

**Investigation into the circumstances surrounding
the death of a man at HMP Wandsworth
in December 2005**

**Report by the Prisons and Probation Ombudsman
for England and Wales**

August 2008

This is the report of an investigation into the circumstances surrounding the death of a man in December 2005. Thirteen days earlier, on 16 December, he had been found hanging in his cell at HMP Wandsworth where he was on remand. Cardio pulmonary resuscitation had been performed and he was taken to a local hospital. Sadly, he did not regain consciousness. He was a foreign national and just 24 years old.

My colleagues and I would like to extend our condolences to the man's family and all those touched by his sad and untimely death.

Two of my colleagues carried out this investigation on my behalf. They were assisted by one of my family liaison officers. In addition, a clinical review of the man's medical care and treatment was conducted by the Medical Director of the Wandsworth Primary Care Trust.

I would like to thank the Governor of Wandsworth and his staff for their co-operation and assistance with this investigation. I am particularly indebted to the officers who acted as liaison for the investigation team.

I very much regret the delay in completing this report. As in a number of my investigations, I have been unable to finish my work until the police have finished theirs. The fact that the man was a foreign national and the need for translation and interpreter services have also prolonged the process.

This is an account of a troubled young man, confused and frustrated by the legal process, who found himself in prison in a foreign country. However, in the midst of this sadness and tragedy, I have also found examples of very good practice on the part of the Prison Service.

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August 2008

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SUMMARY

The man, a foreign national from Central Europe, came to Britain in December 2004.

He initially worked as a technician and rented a flat. In June 2005, he took a holiday abroad. When he returned to his local area he had a dispute with his employer about unpaid holiday wages. He decided to change address but there were problems with his proposed new accommodation and he found himself living in a hotel for a few nights. During his stay there, his possessions – including his passport – were stolen.

On 10 July, the man was arrested by police for making a hoax bomb threat. At that time, he presented as incoherent and disturbed in his behaviour and was admitted to a psychiatric hospital. Arrangements were subsequently made for him to travel to London to pick up travel documents from his country Embassy.

On 1 August, the man was arrested at an underground station in Central London by the British Transport Police, having thrown a bag on to a railway track. The authorities initially treated this as a potential act of terrorism, but it soon became clear that he was drunk at the time and was unaware of his actions. He was remanded to HMP Wandsworth. He was further remanded in October when his barrister believed that he should see a psychiatrist before entering a plea to the court. It was reported that at this hearing he was also told that he might receive a life sentence.

Those who had contact with the man described a change in his mood after this October court hearing. He seemed to believe he was likely to spend a long time in prison and said he would not be able to cope with such a sentence.

The man referred himself to the mental health in-reach team (MHIRT) at Wandsworth, saying he wanted help. He was seen by the wing GP on 29 November. The doctor found him to be generally well and did not recommend any further assessment or treatment, despite the man telling him he was forgetting things and could not sleep.

The man saw a paralegal caseworker, from the firm representing him, on 7 December. She was accompanied by an interpreter and a psychiatrist who was there to assess him for his court case. During the conference, the man asked about the length of sentence he might get, and the paralegal reassured him that he would not receive a life sentence. She agreed to return soon to discuss what might happen in his case.

In mid December, the man was found hanging in his cell. Staff performed cardio pulmonary resuscitation (CPR) and an ambulance was called. He was taken to hospital. Sadly, he did not regain consciousness and died two weeks later.

There is evidence that the man struggled with his mental health. However, the psychiatric assessments carried out did not conclude that he was suffering from significant mental health problems while in prison. Nor did he give the staff at Wandsworth any grounds for supposing that he was at risk of suicide or self-harm. Although he had vouchsafed a little more to fellow prisoners, no-one had drawn specific concerns to the attention of staff

The report includes two recommendations and identifies three examples of good practice.

INVESTIGATION PROCESS

1. I was notified of the man's death on 29 December 2005. My investigators visited the HMP Wandsworth and saw the cell where the man had lived. They reviewed all the relevant prison records, including staff incident reports written at the time the man was found and established a chronology of events. They also met with members of the Independent Monitoring Board and the Prison Officers' Association to explain the nature of the investigation.
2. Notices were issued to staff and prisoners announcing the investigation and inviting anyone who had relevant information to make themselves known to the investigators. Two prisoners asked to see the investigators: one was the man's cellmate and the other his barber. Both were subsequently interviewed.
3. During the investigation all the members of staff involved when the man was found hanging, as well as some staff who had other dealings with him while he was at Wandsworth, were interviewed.
4. The investigators visited the police station and spoke to the Detective Inspector who was involved in the police investigation. Later, in conjunction with the police, they interviewed the paralegal caseworker who met the man in December 2005.
5. One of my Family Liaison Officers met with the man's mother to explain the purpose of the Ombudsman's investigation and to discuss any questions the family might have. His mother did not feel there were particular concerns about her son's time in Wandsworth. However, the family were concerned about the information that had been given to the man about the length of sentence he might receive. The man had told his family that he thought he might receive a life sentence and this would have been too much to bear.
6. An independent clinical review of the healthcare the man received whilst in custody was carried out by the Medical Director of Wandsworth Primary Care Trust.
7. My investigator contacted Her Majesty's Coroner to inform him of the nature and scope of the investigation and to request a copy of the Post Mortem report. Upon completion, this report will be sent to the Coroner to assist him in his enquiries.

HMP WANDSWORTH

8. HMP Wandsworth is a category B local prison for adult male prisoners. It has a Certified Normal Accommodation of 1,173, with an Operational Capacity (maximum crowded capacity) of 1,416. The prison always functions at or near the Operational Capacity figure. Prisoners work on their living unit or in the laundry. There are also education classes available.
9. Healthcare in Wandsworth transferred to the local Primary Care Trust (PCT) from 1 April 2005. At the time of the man's death, the prison had a 14 bed in-patient facility and prisoners undergoing detoxification from drugs were supported by substance misuse nurses working on the wings. A full time doctor is available each week day. Medical cover is provided during the weekends and evenings by two GPs from a local practice. Appointments to see a doctor are triggered by wing application. The waiting time to see a doctor varies from a few days to a few weeks.
10. Her Majesty's Chief Inspector of Prisons (HMCIP), recently published a report of an inspection of HMP Wandsworth. She noted that Wandsworth was an improving prison. However, she expressed concern about the treatment of foreign national prisoners. This was not a concern which separately presented itself during this investigation.
11. There were four apparently self-inflicted deaths in 2005 at Wandsworth, including that of the man who is the subject of this report. Some of my investigations are yet to be completed, but I have identified no significant similarities between those cases and this one.

KEY EVENTS

Before the man was remanded into custody

12. The man came to the UK to work in 2004, and settled in the Bradford area. In June 2005, he took a three week holiday in a city abroad where he had previously worked and lived. While on this trip he had hoped to re-establish a relationship, but was shocked to find that the woman had a new partner and was about to have a baby. Upset and disheartened, he returned to Britain where he fell out with his employer over unpaid holiday wages. It is unclear whether he remained employed at this time, however he made arrangements to change accommodation. Unfortunately, problems arose with his new accommodation and he ended up staying at a hotel. While at the hotel, he had his possessions stolen. They included his passport and credit cards. Although he reported the theft to the local police, he apparently found them unhelpful.
13. We have little information about what happened to the man next, but on 10 July he was arrested by police for making a hoax bomb threat. At that time, he presented as incoherent and disturbed in his behaviour and was admitted to the local hospital under the Mental Health Act.
14. The medical assessment carried out noted that the man seemed cheerful and did not express any wish to self harm. However, it also recorded that his thoughts were disordered and he had some paranoid ideation. He recognised that he was in the custody of the police, but was not apparently aware he was in hospital. The doctor noted that the man did not seem to have any insight into why he had been admitted, but he did say to the doctor "you can find out if I am a loony". He disclosed his use of cocaine and cannabis, but it is unclear if he had used them recently.
15. The man refused to give staff any details about his family, his address or other personal information. Later that night, having been quite elated all day, he accepted medication and slept. The next morning, he showered and dressed and attempted to leave the hospital. However, he was stopped by staff who tried to explain the conditions of his detention. He spent the rest of the day sleeping and, when he woke later, did not know where he was or how he had got there. He spoke with one of the nurses who again explained his situation to him. At that time, she noted the man was warm and amenable and agreed he would stay if he was told to do so. He also said that he would wait for staff to tell him if he was normal or "cuckoo", saying he thought he was "half alright".
16. The man's record shows he had an up and down time during the next few weeks and made several attempts to leave the hospital. On some occasions he was coaxed back to his ward by staff, on others he refused to be

persuaded and left the grounds, returning later. There are also several occasions when he refused medication and fought with other patients. Staff had to explain to him many times why he was there, how he came to be there, and his rights under the Mental Health Act.

17. There is some reference to him becoming frustrated with the language barrier and his understanding of the situation he was in. However, there are also several records of conversations with him that indicate communication was clear on both sides. The man had several episodes of absence without leave from the hospital. On most occasions, he returned saying he had been to work or staying with friends. On some occasions, he was taken back by the police who found him wandering the streets.
18. On 14 July, staff at the hospital received a call from the man's previous employer. He said the man began working with him in January 2005, and described him as a pleasant man who worked hard and was popular with his colleagues. He had lived with two foreign couples, but he had found himself homeless some weeks prior to his arrest. The employer said the man had gone on holiday abroad earlier in the year, but on his return had presented as chaotic and grandiose in his manner. The employer said the man had been arrested by the police for damaging property, was currently on bail, and was due to return to court in August. This version differs in places from the account given by the man himself.
19. On 28 July at 9.15am, the man informed hospital staff that he was going to work and would not be back as he was going to live with a friend. When pressed for details, he was unable to give an address and became aggressive. He refused to take his medication and left the ward. Some time later, a phone call was received from a man with whom the man used to work, saying the man was at his house and was refusing to leave. He was advised to call the police and the man later returned to the hospital.
20. Plans for the man's discharge had been discussed at a meeting on 27 July. The man said he wanted to return to his own country as he did not have an income and was not entitled to any state benefits. The Embassy was contacted and agreed to provide him with travel documents within 24 hours of him presenting himself. Money was provided to purchase a ticket for a flight and a bus ticket to London. It was agreed that he would travel to London on Sunday 31 July. He would be given money to cover two nights accommodation and was to present himself at the Embassy on Monday morning. After spending another night in London, his papers would be ready and he was booked on a flight leaving London on Tuesday 2 August.
21. On 29 July, the man approached a member of staff and said he was going to leave if he could not phone his mother. The member of staff explained that they were waiting for an interpreter to arrive so they could go through the

details of his release plan. The man insisted on speaking to his mother, and did so for about five minutes. When he finished the call, he told staff he was leaving the hospital. It was explained to him that a visit to the Embassy had been arranged, as had a ticket to his country. The man said he did not want to return to his country, but had decided to remain in the UK and work. He then packed his things, refused to see the interpreter or the doctor and left without his medication.

22. On 30 July, the man was taken to a police station in his local area after being found knocking on the doors of strangers looking for accommodation. The people who took him to the police told them the man had said he had the explosive, Semtex, in his mouth. The man was detained at the police station. He saw a doctor, who conducted a full assessment through an interpreter. The doctor reported that the man had said that the Semtex comment was a joke. He explained that he had become increasingly frustrated with the police, as he had been to the station on two or three occasions to try to sort out his stolen documents but had been told to go away.
23. The man said he wished to return to his country as he had no money and nowhere to live. The doctor found him to be unkempt, but otherwise not unwell. She noted the man gave her contradictory information about his drug use, but did say he had used cannabis and cocaine in the last few days. It was decided that there was no benefit in detaining him again and police would try to find him some temporary accommodation and assist him with his journey to London to replace his stolen documents.
24. On 1 August, the man was arrested by British Transport Police at Edgware Road underground station in Central London. He had thrown a plastic bag onto the track.
25. The man later told a psychiatrist that he could not remember much about his arrest. He said he had come to London and met a friend in a bar where they drank five or six pints. He said they then returned to his friend's hotel where they drank several glasses of cognac. When his friend fell asleep, the man said he left the hotel and wandered the streets. He had some memory of entering an underground station, but did not remember throwing anything on the line.
26. It is worth noting at this point that there was some concern about his intention when he threw the bag onto the tracks. Initially, it was viewed as a possible terrorist act to damage part of London's transport system.

Events leading up to the man's death

27. On 2 August, the man was remanded from the Magistrates' Court to Wandsworth prison. On arrival, he went through the usual first night in custody arrangements. As part of this process, he saw a healthcare worker who asked him about his health and assessed whether he was at risk from self harm or drug and alcohol withdrawal. It was noted that the man had sprained his ankle and would need to see a doctor. The man said that he had not been in prison before, did not suffer from any illnesses, did not drink or take drugs, and had not received any treatment for any form of mental health problems. When asked if he had ever tried to harm himself or if he felt suicidal, he answered that he had not.
28. Section one of the man's Cell Sharing Risk Assessment (CSRA) is blank. This indicates that the reception officer completing this form did not have any paperwork relating to the man or his history. The man's account was the only source of information available to the prison, and it was again recorded that he did not drink or take drugs and that he had no concerns about sharing a cell.
29. Wandsworth receives up to 100 prisoners on a daily basis. Amongst its population, over 80 languages are spoken and it is therefore not unusual for prisoners to arrive whose first language is not English. The first night in custody team have put together a team of volunteers from the prisoner population who speak several languages. These prisoners live on the induction wing where they can meet new arrivals. If the newcomers have problems with English, they will either put them in touch with another prisoner who speaks the same language or alert staff to the difficulty.
30. There is nothing in the man's file to indicate that he had any problem with understanding English during reception. Neither did any member of staff make any note saying they were concerned that the man did not understand and needed the help of an interpreter.
31. On 10 August, the man was seen by his solicitor who was accompanied by an interpreter. He was seen again by the same solicitor on 12 August.
32. A representative of the Embassy visited the man on 25 August. She and the man discussed his case and he told her he felt that a "big deal" had been made of the situation. She said she talked to him about the timing of his offences and the difficult climate particularly in relation to terrorist attacks. She said that the man understood this, but still appeared taken aback by finding himself in prison.
33. Prisoner A was a prisoner on the same wing as the man. He said he had spoken to the man on several occasions, first when he cut his hair and on

other occasions when they bumped into each other. He said initially the man was “beside himself” and believed he was going to be charged under the Terrorism Act. Prisoner A described him as “lost, bewildered, as to where he was going, what he was doing”.

34. Prisoner A explained that he had himself been arrested in Spain, and had experienced similar problems in terms of not speaking the language well and trying to get information about his case. He said he understood the situation the man was in. He told him he had used the British consulate and the organisation Prisoners Abroad and suggested that the man do the same. He said the man was frustrated and was “fretting”, saying he could not get any help. Prisoner A said he was concerned by the man’s predicament and so spoke to his own lawyers who promised to see the man the next time they were in Wandsworth.
35. On 7 October, the man was visited by his own solicitor. He returned to see him again on 14 October, on this occasion accompanied by an interpreter.
36. Prisoner A said the man told him he was going to have a legal meeting and was looking forward to it. However, when he came back he seemed to be in a worse state. The man had said his lawyers said the trial would be in early January and he needed to decide if he was going to plead guilty or not guilty. It appeared to prisoner A that things had not been explained properly to the man. Prisoner A observed that the man started to become introverted, and he would see him alone on the exercise yard.
37. On 25 October, the man appeared before the Crown Court. His solicitor told him that his barrister had concerns about his mental health and believed it was in the man’s best interest to undergo a psychiatric assessment. The case was adjourned for six to eight weeks for this to be carried out. The man’s legal notes from the court appearance state that his barrister emphasised the seriousness of the offence to him and the maximum penalty it carried. It is also noted that the barrister advised the man to “plead guilty by reason of insanity”. He explained the process that would follow five times, “so that the man is fully aware of his legal position”. The notes end by recording that the man believed he had mental health problems, as he could not account for his actions.
38. The man completed an application form on 28 October referring himself to Wandsworth’s mental health in-reach team (MHIRT). In response to this application, the acting team leader of the MIHRT wrote to the head of the primary care team. The note is dated 1 November and it suggests that the man should see the GP in the first instance.
39. The man’s cellmate said that he knew the man had moments of depression and knew he had once phoned his mother and told her he was going to kill

himself. However, he believed it was frustration on his part and did not believe he meant it seriously. The cellmate therefore did not feel it necessary to inform staff.

40. During November, the man had three visits. On 10 and 28 November another representative from his solicitors visited him, and on 23 November he was seen again by the representative of the Embassy.
41. On 29 November, the man was seen by the wing GP. He recorded that the man complained of forgetfulness and insomnia. However, he found him to be “fully orientated and in generally good physical and mental health” and did not recommend any further treatment or interventions at that time.
42. The principal officer (PO) worked on A wing and said he remembered speaking to the man on one occasion, a few weeks before he died. The PO said the man had come into his office which is on the third landing. He said many prisoners pop in and out of the office to make general enquires. He said that the man spent about 45 minutes talking to him. He remembered that at the time the man did not seem upset or concerned about anything. He also remarked that the man presented as well groomed, very polite and very forward thinking. However, he did recall that the man had mentioned that he had spent some time in hospital being treated for mental health problems. The PO said that the man had been quite vague about the details, but he got the feeling that the man was referring to a hospital in the UK. He said that the man spoke in broken English, but he thought the man understood him and that they had communicated fairly well.
43. On 7 December, a paralegal visited the man and explained that his original solicitor had left the firm and she would be looking after his case until a new one was appointed. She was accompanied by a psychiatrist and an interpreter. She discussed the man’s request to change his solicitor. The man told her that the last time he had appeared in court he was told that he had been charged with a very serious offence, and that he could go to prison for the rest of his life. He explained that he was scared and worried that they were not doing enough for him and a friend had advised him to engage alternative solicitors.
44. The legal representative explained to the man that he would not receive a life sentence. She clarified that the next stage was a psychiatric assessment and the next court hearing would take place on 1 January 2006. She said the man told her he could read some English and would like to see the paperwork related to his case. She said she agreed to send him copies. She apparently told him that she would make another appointment to see him when he had done so, and would then take his instructions. She said the man seemed happy with this and confirmed that he was happy for them to continue to act for him.

45. The psychiatrist then assessed him. The notes show that he asked the man about his background, whether he had ever had an assessment before and what had happened on the day of the offence. The man talked to him at length and told him that he had applied to see the prison doctor and was waiting to do so. He said he was having trouble sleeping and woke up sweating.
46. Having spent about an hour and a half with the man, the psychiatrist concluded that he was not suffering from any form of mental illness, but rather that he was drunk on the day of the offence and that had led him to act as he did. After an examination of the man's family history, he felt that he was not an alcoholic but a binge drinker.
47. Prisoner B, a prisoner in the cell next door to the man, said he did not know the man's name but that he was known to most people on the wing as "Russian" (As he came from a country in Central Europe). He said he did not know the man very well. He had seemed "very serious and at times moody." He also remarked that the man had worked out a lot and kept himself very fit. On the morning of 16 December, he said he saw the man in his cell and asked him for some cigarette papers. In return, the man asked him for some tobacco and they exchanged goods. He said the man appeared his usual self and he had no reason to suspect he was unhappy.

Finding the man

48. On the morning of 16 December, the man's cellmate went to work as usual. He remembered that he had forgotten something in the cell and had returned briefly to retrieve it. He explained that the man was in the cell because, although he usually attended education in the morning, there was no class on that Friday. The morning routine at Wandsworth starts with all prisoners who attend education or work leaving their cell at 8.00am. After this, prisoners who are left in their cells are offered the opportunity to attend exercise. On that morning, the man was asked if he wished to go out for exercise but he declined.
49. The first wing officer was one of two officers looking after the wing that morning. He explained that his colleague, the second wing officer, was out on the exercise yard and he was alone on the wing. Part of the morning duties includes carrying out fabric checks on each cell. This usually means that two officers will check each cell to ensure that all the fixtures and fittings are sound and secure. That morning, the first wing officer decided to carry out the checks alone while his colleague was on the exercise yard. He explained that usually he would not carry out such checks on his own but, as the wing SO and the prison officer were having a meeting on the third landing, he felt it was safe to do so.

50. The first wing officer said he checked about six cells on the third landing before he came to the man's (number 37) at about 8.50am. He said he opened the cell and found it completely dark inside. He said he looked to the window and realised it had been covered with a towel or a blanket. The first wing officer said he switched on the light and saw the man in a sitting position. He then noticed a ligature around his neck attached to the window. The first wing officer said he paused because he was shocked. He then remembered that the wing SO and the prison officer were nearby and went to get them. He told them they needed to come to cell 37 straightaway, which they did.
51. Once they had looked into the cell, the prison officer said he went to the central office and shouted for assistance. The wing SO said he went into the cell, saw the man hanging and shouted for someone to get a nurse. He sent the first wing officer to the landing office to fetch the cut down kit. He said he lifted the man's body up and supported its weight on his shoulder. At the same time he tried to remove the ligature and managed to loosen it almost immediately. The second prison officer then arrived as did the third prison officer, and they both supported the man's body as the wing SO removed the ligature by loosening it further and taking it off over the man's head.
52. The second principal officer (PO) was the staff member in charge on A wing that day, using the call sign OSCAR 1. He said he was notified that there was a problem by the first prison officer, who had run into the central office saying Hotel 3 (a nurse) was needed as someone had attempted to hang himself. He said it was just before 9.00am and he immediately used his radio to call a 'Code 1'. The control room log shows that the call was raised at 8.55am. The second PO said he made his way to landing 3.
53. When he got there, the second PO said there were three staff members already in the cell helping to get the man down. He instructed them to lay the man on the floor and he moved furniture out of the cell to make room. He said the staff nurse then arrived, but as he believed she had not brought any equipment with her he asked her to go back and fetch the oxygen. The second PO then said he checked with the second prison officer to ensure he was ready to start mouth to mouth, while he began chest compressions. He explained that, as this was going on, he continued talking to staff giving instructions and requested an ambulance be called over the radio. He and the wing SO alternated performing chest compressions. After about two minutes, the staff nurse arrived back accompanied by another nurse. The oxygen was attached, as was a pulse monitor which indicated that there was a heartbeat. He said one of the nurses relayed this information to all the staff present and urged them to keep their efforts going.

54. The second PO estimated that it took him about two minutes between hearing about the incident while on the central control office and reaching the man's cell. He said he and other staff conducted Cardio Pulmonary Resuscitation (CPR) for five to six minutes before the ambulance crew arrived.
55. The staff nurse was designated call sign Hotel 3 on 16 December. This meant she was the nurse who would respond to any emergency call over the radio. She said she was giving out medication when the emergency call came over the radio. She said it just asked her to attend the cell and did not give any other information. She said she collected the emergency bag and went to the cell but then realised, because of the nature of the incident, that she needed the oxygen which was kept in another bag.
56. She said that she checked with the officers who were administering CPR if they were able to continue while she went to collect the oxygen from the treatment room on the landing below. The officers said they were and she explained that she was going to get the oxygen, but would be back quickly.
57. The staff nurse said that, at this point, she asked for an ambulance to be called. When she returned to the treatment room, she received a call sign over the radio telling her what type of incident it was. She returned with the oxygen and inserted an airway into the man. She then took over mouth to mouth resuscitation. She said the first and the second wing nurses then arrived with a pulse oximeter and an ambu-bag.
58. The staff nurse explained that she is often called over the radio to attend an incident and it is customary to treat such calls as an emergency. However, in most cases it does not turn out to be an emergency which is why there are codes to indicate what type of event it might be and the type of equipment that is needed.
59. Both officers and medical staff continued to administer CPR until the ambulance arrived. The control room log shows that the code 1 alarm was raised at 8.56am and an ambulance was requested at 9.01am. The log also shows that the ambulance arrived at 9.06am and left the prison at 9.38am taking the man to hospital.
60. The man failed to regain consciousness. After spending 13 days in hospital, he died there on 29 December.

Post Incident Response

61. A hot debrief took place at the prison on the same day the man was found. All staff members who had been involved were able to attend with the exception of the first wing officer, who was in shock and had been sent home.
62. After the man was taken to hospital, the police were informed about his apparent attempted suicide. They were also contacted when the man died on 29 December.
63. PSO 2710 gives instructions on action to be taken following a death in custody. Wandsworth correctly followed these procedures, including offering care and support to the staff members involved. All the staff spoken to in the course of the investigation were happy with the support they received from both the care team and the safer custody team.
64. The man's cellmate said he had also been spoken to by both staff members and the prison chaplain.

Contact with the man's family

65. The man had not given the prison his next of kin details. In order to establish contact, the prison got in touch with the Embassy. They were able to contact the man's mother and she was told about what had happened to her son. The prison then arranged for her to fly to Britain to visit the hospital and the prison. During her time in London, the man's mother visited his cell and met his cellmate as well as some prison staff.
66. When my family liaison officer met the man's mother, she did not express any specific concerns about her son's care at Wandsworth. Indeed, she was very grateful to the Governor and staff at the prison. I know that the prison's liaison officer has maintained contact with the family through interpreters and the Embassy, and has kept them informed both about the progress of this and the police investigation, and about the inquest.
67. I understand the Governor of Wandsworth has offered to meet the costs of the man's family returning to London for the inquest. However, I understand they have declined the offer.

ISSUES CONSIDERED

Contact with those who knew the man

68. The man's cellmate described the man as a "nice chap, a genuine bloke". He said that the man knew he had been silly, but was very worried that he was going to go to prison for a long time. The man told him that he had come to London to go to the Embassy after the police had "fobbed him off" after he reported the theft of his passport. He said he had been drunk when he was arrested and was angry during the police interview. The cellmate said he had tried to reassure him and tried to explain the legal issues.
69. He said the man did not understand the law and was worried he would be sentenced to life imprisonment. The cellmate believed that "somewhere along the line, his solicitor had said he would get life". He was not sure if the man had misinterpreted this information or if perhaps it had grown in his mind. He said the man had tried to change his solicitor, but had been unable to do so.
70. The man attended an English course every day except Fridays, and his cellmate said his English was improving all the time. He said he was aware that the man had been a bit depressed, but usually he was able to talk him round. He said the man would talk about being worried and confused, but a day or two later he would happily play cards and seem to have got over his worries.
71. He said that, for a couple of days before he was found hanging, the man had been writing and then ripping up the sheets of paper. The cellmate also noticed that the man had stopped doing his exercises. The man did not have a good night's sleep the night before he was found. The cellmate said he "did not sleep at all, he was smoking cigarettes and seemed to be once again in a bad state of mind, worried."
72. Another prisoner, prisoner A, said he knew that the man's cellmate was helping him, but each time the man explained his case to him he seem to become more confused about it. As prisoner A had a job, he did not see the man very often but noticed that he did not come out on the wing so much and that he had become quiet. However, he thought that the man "was getting his head down to face court." With hindsight, he said he believed the man "gave up." He believed that the process had shocked him and that the man could not understand how he had ended up in Wandsworth. He said, "he did not understand it and he could not get it out of his mind or get past it."

Foreign National Prisoners

73. Prison Service Order (PSO) 4630 sets out guidelines for dealing with prisoners who are foreign nationals. In the main, the guidance deals with the management of prisoners who are subject to the processes of the Immigration and Nationality Directorate of the Home Office. It does not specifically focus on prisoners who are nationals of member countries of the European Union and who generally have the right to live and work in the UK.
74. Wandsworth has a comprehensive local policy relating to foreign national prisoners which covers all related issues. This policy gives clear guidance and all the staff interviewed by my investigators were aware of its contents and appeared confident in their management and care of foreign nationals.
75. In terms of information available to prisoners, the induction pack and key information leaflets have been translated into 11 different languages. Additionally, posters in several languages are displayed on the induction and residential wings which explain what is available to prisoners whose first language is not English. As noted earlier, there is a volunteer group who work on the First Night Centre. These volunteers are also allocated to a particular wing, which they visit daily to check if anyone is in need of their help. The volunteers to whom my investigator spoke appeared motivated in their work and took their role very seriously. Their presence is an example of good practice.
76. There is also a weekly meeting for foreign national prisoners. This gives them an opportunity to discuss their cases and access help. The meeting also acts as a forum for outside groups who visit and provide information on issues such as bail and deportation. There is no record kept of these meetings so it is impossible to know if the man ever attended. However, the volunteers my investigator spoke to had no memory of meeting the man. I am not greatly troubled by this. I believe the man had a reasonable grasp of English and managed for example to make an application to the mental health in-reach team. Whether this application was with the help of his cellmate or staff I cannot say, but it does show that he was able to access the services he thought he needed. In this respect, I do not believe that the system at Wandsworth failed him.

The First Wing Officer's Reaction

77. The first wing officer explained that when he first saw the man he was shocked and did not react in the way he had been trained to. However, he was confident that this 'shock' was very short lived as he quickly ran to get help from the staff who were in a nearby cell. When asked why he decided to do this instead of following the procedures he had been trained in, he replied that on that day he was not carrying a radio and therefore would not have

been able to call for assistance. He did acknowledge that he was carrying a whistle and could have used that to alert colleagues. However, he said he was not sure that they would know which cell he was in and consequently their response could have taken longer. The first wing officer believed the quickest way to get assistance for the man was to do as he did, and I am not minded to be critical as I do not believe his reaction caused any undue delay. However, it is important for all staff to follow the training for dealing with urgent and emergency situations.

Radio Call Signs

78. The first prison officer was the first to raise the alarm as he ran to the central office and alerted staff. However, the control room failed to notify the staff nurse that it was a Code 1. Consequently, the staff nurse did not know what kind of incident she was attending and what equipment to carry with her. She did not take the oxygen cylinder with her and later had to retrieve it. I cannot say if this delay had any impact on what followed, but it could have been prevented if the appropriate code had been used.

The Governor should remind staff to use the emergency call system to ensure an appropriate and timely response to emergency situations.

Cut-down scissors or fish-knife

79. Neither the first wing officer nor any of the subsequent officers who found the man carried any means by which to cut through a ligature. Fortunately, the wing SO was quickly able to remove the ligature from around the man's neck. However, this might not have been the case and he could have lost valuable seconds. I believe it would be better and safer for all staff working with prisoners to be issued with personal equipment to cut ligatures. I welcome the fact that the Prison Service is shortly to issue a mandatory operational instruction requiring staff to carry such equipment and therefore make no recommendation on this matter.

Resuscitation aids

80. Some staff to whom my investigator spoke mentioned that they carried emergency resuscitation masks. However, they reported that they did not work very well and felt the equipment needed updating. Although I have not checked the equipment, I agree that staff cannot be expected to work in such situations without been provided with the appropriate equipment.

The Prison health partnership should review the personal first aid and equipment issued to staff and ensure it is appropriate, in working order, and that staff are aware of how to use it.

Clinical Review

81. The clinical review of the man's healthcare notes that the man was under the influence of drugs and alcohol when he was first arrested, but a few hours later was found to be better. By 25 October, when he was again remanded, he told the nurse on reception that he was fit and well.
82. However, the man did complete an application form on 28 October, referring himself to the mental health inreach team. He was seen by the wing GP but, although he complained of forgetfulness and insomnia, the doctor did not recommend any further interventions or investigations.
83. The clinical reviewer comments that, since the man felt the need to seek help for his mental health difficulties, it "is at least possible that a more detailed exploration of his systems may have been helpful". I endorse this and believe a primary mental health assessment would have been appropriate to eliminate or diagnose any mental health needs. If such needs had been identified, an appropriate management and support plan could have been devised. However, I also note that the psychiatrist appointed by the man's legal team could find no evidence of diagnosable mental illness.

Legal Advice

84. Staff at Wandsworth had not judged the man to have been 'at risk' of suicide or self harm. He had been quiet and polite on the wing and seemed to be coping with his period on remand.
85. The man's mother said that her son had written and phoned her often, and he seemed to be coping. However, she said that after his court appearance in October he began to express real fear about the legal process and about the likely sentence he could receive. He told his mother that his solicitor had said that he was likely to receive a life sentence. She believed that the man considered this to be a real possibility, and he sounded very frightened and upset about this.
86. The man's mother said that he spoke of little else when he phoned her. He seemed to be convinced that he would spend the rest of his life in prison and was unable to take on board his mother's reassurances. She said that, in her last conversation with him, she had spent a long time trying to calm him down and reassuring him that there was bound to be another outcome. However, she said he seemed fixed on the idea that what his solicitor had said was right and there was no other view.
87. A paralegal took over the man's case in November 2005 when his previous solicitor left the firm. She explained to my investigator that an appointment

had already been made to see the man, together with the psychiatrist. She had discussed with the man the possibility of him transferring solicitors. However, after discussion, she said the man assured her that he was happy to remain with her firm. After the psychiatrist had conducted his assessment, she asked the man if there were any questions. The man asked her what kind of sentence he was going to get and she said that she did not want to discuss it at that moment as the psychiatrist was present and was not subject to the same legal privilege. As a result, they had agreed to make an appointment for the next week to discuss the issue.

88. The paralegal said the man then said that he had been told that he was going to get life, but she told him that it was not the case. The paralegal asked him who had told him this and the man said that it was a woman in a wig at court. The paralegal explained that the only person involved in the man's case who would have worn a wig was the barrister who represented him on 25 October 2005. However, the paralegal was of the opinion that it could have been a court clerk. The file note shows that counsel did advise the man of the maximum possible tariff for the offence.
89. Unfortunately, we have been unsuccessful in tracing the barrister and I understand she has since left the Bar.
90. When interviewed, the paralegal clarified that this was the first and only time she had met the man. She said that "he appeared down, with slumped shoulders, in my opinion he was depressed." He told her that he had not been sleeping and had asked to see the prison doctor, but had not yet had an appointment. She said the man was like this throughout the assessment. However, after they spoke about his possible sentence he seemed to "straighten up, brighten up and appeared more positive. He was overall brighter and happy that he did not want to transfer representation".
91. Having explained things to the man several times, she was happy he knew that he was not going to get life imprisonment but she could not give him any guide as to what he would receive as a punishment. She had no concerns for his safety. If she had, she would have informed the prison directly.
92. I have been unable to verify directly that the man was ever told that he was likely to receive a life sentence. However, it is clear from the evidence I have seen that at one time he was under the impression that he might receive a life sentence. This prospect was obviously of great concern to him.
93. I can offer no further insights into the man's state of mind on the day he was found hanging.

LIST OF RECOMMENDATIONS

- **The Governor should remind staff to use the emergency call system to ensure an appropriate and timely response to emergency situations.**
- **The Prison health partnership should review the personal first aid and equipment issued to staff and ensure it is appropriate, in working order, and that staff are aware of how to use it.**

Good Practice

- **The staff who carried out CPR on the man are to be commended for their efforts. Although medical staff arrived at the man's cell, the discipline staff continued to provide CPR until they were relieved by the ambulance crew.**
- **The care and thought given to the man's family has been exemplary and certainly much more than that dictated by the current PSO. Wandsworth is to be congratulated for its approach.**
- **I am particularly impressed by the presence of a volunteer group who work on the First Night Centre and who assist those prisoners for whom English is not a first language. This is an initiative that could be followed in other prisons holding large numbers of foreign national prisoners.**