommendation has been accepted. In January, 2010, the ACCT document in Wandsworth was updated. This included a specific section for management checks with guidelines.

   - *Management check guidance will be adapted to focus on main concerns that continue to be highlighted.*
   - *Previously the Duty Governor was responsible for conducting weekly management checks of ACCT forms. However, weekly checks would be more suitably conducted by the unit manager of that area so that the can follow up on whether the points raised have been dealt with.*
   - *An operational E grade manager will carry out a 10% quality check on a weekly basis and raise issues directly with the unit manager and SMT where required.*
   - *Safer prisons team will continue to produce a daily list of ACCT documents, highlighting points that need to be actioned. Further in-depth checks will be conducted on each wing to assess the general quality of ACCTs in that area and feedback any ongoing concerns into the safer prisons meetings*

   A Governor's order will be published to explain responsibilities in terms of management checks.