# Investigation into the death of a male prisoner at HMP Wandsworth on 18 February 2005

**Prisons and Probation Ombudsman for England and Wales**

**November 2005**

This is the report of an investigation into the circumstances surrounding the death of a male prisoner at HM Prison Wandsworth on 18 February 2005. He was found hanging in his cell at 08.00 am that day.

A post mortem examination was performed on 22 March. The pathologist found no injuries apart from those caused by the ligature. These were found to be entirely consistent with the man having hanged himself and being suspended for some time.

I offer my sincere sympathy and condolences to the man's family who have suffered the tragic loss of a loved one. Prisoners and staff at Wandsworth who knew the man expressed their sense of shock at his death.

This investigation was carried out on my behalf by Mr Tom Wright.

My thanks go to the Governor and all Wandsworth at staff. I appreciate their willing cooperation which has enabled the investigation to be thorough, and to be completed in a reasonably timely fashion.

I make six recommendations.

**Stephen Shaw CBE** **November 2005**
**Prisons and Probation Ombudsman**

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## SUMMARY

This is the report of an investigation into the death on 18 February 2005 of a male prisoner at Wandsworth prison. The man was serving two sentences of four years imprisonment. The investigator reviewed the man's records and spoke to a number of staff and prisoners.

The man was a heavily convicted man. He had been in prison custody since 3 February 2003 and at Wandsworth since 6 February 2004. He had a long history of substance abuse and, while not diagnosed as having any treatable mental illness, he was viewed by other people as a loner and as somewhat odd. He had a history of self harm by cutting himself when he was in prison, and had been considered as a suicide risk on several occasions during this period of imprisonment. He was found hanging from the light fitting of his cell at approximately 8.00 am on 18 February 2005 by the wing cleaner. Prison staff were alerted and attended the cell but it was clear that there was little they could do to revive him. The man was pronounced dead at 8.53am.

The report describes the actions taken by staff following the discovery of the man. I find that the prison responded well and that staff arrived as soon as was possible.

It would appear that he had been hanging for some hours when he was found. However, two early roll checks failed to notice that anything was amiss. It is understood that an internal enquiry has been commissioned by the Governor to look into this matter.

The man was not thought to be actively suicidal at the time of his death, but in the past he had been the subject of self harm care plans. The last one was closed on 21 June 2004. Throughout his sentence he denied ever being suicidal. This was despite his self harm behaviour and his having admitted to a failed attempt to hang himself in February 2004.

I requested a clinical review of the medical care that the man received while in prison custody from the local PCT. They declined, on the grounds that they did not have commissioning responsibility at that time. I therefore commissioned my own clinical review. The review concludes that prison staff showed care and compassion for a prisoner who was clearly mentally unwell. The man often self harmed, and admitted to trying to hang himself on occasions. Evidence reflects that the wing staff showed concerns and some understanding towards the man, who was apparently mentally unwell and exhibiting bizarre behaviours, but refusing to engage with mental health services.

I conclude that, on the basis of the evidence I have seen, while the man's death may not have directed predicted or prevented, there are a number of important learning points for the establishment.

## WANDSWORTH PRISON

1. Wandsworth Prison was built in 1851 and has been extensively refurbished in recent years to include integral sanitation for prisoners. It houses a large number of drug users and prisoners with mental health problems. The death of the man and another four days earlier were the first in over a year. A subsequent safer custody audit resulted in a score of 85%.

2. Wandsworth was last inspected by HM Chief Inspector of Prisons nearly a year ago and it was noted that there was a continuing shortfall in staff numbers. The Chief Inspector also recorded her "serious concern" that Wandsworth was not meeting the standards required of a healthy prison.

3. Wandsworth has a Certified Normal Accommodation (CNA) of 1,173 with an Operational Capacity (maximum crowded capacity) of 1,462. The prison always functions at or near the Operational Capacity figure.

4. The staffing numbers deemed necessary to run the establishment includes 295 prison officers.

5. From 2002 to 2005, records indicate that a total of 144 staff had received suicide prevention or awareness training. The Area Suicide Prevention Advisor believes that this figure is an underestimation of the actual figures trained. Wandsworth is one of the first prisons to be using the new Assessment, Care in Custody and Teamwork (ACCT) system for caring for those prisoners thought to be at risk of suicide and self-harm.

6. Eight staff were trained in ACCT awareness from December 2004 to February 2005 and fifteen in March 2005. To February 2005, eleven had been trained in ACCT/anti bullying. There have been eleven case managers and a similar number of ACCT assessors trained since the system was introduced. These recorded figures fall short of the suggested level to ensure the safe implementation of the system. It is of concern that the recorded figures of training do not reflect the actual figures of training.

   **The Governor must ensure that Wandsworth maintain an accurate and auditable record of the numbers of staff trained in suicide awareness and prevention, reflecting the true figures.**

7. Wandsworth have also delivered a 3-day course to a number of staff on 'Pro-social modelling', of which suicide prevention and awareness is a component.

## INVESTIGATION

8. The investigation was opened on 23 February 2005. My investigator, Mr Tom Wright, met with the Governor and the head of safer custody at Wandsworth. He was later given a comprehensive and helpful briefing on the events leading up to and after the man's death. Ombudsman's notices were then issued to staff and prisoners, identifying the scope of the investigation and inviting anyone whom wished to see the investigators to make themselves known. Staff and prisoners in key positions or locations were identified and were invited to speak to Mr Wright. All responded willingly and fully. The local branch of the Prison Officers' Association was briefed. They were helpful and offered constructive comment and advice.

9. Local police were contacted and they provided all the information at their disposal.

10. The investigator requested an independent clinical review from the local Primary Care Trust. They declined to review the clinical aspects of the man's care as they were not currently commissioning healthcare services at HMP Wandsworth.

11. A clinical review was, therefore, completed by Ms Jean May RGN on my behalf.

## FINDINGS

12. The man had contact with the psychiatric services over the years, which included various admissions to hospital. The consensus of opinion among those who treated him was that he suffered from a personality disorder rather than a psychotic illness. The man had a long criminal record. His were predominantly motivated by the need for money.

13. The man was arrested in early February 2003 and charged with robbery. He was remanded to HMP Wormwood Scrubs on 3 February. On 19 April 2003, he was found guilty of the charge and sentenced to four years imprisonment.

14. The man was well known at Wormwood Scrubs. He had been there no fewer than thirteen times before. At times, he exhibited odd behaviour. For example, he refused to have a mattress, and would set fires in his cell apparently to warm water. It is possible that these habits were related to the fact that he had been a street sleeper – and was therefore used to hard floors and to using fire to warm water and to cook.

15. Records suggest that the man was a person with whom it was difficult to communicate. While in prison, he often refused to cooperate in interviews with staff and health professionals.

16. Throughout his sentence, the man had regular contact with the prison healthcare department. He suffered from a chronic ulcerative condition of his leg that did not appear to respond well to treatment. The man also self harmed by cutting himself about the neck with sharp implements. These were not life threatening but did require medical attention.

17. On 16 November 2003, while at Wormwood Scrubs and awaiting treatment in the healthcare centre, the man took a prison nurse hostage. He grabbed her and held broken glass to her neck. He then took medicines from the drugs cabinet and later became unconscious.

18. The man said afterwards that he took this action in a premeditated way because he believed that his medical needs were not being fully met. He was subsequently charged by the police with the false imprisonment of the nurse. He received a further sentence of four years for this offence.

19. On 4 December 2003, while he was located in the segregation unit, an F2052SH (suicide and self-harm monitoring form) was opened. He appeared to be low in mood and was refusing food and exercise. He was also abusive to healthcare staff, complaining that his leg was still painful. At the F2052SH case review, the man denied he was on hunger strike, but was in pain and worried about his leg and therefore not hungry. He denied any thoughts of self harm and the document was closed on 17 December.

20. On 28 January 2004, the psychiatric outreach team at Wormwood Scrubs attempted to make an assessment of the man but he refused to be interviewed.

21. The man was transferred to HMP Brixton on 5 February, and then to HMP Wandsworth on 6 February.

**HMP Wandsworth**

22. On reception into HMP Wandsworth, a cell sharing risk assessment was completed and a decision was taken to allocate him to single cell accommodation.

23. The man was noted as being uncooperative and rude by wing staff, refusing to leave his bed at mealtimes. Generally, he did not speak to wing staff despite the efforts of some officers to engage him in conversation. His response to officers who spoke would often be to ignore them. If he needed something he would approach staff, but he would keep the exchange to the minimum level necessary.

24. The man was worried about an ulcer that he had on his leg, apparently the legacy of an earlier operation. It oozed and gave off an offensive smell. It did not seem to get any better with treatment over time.

25. On 11 February, the man was referred for treatment for self inflicted wounds to his neck. An ACCT document was opened by wing staff and he was re-located to healthcare. A referral to the community psychiatric nurse for review was made. During his nursing assessment, the following day the man told the nurse that he had in fact attempted to hang himself. The sheet that he used as a ligature had been tied to the cell door. However, it gave way and thus he had survived. The nurse appropriately decided to remove the long crepe bandage in his possession and replace it with a tubigrip, to reduce the risk of the bandage being used as a ligature.

26. The man co-operated to some extent with the 24 hour ACCT review, but declined to talk about his feelings in any depth. He said that he was feeling fine and that he wanted to return to the wing. At the healthcare admission assessment, the man was more open, and he disclosed that he was constantly having suicidal ideation, especially about hanging himself. He also spoke of hallucinations and thoughts of harming others. The interviewer was a psychiatric nurse who found that there was no evidence of overt psychotic symptoms. Further, it was thought that due to inconsistencies in the man's reporting of symptoms he might be feigning the signs of mental illness.

27. The man was returned to C wing, but remained the subject of the ACCT document. That same day he had a crepe bandage removed from him by a Principal Officer and a team of staff. They found that there was a dismantled door in the cell that had nails protruding from some parts, but there was no suggestion that the man

had been actively hostile or violent. It was noted, however, that he had expressed homicidal thoughts.

28. On 18 February, The man was transferred to D wing and was verbally warned by wing staff for setting fires in his cell to heat water.

29. On 4 March, the ACCT was closed following a review board during which the man expressed regret for his self harm which he admitted was deliberate.

30. Staff made negative entries about the man on his history sheet while he was on D wing. These were often about his habit of lighting fires in his cell. His lighter was removed in an attempt to stop him doing this and he was referred to the Community Psychiatric Nurse (CPN). The man refused to attend an interview with the consultant forensic psychiatrist from the Prison In-reach Team. Therefore, a CPN went to see him at his cell, where he told the nurse that he wanted no involvement with mental health services. No psychosis or mood disturbance was observed, so it was thought that no further action should be taken for the time being.

31. The man would throw his mattress out of his cell. When staff put it back he would throw it out again until eventually it was accepted that he preferred to sleep on the floor.

32. In common with the other prisoners on the wing, the man spent long periods in his cell without a television. Neither did he have a radio or cell hobby. He rarely took the opportunities for association or exercise and did not work.

33. Following a medical assessment on 23 April, he was allowed to have the crepe bandage on his leg again.

34. On 27 May, the man agreed to attend an interview with the consultant psychiatrist in order to pre sentence report where he denied having suicidal thoughts. She diagnosed the man as having a personality disorder that was not currently amenable to treatment.

35. On 18 June, he was seen by another psychiatrist. He refused to be interviewed and left the room. This psychiatrist went to his cell where, in a brief exchange with her, he denied having thoughts of self harm. Staff spoke to the consultant and reported the man as being someone who kept himself to himself and who became irritated when asked questions. The psychiatrist was concerned that he was at risk of self harm and so opened an ACCT. It was closed on 21 June.

36. The man's fire setting behaviour over the next few months is recorded in entries on his history sheet. He continued to be uncommunicative, having little interaction with staff or prisoners. His leg ulcer had not healed and he was receiving regular treatment from the healthcare centre staff.

37. On 29 November, the Prison In-reach Team requested an interview with the man which he refused. A team member went to his cell and spoke to him and found that there was no evidence of gross disturbance of his mental state. He denied that he had any problems and said that he did not need a psychiatrist. The man was advised how to contact the Prison In-reach Team if he felt the need.

38. The man had not been in prison employment at all up to this point, but had been allocated to the textiles shop on 29 November. He refused to attend. On 2 December, the man was issued with an Incentives and Earned Privileges Scheme first stage warning for declining to go to work. This meant that if he did not conform he ran the risk of being downgraded to the basic privilege level. The man told the officer who issued the warning that he would not go to work. The man refused to attend the Incentives and Earned Privileges Scheme board meeting and consequently was reduced to basic level on 6 January 2005.

39. This measure had no success in improving his conduct. It became clear that the downgrading of his status had had no effect on his non compliance and on 17 January he was reinstated to standard level. The board noted his bizarre behaviour and once again referred him to the Prison In-reach Team.

40. On 8 February, the man was visited at his cell by a doctor but was uncooperative saying that he did not need help.

41. Because of his worrying behaviour, wing staff once again referred him to the healthcare centre. He attended a mental health interview on 15 February, but walked out after a short time. The psychiatrist found him to be orientated and rational, and it was decided that no further action was required unless specifically indicated through the referral system.

42. On the evening of 17 February, the man went to the cell of another prisoner. The man was known to sometimes ask other prisoners for tobacco. The prisoner the man approached found him to be his normal timid and shy self and thought that he had no reason to be concerned about him.

43. An officer locked the door to the man's cell and as he did so said "good night" as he always did. The man unusually made the reply of "goodbye".

44. The night patrol officer reported no call from the man's cell that night.

**Discovery of the death**

45. At approximately 8.00 am, a prisoner was taking hot water to the cells on D4. When he got to cell 14, he saw the man hanging from the light fitting. He alerted two officers, who entered the cell.

46. One officer took the weight of the man's body and the other one went to collect the cut down kit. A third officer entered the cell and assisted them in cutting the man down. The body was stiff and cold and there were no signs of life. A Healthcare Officer advised the staff who had readied the mouth to mouth kit for use that there was nothing that they could do.

47. The ambulance was called at 8.05 am and arrived at 8.17 am. It left at 8.31 am. At approximately 8.45 am, the duty doctor arrived and pronounced death at 8.53 am.

48. The prison subsequently made contact with the man's next of kin – his sister.

## ISSUES

49. The man was never diagnosed as suffering from mental illness, but was well known to the psychiatric services in prison.

50. The evidence suggests that the man rarely spoke to wing staff and would look through them if they approached him on the landing or at his cell. Some staff made a point of speaking to him but he would not respond.

51. The man also suffered from a leg ulcer which did not seem to respond well to the treatment that he received while in prison. A crepe bandage supplied for the ulcer, had been issued by the healthcare centre but removed by healthcare staff and replaced with a tubigrip, as they were concerned that it might be used as a weapon or ligature. It was not returned to the man until healthcare professionals intervened after several weeks.

52. On 3 June 2004, the man was moved to D wing, and a previous cell sharing risk assessment was used. One part is dated 6 February 2004, the other 18 February 2004. While my investigator did not question the decision to locate the man in a single cell, it was noted that that important information on the form dated 6 February was in fact wrong. The tick box answers to the questions about drug taking, and whether he had ever been the subject of F2052SH, were both answered in the negative despite knowledge to the contrary. These errors on a cell sharing risk assessment are regrettable. It is obvious that they could have serious consequences in some circumstances.

    **The Governor should remind staff that, at each change of a prisoner's location, a new Cell Sharing Risk Assessment should be raised and the information recorded in it checked for accuracy.**

53. The man had been identified as a suicide risk and been the subject of three suicide prevention documents during this period of custody. The last of these documents – an ACCT that had been opened by the psychiatrist following her concern that he was at risk of suicide while "… withdrawn and not engaged in activities" – had been opened on 18 June and closed on 21 June 2004.

54. The ACCT had been closed without the 24 hour assessment interview having taken place, as the man had refused to be interviewed saying that he did not wish to speak to anyone. Furthermore there was no care map identified in accordance with ACCT procedures and there is no documentary evidence to support a review, at which the decision to close the document was taken. The closure does not appear to have been followed up with the required post-closure review. It seems odd that an ACCT opened at least partially because the man was withdrawn should be closed because he refused to communicate! The decision to close the ACCT was over seven months before the man's death and whilst not directly

connected to it, the failure to use the process correctly could be significant in other cases.

**The Governor should review the ACCT training programme to ensure, as many staff as possible are fully familiar with the system.**

55. On the day he was found hanging, the man was discovered by a prisoner delivering the morning hot water. Given the condition of the body, it is reasonable to suppose that the man died some hours earlier and therefore had been hanging at the times of the two required roll checks, conducted and signed for by staff. Given that the man was hanging from the light fitting, he was plainly in view through the hatch in the cell door. That fact, plus the likelihood that he had been hanging for some hours, calls the details of these roll checks into question. It is understood that the Governor of Wandsworth has commissioned an investigation into this matter.

56. The day after the man's death, a prisoner reported that on 17 February he had observed the man and an unnamed prisoner in an exchange during which it appeared that the man was being pressured to return borrowed tobacco. If this information is correct, it may have worried the man and could have contributed to his state of mind. The informant was not able to provide more details so this issue cannot be explored any further. There was no other indication that he was bullied by prisoners or was in debt.

57. My investigator noted that the light fitting in the man's cell was of a tamper proof design but still provided an obvious ligature point.

58. It was also noted that he spent long periods alone in his cell with nothing to occupy him. This too may have contributed to his state of mind while in prison.

59. The recorded training figures for ACCT at Wandsworth are low, as are the numbers trained in the related areas of suicide prevention and awareness.

60. The prison roll has been at or near operational capacity in recent times. Apart from temporary reductions in numbers related to refurbishment programmes, it is predicted to remain at this level for the foreseeable future. The 7% shortage of officers affects the regime offered to prisoners.

**Clinical review**

61. As noted, I commissioned my own Clinical Review following the decision of the local PCT not to contribute. The man's contact with the health care services at Wandsworth was reviewed in light of his medical needs.

62. The initial Reception Health Screening assessment noted that he appeared to be in good physical health. The drug/alcohol and psychiatric section of the

assessment revealed that he had a history of drug and alcohol abuse and suffered from depression. He was known to self harm and had attempted suicide on at least two occasions. The man was taking an anti depressant (Prozac 20 mgs) daily at this time. However, the prescription had been discontinued at the time of his death.

78. The man exhibited episodes of bizarre behaviour and serious deliberate self-harm attempts whilst in custody. Attempts were regularly made by the In-Reach team to review and assess the man. They were at times unable to effectively engage with him, due to his reluctance to participate or attend a number of consultations. Whilst the man was clearly exhibiting bizarre behaviours, for example setting fires in cell to heat hot water and sleeping on the floor, he did not want to engage with the mental health services.

79. Healthcare staff gave clinical treatment and care in relation to the man's physical health needs and well being, comparable to that which is available in the Community.

80. Documentation in the medical records was in my opinion at times very difficult to read, some entries are not signed and the designation of staff making the entries is not always evidenced.

    **Healthcare staff should be reminded of the requirements of accurate and contemporaneous record keeping in accordance with the requirements of the General Medical Council and Nursing and Midwifery Council. A clinical audit programme must be implemented to measure compliance against standards for records and record keeping.**

81. The medical records do not record what actions healthcare staff, following the discovery of the man, on the morning of the 18 February took. It is known from other sources, that the London Air Ambulance were in attendance and attempted resuscitation before the Medical Officer certified the death at 8.53am.

    **Records must be made following emergency interventions and recorded in the medical record. Attempts must be made to obtain a copy of the ambulance team log to support the record of clinical interventions.**

## CONCLUSIONS

63. The man was a quiet, self contained man, who did not seem to relate easily to others in prison – whether staff or prisoners. He suffered from a chronic medical condition which clearly bothered him. At times, he expressed dissatisfaction with the treatment he received for it.

64. The man often harmed himself by cutting and had been identified in the past as being at risk of suicide. However, the man was not covered by any formal suicide prevention measures at the time of his death. Nor had he given recent grounds for believing he was at special risk.

65. Given the man's character and typically withdrawn mood, it was difficult for staff or prisoners to notice anything unusual that might alert them if he was experiencing a personal crisis. He seemed to have a deep disregard for authority figures such prison officers and would only speak to them on rare occasions. The man did talk to some prisoners but he did not encourage relationships beyond short exchanges. Communication usually happened when he wanted tobacco from a prisoner or something from staff. Even on these occasions, no conversation of any depth seems to have occurred.

66. The man's treatment by wing staff seems to have been reasonable, given the difficulty of communicating with him. The landing officers on D wing made a point of speaking to him, but found themselves "blanked" by him. It is a reflection of their concern that they asked another prisoner to assist by keeping an eye on him because it was known that they would sometimes speak.

67. Poor communication amongst staff appears to have hampered the man's care, while he was on C wing. This may not have encouraged him in his subsequent dealings with staff on D wing.

**The Governor should remind staff of the importance of updating the wing history sheets with relevant information to aid communication. Random management checks of the accuracy of entries should be undertaken.**

68. The decision to close the ACCT of 18-21 June 2004 is open to question given the circumstances at the time. However, there is no reason to suppose that it would not have been closed subsequently and I see no direct link with the man's death some seven months later.

69. Three days before the man died, the In-reach Team had seen him. The man refused once again to engage with the clinical team, walking out of the interview.

70. In the aftermath of the man's death, the staff care team was alerted and an immediate "hot" debrief was arranged. This gave the opportunity for all those involved to contribute to the post incident review and learning process.

71. The lack of occupation for prisoners at Wandsworth is an issue of general concern that may have had some influence on the man's mood. It is understood that in cell electricity is being installed throughout the prison, enabling prisoners to have televisions and mains radios during the long hours of "bang up". This will enable all prisoners – but especially those who perhaps do not read very much – a potential diversion that will reduce boredom. This to be welcomed, but it is no substitute for work, education, programmes and access to association and the gym.

72. The recorded training figures for ACCT are unacceptably low, as are the numbers trained in the related areas of suicide prevention and awareness. It will not assist in ensuring that staff awareness of potential suicidal prisoners is kept high. Neither, will it contribute to the correct and safe operation of ACCT. The Area Suicide Prevention Co-ordinator believes the actual figures to be higher than the recorded figures.

73. Given the size of Wandsworth's prisoner population, it is unfortunate that staffing levels are 7% below complement. A full complement could ensure more activity and time out of cell for prisoners.

## RECOMMENDATIONS

### Operational

1. The Governor must ensure that Wandsworth maintain an accurate and auditable record of the numbers of staff trained in suicide awareness and prevention, reflecting the true figures.

2. The Governor should review the ACCT training programme to ensure, as many staff as possible are fully familiar with the system.

3. The Governor should remind staff that, at each change of a prisoner's location, a new Cell Sharing Risk Assessment should be raised and the information recorded in it checked for accuracy.

4. The Governor should remind staff of the importance of updating the wing history sheets with relevant information to aid communication. Random management checks of the accuracy of entries should be undertaken.

### Health

5. Healthcare staff should be reminded of the requirements of accurate and contemporaneous record keeping in accordance with the requirements of the General Medical Council and Nursing and Midwifery Council. A clinical audit programme must be implemented to measure compliance against standards for records and record keeping.
6. Records must be made following emergency interventions and recorded in the medical record. Attempts must be made to obtain a copy of the ambulance team log to support the record of clinical interventions.